PSYCHIATRY NOTES LEVEL VI MBCHB 2019

COMPILED BY NAILA KAMADI

JESUS CHRIST IS LORD

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A. TREATMENTS IN PSYCHIATRY: PHYSICAL & PSYCHOTHERAPY LEVEL VI 2019

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PHYSICAL TREATMENTS: ECT & OTHERS

BY: PROF
WANGARI
KURIA

BACKGROUND: HISTORY OF TREATMENTS IN PSYCHIATRY

- Mid 20th century → Insulin coma to treat morphine addiction and schizophrenia.
- 1930’s → Shock therapy (metronidazole)
- ECT → 1930s
- 1st antipsychotic → Chlorpromazine
- TCAs and MAOIs → 1950s
- Benzodiazepines (BDZs) → 1960s
- Psychoanalysis → 1st half of the 20th century

TYPES OF THERAPIES

THERE ARE 3 MODES OF TREATMENTS:

- PHYSICAL TREATMENT
- PHARMACOTHERAPY
- PSYCHOTHERAPY

A. ELECTROCONVULSIVE THERAPY (ECT)

- This is the treatment of particular psychiatric disorders by inducing seizures.
- It was developed by ***Cerletti & Lucio Bini*** in 1938.
- Initially **Cardiazol**, or just passing an electric current into the brain was done
- Now made safer with use of ***brief anesthesia*** & ***muscle relaxants***
- Other physical treatment: *Transmagnetic Stimulation*

OBJECTIVES

- Mechanism of action
- Development
- Indication
- Understand the procedure
- Adverse effects
- Contraindications

MECHANISM OF ACTION

- The induction of a ***bilateral generalized seizure*** is necessary for both the beneficial effects & adverse effects of ECT.

THEORIES EXPLAINING THE MOA:
(A) NEUROPHYSIOLOGICAL THEORY

- Studies have shown that during seizures, CBF, use of glucose & oxygen & permeability of the BBB increase. After the seizure blood flow & glucose metabolism is reduced.
- The theory indicates that the decrease in cerebral metabolism (***hypometabolism***) correlates with the therapeutic response.
  - It is interesting to note that during inter – Ictal periods in idiopathic epilepsy there is hypo – metabolism.
- ECT has an anticonvulsant effect since it ***increases the seizure threshold*** as treatment progresses.

(B) NEUROCHEMICAL THEORY

- Virtually every neurotransmitter is affected by ECT.
- ECT causes changes in the brain monoamine pathway by:
  1. Down regulation of the postsynaptic NE β-adrenergic receptors.
  2. Increased expression of D2 receptors
- The same receptor change is observed in treatment with antidepressants.

INDICATIONS OF ECT

- Major depressive disorder (MDD): benefit the most from ECT
- Acute schizophrenia → especially in patients with:
  - ***Positive symptoms, catatonia or affective symptoms***.
- Manic episodes not responding to mood stabilizers
- Medically ill who cannot tolerate other treatments
- Geriatric patients: as long as there is no contraindication to anesthesia
- Post – partum psychosis

MDD

- Patients who have failed medication trials or have not tolerated medications
- Patients with psychotic symptoms, failure to eat or drink
- Patients who are acutely suicidal or homicidal or have marked symptoms of agitation or stupor
- Depressed pregnant women who require treatment but cannot take medication
- In puerperium especially for breastfeeding mothers

CLINICAL GUIDELINES

- Obtain informed consent: This should include the discussion of the disorder, its natural course & the option of receiving no treatment.
- Standard physical neurological & pre - anesthesia examination should be done.
- Complete medical history should be available.

CONT.

- On going medications should be assessed for possible interactions with the induction of seizure or with drugs used during ECT e.g.
  - Benzodiazepines should be withdrawn because of their anticonvulsant activity.
  - Lithium carbonate should be withdrawn because it causes increased post - ictal delirium & prolonged seizure activity.
  - Anticonvulsants (according to half life)

PRE - MEDICATIONS

- NPO for 6 hours before treatment
- Check dentures & other foreign objects in the mouth
- Establish IV line
  - For stopping a convulsion if they go into status epilepticus
  - For resuscitation
  - For administering anesthesia
- Shave the head to allow electrode placement as hair is not a good conductor.
- Empty bladder before procedure.

PROCEDURE

- Insert <u>bite block</u> just before procedure to avoid biting the tongue during seizure
- Administer <u>100% oxygen</u> at a rate of 5L/min ***except during electrical stimulation***
- Emergency equipment for establishing of an airway should be available

DRUGS

- **Anticholinergic drugs** → mainly atropine 0.3 - **0.6 mg IM** is given 30 - 60 minutes before the procedure or 0.4 to 1 mg IV 2 - 3 minutes before anesthesia
- *Reasons:*
  - Minimize secretions
  - Block bradycardias

CONT.

- **General anesthetics**: Short acting anesthetic is given usually:
  - Propofol (preferred; easier to reverse)
  - Thiopental
  - Methohexital
  - Ketamine (sometimes): Although may cause psychotic episodes after anesthesia

CONT.

- Muscle relaxants
  - Succinylcholine: fast acting depolarizing blocking agent is used to minimize the risk of bone fractures & other injuries resulting from motor activity during seizure. (Dose ***0.5 - 1.0mg per kg***)
  - In patients with pseudo - cholinesterase deficiency, curare is used instead of succinylcholine.
    - For such patients they will have a history of prolonged paralysis post – operatively.

ELECTRODE PLACEMENT

- Bilaterally placed electrodes
  - Placed bifronto – temporally.
  - Each electrode has its center about ***one inch above the midpoint of an imaginary line drawn from the tragus to external canthus***.
- Unilaterally placed electrodes (not available)
  - One electrode is placed over the ***non – dominant fronto - temporal area***.
  - The other is placed on the ***non dominant centro - parietal scalp***, just lateral to the midline vertex.

DIFFERENCES BETWEEN BILATERAL & UNILATERAL PLACEMENT

- In general, bilateral placement of electrodes results in more rapid therapeutic response and unilateral placement results in less marked cognitive adverse effects in the first 1 – 2 weeks after treatment although that difference between placements is absent 2 months after treatment.

ELECTRICAL STIMULUS

- The electrical stimulus is provided by the ECT machine & will depend on the seizure threshold.
- The machines currently used can be adjusted to administer the electricity under conditions of constant current, voltage or energy
- The quality of current used in ECT can be described by ***Ohms law***
- Apply good ***conductor ge***l on electrodes to reduce. Shave the area of electrode placement if hairy.

OHMS LAW

- $E = IR$ or $I = E/R$
- Where E is voltage, I is current & R is resistance
- Resistance is synonymous with impedance in the case of ECT

CONT.

- Major determinants of resistance in ECT is contact of electrode with the body & the nature of the tissue e.g. hair is not a good conductor.
- Skull has high & brain low impedance

INDUCED SEIZURES

- Brief muscular contraction especially in the jaw & facial muscles occurs after electrical stimulation ***regardless of whether a seizure occurs***.
- The ***<u>first sign of a seizure is often a plantar extension</u>*** which lasts 10 - 20 sec & marks the tonic phase.
- The tonic phase is followed by rhythmic (clonic phase) contractions that decrease in frequency and finally disappears.
- EEG shows marked activity

IF SEIZURE IS MISSED:

- Check whether there is power (*in our set up*).
- Check contact between electrodes & skin
- Increase intensity of stimulus (*ordinarily 4 – 6s is enough but this may need to be added*)
- Review any medications that should have been stopped.
- NB: *Prolonged seizures or status epilepticus can be terminated by diazepam*

NUMBER & SPACING OF ECT EPISODES:

- Usually administered 2 – 3 times a week on alternate days. Patients in our set up improve sooner.
- Major depressive illness → 6 – 12 treatments
- Manic episodes →8 – 20 treatments
- Schizophrenia → 15 treatments
- Catatonia → as few as 1 treatment

POINT OF MAXIMUM THERAPEUTIC RESPONSE

- Patient should be treated until they achieve the maximum therapeutic response.
- The point of maximal improvement is usually thought to be ***that point at which a patient fails to continue to improve after 2 consecutive treatments***
- Treatment past this point does not result in any therapeutic benefit ***but increases severity and duration of side effects***.

MAINTENANCE TREATMENT

- Maintenance ECT treatments (weekly, biweekly or monthly) have been reported to be effective in relapse prevention.
- Indications for this maintenance treatments are:
  - Rapid relapse after initial ECT
  - Severe symptoms
  - Inability to tolerate medication e.g. prone to fatal side effects e.g. NMS

FAILED ECT TRIAL

- If patient fails to improve after ECT he should be ***treated with drugs that failed in the past***.
- Data indicates that <u>after failed ECT they respond to previously failed medications</u>.
  - May be due to improved BBB impermeability.

CONTRAINDICATIONS TO ECT

- There are no absolute contraindications
- ***NB: Pregnancy is not a contraindication***

Risk Patients

- SOL e.g. brain tumor because of risk of ***edema & brain herniation after ECT***
- Patients with increased ICP (e.g. cerebro – vascular diseases, aneurysms) because of risk of cerebral bleeding
- Patients with lateralizing signs
- Recent myocardial infarction
- Uncontrolled HTN

ADVERSE EFFECTS

- Retrograde & anterograde ***amnesia*** is the commonest side effect. This is transient & memory returns to normal within 6 months.
- ***Mortality***: 0.01% of each patient. This compares with the risk associated with general anesthesia
- ***Brief disorientation/ confusion*** within 30 minutes of the seizure in 10% of patients
- ***Delirium*** especially in patients with ***co-existing neurological disorders*** (re – evaluate patient; do EEG)
- ***Headache***

CONCLUSION

- ECT is safe & effective treatment of patients with major depression, manic episodes & other serious mental disorders.

B. NEUROSURGERY FOR MENTAL DISORDERS

- Began in 1936 → work of Moniz – Nobel prize in 1949
- Controversial
- Indications
  - Severe mood disorders, OCD, severe anxiety disorders
  - Patient must want the operation
  - All reasonable Rx have completely failed
  - Patient remains ill but has capacity to provide consent

CONT.

- Stereotactic procedures used include
  - Sub-caudate tractotomy
  - Anterior cingulotomy
  - Limbic leucotomy
  - Anterior capsulotomy
- A/E
  - Operative mortality, hemorrhage, hemiplegia, epilepsy, personality changes

C. LIGHT THERAPY

- Rx of seasonal affective disorder
- Used to ameliorate symptoms of winter depression due to effects on circadian and seasonal rhythms
- Administered using light box, 2 hours/20 minutes a day for 1-3 weeks
- Dawn stimulating alarm clocks
  - Light fills the room when it’s supposed to be dawn

D. REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS)

- Used for Rx of **resistant depression**
- No longer experimental
- An electromagnetic coil is placed on the scalp, pulses of current then produce a powerful magnetic field.

PSYCHOTHERAPY LEVEL VI MBCHB 2019

COMPILED BY NAILA KAMADI

TYPES

- General overview on types, indications & contraindications of psychotherapy (Check Dr. Kumar's pdf notes in 4th yr.)
- Behavior Therapy (slide 46)
- Cognitive Behavior Therapy (slide 101)
- Group Therapy (slide 163)
- Solution Focused Therapy (slide 190)
- Family Therapy (slide 227)
- Psychoanalysis (check Dr. Kumar's pdf notes in 4th yr.)
- Crisis consultation intervention (slide 260)
- Individual Psychotherapy (slide 286)
- Biofeedback (slide 302)
- Marital Therapy

BEHAVIOR THERAPY

OBJECTIVES

1. ***Define*** behavior therapy.
2. Understand the ***principal*** behind behavior therapy.
3. ***Outline*** behavior therapies.

HISTORY

- **J. B. Watson** emphasized the overriding importance of the environmental events, rejecting covert aspects of the individual.
- He claimed that all behavior could be understood as a result of learning (Nature vs. Nurture).

DEFINITION OF BEHAVIOR THERAPY

- This treatment ***aims at modifying faulty behavior:***
  - The therapy is based on the fundamental belief that ***persistent maladaptive behaviors and anxieties have been conditioned (learned)*** & treatment therefore involves ***deconditioning.***
  - The therapy should be directed at ***specific delineated habits.***

CONT.

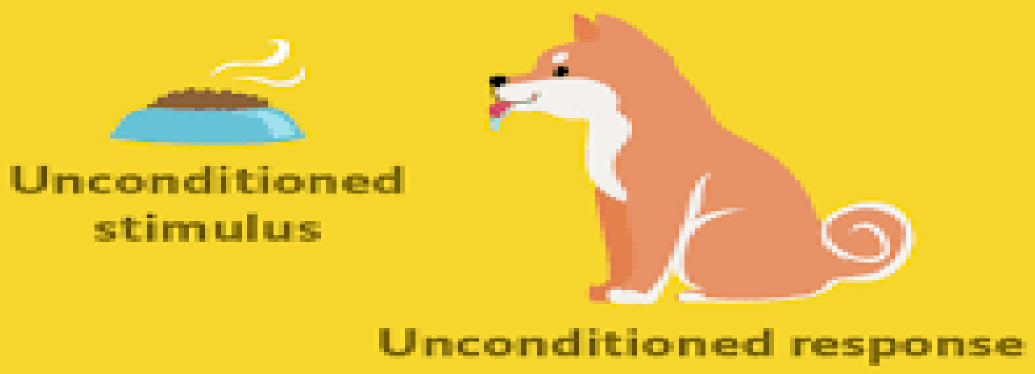
- Instead of probing the unconscious or exploring the patient's thoughts & feelings, the behavior therapist tries to eliminate the symptoms & modify ineffective or maladaptive patterns by applying basic learning techniques.

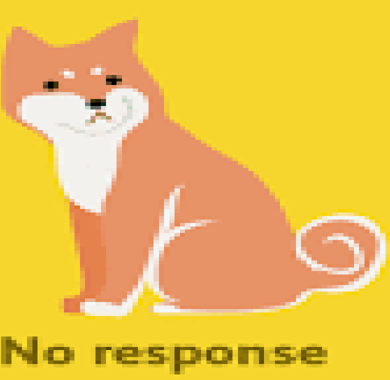
CONT.

- Behavior therapy is based on principals of learning theory particularly:
  1. Classical conditioning by Ivan Pavlov
  2. Operant conditioning by B. F. Skinner

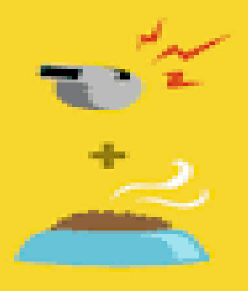
CLASSICAL CONDITIONING BY IVAN PAVLOV

Before Conditioning





During Conditioning



After Conditioning

CONT.

1. Before conditioning:
   - Unconditioned Stimulus, UCS (food) elicits an unconditioned response UCR (salivation)
   - Neutral stimulus, NS (bell) elicits no response.
2. During conditioning: UCS + NS = UCR
3. After conditioning: CS (Bell) elicits CR (salivation)

OPERANT CONDITIONING BY B. F. SKINNER

- ***B.F Skinner & the rat experiment***
  - Rat rewarded with food for pressing on a rod. The rat learned to press on the rod to receive food.
  - In another experiment the Rat was punished (electric shock). The rat learned to avoid the electric rod

Operant Conditioning

Specific consequences are associated with a voluntary behavior

Rewards introduced to increase a behavior

Punishment introduced to decrease a behavior

verywell

Positive Reinforcement

FREDDY IS HAPPY TO
HAVE GOT SOMETHING NICE

FREDDY IS DISAPPOINTED TO
HAVE LOST SOMETHING HE LIKES

FREDDY IS UPSET TO HAVE
EXPERIENCED SOMETHING NASTY

Positive Punishment

FREDDY IS RELIEVED TO HAVE ESCAPED
OR AVOIDED SOMETHING NASTY

Negative Reinforcement

www.fedupfred.com

DETERMINE THE FOLLOWING BEFORE AND DURING THERAPY:

1. What are the problems & goals for therapy?
2. How can progress be measured or monitored?
3. What environment contingencies are maintaining the problem?
4. Which interventions are likely to be effective?

GOALS OF BEHAVIOR THERAPY

- It is fundamental to behavior therapy that the patient should have the major say in setting treatment goals.
- It is important that the patient is fully informed & consents to & participates in setting goals.
- The therapist should:
  - Provide direction to therapy
  - Provide a basis for selecting & using strategies & interventions
  - Provide a framework for evaluating the outcome.

PROCESS OF SETTING GOALS

1. The therapist explains the purpose of goals.
2. Patient specifies the positive changes desired as a result of the therapy.
3. Together they explore whether the goals are realistic.
4. They discuss advantages and disadvantages of the goals.
5. On the basis of the information obtained about client – stated goals, the counselor and the client make one of the following decisions: to continue counseling, to reconsider the client's goals, or to seek a referral.

ADVANTAGES OF GOAL SETTING

- It increases the chances of making the counselor/client alliance operational.
- It emphasizes the importance of their active participation in the process, rather than fostering an attitude of being a passive spectator.
- It is the basic link between whatever therapeutic procedures or techniques are used and the concrete goals of the client.

THERAPIST’S FUNCTION & ROLE

- Behavior therapists must assume an active, direct role in treatment.
- Behavior therapists function as teacher, director, and expert in prescribing curative procedures that will lead to improved behavior.

CONT.

- Use techniques such as summarization, reflection, clarification & open – ended questions.
- They focus on specifics, systematically getting information about specific *antecedents*, the dimensions of the problem behavior, and the *consequences* of the problem. (Goldried & Davison, 1976)

MODELING TECHNIQUES

- The therapist's role is also modeling behavior for the client.
- Because clients often view their therapist as worthy of emulation, they pattern attitudes, values, beliefs, and behavior after him or her.
- Therapists need to be aware of the power they play in this process.

RELATIONSHIP BETWEEN THERAPIST & CLIENT

- Exemplified by warmth, empathy, authenticity, permissiveness, and acceptance as necessary but not sufficient conditions for behavioral change.
- Behavior therapists are more self-disclosing when it benefits the motivation of the client.

BEHAVIOR THERAPY TECHNIQUES

1. Systemic desensitization
2. Graded exposure
3. Flooding/ implosive therapy
4. Aversion therapy
5. Assertiveness & social skill training
6. Cognitive Behavior Therapy
7. Behavioral modification
8. Positive reinforcement: response shaping, modelling, token economy

1. SYSTEMIC DESENSITIZATION

- Developed by ***Joseph Wolpe***
- It is based on the behavioral principal of ***counter conditioning***, which states that: a person can overcome maladaptive anxiety elicited by a situation or object by approaching the feared situation gradually & in a psycho physiological state that inhibits anxiety.

CONT.

- The objective of the therapy is to reduce or eliminate fear or anxiety whereby the therapist trains the patient in **deep muscle relaxation.**
- In systematic desensitization the ***patient attains a state of complete relaxation*** & is then exposed to the stimulus that elicits an anxiety response. The negative reaction of anxiety is then inhibited by the relaxed state, a process called ***reciprocal inhibition***.

SYSTEMATIC DESENSITIZATION COMPRISES OF 3 STEPS

1. Relaxation training
2. Hierarchy construction
3. Desensitization of stimulus

HIERARCHY

- In hierarchy, the patient & therapist prepares a graded list of hierarchy of anxiety provoking scenes associated with the patients’ fears (specific phobia e.g. fear of death, animals etc.)
- These are placed in order from the strongest to the weakest cause of anxiety in the patient.

DESENSITIZATION

- Desensitization of stimulus is done by having the patient proceed through the list from the least anxiety – provoking scene to the most anxiety – provoking one while in deeply relaxed state.

USE OF DRUGS

- Drugs have been used to hasten desensitization; Examples of such drugs are:
  - Sodium Methohexital
  - Diazepam
- The advantages of pharmacological desensitization is that ***training in relaxation is shortened & treatment is shortened***.

INDICATIONS

- It is indicated for an identified anxiety – provoking stimulus e.g.
  - Phobias
  - Obsessions
  - Compulsions
  - Certain sexual disorders

2. GRADED EXPOSURE

- This is similar to systematic desensitization except that training relaxation is not involved and treatment is usually carried out in real life context.

3. FLOODING

- This is based on the fact that ***escaping from anxiety provoking situation reinforces the anxiety through conditioning***. Thus by not allowing patient to escape, the anxiety is extinguished & the conditioned avoidance behavior prevented.
- Its basis is the opposite of that of systemic desensitization.

CONT.

- The patient is encouraged to confront a maximum – intensity anxiety – provoking stimulus directly either in imagination or in real life. There is ***no gradual build up*** as in systematic desensitization or graded exposure. ***No prior relaxation exercise is involved.***

CONT.

- The success depends on patient remaining in the fear – generating situation until they are calm & feel no actual danger. Escape before this tends to reinforce the conditioned anxiety & avoidance behavior.

A VARIANT OF FLOODING: IMPLOSION

- A variant of flooding is called ***implosion*** in which the feared object or situation is confronted ***only in imagination rather than in real life***.
- The compliant is poor because of psychological discomfort involved. ***It is also contraindicated in whom intense anxiety would be hazardous*** e.g.
  - Patients with cardiovascular disease
  - Patients with fragile psychological adoption.
- The technique works for specific phobia.

EXAMPLE

- John has developed intense phobia of a lizard.
- During psychotherapy session suddenly the therapist puts a rubberized lizard on the table. For a minute the patient may get scared but gradually may start handling a rubberized lizard while talking.

4. AVERSION THERAPY

- In Aversion therapy a noxious stimulus (punishment) is presented immediately after a specific behavioral response.
- The patient therefore is conditioned to avoid an undesirable behavior or symptoms by associating them with painful or unpleasant experiences.
- Coupling of the negative stimulus with the undesired behavior ultimately suppresses the latter.

THE NOXIOUS STIMULI MAY BE:

- Putting a bitter taste on nails or tongue for nail biting
- Giving medication like apomorphine which causes nausea and vomiting on taking alcohol
- An electric shock to treat a child with enuresis.
- Corporal punishment
- Social disapproval

INDICATIONS OF AVERSION THERAPY

- Alcohol abuse
- Transvestisim
- Compulsive unacceptable social behavior like homosexuality & other sexual deviations e.g.
- Paraphilia
- Other behavioral adaptations with compulsive or impulsive qualities.

CONT.

- Aversion therapy is controversial in that punishment does not always lead to a decrease in response & sometimes may positively reinforce (change).
- Typically, 20 – 40 session are given, with each session lasting about 1 hour. After completion of treatment, booster session may be given

5. ASSERTIVENESS & SOCIAL SKILL TRAINING

- To be assertive requires that person have confidence in their judgments & sufficient self – esteem to express their opinions.
- Social skills training also deals with assertiveness but also attends to a variety or real life tasks such as food shopping, looking for work interacting with other people and overcoming shyness.

CONT.

- A behavior therapy technique in which the patient is given training to bring about changes in emotional & other behavioral patterns by asserting him/herself.
- One is encouraged not to be afraid of showing an appropriate response, negative or positive, to an idea or suggestion.
- The assertive behavior training is given by the therapist first by role playing & then by practice in a real life situation.
- This is used to discourage students to experiment with drugs or antisocial behaviors.

CONT

- Attention is focused on more effective interpersonal skills.
- The most common technique used in assertiveness training is ***behavioral rehearsal***, in which the patient acts out problematic interpersonal interactions with the therapist.
- After this role – playing, specific maladaptive behavior are identified & the client behavior can be adapted.
- This training can be used for clients with **bulimia nervosa & major depression**; as well as the mentally healthy & mentally ill persons.

6. COGNITIVE BEHAVIOR THERAPY

- It is a psychotherapeutic approach based on the idea that emotional problems in an individual arise due to faulty ways of thinking & distorted attitude towards oneself & others.
- The therapist takes the role of a guide who helps the patient to correct & revise his perceptions & thoughts.
- This helps the patient to change his thoughts, feelings & behavior about himself.
- Cognitive behavior therapy is considered effective in the treatment of **depression & adjustment difficulties**.

7. BEHAVIORAL MODIFICATION/ SIMPLE EXTINCTION

- Learned behavior pattern disappears if it is not reinforced.
- To eliminated a maladaptive behavior one has to remove the reinforcement for it.
- It is effective when reinforcement is being used without the knowledge of the affected individual

8. POSITIVE REINFORCEMENT

- If a behavioral response is followed by a generally rewarding effect it is strengthened & it occurs more frequently than before reward. The reward may be food, avoidance of pain or praise.
  - E.g. as soon as an infant gets up & walks, the mother claps & gives the infant a piece of chocolate to enjoy.
- This is successful especially in mental patients who are rewarded for certain desired behavior with tokens, i.e., **token economy.**
- A positive relationship between the clinician and patient is important.

TECHNIQUES OF POSITIVE REINFORCEMENT

a. Responsive shaping
b. Modelling
c. Token economy

A. RESPONSIVE SHAPING

- Positive reinforcement is used in response shaping or incorporating or establishing a response which is not existing in an individual's behavior.
- This technique is used in a behavior problem or mental retardation.

B. PARTICIPANT MODELLING/ OBSERVATION LEARNING

- Modelling is a behavior therapy technique in which ***learning occurs through observation/ imitation***.
- The client watches someone else perform a particular action such as answering telephone.
- Models are often parents or other adults & children
- Modelling is a form of social learning & is often called ***observation learning***.

CONT.

- It may be used in phobia especially in children who can be put together with those of the same age and sex and then approach the anxiety – provoking situation.
- In adults the therapist may act out variants of the procedure is called ***behavior rehearsal*** in which real-life problems are acted out under the therapist's observation or direction.
- Indications: Job interviews, Shyness

C. TOKEN ECONOMY

- It is a behavioral therapy program usually conducted in a hospital or classroom setting.
- In token economy the desired behavior is reinforced by offering tokens that can be exchanged for special food, games, comics or other rewards.
- For example; a patient with schizophrenia does not maintain personal hygiene. The day he maintains he gets a token as a reinforcer that he can watch T.V. when he desires. Like this he is able to collect many tokens & adapt behavior which is socially acceptable. like maintaining personal hygiene. Sometimes in return of tokens the patient may ask for parole money & this is usually discouraged.

BEHAVIOR THEORY OF PERSONALITY

- **Discrimination:** responding differentially to stimuli that are similarly based on different cues or antecedent events.
- **Extinction:** the process of no longer presenting a reinforcement. It is used to decrease or eliminate certain behaviors.

SOCIAL COGNITIVE/ LEARNING THEORY

- **Albert Bandura** believed that behavior was based on 3 interacting systems:
  - External stimulus
  - External reinforcement
  - Cognitive mediational process (most important)

CONT.

- Reciprocal determinism: Psychological functioning involves a reciprocal interaction among 3 interlocking sets of influences:
  - Behavior
  - Cognitive processes &
  - Environmental factors

OBSERVATIONAL LEARNING CONCEPTS

- **Observational learning:** a type of learning in which people are influenced by observing the behaviors of others.
- **Covert behavior:** behavior that others cannot directly perceive such as thinking or feeling.

CONT.

- **Attentional processes:** The act of perceiving or watching something and learning from it.
- **Retention processes**: This basically refers to remembering that which has been observed.
- **Motor reproduction processes**: This refers to translating what one has seen into action using motor skills.

CONT.

- **Motivational processes:** For observations to be put into action and then continued for some time, reinforcement must be present. Reinforcement brings about motivation.
- **Self – Efficacy**: The individual's perceptions of their ability to deal with different types of events.

CONCLUSION

- Behavior therapy is an important treatment in various conditions including:
  - Substance abuse
  - Anxiety disorders esp. phobia
- It is important to specify the behavior targeted for change

COGNITIVE BEHAVIOR THERAPY (CBT)

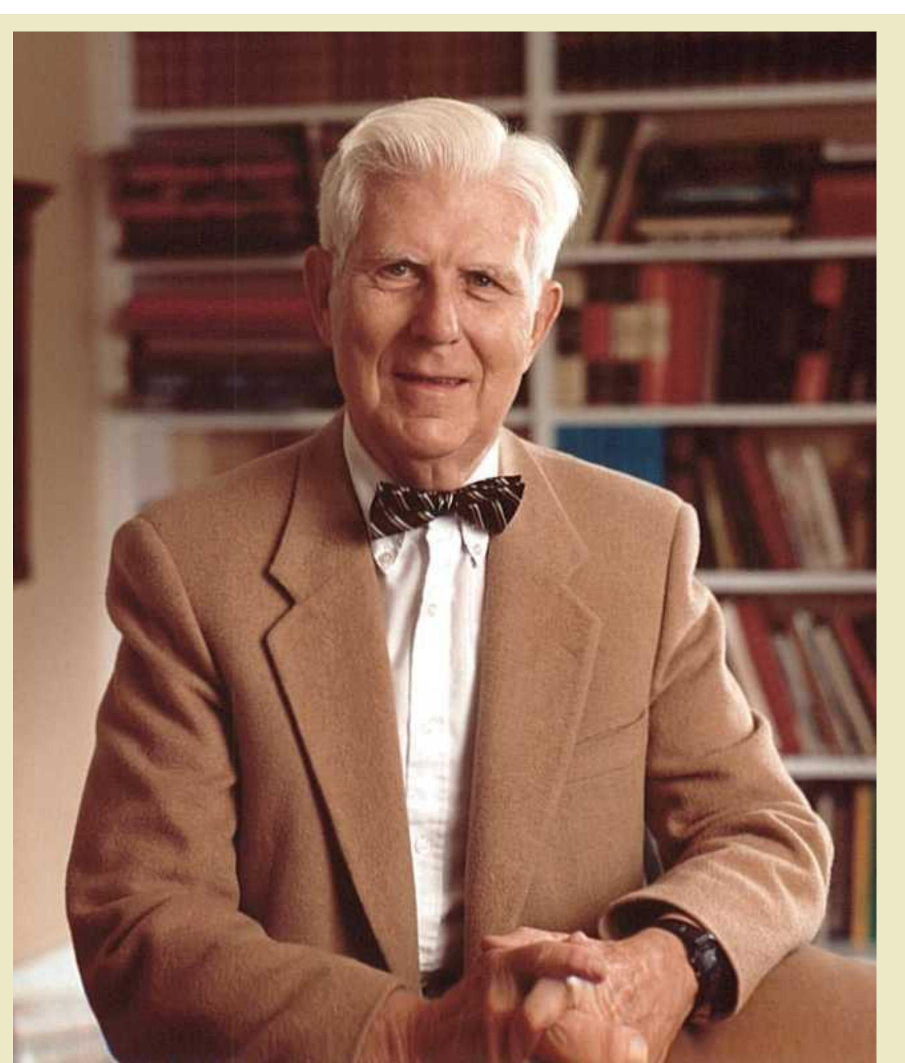
JAN/9/2019

INTRODUCTION

- The term ‘CBT’ has evolved into a generic term to include a whole range of cognitively – oriented psycho – therapies & is also used to refer to the category of cognitive therapies including:
  - **Beck’s specific variation of the CBT model**
  - Ellis’ Rational Emotive Behavior Therapy (REBT)
  - Among other approaches.

AARON BECK

- A Philadelphia psychiatrist who was originally trained as a psychoanalyst. His approach to mental disorders emphasizes ***the importance of cognitive thinking, especially dysfunctional thoughts***.
- Found that cognitive therapy is effective as a short – term treatment for ***depression*** and ***GAD.***



CONT.

- Proposed that psychological issues arise because of:
  - Engagement in faulty thinking.
  - Making incorrect inferences on inadequate or incorrect information.
  - Failing to distinguish between fantasy & reality.

HISTORICAL BACKGROUND OF CBT

- Psychologist Aaron Beck developed the CBT concept in the 1960s.
- CBT is linked philosophically to the concepts of the Eastern schools of thought such as ***Taoism*** and ***Buddhism*** and ***Greek Stoic*** philosophers.
- Epictetus, Greek philosopher, observed that ***people are not disturbed by things that happen but by the view they take of things that happen***.
- CBT is based on the scientific fact that ***our thoughts cause our feelings and behaviors***, not external things, like people, situations & events.

CONT.

- CBT is a system of psychotherapy based on the concept that ***emotions & behaviors result primarily from cognitive processes***; & that ***it is possible for human beings to modify such processes to achieve different ways of feeling and behaving***.
- CBT teaches one how ***certain thinking patterns cause symptoms*** — by giving one a distorted picture of what's going on in their life & making one feel anxious or depressed or provoking ill – chosen actions.
- CBT ***aims at changing the way of thinking & is directed primarily at modifying maladaptive cognitions and related behavioral dysfunction***.

CONT.

- Aaron Beck's cognitive therapy is directed towards changing the clients' ***maladaptive cognition***.
  - Goal: to change the way clients think by:
    - Detecting & recognizing negative thoughts
    - Reality testing
    - Kinship with behavior therapy
- The behavioral & cognitive approaches have tended to merge & are called **CBT**.

CONT.

- CT also incorporates theories of & treatment methods of behavior therapy. Behavioral procedures such as ***graded task assignments***, ***exposure***, ***social skill training*** and ***activity scheduling*** play a fundamental role in CT.
- When cognitive therapy & behavior therapy are combined into cognitive behavioral therapy (CBT), modifying cognition through the use of cognitive & behavioral techniques can lead to productive change in dysfunctional emotions and behaviors.

CONT.

- CBT is designed to address ***unrealistic thinking and outcome expectations*** associated with depression.
- Uses verbal techniques to investigate the ***reasoning behind specific attitudes/ assumptions***.
- Client is taught to recognize, monitor & record negative thoughts on a daily record.
- Beck recommends first including behavioral techniques:
  - Using pleasurable activities for reinforcement.
  - Breaking tasks into simple steps.
  - Providing assertiveness training.
  - Guidance in role – playing & mental rehearsal

THE GENERAL COGNITIVE MODEL

Automatic thoughts & images

Reaction: emotional, behavioral & psychological

BECK'S VIEWS OF THE ROOTS OF DISORDERS

Negative thinking

- Blame setbacks on personal inadequacies
- Focus selectively on negative events
- Make unduly pessimistic projections about future
- Draw negative conclusions about personal worth

→ Increased vulnerability to depression

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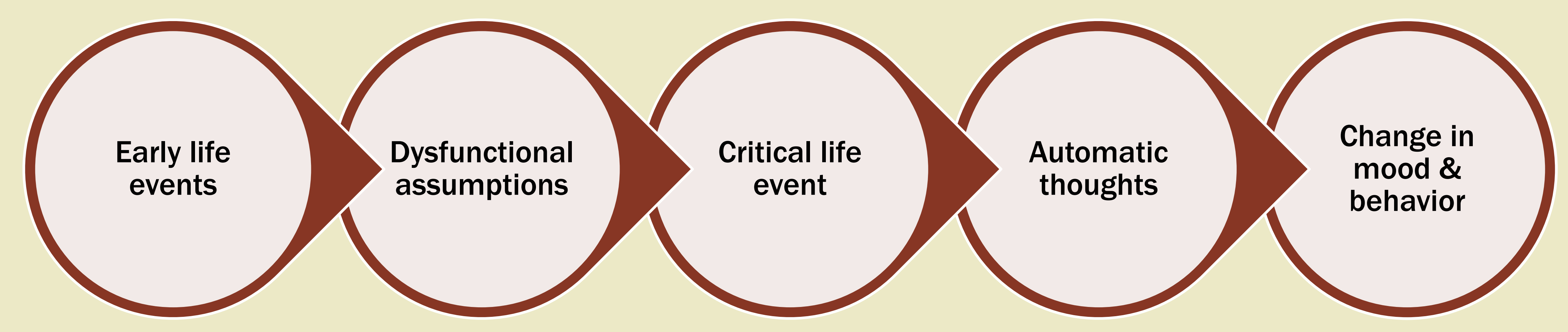
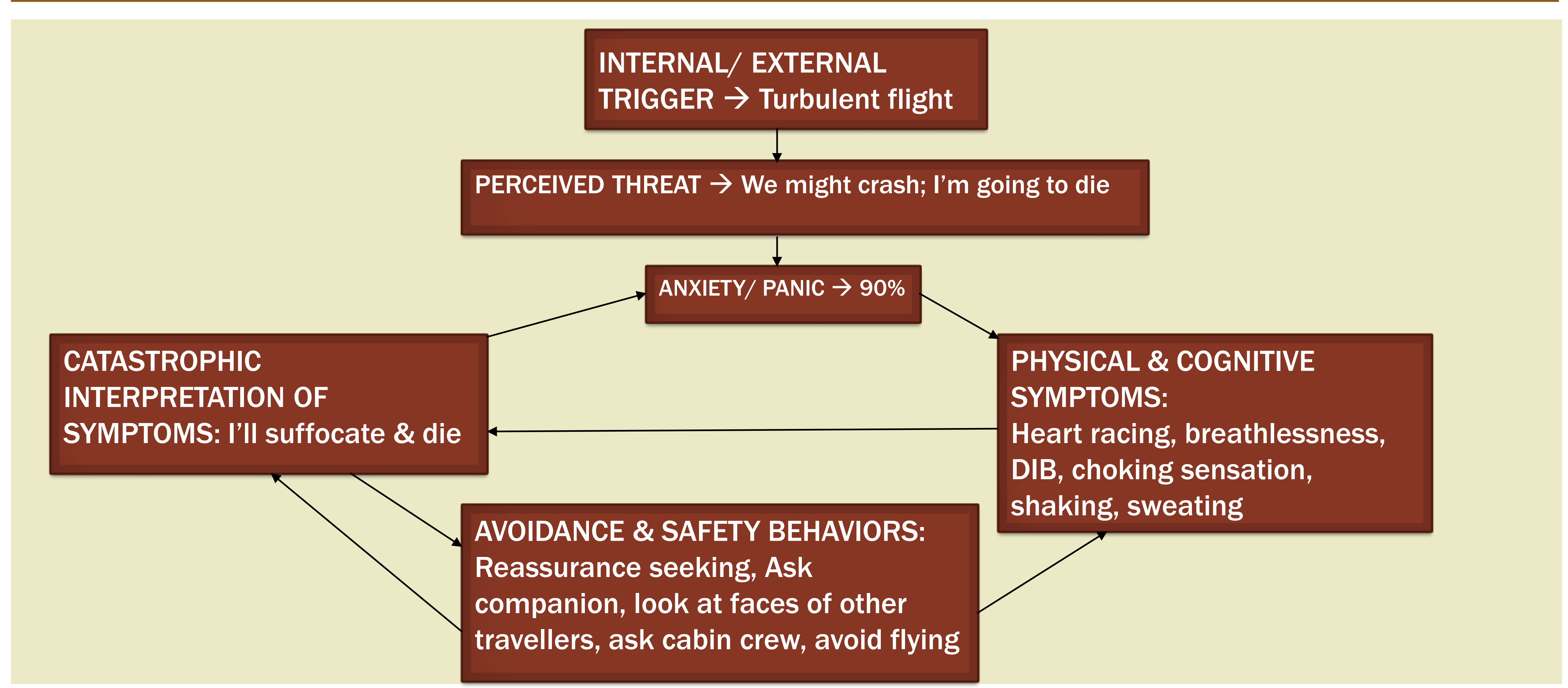
BECK'S THEORY

- Depressed people have a negative view of:
  - Themselves
  - The world
  - The future
- Depressed people have negative schemas or frames of reference through which they interpret all events & experiences.

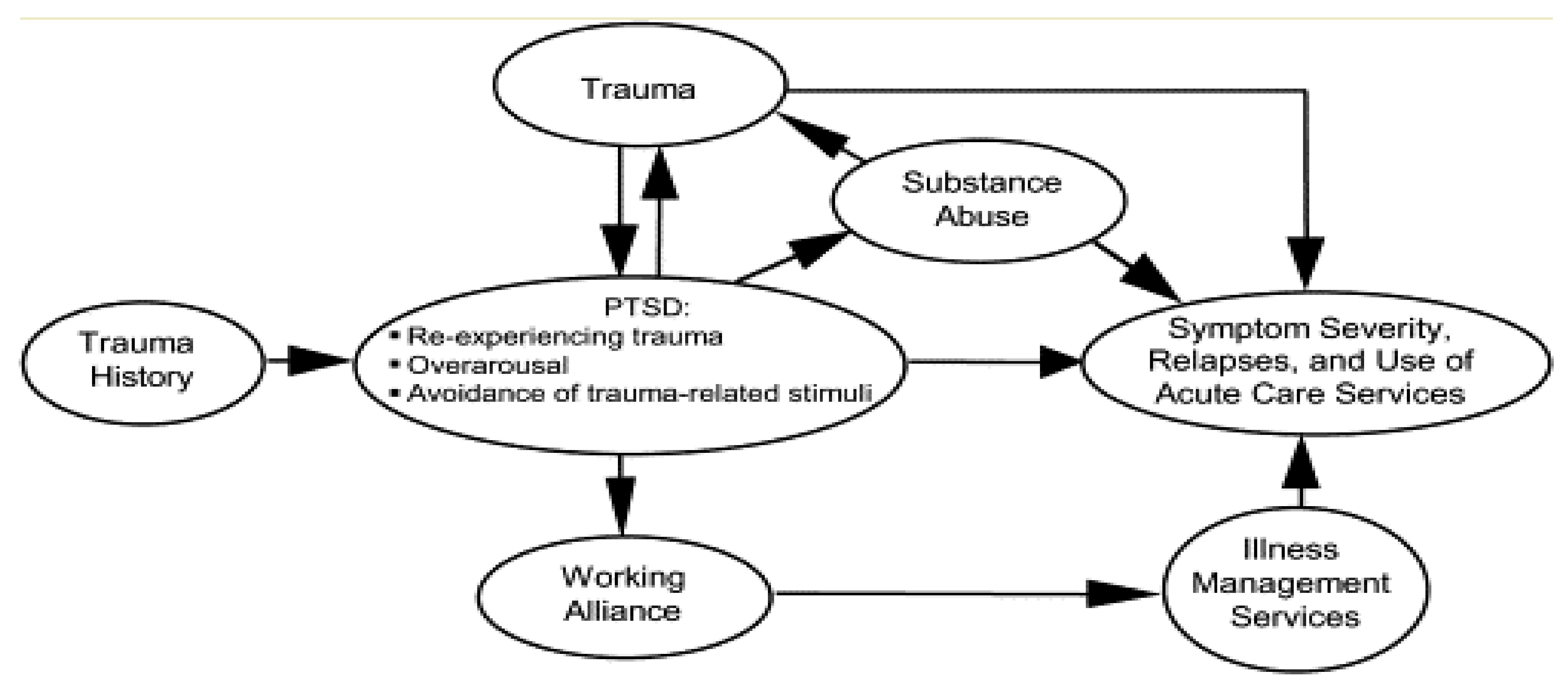
BECK'S MODEL FOR DEPRESSION



COGNITIVE MODEL FOR PANIC



INTERACTIVE MODEL OF TRAUMA, PTSD & SMI (MUESER ET. AL. 2002)



GOALS OF BECK'S CBT

1. Change the way clients think by restructuring their automatic thoughts & schema, i.e.:
   - Deactivating them
   - Modifying their content
   - Constructing more adaptive modes
2. Gather & weigh evidence
3. Discriminate between thoughts & reality
4. Behave in a way that is congruent with healthier, realistic ways of thinking.

OVERVIEW OF CBT

- Short term, time – limited psychotherapy: 20 sessions over 10 – 15 weeks
- The CBT approach is:
  - Collaborative (builds trust)
  - Active
  - Based on open – ended questioning
  - Highly structured & focused

CONT.

- Comparable to scientific investigation:
  - Collecting data (events, thoughts, feelings)
  - Formulating hypotheses based on data
  - Testing and revising hypotheses (i.e. thinking patterns) based on new information

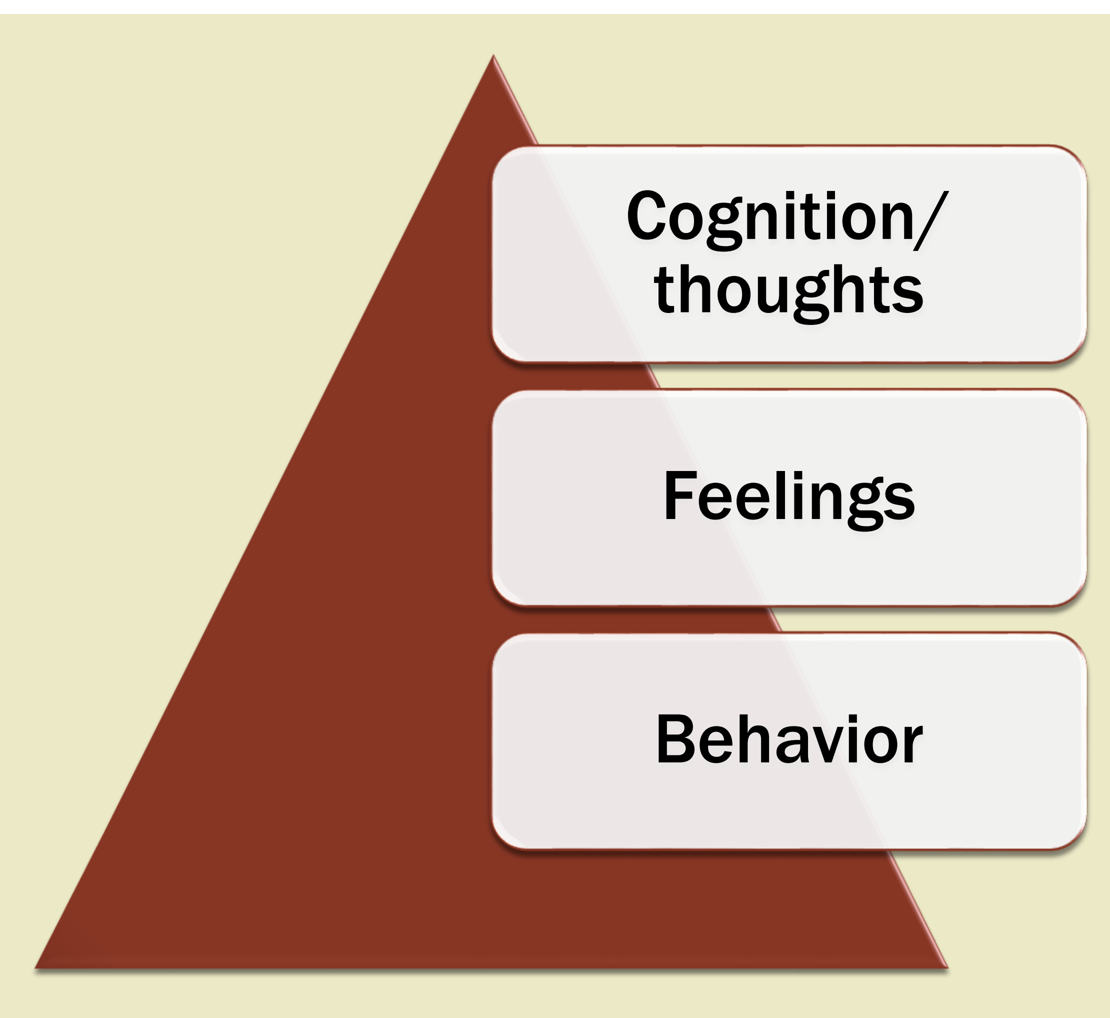
CONT.

- CBT is a system of psychotherapy based on theories of pathological processing in mental disorders. It is based on the concept that **emotions & behaviors result primarily from cognitive processes** & that **it is possible for human beings to modify such processes to achieve different ways of feeling and behaving.**

CONT.

- According to CBT mental health problems happen when people exhibit maladaptive & extreme patterns of thinking and behavior. CBT teaches one how certain *thinking patterns* cause symptoms — by giving one a distorted picture of what's going on in their life and making one feel anxious or depressed or provoking ill – chosen actions.
- Therefore, CBT is aimed at **changing the way of thinking**. Treatment is directed primarily at modifying distorted or mal – adaptive cognitions and related behavioral dysfunction.

THE CBT TRIAD



THE 3 PROPOSITIONS OF CBT

Cognitive activity **affects behavior**

Cognitive activity **may be monitored and altered**

Desired behavior change may be effected through cognitive change

HOW DOES COGNITIVE ACTIVITY AFFECT BEHAVIOR?

- There is evidence that cognitive appraisal of events can affect response to those events.
- There is clinical value in modifying the content of some of these appraisals. As clinicians, our aim is to gain access to the cognitive activity, recognize & assess dysfunctional thinking patterns & help the clients to change them.
- This may be achieved by identifying & altering the underlying beliefs or assumptions that predispose the individual to engaging in faulty thinking patterns.

GENERAL CLINICAL PRINCIPLES OF CBT

- Engagement
- Assessment/Exploration
- Psycho education regarding the problem
- Application of specific techniques, geared both to the individual and to the problem
- Monitoring & evaluation, followed by modification of approach as necessary

CONT.

- There being several psychotherapy treatment modules, always remember to assess the patient so as to determine whether CBT is the ideal treatment module.

PRINCIPLES IN APPLICATION OF CBT TECHNIQUES

- Collaborative Therapist Stance
- Encourage Empiricism
- Problem – Solving Approach

STRUCTURE OF A TYPICAL CBT SESSION

- ***Assess*** mood (subjective & objective reports) & ***review*** recent events.
- Collaboratively set an ***agenda*** for the session.
- Review ***homework from the previous session***; ***reinforce progress.***
- Discuss "***issues & incidents***" on the agenda
- Introduce or review ***specific skill or "module"*** to address these concerns.
- Formulate a ***homework task***, identify factors that may interfere with successful completion
- Help patient to summarize main points and conclusions
- Discuss thoughts and feelings about the session

SESSIONS 1 & 2

- Establishing rapport
- Providing reassurance
- Reviewing the problem list to identify the areas that are more distressful to the individual
- Providing psychoeducation about the condition that they are having to lessen the anxiety.
- Tell them about the treatment: provide a general outline of the therapy & ask if the patient is okay with it; emphasize the importance of self – monitoring; emphasize the importance of doing assignments; talk about inviting family members to one of the sessions & get reactions from the patient about the whole outlined process.

SESSIONS 3 - 5

- Provide **relaxation training** (different relaxation techniques)
- Address issues related to not completing any given assignments
- Ask for reactions from the patient (this should be done at the end of every session)

SESSIONS 6 - 8

- Review of assignments.
- Assess the practice of relaxation techniques taught in sessions 3 – 5.
- Assess how the techniques above are modifying their thoughts.
- Teach **problem solving strategies** so as to avoid getting overwhelmed.
- Ask for reactions from the patient (this should be done at the end of every session)

SESSION 10

- Review of assignments.
- Assess the techniques & strategies taught before, i.e.,
  - Relaxation techniques
  - Problem solving strategies
- Teach about:
  - Sleep hygiene
  - Thought – stopping methods (what can they do when the wrong kind of thoughts keep coming?)
  - Scheduling a specific ***worry time*** during which they allow themselves to worry about any issues instead of carrying worry within them all the time.

SESSIONS 11 & 12

- Review assignments.
- Assess the techniques & strategies taught before.
- Teach on **assertiveness & communication skills**
- For demonstration, do a role play with the patient.

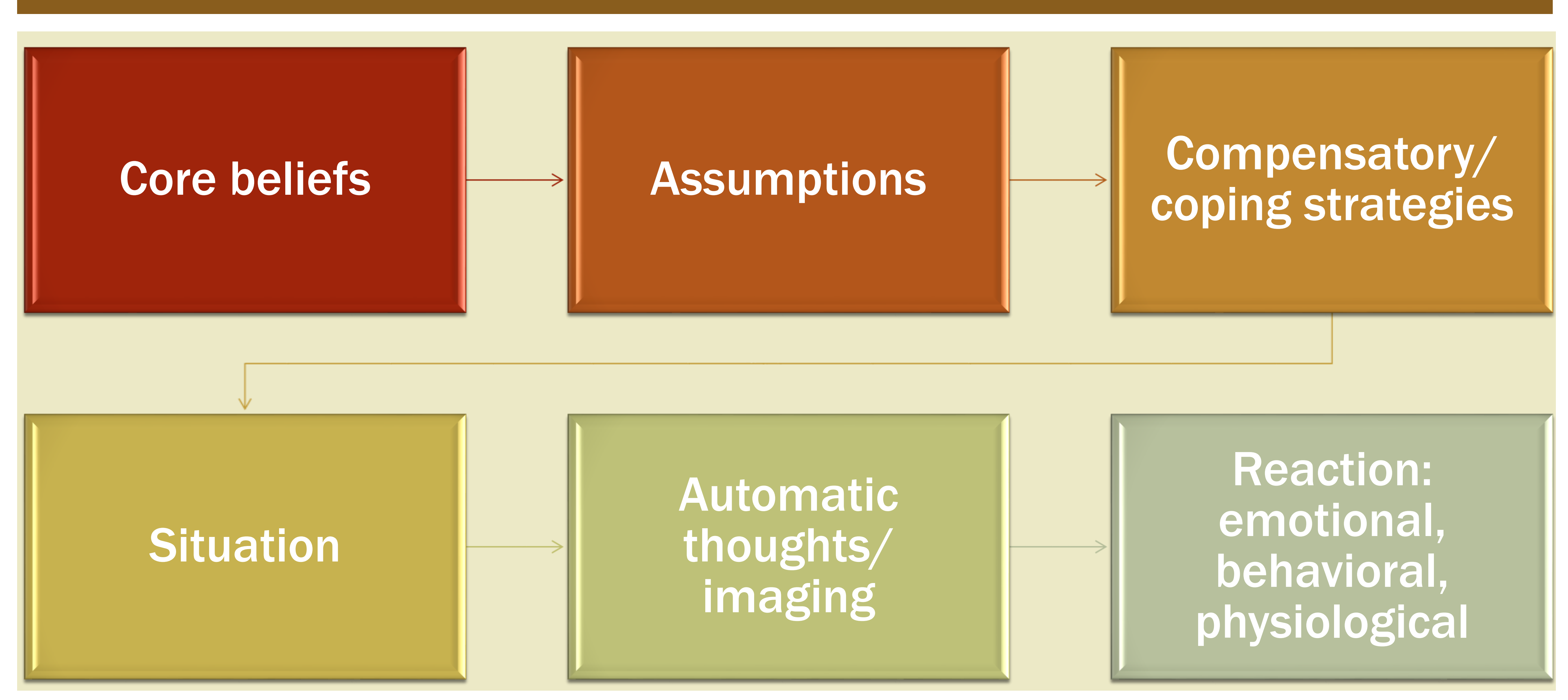
SESSIONS 13 & 14

- Help the patient look for pleasant activities they can engage themselves in.
- Keep checking on how they are doing.
- Guide them on learning to accept & deal with the events that they cannot change.

PSYCHOEDUCATION

- Mini – lessons in session e.g., elicit automatic thoughts & then explain the nature of the automatic thoughts.
- Provide an exercise template – e.g., complete a sample homework sheet in session.
- Encourage use of a therapy notebook
- Suggest readings—consider visual issues
- With the aged: basis of psychoeducation ***is an effective interview & hearing the client***
  - Remove blame—"this is a medical problem"
  - Value the relationship above the protocol

THE COGNITIVE MODEL



IDENTIFYING THOUGHTS

- Automatic thoughts are often based on legitimate concerns but conclusions and meanings are drawn from experiences are not reasonable, i.e., ***valid but not useful (1995)***
- Introduce the concept of an internal dialogue.
- Have the person think of a recent example when something went wrong.
- Ask person what they were thinking when that happened.

IDENTIFYING DISTORTIONS

- Jumping to Conclusions
- Overgeneralization
- Magnification or Minimization
- Personalization and blame
- All – or – nothing thinking
- Catastrophizing
- Mental Filter
- Discounting the Positives
- Emotional Reasoning
- “Should Statements”
- Labeling

COGNITIVE ERRORS

- **Selective abstraction**: drawing a conclusion based on only a small portion of the available data.
- **Arbitrary inference**: coming to a conclusion without adequate supporting evidence or despite contradictory evidence.
- **Absolutistic thinking**: “all or none” thinking
- **Magnification & minimization**: over- or undervaluing the significance of a personal attribute, a life event, or a future possibility.
- **Personalization**: linking external occurrences to oneself (e.g. taking blame, criticizing oneself) when there is little or no basis for making these associations.
- **Catastrophic thinking**: predicting the worst possible outcome while ignoring more likely eventualities.

CONT.

- CBT integrates features of behavioral modification into the traditional cognitive restructuring approach.
- In CBT, the therapist works with the patient to ***identify the thoughts that are causing distress, and employs behavioral therapy techniques to alter the resulting behavior***.

CONNECTING THOUGHTS TO FEELINGS
ABC MODEL

- A: ADVERSITY (Any negative event)
- B: BELIEFS (Beliefs and interpretations about A)
- C: CONSEQUENCES (Behavior/ feelings following A)

COGNITIVE RESTRUCTURING

- Connection between thoughts & feelings
- Examine evidence for & against thoughts
- Challenge & modify beliefs through evidence
- Develop action plans

FINDING, EVALUATING & CHANGING SCHEMAS

- Schemas: core beliefs underlying automatic thoughts.
- Cognitive restructuring techniques:
  - Socratic Questioning
  - Generating Alternatives
  - Imagery & role Play
  - Thought Recording
  - Validity Testing
  - Guided discovery
  - Journaling
  - Homework
  - Modeling

COGNITIVE RESTRUCTURING: MODIFYING AUTOMATIC THOUGHTS

- **Socratic Questioning:**
  - Ask open – ended questions that help the clients think about the problem. Avoid leading questions.
- **Generate Rational Alternatives:**
  - Encourage openness to full range of possibilities.
  - Brainstorm: list lots of ideas
- **Examine the Evidence for and against**
- **Decatastrophizing**
  - What is the worst that can happen?; Could you tolerate this for 15 minutes?

CONT.

- Reattribution
  - _____W_______________T______
    - W: where I want to be
    - T: where I a today
- Thought change record:
  - Notice it → question it → change it

CONT.

- Cognitive Rehearsal
  - Think through the situation in advance
  - Identify possible automatic thoughts and behavior
  - Modify the automatic thoughts (thought change record)
  - Rehearse the new way of thinking and behaving
  - Implement the new strategy
- Coping Cards

BEHAVIORAL THERAPY TECHNIQUES

- Questioning to identify behavioral patterns
- Activity scheduling with mastery & pleasure recording
- Self – monitoring
- Graded task assignments
- Behavioral rehearsal
- Response prevention
- Distraction
- Relaxation exercises
- Respiratory control
- Assertiveness training
- Modeling
- Social skills training

BEHAVIORAL METHODS

- Behavioral Activation: What could you do?
- Activity Scheduling & Monitoring
  - Keep a schedule
  - Monitor for Mastery and Pleasure
  - Increase Mastery and Pleasure activities
- Graded Task Assignment: break into steps
- Behavioral Rehearsal – role playing
- Specific skills: Thought stopping & Breathing Retraining
- Problem – solving

DISORDERS FOR WHICH CBT IS EFFECTIVE

- Beck's original model applied to ***depression***. Since then different models applied to different problems/diagnoses
- Now we have CBT for everything from ***pain***, to ***psychosis*** via ***insomnia***.
- Empirically supported treatment for
  - Depression
  - Generalized anxiety disorder
  - Obsessive compulsive disorder
  - Panic disorder

OTHERS

- Post – Traumatic Stress Disorder
- Different phobias
- Eating disorders
- Sleeping problems

CHILDREN EXPOSED TO TRAUMATIC EVENTS

- Child intervention:
  - Education
  - Cognitive training/ restructuring
  - Relaxation training
  - Thought stopping
  - Positive imagery
  - Exposure, response prevention & desensitization

CBT FOR PSYCHOSIS

Rationale	Description	Who Benefits?
Persistent psychotic symptoms are present in 25 – 40% of consumers with schizophrenia & persistent psychotic symptoms predict relapse & re – hospitalization	- Collaborative partnership with consumer - Education about stress – vulnerability - Behavioral tests	- Consumers with cognitive impairments - Consumers with a diagnosed psychiatric illness. - Consumers with psychotic symptoms

SKILLS TRAINING

Rationale	Description	Who Benefits?
Impaired social functioning predicts the worst outcomes	❑ Multiple weekly training sessions over time (between 3 months and 1 year) ❑ Individual and group formats ❑ 'In vivo' training to facilitate generalization of skills	Consumers with cognitive impairments Consumers with a diagnosed psychiatric illness Consumers with psychotic symptoms

CONT.

- The assumption is that most people come to therapy because they are doing things that make them unhappy or are behaving in ways that cause problems in their lives.
- Emotional problems come from what people are doing or because of what they think and believe.
- People are the way they are because of what they have learned.
- Behaviorists are focused on what maintains the behavior.

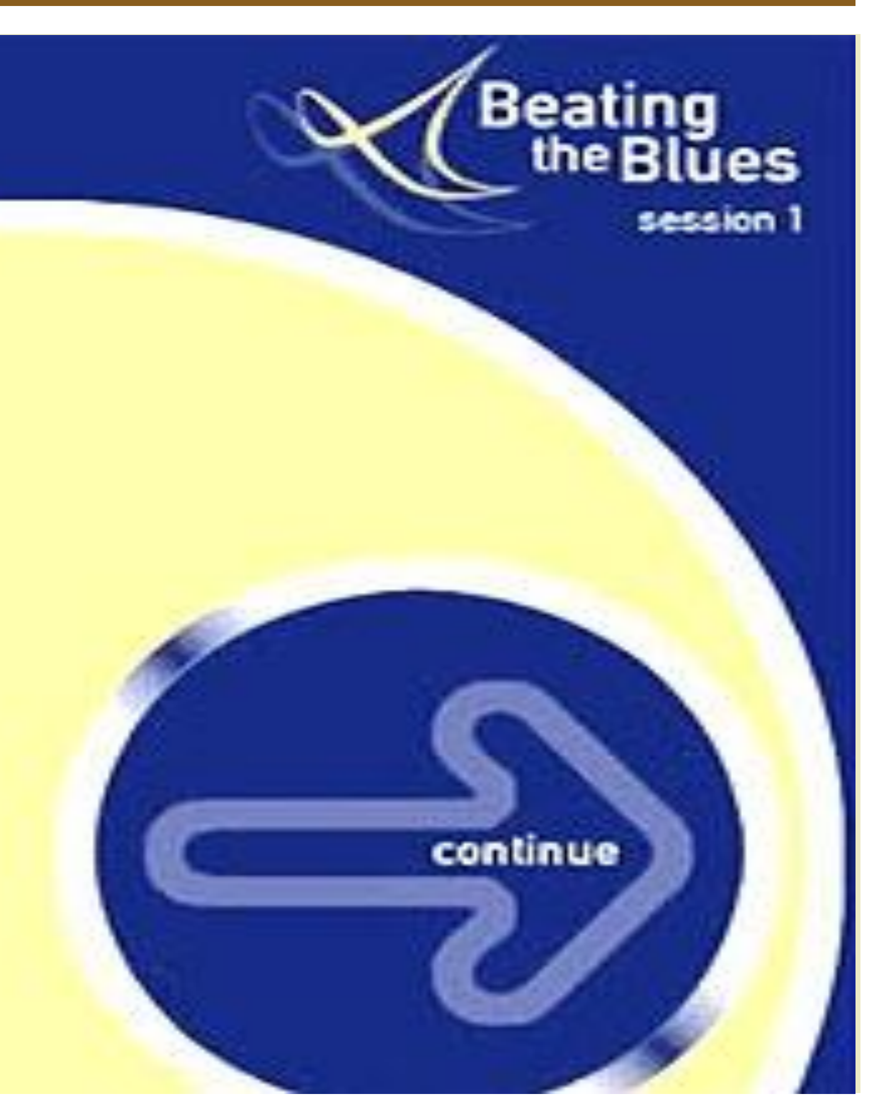
COGNITIVE BEHAVIORAL GROUP THERAPY

- Assessment is a primary function of cognitive behavioral group therapy. The cognitive, behavioral and affective components of the problem are explored.
- The therapist's role is to expect and reinforce change. The therapist normalizes problems and also breaks them into manageable tasks.
- Cognitive – behavioral group leaders might use ***bibliotherapy*** and audio or video taping to help with therapy.

TECHNIQUES

- Problems are identified and interventions are designed specifically for that problem. Examples of such interventions include:
  - Social skills training
  - Cognitive restructuring
  - Systematic problem solving

COMPUTERISED CBT



COMPUTERISED CBT

- One trial in UK funded by the company that produces the programme ***Beating the Blues***.
- Need independent evaluations
- The degree of support needed is unknown but is probably required.

BEHAVIOURAL ACTIVATION

- Began life as a “component” of CBT
- Counteract patterns of avoidance, withdrawal and inactivity
- Simpler than CBT but requires detailed behavioural analysis
- Keeps collaborative framework
- Maybe as or more effective in more severe depressions

NEW DIRECTIONS

- Mindfulness – based Cognitive Therapy (Segal)
- Acceptance & Commitment Therapy (Hayes)
- Dialectical Behavior Theory (Linehan)

COGNITIVE – BEHAVIORAL PLAY

- (Knell) focuses on:
  - Child's thoughts, feelings, fantasies, and environment
  - Teach more adaptive behaviors through modeling, role – playing & behavioral contingencies

TYPED BY NAILA KAMADI

…And we lead every thought & purpose away captive into the obedience of Christ (the Messiah, the Anointed one)

- 2 Cor. 10:5b

GROUP THERAPY

OBJECTIVES

- At the end of the lesson, students should be able to:
  - Define group therapy
  - Explain the reasons for conducting group therapy
  - Describe who is involved in group therapy?

INTRODUCTION

- A group is a collection of **2 or more individuals** who meet in a **face to face interaction, interdependently** with the **awareness** that each belongs to the group & for the purpose of achieving a pre – determined, mutually agreed upon goal.
- A group can be identified by its task or function. Without task focus, the group remains a collection of individuals.
- Group therapy can be viewed as a means of *“Helping one another heal & grow”*

CONT.

- Group therapy is a psychological treatment where individuals (between 6 to 12), with similar psychological/ mental health issues come together for a face to face interaction led by a trained group therapist.
- Group therapy focuses on treatment & remedial of those who are ***severely disturbed or who are exhibiting socially deviant behavior***.

USES/ IMPORTANCE OF GROUP THERAPY

- Group therapy provides an opportunity to learn:
  - 'With' & 'from' other group members from the accounts related by them.
  - That you are not as different as you think, others have similar problems as you.
  - That you are not alone in your thinking.
  - An entire group can benefit from sharing thoughts & experiences.

CONT

- An entire group can benefit from sharing thoughts and experiences.
- By focusing ***on interpersonal learning***:
  - It helps individuals get along in a more honest & authentic way with other people.
  - It provides a support network for specific problems & challenges.

CONT

- Being part of a group working towards a similar goal provides the patient with the reassurance of being part of a team & are ∴ not judged harshly by members of the group compared to the outside world
- This is through confidentiality observed – thus safe haven
- Group interaction gives group members an opportunity to try out new ways of behaving and to learn more about the ways they interact with others
- It increases social networks

11 CHARACTERISTICS THAT MAKE GROUP THERAPY EFFECTIVE

- Universality: "***I'm not alone nor am I having unique problems***"
- Group Cohesiveness
- Altruism: unselfish giving
- Instillation of Hope
- Imparting Information: educational

CONT.

- Interpersonal learning
- Development of socializing techniques
- Imitative Behavior
- Corrective recapitulation of the Primary Family Group
- Catharsis: provides a point of let out.

THE HISTORY OF GROUP THERAPY

- Originally found ***successful in treating patients with TB in early 1900's***
- Later used during WWII for treating those with ***emotional reactions.***
- In the 1950's **Bion's** work with the group at Tavistock Clinic in London
- **Lewin – Systems Theory:** *the group whole is greater than the sum of its parts*

STARTING A GROUP

- Good group therapy begins with good client selection. Clients improperly assigned to a therapy group are unlikely to benefit from their therapy experience.
- In selecting group members, the therapist should ask 2 questions:
  - Is the member likely to benefit from the group experience?
  - Is the member likely to make a positive contribution to other members?

CONT.

- Consider:
  - Heterogeneity/ homogeneity
  - Appropriateness of group due to behavior
  - Gender balance

EXCLUSION CRITERIA

- Unwillingness or low motivation to participate – generally, individuals benefit from group therapy when they wish to be in a group
- Extremely high level of distress – an individual with very high levels of distress cannot benefit at that point in time
- Incapacity for connection
- Non – compliance with rules – every group has rules that safeguard the rights and safety of the members and that create an atmosphere in which goals of the group can be pursued
- Maintaining confidentiality, putting feelings into words rather than actions, attending the sessions regularly and making timely payments are among the most common rules that group therapists establish
- When individuals provide evidence that they are unable or unwilling to observe these rules, they are not appropriate for the group

CAPACITY FOR CONNECTION

- Group therapy in most of its forms requires that members have some rudimentary ability to attend to, identify with & form a relationship with one another
- This requires the therapeutic factor of universality.

COGNITIVE LIMITATIONS

- Group therapy makes cognitive demands on members
- It requires that they be able to listen to one another, respond appropriately and concentrate in a sustained way on the events of the session.

CONT.

- It is important to remember that:
  - Clients will fail in group therapy if they are unable to participate in the primary task of the group – whether due to:
    - Logistical problems
    - Intellectual problems
    - Psychological or interpersonal reasons

CONT.

- Clients in the midst of some acute situational crisis are not good candidates for group therapy.
- They are far better treated in crisis – intervention therapy in an individual, family or social network
- Deeply depressed suicidal clients are best not admitted to an interaction – focused heterogeneous therapy group either this is because:
  - They give enormous stress on the rest of the group
- Good attendance is so necessary for the development of a cohesive group that it is wise to exclude the clients and have them do individual therapy

TRAITS A CLIENT MUST POSSESS TO PARTICIPATE IN THE PRIMARY TASK

- A capacity and willingness to examine their interpersonal behaviors
- To self – disclose
- To give and receive feedback

IN SELECTING MEMBERS ONE MUST TAKE INTO ACCOUNT

- Heterogeneous/ homogeneous – to be informed the purpose which the group was formed
- Appropriateness of group due to behavior
- Gender balance

RECRUITING GROUP MEMEBRS

- Conduct screening interview to ensure the clients are homogeneous
- Take into account the group size: >12 is too big
- Group setting

GROUP STAGES

- Initial stage (orientation & exploration)
  - Get acquainted
  - Determine the structure of the group
  - Explore the members' expectations
- Transition stage (challenge & resistance occurs)
  - Group leader may be challenged
  - Increased anxiety in members

CONT.

- Working stage (*cohesion & productivity occurs*)
  - Members focus on identifying goals & concerns
  - Work on goals in the group and outside of the group.
  - Practice new behaviors

GROUP COUNSELLING PROCES

- First session
  - Clarify ground rules and guidelines
  - Build cohesiveness & trust
  - Discuss confidentiality
  - Discuss active listening for each other

REMAINING SESSIONS

- Summary of the initial meeting
- Establishing a therapeutic atmosphere
- Leader models facilitative behaviors
- Establish a relationship
- Address members' concerns/ problems
- Explore previous solutions & look at alternatives.
- Set goals, try new behaviors, assign homework
- Report & evaluate results

CONT.

- Groups generally meet once or twice a week with each meeting lasting anywhere from one to 2 hours
- Sessions can be structured to allow new members to join at any time or the meetings may remain closed to just the original members of the group until the program is over, which could be several weeks to a year

IMPLICATIONS FOR DIFFERENT AGES

- Group counseling can help children in formative years acquire social skills, improve ethnic/racial relationships and shape a positive attitude towards school.
- Group counseling can support pre – adolescents in dealing with family, peer pressure & anger management.
- Group counseling can help high school students with making choices, stress and aggression.
- Group counseling can help students with low self-esteem, self-determination, body awareness and self-concept.

~END~

Two are better than one' because they have a good reward for their labor. For if they fall, the one will lift up his fellow; but woe to him that is alone when he falleth; for he hath not another to help him up.

#Jesus_Is_Lord

SOLUTION FOCUSED THERAPY 14/1/2019

DEVELOPERS

- Steve De Shazer
- Insoo Kim Berg
- Bill O'Hanlon ('Solution Oriented Therapy')
- Arising from Milton Erickson's work & brief strategic therapy

BASIC PHILOSOPHY

- Change is constant & inevitable.
- Clients are the experts & they define goals.
- Future orientation: history is not essential.
- Emphasis is on what's possible & changeable: 'what can be done differently?'

CONT.

- Short term: only a small amount of change needed
- Clients want change
- Current solutions are the problem
- Exceptions = differences that make a difference
  - Behaviors, perceptions, thoughts & feelings that contrast the complaint.

PRINCIPLES

- If it isn’t broken, do Not fix it.
- If it works, keep doing it.
- If it is not working, stop.
- Small changes lead to larger ones.
- Keep intervention as simple (concrete) as possible.

HOW BRIEF IS THE THERAPY

- Aim for 5 sessions
- Each session: 45 minutes
- Rarely beyond 8 sessions
- Sometimes 1 session is enough.
- Look for any improvements after 3 sessions?
- Increase gap between sessions as time goes on.

SOLUTION FOCUSED THERAPY

- Problems are maintained by doing things the same way & expecting a change.
- Solution focused therapy is based on the principles that:
  - If it is not broken, do not fix it.
  - Once you know what works, do it more.
  - If it doesn't work, do something different.

CONT

- Acknowledge distress
- Focus on success
- Talk should be about solutions & not problems.
- Techniques:
  - Miracle questions
  - Scaling questions
  - Client goals

BASIC ASSUMPTIONS

- Clients have resources & strengths to resolve complaints.
- Change is constant.
- The therapist's job is to identify & amplify change.
- It is usually unnecessary to know much about the complaint in order to resolve it. It is not necessary to know the cause or function of a complaint to resolve it.

CONT.

- A small change is all that is necessary.
  - A change in one part of the system can affect change in another.
- Clients define the goals
- There is no one right way to view things
  - Different views may be valid
- Focus on what is possible and changeable, rather than what is impossible & intractable/ stubborn.

MILTON ERICKSON

- Client centered works → Carl Rodgers
- Permission
  - Give clients permission for who they are
- Validation
  - Any response or behavior is valid
- Observation
- Utilization: making use of what clients bring
- Human givens, strategic, solution focus/ oriented, systemic therapies

3 TYPES OF CLIENTS

- Visitors: no complaints, along for the ride; complimented and given no tasks
- Complainants: going along to placate and appease; complain, distant, observant, and expectant - given observational and thinking tasks
- Customers: Do Something – want to change; given behavioral tasks

CLIENT'S GOALS

- Important to the client
- Small, realistic & achievable
- Concrete, specific, behavioural
- Presence of something, rather than absence
- Expressed as beginnings rather than endings
- Requiring '***hard work***'

INTERVIEWING IDEAS

- Past successes
- Pre – session changes
- Exceptions
- Miracle question
- Scaling questions
- Coping questions
- Reframing

TYPICAL FIRST SESSION

- Opening: Social introductions, structure session
- Collect Complaints - Problem
- Rank Complaints
- Discuss Exceptions

SESSION STRUCTURE

- Miracle question process
- Exceptions / pre – session changes
- Identify Goals
- Scales: situation now, willingness, confidence
- Anything else/ Break
- Message

SUBSEQUENT SESSIONS

- Less Time on Complaint(s)
- More Time on Exceptions & Solutions
  - Opening: What's different this week from last
  - Exceptions: elicit, recognize, discuss, amplify (use listening skills by applying MI skills' approaches-OERS)
  - Scaling: Accentuate/emphasize any improvement
- Therapeutic Break: time for reflection & consider task for next week
- Compliments & Summary
- Tasks & Homework

QUESTIONING

- Be respectfully curious
- Ask questions as part of conversation
- Not asked as a list of questions
- Questions are the main intervention
- Not to gather information
- Constructive questions generate new experience about possible solutions, client strengths and capabilities

CONT.

- Problem focused:
  - How long have you been depressed?
- Solution focused:
  - What would your life be like if you weren’t depressed?

TYPES OF QUESTIONS

- Goal setting questions
- Miracle questions
- Exception questions
- Coping questions
- Scaling questions

IDENTIFYING GOALS

- What are your goals?
- How will you continue to accomplish goals?
- How will you know when you got what you wanted from therapy?
- What will be different?
- Who will notice?
- What will they notice?

ADLER'S FUNDAMENTAL QUESTION

- What would be different if all your problems were solved? – Dr. Jonathan E. Adler

ERICKSON'S CRYSTAL BALL

- Erickson asked his client to look into the future and see themselves as they wanted to be, problems solved, and then to explain what had happened to cause this change to come about.
- He also used a technique whereby he asked them to think of a date in the future, then worked backwards, asking them what had happened at various points on the way.

O'HANLON'S VIDEO TAPE QUESTION

- Let's say that a few weeks or months of time had elapsed, and your problem had been resolved. If you and I were to watch a videotape of your life in the future, what would you be doing on the tape that would show that things were better? (1987)

DE SHAZER'S MIRACLE

- Suppose that one night, while you are asleep, there is a miracle and the problem that brought you here is solved. However, because you are asleep you don't know that the miracle has already happened. When you wake up in the morning, what will be different that will tell you that the miracle has taken place? What else? (1988)

THE MIRACLE QUESTION

- What difference would you (& others) notice?
- What are the first things you notice?
- Has any of this ever happened before?
- Would it help to recreate any of these miracles?
- What would need to happen to do this?

5 USEFUL QUESTIONS

- The Miracle (Magic Wand) Question
- Has anything been better since the last appointment? What's changed? What's better?
- Can you think of a time in the past (month / year / ever) that you did not have this problem?
  - What would have to happen for that to occur more often?
- Scaling Questions 1 – 10
- With all of that going on, how do you manage to cope?

ASSESSMENT QUESTIONS

- Identify problems & exceptions
  - When doesn't the problem happen?
  - What's different about those times?
  - What are you doing or thinking differently during the "good " times?
  - What do you want to change about the problem?

COPING QUESTIONS – CURRENT PROBLEM

- How do you cope with these difficulties?
- What keeps you going?
- How do you manage day – to – day?
- Who is your greatest support? What do they do that is helpful?
- This problem Feels so difficult at the moment, yet you still managed to get here today. What got you here?
- Sometimes problems tend to get worse, what do you do that stops it getting worse?

COPING QUESTIONS – PAST PROBLEM

- How did you get through that period?
- Who was your greatest person?
- How did they help?
- How did you manage to solve that problem in the past?
- Other people might have had more difficulty, but you managed to survive and get here today. How did you manage to achieve that?

SCALING

- Scale of 1 – 10
  - 1 is the worst it's ever been
  - 10 is after the miracle happened
- Where are you know?
- Where do you need to be?
- What will help you move up one point?
- How can you keep yourself at that point?

SCALING QUESTIONS - STANDARD

- On a scale of 1 to 10, where 10 is where you achieve your goal completely and 1 is the furthest away you have ever been, where would you place yourself not?
- On a scale of 1 to 10, where 1 is the worst things have been and 10 is best, where would you place yourself today?

SCALING QUESTIONS – FOLLOW UP

- What makes you think you got that far?
- What things have you done already that got you to this point?
- What do you think will move you one step further on?
- What would be the first sign that you had moved one point further on?
- Who would be the first person to notice that you had moved one point on? What would they notice about you?

EXCEPTION QUESTIONS

- Tell me about the times when (the complaint) does not occur, or occurs less than at other times.
- When does your partner/parent listen to you?
- Tell me about the days when you wake up more full of life.
- When are the times you manage to get everything done at work/school?

CONT.

- Variations
  - When are the times when you have come closest to?
  - When did you last wake up feeling quite good?
  - When have you been able to stop yourself doing?
  - Are there times when you expect to… but you remember something that calms you down?

CONT.

- Amplifying the exception?
  - How do you explain to yourself why these times are different?
  - How do you achieve that?
  - What do you do differently then?
  - Who else is involved that notices the difference? What do they say or do? What else?

DE SHAZER'S SKELETON KEYS

- Between now & next time…observe what works
- Do something different
- Pay attention to when… exception
- Normalize "a lot of people in your situation"
- Write, read and burn thoughts
- All interventions give hope

FAMILY THERAPY

WHAT DEFINES A FAMILY

Webster's Dictionary definitions:

- Group of people who are (1) bound by philosophical, religious, or other convictions, (2) common ancestry, and (3) living under the same roof. And
- Basic biosocial unit in society having as its nucleus two or more adults living together and cooperating in the care and rearing of their own or adopted children

THE FIRST INTERVIEW

- Goals for the initial phone call
  - This is your first contact with the client
  - Overview of problem
  - Arrange for family to come in for consultation
    - The more people, the better
  - Be empathetic
  - Validate their struggle
    - "It sounds like you are having a really difficult time in your marriage"
  - Communicate a sense of competency
    - Ex. Is this something you can help us with?

2 IMPORTANT OBJECTIVES FOR FIRST INTERVIEW

I. Initiate engagement

- Did you have hard time finding the office? Were my instructions clear? Etc.
- Provide the format:
  - *"The main purpose of this meeting is to give you an opportunity to meet me and to let me meet you. I understand that a lot has been occurring in your family that has been upsetting for all of you. What I would like to do in this meeting is to hear everyone's point of view about what's going on. Finally, at the end of our meeting, I would like to share with you my perceptions, give you my recommendations, and allow time for you to ask me questions."*

II. Initiate Assessment

- Gather necessary information
  - Chronological? Vs. thematic?
- Formulate hypothesis about what is causing/maintaining the problem
- Different than in individual therapy
  - No diagnosis
  - No particular family member is singled out

DURING ASSESSMENT:

- Don't forget that every case is unique
- Listen carefully to the family's account of the problem and ask detailed questions
- Try to move families from linear and medical model thinking (He has ADHD) to an interactional perspective
- Be sensitive to gender inequalities, cultural issues, and ethical issues
- Be careful for land mines like: "What should we do?, what's wrong with Johnny?"

THE FAMILY AS A SYSTEM

- Systems are composed of units who have some relationship to each other and are organized around those relationships
  - Solar system
  - Educational system

- A change in one part causes a change in another

SYSTEMS THEORY AND FAMILIES

- System = organized unit made up of interdependent parts
- Whole unit is greater than the sum of its parts
- Change in any part affects all other parts
- Family is system in which each member has a significant influence on all other members

THE ETIOLOGY OF PROBLEMS

- Family characteristics: Problems (even an individual's psychological symptoms) are assumed to be caused by a dysfunctional family characteristic
  - family boundaries/structure (adaptability and cohesion)
  - the nature of family interactions

- Family Homeostasis: When disruption occurs, family members try to regain a stable environment by using strategies that decrease stress and restore balance. These strategies are not always adaptive in long-run.

FAMILY CHARACTERISTICS: BOUNDARIES

Boundaries are implicit family rules that determine how family members relate to each other, including who talks to (or spends time with) whom, how decisions are made and by whom, and how much family members know about each other's lives.

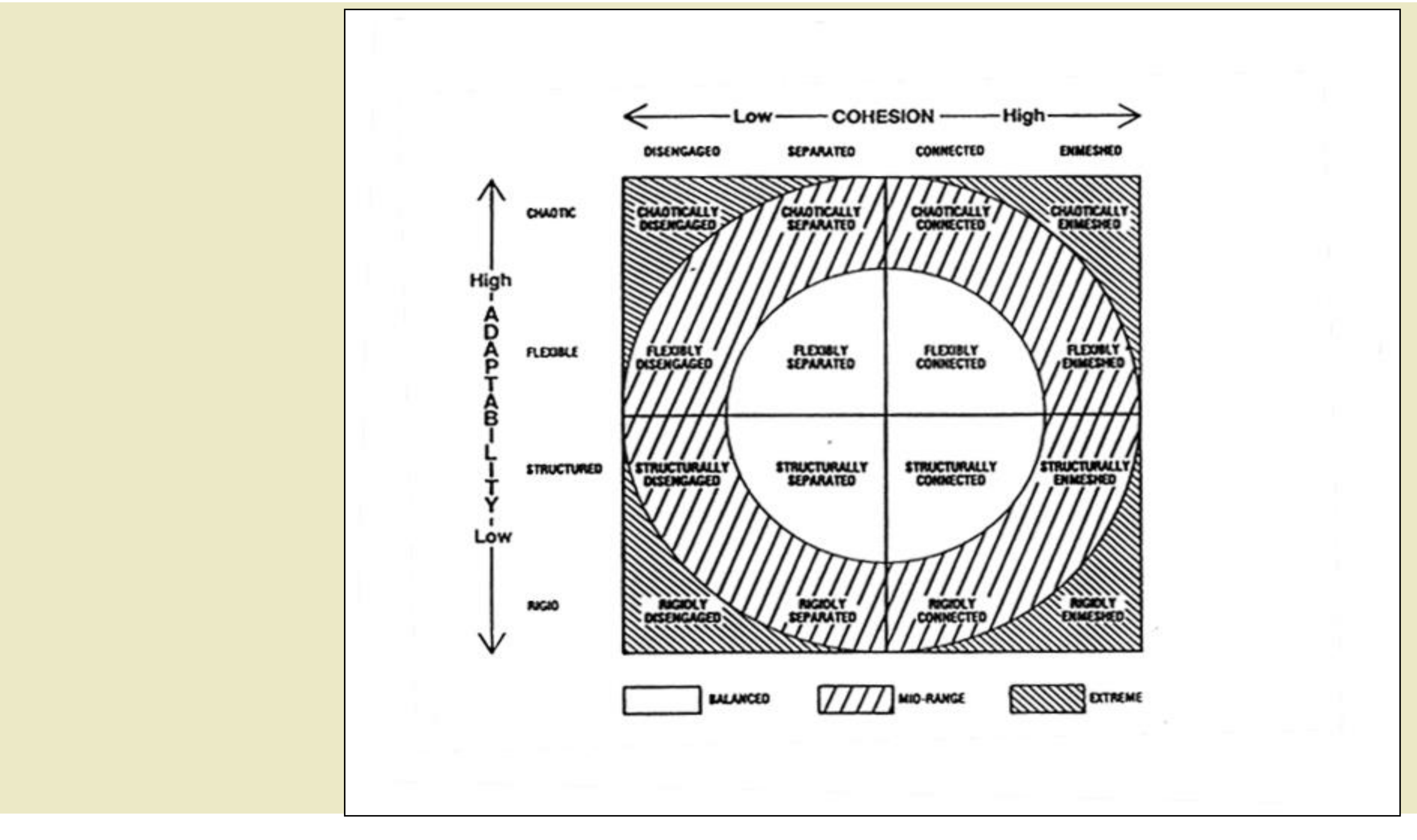
FAMILY CHARACTERISTICS: BOUNDARIES/COHESION

- Enmeshment (very low differentiation)
  - People are enmeshed (or fused) when they are unable to think or act autonomously.
  - People who are not enmeshed are autonomous and have emotional separation from their family.
  - A person's level of differentiation is often related to his or her parents' level of differentiation. It's often transgenerational.
  - People with low levels of differentiation are more reactive to environmental stressors. When under stress they are more likely to try to resolve it by:
    - Withdrawal
    - Destructive conflict
    - Dysfunction
    - Triangulation
- Disengagement (very high differentiation)

FAMILY ADAPTABILITY

- Adaptability refers to the family's rules about who does what and it's ability to adapt as necessary
  - When there are few rules (or rules are not enforced), family functioning is chaotic
  - When the rules are too rigid, families have trouble adapting to change

FAMILY CIRCUMPLEX MODEL



FAMILY LIFE CYCLE STAGES

- Single young adult leaves home
- Forms a family through marriage
- Has young children
- Children reach adolescence
- Children move out
- Retires

FAMILY LIFE CYCLES AND FAMILY FUNCTIONING

- Family dysfunction often is a result of unmet family developmental tasks.
- Family life cycle changes are a major source of stress and disequilibrium for families.
  - As families grow, there are developmental tasks that are required; when a family negotiates these tasks successfully, family roles and structures change.
  - When the family does not or can not accommodate these changes, stress and symptomatology will occur.
  - It is not the normal difficulties that create the problem but rather the chronic mishandling of problems over time.

THE NATURE OF CHANGE

- Change/healing occurs when family members

1) Gain insight about their dynamics
2) Change repetitive patterns that hinder the family
    - Learn more effective ways of communicating
    - Change family roles
    - Develop more healthy boundaries

THE INITIAL INTERVIEW

- **Pre-session Planning:** The therapist and family determine in advance who will attend the session.
- **The Joining Stage:** The therapist joins with the family, taking on their affective tone, tempo, language and structure.
- **The Problem Statement Stage:** Who gets to initially frame the "problem"? Sometimes the person who has the least involvement with the problem is addressed first.

INITIAL INTERVIEW (CONTINUED)

- The Interaction Stage: The therapist focuses in on determining the patterns of interaction sustaining the problem.
- In-Session Conference: The therapist leaves the family for a few minutes and confers with observers or takes a moment alone to think about what has been said and how that relates to the therapist's hypothesis regarding the problem.
- Goal Setting Stage: The therapist reaches an agreement with the family on a solvable problem, stated in behavioral terms so that all involved will know when the problem has been solved.
- Ending Stage: The therapist sets the next appointment and indicates which family members will be present.
- Post-session: Debriefing and processing

FAMILY THERAPY ASSESSMENT TECHNIQUES

- Family Interview
- Circular Questioning: The same question is asked of each family member.
- Family Sculpting: Assessment tool that examines power and closeness in a family by asking each family member to physically arrange all other family members in order of relationships (or in reference to a particular salient event).
- Reenactment: Asking the family to act out a situation rather than describe it verbally.
- Genogram: Gives a picture of three or more generations (like a family tree) and notes important family dynamics, rules, patterns, mental health issues, alcohol/substance use etc.

ASSESSMENT OF FAMILY FUNCTIONING

- Role of the symptom in the system
- Family dynamics
- Family roles
- Family life chronology
- Survival triad
- Survival stances
- Six levels of experience: the iceberg
- Self-worth and self-esteem
- Mind-body connection

ROLE OF THE SYMPTOM IN THE SYSTEM

Emotional Role

- Symptom has a role in the family system.
  - Ex: Child's exaggerated acting out may serve to reduce tension in marriage by getting parents on same page.
- Have emotional function in family system, even if they are consciously and logically unwanted.
- If therapist can understand how symptom makes emotional sense, it will be easier to help find ways to interact successfully.

FAMILY DYNAMICS

Problematic family dynamics

- **Power struggles:** Can be within family and couple or with extended family member.
- **Parental conflicts:** Can involve parents disagreeing about how to parent and care for children.
- **Lack of validation:** Family openly expresses little emotional support or validation.
- **Lack of intimacy:** Minimal sharing of significant personal information and one's emotional life.

FAMILY ROLES

Roles

- Each person's role in family assessed to understand function of problem.
- Possible roles:
  - The martyr/victim
  - The victim or helpless one
  - The rescuer
  - The good child or parent
  - The bad child or parent

FAMILY LIFE CHRONOLOGY

Definition

- Timeline that includes major events in individual's or family's life:
  - Births and deaths.
  - Important family events such as marriages, moves, tragedies, major illnesses, job loss.
  - Important historical events such as wars, natural disasters, economic downturns.
- Gives both therapist and client insight into context of problem as well as strengths and resources might exist.

SURVIVAL TRIAD

What it is

- Child, mother, and father and quality of relationship between them.
- In this primary triad, a child learns how to be human.
- The triad should serve as nurturing system for child.
  - When child is experiencing difficulty, therapist considers how the nurturing function of these relationships can be improved.

SIX LEVELS OF EXPERIENCE: THE ICEBERG

Layers of the iceberg

- **Behavior:** Behavior on surface; external manifestation of person's inner world.
- **Coping:** Defenses and survival stances; come out in times of stress, person may use different stances in different relational contexts.
- **Feelings:** Present feelings that are strongly past-based, using past events to interpret the present.
- **Perceptions:** Beliefs, attitudes, and values that inform one's sense of self; most formed when very young and based on limited view of reality.
- **Expectations:** Strong belief about how life should go, how people should behave, and how one should perform; most formed while young and are unrealistic.
- **Yearnings:** Universal longings to be loved, accepted, validated, and confirmed.

SELF-WORTH AND SELF-ESTEEM

How they are employed

- Consider *aspects of the self* that client *values* and aspects of which he/she is ashamed.
- *Self-compassion,* or acceptance of one's strengths and weaknesses, is better indicator of happiness than self-esteem.
- People who overestimate abilities and worth have high self-esteem but problems in interpersonal relationships due to unrealistic expectations.
- People who are judgmental, impatient, or intolerant of others' weaknesses are almost always equally harsh on themselves.
- As self-compassion and self-worth rise, people become more realistic and tolerant of their own and others' weaknesses.

MIND – BODY CONNECTION

What it is

- How emotional issues may be manifesting in the body, either *symbolically* or *functionally.*
- Way body is used indicates person's communication stance:
  - *Congruent communication*: Open and relaxed body postures.
  - *Placating:* Timid and reserved postures.
  - *Blaming:* Pointing, angry, and stiff postures.
  - *Super-reasonable:* Cold and distant postures.
  - *Irrelevant*: Hyper and distracted

FAMILY THERAPY INTERVENTION TECHNIQUES

- Reframing: The problem must be put into solvable, behavioral terms, be referenced as a family problem and not just the problem of one family member, and be put into positive terms (i.e., what will happen, not what won't).
- Giving Directives: Creating or selecting an intervention that will impact the presenting problem.
  - Modifying the structure
  - Switching roles

FAMILY THERAPY TECHNIQUES (CONT.)

- Rituals: Symbolic acts that help the family move. (e.g. burying a box that contains family anger.)
- Ordeals: An ordeal is a behavior that is more obnoxious, frustrating, and time consuming than the behavior that is considered the symptom. When the symptom behavior occurs, the family is instructed to perform the ordeal.
- Ambiguous Assignments: Helps break down linear thinking and causes the family to be more creative in problem solving.

MAJOR FAMILY THERAPIES

- 1950's: Several psychologists break away from psychodynamics and argue that dysfunctional behavior is rooted in the individual's past and present family life.
- Jay Haley (and others) develop strategic family therapy.
- Virginia Satir develops conjoint family therapy
- Salvador Minuchin develops **structural family therapy**.
- Murray Bowens develops transgenerational family therapy.
- Carl Whitakers develops experiential family therapy.

THERAPEUTIC PRESENCE: WARMTH AND HUMANITY

Theoretical Foundations

- Based on Roger's therapist qualities:
  - Congruence
  - Accurate empathy
  - Unconditional positive regard
- The more *congruent* therapists are, the better they create therapeutic warmth and humanity

MAKING CONTACT (CREATING RAPPORT)

What it is

- Series of connections both within therapist and between therapist and other.
- Therapist makes contact with each client in room, engages mind, body, and spirit.
- Open-body positioning and congruent communication critical.
- Therapist works to help family members make contact with each other.

Making contact involves

- Making direct eye contact with clients.
- Touching clients (e.g., shaking hands).
- Sitting or standing at the same physical level so that eye contact is easy.
- Asking each person's name and how he or she prefers to be called.

EMPATHY

What it is

- An accurate understanding of another's emotional reality.
- Conveys understanding of clients' subjective, inner realities.
- Doesn't ignore client's responsibility, take client's side, and avoids confronting inconsistencies.
- Emphasizes it is not wrong or right to feel a certain way.
  - Simply how client feels and is "truth," at least for now.

How it works

- Client sees other person has unique experience that is also "true;" understand how realities may collide and create problematic interactions.

CRISIS CONSULTATION INTERVENTION 21/1/2019

BY: DR. MULINDI

INTRODUCTION

- There are 3 kinds of treatment in psychiatry:
  - Psychopharmacology
  - Physical/ biological treatment (ECT)
  - Psychotherapy/ psychological treatment

PSYCHOTHERAPY

- Psychotherapy is a planned, emotionally charged, confiding interaction between a trained, socially sanctioned healer/ therapist & a sufferer.

TYPES OF PSYCHOTHERAPY INCLUDE:

- Cognitive Behavior Therapy (CBT)
- Group Therapy
- Brief Solution Focused Therapy
- Family Therapy
- Psychoanalysis
- **Crisis Consultation Intervention**
- Individual Psychotherapy
- Behavior Therapy
- Supportive Therapy
- Marital Therapy

CRISIS CONSULTATION INTERVENTION

- This is a form of psychotherapy that is derived from Chinese literature. The word crisis & opportunity in Chinese are represented by the same symbol. This concept of crises & opportunities occurring simultaneously is supported in the disciplines of medicine & nursing.

WHAT IS A CRISIS?

- This is a state of emotional & psychological disequilibrium resulting from a stressor in one's life or a sudden emergency that confronts them with an overwhelming force that the usual coping mechanisms are rendered inadequate to deal with the stressors.
- Crises often necessitate a reorganization of the psychological structure & behavior of a person.

CONT.

- Crises are experienced by patients and their families and they present an opportunity for growth for the patient & one of care for the medical team.
- Crises are also experienced by health care workers as they care for patients & these present an opportunity for growth.

WHAT IS CRISIS CONSULTATION INTERVENTION?

- This is a type of psychiatric treatment in which individuals &/or their families are helped in their efforts to forestall the process of mental decompensation in reaction to severe emotional stress by direct and immediate supportive approaches.
- Crisis intervention can offer immediate help that a person in crisis needs in order to re – establish his equilibrium. It is short-term therapy that focuses on solving the immediate problem.

THERE ARE 2 MAIN TYPES OF CRISIS

1. TRANSITIONAL/ MATURATIONAL CRISIS
2. SITUATIONAL CRISIS

1. TRANSITIONAL/ MATURATIONAL CRISIS

- This type of crisis occurs as a result of human development from one state to another (Erickson 1965)
- It includes crucial stages such as:
  - Beginning school
  - Leaving home
  - Beginning first employment
  - Marriage and retirement
  - Menopause

CONT.

- At each stage, one is forced to make adjustments as well as resolve anxiety and conflicts necessitated by the transition.
- Successful resolution of maturational crises leads to personal growth, emotional stability & good mental health.
- Unsuccessful resolution results in unresolved anxiety & internal conflicts which may lead to unstable emotional disposition, maladaptive behavior & disorders of personality.

2. SITUATIONAL CRISIS

- This type of crisis results from specific & intense environmental stressors, hazardous events or a threat to one's life.
- Examples include:
  - Terror attack e.g. The incident at Dusit (2019 Jan)
  - Loss of a loved on, possession or status.
  - A severely disabling accident: amputation or disfigurement.
  - Natural (acts of God) or unnatural disasters e.g. floods, earthquake, cyclone or war.
  - A diagnosis of AIDS, Cancer
  - Sexual abuse e.g. rape, intimate partner violence

CONT.

- An unresolved situational crisis may lead to deliberate self – injury, accident prone – ness, suicidal tendencies, violence, homicide, acute stress reaction, PTSD, adjustment disorder, gambling, chronic distrust, morbid anger & social withdrawal etc.
- It thus calls for immediate action.
- Victims and survivors of such emotionally traumatic experiences need urgent crisis intervention if serious emotional and psychiatric problems are to be avoided. This is referred to as **crisis management or intervention**.

THE TREATMENT

- Involves psychological resolution of the individuals immediate crisis and restoration to at least the level of functioning that existed prior to the crisis period.
- Improvement in functioning above the pre-crisis level can also be achieved.
- Treatment period: 6 – 8 weeks.

STEPS IN CRISIS INTERVENTION

- Assessment
- Identification & categorization of problems
- Planning for possible solutions
- Planning for therapeutic interventions
- Implementation of the chosen plan of action
- Evaluation

I. ASSESSMENT

- This comprises assessment of the individual and his problem or situation to determine the kind of intervention necessary.
- Some may require admission and others a referral to a psychiatrist.

ASSESSMENT INVOLVES

- Brief psychosocial history.
- Factors that have contributed to the current crisis – with focus on the current problem.
- Assessment of how the patient perceives the crisis and stressors causing it.
- How the family and significant others perceive the crisis.
- The doctors or workers evaluation of the seriousness of the problem/crisis compared to the patient and significant others.
- Assessment of any underlying psychological, social, personality problem e.g. psychiatric illness, emotional disorder, marital problem, substance abuse etc.
- Assessment of the patient's available social and human resources, which can be mobilized and utilized to assist the patient cope with or overcome the current crisis.
- Assessment of the current physical medical state as warranted by the crisis.

II. IDENTIFICATION & CATEGORIZATION OF THE PROBLEMS

- The patient is assisted to clarify, categorize and prioritize the major problems, which have contributed to the crisis.
- This helps put the individual's mind in proper perspective and direct attention to the real issues of the crisis.
- Therapeutic process because it lessens futile emotional reactions and maladaptive behavior.

III. PLANNING FOR POSSIBLE SOLUTIONS

- Formulation of objectives for each of the identified problems.
- Patient encouraged to think of possible solutions to each identified problems and each solution discussed in terms of practicability, implications and consequences.
- **The role of the doctor or the therapist is not to provide solutions but to assist the patient think through his or her problems and suggest alternative ways of dealing with the problem.**
- The doctor or the therapist can assist by enlightening the patient on how others with similar difficulties have managed to cope or overcome the difficulties.
- Encourage patient to generate possible solutions to problems e.g. in alcoholism's drinking manual.

IV. PLANNING THERAPEUTIC INTERVENTION

- It is important to know how much the crisis disrupted the individual's life and the effect of the disruption on others in his environment.
- Information is sought to determine what strength the individual has, what coping skills (s)he may have used successfully in the past and is not using presently and what other people in his life might be used as support for him.

V. IMPLEMENTATION OF THE CHOSEN PLAN OF ACTION

- Mobilizing collaborative support from the patient's own social support network (system), family, friends, colleagues, social workers, clinical psychologists or voluntary organizations.
- Reducing the high level of anxiety through therapeutic techniques e.g. encouraging the patient to ventilate emotions, being a good empathetic listener, use of verbal and non - verbal techniques to calm the patient e.g. touching or holding, sitting quietly beside him etc.
- Assisting the patient to utilize his/her usual coping mechanisms where these are effective in dealing with current crisis.

THERAPEUTIC ACTIONS INVLUDE

- Assisting the patient understand the nature of the crisis and explaining the relationship between crisis and the event in his life.
- Helping the person to develop more effective coping strategies and problem solving capabilities.
- Assist the patient formulate realistic future plans in life goals and incorporate them into the overall solution of the current and possible future crisis.
- The doctor or health worker should assist and support the patient throughout the process of implementing the plan of action.
- Monitoring progress and where necessary giving professional support.

VI. EVALUATION

- Evaluation helps the patient and the health worker to find out how effective the interventions have achieved each of the set objectives and overall goal of restoring the patient's emotional state to the pre-crisis level of functioning.
- Re – planning may be necessary where any of the objectives has not been met.

CONCLUSION

- The approach to crisis intervention is multidisciplinary & the use of open – ended questions cannot be over – emphasized.
- To avert a crisis, positive responses should be reinforced. It must be made clear to the client that stressful events are not a crisis but they can precipitate a crisis.
- The clinician should never see themselves as a problem solver; rather, they should help the patient solve their own problems.

TYPED BY NAILA KAMADI

WHEN YOU HIT ROCK BOTTOM YOU WILL DISCOVER THAT JESUS, OUR SAVIOR & FRIEND, IS THE ROCK AT THE BOTTOM.

DON'T WAIT THAT LONG. ☺

He only is my rock and my salvation; He is my defense & my fortress, I shall not be moved

- Ps. 62.6 –

#JesusReigns

INDIVIDUAL PSYCHOTHERAPY (BRIEF AND SUPPORTIVE)

BY R. A. OKOTH.

WHAT IS BRIEF PSYCHOTHERAPY

- This is an umbrella term for a variety of approaches including short –term Solution therapy.
- Highly strategic
- Exploratory
- Solution oriented NOT problem oriented
- Concerned with the current factors sustaining the problem and preventing change
- The approach is a combination or multidimensional, ie there is NO CORRECT approach

EMPHASIS

- Focus on specific problem
- Direct intervention

PROPONENTS OF BRIEF PSYCHOTHERAPY

- **Milton Erickson (clinical hypnosis)**
- **Richard Bandler (Neuoro linguistic programing)**

COMMON FACTORS IN PSYCHOTHERAPY

I. Therapeutic relationship
II. Listening
III. Release of emotion
IV. Restoration of morale
V. Providing information
VI. Providing a rationale
VII. Advice and guidance
VIII. Suggestion

COUNSELLING AND CRISIS INTERVENTION

- Counselling
  - Counselling incorporates the non-specific factors shared by all kinds of psychotherapy

- Crisis intervention
  - Helps patients cope with a crisis in their lives, and to learn effective ways of dealing with future difficulties.

COUNSELLING 1

- Approaches to counselling
  - Problem-solving counselling
  - Interpersonal counselling
    - Loss, interpersonal disputes, role transitions, and interpersonal deficits.
  - Psychodynamic counselling

COUNSELLING 2

- Counselling for specific purposes
  - Debriefing
  - Relationship problems
  - Late effects of trauma
  - Risks
  - Students
  - In primary care

CRISIS INTERVENTION 1

- Problems leading to crisis
  - Loss problems
  - Role changes
  - Relationship problems
  - Conflict problems
- Indications:
  - well-motivated people with stabel personalities who are facing major but transitory difficulties.

CRISIS INTERVENTION 2: METHODS

- Stage Ⅰ:
  - reduce arousal;
  - focus on current problems;
  - encourage self-help
- Stage Ⅱ:
  - assess problems;
  - consider solutions;
  - test solutions
- Stage Ⅲ:
  - consider future coping methods

SUPPORTIVE PSYCHOTHERAPY

It is a therapeutic approach that intergrates

- ✓ **psychodynamic psychotherapy**
- ✓ **Cognitive – behavioral**
- ✓ **Interpersonal conceptual model technique**

SUPPORTIVE PSYCHOTHERAPY OBJECTIVE

The therapists objective is to reinforce the patient's healthy and adaptive patterns of thought behaviours in order to reduce the intra psychic conflicts that produce symptoms of mental disorders.

SUPPORTIVE PSYCHOTHERAPY

- Table22.3

TABLE 22.3 Basic procedures of supportive treatment

- Develop a therapeutic relationship
- Listen to patients' concerns
- Inform, explain, and advise
- Allow the expression of emotion
- Encourage hope
- Review and develop assets
- Encourage self-help

AIMS OF SUPPORTIVE PSYCHOTHERAPY

- **Help patient to reach and maintain their best psychological and social functioning**
- **Reduce subjective stress**
- **Reduce behavioral dysfunction**
- **Improve self esteem**
- **Minimise relapses**
- **Enhance the patients strengths and coping skills**
- **ALLOW THE PT TO ACHIEVE MAXIMUM POSSIBLE SUPPORT FROM OTHER SOURCES**

COGNITIVE BEHAVIOUR THERAPY 1

- General features: 8 types

- Assessment
  - Topics to be consided
  - Source of information for the assessment
  - The formulation

INDIVIDUAL DYNAMIC PSYCHOTHERAPIES

- **Brief insight-oriented psychotherapy**
- **Cognitive-analytical therapy**
- **Psychodynamic interpersonal therapy**
- **Long-term individual dynamic psychotherapy**

BIOFEEDBACK

BY: R. A. OKOTH

WHAT IS BIOFEEDBACK?

- **BASIC:** Biofeedback is a technique that enables an individual to learn how to change *maladaptive physiological activity* and correct *dysfunctional Autonomic Nervous System (ANS)* activity
- **SCIENTIFIC:** Biofeedback instruments are used to "feed back" information about physiological processes, assisting the individual to increase awareness of these processes and to gain voluntary control over body and mind.
- **HOLISTIC:** Biofeedback is based on the recognition that changes in the mind and emotions affect the body, and changes in the body influence the mind and emotions.
- **RESILIENCE:** Biofeedback emphasizes training individuals to self-regulate, gain awareness, increase control over their bodies, brains, and nervous systems, and improve flexibility in physiologic responding.

HISTORICAL PERSPECTIVE

- Biofeedback is a technique that gained popularity in the late 1960s
- Most people's exposure to biofeedback is from polygraph tests

BENEFITS OF BIOFEEDBACK

Skilled at Self-Regulation, Self-Soothing, Relaxation

Resilient to Effects of Stress

Psychologic

Improved Mood Stability

Able to Adjust Pain Perception

BENEFITS OF BIOFEEDBACK

Recovery from Stress Response

Brain-Heart-Breath Entrainment

Physiologic

SNS and PNS Regulation

Pain Modulation

OVERVIEW OF BIOFEEDBACK MODALITIES

Modality	Description
Brainwave (EEG)	Uses scalp sensors to monitor the brain's electrical activity using (EEG) sensors
Breathing	Uses bands placed around the abdomen/chest to monitor breathing pattern and pace and calculate resonant breathing frequency.
Heart Rate Variability (HRV)	Uses a finger/earlobe sensor to measure heart rate and calculate heart rate variability and coherence.
Muscle (EMG)	Uses sensors placed over skeletal muscles to monitor the electrical activity that causes skeletal muscle contraction.
Sweat Gland (GSR)	Uses sensors placed around the fingers to monitor changes in skin moisture produced by sweat glands.
Temperature	Uses a finger sensor to measure changes in blood flow controlled by dilating and constricting blood vessels.

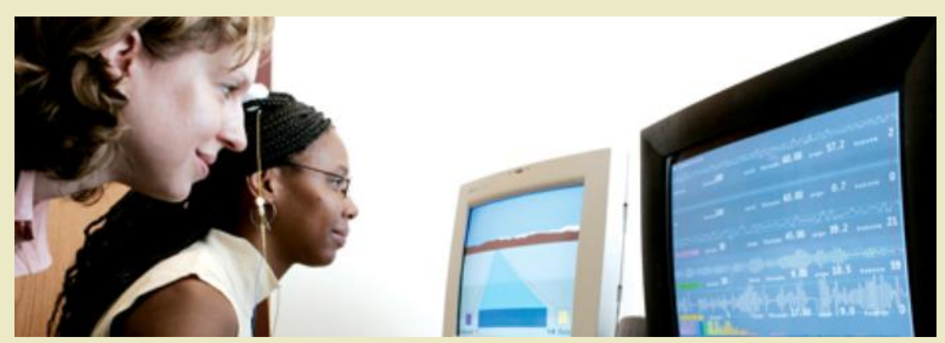
Source: BCIA

MAJOR TYPES OF BIOFEEDBACK

Temperature biofeedback is used to treat headache, high blood pressure, Raynaud's disease, and swelling.

BIOFEEDBACK GIVES YOU EXCITING CHOICES

Biofeedback provides you with the opportunity to take control of your health and to choose *skills instead of MEDICATION*.



BIOFEEDBACK

- Biofeedback is a process of gathering information about specific physiological functions such as:
  - heart rate
  - respiration
  - body temperature

CLINICAL BIOFEEDBACK

- Clinical biofeedback is the use of monitoring instruments to amplify the electrochemical energy produced by various body organs.

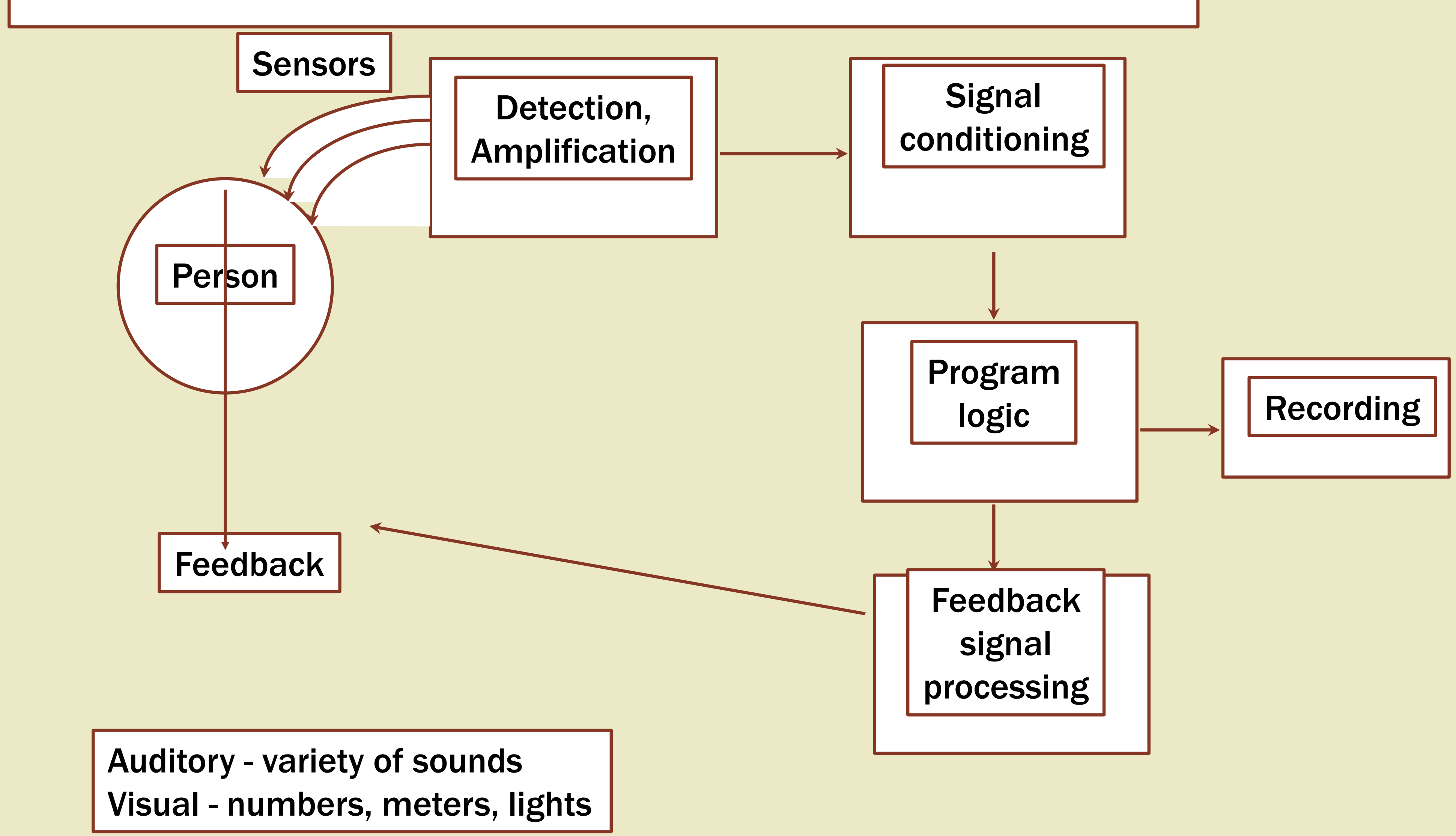
CLINICAL BIOFEEDBACK (CONTINUED)

- Clinical biofeedback allows a person to increase awareness of his or her own physiological responses by learning to monitor them through data gathered by a particular instrument.

CLINICAL BIOFEEDBACK (CONTINUED)

- The purpose of biofeedback is to teach people with stress-related disorders to recondition their responses so that they gain control over the physiological system responsible for their symptoms.

THE BIOFEEDBACK LOOP



BIOFEEDBACK

- Biofeedback teaches people how to monitor and change the frequency and amplitude of the electronic signals by controlling (relaxing) the body region to which the electrodes are attached. The three phases of biofeedback are:
  - Awareness of physiological response
  - Control of physiological response
  - Application of reconditioned response in everyday routines

CLINICAL BIOFEEDBACK

- Clinical biofeedback, to strengthen the conditioned response, combines sophisticated technology and various other forms of relaxation, including:
- diaphragmatic breathing
- autogenic training
- progressive muscular relaxation
- mental imagery

CLINICAL BIOFEEDBACK (CONTINUED)

- There are several types of clinical biofeedback, each monitoring a specific physiological system; these are:
- electromyography (EMG)
- electroencephalography (EEG)
- electrocardiography (EKG)
- electro dermal (EDR)

BEST APPLICATION OF BIOFEEDBACK

- To learn to reduce chronic pain of:
  - Headaches
  - Stomach cramp
  - Colitis
  - Back pain
  - Raynaud's disease
  - Insomnia

BIOFEEDBACK IS INFORMATION

Biofeedback displays your performance back to you.

BIOFEEDBACK IS INFORMATION

You probably use biofeedback every day without recognizing it.

BIOFEEDBACK IS INFORMATION

You receive ***weight biofeedback*** whenever you step on a bathroom scale.

BIOFEEDBACK IS INFORMATION

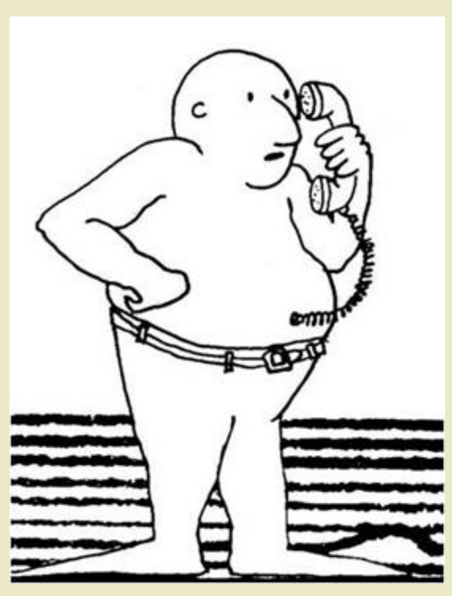
If you are diabetic, you receive ***blood sugar biofeedback*** after pricking your finger.

BIOFEEDBACK IS INFORMATION

Professionals use sophisticated devices called ***electroencephalographs*** to treat Attention Deficit Hyperactivity Disorder (ADHD) and addictive disorders.

BIOFEEDBACK IS INFORMATION

Biofeedback provides you with information about your performance to increase your awareness and control over your own body.



© 1979 by Erik Peper

MAJOR TYPES OF BIOFEEDBACK

Six major types of biofeedback include:

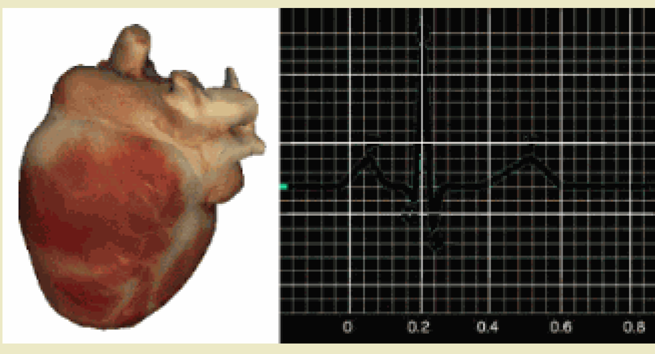
- Heart rate variability (HRV) biofeedback
- Muscle biofeedback
- Neurofeedback
- Respiratory biofeedback
- Sweat gland biofeedback
- Temperature biofeedback

MAJOR TYPES OF BIOFEEDBACK

Professionals use these tools to treat medical and psychological disorders, and to train athletes and musicians to achieve optimal performance.

MAJOR TYPES OF BIOFEEDBACK

Heart rate variability (HRV) biofeedback uses sensors placed on a finger or earlobe, or on your chest and lower torso, or wrists to measure the time interval between each heartbeat.



MAJOR TYPES OF BIOFEEDBACK

HRV biofeedback is used to treat anxiety, asthma, heart disease, depression, high blood pressure, irritable bowel disorder, Posttraumatic Stress Disorder (PTSD), and unexplained abdominal pain.

MAJOR TYPES OF BIOFEEDBACK

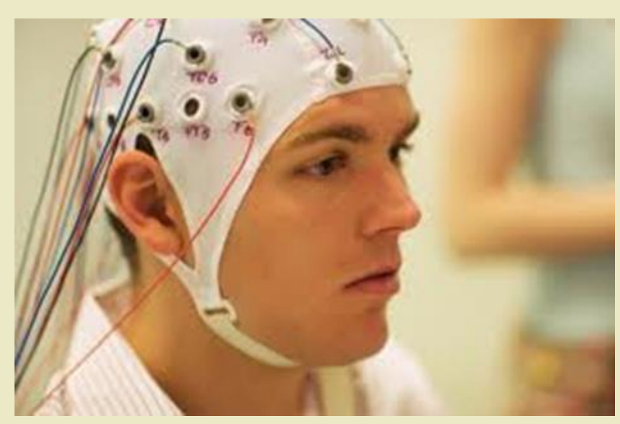
Muscle (or EMG) biofeedback uses sensors placed over skeletal muscles to monitor the electrical activity that causes muscle contraction.

MAJOR TYPES OF BIOFEEDBACK

Muscle biofeedback is used to treat disorders
as diverse as anxiety, asthma, cerebral palsy,
headache, high blood pressure, low back pain, spinal cord injury, and stroke.

MAJOR TYPES OF BIOFEEDBACK

Neurofeedback (EEG biofeedback) uses scalp sensors to monitor the brain's electrical activity.

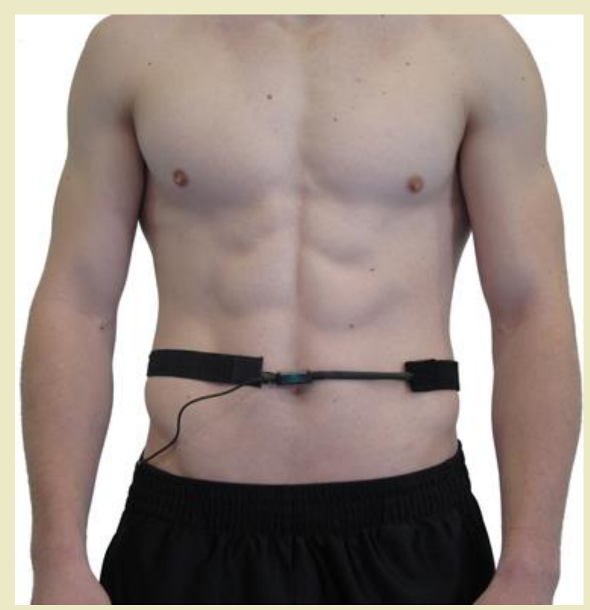


MAJOR TYPES OF BIOFEEDBACK

Neuro feedback is used to treat ADHD, alcoholism and abuse of other substances, epilepsy, migraines, PTSD, and traumatic brain injury.

MAJOR TYPES OF BIOFEEDBACK

Respiratory biofeedback uses sensor placed around the abdomen and chest to monitor breathing patterns and respiration rate.



MAJOR TYPES OF BIOFEEDBACK

Respiratory biofeedback is used to treat anxiety, asthma, chronic obstructive pulmonary disease (COPD), hyperventilation syndrome (HVS), and high blood pressure.

MAJOR TYPES OF BIOFEEDBACK

Sweat gland biofeedback uses sensors placed on the fingers or palms to monitor changes in skin moisture produced by sweating.

MAJOR TYPES OF BIOFEEDBACK

Sweat gland biofeedback is used to treat excessive sweating (called hyperhidrosis) and high blood pressure, and to teach relaxation.

STUDY GUIDE QUESTIONS

1. Explain the rationale for biofeedback as an effective relaxation technique.

2. Explain three different types of biofeedback.

3. List five health conditions that could possibly be improved with the use of biofeedback.

MAJOR TYPES OF BIOFEEDBACK

Finally, ***temperature biofeedback*** uses sensors placed on the hands or feet to measure blood flow to the skin.

STUDY RESULTS IN THE LITERATURE

- Reduces blood pressure in hypertension (McCraty, 2001)
- Improves asthma (Lehrer, 2000)
- Increases calmness and well-being (Friedman, 2000)
- Increases emotional stability (McCraty, 2001)
- Improves cognitive performance (McCraty, 2001)
- Improves hormonal balance (McCraty, 1998)

PSYCHODYNAMIC APPROACH

Dr. Manasi Kumar
Lecturer
Department of Psychiatry

FREUD'S THEORIES, IN CONTEXT

- Freud was originally trained as a Neurologist- biological approach to illness
- Treated mostly Hysteria (conversion disorders)
- Applied findings from abnormal patients to "normal" development

FREUD: A SIGN OF THE TIMES?

- Time period: late 1800’s
- Victorian times: conservative, repressed society
- Prohibitions against sex

KEY CONTRIBUTIONS OF FREUD

- Psychic Determinism/ Dynamic Model
- Topographical Model of the Mind
  - Unconscious, Preconscious, Conscious
- Stages of Psychosexual Development
- Structural Model of the Mind
- Defense Mechanisms
- Transference and Countertransference

BASIC PRINCIPLES OF PSYCHODYNAMICS

- Freud sees people as passive; behaviors determined by interaction of external reality and internal drives
- Psychic Determinism: all behaviors driven by antecedent events, experiences. There are no accidents; nothing happens by chance

BASIC PRINCIPLES

- Pleasure Principle: constant drive to reduce tension thru expression of instinctual urges
- Mind is a dynamic (changing/active) process based on the Pleasure Principle

BASIC PRINCIPLES

- Libidinal (sexual, aggressive) instincts drive people
  - In children “libido” isn’t purely sexual, it’s pleasure thru sensations (oral, anal gratification, etc.)
- Behaviors result from conflicts:
  - Between instinctual libidinal drives (aggression, sex) and efforts to repress them from consciousness)

MORE BASIC PRINCIPLES

- The Cathartic Method
- Primary vs. Secondary Gain
- Transference and Countertransference
- Ego-Syntonic vs. Ego-Dystonic

CATHARTIC METHOD

- Therapy benefits thru release of pent-up tensions, “catharsis”
- Some inherent value in the “talking cure”- being able to “unload”, or “get stuff off your mind”

PRIMARY VS. SECONDARY GAIN

- **Primary Gain:** symptoms serve a purpose: they function to decrease intra-psychic conflict and distress by keeping such unpleasantries from conscious awareness

PRIMARY GAIN: EXAMPLES:

- Comfort of being taken care of thru assumption of the sick role
- Conversion Disorder- psychological conflict is converted into physical symptom that allows for more acceptable expression of an unacceptable wish

SECONDARY GAIN

- Actual or external advantages that patients gain from their symptoms, or from being ill:
  - Relief from duties, responsibilities (work)
  - Prescription drugs (ex. Opiates)
  - Manipulation in relationships
  - Deferring of legal proceedings, exams
  - Food, shelter, money (financial gain)

TRANSFERENCE

- Displacement (false attribution) of feelings, attitudes, behavioral expectations and attributes from important childhood relationships to current ones

TRANSFERENCE

- Traditionally refers to what the patient projects onto the therapist, but applies to other situations as well- ex. relationships in general
- Aka “emotional baggage”
- Occurs unconsciously (person’s unaware they’re doing it)

COUNTERTRANSFERENCE

- Feelings toward another are based on your own past relationships/ experiences.
- Traditionally refers to the therapist projecting their own feelings ("issues", "emotional baggage") onto their patient

EGO-SYNTONIC VS. DYSTONIC

- Neurotic symptoms are distressing to the person, or ego-dystonic
  - Vs.
- Character pathology, which is ego-syntonic; patient doesn't perceive as a problem; only problematic in dealings with others/ external world

TOPOGRAPHICAL MODEL

- Freud's first model of psychopathology
- Division of the mind into three different layers of consciousness:
  - Unconscious
  - Preconscious
  - Conscious

UNCONSCIOUS

- Contains repressed thoughts and feelings
- Unconscious shows itself in:
  - Dreams
  - Parapraxes (Freudian slips)
- Driven by Primary Process Thinking

PRIMARY PROCESS THINKING

- Not cause-effect; illogical; fantasy
- Only concern is immediate gratification (drive satisfaction)
- Does not take reality into account
- Seen in dreams, during hypnosis, some forms of psychosis, young children, psychoanalytic psychotherapy

FREUDIAN SLIPS (PARAPRAXES)

- A “slip of the tongue”
- Errors of speech or hearing that reveal one’s true but unconscious feelings

PRECONSCIOUS

- Accessible, but not immediately available
- Always running in the background/ behind the scenes

CONSCIOUS

- Fully and readily accessible
- Conscious mind does not have access to the unconscious
- Utilizes Secondary Process Thinking:
  - Reality-based (takes external reality into consideration), logical, mature, time-oriented

PSYCHOSEXUAL DEVELOPMENT

- Children pass thru a series of age-dependent stages during development
- Each stage has a designated “pleasure zone” and “primary activity”
- Each stage requires resolution of a particular conflict/task

PSYCHOSEXUAL STAGES

- Failure to successfully navigate a stage's particular conflict/ task is known as Fixation
  - Leaving some energy in a stage
- Specific problems result from Fixation, depending on which stage is involved
  - Fixation may result from environmental disruption

PSYCHOSEXUAL STAGES

- Freud's stages are based on clinical observations of his patients
- The Stages are:
  - Oral
  - Anal
  - Phallic
  - Latency
  - Genital

ORAL STAGE

- Birth to 18 months
  - Pleasure Zone: Mouth
  - Primary Activity: Nursing
  - Fixation results in difficulties with trust, attachment, commitment
  - Fixation may also manifest as eating disorders, smoking, drinking problems

ANAL PHASE

- 18months- 2yrs
  - Pleasure Zone: Anus
  - Primary Activity: Toilet training
  - Failure to produce on schedule arouses parental disappointment

ANAL PHASE

- 18months- 2yrs
  - Parental disappointment, in turn, arouses feelings in child of anger and aggression towards caregivers, which are defended against
  - Fixation may result in either:
    - Anal retentiveness: perfectionism, obsessive-compulsive tendencies
    - Anal expulsive: sloppy, messy, disorganized

PHALLIC (OEDIPAL) PHASE

- Ages 3-6
  - Pleasure Zone: Genitals
  - Primary Activity: Genital fondling
  - Must successfully navigate the Oedipal Conflict

OEDIPAL CONFLICT

- Boys want to marry mom and kill father, aka Oedipal Complex, but fear retaliation from father (castration anxiety); ultimately resolved thru identification with father
- Girls have penis envy, want to marry dad, aka “Electra Complex”; identify with mom to try to win dad’s love

PHALLIC (OEDIPAL) PHASE:

- Ages 3-6
  - Resolution of the Oedipal Conflict results in formation of the Superego
  - Fixation results in attraction to unattainable partners

LATENCY PHASE

- Ages 6-11
  - Pleasure Zone: Sex drive is rerouted into socialization and skills development
  - Primary Activity: Same sex play; identification of sex role
  - Don’t like opposite sex (has “cooties”)
  - Fixation results in lack of initiative, low self esteem; environmental incompetence

GENITAL PHASE

- Ages 13- young adulthood
  - Pleasure Zone: Genitals
  - Primary Activity: Adult sexual relationships
  - Fixation results in regression to an earlier stage, lack of sense of self

STRUCTURAL (TRIPARTITE) THEORY

- Freud's second model of the mind to explain psychopathology
- Developed in the early 1900's

THE ID

- Home of instinctual Drives
- “I want it and I want it NOW”
- Completely unconscious
- Present at birth
- Operates on the Pleasure Principle and employs Primary Process Thinking

TO REVIEW:

- Pleasure Principle: constant drive to reduce tension thru expression of instinctual urges
- Primary Process Thinking: Not cause-effect; illogical; fantasy; only concern is immediate gratification (drive satisfaction)

THE SUPEREGO

- Internalized morals/values- sense of right and wrong
- Suppresses instinctual drives of ID (thru guilt and shame) and serves as the moral conscience

THE SUPEREGO

- Largely unconscious, but has conscious component
- Develops with socialization, and thru identification with same-sex parent (via introjection) at the resolution of the Oedipal Conflict
- Introjection: absorbing rules for behavior from role models

THE SUPEREGO- 2 PARTS:

- **Conscience:** Dictates what is proscribed (should not be done); results in guilt
- **Ego-Ideal:** Dictates what is prescribed (should be done); results in shame

THE EGO

- Created by the ID to help it interface with external reality
- Mediates between the ID, Superego, and reality
- Partly conscious
- Uses Secondary Process Thinking:
  - Logical, rational

"EGO" DEFENSE MECHANISMS

- The Ego employs "ego defense mechanisms"
- They serve to protect an individual from unpleasant thoughts or emotions
  - Keep unconscious conflicts unconscious
- Defense Mechanisms are primarily unconscious

“EGO” DEFENSE MECHANISMS

- Result from interactions between the ID, Ego, and Superego
- Thus, they’re compromises:
  - Attempts to express an impulse (to satisfy the ID) in a socially acceptable or disguised way (so that the Superego can deal with it)

“EGO” DEFENSE MECHANISMS

- Less mature defenses protect the person from anxiety and negative feelings, but at price
- Some defense mechanisms explain aspects of psychopathology:
  - Ex. Identification with aggressor: can explain tendency of some abused kids to grow into abusers

PRIMARY REPRESSION

- Conflict arises when the ID’s drives threaten to overwhelm the controls of the Ego and Superego
- Ego pushes ID impulses deeper into the unconscious via repression
- Material pushed into unconscious does not sit quietly- causes symptoms

CLASSIFICATION OF DEFENSES

- Mature
- Immature
- Narcissistic
- Neurotic

MATURE DEFENSES

- Altruism
- Anticipation
- Humor
- Sublimation
- Suppression

ALTRUISM

- Unselfishly assisting others to avoid negative personal feelings

ANTICIPATION

- Thinking ahead and planning appropriately

SUBLIMATION

- Rerouting an unacceptable drive in a socially acceptable way; redirecting the energy from a forbidden drive into a constructive act
  - A healthy, conscious defense
  - Ex. Martial Arts

SUPPRESSION

- Deliberately (consciously) pushing anxiety-provoking or personally unacceptable material out of conscious awareness

IMMATURE DEFENSES

- Acting Out
- Somatization
- Regression
- Denial
- Projection
- Splitting
- Displacement
- Dissociation
- Reaction Formation
- Repression
- Magical Thinking
- Isolation of Affect
- Intellectualization
- Rationalization

ACTING OUT

- Behaving in an attention-getting, often socially inappropriate manner to avoid dealing with unacceptable emotions or material

SOMATIZATION

- Unconscious transformation of unacceptable impulses or feelings into physical symptoms

REGRESSION

- Return to earlier level of functioning (childlike behaviors) during stressful situations
  - Ex. Kids regress after trauma

DENIAL

- Unconsciously discounting external reality

PROJECTION

- Falsely attributing one's own unacceptable impulses or feelings onto others
  - Can manifest as paranoia

SPLITTING

- Selectively focusing on only part of a person to meet a current need state; seeing people as either all-good or all-bad
- Serves to relieve the uncertainty engendered by the fact that people have both bad and good qualities
- Considered normal in childhood

DISPLACEMENT

- Redirection of unacceptable feelings, impulses from their source onto a less threatening person or object
  - Ex. Mad at your boss, so you go home and kick the dog

DISSOCIATION

- Mentally separating part of consciousness from reality; can result in forgetting certain events
  - Ex. Dissociative amnesia

REACTION FORMATION

- Transforming an unacceptable impulse into a diametrically opposed thought, feeling, attitude, or behavior; denying unacceptable feelings and adopting opposite attitudes
  - Ex. Person who loves pornography leads a movement to outlaw its sale in the neighborhood

REPRESSION

- Keeping an idea or feeling out of conscious awareness
- The primary ego defense
- Freud postulated that other defenses are employed only when repression fails

MAGICAL THINKING

- A thought is given great power, deemed to have more of a connection to events than is realistic
  - Ex. Thinking about a disaster can bring it about
  - Can manifest as obsessions

ISOLATION OF AFFECT

- Stripping an idea from its accompanying feeling or affect
- Idea is made conscious but the feelings are kept unconscious

INTELLECTUALIZATION

- Using higher cortical functions to avoid experiencing uncomfortable emotions; thinking without accompanying emotion

RATIONALIZATION

- Unconscious distortion of reality so that it's negative outcome seems reasonable or "not so bad, after all" (making lemonade out of lemons)
- Giving seemingly reasonable explanations for unacceptable or irrational feelings

TRANSFERENCE AND COUNTERTRANSFERENCE

BY: DR. MANASI KUMAR

TRANSFERENCE AND COUNTERTRANSFERENCE

- Transference and countertransference are unconscious mental attitudes based on important past personal relationships (e.g., with parents). These phenomena increase emotionality and may thus alter judgment and behavior in patients' relationships with their doctors (transference) and doctors' relationships with their patients (countertransference).

TRANSFERENCE AND COUNTERTRANSFERENCE

- Transference is a term that that refers to the displacement of attitudes and feelings originally experienced in relationships with persons from the past onto the analyst.
- In positive transference, the patient has confidence in the doctor. If intense, the patient may over-idealize the doctor or develop sexual feelings toward the doctor.

TRANSFERENCE AND COUNTERTRANSFERENCE

- In negative transference, the patient may become resentful or angry toward the doctor if the patient's desires and expectations are not realized. "This may lead to noncompliance with medical advice.

TRANSFERENCE AND COUNTERTRANSFERENCE

- Introduced by Freud – parallel process between how you relate to key figures in your life and how you relate to your therapist
- Conversely, your relationships as a therapist effect how you relate to your clients
- Although transference and countertransference are key in some approaches (psychoanalysis, psychodynamic approach), they are recognized by most theorists

TRANSFERENCE

- Client may infer your reaction or thoughts (e.g., I know what you are thinking…)
- Client may have a greatly exaggerated response compared to what would normally be expected
- Eventually come to realization that therapy is not really about you

TRANSFERENCE AND COUNTERTRANSFERENCE

Counter transference:

- According to Freud – analyst’s transference to a patient.
- Broad meaning – an analyst’s feelings that are thought to be related to what the patient is projecting onto the psychoanalyst.
- Most common meaning – a joint creation involving contributions from the analyst’s past and the patient’s internal world.

- In countertransference, feelings about a patient who reminds the doctor of a close friend or relative can interfere with the doctor's medical judgment.

COUNTERTRANSFERENCE

- Can include intense feelings of attraction or repulsion
- More than just reminding you of someone
- Can be increased by having a client with a similar history / difficulties to yourself
- Need to be aware of your own process and seek consultation as needed

PSYCHOSOCIAL ASPECTS OF CHONIC ILLNESS

BY: SOBBIE MULINDI

TERMINALLY ILL PATIENTS

- When diagnosis is made
- Facing the threat of death
- The threat of the end of life
- Is something that happens to others people
- Human minds are very good at coping with bad news
- News that may drastically affect our future
- Is difficult to get a fix on it
- Several kinds of reactions emerge, Elizabeth Kubler Ross studied Patient's Reactions of chronically ill patients.

THE PATIENTS FEELINGS?

- 1. Shock and Disbelief
- Almost all patients facing the threat of terminal illness and death
- They g through shock and disbelief
- Shock is highly unpleasant and distressing state
- Most people do not recover instantly
- I"ll keep on thinking it's all a dream"
- This sort of genuine disbelief

THE PATIENTS FEELINGS?

- Is completely normal reaction to overwhelming news
- **Shock** suggests a fuller impact on the patient's ability to think and behave
- A patient in shock finds it difficult to experience normal thoughts and emotions
- Shock like disbelief waxes and wanes
- There is a breakdown in the ability to make decision

THE PATIENTS FEELINGS?

- Other symptoms include forgetfulness, slowing down, staring into space, lost to the outside world, inert and apathetic
- The patient may also cling and accept a loss of independence
- There may be other forms of regressive behavior
- The patient realizes he is in trouble
- He feels he should be able to simply snap out of it.
- No one simply snaps out of shock

THE PATIENTS FEELINGS?

- This is normal reaction to overwhelming news
- Most people do not recover instantly
- They instead recover gradually over time
- As time goes on, the sensation fades

THE PATIENTS FEELINGS?

- 2. **Denial**
- There is a real difference between denial and disbelief
- I cannot take this in (**Disbelief**)
- I will not take this on board (**Denial**)
- Denial can occur at several levels
- Denial can be unconcern's or concerns
- A well known physician had an exploratory operation

THE PATIENTS FEELINGS?

- It showed he had advance cancer of pancreas. (Incurable)
- “What did the operation Show’? x 5
- Another doctor had developed cancer of the prostate
- He was certain in his heart that it wasn’t cancer
- This isn’t prostate cancer”
- The important point is that denial is a conflict between knowledge and belief

THE PATIENTS FEELINGS?

- Denial is simply inability to believe facts
- Denial is a normal coping mechanism of the human mind
- Denial cannot be wiped out by simply confronting the patient with facts
- Several patients have fairly clear guidelines
- What they will or will not listen to
- “Don’t tell me bad news, if it’s serious talk to my wife”

THE PATIENTS FEELINGS?

- The patient knows deep down how bad news is
- But may not want to face it in the open
- Many patients and families may feel differently
- They may think that knowledge itself will hasten death
- “Don’t tell our mum she’s got cancer
- The news alone would kill her

THE PATIENTS FEELINGS?

- Keeping patients uniformed is not helpful
- Studies indicate that majority of patients want to know **the diagnosis**
- They want to know what's going on
- They need to know to make informed decisions/plans
- Withholding information infringes on patient's ethical, moral and legal rights

THE PATIENTS FEELINGS?

- Patient has a right to information that concerns him
- Denial can be damaging to both the patient and relatives
- Especially if denial is causing the patient great distress
- That can sometimes lead to suicide
- Expert assessment and help may be needed
- To help the patient face the facts.

THE PATIENTS FEELINGS?

- 3. **Anger**
- Anger is common in all illness
- With chronic illness, the anger is there everyday
- Why do patients get angry when ill?
- Is loss of control and antinomy
- Ability to make personal choices and decisions is curtailed
- Illness does not happen on our way It happens on its own way Patients experience three types of anger

THE PATIENTS FEELINGS?

- Why should I get this illness?
- Many illnesses have no relationship to previous health of the person
- These illnesses are nothing more than the product of mischance and bad luck
- Anger can be projected, painfully, personally and directly at a friend or supporter

THE PATIENTS FEELINGS?

- One may be asked to take sides and judge between patients and doctor
- Patients become angry when dealing with a disease
- The anger is a result of the situation the patient finds himself/herself
- It isn’t really personal as all

THE PATIENTS FEELINGS?

- 4. Fear
- Fear of serious illness and death is common, expected and accepted by all
- Fear of dying is complex
- One of the most common fears is the fear of being afraid
- We are not suppose to be afraid of things
- We are taught to be bold, brave
- People are frightened of fear itself

THE PATIENTS FEELINGS?

- Fear requires imagination
- People who are afraid are thinking and are imagining
- Fear of dying is not one fear but many fears
- There are fears to do with physical illness and incapacity
- Fears of being handicapped, of being a burden on family, friends
- Fears of not being able to support the family
- Fears about physical pain

THE PATIENTS FEELINGS?

- Existential fears, about ending life itself
- Spiritual fears. What happens afterward? Will there be an afterlife?
- Could there be punishment?
- There are also practical fears
- What will happen to the children afterward
- What will happen to surving spouse?
- What will happen to running the home?

THE PATIENTS FEELINGS?

- There are fears about rift conflicts between family members/ friends
- Past grievances/ mistakes/consequences
- Fears not having achieved enough
- Not having succeeded
- Not having made best time

THE PATIENTS FEELINGS?

- 5. **Hope, Despair, Depression**
- Facing death is a monumental task for the patient
- That once the hope of a long and healthy life is gone
- Nothing remains but despair
- Despair like anger, denial and fear is common
- No magic formula can instantly banish it

THE PATIENTS FEELINGS?

- Despair means loss of hope
- Despair usually comes in cycles
- Despair is a change in thinking
- Depression is a change in mood or feeling
- Despair is very often accompanied by depression

THE PATIENTS FEELINGS?

- **What are Physical signs of Depression?**
  - Insomnia (inability to sleep), waking up early, inability to go back to sleep.
  - Crying much of the time
  - Loss of appetite
  - Loss of interest in conversation and interaction with relatives, friends, staff
  - Loss of facial expression
  - Loss of smiling

THE PATIENTS FEELINGS?

- Assessing major depression is tricky
- The need for a psychiatrist might be helpful
- Don’t use the word psychiatrist
- Patient’s/everybody associate psychiatrists with going crazy/mad
- “First I get an illness, then I discover am going to die, and now you think am losing my mind as well????!

THE PATIENTS FEELINGS?

- Many different medications are now available that help to cope with depression.

- 5. **Bargaining**
- Bargaining is another way the mind struggle with threat of death
- The patient may bargain in many ways
- "If I agree to have the treatment, will you promise me it will work?'
- The patient may promise to change some aspect of his behaviors
- May take the form of a pact between the patient and his God
- "Get me out of this, and I'll go to church every Sunday"
- Getting born again is another strategy

THE PATIENTS FEELINGS?

- Bargaining is a battle between hope and despair
- The bargaining mind accept the news in small pieces, rather than being overwhelmed by it
- Bargaining is not a stage of dying process
- It is the result of the struggle within the patient's mind.
- Between the reality of the situation and the forces of hope and despair.
- **NB.** Coping with the patient's despair is one of the most difficult aspects of supporting a dying person.
- It terms of effort and exhaustion

THE PATIENTS FEELINGS?

- 7. **Guilt**
- When anyone becomes seriously ill
- Guilt seems to accumulate everywhere
- Guilt is consistent feeling of responsibility
- There are two concept that characterize quilt: Personal responsibility and punishment

THE PATIENTS FEELINGS?

- Guilt is a common emotion to all
- Society ingrains ideas of reward and punishment, and of responsibility
- Everybody tends to feel guilty when there is a catastrophe such as serious illness
- Looking up for cause of calamity is universal
- The threat of death there is a strong instinct to allocate blame
- The most natural instinct is that the patient himself
- May regard the illness as a punishment for sins committed in the past

THE PATIENTS FEELINGS?

- To make matters worse, some diseases are caused by personal habits (cirrhosis of the liver due to drinking) cancer of the lung due to smoking
- The patient may regard illness as retribution
- Random punishment may actually induce an effort to find a cause where none exists.
- Some people capitalize on inherent sense of quilt
- The first major cause of quilt lies in seeing illness as a judgment or
- Judicial sentence passed on the patient’s previous life.

THE PATIENTS FEELINGS?

- The threat of death telescopes the future, putting a tremendous pressure on both patient and family
- Telescoping the future "Life – threatening illness immediately reduces the time scale by which we all live
- A sense of urgency magnifies any unfinished business

THE PATIENTS FEELINGS?

- We all have unfinished emotional business
  - Unresolved arguments with friends or relatives
  - Aggressive or selfish things we have done
  - Actions in some way unworthy of the way we would like to imagine ourselves
- While we are in good health we carry this list with us
- We assume that we have sufficient time to sort it out later
- The threat of illness reduces that “later” to “soon” A sense of deadline arises

THE PATIENTS FEELINGS?

- The sense of guilt about that unfinished business, may seem to have arisen from nowhere
- People feel quality if they are sensitive about their actions and aware of other people’s feelings and reactions
- In the same way in which fear requires imagination, so guilt requires sensitivity

THE PATIENTS FEELINGS?

- This neither compensates for the feeling of guilt nor abolishes the feeling
- Guilt may not have a definite purpose
- But it certainly does signal some positive qualities in the sufferer

THE PATIENTS FEELINGS?

- 8. **Acceptance**
- This is the last stage of terminal illness
- The patient recognizes the inevitability of death
- And accepts that it is going to happen in the immediate future
- Some patients accept it early in the illness
- Some never accept it at all
- Similarly, among health professionals

THE PATIENTS FEELINGS?

- Some authorities feel that patients must accept it
- While others feel that patients don't have to accept it openly
- But it is generally better for them and their friends if they do.
- Some patients have courage and insight, use every minute available to them, right up to the end of their lived, to keep emotional contact, to get support from and give support to their families

WHAT DOES ACCEPTANCE MEAN TO THE PATIENT?

- As acceptance grows, the patient usually feels sad a, and often tender
- There is unusually more peace and less anger
- Acceptance always bring true sadness (as opposed to depression)
- The patient is sad at the prospect of being parted from friends/family
- About leaving the enjoyable things of life
- This sadness is natural

WHAT DOES ACCEPTANCE MEAN TO THE PATIENT?

- Allow the patient to express this sadness candidly
- Patients with strong religious beliefs
- Do not experience sadness
- Instead they look forward to being reunited with those who have died before the

WHAT DOES ACCEPTANCE MEAN TO THE PATIENT?

- This belief creates an enormous comfort these patients are generally very strong about facing the end of life
- They are able to communicate easily with their friends and family
- For most people, sadness is a central part of the final stage
- The sadness itself contains grief
- Many people are at the end of their life mourning for themselves
- They don’t want to stop living and so they mourn

WHAT DOES ACCEPTANCE MEAN TO THE PATIENT?

- In the same way the survivng relatives will mourn after their bereavement
- Most people die as they have lived
- If one is easy and cheerful approaches the end of life in the same manner
- If one is neurotic and cantankerous ends the same way, with same mixture of traits and moods
- Some deaths are so much in character that they seem to amplify the person's life.

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PSYCHOTHERAPY FOR THE CHRONICALLY ILL

BY: SOBBIE Z. A. MULINDI

INTRODUCTION

- Chronically ill patients face many challenges.
- Their terminal condition is associated with:
  - Dread
  - Fear
  - Anxiety
- Sometimes terminally ill patients are separated from other patients.

INTRODUCTION

- They are put in a special category.
- Defined by ideas of success or failure.
- Success is equated with curable.
- Some patients require optimum adaptation to the disease.
- They need certain coping strategies.
- This is where psychotherapy comes in handy.

INTRODUCTION

- Diseases like cancer are very stressful.
- Both for the patients, their families and those who care for them.
- There is emotional exhaustion and burn out phenomena.
- This is because most of the patients are seriously ill or dying.
- They have to deal with depression, anxiety, fears and other powerful emotions.

INTRODUCTION

- Positive approach working with cancer patients is not to regard them curable or incurable.
- The focus should be on promoting control of the disease.
- Rehabilitation allows to assist patients effectively in coping.

INTRODUCTION

- Since cancer is a prolonged battle.
- Focus is on patients adaptation to their level of maximum functioning.
- Care and comfort are critical in meeting patients' individual needs.

INTRODUCTION

- Problem solving behaviour
- Designed to bring about change
- Relief, reward, quiescence and equilibrium
- Common task physicians, psychiatrists and patients
- Solve problems related to being sick
- Psychotherapy is an integral part of medical practice
- Patients have different problems
- Physicians react to a wide variety reactions, diagnoses and management

COPING STRATEGIES

- Aim is to identify problems that distress a patient
- Evaluate the degree of turmoil
- Medical problems relate to disease, sickness and vulnerability
- Being sick means feeling sick
- Means filling the sick role within the hospital structure and its relationships
- Patienthood imposes certain tacit obligations
- There are rules and regulations that define proper behaviour and medical expectations
- A good patient is promised an average expectable outcome

COPING STRATEGIES

- Patient with good doctor-patient relationship are less distressed
- Many psychiatric consultations stem from staff's intolerance of aberrant behavior
- Some patients struggle for power or manipulate staff
- Others are uncooperative, resistant or passive aggressive
- Sometimes health workers see their work thwarted by patients and families
- Their jobs are made difficult because these challenges

COPING STRATEGIES

- That hinder progress
- Careful not to judge these faults
- Even cooperative patients do have issues
- Psychiatrists codify their findings in medical format to be fully accepted by their colleague

2) DISEASE – RELATED PROBLEMS

- Different diseases have their own complications
- Patients have to cope with them
- A disfiguring scar, ataxia colostomy, a restrictive diet
- Require some form habilitation and retraining
- This entails coping processes
- Not every patient seen by a psychiatrist suffers from mental or emotional problems
- Liaison psychiatry deals with complications of rehabilitative procedures

2) DISEASE – RELATED PROBLEMS

- Example of an amputated patient
- Responding to fears of walking unaided
- Psychiatrists are being consulted for patients
- Suffering diseases of progress
- Every advance in medicine is followed by an unexpected complication

2) DISEASE – RELATED PROBLEMS

- Treatments that save patients from one disease
- May expose them to several others
- Secondary problems of immunosuppression are prominent examples
- These require psychosocial interventions

SICKNESS RELATED PROBLEMS

- Illness has its interpersonal and intrapsychic qualities
- There are limits of medicine and surgery
- Quite often psychosocial factors take over
- A young father who develops carcinoma of the lung
- He may complain to and about the physician

SICKNESS RELATED PROBLEMS

- Argue with his wife and blame children for his plight
- This conceals deep pessimism about survival
- Fear of abandoning people closest to him
- Fears of being irreparably harmed or incapacitated
- Asking indirect questions
- "How has this illness been a problem for you and the people closest to you?"

SICKNESS RELATED PROBLEMS

- Fears about dying are more difficult to enquire about
- Every illness carries a balance of gains and losses the individual
- An expected improvement or recovery can be a challenge
- Being accustomed to individualism and sick role
- Requires careful management
- Survival, support and self-esteem are three important problems faced by chronically ill patient

VULNERABILITY

- Refers to the emotional distress that is the most aspect of illness
- It reflects impairment of competence, control and consciousness
- It is important to recognize distress and disposition in vulnerable patients
- Depressed patients are dejected and hopeless about the future
- Their sense of doom leads to apathy and indifference

VULNERABILITY

- Truculent patients feel angry, victimized, resentful and misled
- Both kinds of patients discourage others from coming to their aid
- There are thirteen common types of vulnerability
- Found among hospitalized medical and surgical chronic patients
- Hopelessness
- Turmoil/Perturbation

VULNERABILITY

- Frustration
- Despondent/Depressed
- Helplessness/Powerlessness
- Anxiety/Fears
- Exhaustion/Apathy
- Worthless/Self-rebake

VULNERABILITY

- Painful Isolation/Abandonment
- Denial/Avoidance
- Truculence/Annoyance
- Repudiation of Significant Others
- Closed Time Perspective

INTENSIVE CARE SETTINGS

- Machinery and computerized environment
- Medical caregivers, physicians and nurses
- Skilled personnel trained to treat complicated cases
- Cardiac and respiratory problems
- Burns and surgical recoveries of critically ill
- ICU shares common features

INTENSIVE CARE SETTINGS

- Severity of illness and staff competency
- Dramatic life saving interventions are undertaken
- Combining unique air of danger, urgency and heroism.
- There are two psychotherapeutic approaches
- Problems for which the patient requires assistance
- Difficulties that affect staff members working in ICU

SOME TYPICAL PROBLEMS AND THEIR TIMING

- Consultation requests for emotional difficulties in chronically ill
- Fear and anxiety
- Denial (Desire to sign out)
- Depression
- Management of behavior
- Dependency
- Hostility
- Delirium

STRESS ON THE STAFF OF ICU

a)Anxiety

- Tense
- Frightening
- Overwhelming
- Uptight

b)Conflict

- Frustrating
- In conflict
- Hostile
- Irritating
- Complaining
- Catty

STRESS ON THE STAFF OF ICU

c)Discouragement

- Discouraging
- Sad
- Blue
- Heavy

d) Harmony

- Smooth
- Coordinated
- Together
- Harmonious
- Close

THE DYING PATIENT: (THE C'S)

- Competence
- Concern
- Comfort
- Communication
- Children
- Family Cohesion and integration
- Cheerfulness
- Consistency and Perseverance

THE DYING PATIENT

- Equanimity
- Breaking bad news
- Role of religious faith and value system

TREATMENT

- Community therapy
- Family therapy
- CBT
- Individual therapy
- Behavioral therapy: conditioning, desensitization, psychogrammar, punishment or attention**
- Biofeedback
- Relaxation
- Hypnosis
- Music therapy
- Acupuncture/ yoga

SUMMARY

- Patients with chronic illnesses experience:
  - Anxiety
  - PTSD
  - Change in personality
  - Depression
    - Medication: steroids, reserpine
    - Endocrine abnormalities
    - Nutritional deficiencies
    - Awareness of death coming soon
  - Guilt about burdening family, betraying loved ones, decreased self worth, self – criticism (existential causes)

CONT.

- Change in appetite & weight
  - If a patient has suddenly refused to eat, consider depression & administer antidepressants
  - Rx: antidepressants (TCAs or SSRIs)
  - Supportive therapy for the depressed and terminally ill
- Patients with advanced disease experience delirium.

CONT.

- Problems with diagnosis:
  - Disorientation
  - Impaired memory, concentration,
  - This may be the beginning of dementia
  - Impaired arousal

CONT.

- Other causes of delirium in terminally ill patients:
  - Opioids, steroids
  - Hypoxemia
  - Infections
  - ISS
  - Major organ failure
  - Vascular disorders
  - Endocrine disorders

CONT.

- When dealing with patients that are approaching the end of their lives, ability to listen is important. The doctor should give the patient undivided attention.
- The ability to listen opens the door to sharing burdens & this brings relief to the patient.
- Patients don't need treatment first, they need to be listened to.

- Reaction to family neglect: Depression, anger
- The cancer patient must acknowledge possible death while expecting cure.
- With increased physical disability and dependence there comes loss of autonomy, self esteem, appetite
- As a doctor pay attention to non – verbal communication.

DEATH & DYING

BY: R. A. OKOTH

- Death and dying confront every new doctor where as your first encounter is in human anatomy during dissection!!!!!!!!
- YOU become a doctor for what you imagine to be the satisfaction of work, and that turns out to be the satisfaction of competence.
- In medicine air always goes in and out, blood goes round and round, oxygen is good, BUT death is inevitable1!!!!

WHY LEARN ABOUT DEATH?

- Personal concern because of unresolved previous experience and ongoing experience
- Being a medic
- A general wish to understand death and dying issues ie it is inevitable , a mystery, makes life more precious,
- Dying provides an opportunity of transformation

DEATH AND DYING – IMPORTANT DEFINITIONS

- Thanatology: the study of the death and dying.
- Hospice care: warm, personal, patient and family centered care for the terminally ill, focused on the relief of pain, control of symptoms, and quality of life.
- Palliative care: relieving the pain and suffering and allowing people to die in peace and dignity.
- Terminal drop: a sudden decrease in cognitive functioning shortly before death, typically present on intelligence tests.
- Bereavement: is the loss of someone to whom a person feels close and the process of adjustment to it.
- Grief: is the emotional response experienced in the early phases of bereavement, ranging from numbness to anger

- Anticipatory grief: symptoms of grief experienced while the person is still alive; may help survivors handle the actual death more easily.
- Grief work (Kubler-Ross) the working out of psychological issues connected with grief.
- Mourning: refers to the ways, usually culturally accepted, in which the bereaved and the community act while adjusting to a death.
- Active euthanasia / mercy killing: direct action taken deliberately to shorten a life in order to end suffering or allow a terminally ill person to die with dignity. (generally illegal.)
- Passive euthanasia: is deliberately withholding or discontinuing treatment, such as medication, life-support systems, or feeding tubes, that might extend the life, or postpone the natural death, of a terminally ill patient.
- Assisted suicide: in which a physician or someone else helps a person bring about a self-inflicted death by, for example, prescribing or obtaining drugs or enabling a patient to inhale deadly gas.

Living will: a person who signs a living will must be legally competent at the time, and the document generally cannot be witnessed by anyone who stands to gain. May explain specific provisions with regard to: relief of pain, cardiac resuscitation, mechanical respiration, antibiotics, and artificial nutrition and hydration. (currently not practised in Kenya)

Persistent vegetative state: a state while technically alive, they have no awareness and only rudimentary brain functioning.

Durable power of attorney: the appointing of a person to make such decisions, if the person him/herself is unable to do so.

HISTORICAL PERSPECTIVE

- Death was a normal, expected event, sometimes even welcomed as a peaceful end to suffering.
- Caring for a dying family member at home, was a common experience for adult and children in the 19th century.
- Advances in medicine and sanitation during the 20th century brought about a “mortality revolution” in developed countries.
- Care of the dying and the dead, including preparation of the bodies for burial, became largely a task for professionals.

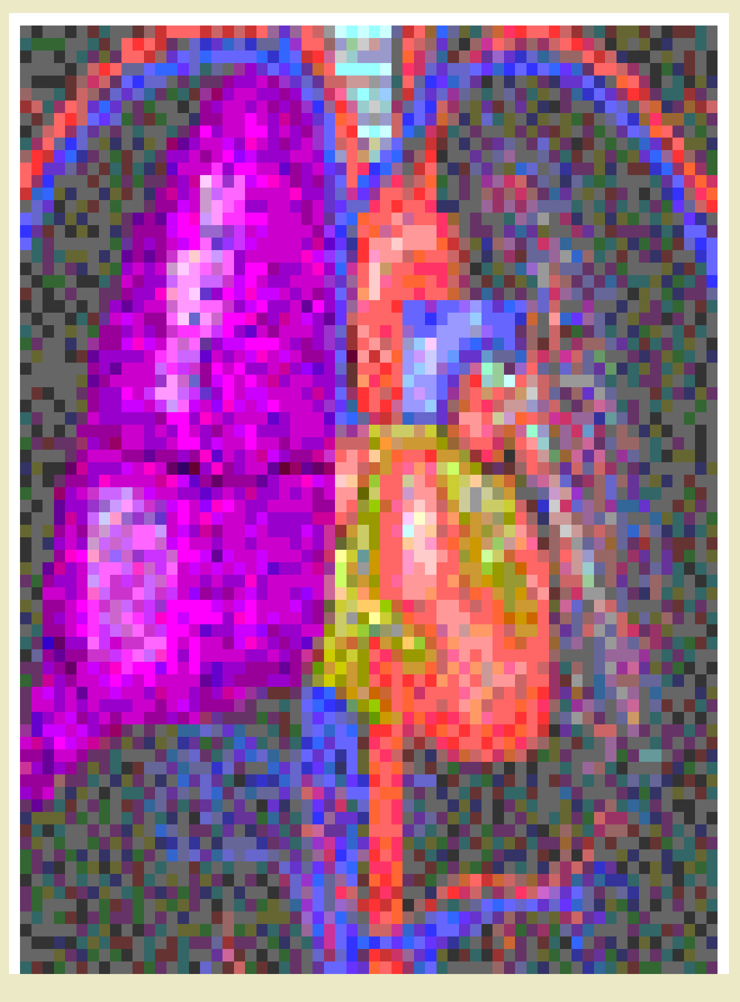
SOMETHING TO THINK ABOUT…

- If there is something certain in life, it is death.
- For the most part the more wisely we approach it, the more fully we can live until it comes.
- Death is of course a biological fact, but it also has legal, social, medical, and psychological aspects.
- Although the legal definition varies from place to place, death is generally considered to the cessation of bodily process.
- Because of the new medical technology, it is becoming more and more difficult to have a definite definition of death that encompasses all of these multiple issues.
- All deaths are different, just as all lives are different.
  - Dying from AIDS, versus dying from a car accident or from suicide.

PHYSIOLOGY OF DYING

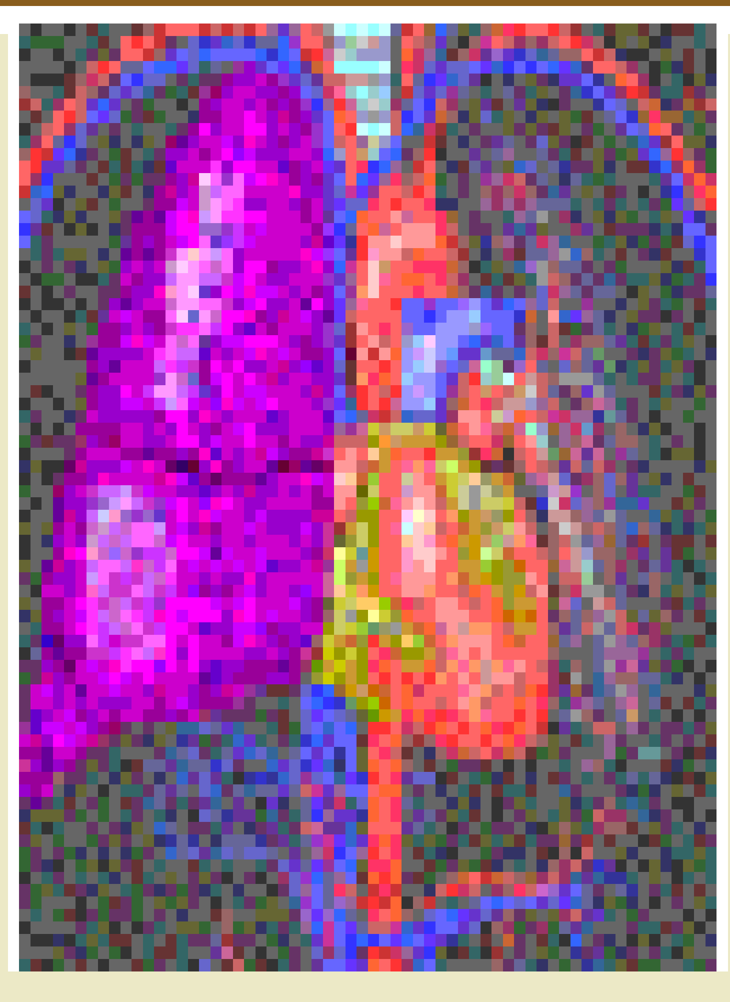
- Somatic death or death of the body
- Series of irreversible events leading to cell death
- Causes of death varies
- However, there are basic body changes leading to all deaths

THESE BASIC BODY CHANGES RESULT IN THE DEATH OF ALL VITAL BODY SYSTEMS



- PULMONARY:
- Unable to oxygenate the body
- Assess for poor oxygenation-skin pale, cyanotic, mottled, cool
- in dark skinned - assess mucous membranes, palms of hands, soles of feet

CARDIOVASCULAR



- Large load on heart when lungs fail
- Heart not getting needed oxygen
- Pumping heart not strong enough to circulate blood
- Blood backs up causing failure
- Leads to pulmonary and liver congestion

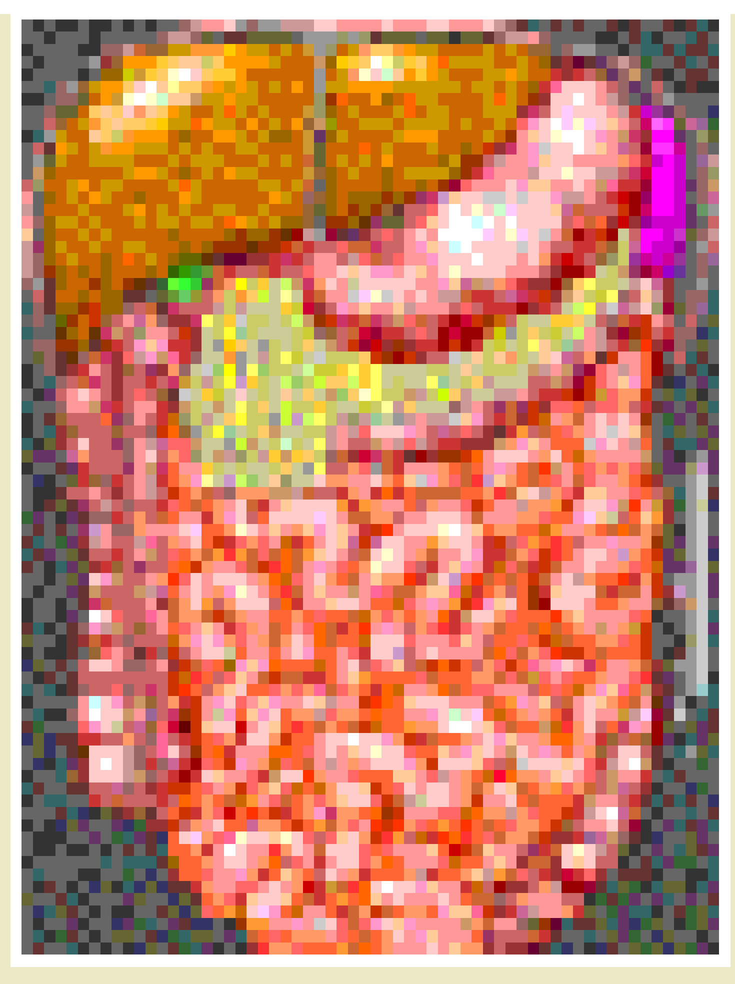
BLOOD CIRCULATION

- Decreased, as heart less able to pump
- May have a "drenching sweat" as death approaches
- Pulse becomes weak and irregular
- If pulse relatively strong, death is hours away
- If pulse is weak and irregular, death is imminent

COMBINATION OF THESE EVENTS LEADS TO CELL DEATH, AND DEATH OF THE ORGANISM (HUMAN)

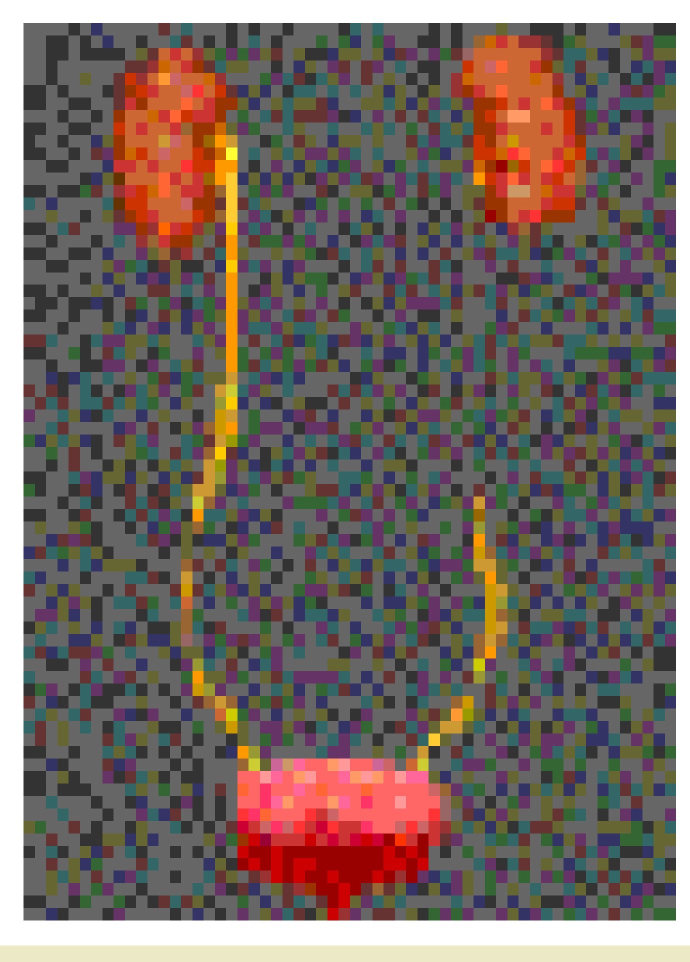
- As pulmonary and cardiovascular systems fail, other body systems begin to fail, also.

FAILING METABOLISM



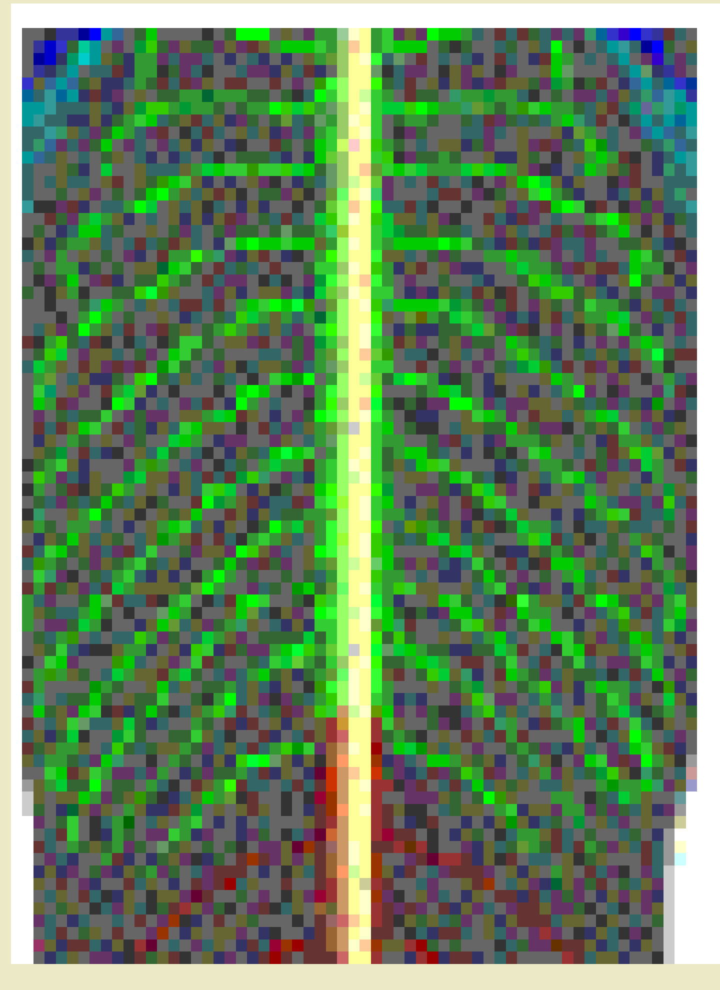
- Metabolic rate decreases, almost stopping
- Feces might be retained or incontinence might be present

FAILING URINARY SYSTEM



- Urinary output decreases
- Blood pressure too low for kidney filtration
- Further load on cardiovascular system due to increase circulating volume

FAILING NERVOUS SYSTEM



- Decrease oxygen to the brain, means decreasing brain function
- Sensation and power lost in legs, first, then arms
- May remain conscious, semi-conscious, or comatose

SPECIFIC SENSORY DECLINE

- Dying person turns toward light - sees only what is near
- Can only hear what is distinctly spoken
- Touch is diminished - response to pressure last to leave
- Dying person might turn toward or speak to someone not visible to anyone else
- Eyes may remain open even if unconscious
- Person might rally just before dying

ISSUES IN DETERMINING DEATH

- **Brain death** — neurological definition of death
  - All electrical activity of brain has ceased for a specified period of time
  - Flat EEG recording
  - Some medical experts argue criteria for death should include only higher cortical functioning

FURTHER NEUROLOGIC DECLINE AT DEATH

- Pupils might react sluggishly or not at all to light
- Pain might be significant
- Assess for pain if person unable to talk: restlessness, tight muscles, facial expressions, frowns
- Provide pain medication as needed

NEVER LOSE SIGHT. . .

- Death is the end, as we know it, for that person
- We can only support, listen therapeutically, and
- Make the person as physically comfortable as possible
- We can also use our knowledge and expertise to strengthen, support, and prepare the family

DEATH CAN INVOLVE FEARS THAT ARE PHYSICAL, SOCIAL, AND EMOTIONAL

- PHYSICAL - Helplessness, dependence, loss of physical faculties, mutilation, pain
- SOCIAL - Separation from family, leaving behind unfinished business
- EMOTIONAL - Being unprepared for death and what happens after death

INTERVENTIONS FOR FEARS

- Talk as needed
- Avoid superficial answers, i.e. “It’s God’s will
- Provide religious support as appropriate
- Stay with the patient as needed
- Work with families to strengthen and support

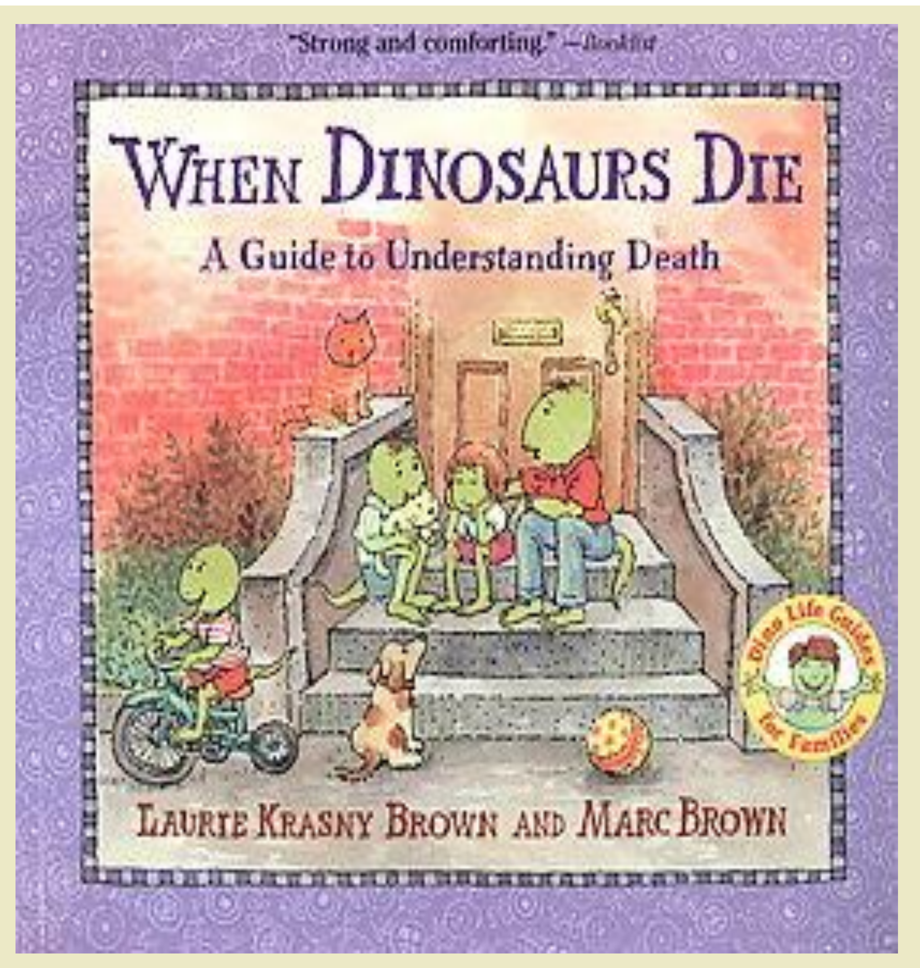
ATTITUDES TOWARDS DEATH AND DYING ACROSS THE LIFE-SPAN

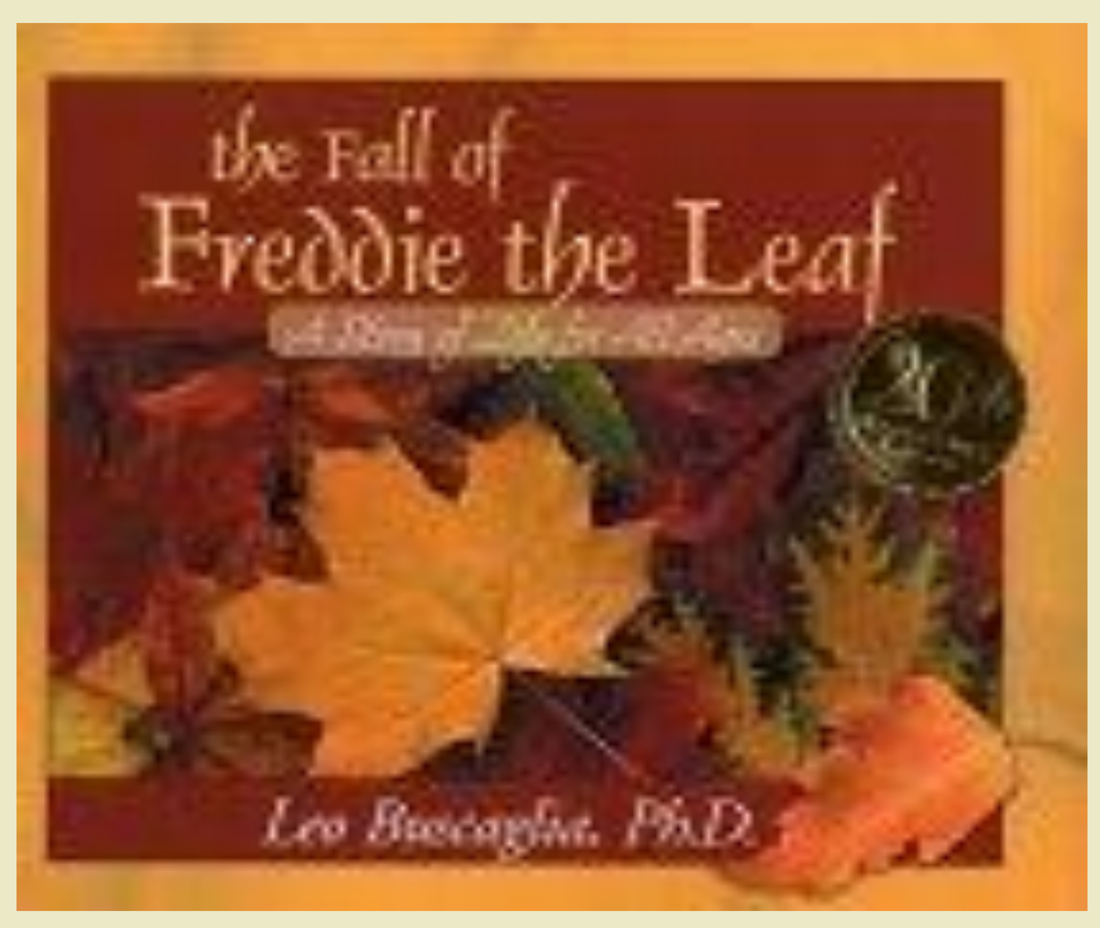
Childhood

- Not until between the ages of 5 and 7 do most children understand that death is irreversible.
- They also come to terms with the fact that death is *universal* (all living things die), and that a dead person is *nonfunctional* (all life functions end at death.)
- Children would benefit from being introduced to the notion of death early on: (i.e. dead leaves, dead pets, etc.,)
- Many books help children understand and deal with their feelings when someone they care about dies.
- Links - books on death and dying:

http://www3.baylor.edu/~Charles_Kemp/terminal_illness/childrens_books.htm

http://www.best-childrens-books.com/childrens-books-about-death.html


"Strong and comforting." —Booklist
WHEN DINOSAURS DIE
A Guide to Understanding Death
Dino Life Guides for Families
LAURIE KRASNY BROWN AND MARC BROWN


the Fall of
Freddie the Leaf
Leo Buscaglia, Ph.D.

INFANTS AND TODDLERS

- This age may **not understand** death.
- They will **react to the change in emotions exhibited by adults.**
- If it is a **parent who has died**, the child will experience **separation anxiety.**
- The change in routine that occurs when someone has died can be upsetting to a child this age.
- Encourage the caregiver to provide as consistent a routine as possible. The caregiver should try to spend some time each day with the child to help them feel secure.

PRESCHOOL AGE

- This age has trouble understanding death. They may not understand that death is permanent,
- Tell the child what to expect as far as changes in routine or what they may see.
- This age group is very egocentric, and may feel that the death is result of something they did or thought.
- A child at this age may be concerned about where the person who died has gone or how that person will perform basic life functions.
- Fear of "catching death" or falling asleep and not awaking is not uncommon in this age group.
- Opportunities to express their feelings and repeated clear explanations will benefit a child at this age.

SCHOOL AGE

- Although the younger child in this age group does not believe it can happen to them, this aged child is **beginning to understand death a little more fully.**
- A school age child **may worry about other significant people in their life dying.**
- There is often a need for more details about how or why the person died.
- **Feelings may be difficult to express or understand** for this child.
- Letting them know that different people handle their feelings differently and being supportive will help a child in this age group.

- Death is not something that adolescents normally think much about.
- Elkind ' s *personal fable* (tendency to believe they are invulnerable) has been questioned, yet many teens take some heedless risks.
- When teens are terminally ill, they may deny their condition and talk as if they are going to recover when they know they are not.
- Denial and repression of emotions, helps them deal with this crushing blow to their dreams and expectations, and anger.

ADOLESCENTS

- This age group is beginning to think more abstractly and more like an adult.
- They may act as if they do not want help, do not want to talk about death, or they may try to hide their feelings.
- It is important to encourage communication and to include the adolescent in decision making.
- It is unfortunately common for this age group to come across someone they know who has died a violent death.
- Seek professional help if needed.

Adulthood:

- Young adults, recently graduating, married or new parents, may have a great deal of difficulty dealing with death and dying; they may be very frustrated and become quite rageful (in hospital settings.)
- Middle aged people, if they have been able to resolve Erikson's stage successfully, may be in better terms to deal with the undeniability of death.
- They have lost friends, and parents, thus may be better able to deal with their own mortality.
- Even in the very old, acknowledgment of imminent death may be mixed with affirmation of the preciousness of the life that is slipping away.

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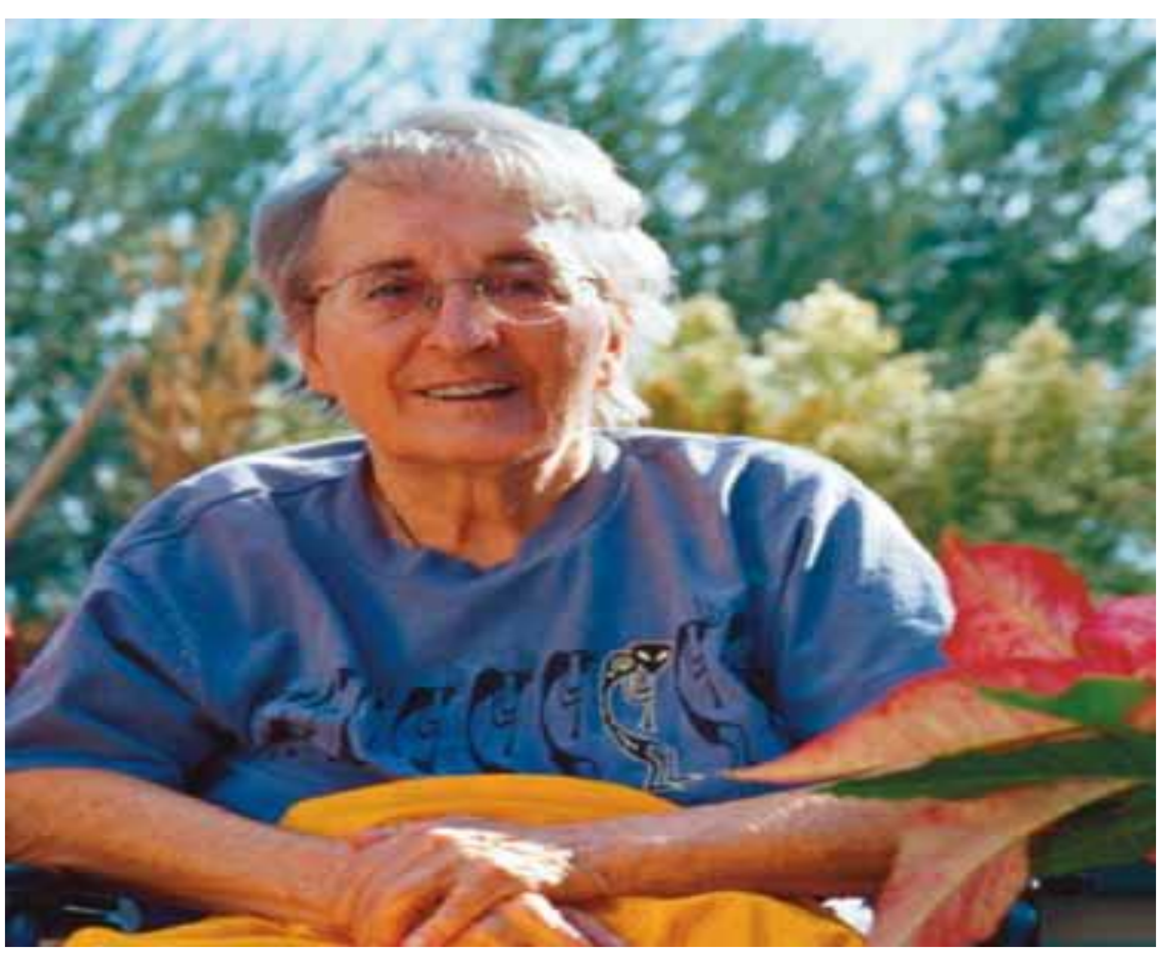
Kübler-Ross's Stages of Dying



- Denial and isolation
- Anger
- Bargaining
- Depression
- Acceptance

GRIEF WORK: THREE STAGES

- **Grief work generally takes the following path:**

1. Shock and disbelief:
   - This first stage may last several weeks, especially after a sudden or unexpected death. It may protect the person from more intense reactions. Hallucinations and constant crying may be very common. Usually, confusion is also present. Somatization may also be present: nausea, numbness, headaches, etc.
2. Preoccupation with the memory of the death person:
   - May last up to 6 months; the survivor tries to come to terms with the death but cannot yet accept it. Crying still continues, may diminish and increase once again on anniversary dates.
3. Resolution:
   - The final stage has arrived when the bereaved person renews interest in everyday activities; memories of the dead person bring fond feelings mingled with sadness, rather than sharp pain and longing.

DENIAL AND ISOLATION

- At first, we tend to deny the loss has taken place, and may withdraw from our usual social contacts. This stage may last a few moments, or longer.

ANGER

- The grieving person may then be furious at the person who inflicted the hurt (even if she's dead), or at the world, for letting it happen.
- He may be angry with himself for letting the event take place, even if, realistically, nothing could have stopped it.

BARGAINING

- Now the grieving person may make bargains with God, asking, "If I do this, will you take away the loss?"

DEPRESSION

- The person feels numb, although anger and sadness may remain underneath.

ACCEPTANCE

- This is when the anger, sadness and mourning have tapered off. The person simply accepts the reality of the loss.

SPECIAL LOSSES

- Surviving a Spouse
- Losing a Parent in Adulthood
- Losing a Child
- Mourning a Miscarriage

MEDICAL, LEGAL, AND ETHICAL ISSUES: THE "RIGHT TO DIE"

- Suicide
- Aid in Dying
  - Advance Directives
  - Attitudes Toward Euthanasia and Assisted Suicide
  - Efforts to Legalize Physician Aid in Dying
  - End-of-Life Options

CARE FOR DYING INDIVIDUALS ?

- Death in U.S.: often lonely, prolonged, painful
- Plan for your death
  - Make a living will
  - Give someone power of attorney
  - Give your doctor specific instructions
  - Discuss desires with family and doctor
  - Check insurance plan coverage

COMMUNICATING WITH THE DYING PERSON

- Establish your presence
- Eliminate distraction
- Limit visit time
- Don’t insist on acceptance
- Allow expressions of guilt or anger
- Discuss alternatives, unfinished business

CONT.

- Ask if there is anyone s/he would like to see
- Encourage the dying individual to reminisce
- Talk with the individual when s/he wishes to talk
- Express your regard

EUTHANASIA

- Painlessly ending lives of persons suffering from incurable diseases or severe disabilities
- **Passive euthanasia** — withholding of available treatments, allowing the person to die
- **Active euthanasia** — death induced deliberately, as by injecting a lethal dose of drug
- Publicized controversy: assisted suicide

CARE FOR DYING INDIVIDUALS

- **Hospice** — humanized program committed to making the end of life as free from pain, anxiety, and depression as possible
- **Palliative care** — reducing pain and suffering and helping individuals die with dignity

WHEN OTHERS DECIDE

- Terry Schaivo read!!!!!
- What is a persistent vegetative state?
- Who decides?
- What are their motives?

GRIEVING

- **Grief**: emotional numbness; a complex emotional state of…
- Disbelief
  - Separation anxiety
  - Despair
  - Sadness
  - Loneliness

…that accompanies loss of someone we love

CULTURAL DIVERSITY IN HEALTHY GRIEVING

- Contemporary western orientation
  - Breaking bonds with the dead
  - Returning survivors to autonomous lifestyle
- Non-Western cultures
  - Maintaining ties with deceased
- Influenced by religious beliefs and lifestyle

MAKING SENSE OF GRIEF

- Grieving stimulates many to try to make sense of their world — positive themes linked to hopeful future and better adjustment
- Effort to make sense of it pursued more vigorously when caused by an accident or disaster

LOSING A LIFE PARTNER

- Those left behind after the death of an intimate partner suffer profound grief and often endure
  - Financial loss
  - Loneliness linked to poverty and education
  - Increased physical illness
  - Psychological disorders, including depression

MARITAL QUALITY AND ADJUSTMENT TO WIDOWHOOD

- Widowhood associated with increased anxiety among those highly dependent on their spouses
- Lower anxiety for those who did not depend on their spouse very much

FORMS OF MOURNING

- Approximately 80 percent of corpses are disposed of by burial, the remaining 20 percent by cremation
- Funeral industry is source of controversy
- Funeral is important aspect of mourning in many cultures
- Cultures vary world over in how they practice mourning

SOCIAL TREATMENTS AND THE ROLE OF THE SOCIAL WORKER

BY: TERESIA MUTAVI

INTRODUCTION

- Bio-psychosocial model in management.
- Due to the multiplicity factors include: physical, psychological and social.
- Social treatment utilizes social methods.
- Both the social systems and the individual are influenced.

- **The individual**
- Helped to:
  - Develop knowledge on social factors contributing to his illness
  - Acquire communicative skills

- Understand his/her weaknesses and strength in handling the problem
- Gain knowledge about the available social resources and sources of help in general.

The social systems

- Introduce new organizational structures or utilize existing ones to take care of social needs as they arise.
- Adopt treatment methods to fit the local political, economic and ethnic values and practices.

ROLE OF MSW IN HOSPITALS

- COUNSELING
- CARE PLANNING
- FINANCIAL ASSISTANCE
- ASSESSMENT
- ADVOCACY
- LEGAL ASSISTANCE

ROLE OF PSW

- Multidisciplinary approach to treatment in psychiatry
- PSW is member of psychiatric team
- Key member of the team
- Has two major roles to play i.e. social assessment and rehabilitation

SOCIAL ASSESSMENT

- Assessment of patient needs by appraising the nature of the problem e.g.
  - Does not identify the illness but rather appraises the nature of the problem i.e.
  - The patient background
  - Factors leading to the development of the problem – precipitating factors

Those that lead to its perpetuation - Perpetuating/maintaining factors.

  - Protective factors
  - Identifies personal, family and social resources for alleviating the problems

FORMULATION

- Clear view of the problem
- Definition of intervention to be used
- The methods by which these may be achieved
- Have recognized goals to be achieved evaluated
- Utilized with other assessment to plan intervention

SOCIAL REHABILITATION

- **Definition**
  - Process through which a person is helped to adjust to the limitations of his disability by gaining loss of skills and coping strategies.
- **Aim**
  - To restore the individual to a dignified living with opportunity to develop self-reliance and self responsibility.
- **Who requires social rehabilitation**
  - Those with social disablement

- One who is unable to perform socially up to the standard expected by himself, people important to him and society in general.

- **The social disablement is caused by:**
  - Psychiatric impairment or symptoms
  - Social disadvantage – poverty, poor housing, unemployment, lack of vocational skills etc.
  - Adverse personal reaction – low self-esteem, feelings of inadequacy, lack of vocational skills, lack of confidence, lack of motivation , isolation and loneliness.

SOCIAL REHABILITATION TOOLS

1. Counseling

- Child psychiatry:
  - The focus is on the family coz problem reflect parental anxieties
  - PSW provides counseling and guidance to the parent of handicapped child.
  - Provide genetic counseling
  - Group counseling for children and parents.

- **Adult psychiatry**
  - Link between the team and family
  - Sound counseling at discharge
  - Advice and guidance on matters of finances and domestic difficulties
  - Marital and group counseling.

2. Social support

- Provides social support
- Family, friends, community organizations and schools

3. Environmental manipulation

- Meeting basic needs e.g. education, financial support and housing.
- Providing opportunities for work, social contacts etc.
- Removal of patient from home e.g. in the case of high expressed emotions in the family.

4. Provision of practical help.

- Providing financial support
- Resolving housing problems
- Advocacy.
- Arranging legal help.

5. Social programming

- Teaching basic social skills e.g. to be assertive.
- Educate patient on how to behave at social gatherings
- What side effects to watch for when taking drugs.

6. Occupational therapy

- Activity oriented
- Involves resettlement of patients back into the community

7. Public Education:

- Creating awareness about mental illnesses

8. Community Based Care

- Care of the family with network of support.
- Care arranged for the patient while at home within the community
- SW Arranges or follows up patients in community

SUMMARY

- Social treatments are social methods utilized to help the individual function normally in the community.
- In social treatment the social worker helps the individual utilize his/her resources to meet his physical, social and psychological needs so that he/she may be able to function normally in the community.
- The PSW is the provider of personal help, a resource person, an interpreter of patient needs to him and to the family group and helping them to adjust one another, an educator and provider of practical help.

Social Workers Dominate Mental Health Services

Source: *U.S. Substance Abuse and Mental Health Services Administration, 2000*

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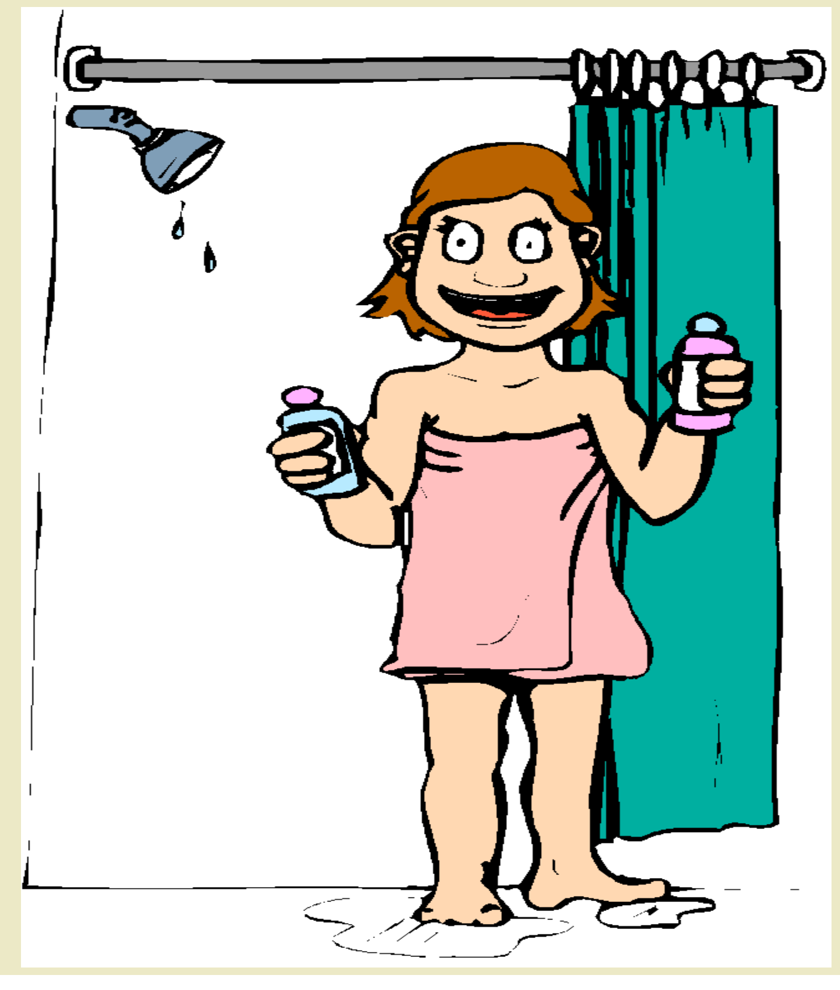
THE ROLE OF OCCUPATIONAL THERAPY IN PSYCHIATRY

BY: TERESIA MUTAVI

HOW WOULD YOU…

HAVE A SHOWER IF………………………..



- You have rigidity in your muscles?
- You had poor balance?
- You couldn't reach your arms up to your hair?

HOW WOULD YOU...

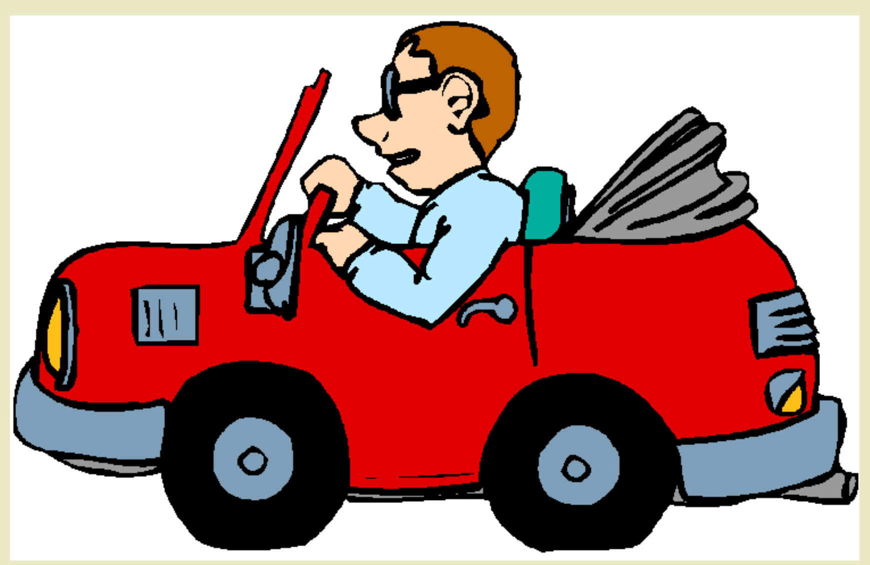
HAVE BREAKFAST WITH FAMILY IF................

- You couldn’t hold a spoon/fork?
- You take a long time to finish your meal?
- You just couldn’t cope with getting out of bed?

HOW WOULD YOU…

DRIVE A CAR IF……………………

- You were paralyzed from the waist down?
- You were fearful leaving the garage?
- You lost the use of your right hand?



HOW WOULD YOU ………..

HAVE COME TO ATTEND THIS MEETING IF…

- You had pain in your back?
- You heard voices in your head?
- You had tremors in your hands?

WHAT IS OCCUPATIONAL THERAPY

- A profession that helps people across the lifespan participate in things they want and need to do through the therapeutic use of everyday activities or occupations.
- Occupations :The day to day activities we do every day. Feeding, Bathing, dressing ,grooming etc.
- A type of rehabilitation therapy that uses real life activities to reach a specific goal.

- **Occupational therapists** treat injured, ill, or disabled patients through the therapeutic use of everyday activities. They help these patients develop, recover, improve, as well as maintain the skills needed for daily living and working.

- The aim of OT services in mental health is to help individuals develop and maintain positive mental health, prevent mental ill health, challenges in order to live a full and productive lives

- They emphasize the use of meaningful occupations to promote participation in occupations such as education, play, leisure, social participation, ADL, sleep and rest within a variety of environments such as school, home, community, work, residential and health care settings

OCCUPATIONAL THERAPISTS

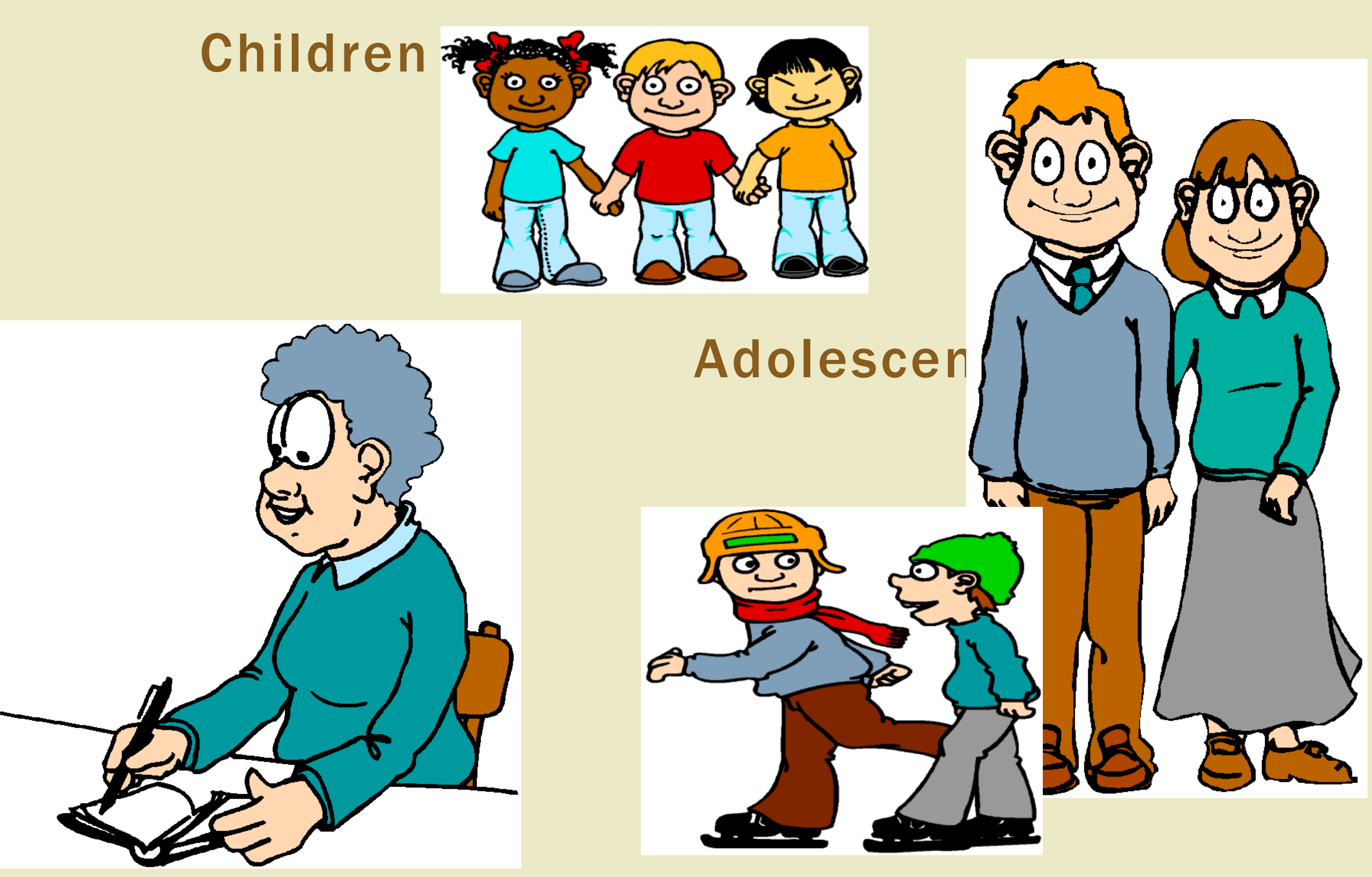
- ………have the knowledge and the skills to help people overcome these and other barriers they may face in doing their everyday occupations!
- They help patients increase their independence using meaningful activities
- Broadly an OT will help the patient :
  - Develop personal goals
  - Understand what is preventing him/her from achieving the goals.

- Achieve goals by using the patient strengths and support systems
- Specifically an OT will achieve these by helping the patient:
- Develop skills of daily living e.g. shopping, cooking, budgeting, using public transport and home management.
- Learn how to cope with stress or anxiety.
- Take part in enjoyable activities.
- Make friends and find social support
- Returning to or staying in work or education
- Return back to the community

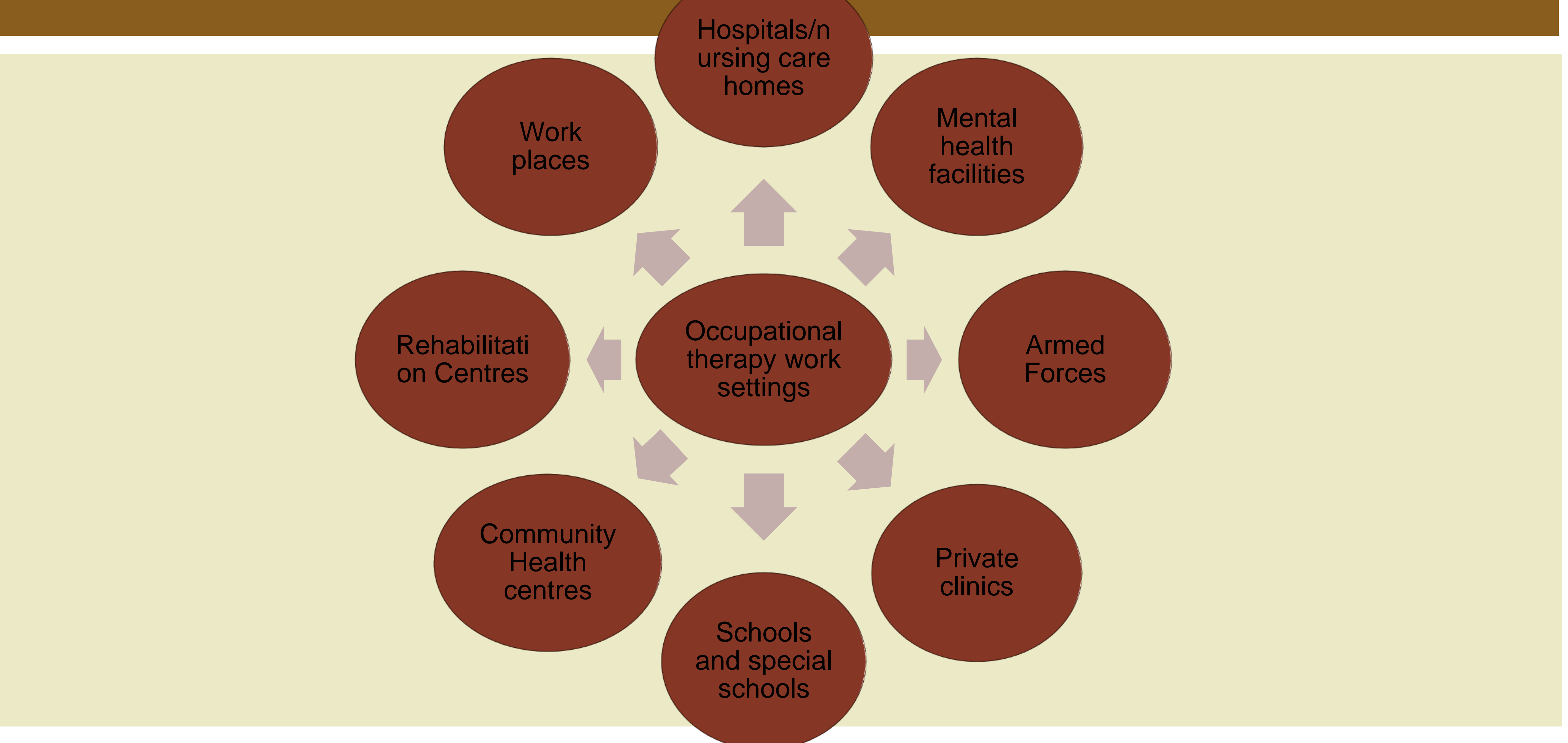
WHO IS AN OCCUPATIONAL THERAPIST?

- Health Care Professionals who enable people to lead a more productive, satisfying, and independent life through purposeful activities.

WHO DO OCCUPATIONAL THERAPISTS WORK WITH?



WHERE DO OCCUPATIONAL THERAPISTS WORK



AIM OF OCCUPATIONAL THERAPY

- Primary goal of OT is to enable people participate in activities of everyday life.
- Help individuals develop interests, skills and abilities.
- Helps individual gain control over himself and his environment.
- Rehabilitate patients for their return home or former work.
- Help patients overcome particular anxieties at work.

- Help patient deal with difficult working relationships with others.
- Help patient respond to treatment.
- OT motto is helping patient's "live life to its fullest."
- By helping people live life to its fullest, an OT help people consider not only their needs, strengths, abilities, and interests, but also their physical, social, and cultural environment.

GENERAL PRINCIPLES OF OT

- Used as a means of :-
  - Assessment of the patient capacity and skills for resettlement.
  - Restoring general health and function of the patient.
  - Helping the permanently disabled become independent.

Requiring assistance in returning to former employment.

Those who lack skills of daily living such as general hygiene and grooming, housekeeping, and use of public facilities (transport and community resources}

Looking for a job and lack skills interviewing and the ability to complete forms.

Recovering from mental illness

Patients suitable for OT

Chronic psychiatric patients who lack skills to maintain their jobs or find new ones.

OCCUPATIONAL THERAPY ACTIVITIES AND BENEFITS TO PATIENTS

1) **General Activities**

- Creative
- Recreation
- Commercial
- Intellectual
- Industrial
- Domestic
- Used to improve secondary motor ability
- Provide a realistic opportunity to increase personal and work efficiency
- Therapeutic because they make one physically and mentally active.

Activities for psychiatric patients

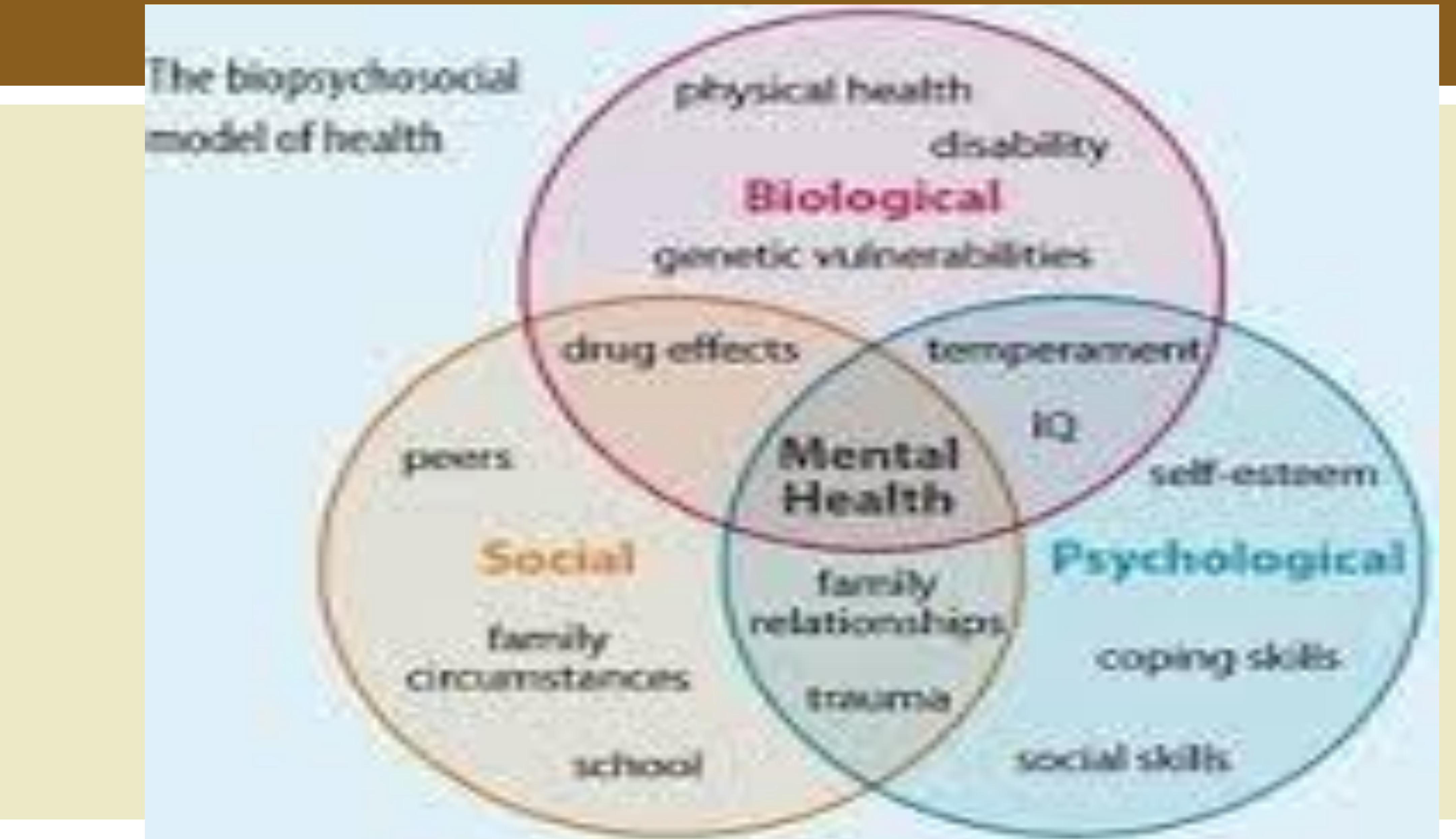
Related to work e.g. clerical work, gardening, printing etc.

Improve physical well-being e.g. relaxation exercises, health and beauty exercises, swimming, gardening, walking etc.

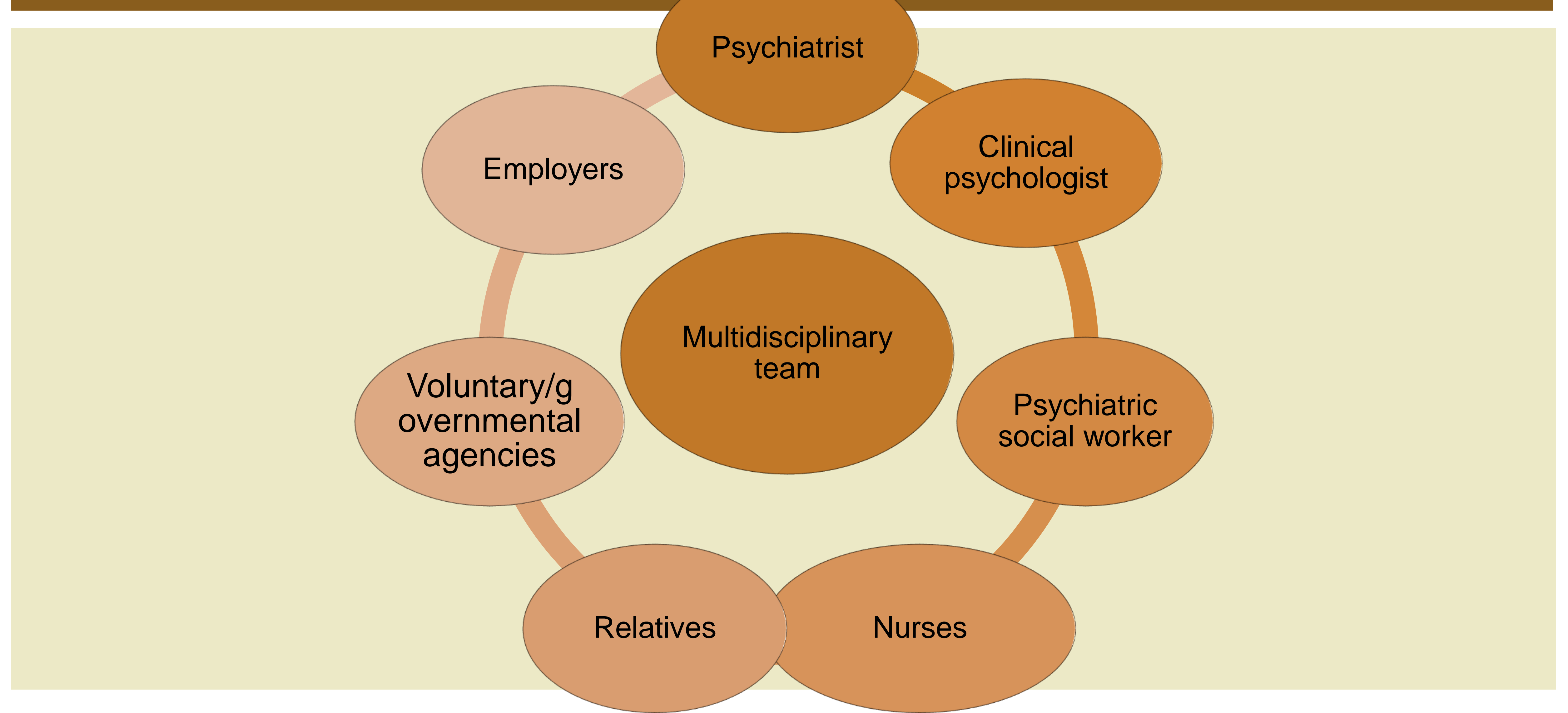
Enrich interpersonal relationships and socialization e.g. dancing, drama and any other group activities.

Encourage personal expression and creative use of leisure time e.g. music, painting, photography, gardening, drama etc.

THE BIOPSYCHOSOCIAL MODEL



THE ROLE OF AN OCCUPATIONAL THERAPIST IN PSYCHIATRY



THE ROLES

- Plays two major roles

1. **Assessment**

- The components of assessment are observation, evaluation and examination
  - Observation to determine ability to function and live alone safely (e.g. Schizophrenia) and
  - Interview to identify important roles and occupations.

- Information obtained is used to determine the skills, supports, and environmental modifications necessary for planning programmes and rehabilitation.

a) **Physical assessment**

- Movements, balance, perception, orientation, memory, concentration, comprehension, writing

b) **Social assessment**

- Patient skills for occupational therapy activities and for resettlement.
- Important for planning treatment, program adjustment and for reporting.

SOME AREAS OF SOCIAL ASSESSMENT

- Activities of daily living (e.g., bathing, dressing, eating)
- Instrumental activities of daily living (e.g., driving, money management, shopping)
- Education
- Work /occupation
- Habits, roles and routines
- Housing

- Through comprehensive assessment OTs are able to identify:
  - An individual's abilities and limitations
  - The issues that prevent a person from fully participating in their chosen occupations.
- The ability to assess competently is one of the hall-marks of an effective therapist.

2) **Rehabilitation**

a) **Treatment:**

- Through use of purposeful activities
  - Encourage new skills
  - Perfect poorly used ones and
  - Help patient relearn forgotten ones.
- All these results in restored self-confidence and more mature sense of responsibility.

b) Resettlement

- Is the act of re-establishing a person in the community
- Help develop skills for resettlement back into the community.
- Like PSWs OTs do home visits and improve patients environment for their recovery
- Help patient retain his job or get a job and become self reliant.
- OTs collaborate with educators, employers, and other agencies to rehabilitate and resettle patients.

BENEFITS OF OCCUPATIONAL THERAPY

- Combination of the therapies can.....
- Promote independence
- Increase participation
- Facilitates motor development and function
- Improves strength
- Enhances learning opportunities
- Eases care giving
- Promotes health and wellness

OT FOR SPECIFIC PSYCHIATRIC CONDITION

- **Senile dementia**
  - This is a psychotic condition resulting in part from cerebral deterioration
- **Aim of OT**
  - Alleviation of anxiety which is the natural outcome of confusion.
  - Preserving good habits which still remains
- **Activities**
  - For women, needlework, crochet, knitting.

- Simple domestic work e.g. laying tables, preparing vegetables, polishing etc. may give satisfaction
- For men, simple woodwork, gardening or industrial work.
- Radio, television, can help to stimulate the patient and turn his attention outside the narrow confines of the ward.
- Therapist observes any decline in the mental and physical condition and modify activities to avoid stress.

- **Contra-indications**
- **Activities which involves:**
  - Learning new processes
  - Judgment and initiative
  - The use of dangerous tools, equipment or materials i.e. boiling water etc.

PATIENT WITH PARKINSON'S DISEASE

- Increase and maintain independence in activities of daily living (ADL)
- Increase mobility & co-ordination

SUPPORT FOR THE PATIENT AND FAMILY

- Reassure
- Therapist should help the family to be realistic in their expectations.
- The family should not expect the patient to perform activities beyond his capacity, but emphasize those he can do.

- **Social Activities**
- Work in small groups (to avoid isolation and to assist communication).
- Positive and purposeful.
- Familiar and interesting activities
- A wide variety of stimuli in the form of color, sound and touch.
- The therapist should work within the concentration span of the patient.
- Maintain social contact through
  - Hobbies
  - Pastimes.
  - Visits.
  - Outings.

SOCIAL PARTICIPATION

- This include participating in community activities.
- The OTS will make sure that people with mental health issues participate and access to services in the society with an aim to curb stigma and discrimination.

LEISURE ACTIVITIES

- People who suffer mental illness have less opportunities to participate in their leisure activities
- OTS will facilitate their participation by engaging them in those activities.
- Leisure activities gives one a moment of relaxation, fun and its way to exercise

WORK

- Part-time work.
- less responsibility at work may be considered.

- It is unwise for the patient to persist with work to the point where he becomes exhausted and possibly unsafe.

EMPOWERMENT

- This include School, vocational placement, livelihood opportunities, work and IGAS
- People with mental health problems have minimal opportunities for empowerment
- .OTS will assess and place them in the appropriate field.

SUPPORT GROUPS

- This are groups comprising of people with mental health problems who come together for a purposeful meaning, also people without mental health problems are included in these groups. This groups are meant for sharing experiences, social interaction..
- The OT provides the dynamics of forming and conducting the sessions of these groups.

SUMMARY

- Mental illness is the leading cause of disability in the world (Scheinholtz, 2010).
- It can significantly impact an individual's ability to engage in daily life activities that are meaningful and lead to productive daily routines.
- Occupational therapy is a profession vital to helping individuals with mental illness develop the skills needed to live life to its fullest

- OT is an active method of treatment in which the individual through the use of his/her hands influences his/her health.
- The Occupational therapist plays two roles i.e. assessment and rehabilitation
- Through development of skills the patient is able to live a full and independent life within the community.

REHABILITATION IN PSYCHIATRY

BY: DR. ANNE OBONDO

INTRODUCTION

- Definition
- Rehabilitation is the process of restoring an individual to the highest level of functioning possible.
- Objectives

- Help patients with long admission in hospital return to the community

- Support the chronic mentally ill within the community to reduce prolonged stay in hospital

- Rectify the patient’s social environment
- Prevent relapse of patients
- Prevent or treat the disabilities induced by mental illness
- Re-integrate patients into community life as soon as possible.

PROCESS

- Rehabilitation process begins at admission to hospital and includes:

a) ***Medical intervention***

- Patients require medication for the symptoms of their disease.

b) ***Psychological intervention***

- Individual, group, supportive psychotherapy and behavioral programs

c) ***Social intervention***

- Social support, social skills training.

EFFECTIVE REHABILITATION DEPEND UPON:

- Accurate diagnosis
- The patients deficits, assets and strengths
- Skills and performance in personal, domestic and vocation.

- Psychological, physical and social needs
- These needs have to be addressed.
- The biopsychosocial approach in management,

TYPES OF REHABILITATION

- Hospital based rehabilitation
- Community based rehabilitation

TECHNIQUES

- Admission to hospital
- Counseling
- Psychotherapy
- Social support

- Environmental manipulation
- Community care
- De-institutionalization
- Prevention

- Community psychiatry – promotion of mental health
- Based on public health principles (primary, secondary and tertiary prevention)

SW ROLE IN REHABILITATION

- Assessment, Social support, Environmental manipulation, Counseling, Mobilization of community services, Community education, follow-up and referral

SUMMARY

- Rehabilitation in psychiatry is the process by which the individual is helped to return to his/her former normal functioning
- Achieved through hospital based care and community based care.

REFERENCE

- Corrigan P.W., Mueser K. T., Bond G.R., Drake R.E., Solomon P., (2009), "Principles and Practice of Psychiatric Rehabilitation". An Empirical Approach. The Guilford Press. New York.

B. PSYCHOPHARMACOLOGICAL MANAGEMENT LEVEL VI 2019

COMPILED BY

NAILA KAMADI

B. PSYCHOPHARMACOLOGICAL MANAGEMENT (SLIDE 612) OUTLINE

1. GENERAL PRINCIPLES OF PSYCHOPHARMACOLOGY (slide 614)
2. PHARMACOLOGICAL MANAGEMENT OF SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS (slide 654)
3. PHARMACOLOGICAL MANAGEMENT OF MANIA (slide 702)
4. PHARMACOLOGICAL MANAGEMENT OF DEPRESSION (slide 746)
5. PHARMACOLOGICAL MANAGEMENT OF ANXIETY DISORDERS (slide 818)

1. GENERAL PRINCIPLES OF PSYCHOPHARMACOLOGY MBCHB LEVEL VI 2019 UON

BY DR. GITAU

OUTLINE

- Background
- Pharmacokinetics
- Pharmacodynamics
- Prescribing principles
- Classification of drugs in psychiatry

HISTORY OF TREATMENTS IN PSYCHIATRY

1934 Insulin coma treatment (Sakel)

1936 Frontal leucotomy (Moniz)

1936 Metrazole convulsive therapy (Meduna)

1938 Electroconvulsive therapy (Cerletti and Bini)

1941 Amphetamine for hyperactivity in children (Bradley)

1949 Lithium (Cade)

1952 Chlorpromazine (Delay and Deniker)

1954 Benzodiazepines (Sternbach)

1957 Iproniazid (Crane and Kline)

1957 Imipramine (Kuhn)

1966 Valpromide (valproate) in bipolar disorder (Lambert *et al.*)

1967 Clomipramine in obsessive–compulsive disorder (Fernandez and Lopez-Ibor)

1971 Carbamazepine in bipolar disorder (Takezaki and Hanaoka)

1988 Clozapine in treatment-resistant schizophrenia (Kane *et al.*)

1999 Lamotrigine in bipolar depression (Calabrese *et al.*)

2001 Atypical antipsychotic augmentation in depression (Shelton *et al.*)

2005 Quetiapine in bipolar depression (Calabrese *et al.*)

CONT.

- Their efficacy & their indications were first recognized through clinical observation & were subsequently confirmed by controlled clinical trials. None of these agents was introduced on the basis of an etiological hypothesis. Indeed, such etiological hypotheses as there are in biological psychiatry have been largely derived from knowledge of the mode of action of effective drugs.

PHARMACOKINETICS

- Before psychotropic drugs can produce their therapeutic effects, they must reach the brain in adequate amounts.
- The extent to which they do so depends on their;
  - ***Absorption***: easily absorbed from the gut as most are lipophilic.
  - ***Distribution***: Largely bound to proteins e.g. diazepam, amitriptyline are ~95% bound. They pass easily from plasma to the BBB from which they are released slowly long after the patient has ceased to take the drug. Psychotropic drugs tend to have a large V_d.

CONT.

- ***Metabolism***: Most psychotropic drugs are metabolized in the liver. Some drugs, such as carbamazepine, induce their own metabolism, especially after being taken for a long time. Not all drug metabolites are inactive— for example, fluoxetine is metabolized to a hydroxy derivative, norfluoxetine, which is also a potent 5 – HT reuptake inhibitor.
- ***Excretion***: Psychotropic drugs & their metabolites are excreted mainly through the kidney.

PLASMA $T_{1/2}$

- The $t_{1/2}$ of a drug in plasma is the ***time taken for its concentration to fall by a half***, once dosing has ceased.
- For most psychotropic drugs, ***the amount eliminated over time is proportional to the plasma concentration***, & in this case ***it will take approximately five times the $t_{1/2}$ for the drug to be eliminated from plasma***.
- Equally, when dosing with a drug begins, it will take five times the $t_{1/2}$ for the concentration in plasma to reach steady state.

PHARMACODYNAMICS

- Psychotropic drugs interfere with neurotransmitter function in several ways:
  - On neurotransmitter receptors
  - Storage
  - Release
  - Reuptake
  - Metabolism
- Drugs can be **agonists** (mimic endogenous neurotransmitters) or **antagonists** (bind receptors and block the action of agonists)

NEUROTRANSMITTERS

- Important neurotransmitters implicated in psychopharmacology include:
  - **Acetylcholine**: ↓ implicated in ***Alzheimer's Dementia***
  - **Serotonin**: regulates mood, anxiety & arousal
  - **Dopamine**: plays a role in ***Schizophrenia*** and ***Parkinson's disease***
  - **Norepinephrine**
  - **Epinephrine**
  - **Glutamate**: Excitatory neurotransmitter
  - **GABA**: Inhibitory neurotransmitter

DRUG INTERACTION

- When 2 psychotropic drugs are given together, one may interfere with or enhance the actions of the other through;
  - **Pharmacokinetic interactions:** Alterations in absorption, binding, metabolism, or excretion.
  - **Pharmacodynamics interactions:** By interaction between the pharmacological mechanisms of action.

PHARMACOKINETIC INTERACTIONS

- **Absorption**: Absorption of chlorpromazine is reduced by antacids.
- **Metabolism**: Inhibition of the metabolism of antipsychotic drugs by *some SSRIs* & the stimulation of the metabolism of many psychotropic drugs by *carbamazepine*, which induces the relevant cytochrome P450 enzymes.
- Interactions that affect **renal excretion** are mainly important for *lithium*, ***the elimination of which is decreased by thiazide diuretics***.

PHARMACODYNAMICS INTERACTIONS

- These are exemplified by the **serotonin syndrome**, in which drugs that potentiate brain 5 – HT function by different mechanisms (e.g. SSRIs & MAOIs) can combine to produce dangerous 5 – HT toxicity.
- As a rule, **a single drug can be used to produce all of the effects required of a combination** e.g. many antidepressant drugs have useful antianxiety effects.
- **Avoid combinations of psychotropic drugs whenever possible**

PRESCRIBING PRINCIPLES

- Thorough medical evaluation
- Beware of side effects, current & previous response
- Inform family of benefits and risks, delay in therapeutic response
- Start low & increase slowly (dosage)
- Special considerations for special populations (children, geriatrics, pregnant & nursing women)
- Beware of drug interactions

CLASSIFICATION OF DRUGS

- According to their major therapeutic use, however, the therapeutic effects of different classes of drugs may overlap considerably.
  1. Anxiolytics & hypnotics
  2. Antipsychotics
  3. Antidepressants
  4. Mood stabilizers
  5. Prescription stimulants

1. ANTIPSYCHOTICS

- Used to ***treat psychosis*** e.g. In schizophrenia & mania.
- Psychotic patients experience ***delusions*** & ***hallucinations***.
- Also useful for ***sedation*** & ***tranquilisation***.
- Non psychotic indications: ***Tic disorders***

CONT.

Typical antipsychotics	Atypical antipsychotics:
• Typically produce extrapyramidal side effects (EPSE): Parkinsonism (*muscle rigidity, tremor, bradykinesia*), acute dystonic reactions, dyskinesia, akathisia, tardive dyskinesia.	• Have a **lower propensity to produce EPSE** & cause **prolonged elevation of prolactin levels** due to tuberoinfundibular tract blockade. • They have greater effects on the ***negative symptoms of schizophrenia.***

EXAMPLES OF TYPICAL/ 1ST GENERATION ANTIPSYCHOTICS INCLUDE:

1. Phenothiazines:
   - Low potency: Chlorpromazine, thioridazine
   - High potency: Fluphenazine
2. Other high potency typical antipsychotics:
   - Thioxanthines: Flupenthixol
   - Thiothixene
   - Butyrophenones: Haloperidol
   - Pimozide

EXAMPLES OF ATYPICAL/ 2ND GENERATION ANTIPSYCHOTICS INCLUDE:

- Aripiprazole
- Amisulpiride
- Clozapine
- Olanzapine
- Paliperidone
- Risperidone
- Quetiapine
- Sertindole
- Ziprasidone

MECHANISM OF ACTION

- Dopamine (D2) receptor blockade
  - This accounts for ***antipsychotic activity*** & ***propensity to cause EPSEs***
- Some atypical anti psychotics have low D2 receptor occupancy & ***high 5HT receptor occupancy***

DEPOT ANTIPSYCHOTIC DRUGS

- Slow release preparations
- Where compliance cannot be assured
- Given IM

DEPOT ANTIPSYCHOTIC PREPARATIONS INCLUDE

- Fluphenazine decanoate
- Flupenthixol decanoate
- Haloperidol decanoate
- Zuclopenthixol decanoate
- Olanzapine pamoate
- Pipotiazine palmitate
- Risperidone Consta

SIDE EFFECTS

- **Antidopaminergic EPSEs:** Acute dystonia, akathisia, parkinsonian syndrome, tardive dyskinesia.
- **Anticholinergic S/Es:** dry mouth, urinary retention, constipation, blurred vision.
- **Antiadrenergic S/Es:** Sedation, postural hypotension, inhibition of ejaculation.
- **Cardiac:** arrhythmias, prolongation of QT interval.

CONT.

- Metabolic effects
- Sensitivity reactions
- Neuroleptic malignant syndrome: Muscle rigidity, breakdown of muscle fibres, fever, altered consciousness, death.
- Amenorrhoea
- Galactorrhoea

2. ANTIDEPRESSANTS

- Indicated to treat the various symptoms of depressive disorders.
- According to the **biogenic monoamine theory**, ***depression results from a deficiency of monoamines (norepinephrine, serotonin) in certain brain areas***. Antidepressants exert antidepressant activity by ***increasing the availability of monoamines*** via:
  - Presynaptic ***inhibition of reuptake of 5HT, NE, Dopamine***.
  - ***Inhibition of monoamine oxidase*** reducing neurotransmitter breakdown.
  - Increasing the ***availability of neurotransmitter precursors***.

CONT.

- Initial resolution of depressive symptoms generally takes ***10 – 20 days***.
- Other uses:
  - Anxiety, Sleep disorders, OCD, Eating disorders, Neuropathic pain, Migraines, ADHD.

TRICYCLIC ANTIDEPRESSANTS

- MoA: inhibit reuptake of both 5HT & noradrenaline.
- Include: ***amitryptiline, clomipramine, imipramine***
- S/E: autonomic, psychiatric, cardiovascular, neurological, withdrawal effects.
- Toxic effects in overdose.

MONOAMINE OXIDASE (MAO) INHIBITORS & REVERSIBLE MONOAMINE OXIDASE INHIBITORS (RIMAS)

- Inactivate enzymes (MAO A & B) that oxidise noradrenaline, 5HT, dopamine & tyramine.
- Include:
  - ***MAOI: Phenelzine, Isocarboxazid, Tranylcypromine***
  - ***RIMA: Moclobemide***
- Interact with food & drugs
- S/E: hypertensive crises, insomnia, anxiety, antimuscurinic, ankle oedema, hepatotoxicity, weight gain & hypotension.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)

- Inhibit the reuptake of 5 – HT with high potency & selectivity leading to increased 5 – HT in the synaptic cleft.
- Include: ***fluoxetine, fluvoxamine, paroxetine, escitalopram, citalopram, sertraline.***
- Advantages:
  - Easier dosing
  - Low toxicity in overdose
  - Better tolerance than TCAs & MAOs.
  - Fewer anticholinergic side effects, not sedating
- Side effects:
  - Gastrointestinal, sexual dysfunction, suicidal behaviour, Serotonin syndrome

OTHER ANTIDEPRESSANTS

- Serotonin antagonist/ reuptake inhibitors (SARIs): ***Trazodone***.
- Serotonin/noradrenaline reuptake inhibitors (SNRIs): ***Venlafaxine, duloxetine***
- Noradrenergic & specific serotonergic antidepressants (NaSSA): ***Mirtazapine***
- Noradrenaline reuptake inhibitor (NARI): ***Reboxetine***
- Noradrenaline & dopamine reuptake inhibitor (NDRI): ***Bupropion***
- Melatonin agonist & specific serotonin antagonist (MaSSA): ***Agomelatine***
- Tetracyclic antidepressants: ***Mianserin***
  - MOA similar to TCA but with ***less anticholinergic side effects***

3. MOOD STABILIZERS

- Effective for treating both ***mania & depression*** in bipolar patients.

Lithium

- MOA: it directly inhibits 2 signal transduction pathways namely →
  - Inositol signalling through depletion of intracellular inositol.
  - Glycogen synthase kinase – 3 (GSK – 3)
- S/E: polyuria, polydypsia, weight gain, cognitive problems, tremor, hypothyroidism, GI problems, teratogenic (*Ebstein anomaly*)
- Narrow therapeutic index
- Toxicity: marked tremor, nausea, diarrhoea, ataxia, drowsiness, confusion, seizures, coma.

ANTICONVULSANTS

Valproate/Valproic acid:

- Indications: Acute mania, mixed episodes, prophylactic agent, rapid cycling bipolar.
- S/E: nausea, tremor, sedation, hair loss, weight gain, deranged LFTs, Teratogenesis
- Wide therapeutic index though can be fatal in overdose

Carbamazepine

- Indications: Acute mania, bipolar depression; prophylactic agent
- Interacts with many drugs:
  - Decreases plasma levels of antipsychotics, BDZs, TCAs, hormonal contraceptives
  - Levels can be decreased by: erythromycin, CCBs

CONT.

- **Lamotrigine**: Maintenance treatment esp. for bipolar depression.
- ***Gabapentin***: used in non – responders.

4. ANXIOLYTICS

- Used to curb anxiety

BDZs

- Reduce anxiety, agitation & tension
- Uses: anxiolytic, sedative, muscle relaxant, anticonvulsant
- MoA: Enhance GABA neurotransmission

Are addictive & hence should not be routinely prescribed for > 2 wks.!

CONT.

- Long acting compounds with a half life > 12 hours (***diazepam, chlordiazepoxide, alprazolam, clonazepam)*** are preferable for management of anxiety.
- S/Es:
  - **Headache, confusion, ataxia, blurred vision, GI disturbance, jaundice, paradoxical excitement.**
- BDZ potentiate the effects of alcohol
- They cause dependence which is associated with a ***withdrawal syndrome*** characterized by apprehension, insomnia, nausea, tremor heightened sensitivity to perceptual stimuli.
- **Flumazenil** is a BDZ receptor antagonist, useful in reversing toxicity.

AZAPIRONES: BUSPIRONE

- Useful in treatment of ***Generalised Anxiety Disorder***.
- Effects take several days to develop.
- MoA: stimulates ***5 – HT_{1A} receptors.***
- Not sedative but associated with ***light headedness, nervousness & headache.***

CONT.

- ***Antidepressant drugs: TCA, SSRIs, MAOIs***
  - Onset of effect much slower than that of BDZs.
- ***β – adrenoceptor antagonists: propranolol***
  - Relieve autonomic symptoms of anxiety esp. if main symptoms are tremors & palpitations.
  - Contraindicated in: ***hypotension, bradycardia, heart block, bronchospasms***

5. HYPNOTICS

- Are used to ***improve sleep***.
- Primary chronic insomnia is rare.
- Comorbidity is the rule.
- Non pharmacological methods are tried first: ***Sleep Hygiene***
- The ***ideal hypnotic would increase the length & quality of sleep without residual effects the next morning***.
- Many anxiolytic drugs also act as hypnotics.
- ***Antihistamines & low doses of sedating anti depressants*** e.g. **amitriptyline** are also used to facilitate sleep.

SLEEP HYGIENE

- Use comfortable bed.
- Sleep at the same time everyday (within 1 – 2 hours).
- Avoid stimulants & use:
  - Hot cup of milk instead of coffee
  - Radio or relaxed reading to TV etc.
- Practice relaxation techniques.
- Avoid daytime nap.

HYPNOTICS

- Most enhance the action of GABA.
  - BDZ:
    - Shorter acting compounds lack hang over effects the next day whereas, longer acting compounds produce some cognitive impairment the next day (e.g. flurazepam, Nitrazepam).
  - Non BDZ ligands: Zoplicone, Zolpidem.
  - Melatonin: not addictive; nudges one to sleep.

5. PSYCHOSTIMULANTS

- Include:
  - Amphetamines: Dextroamphetamine
  - Methylphenidate
- MoA: increase the release & block the reuptake of dopamine & noradrenaline.
- Indications:
  - Narcolepsy
  - ADHD (Rx → methylphenidate, dextroamphetamine, pemoline)
- Side effects: restlessness, insomnia, poor appetite, dizziness, tremor, palpitations, arrhythmias

2. PHARMACOLOGICAL MANAGEMENT OF SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS MBCHB LEVEL VI 2019 UON

TYPED BY NAILA KAMADI

BY. DR. KAMAU JUDY

INTRODUCTION

- The biopsychosocial approach is used, i.e.:
  - Biological therapy: pharmacological management & ECT
  - Psychological therapy
  - Social therapy
- Physical exam is important for all patients.
- Lab work is done as an adjunct to /PE to *rule out other medical conditions* e.g. infective disorders or substance abuse.
- Brain imaging is indicated in suspected intracranial pathology or head injury.
- *Ensure comorbidities are managed* along with the psychotic disorder.

1. SCHIZOPHRENIA

- This is a disorder characterized by ***derangement of thought processes, affect & behaviour***.
- It involves expression of both positive & negative symptoms.
- Positive symptoms include:
  - Delusions
  - Hallucinations
  - Catatonia
  - Agitation

CONT.

- Negative symptoms include:
  - Affect flattening
  - Apathy
  - Social withdrawal
  - Anhedonia
  - Poverty of thought
  - Poverty of content of speech
- ***Schizophrenia is best treated by drugs & social treatments.***

EVALUATION & INVESTIGATIONS

- Physical examination
- Lab work to R/O other medical conditions e.g. infective disorders, substance abuse
- Brain imaging in suspected intracranial pathology or head injury

ANTIPSYCHOTICS

- These are the ***mainstay of treatment.***
- Chlorpromazine is the oldest one & was introduced in 1952.
- Action:
  - Diminish psychotic symptom expression by ***mesolimbic & mesocortical tract blockade.***
  - ↓ relapse rates: ~ 70% of patients treated with any antipsychotics achieve remission.
- They do this by ***antagonizing post synaptic dopamine receptors*** in the brain, especially the *mesolimbic* and *mesocortical* tracts.

THERE ARE 2 MAIN GROUPS OF ANTIPSYCHOTICS, NAMELY:

1. 1st generation/ typical antipsychotics: ***dopamine (D_2) receptor antagonists***
2. 2nd generation/ atypical antipsychotics: ***dopamine (D_2 & D_4) & serotonin receptor antagonists***
   - These can produce antipsychotic effects ***without producing extra – pyramidal side effects (EPSEs)***
   - They have ***improved efficacy against both +ve & -ve symptoms*** of psychosis (due to 5 – HT receptor blockade) relative to typical agents.

TYPICAL ANTIPSYCHOTICS

- Phenothiazines
  - Aminoalkyl compounds: Chlorpromazine
  - Piperidine compounds: Thioridazine
  - Piperazine compounds: Trifluperazine; fluphenazine
- Butyrophenenones: Haloperidol
- Thioxanthines: Flupenthixol; Clopenthixol

CONT.

- Low potency:
  - Chlorpromazine
  - Prochlorperazine
  - Thioridazine
- High potency
  - Fluphenazine
  - Flupenthixol
  - Haloperidol
  - Pimozide
  - Thiothixene

ATYPICAL ANTIPSYCHOTICS

- Amisulpiride
- Aripiprazole
- Clozapine
- Olanzapine
- Paliperidone
- Quetiapine
- Risperidone
- Sertindole
- Ziprasidone

DEPOT ANTIPSYCHOTIC DRUGS

- These are slow release preparations that are ideal for ***patients whose compliance cannot ensured.***
- Include:
  - Fluphenazine decanoate
  - Flupenthixol decanoate
  - Zuclopenthixol decanoate
  - Haloperidol decanoate
  - Olanzapine pamoate
  - Slow release risperidone (*risperidone consta*)
  - Pipotiazine palmitate

PHARMACOKINETICS

- Well absorbed.
- Oral formulations go through first pass metabolism.
- Are highly protein bound.
- Extensively metabolised by the liver (***except Amisulpiride which is excreted unchanged by the kidney***).
- Half life of most antipsychotics is around 20 hours allowing for OD dosing.
  - Quetiapine has a $t_{1/2}$ of 7 hours hence has twice daily dosing.
- Several weeks are needed for steady state achievement for depot preparations.

UNWANTED SIDE EFFECTS

- Side effects are related to their ***anti – dopaminergic, anti – adrenergic & anti – cholinergic*** effects.

EXTRAPYRAMIDAL SIDE EFFECTS (EPSES)

- These are related to **anti – dopaminergic** effects of the drugs on the basal ganglia (nigrostriatal tract) as well as an ↑ **in cholinergic activity**. They include:
  a) Acute dystonia e.g. torticollis, oculogyric crisis
  b) Akathisia
  c) Parkinsonian symptoms
  d) Tardive dyskinesia

CONT.

a. Acute dystonia:

- Develops ***hrs. to days*** after starting medication.
- Clinical presentation: torticollis, tongue protrusion, grimacing & opisthotonus
- Controlled by: **anticholinergic agents** e.g. benztropine, trihexyphenidyl/ benzhexol (*Artane* PRN).

CONT.

b. Akathisia

- Develops ***weeks – months*** after starting medication.
- Unpleasant feeling of physical restlessness & need to move leading to an ***inability to keep still***.
- Rx:
  - Lowering the dose
  - BDZ
  - β – blocker
  - Switch to atypical antipsychotic

CONT.

c. Parkinsonian syndrome/ Bradykinesia

- Appears ***few months*** after taking the meds
- Characterised by akinesia, expressionless (mask – like) face, lack of associated movements when walking, cog wheel rigidity, coarse tremor, stooped posture, festinating (slow, shuffling) gait, pill rolling
- More common in the elderly.
- Symptoms controlled with ***antiparkinsonian drugs***

CONT.

d. Tardive dyskinesia

- This is seen esp. with the typical antipsychotics.
- Due to ***supersensitive dopamine receptors after chronic blockade***.
- Not always reversible after stopping meds.
- Risks: older female
- Characterised by chewing & sucking movements, grimacing, choreoathetoid movements, akathisia
- Mainly affects the face
- Rx: stop the meds if the state of the mental illness allows this.

OTHER UNWANTED SIDE EFFECTS

- Anti – adrenergic effects:
  - Sedation: chlorpromazine, olanzapine, quetiapine, clozapine.
  - Postural hypotension esp. with low potency medication: chlorpromazine
  - Nasal congestion: ziprasidone, risperidone
  - Inhibition of ejaculation: Thioridazine
    - Risperidone cause retrograde ejaculation

CONT.

- **Anticholinergic effects** esp. with chlorpromazine, clozapine, thioridazine, olanzapine.
  - Dry mouth
    - ***Clozapine, however, causes hyper salivation/ drooling***
  - Urinary hesitancy, retention
  - Reduced sweating
  - Blurred vision esp. with atypical side effects.

CONT.

- Cardiac conduction effects:
  - Cardiac arrhythmias
  - Prolongation of QT interval: Thioridazine, ziprasidone
- Depression of mood
- Endocrine & metabolic changes:
  - Weight gain & ↑ risk of type 2 DM : olanzapine, clozapine
  - Gynecomastia, galactorrhoea & amenorhoea due to ↑ prolactin after blockade of the tuberoinfundibular tract: chlorpromazine, haloperidol, risperidone, olanzapine

CONT.

- **Hypothermia & eye problems** especially the elderly
  - Thioridazine causes retinitis pigmentosa
- **Sensitivity reactions**
- **Lower seizure threshold** e.g. chlorpromazine, clozapine; if the patient has concomitant epilepsy they may get seizures frequently when on these medications.

NEUROLEPTIC MALIGNANT SYNDROME

- Onset in the first days of treatment.
- Rapid onset of severe **motor** (*generalised hyper tonicity*), **mental** (akinetic mutism, stupor, *impaired consciousness*) & **autonomic** (*hyperpyrexia*, unstable BP, tachycardia, excessive sweating, salivation, urinary incontinence) disorders
- Blood **creatinine phosphokinase (CPK)** levels are ↑, WBC ↑.
- Treatment:
  - Symptomatic: stop antipsychotics, cool the patient, maintain fluid balance, treat inter – current infections
  - **Diazepam** can be used for muscle stiffness
  - **Dantrolene** for malignant hyperthermia,

CLOZAPINE SIDE EFFECT PROFILE

- Leukopenia that can progress to agranulocytosis (keep doing FHG as a F/U)
- Hyper salivation
- Postural hypotension
- Weight gain
- Hyperthermia

CLOZAPINE & AGRANULOCYTOSIS

- ***Mild leukopenia*** (WBC = 3,000 – 3,500), with or without clinical symptoms such as lethargy, fever, sore throat, or weakness:
  - Monitor the patient closely
  - Institute a minimum of twice – weekly CBC tests with differentials included.
- ***More serious leucopenia*** (WBC = 2,000-3,000):
  - Get daily CBCs
  - Stop the clozapine
  - May be reinstituted after the WBCs normalize.
- ***Uncomplicated agranulocytosis*** (no signs of infection):
  - Place patient in protective isolation
  - Discontinue clozapine & never re – challenge
  - BMA → ?

CONTRAINDICATIONS

- Myasthenia gravis, Addison's disease, glaucoma (***where compounds have significant anticholinergic activity***)
- Clozapine in BMS
- Caution in liver disease, cardiovascular disorder, epilepsy, serious infections

PRESCRIBING GUIDELINES

- ***Lowest possible doses*** should be used.
- ***Single antipsychotic*** use is recommended for a large majority of patients.
- ***Antipsychotics should not be used as PRN sedatives.***
- Those receiving antipsychotics should undergo **close monitoring of physical health** (BP, PR, ECG, plasma glucose, plasma lipids).
- ***Do not use a loading dose of an antipsychotic***.
- Consider offering depot/ long acting antipsychotic medication to those who would prefer such a treatment after an acute episode or where avoiding covert non – adherence

TREATMENT OF ACUTE PSYCHOSIS IN SCHIZOPHRENIA

- This phase lasts **4 – 8 weeks.**
- Acute schizophrenia is usually associated with ***severe agitation resulting from frightening delusions, hallucinations or suspiciousness***

TO RAPIDLY CALM/ TRANQUILIZE THE PATIENT

- Antipsychotics:
  - IM Haloperidol
  - Injectable short acting Olanzapine
  - IM chlorpromazine
- BDZs

TREATMENT DURING STABILISATION & MAINTENANCE PHASE

- Goal is to ***prevent psychotic relapse*** & ***assist patients in improving their level of functioning***.
- Stable patients **maintained on antipsychotics** have a much lower relapse rate than patients who have their medications discontinued.
- 16 – 23% of patients receiving treatment will relapse within a year & 53 – 72% will relapse without medication.

CATATONIA

- Marked psychomotor disturbance that may involve ***immobility or excessive purposeless motor activity, extreme negativism (lack of response to attempts to move), mutism, peculiarities in voluntary movement, echolalia, echopraxia***.
- History: standing at a single point for a long time, lying in bed for a long time without response.
- Associated with schizophrenia & mood disorders.
- Manage with **BDZs**, response seen within ***3 – 7 days***: They increase GABA transmission.
  - Patients with schizophrenia may at times not respond as fast
- **ECT** works very fast.

NON COMPLIANCE

- An estimated 40 – 50% of patients become noncompliant within 1 or 2 years.
- **Long acting medications** improve compliance.
- NB: ***When beginning long acting drugs, some oral supplementation may be needed while peak plasma levels are being achieved***

POOR RESPONDERS

- With antipsychotic medication, approximately 60% of patients will improve to the extent of achieving full remission or experience only mild symptoms.
- The remaining 40% will improve but still demonstrate variable levels of positive symptoms resistant to meds

CONT.

- Poor responder: a 4 – 6 week trial on an adequate dose of an antipsychotic:
  - Directly observe taking medication
  - Monitor plasma levels
  - Increase doses
  - Administer add on medication (combination therapy)
  - Change to another drug
  - ECT

MANAGING SIDE EFFECTS

- EPSEs
  - ↓ the dose of the antipsychotic.
  - Add an **antiparkinsonian medication** (S/E: dry mouth, constipation, blurred vision): procyclidine, benzhexol, orphenadrine, benztropine.
  - Change to an atypical antipsychotic
  - Centrally acting β – blockers may relieve akathisia

CONT.

- Tardive dyskinesia
  - Use lowest dose of antipsychotic
  - Prescribe cautiously in children & the elderly
  - Examine patients regularly for TD
  - Consider switching to another drug, e.g., Clozapine

OTHER PSYCHOTIC DISORDERS

SCHIZOPHRENIFORM

- Similar to schizophrenia only that symptoms last for $\geq$ 1 month but < 6 months.
- Patients usually return to baseline level of functioning once disorder has resolved.
  - For a patient to meet the diagnosis of schizophrenia, symptoms must last for $\geq$6 months
- Many patients progress to full blown schizophrenia despite Rx.

CONT.

- Psychotic symptoms can be treated by ***3 – 6 month course of antipsychotics: risperidone, haloperidol***
- Patients ***respond much more rapidly to treatment than in schizophrenia***.

SCHIZOAFFECTIVE

- Present with:
  - ***Manic episode with acute psychotic symptoms*** suggestive of schizophrenia
  - ***Major depressive episode with acute psychotic symptoms*** suggestive of schizophrenia.
  - Episode of ***psychotic symptoms without mood symptoms in a patient in whom a mood disorder has been previously diagnosed***.

MANAGEMENT:

- **Antipsychotics** are used to manage the psychotic symptoms.
- **Mood stabilizers** are also used in combination with antipsychotics: ***carbamazepine, lithium***.
- **Antidepressants (SSRIs)**: may be added; ***care should be taken not to precipitate a cycle of rapid switches from depression to mania***.

DELUSIONAL DISORDER & SHARED PSYCHOTIC DISORDER

- Although delusions can be quite elaborate, ***they should not be bizarre for a delusional disorder to be diagnosed***.
  - There is thus a need for an accurate & corroborative history.
- Diagnosis is made when a person exhibits ***non – bizarre delusions*** for ≥ 1 month duration that cannot be attributed to any other psychiatric disorders.
  - Non – bizarre means that the delusions must be about situations that can occur in real life.
- **Shared psychotic disorder:** transferred delusions from one person to another

CONT.

- In severe agitation: ***IM antipsychotic***
- Patients likely to refuse medications & can easily incorporate administration of meds into their delusions
- Rapport has to be established.
- Explain A/Es so that the patient doesn't later suspect that their doctor lied.
- Antipsychotics are effective.
- Start low and increase slowly.

BRIEF PSYCHOTIC DISORDER

- Similar to schizophreniform
- Illness last between 1 day – 1 month
- Specifications:
  - With marked stressor
  - Without marked stressor
  - With post – partum onset.
    - Puerperal psychosis is a brief psychotic disorder with post – partum onset.

MANAGEMENT

- Antipsychotics
  - Typical
  - Atypical
- BDZs for short term

PSYCHOTIC DISORDER NOS

- It is a diagnosis of exclusion mainly reserved for patients who have some diagnostic features of schizophrenia but do not meet all of the diagnostic criteria of schizophrenia fully.
- The patient has to have **non – organic psychosis**
- Can be a working diagnosis when one doesn't have enough information about the patient or when there is contradictory information or when one is running further investigations.

PSYCHOTIC DISORDER DUE TO GENERAL MEDICAL CONDITION

- Delirium esp. alcohol withdrawal, renal failure
- Dementia esp. Alzheimer's, paranoid
- Focal brain abnormalities: frontal & temporal lobe tumors
- Non – focal/ generalized brain problems
- Treatment
  - Identify general medical condition
  - Evaluate patient & ensure safety
  - ***Antipsychotic agents*** may be necessary for immediate & short term control of psychotic or aggressive behavior
  - Consider underlying medical condition while prescribing drugs e.g. ***haloperidol is quite safe in liver disease***

SUBSTANCE INDUCED PSYCHOTIC DISORDER

- Patients with substance induced psychotic disorder & impaired reality resting.
- Consider:
  - Type of substance involved
  - Stage of substance use when the disorder began (intoxication or withdrawal) e.g. psychosis in alcohol withdrawal
  - Clinical phenomena (hallucinations or delusions)
- Treatment
  - Identify the particular substance involved
  - Directed toward the underlying condition & the patient's immediate behavioral control
  - Antipsychotics, BDZs

3. PHARMACOLOGICAL MANAGEMENT OF MANIA MBCHB LEVEL VI 2019 UON

BY: DR. GITAU

CORE DIAGNOSTIC CRITERIA

- Increased activity or physical restlessness
- Talkativeness: pressure of speech in mania
- Difficulty in concentration or distractibility: flight of ideas in mania
- Decreased need for sleep
- Increased sexual energy
- Overspending or other reckless behavior: more pronounced in mania
- Increased sociability or over – familiarity
- Increased self esteem or grandiosity

DIAGNOSTIC SYMPTOMS OF MANIA: ELEVATED, IRRITABLE MOOD

- Distractible mood
- Grandiosity
- Racing thoughts
- Pressured speech
- Risky behavior

CORE SYMPTOMS OF MANIA

- Social disinhibition
- Self confidence
- Making plans
- Aggression
- Psychosis
- Impulsivity

CLASSIFICATION OF MANIA

- Hypomania:
  - Mood is mildly elevated
  - Symptoms do not lead to severe disruption of work or social rejection
  - 3 or more symptoms lasting at least 4 days (DSM V)

CONT.

- Mania
  - Mood is elevated out of keeping with the patient's circumstances
  - Symptoms may result in behavior that is inappropriate and reckless.

CONT.

- Mania with psychotic symptoms
  - In addition to mania there are delusions (usually grandiose) or hallucinations usually 2nd person.
- Mixed affective states

DEPRESSED MOOD

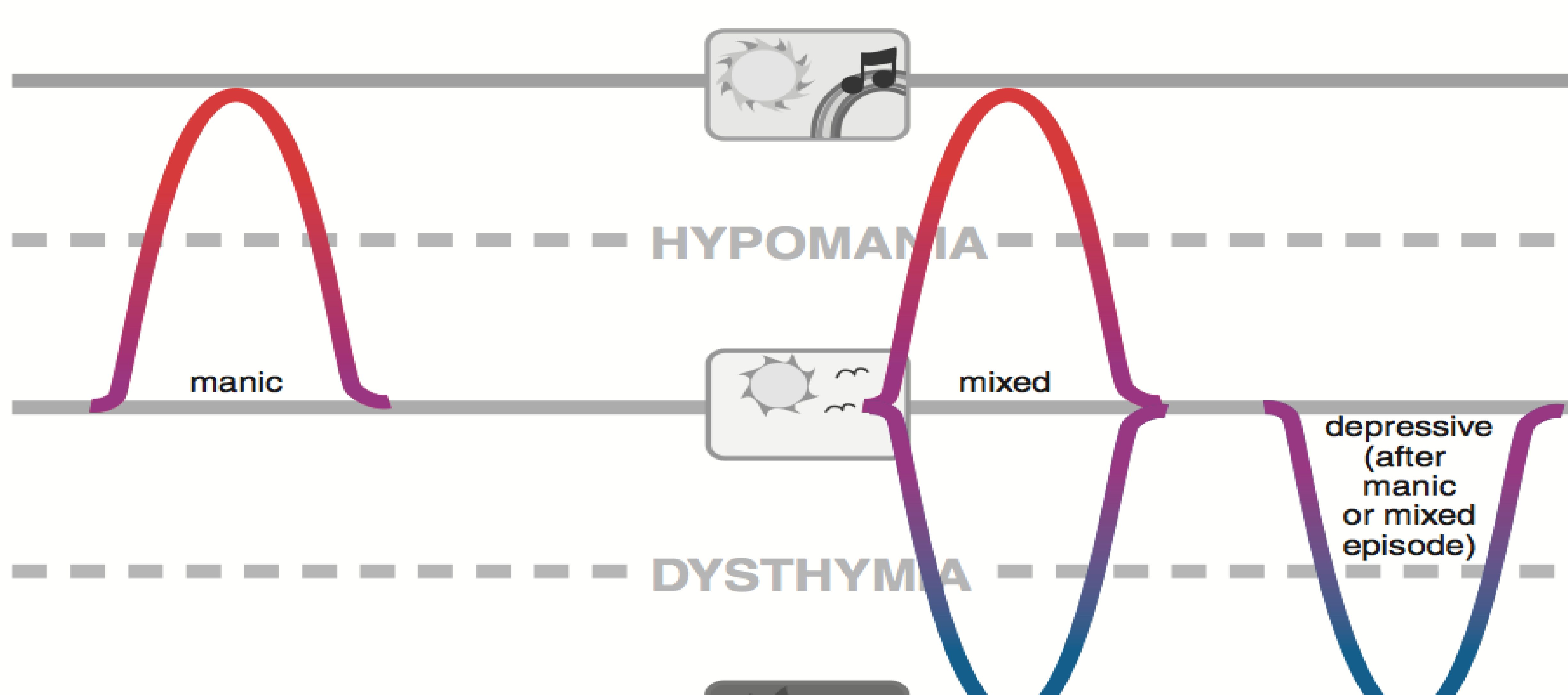
- Anhedonia
- Self depreciation
- Hopelessness
- Suicide ideas/ plans
- Loss of interest
- Guilt

CLASSIFICATION OF BIPOLAR DISORDER

- Bipolar 1: full manic & depressive episodes
- Bipolar 2: 1 hypomanic & 1 full depression episode
- Bipolar 3: depressive episode with antidepressant induced mania
- Watch for bipolar depression
- Mixed states
- Rapid cycling

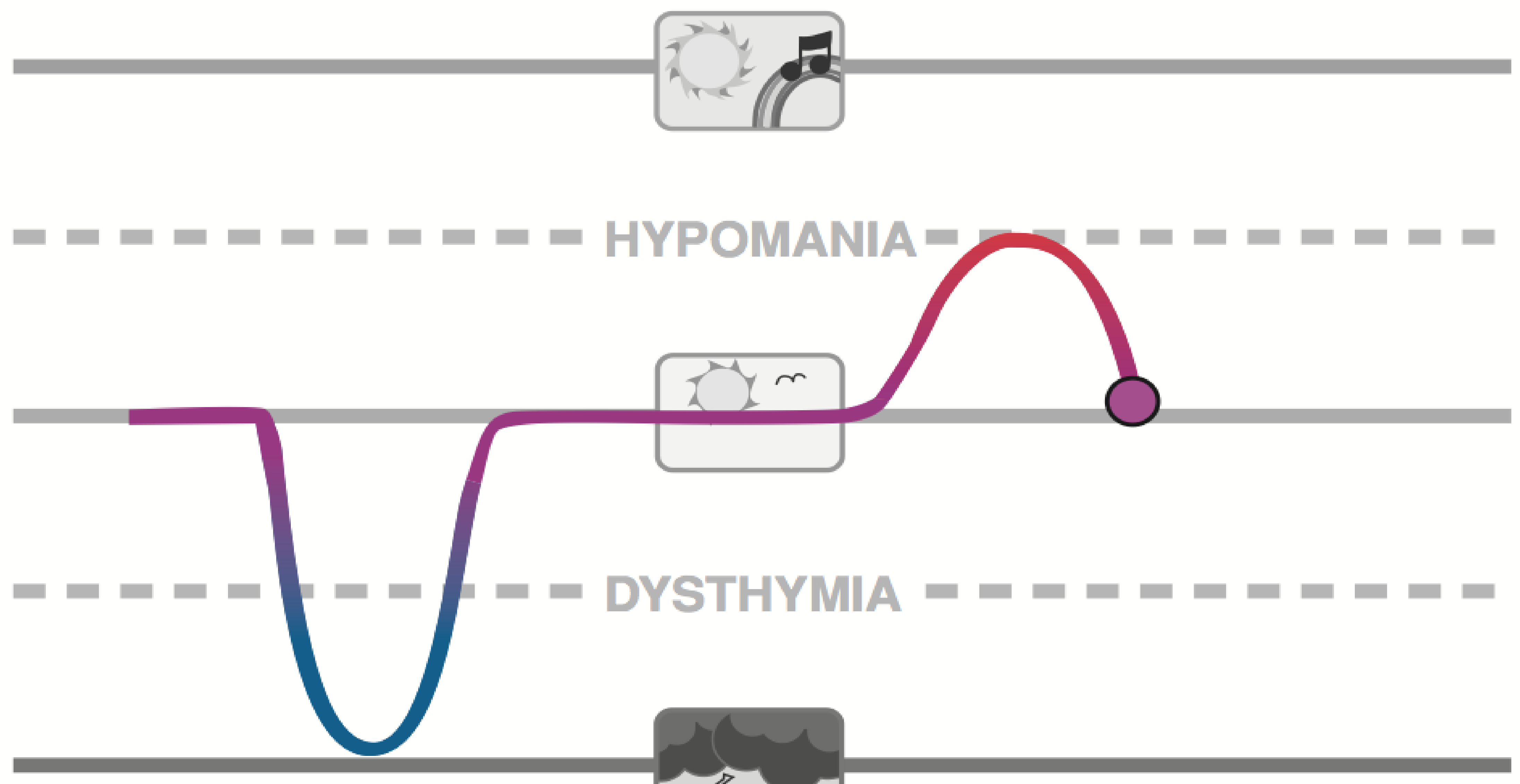
Bipolar I

Manic or Mixed Episode ± Major Depressive Disorder



Bipolar II

Depressive and Hypomanic Episodes



MANAGEMENT

- Information gathering
- Investigations
- Specific management
  - Pharmacological management
  - Psychosocial management
  - Prophylaxis

INFORMATION GATHERING

- Exclude other causes & do appropriate investigations
- Sources of information:
  - Patient
  - Collateral (corroborative) history
  - Primary physician (GP) records
  - Hospital records
  - Prison records (inmate records)

MEDICATION THAT MAY CAUSE MANIA

- Antidepressants
- Other psychotropic medication
- Anti – parkinsonian medication
- Analgesics: buprenorphine, codeine, indomethacin
- Cardiovascular drugs: captopril, digoxin
- Respiratory drugs
- Anti – Infection: anti TB, chloroquine, ARVs
- GIT drugs: cimetidine, ranitidine, metoclopramide
- Steroids: ACTH, corticosteroids, dexamethasone

EVALUATION & INVESTIGATIONS

- P/E
- Routine: FHG, ESR, RBS, U/E (Ca^{2+}), TFTs, LFTs, Drug screen, ECG, CrCl.
- Others: urinary copper (Wilson's disease), ANF (SLE), Infection screen (VDRL, HIV), CT/ MRI scan

SPECIFIC CONSIDERATIONS OF MANAGEMENT

- ***Risk assessment***: Violence, Self harm, harm to others, damage of property etc.
- ***Where*** will the patient be managed from: primary care, home treatment or hospitalisation?
- ***Who*** are required to manage the patient?
- Address ***specific psychosocial stressors***.
- ***Associated factors***: Psychosis, Catatonic symptoms, Substance use disorder, Other co-morbidities (*personality disorder, anxiety disorder, ADHD & conduct disorder*).

SPECIFIC TREATMENT: MANIC PHASE

1. ***First line***: Lithium, Antipsychotics
2. ***Second line***: Carbamazepine, Valproate, Lamotrigine, Gabapentin
3. ***Third line***: ECT

NICE GUIDELINES FOR THE TREATMNT OF ACUTE MANIA

- Consider, taking into account side effects & future prophylaxis:
  - Use an **antipsychotic** (***olanzapine***, ***quetiapine*** or ***risperidone***), especially if symptoms are severe or behaviour is disturbed.
  - Use **valproate** if symptoms have responded before (***avoid in women of childbearing potential***)
  - Use **lithium** if symptoms are not severe & have responded to this treatment before.

CONT.

- Consider adding a ***short - term benzodiazepine (such as lorazepam)*** for behavioural disturbance or agitation.
- Note:
  - **Carbamazepine** should ***not*** be routinely used for acute mania.
  - **Gabapentin, lamotrigine & topiramate** are not recommended for acute mania.

ANTIPSYCHOTICS

- These are used in the treatment of acute mania ***(even when psychotic symptoms are not present***).
- They have rapid onset of action.
- ***Atypical antipsychotics*** have improved tolerability.
- The following can be used:
  - Aripiprazole
  - Olanzapine (***shown to have superior efficacy to valproate***)
  - Quetiapine
  - Risperidone

LITHIUM

- **Lithium** is at least as effective as antipsychotic medication (NNT = 5 in one meta analysis).
- Indications: Prophylaxis (Mainly).
- The following **predict poor response to lithium alone**:
  1. Prominent ***depressive symptoms***
  2. Presence of ***psychotic*** features
  3. ***Rapid cycling***

DISADVANTAGES OF LITHIUM

- Slower onset of action ($\geq$ 1 week)
- Coadministration with antipsychotics ↑ risk of neurological side effects.
- There is difficulty in:
  - Achieving therapeutic plasma levels &
  - Monitoring in uncooperative patients

SIDE EFFECTS OF LITHIUM

- Short – term:
  - Drowsiness, fine tremor, thirst, GI disturbances (N, V & D), polyuria, polydipsia, muscle weakness.
- Long – term:
  - Nephrogenic diabetes insipidus, hypothyroidism, cardiotoxicity, irreversible kidney damage, edema, weight gain, tardive dyskinesia & other movement disorders

TOXIC EFFECTS OF LITHIUM

- ↑ GIT disturbances
- CNS disturbances:
  - Coarse tremor, drowsiness, ataxia, nystagmus, incoordination, slurring of speech, convulsion, coma.

DRUG INTERACTIONS OF LITHIUM

- Lithium plasma levels are ↑ by:
  - ACEIs & ARBs
  - Analgesics: NSAIDs
  - Antidepressants (***esp. SSRIS***)
  - Anti – epileptics
  - Anti – psychotics
  - Anti – hypertensives
  - CCBs
  - Diuretics
  - Metronidazole
- Lithium plasma levels ↓ by
  - Antacids
  - Theophylline

OTHER DRUG INTERACTIONS

- Anti – arryhthmics (amiodarone): ↑ risk of hypothyroidism
- Anti – diabetics: may sometimes impair glucose tolerance
- Anti – psychotics: ↑ risk of EPSE
- Muscle relaxants: enhanced effect
- Parasympathomimetics: antagonises neostigmine & pyridostigmine

PRE – TREATMENT TESTS, INITIATING DOSE & MONITORING OF LITHIUM

- Baseline: P/E, FBC, U/E/Cr, Creatinine Clearance (CrCl), TFTs, ECG
- Starting dose: 400 – 600mg nocte, ↑ weekly to a max. of 2g (usual range ***800mg – 2g***)
- Monitoring
  - Do lithium levels 5 days after starting & 5 days after each dose change.
  - Take blood samples 12 hrs. post dose
- If stable at 0.6 – 1.2mmol/L, check the following:
  - Lithium levels & U/E every 3 months
  - TFT every 6 – 12 months
  - CrCl every 12 months

VALPROATE

- Valproate is ↑ being used.
- Studies suggest that it is ***equivalent to lithium in efficacy*** **&** ***may be better in rapid cycling patients.***
- The ***onset of action is quicker*** than other agents (1 – 4 days) & titration can be rapid.

CONT.

- ***Valproate semi – sodium permeates the BBB more easily compared to sodium valproate*** resulting in higher concentrations of valproate in the brain.
- In treating mania it is effective in high doses ***600mg – 1200mg***
- Therapeutic response occurs in the 2nd week so anti – psychotic drugs are preferred.

ADVERSE EFFECTS OF VALPROATE

- Sedation
- Weight gain, hair loss
- Hepatic & pancreatic disturbance
- ↑ androgen levels & hence incidence of PCOS
- Haematological disturbance
  - Thrombocytopenia
  - Inhibition of platelet aggregation

CARBAMAZEPINE

- May be used in ***acute mania*** but there is relatively less evidence to support its efficacy.
- Research suggests that it is
  - Equivalent in efficacy to antipsychotics
  - Less effective than lithium & valproate.
- ***NICE guidelines advocates against the routine use of Carbamazepine in treatment of acute mania.***

MOA OF CARBAMAZEPINE

- Similar molecular structure to TCAs.
- Inhibits ***repetitive neuronal firing by blocking voltage – dependent Na^+ ion channels.***
- ↓ glutamate release
- ↓ dopamine & norepinephrine turnover
- Other
  - ↑ potassium conductance
  - Modulates high voltage – activated calcium channels

PRE – TREATMENT TESTS & MONITORING

- Baseline: Weight measurement, U/E, FBC & LFT.
- Monitoring:
  - U/E
  - FBC
  - LFT
  - Weight or BMI every 6 months.

ADVERSE EFFECTS

- Common:
  - Dizziness, diplopia, drowsiness, ataxia, headache
  - GIT disturbance (nausea, anorexia, constipation), Dry mouth
  - Edema, hyponatremia
  - Sexual dysfunction
- Rare:
  - Generalised erythematous rash (3%)
  - Blood disorders: Leukopenia & agranulocytosis (1:20,000)
  - Serious exfoliative dermatitis (genetically determined; testing of Han Chinese & Thai recommended)

DRUG INTERACTIONS

- Drug interactions involving carbamazepine are almost exclusively related to the ***drug's enzyme – inducing properties***.
- The ↑ metabolic capacity of hepatic enzymes may cause:
  - A ↓ in steady – state carbamazepine concentrations &
  - ↑ rate of metabolism of: primidone, phenytoin, ethosuximide, valproate, clonazepam, OCPs, Warfarin
- The following drugs induce carbamazepine's clearance & ↓ its steady – state concentrations:
  - Phenytoin, phenobarbital
- The following drugs inhibit carbamazepine's clearance & ↑ its steady state concentrations:
  - Valproate, erythromycin, cimetidine, CCBs, INH

BENZODIAZEPINES

- These are useful adjuncts
- ***They should not be used as a sole treatment***
- Dose & length of treatment should be limited to avoid tolerance & dependence.

PROPHYLAXIS OF BIPOLAR DISORDER: INDICATIONS

- After a **single manic episode** that was associated with significant risk & adverse consequences.
- In the case of **bipolar I illness after $\geq$ 2 acute episodes**.
- In the case of **bipolar II illness, if there is significant functional impairment, frequent episodes or significant risk of suicide**.

PHARMACOLOGICAL PROPHYLAXIS IN BIPOLAR DISORDERS: LITHIUM, OLANZAPINE OR VALPROATE

- The choice should depend on:
  - Previous response.
  - The relative risk & known precipitants of manic vs. depressive relapse/
  - Physical risk factors: particularly renal disease, obesity & DM.
  - Patient's preference & history of adherence.
  - Gender: ***caution in women should be taken when prescribing valproate***.
  - A brief assessment of cognitive state (e.g. MMSE) if appropriate, for example, for older people.

RESISTANT CASES

- ***Haloperidol, Olanzapine, Risperidone* & *Quetiapine*,** when ***combined with lithium or valproate***, have been shown to be superior to lithium or valproate alone.
- **ECT** is effective in the treatment of mania.
  - It tends to be reserved for the treatment of ***prolonged, life - threatening or treatment - resistant cases***.

CONT.

- If the patient has frequent relapses or symptoms continue to cause functional impairment consider:
  - Switching to an alternative monotherapy or
  - Adding a 2nd prophylactic agent (lithium, olanzapine, valproate). Possible combinations are:
    - Lithium + valproate
    - Lithium + olanzapine
    - Valproate + olanzapine.

RAPIDLY CYCLING BIPOLAR DISORDER: ACUTE EPISODES

- Treat as for manic & depressive episodes, but in addition:
  - Review previous treatments & consider a further trial of any that were inadequately delivered or adhered to.
  - Focus on optimising long - term treatment rather than treating individual episodes & symptoms. ***Trials of medication should usually last at least 6 months***.
  - Encourage patients to keep a ***mood diary*** to monitor the impact of interventions.

RAPIDLY CYCLING BIPOLAR DISORDER: LONG TERM MANAGEMENT

- 1st Line: **Lithium + Valproate***
- 2nd Line:
  - Lithium monotherapy Or
  - ↑ dose of lithium if already taking lithium
  - Lithium/ Valproate + lamotrigine (esp. in bipolar II disorder)
- Check TFTs every 6 months & Thyroid antibodies if indicated.
- ***Avoid using antidepressants, except on advice from a specialist.***

BIPOLAR DEPRESSION: TREATMENTS

- Established:
  - Lithium
  - Lithium + antidepressant
  - Lamotrigine
  - Olanzapine + fluoxetine
  - Quetiapine
- Alternatives:
  - Pramipexole (dopamine agonist)
  - Valproate
  - Carbamazepine
  - Antidepressants

OTHER POSSIBLE TREATMENTS

- Aripiprazole
- Gabapentin
- Inositol
- Modafinil
- Riluzole
- Thyroxine
- Mifepristone
- Zonisamide

4. PHARMACOLOGICAL MANAGEMENT OF DEPRESSION MBCHB LEVEL VI 2019 UON

BY. DR. GITAU

OUTLINE

- Classification of Antidepressants
- Mechanism of Action
- SSRIs
- Tricyclic Antidepressants
- Monoamine Oxidase Inhibitors
- 5 – HT2 receptor antagonists

CLASSIFICATION OF ANTIDEPRESSANTS

- Can be divided into 3 main classes, depending on their acute pharmacological properties.

  1. **Monoamine reuptake inhibitors**: These are compounds that inhibit the reuptake of noradrenaline &/or serotonin (5 – HT).
  2. **Monoamine oxidase inhibitors (MAOIs)**: These are compounds that deactivate monoamine oxidase irreversibly or reversibly.
  3. **5 – HT2 receptor antagonists**: These drugs have complex effects on monoamine mechanisms but share the ability to block 5 – HT2 receptors.

MONOAMINE REUPTAKE INHIBITORS

- These are compounds that inhibit the reuptake of noradrenaline and/ or serotonin. They include:
  1. Tricyclic Antidepressants (TCAs)
  2. Selective Serotonin Reuptake Inhibitors (SSRIs)
  3. Selective noradrenaline and serotonin reuptake inhibitors (SNRIs)
  4. Selective noradrenaline reuptake inhibitors (NARIs).

MONOAMINE OXIDASE INHIBITORS (MAOIS).

- These are compounds that deactivate monoamine oxidase either:

1. Irreversibly E.g. Phenelzine, Isocarboxazid & Tranylcypromine
2. Reversibly E.g. Moclobemide

5 – HT2 RECEPTOR ANTAGONIST

- These drugs include ***mirtazapine*** and ***trazodone***.
- They have complex effects on monoamine mechanisms but share the ability to block 5- HT2 receptors.

Drug	Advantages	Disadvantages
Tricyclic antidepressants	Well studied Efficacy never surpassed	Cardiotoxic*, dangerous in overdose
		Anticholinergic side effects**
	Useful sedative effect in selected patients	Cognitive impairment
		Weight gain during longer-term treatment
SSRIs/SNRIs	Lack cardiotoxicity***: relatively safe in overdose†	Long-term toxicity not fully evaluated
	Not anticholinergic	Gastrointestinal disturbance, sexual dysfunction
	No cognitive impairment	May worsen sleep and anxiety symptoms initially
	Relatively easy to give effective dose	Greater risk of drug interaction
Trazodone	Lacks cardiotoxicity††, relatively safe in overdose	Daytime drowsiness
Mirtazapine	Useful sedative effect in selected patients	Weight gain common Less well-established efficacy in severe depression

NOTE:

- ***Lofepramine*** is relatively safe in overdose.
- Long – term use of anticholinergic drugs may increase risk of dementia.
- ***Citalopram & escitalopram*** prolong the QT interval.
- ***Venlafaxine*** is more dangerous than SSRIs in overdose.
- Cardiac arrhythmias have rarely been reported with ***trazodone***.

MECHANISM OF ACTION

- The acute effect of **reuptake inhibitors & of MAOIs** is to **enhance the functional activity of noradrenaline and/ or 5- HT.**
- These actions can be detected within hours of the start of treatment but ***full antidepressant effects of drug treatment is delayed for several weeks***.
  - The delay in the onset of therapeutic activity may be due to pharmacokinetic factors e.g. the half – life is around 24 hours, therefore steady – state plasma drug levels will be reached only after 5 – 7 days. However, this does not completely account for the lag in antidepressant activity.
  - It has been suggested that at least 6 weeks should elapse before an assessment of the effects of an antidepressant drug can be made in an individual patient.

MECHANISM OF ACTION

- The delay in onset of obvious therapeutic effect with antidepressant medication led to suggestions that ***the antidepressant effect of current treatments is a consequence of slowly evolving neuroadaptive changes in the brain, which are triggered by acute potentiation of monoamine function***.

MECHANISM OF ACTION

- Mechanisms that might underlie this effect, include:
  - **Desensitization of inhibitory autoreceptors on 5 – HT & noradrenaline cell bodies**
  - **Increased production of neurotrophins**, such as brain- derived neurotrophic factor (BDNF)
  - **Increased synaptogenesis & neurogenesis.**

MECHANISM OF ACTION

- Other studies have shown the effects of antidepressant drugs on the neuropsychological mechanisms involved in the processing of emotional information. (Positive bias in healthy individuals after a single dose of antidepressants)
- These findings suggest that relevant neuropsychological effects of antidepressants can be detected from the beginning of treatment
- The delay in the appearance of obvious therapeutic effects of antidepressant medication may stem from the time taken for changes in emotional processing to be experienced as subjective changes in mood as an individual with this new emotional 'set' interacts with their environment

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS): FIRST – LINE TREATMENT OF DEPRESSION.

- They are moderately better tolerated & markedly less toxic in overdose.
- They include:
  - Fluoxetine
  - Fluvoxamine
  - Paroxetine
  - Escitalopram
  - Citalopram
  - Sertraline

PHARMACOLOGICAL PROPERTIES

- They are a structurally diverse group, but they all ***inhibit the reuptake of serotonin (5 – HT) with high potency & selectivity***.
- None of them has an appreciable affinity for the noradrenaline uptake site.
- They have a low affinity for other monoamine neurotransmitter receptors.

PHARMACOKINETICS

- Generally absorbed slowly & reach peak plasma levels after about 4 – 8 hrs., although ***citalopram & escitalopram are absorbed more quickly.***
- The ***half – lives of citalopram, escitalopram, fluvoxamine, paroxetine & sertraline are between 20 & 30 hours***, whereas the ***half – life of fluoxetine is 48 – 72 hours***.
    - Fluoxetine is metabolized to norfluoxetine, which is also a potent 5 – HT uptake blocker and has a half – life of 7– 9 days.
- SSRIs are primarily ***eliminated by hepatic metabolism***.

SIDE EFFECTS

- **Gastrointestinal effects:** Nausea occurs in about 20% of patients, although it often resolves with continued administration. Other side effects include bloating, flatulence, & diarrhea.
- **Neuropsychiatric effects:** These include insomnia, daytime somnolence, agitation, tremor, restlessness, irritability, & headache.
- SSRIs have also been associated with ***seizures & mania***
- EPSEs such as parkinsonism & akathisia have been reported, but are uncommon.
- ***SSRIS are less likely than TCAs to cause mania***.

OTHER SIDE EFFECTS.

- Sexual dysfunction, including ejaculatory delay & anorgasmia.
- Sweating & dry mouth.
- ***CVS effects are rare with SSRIs, but some reduction in pulse rate may occur & postural hypotension has been reported.***
- Associated with ***skin rashes*** &, rarely, a ***more generalized allergic reaction with arthritis***.
- Increase the risk of ***UGIB***, particularly when combined with NSAIDs or aspirin.
- Long – term use of SSRIs has been associated with an ***increased risk of osteoporotic fracture***

SSRIS AND SUICIDAL BEHAVIOR

- SSRIs can cause ***agitation & restlessness early in treatment*** & it is possible that in predisposed individuals this might trigger dangerous behavior.
- Studies have shown a 4 fold ***increase in risk of attempted suicide seen with all antidepressants in the 1st 9 days of treatment***.
- In adolescents & children the risk of self – harm with SSRIs might be greater.
- ***Patients should be closely monitored when starting antidepressant medication***

CONT.

- Some of the reasons for increased risk of suicide within the first 9 days are:
  - Depressed people may visit their doctor & start treatment when they are severely depressed.
- The alternative/traditional view is that the greatest risk of suicidal behavior occurs during the early stages of antidepressant treatment, ***because improvement in motor retardation precedes resolution of depressed mood***.

PHARMACODYNAMICS INTERACTIONS

- The most serious interaction reported is where ***simultaneous administration of SSRIs & MAOIs has provoked a 5 – HT toxicity syndrome (the 'serotonin syndrome')*** with:
  - Agitation
  - Hyperpyrexia
  - Rigidity
  - Myoclonus
  - Coma & death

SSRIS

- Other drugs that increase brain 5 – HT function & that must therefore be ***used with caution in combination with SSRIs*** include **lithium** & **tryptophan**, which have been reported to be associated with mental state changes, myoclonus & seizures.
- Other medical drugs that have been implicated in the serotonin syndrome when combined with SSRIs include:
  - Tramadol
  - Linezolid
  - Sumatriptan (5 – HT receptor antagonist)

PHARMACOKINETIC INTERACTIONS

- Some SSRIs, particularly **fluvoxamine, fluoxetine & paroxetine**, can produce substantial ***inhibition of hepatic cytochrome P450*** enzymes & can decrease the metabolism of several other drugs, thereby elevating their plasma levels .
  - ***Citalopram***, ***escitalopram*** & ***sertraline*** cause fewer reactions of this nature.
- Examples where clinically important reactions have been reported include ***TCAs, antipsychotic agents (including clozapine & risperidone), anticonvulsants & warfarin***.

	CYP 1A2	CYP 2D6	CYP 2C9	CYP 2C19	CYP 3A/4
Inhibitors	Fluvoxamine (+++) Duloxetine (+)	Fluoxetine (+++) Paroxetine (+++) Duloxetine (++) Sertraline (+) Citalopram (+) Escitalopram (+)	Fluoxetine (+++) Fluvoxamine (+++)	Fluvoxamine (+++) Fluoxetine (++) Venlafaxine (+)	Fluvoxamine (++) Fluoxetine (+)
Some substrates (plasma level increased)	Olanzapine Clozapine Haloperidol Tricyclic antidepressants Theophylline	Tricyclic antidepressants Venlafaxine Haloperidol Thioridazine Risperidone Clozapine Olanzapine	Warfarin Tolbutamide Phenytoin	Tricyclic antidepressants Diazepam Propranolol Omeprazole	Benzodiazepines Carbamazepine Quetiapine Clozapine

Inhibition: +, mild; ++, modest; +++, strong.

DIFFERENCES BETWEEN SSRIS

Drug	Risk of pharmacokinetic interaction*	Discontinuation syndrome	Other
Citalopram	+	+	Increases QT interval
Escitalopram	+	+	Increases QT interval
Fluoxetine	+++	0	Increased risk of agitation, slower onset of action
Fluvoxamine	+++	+++	Less well tolerated
Paroxetine	+++	+++	Weight gain
Sertraline	++	++	May have dopaminergic effects

+, present; ++, common; +++, marked.

SSRIS

- Explain to the patient that ***they may become more anxious & agitated early during SSRI treatment which is not an indicator that the underlying depression is worsening***.
- Anxiety & agitation usually diminish, when treatment persists but ***short – term treatment with a BDZ*** may be helpful, particularly if sleep disturbance is a problem.
  - Patients should be reviewed frequently during the first few weeks of treatment, to ensure compliance with medication.
- ***Should be continued for at least 6 months***, this lowers the rate of relapse.
- Effective in the ***prophylaxis of recurrent depressive episodes***.
- Should not be stopped suddenly, due to withdrawal reactions (insomnia, nausea, agitation & dizziness).
- Small doses of ***trazodone (50 – 150 mg)*** may also help sleep, although there are occasional reports of serotonin toxicity with this combination.

TRICYCLIC ANTIDEPRESSANTS

- **Pharmacology:** TCAs have a 3 – ringed structure with an attached side chain. There are 2 groups

1. **Secondary amines**: don't have a terminal methyl group on the side chain e.g. ***desipramine, nortriptyline***.
2. **Tertiary amines:** have a terminal methyl group on the side chain. Compared with secondary amines, they have ***a higher affinity for the 5 – HT uptake site & are more potent antagonists of α_1 – adrenoceptors & muscarinic cholinergic receptors***. Therefore, in clinical use, they are ***more sedating & cause more anticholinergic effects*** e.g. ***Amitriptyline, Clomipramine & Imipramine***

PHARMACOLOGY

- TCAs ***inhibit the reuptake of both 5 – HT & noradrenaline***.
- They also have ***antagonist activities at a variety of neurotransmitter receptors***. The receptor – blocking actions have been thought to cause adverse effects.
- Although the ability of some TCAs to antagonize brain 5 – HT2 receptors may also mediate some of their therapeutic effects.
- Tricyclics have ***quinidine – like membrane – stabilizing effects & this may explain why they impair cardiac conduction & cause high toxicity in overdose***.

PHARMACOKINETICS

- They are well absorbed from the GIT & peak plasma levels occur 2–4 hours after ingestion.
- Tricyclics are subject to significant 1st pass metabolism in the liver & are highly protein – bound. The free fraction is widely distributed in body tissues.
- Tricyclics are ***metabolized in the liver by hydroxylation & demethylation***.
- Demethylation of tricyclics with a tertiary amine structure gives rise to significant plasma concentrations of the corresponding secondary amine.
- They should be given once daily due to elimination half – life. ECG monitoring is useful.

TRICYCLIC ANTIDEPRESSANTS

Clomipramine

- Most potent of the TCAs in inhibiting the reuptake of 5 – HT.
- Its secondary amine metabolite, ***desmethylclomipramine***, is an effective noradrenaline reuptake inhibitor.
- Unlike other TCAs, clomipramine is useful in ameliorating the symptoms of obsessive compulsive disorder (OCD).

Lofepramine

- Tertiary amine which is metabolized to ***Desipramine***.
- Lofepramine is a fairly selective inhibitor of noradrenaline reuptake, & has fewer anticholinergic & antihistaminic properties than amitriptyline.
- It is not cardiotoxic in overdose.

SIDE EFFECTS OF TCAS

- Anticholinergic side effects include:
  - Dry mouth
  - Disturbance of accommodation
  - Difficulty in micturition → leading to retention
  - Constipation, leading rarely to ileus
  - Postural hypotension
  - Tachycardia &
  - Increased sweating
- Retention of urine, especially in elderly men with enlarged prostates & worsening of glaucoma are the most serious of these effects.
- Dry mouth & accommodation difficulties are the most common.

PSYCHIATRIC SIDE EFFECTS OF TCAS

- Tiredness & drowsiness with amitriptyline & other sedative compounds.
- Insomnia with ***Desipramine*** & ***Lofepramine***.
- Acute organic syndromes.
- Mania may be provoked in patients with bipolar disorders.

TCAS

Cardiovascular effects include:

- Tachycardia & postural hypotension occur commonly.
- Prolongation of PR & QT intervals
- Depressed ST segments
- Flattened T – waves.
- Ventricular arrhythmias & heart block develop occasionally, more often in patients with pre – existing heart disease.

Neurological effects include:

- Fine tremor (commonly)
- Incoordination
- Headache
- Muscle twitching
- Epileptic seizures in predisposed patients
- Peripheral neuropathy (rarely)

TRICYCLIC ANTIDEPRESSANTS

- **Other effects** include ***weight gain*** **&** ***sexual dysfunction***.
- **Withdrawal effects:**
  - Sudden cessation may be followed by ***nausea, anxiety, sweating, GI symptoms & insomnia with vivid dreaming***.
- **Toxic effects:**
  - Ventricular fibrillation, conduction disturbances & low blood pressure.
  - Sedation & coma lead to respiratory depression.

INTERACTIONS WITH OTHER DRUGS

- They antagonize the hypotensive effects of α_2 ***adrenoceptor agonists such as clonidine***, but can be safely combined with thiazides and angiotensin – converting enzyme (ACE) inhibitors.
- The ability of tricyclics to block noradrenaline reuptake can lead to hypertension with systemically administered noradrenaline & adrenaline.
- Tricyclics should not be used in conjunction with antiarrhythmic drugs, particularly amiodarone.

INTERACTION WITH OTHER DRUGS

- Tricyclics increase the QT interval & should not be given with other drugs that can produce a similar effect, for example, Pimozide, astemizole, erythromycin, clarithromycin, diphenhydramine & tamoxifen.
- Plasma levels of TCAs can be increased by numerous other drugs, including cimetidine, sodium valproate, CCBs & SSRIs.
- Tricyclics may increase the action of warfarin.

CONTRAINDICATIONS OF TCAS

- Agranulocytosis
- Severe liver damage
- Glaucoma
- Prostatic hypertrophy
- Uncontrolled epilepsy
- Significant cardiovascular disease
- Caution:
  - ***Tricyclics must be used cautiously in epileptic patients & in the elderly.***

CLINICAL USE OF TRICYCLIC ANTIDEPRESSANTS

- ***Amitriptyline***: sedating.
- ***Nortriptyline***: less sedating.
- ***Lofepramine:*** can be used for patients who present a risk of overdose.
- ***Clomipramine*** can be reserved for patients in whom a depressive disorder is related to **obsessive– compulsive disorder**.
  - Its efficacy is thought to be related to its effects on inhibition of serotonin reuptake. **SSRIs** are also effective medications for the treatment of OCD.

TRICYCLIC ANTIDEPRESSANTS

- Amitriptyline starting dose will depend to some extent on the ***patient's age, weight, physical condition & history of previous exposure to tricyclics***; daily doses of 25– 50 mg for an outpatient and 50 – 75 mg for an inpatient would be reasonable.
- The whole dose can be given at night about 1 – 2 hours before bedtime, because the sedative effects of the drug will aid sleep.
- The dose of amitriptyline to be aimed for is about 125 mg daily or above. This dose can usually be reached over a period of 2 – 4 weeks.

CONT.

- Explain to the patient that side effects may be noticed early in treatment, any significant improvement in mood may be delayed for a week or more & therefore it is important to persist.
- Early signs of improvement may include better sleep & a lessening of tension.
- Start with a low dose. It is usually advisable to continue amitriptyline for 4 weeks at the maximum tolerated dose before deciding that the drug is ineffective.
- In doses above 225 mg daily, it is wise to monitor the ECG before each further dosage increase.

TRICYCLIC ANTIDEPRESSANTS

Maintenance & prophylaxis

- If patients respond to amitriptyline, they should be maintained on treatment for at least 6 months, as continuation therapy greatly reduces the risk of early relapse.
- The same dose of amitriptyline should be maintained if possible.
- In some patients depression is a recurrent disorder, therefore long – term prophylactic treatment may be justified.

MONOAMINE OXIDASE INHIBITORS (MAOIS)

- MAOIs were introduced just before the TCAs.
- Their use has been less widespread due to troublesome interactions with foods & drugs.
- In adequate doses MAOIs are useful antidepressants, often producing clinical benefit in depressed patients who have not responded to other medication or ECT.
- In addition, MAOIs can be useful in refractory anxiety states.
- In practice conventional MAOIs are used only in patients who failed to respond to multiple other treatments.

PHARMACOLOGICAL PROPERTIES OF MAOIS

- MAOIs ***inactivate enzymes that oxidize noradrenaline, 5 – HT, dopamine, tyramine & other amines*** that are widely distributed in the body as transmitters, or are taken in food & drink or as drugs.
- Monoamine oxidase (MAO) exists in a number of forms that differ in their substrate & inhibitor specificities.
- MAO – A metabolizes intraneuronal noradrenaline & 5 – HT. Both MAO – A & MAO – B metabolize dopamine & tyramine.

COMPOUNDS AVAILABLE

- **Phenelzine** is the most widely used.
- **Isocarboxazid** has fewer side effects than Phenelzine. Useful in patients who suffer from side effects of Phenelzine such as hypotension or sleep disorder.
- **Tranylcypromine** differs from the other compounds in combining the ability to inhibit MAO with an amphetamine – like stimulating effect, which may be helpful in patients with anergia & retardation. However, some patients become dependent on the stimulant effect of tranylcypromine.
  - Compared with Phenelzine, tranylcypromine is more likely to give rise to hypertensive crises, although it is less likely to damage the liver.

MAOIS

- **Moclobemide** differs from the other compounds in selectively ***binding to MAO – A, which it inhibits in a reversible way***. This results in a lack of significant interactions with foodstuffs & a quick offset of action.

PHARMACOKINETICS

- Phenelzine, Isocarboxazid & Tranylcypromine are rapidly absorbed & widely distributed.
- They have short half – lives (about 2 – 4 hours), as they are quickly metabolized in the liver by acetylation, oxidation & deamination.
- They bind irreversibly to MAO – A & MAO – B by means of a covalent linkage. This means that the enzyme is permanently deactivated & MAO activity can be restored only when new enzyme is synthesized.
- Despite their short half – lives, irreversible MAOIs cause a long – lasting inhibition of MAO.
- People differ in their capacity to acetylate drugs

MAOIS

- **Moclobemide** binds reversibly to MAO – A.
- This compound has a short half – life (about 2 hours) & therefore its inhibition of MAO – A is brief, declining to some extent even during the latter periods of a three times daily dosing regimen.
- Full MAO activity is restored within 24 hours of stopping Moclobemide, whereas with the irreversible MAOIs, a period of 2 weeks or more may be needed for synthesis of new MAO.

EFFICACY OF MAOIS IN DEPRESSION

- Phenelzine doses of up to 90 mg daily if side effects permit are superior to placebo and are generally equivalent to TCAs in their therapeutic activity.

MAOIS SIDE EFFECTS

Central nervous system

Insomnia, drowsiness, agitation, headache, fatigue, weakness, tremor, mania, confusion

Autonomic nervous system

Blurred vision, difficulty in micturition, sweating, dry mouth, postural hypotension, constipation

Other

Sexual dysfunction, weight gain, peripheral neuropathy (pyridoxine deficiency), oedema, rashes, hepatocellular toxicity (rare), leucopenia (rare)

INTERACTIONS OF MAOIS WITH FOODSTUFFS

- Some foods contain tyramine, a substance that is normally inactivated by MAO in the liver & the gut wall.
- When MAO is inhibited, tyramine is not broken down & is free to exert its hypertensive effects.
- These effects are due to release of noradrenaline from sympathetic nerve terminals with a consequent elevation in blood pressure.
- The elevated BP may occasionally result in subarachnoid hemorrhage.

CONT.

- Important early symptoms of such a crisis include a ***severe and usually throbbing headache***.
- The incidence of hypertensive reactions is about 10% in patients who are taking MAOIs, even in those who have received dietary counselling. Therefore regular reminders about dietary restrictions may be helpful, particularly in patients on longer – term treatment .
- If a forbidden food has been consumed on one occasion without adverse effects, this does not preclude a future reaction.

FOODS TO BE AVOIDED DURING MAOIS USE;

- All cheeses except cream, cottage & ricotta cheeses
- Red wine, sherry, beer & liquors
- Pickled or smoked fish
- Brewer's yeast products
- Broad bean pods (e.g. Italian green beans)
- Beef or chicken liver
- Fermented sausage (e.g. bologna, pepperoni, salami)
- Unfresh, overripe or aged food (e.g. unfresh dairy products)

MAOIS

- 80% of all reported reactions between foodstuffs & MAOIs, and nearly all of the deaths, have followed the consumption of cheese.
- Hypertensive reactions should be treated with ***parenteral administration of an α_1 – adrenoceptor antagonist***.
  - ***Oral Nifedipine*** has also been advocated.
- Whatever treatment is given, ***blood pressure must be monitored carefully***.

MOCLOBEMIDE AND TYRAMINE REACTIONS

- Tyramine is metabolized by both MAO – A & MAO – B.
- Tyramine has relatively little effect in patients who are receiving Moclobemide because MAO – B (***present in the gut wall and the liver***) is still available to metabolize much of the tyramine ingested.
- The interaction between Moclobemide & MAO – A is reversible, thus allowing displacement of Moclobemide from MAO when tyramine is present in excess.

MAOIS

- **The serotonin syndrome:**
  - A number of drugs that potentiate brain 5 – HT function can produce a severe neurotoxicity syndrome when combined with MAOIs.
- **Neurological**: Myoclonus, nystagmus, headache, tremor, rigidity, seizures.
- **Mental state:** Irritability, confusion, agitation, hypomania, coma
- **Others:** Hyperpyrexia, sweating, diarrhoea, cardiac arrhythmias

CONTRAINDICATIONS TO MAOIS

- Liver disease
- Phaeochromocytoma
- CCF
- Conditions that require the patient to take any of the drugs that react with MAOIs.

CLINICAL USE OF MAOIS IN DEPRESSION

Phenelzine.

- Treatment should start with 15 mg daily, increasing to 30 mg daily in divided doses (with the final dose taken not later than 3.00 pm) in the first week.
- The dose can be increased by 15 mg weekly if side effects permit.
- Side effects that are likely to be particularly troublesome are ***insomnia & postural hypotension***.

CONT.

- ***Patients should be given clear written instructions about foods to be avoided and should be warned to take no other medication unless it has been specifically checked with a pharmacist or doctor who knows that the patient is taking MAOIs***.
- As always, patients should be warned about the delay in therapeutic response (up to 6 weeks) and about common side effects (sleep disturbance & dizziness).

WITHDRAWAL FROM MAOIS

- Even gradual withdrawal can be associated with ***increasing anxiety & depression***.
- ***MAOIs produce a more severe discontinuation syndrome than other antidepressants.***
- It is emphasized that, because of the time taken to synthesize new MAO, 2 weeks should elapse between the cessation of irreversible MAOI treatment & the easing of dietary and drug restrictions.

5 – HT2 RECEPTOR ANTAGONISTS

- 5 – $HT2_C$ receptors are $G_{\alpha q}$ – coupled heteroreceptors that are ***expressed in several limbic structures including the <u>hippocampus</u> (especially enriched in CA3), <u>amygdala</u>, <u>anterior olfactory</u> & <u>endopiriform nuclei</u> & <u>cingulate and piriform cortex</u>***.
- ***Over activity of 5 – $HT2_C$ receptors*** may contribute to the etiology of depression and anxiety as some suicide victims have abnormally high expression of 5-HT2CRs in the prefrontal cortex.

5 – HT2 RECEPTOR ANTAGONISTS

- ***Agomelatine***, a mixed melatonergic agonist/ 5 – HT2CR antagonist is an effective anxiolytic & antidepressant in both preclinical & clinical populations.
- Acute administration of SSRIs can lead to negative side effects (such as increased anxiety) presumably through activation of both 5 – $HT_{1A}R$ auto – receptors & 5 – $HT_{2C}R$ heteroreceptors.

(Yohn CN, Gergues MM, Samuels BA. The role of 5-HT receptors in depression. Mol Brain. 2017;10(1):28. Published 2017 Jun 24. doi:10.1186/s13041-017-0306-y)

AGOMELATINE

- It is a ***melatonin receptor agonist and a somewhat weaker antagonist at 5 – HT2C receptors***.
- The mechanism of antidepressant action of Agomelatine is not established, but could be mediated through a melatonin – like action on circadian rhythms.
- It is also possible that 5 – HT_{2C} receptor blockade might lead to ***increased dopamine release in the prefrontal cortex***.

AGOMELATINE

- Pharmacokinetics: Agomelatine is rapidly absorbed, reaching maximum levels within 1 – 2 hours of ingestion.
- It has a high 1st pass metabolism, with a bioavailability of only 5 – 10%.
- It has a short half – life of about 2 hours & no metabolites likely to contribute to its therapeutic action.

AGOMELATINE

<u>Unwanted effects</u>

- The most common adverse effects of Agomelatine are ***nausea & dizziness***.
- Some patients experience somnolence & insomnia has also been reported.
- Anxiety & fatigue,
- Diarrhea & constipation.
- Sexual dysfunction is less frequent than with SSRIs.
- The ***most serious potential adverse effect of Agomelatine is an increase in liver enzymes (ALT and AST).***

CONT.

- Treatment with Agomelatine should be ***preceded by measurement of liver function tests, which should be repeated after approximately at 3, 6, 12 & 24 weeks***.
- Any clinical suspicion of impaired hepatic function should be followed by urgent liver function tests & treatment with Agomelatine should be stopped if the results are abnormal.

AGOMELATINE

Drug interactions

- The main interaction of Agomelatine is with ***drugs that inhibit the hepatic microsomal enzymes, CYP1A2 & CYP2C9/ 19***. T
  - his is because these enzymes metabolize Agomelatine & higher blood levels of Agomelatine are likely to increase the risk of hepatic dysfunction.
- Agomelatine should not be given with potent CYP1A2 inhibitors such as ***fluvoxamine and ciprofloxacin***.
- Coadministration with more moderate inhibitors (estrogens, propranolol) should be employed with caution.

MIRTAZAPINE

- It is a quadricyclic compound with complex pharmacological actions.
- MoA:
  - Fairly potent ***antagonist at several 5 – HT receptor subtypes, particularly 5 – HT2 & 5 – HT3 receptors***.
  - ***Competitive antagonist at histamine H_1 receptors & α_1 – & α_2 – adrenoceptors*** (The latter leads to an increase in noradrenaline cell firing and release).
- Mirtazapine is not a muscarinic cholinergic antagonist & is not cardiotoxic.
- It has a ***sedating profile*** and is relatively safe in overdose.

MIRTAZAPINE

Pharmacokinetics

- Mirtazapine is well absorbed, with peak plasma levels being reached between 1 and 2 hours.
- The half – life is about 16 hours & the daily dose can be given at night.
- Mirtazapine is extensively metabolized by the liver & has only minor inhibitory effects on cytochrome P450 isoenzymes.
- **Efficacy:** The effective dose is usually between 10 mg and 45 mg daily.

MIRTAZAPINE

Unwanted effects

- The common adverse effects are attributable to its ***potent antihistaminic actions*** & include
  - Drowsiness & dry mouth.
  - Increased & and body weight.
- Leucopenia is not common however monitoring is recommended.

MIRTAZAPINE

Drug interactions

- May Potentiate other centrally acting sedatives.
- There is a theoretical risk that mirtazapine could reverse the therapeutic effect of α_2 adrenoceptor agonists such as clonidine.

TRAZODONE

- Trazodone is a triazolopyridine derivative with complex actions on 5 – HT pathways.
- MoA:
  - Some ***weak 5 – HT reuptake – Inhibiting properties***.
  - Antagonist actions at 5 – HT2 receptors, but its active metabolite, ***m- chlorophenylpiperazine (m – CPP)***, is a 5 – HT receptor agonist.
  - Blocks postsynaptic α_1 – adrenoceptors.
  - Overall it has a distinct sedating profile.
- The precise balance of effects on 5 – HT receptors during trazodone treatment is difficult to determine & may depend on relative blood levels of the parent compound & metabolite.

TRAZODONE

- Pharmacokinetics: Trazodone has a short half – life (about 4–14 hours). It is metabolized by ***hydroxylation & oxidation***, with the formation of a number of metabolites, including m – CPP.
- Efficacy of trazodone is improved if treatment is started at low doses (50 mg) & increased slowly to 300 mg over 2 – 3 weeks.
- OD administration of the drug is often sufficient.
- The drug is usually given in the evening to take advantage of its sedative properties.
- Doses above 300 mg daily are usually better given in divided amounts.

TRAZODONE

Unwanted effects

- ***Sedation***, which can result in significant cognitive impairment.
- Nausea & dizziness
- Postural hypotension
- Cardiac arrhythmias may be worsened in patients with cardiac disease.
- **The most serious side effect of trazodone is priapism. This reaction is seen rarely (about 1 in 6000 male patients).**
  - It is recommended that male patients be warned of priapism & advised to seek medical help urgently if persistent erection occurs.

5. PHARMACOLOGICAL MANAGEMENT OF ANXIETY DISORDERS
MBCHB LEVEL VI
2019
UON

BY. DR. GITAU

OUTLINE

- Benzodiazepines
- Azapirones: Buspirone
- Antidepressants
- β – adrenoceptor antagonists
- Pregabalin
- Hypnotics
- Advice on management of anxiety disorder

ANXIETY DISORDERS

An anxiety disorder is a debilitating mental illness that shows signs of fear, worry, and uneaseness.

TYPES OF ANXIETY

POSTTRAUMATIC STRESS DISORDER PTSD

GENERALIZED ANXIETY DISORDER

OBSESSIVE-COMPULSIVE DISORDER - OCD

SPECIFIC PHOBIA (FEAR)

PANIC DISORDER

BENZODIAZEPINES

Pharmacology

- Benzodiazepines have several actions:
  - Anxiolytic
  - Sedative and hypnotic
  - Muscle relaxant
  - Anticonvulsant

BENZODIAZEPINES

- Their pharmacological actions are mediated through ***specific receptor sites located in a supramolecular complex with gamma – aminobutyric acid ($GABA_A$) receptors***.
- ***BDZs enhance GABA neurotransmission***, thereby indirectly altering the activity of other neurotransmitter systems, such as those involving noradrenaline & 5 – HT.

BENZODIAZEPINES

- Differ both in the ***potency*** with which they interact with BDZ receptors and in their ***plasma half – life***.
- In general, ***high – potency BDZs & those with short half lives are more likely to be associated with dependence and withdrawal***.
- BDZs with short half – lives (< 12 hrs.) include:
  - Lorazepam
  - Temazepam
  - Lormetazepam.

BENZODIAZEPINES

- Because of problems with dependence, ***long – acting benzodiazepines are preferable for the management of anxiety, even if such treatment is to be given intermittently on an 'as- required' basis***.
- Long – acting benzodiazepines include drugs such as:
  - Alprazolam
  - Clonazepam
  - Diazepam
  - Chlordiazepoxide

HALF – LIVES OF SOME DRUGS THAT ACT AT THE GABA – BDZ – RECEPTOR COMPLEX

Diazepam	20–100 h*
Chlordiazepoxide	5–30 h*
Lorazepam	8–24 h
Temazepam	5–11 h
Zopiclone	4–6 h
Zolpidem	1.5–2 h
Chlormethiazole	4–6 h
	(4–12 h in the elderly)
Chloral	6–8 h

* Active metabolite increases half-life further.

BENZODIAZEPINES

<u>Pharmacokinetics</u>

- Benzodiazepines are **rapidly absorbed**.
- They are strongly bound to plasma proteins but, because they are lipophilic, pass readily into the brain.
- They are metabolized to a large number of compounds, many of which have therapeutic effects of their own; ***temazepam & oxazepam are among the metabolic products of diazepam***.

BENZODIAZEPINES

- **Excretion** is mainly as conjugates in the urine.
- BDZs with short half – lives, such as temazepam & lorazepam, have a 3 – hydroxyl grouping, which allows a one – step metabolism to inactive glucuronides.
- Other BDZs, such as diazepam & clorazepate, are metabolized to long – acting derivatives, such as desmethyldiazepam, which are themselves therapeutically active.

CONT.

- ***It is now common practice to give BDZs (often in combination with low – dose antipsychotic drugs) to produce a rapid calming effect in psychosis.***
- In this situation, BDZs may be given parenterally & it is worth noting that ***the absorption of diazepam following IM injection is poor & lorazepam should be preferred if this route of administration is used.***

BENZODIAZEPINES

- BDZs are well tolerated.
- Main side effects are due to the ***sedative properties*** of large doses, which can lead to ataxia, drowsiness & falls (especially in the elderly) & occasionally to confused thinking & amnesia.
- Minor degrees of impaired coordination & judgement.

CONT.

- Patients should be advised about these dangers & about the potentiating effects of alcohol.
- The prescriber should remember that ***these effects are more common among elderly patients and those with impaired renal or liver function***.
- ***Use of BDZs for more than 3 months has been linked to an increased risk of dementia (NICE, 2015).***

BENZODIAZEPINES

<u>Toxic effects</u>

- BDZs have few toxic effects.
- Patients usually recover from large overdoses because ***these drugs do not depress respiration & blood pressure as barbiturates***.
- Fatal overdoses of benzodiazepines have occasionally been reported.

BENZODIAZEPINES

Drug interactions

- Potentiate the effects of alcohol and of drugs that depress the CNS.
- Significant respiratory depression has been reported in some patients receiving combined treatment with benzodiazepines & clozapine.

BENZODIAZEPINES

- ***Dependence and tolerance*** develops after prolonged use.
- The withdrawal syndrome associated with benzodiazepines is characterized by several different kinds of symptoms:
  - Apprehension
  - Anxiety & Insomnia
  - Tremor
  - Nausea
  - Heightened sensitivity to perceptual stimuli & perceptual disturbances
  - Depression & suicidal thinking
  - Epileptic seizures (rarely).

CONT.

- It can sometimes be difficult to decide whether the patient is experiencing a BDZ withdrawal syndrome or a recrudescence of the anxiety disorder for which the drug was originally prescribed.
  - ***Perceptual disturbances are more likely to indicate BDZ withdrawal.***

BENZODIAZEPINES

- Withdrawal symptoms generally begin within:
  - 2 to 3 days of stopping a short – acting BDZ.
  - 7 days of stopping a long – acting one.
- The symptoms generally last for 3 – 10 days.
- Withdrawal symptoms seem to be more frequent after taking drugs with a short half – life than after taking those with a long one.
- ***Best to withdraw them gradually over a period of several weeks, if taken over a long duration.***

BENZODIAZEPINES

- BDZs should be administered on a short – term basis only (**not more than 4 weeks**) to help a patient to cope with functionally disabling anxiety while other treatment measures are instituted.

BUSPIRONE

- **Indications:** Effective in the treatment of generalized anxiety disorder.

Pharmacology

- No affinity for BDZ receptors.
- Stimulates a subtype of 5 – HT receptor called the ***5 – HT1A receptor***. This receptor is found in high concentration in the ***raphe nuclei in the brainstem***, where it regulates the firing of 5 – HT cell bodies.
- Buspirone lowers the firing rate of 5 – HT neurons & thereby decreases 5 – HT neurotransmission in certain brain regions. This action may be the basis of its anxiolytic effect.

BUSPIRONE

Pharmacokinetics & adverse effect

- Buspirone has poor systemic availability because it has an extensive 1st – pass metabolism.
- Buspirone is often associated with ***lightheadedness, nervousness & headache early in treatment***.
- There is little evidence that tolerance and dependence occur during Buspirone use.

BUSPIRONE

Drug interactions

- It is relatively free from significant drug interactions, but combination with MAOIs has been reported to cause raised blood pressure.

ANTIDEPRESSANT DRUGS USED FOR ANXIETY

- **TCAs** are effective, whether or not significant depressive symptoms are present in the management of;
  - GAD
  - Panic disorder
  - PTSD
- **Selective Serotonin Reuptake Inhibitors (SSRIs)** are effective in a broad range of anxiety disorders, including OCD (Baldwin et al., 2014).

ANTIDEPRESSANT DRUGS USED FOR ANXIETY

- **Selective serotonin & noradrenaline reuptake inhibitors (SNRIs)**, are licensed for the treatment of GAD as well as depression E.g. ***Venlafaxine and Duloxetine***.
- The time of onset of effect is much slower with antidepressants & particularly in panic disorder.

ANTIDEPRESSANT DRUGS USED FOR ANXIETY

- There may be an exacerbation of symptoms early in treatment.
- The ultimate therapeutic effect of antidepressants is at least as great as that of benzodiazepines, and they are less likely to produce cognitive impairment (Baldwin et al., 2014).
- The use of antidepressants is not associated with tolerance & dependence although, as noted above, sudden cessation of treatment can cause abstinence symptoms.

ANTIPSYCHOTIC DRUGS USED FOR ANXIETY

- Conventional & atypical antipsychotic drugs have sometimes been prescribed in low doses for their anxiolytic effects, particularly in patients with:
  - Persistent anxiety who have become dependent on other drugs.
  - Patients with aggressive personalities who respond badly to the disinhibiting effects of BDZs.
- However, an indication should be restricted to specialist use in patients with anxiety disorders that have not responded to other pharmacological & psychological approaches (Baldwin et al., 2014).

BETA – ADRENOCEPTOR ANTAGONISTS

- These drugs ***relieve some of the autonomic symptoms of anxiety, such as tachycardia, almost certainly by a peripheral effect***.
- They are best reserved for anxious patients whose main symptom is palpitation or tremor, particularly in social situations.
- An appropriate drug is ***propranolol in a dose of 20–40 mg three times a day***.

BETA – ADRENOCEPTOR ANTAGONISTS

- Contraindications are:
  - Heart block
  - Beta – adrenoceptor antagonists ***precipitate heart failure in a few patients & should not be given to those with atrioventricular node block.***
  - SBP < 90 mmHg
  - PR < 60/ min
  - History of bronchospasm
- They can exacerbate:
  - Raynaud's phenomenon &
  - Hypoglycemia in diabetics.

PREGABALIN

- Pregabalin is a derivative of the anticonvulsant drug, gabapentin.
- Like gabapentin, pregabalin has anticonvulsant & analgesic properties.
- It is licensed for the treatment of GAD but not other anxiety disorders.

PREGABALIN

- Both ***gabapentin and pregabalin are analogues of GABA***; however, **neither compound is active at GABA or BDZ receptors**.
- Therapeutic effects are mediated through interaction with the $\alpha_2 \delta$ subunit of voltage – gated calcium channels with a consequent modification of neurotransmitter release.
- Doses of 150 – 600 mg, are effective in the treatment of generalized anxiety disorder.
- Pregabalin is at least as efficacious as other agents used to treat GAD, including the SSRIs (Baldwin et al., 2014).

PREGABALIN

Pharmacokinetics & adverse effects

- Rapidly absorbed, with peak plasma concentrations occurring within about 1 hour.
- Its half – life is about 6 hours .
- It is eliminated unchanged primarily through renal excretion.
- Dose adjustment is therefore required in patients with impaired renal function.

PREGABALIN

- Because of its pattern of elimination, it does not cause pharmacokinetic interactions with other drugs, but ***the effects of central sedatives (e.g. BDZs & alcohol) may be potentiated.***
- The most common adverse effects are ***somnolence and dizziness.***
- Other common unwanted effects include increased appetite, mood changes, confusion, ataxia, tremor & memory impairment.

PREGABALIN

- The most potentially serious reactions are visual disturbances, including vision loss, blurred vision, and other changes of visual acuity. These symptoms mostly improve when pregabalin is discontinued.
- Associated with discontinuation symptoms, such as insomnia, headache, nausea, diarrhoea, anxiety, sweating, and dizziness.

HYPNOTICS

- Hypnotics are ***drugs that are used to improve sleep.***
- Many ***anxiolytic drugs also act as hypnotics.***
- Most prescribed hypnotics ***enhance the action of GABA through interaction with either the BDZ receptor or other adjacent sites located on the GABA macromolecular complex.***

HYPNOTICS

- The MC used hypnotics are ***BDZ or non – BDZ ligands [zopiclone & zolpidem ('the Z drugs')].***
- The actions of these drugs can be reversed by the BDZ receptor antagonist, ***flumazenil***.
- Other available hypnotic agents include:
  - Chloral hydrate (or its derivatives)
  - Chlormethiazole
  - Sedating antihistamines

CONT.

- A ***sustained – release form of melatonin, Ramelteon,*** is also licensed for the short – term treatment of insomnia in the middle – aged & elderly.
- Like BDZ, an epidemiological study has linked ***prolonged use of Z drugs with an increased risk of dementia*** (National Institute for Health and Care Excellence, 2015).

UNWANTED EFFECTS

- Residual effects: feelings of being slow & drowsy.
- Tolerance
  - Tolerance is less of a problem with ***sedating antidepressants***, but such drugs have long half – lives accompanied by residual psychomotor effects the next day.
- 'Rebound' insomnia on withdrawal, which makes preparations difficult to stop.

CONT.

- The most important interaction of hypnotic drugs is with ***alcohol, where a potentiated effect can be seen***.
- The common causes of disturbed sleep include excessive caffeine or alcohol, pain, cough, pruritus, dyspnea, anxiety & depression. When any primary cause is present, this should be treated, not the insomnia.

ADVICE ON MANAGEMENT OF ANXIETY DISORDERS

- Before an anxiolytic drug is prescribed, ***<u>the cause of the anxiety should always be sought</u>***.
- It is helpful to classify the nature of the anxiety disorder, as this can have implications for drug treatment.
- Although medication is helpful, psychological treatments are as effective & are often preferred by patients.
- Medication tends to be used when psychological treatments are not readily available or have not been successful.

ADVICE ON MANAGEMENT OF ANXIETY DISORDERS

- If an anxiolytic is needed, a BDZ should be given for a short time — not more than 3 weeks— & withdrawn gradually.
- It is important to remember that dependency is particularly likely to develop among people with alcohol – related problems.
- If the drug has been taken for several weeks, the patient should be warned that they may feel tense for a few days when it is stopped
- For most patients with anxiety symptoms, attention to life problems, an opportunity to talk about their feelings, and reassurance from the doctor are enough to reduce anxiety to tolerable levels.

ADVICE ON MANAGEMENT OF ANXIETY DISORDERS

- For longer – term treatment of severe GAD, ***antidepressant medication*** is more appropriate.
- Antidepressants are often helpful in the treatment of panic disorder, although the risk of early symptomatic worsening must be remembered and explained to the patient.
- The use of small doses early in treatment (e.g. 10 mg imipramine, 5 mg citalopram) can be helpful.

REFERENCE

- Shorter Oxford textbook of Psychiatry-Oxford University Press(2017).

‘Jesus said to him, You do not understand now what I am doing, but you will understand later on.’

John 13:7

#Trust_The_Process ☺

#Jesus_Lord_Over_All

C. MANAGEMENT OF OTHER PSYCHIATRIC DISORDERS LEVEL VI MBCHB 2019

COMPILED BY NAILA KAMADI

C. MANAGEMENT OF OTHER PSYCHIATRIC CONDITIONS (SLIDE 861) OUTLINE

1. ORGANIC BRAIN SYNDROME (slide 863)
2. PSYCHIATRIC EMERGENCIES (slide 911)
3. PSYCHOSOMATIC MEDICINE (slide 1071)
4. SOMATOFORM DISORDERS (slide 1095)
5. PSYCHOSEXUAL DISORDERS (slide 1139)
6. GBV (slide 1191)
7. PERSONALITY DISORDERS (slide 1221)
8. CHILD PSYCHIATRY (slide 1295)
9. MATERNAL PSYCHIATRY (slide 1585)

C1. MANAGEMENT OF ORGANIC BRAIN SYNDROME

BY: DR. OWITI

OUTLINE

- Delirium.
- Dementia.
- Other organic psychiatric syndromes.
- Neurological syndromes.
- Epilepsy

WHAT ARE ORGANIC PSYCHIATRIC DISORDERS?

- Psychiatric disorders resulting from ***brain dysfunction caused by organic pathology*** inside or outside the brain.

CLASSIFICATION OF ORGANIC MENTAL STATES

- Global syndromes:
  - Dementia
  - Delirium
- Specific syndromes
  - Amnesic syndrome
  - Organic mood disorder
  - Organic delusional disorder
  - Organic personality disorder

DELIRIUM

- ***Acute*** generalized impairment of brain function.
- The most important features is **impairment of consciousness**.
- The **primary cause is often outside** the brain (e.g. anoxia due to respiratory failure).

DELIRIUM

- It is a common accompaniment of physical illness occurring in:
  - 5 – 15% of patients in general medical & surgical wards.
  - 20 – 30% of patients in surgical ICUs.
- It is ***especially common in the elderly***.
- Most patients recover quickly & a few need specific treatment.
- Terms such as **confusional state** & **acute organic syndrome** are outdated.

CLINICAL FEATURES

- **Impaired consciousness:** disorientation, poor concentration
- **Behavior:** over active or under active
- **Thinking:** muddled (confused), ideas of reference, delusions
- **Mood:** irritable anxious, depressed, perplexed

CONT.

- **Perception**: misperceptions – illusions, hallucinations
- **Memory**: impaired
- **Insight**: impaired
- **Fluctuating course**: worse in the evening
- **Amnesia** (on recovery)

CAUSE [*I WATCH DEATH*]

- ***I***nfections
- ***W***ithdrawal syndrome: alcohol
- ***A***cute metabolic syndromes: DKA, thyrotoxicosis
- ***T***rauma: post – surgery
- ***C***NS pathology
- ***H***ypoxia
- ***D***eficiencies in nutrients e.g. vitamin B1
- ***E***ndocrinological abnormalities
- ***A***cute vascular events e.g. CVA
- ***T***oxins & drugs
- ***H***eavy metals e.g. lead

AETIOLOGY

- **Alcohol Withdrawal**
- **Metabolic failure:** cardiac, respiratory, hepatic, hypoglycemia
- **Fever:** systemic infection
- **Neurological causes:** encephalitis, SOL, raised ICP, post – ictal.
- **Drug Intoxication**

MANAGEMENT OF DELIRIUM

- Obtain information from other informants & medical notes.
- Assess the patient's mental state
- Confirm the diagnosis of delirium
- Determine the physical cause & treat it
- Reduce disorientation
  - Reorient repeatedly
  - Consistent routine

CONT.

- Reduce anxiety
  - Reassure
  - Medication
- Avoid over or under stimulation
- If calm: monitor progress
- If agitated, disturbed or distressed:
  - Consider ***hypnotics*** at night; regular medications
  - Monitor progress & review medications.
- Inform & support relatives

DEMENTIA

- **Chronic** generalized impairment of brain function.
- Characterized by ***impairment of intellect, memory & personality*** **without impairment of consciousness**.
- The primary cause is **within the brain**.
- Most cases are **irreversible** (few can be treated).

CLINICAL FEATURES

- **Appearance & behavior**: odd & disorganized, restless & wandering; self neglect, disinhibition
- **Speech & conversation**: aphasia
- **Thought**: process → slow & impoverished; content → delusions
- **Mood & affect**: anxiety, depression
- **Abnormal perceptions**: illusions, hallucinations
- **Dementia & cognition screen:** poor memory, impaired attention, aphasia, agnosia, apraxia, disorientation.
- **Insight**: impaired

ETIOLOGY

- Degenerative neurological disorders
  - Alzheimer's disease
  - Vascular dementia
  - Lewy Body Dementia (LBD)
  - Frontotemporal dementia (FTD)
  - Huntington's chorea
  - Prion disease
  - Parkinson's disease

CONT.

- **NPH**
- **SOL**: Intracranial tumor, Chronic SDH
- **Traumatic**: severe head injury
- **Infection**: post encephalitis, HIV
- **Vascular**: multi – infarct dementia
- **Toxic**: alcohol

CONT.

- **Anoxia:** cardiac arrest, CO poisoning
- **Vitamin deficiency:** vitamin B12, Folic acid, Thiamine
- **Metabolic:** DM
- **Endocrine:** Hypothyroidism

MANAGEMENT

- Detailed history (informant)
- MMSE
- Investigations
  - ***CT scan***: diagnosis of both focal & diffuse cerebral pathology
  - Psychological testing
    - Specific tests of memory, learning & other aspect of cognitive function → localized brain lesions.
    - **Wechsler Adult Intelligence Scale (WAIS)**: provides a profile of verbal & non verbal abilities .

ASPECTS OF DIFFERENTIAL DIAGNOSIS

- Organic vs. Functional
  - Organic:
    - The cognitive disorder preceded the mood or other disorder.
    - Cognitive defects occur in specific areas of intellectual function.
    - Neurological signs.
    - The presence of symptoms seldom found in non – organic disorder, such as visual hallucinations.
  - Functional:
    - By exclusion of organic causes
    - By finding positive evidence of psychological etiology.

PSEUDODEMENTIA

- In this syndrome, ***a depressed patient complains of poor memory & appears intellectually impaired because poor concentration leads to inadequate registration & depressive mood leads to slowness & self – neglect***.
- Characteristic features:
  - A history from another informant that the *depressed mood preceded the memory problems*.
  - Memory testing shows that the *poor performance improves when interest is aroused*.
  - The *patient is retarded & unwilling to cooperate in the interview*.

DELIRIUM VS. DEMENTIA

Delirium	Dementia
• Acute onset	• Insidious onset
• Fluctuating course	• Stable or progressive course
• Impaired consciousness	• Normal consciousness
• Disorganized thinking	• Impoverished thinking
• Perceptual disturbance	• Perceptual disturbances uncommon
• Alertness usually impaired	• Patient normally alert

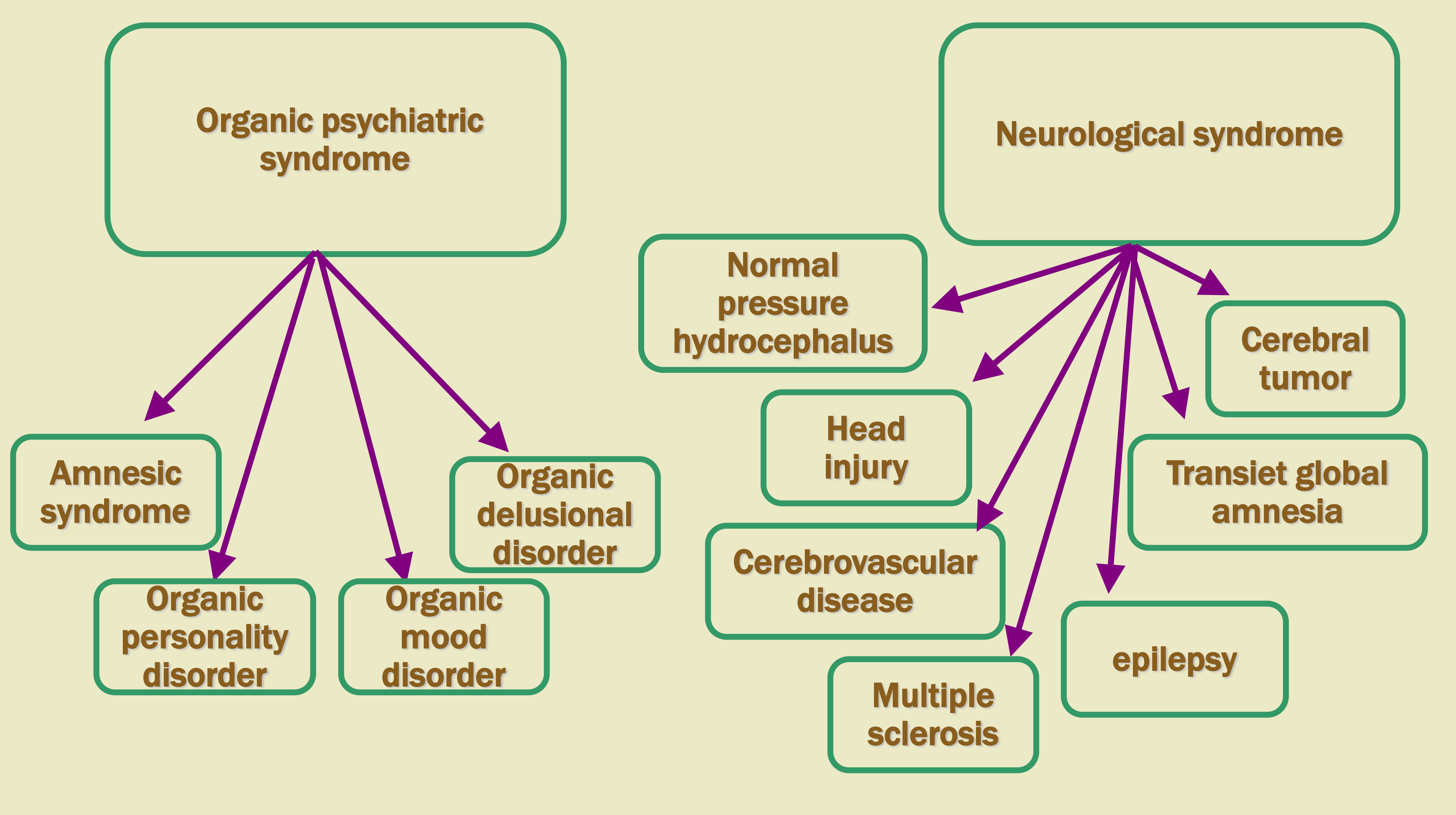
STUPOR

- Rare condition in which the ***patient is immobile* & *unresponsive* but has a normal level of consciousness**.
- It can occur in **severe affective disorder** & **schizophrenia**.
- Lesions of ***brainstem or mesencephalon*** can cause a similar picture, although in these cases there may be some impairment of consciousness.

TREATMENT

- Aims of treatment:
  - Maintain any remaining ability as far as possible.
  - Relieve distressing symptoms
  - Arrange for the practical requirements of the patient.
  - Support the family.

OTHER PSYCHIATRIC & NEUROLOGICAL SYNDROMES



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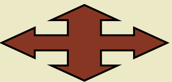
Multiple sclerosis
epilepsy
Transiet global amnesia
Cerebral tumor

AMNESIC SYNDROME

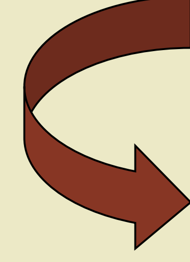
Korsakoff's syndrome

- Prominent disorder of ***recent memory***
- No intellectual impairment or impaired consciousness



Wernicke's encephalopathy

- Impairment of consciousness, memory defect, ***disorientation, ataxia & ophthalmoplegia***.



Wernicke – Korsakoff's syndrome

ETIOLOGY

- Lesion in:
  - Posterior hypothalamus
  - Bilateral hippocampal lesions.
- Alcohol → thiamine deficiency
- CO_2 poisoning
- Vascular lesions
- Encephalitis
- Tumor in the 3rd ventricle.

CONT.

CLINICAL FEATURES

- Recent memory severely impaired.
- ***Remote memory spared.***
- Disorientation in time.
- Confabulation:
  - Detailed account of recent activities turn out to be inaccurate.

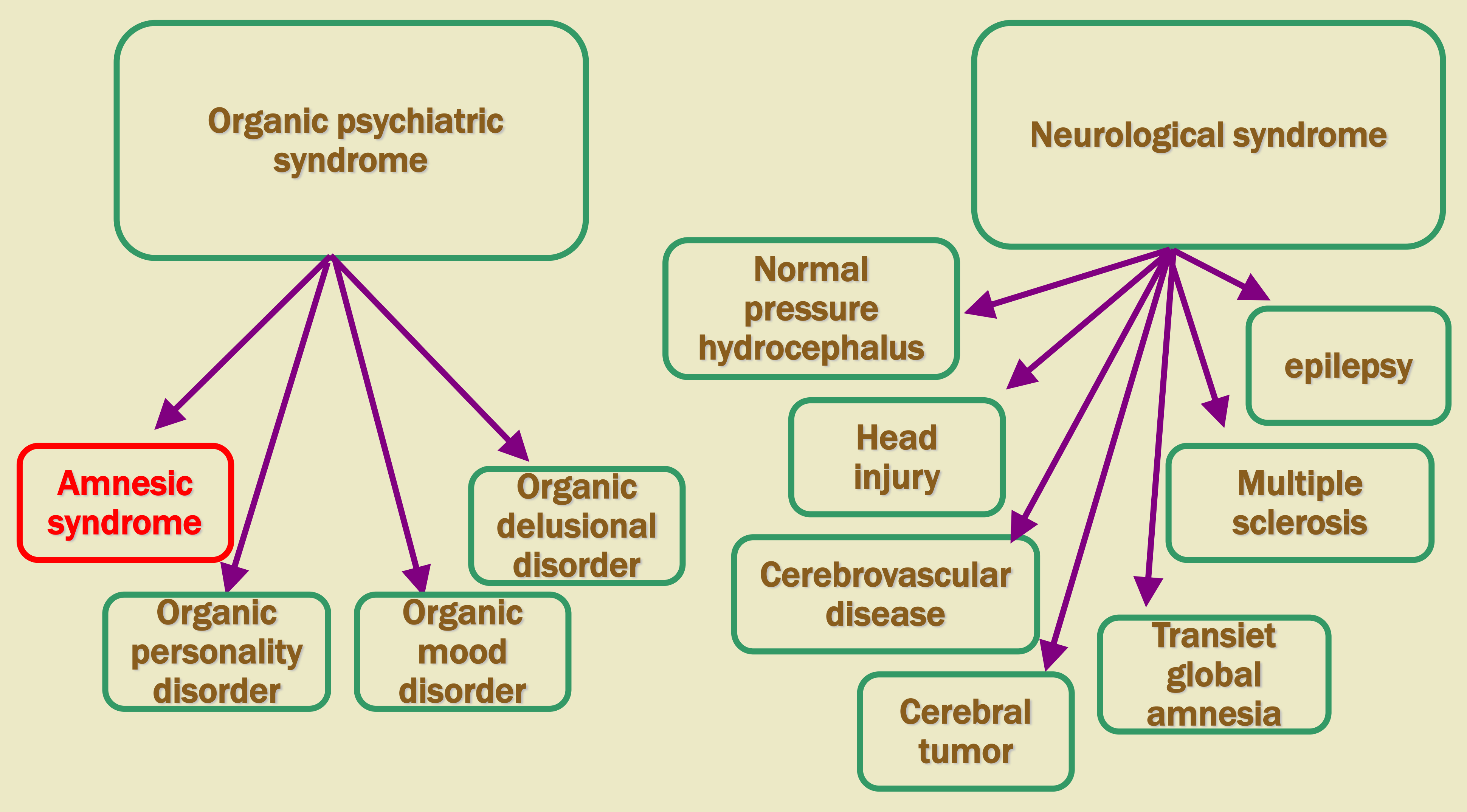
CONT.

TREATMENT

- If thiamine deficiency → vitamin supplement.

PROGNOSIS

- Chronic
- Better if due to thiamine deficiency



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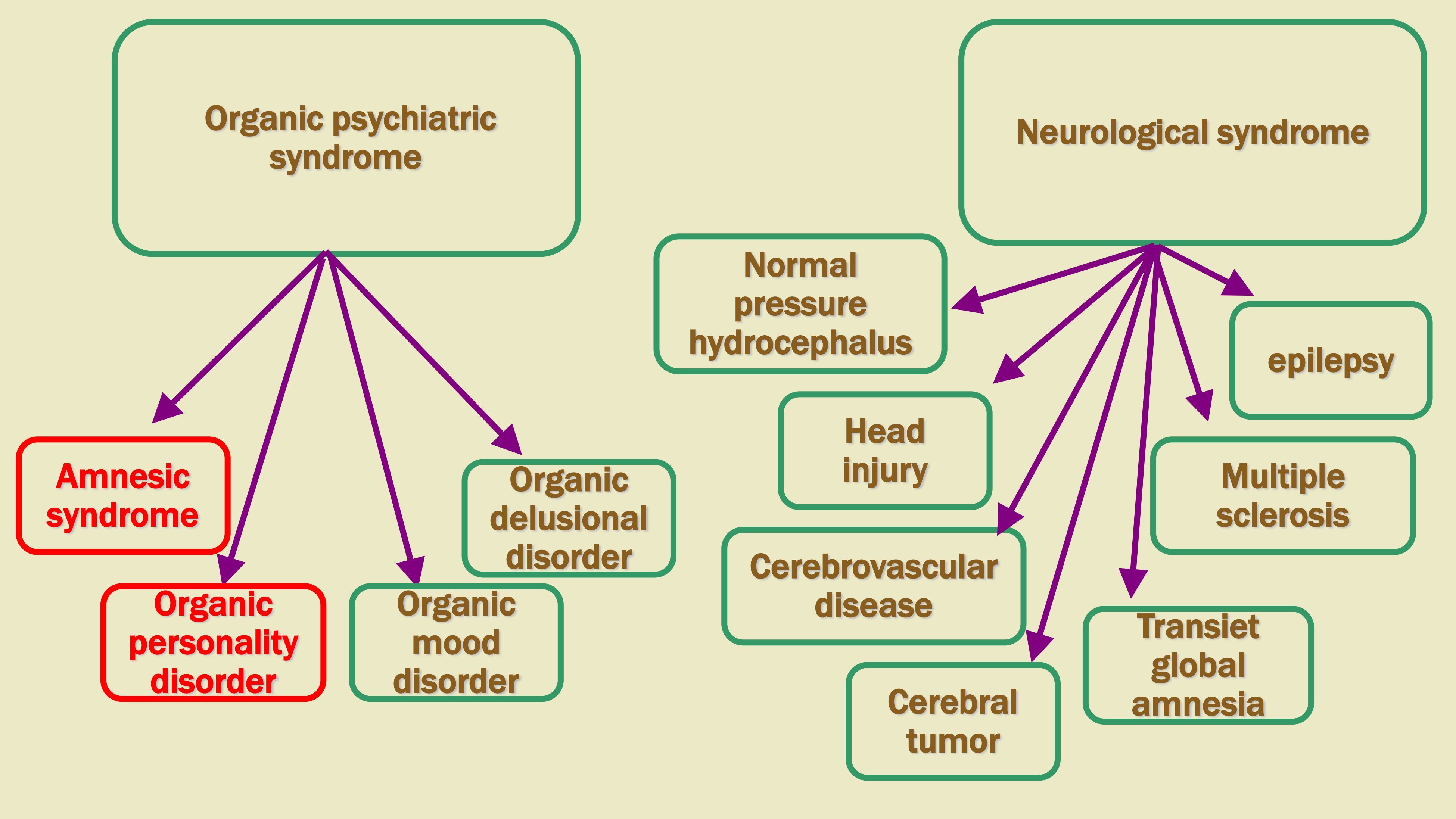
ORGANIC PERSONALITY DISORDER

- Due to frontal lobe damage

Clinical features

- Behavior:
  - Disinhibited, overfamiliar, tactless
  - Patient is overtalkative, makes inappropriate jokes, disregards the feeling of others.
- Mood: euphoric.
- Concentration, attention & insight :impaired.



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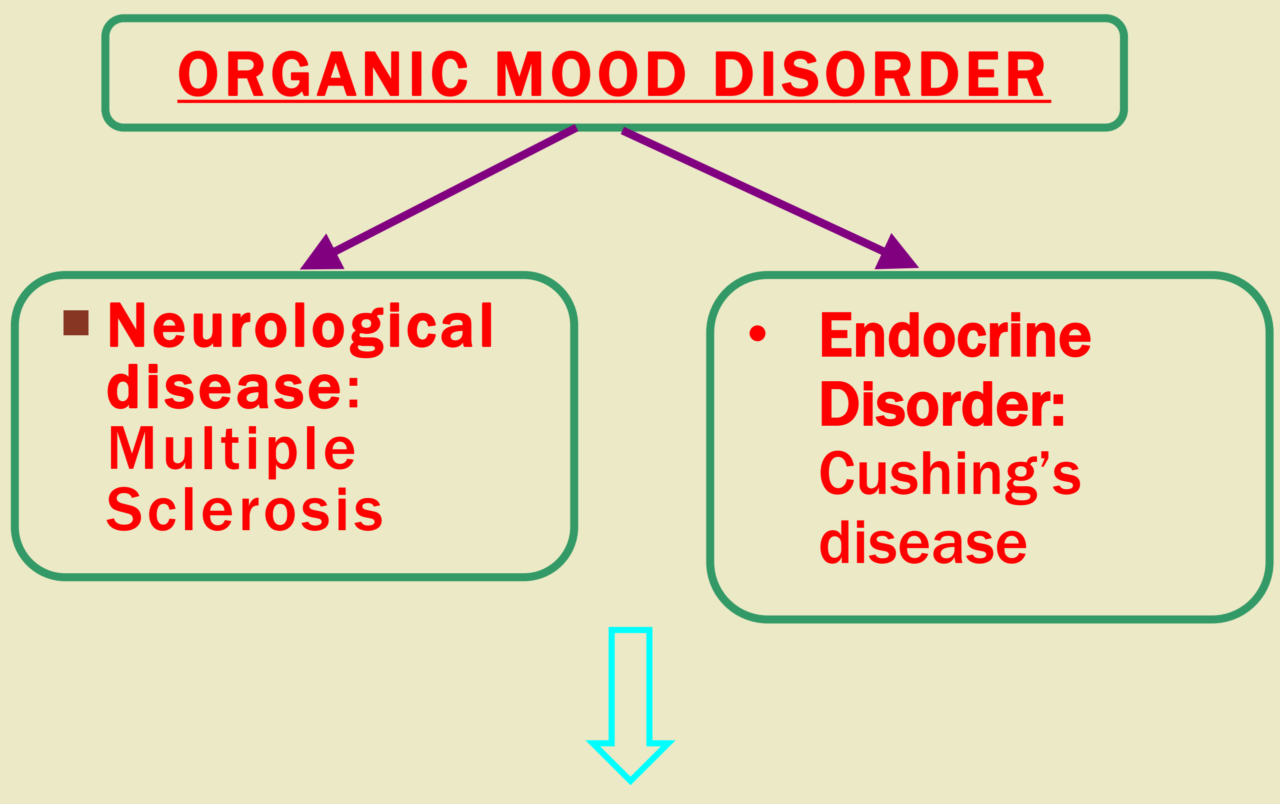
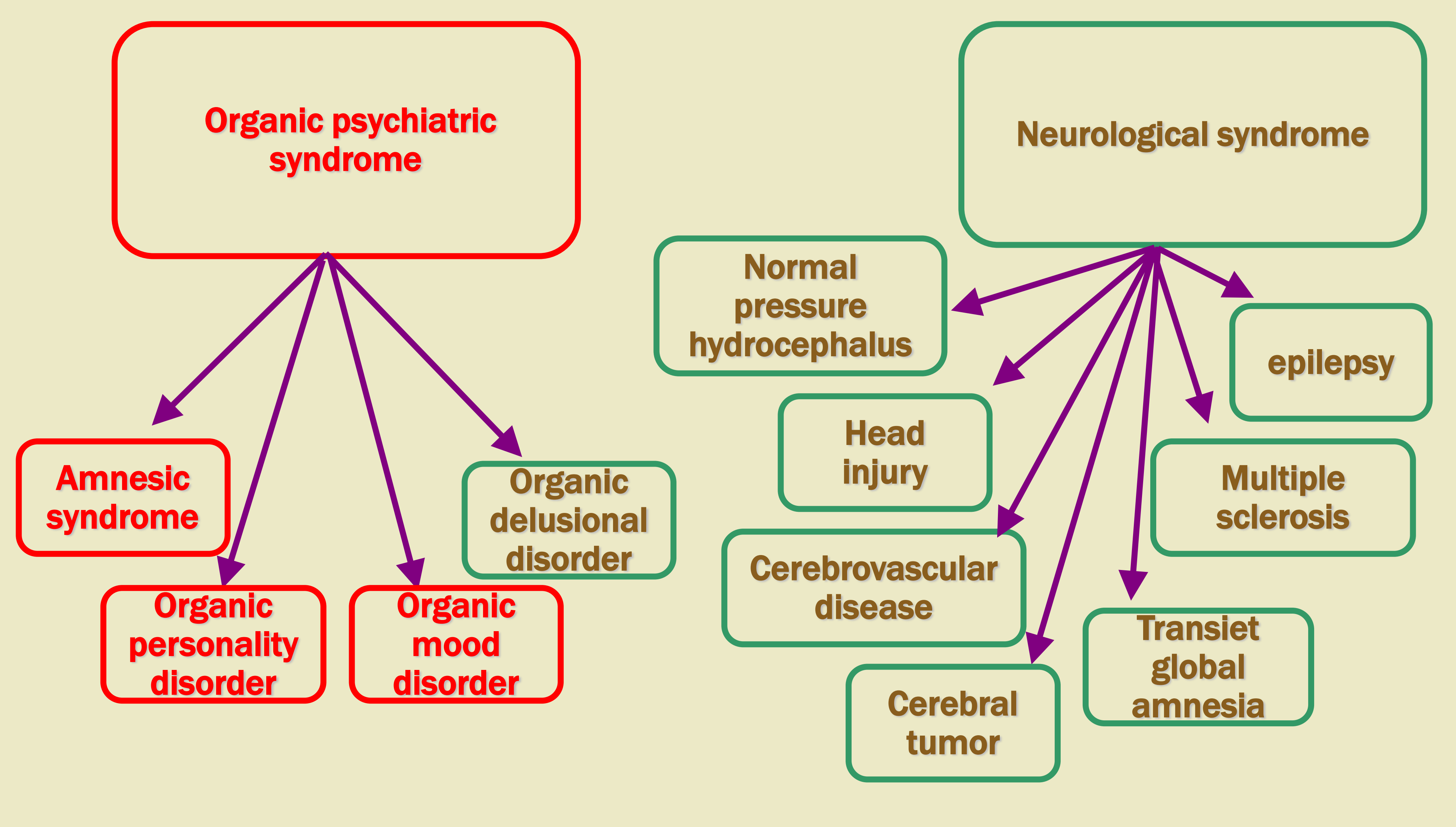


- Depression, mania or anxiety



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NORMAL PRESSURE HYDROCEPHALUS

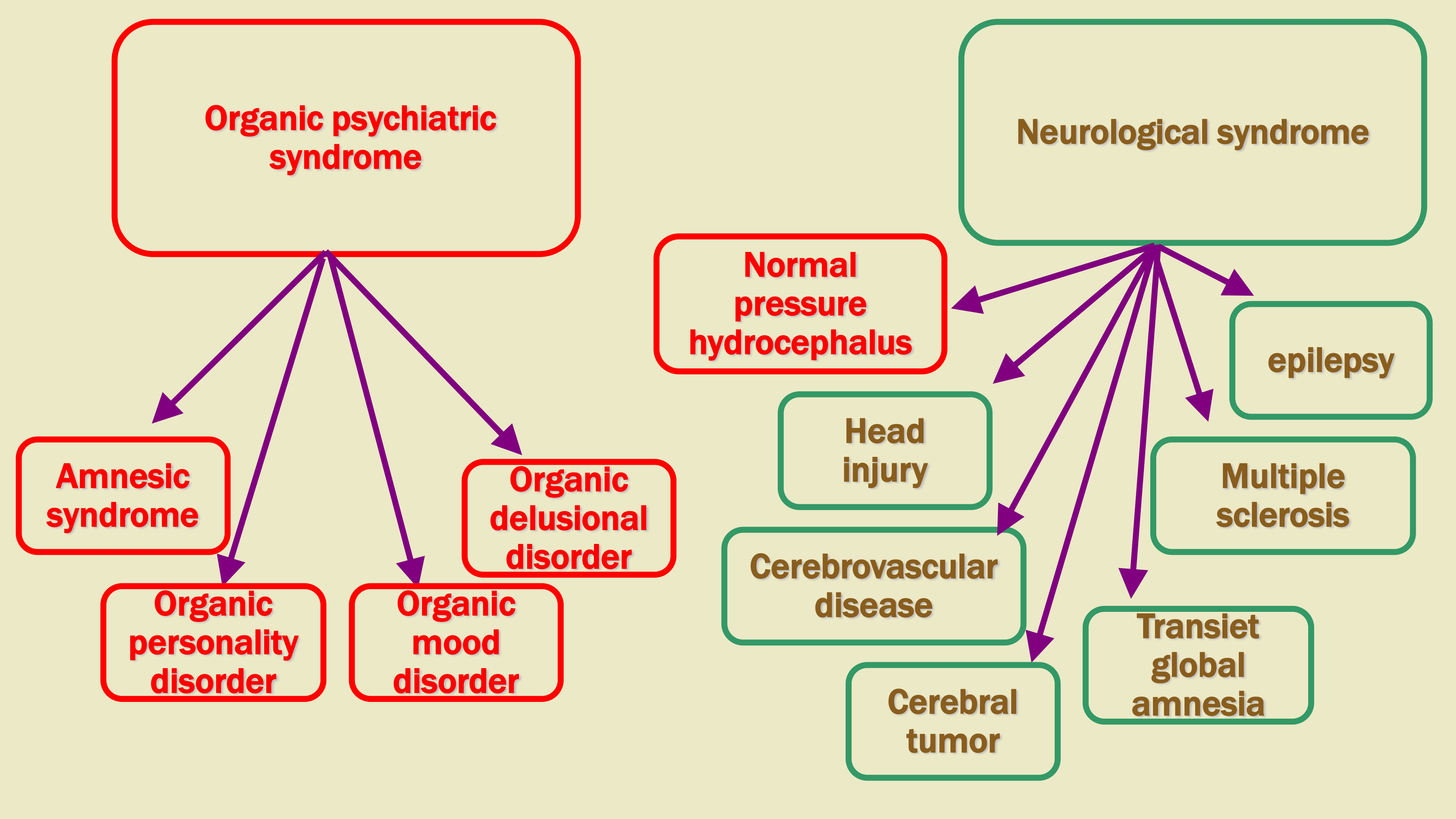
- Obstruction in the subarachnoid space.

Clinical features

- Progressive memory impairment, slowness, unsteadiness of gait & urinary incontinence.

Treatment

- Shunt operation to improve the circulation of CSF.



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HEAD INJURY

Acute psychological effects include:

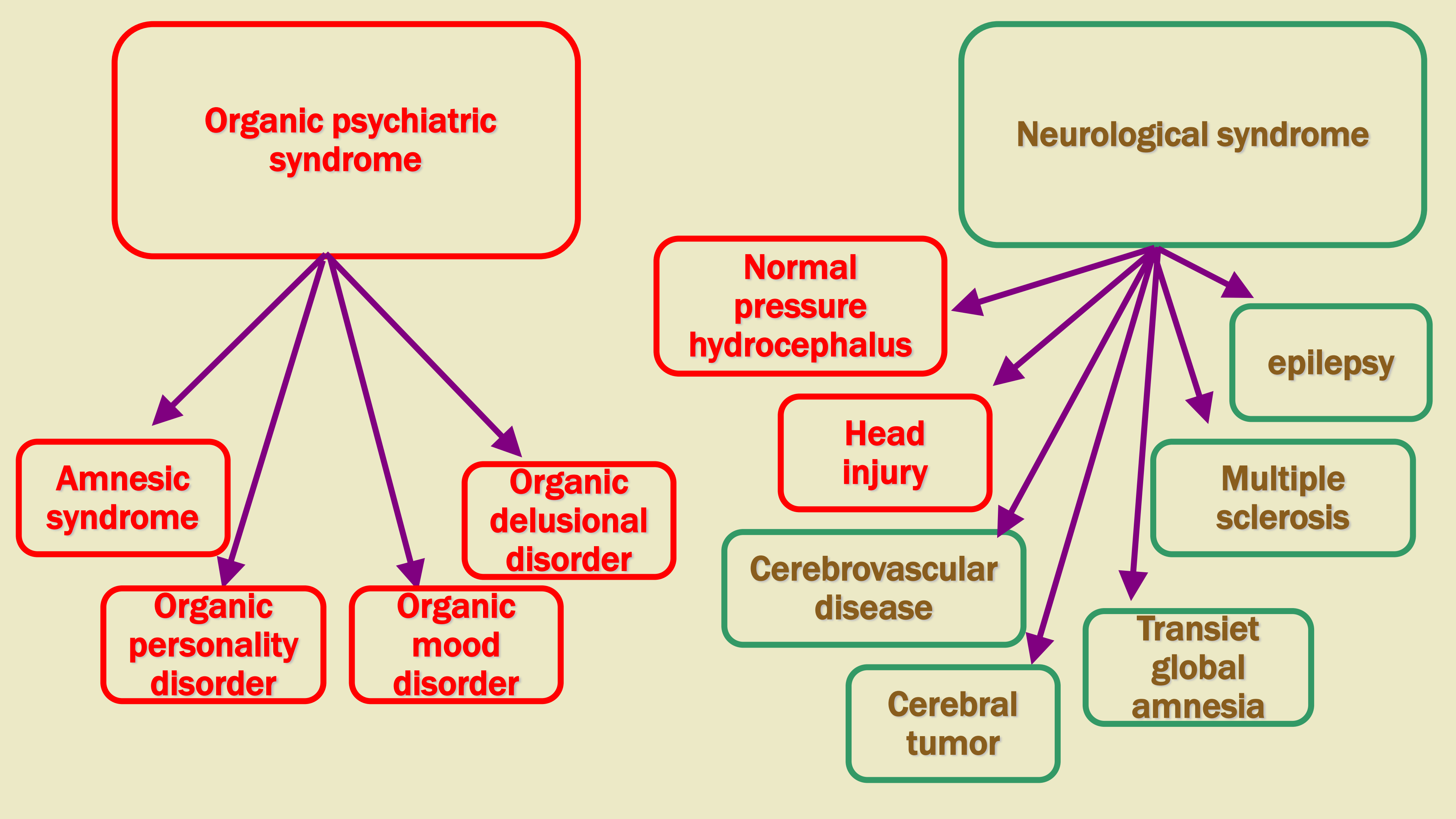
- Impairment of consciousness.
- Delirium.
- Post – traumatic amnesia of > 24 h. followed by persistent cognitive impairment.
- Personality change:
  - Severe: damage to frontal lobe
  - Irritability, loss of spontaneity & drive & reduced control of aggressive impulses
- Emotional symptoms: anxiety & depression with headache, poor concentration & insomnia.

ASSESSMENT

- Neurological signs and physical disability.
- Any neuropsychiatric problems and their future course.
- Social circumstances, social support & the possibility of return to work

MANAGEMENT

- Physiotherapy
- Try to minimize disability
- Deal with specific cognitive deficits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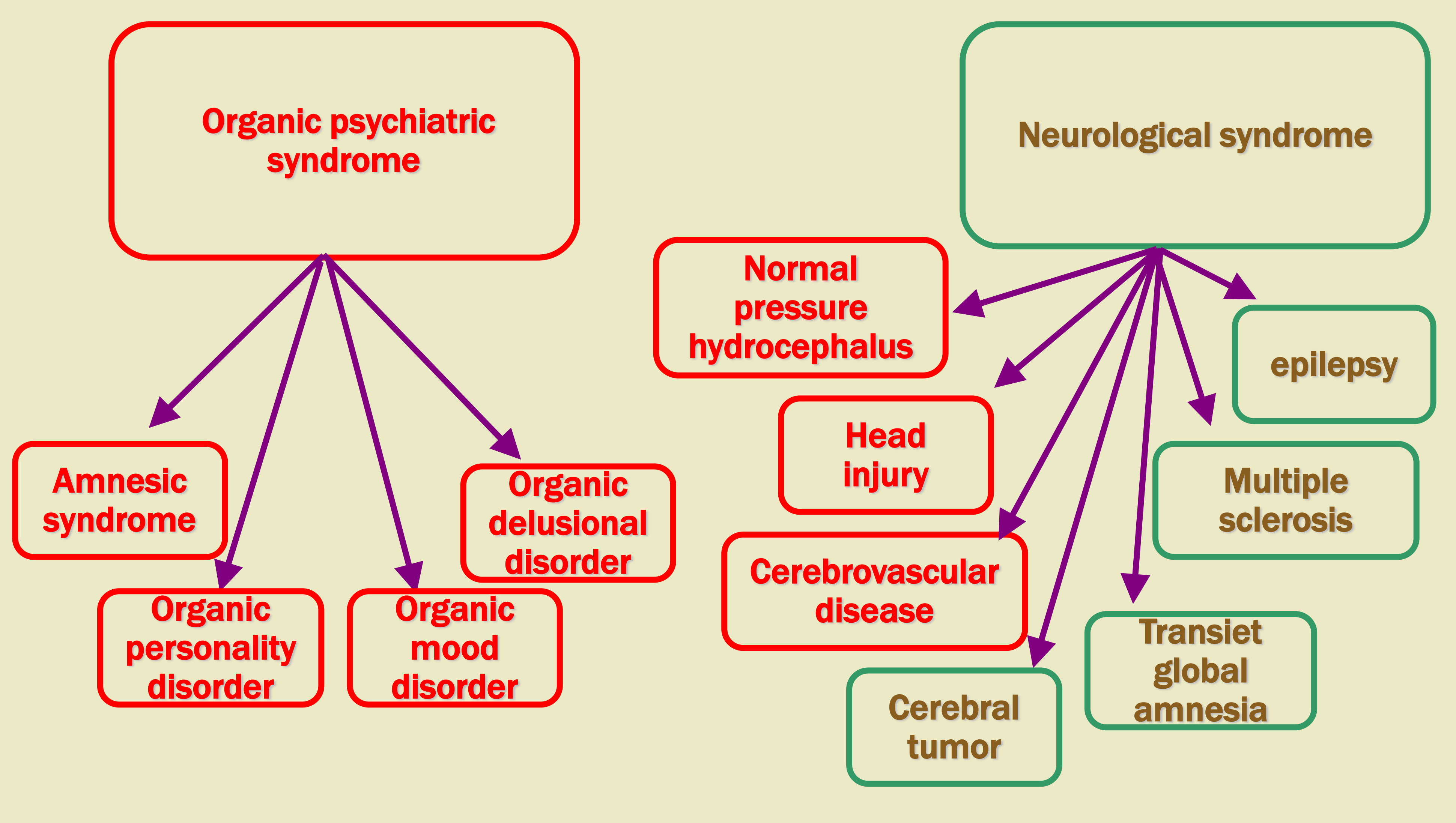
CEREBROVASCULAR DISEASE

- **Cognitive defects:** Dementia, dysphasia & dyspraxia
- **Personality change**: irritability, apathy or lability of mood; Failure to cope with everyday problem → catastrophic reaction
- **Depressed mood:** psychological reaction to handicap or direct consequence of any localized brain damage
  - Treatment: **ANTIDEPRESSANT**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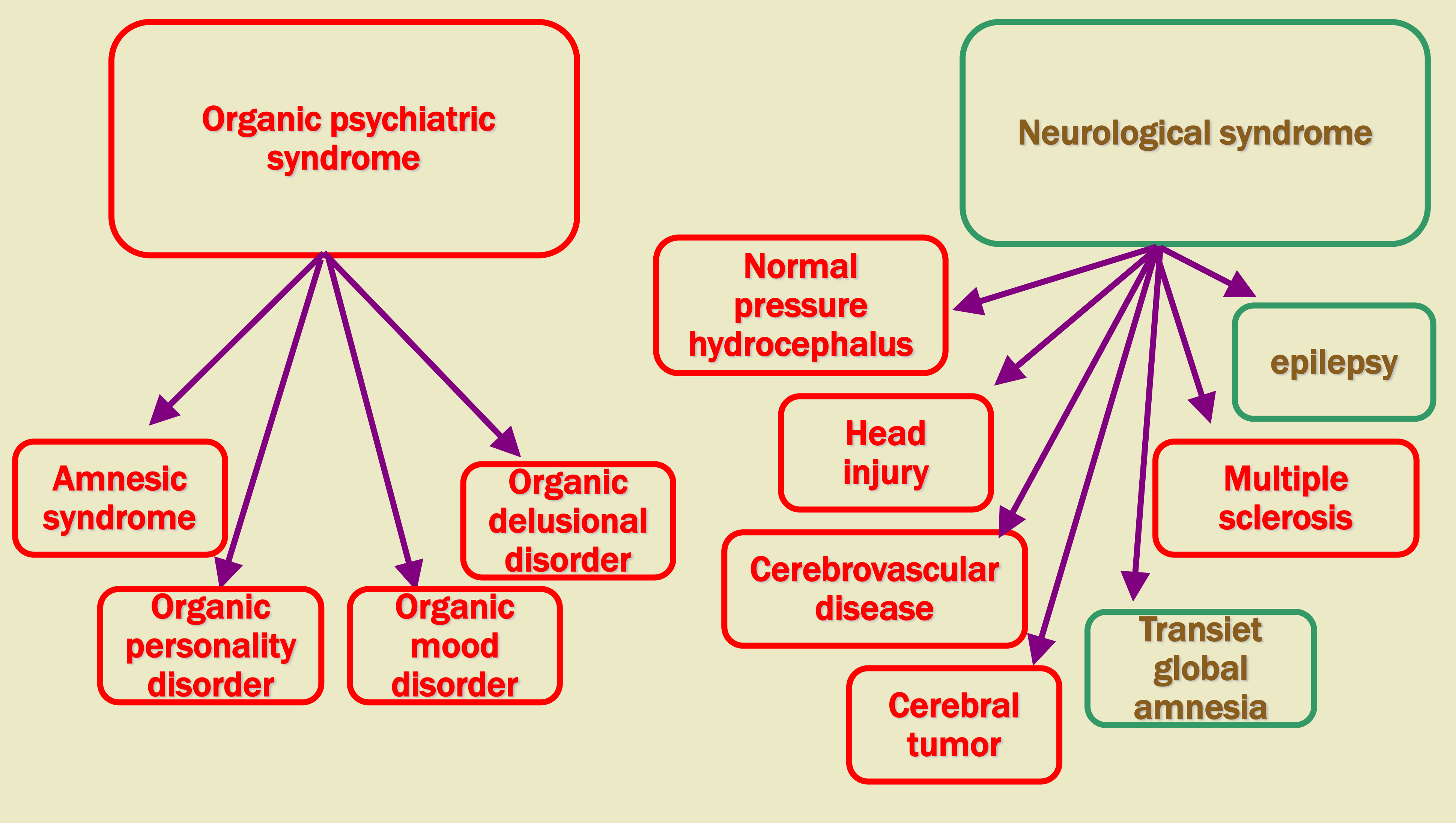
CEREBRAL TUMOR

- Fast growing tumor → delirium
- Slow growing tumor → dementia

MULTIPLE SCLEROSIS

- Depression or elation
- Dementia



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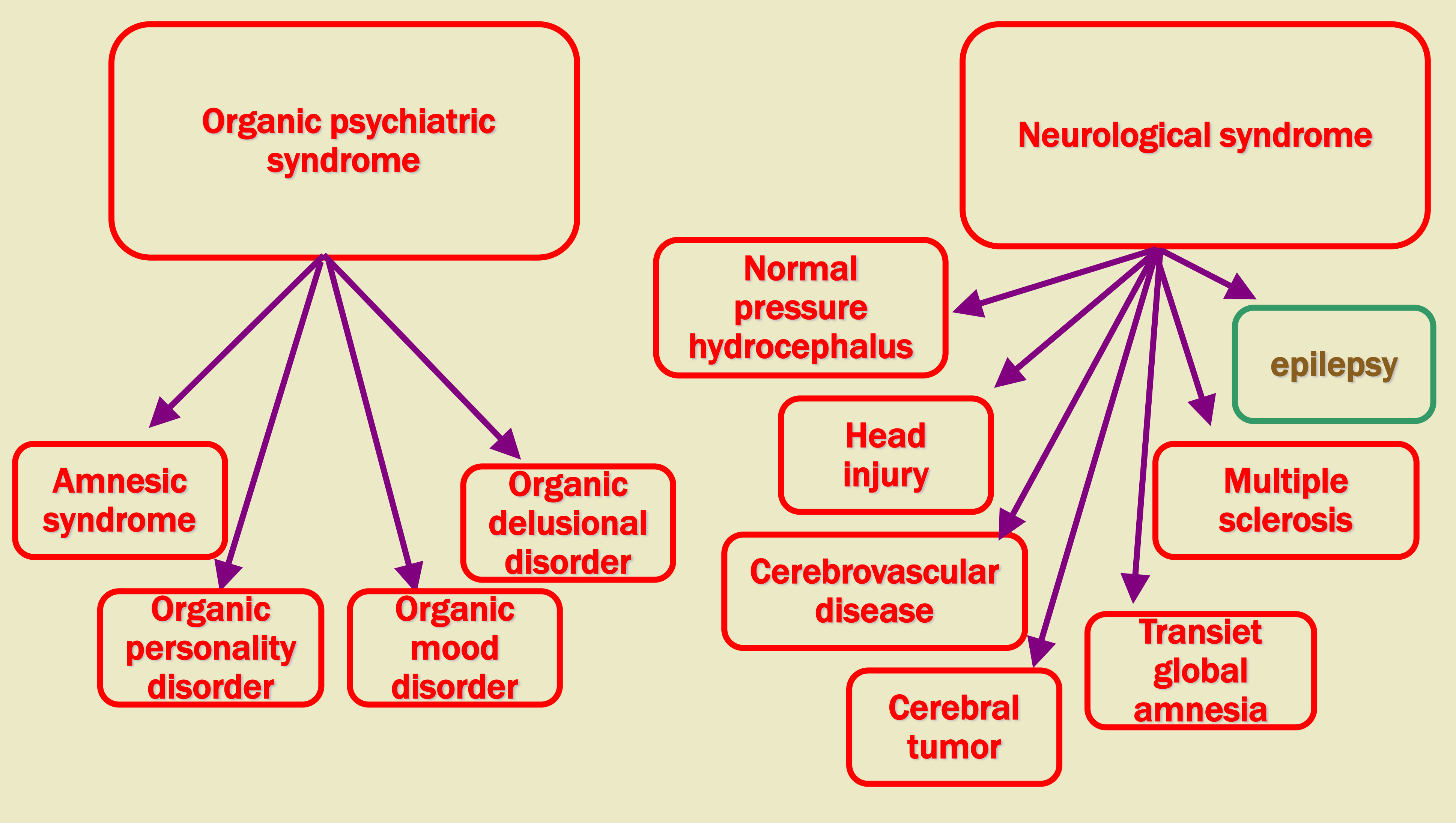
TRANSIENT GLOBAL AMNESIA

- Unknown cause
- Middle or late life
- Occasional
- ***Abrupt episodes of unusual behavior & global loss of recent memory for several hours***
- Patient alert & responsive
- Unable to understand his experience
- ***Complete recovery except for amnesia of the episode***
- No specific treatment



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EPILEPSY

Association between epilepsy & psychological problems of epileptic individual:

- Effect of stigma & social restriction.
- Psychiatric disorder due to the cause of epilepsy:
  - If due to brain damage → intellectual impairment & personality problems
  - Behavioral disturbance:
    - Pre – Ictal: tension, irritability, depression
    - Ictal: complex partial seizure
    - Post – ictal: automatism
  - Inter – ictal: cognitive impairment, personality disorder, sexual dysfunction, increased self harm & suicide.

C2. MANAGING PSYCHIATRIC EMERGENCIES LEVEL VI MBCHB 2019

COMPILED BY NAILA KAMADI

INTRODUCTION

- A psychiatric emergency is any ***disturbance in thoughts, feelings or actions for which immediate therapeutic intervention is necessary***.
- Psychiatric emergencies are highly subjective.

PSYCHIATRIC EMERGENCIES INCLUDE

- Suicide e.g. in severe depression
- Manipulative & violent patient
  - Bipolar manic phase
  - Paranoid schizophrenia
- Excitement
- Delirious state
- Catastrophic reaction in Dementia
- Epileptic or post – epileptic confusional states

CONT.

- Drug reactions: Acute dystonia, neuroleptic malignant syndrome, SIADH, serotonin syndrome
- Mood disorders: bipolar manic phase
- Alcohol dependence
- Drug withdrawal
- Stupor
- Panic

GENERAL PRINCIPLES OF MANAGEMENT

- Primary goal is ***timely assessment***
- History taking: initial diagnosis, identifying precipitating factors & immediate needs & begin treatment or refer.

EMERGENCY EVALUATION SHOULD BE ADDRESSED:

- Is it safe for patient to be in emergency room?
- Is the problem ***organic, functional or a combination of both***?
- Is patient ***psychotic***?
- Is patient ***suicidal*** or ***homicidal***
- To what degree is the patient capable of self – care?

Table 23.2-1
General Strategy in Evaluating the Patient

I. **Self-protection**
   A. Know as much as possible about the patients before meeting them.
   B. Leave physical restraint procedures to those who are trained.
   C. Be alert to risks of impending violence.
   D. Attend to the safety of the physical surroundings (e.g., door access, room objects).
   E. Have others present during the assessment if needed.
   F. Have others in the vicinity.
   G. Attend to developing an alliance with the patient (e.g., do not confront or threaten patients with paranoid psychoses).

II. Prevent [illegible]

paranoid psychoses).

II. Prevent harm

A. Prevent self-injury and suicide. Use whatever methods are necessary to prevent patients from hurting themselves during the evaluation.

B. Prevent violence toward others. During the evaluation, briefly assess the patient for the risk of violence. If the risk is deemed significant, consider the following options:

1. Inform the patient that violence is not acceptable.
2. Approach the patient in a nonthreatening manner.
3. Reassure, calm, or assist the patient's reality testing.
4. Offer medication.
5. Inform the patient that restraint or seclusion will be used if necessary.
6. Have teams ready to restrain the patient.
7. When patients are restrained, always closely observe them, and frequently check their vital signs. Isolate restrained patients from surrounding agitating stimuli. Immediately plan a further approach—medication, reassurance, medical evaluation.

III. Rule out organic mental disorders.

IV. Rule out impending psychosis.

Table 23.2-2
Features that Point to a Medical Cause of a Mental Disorder

Acute onset (within hours or minutes, with prevailing symptoms)
First episode
Geriatric age
Current medical illness or injury
Significant substance abuse
Nonauditory disturbances of perception
Neurological symptoms—loss of consciousness, seizures, head injury, change in headache pattern, change in vision
Classic mental status signs—diminished alertness, disorientation, memory impairment, impairment in concentration and attention, dyscalculia, concreteness
Other mental status signs—speech, movement, or gait disorders
Constructional apraxia—difficulties in drawing clock, cube, intersecting pentagons, Bender gestalt design

SPECIFIC INTERVIEW SITUATIONS WHERE YOU SHOULD BE CAREFUL:

- Psychosis
- Depression & potentially suicide patients
- Violent patients
- Rape & sexual abuse

Table 23.2-4
Assessing and Predicting Violent Behavior

1. Signs of impending violence
   a. Very recent acts of violence, including property violence
   b. Verbal or physical threats (menacing)
   c. Carrying weapons or other objects that may be used as weapons (e.g., forks, ashtrays)
   d. Progressive psychomotor agitation
   e. Alcohol or drug intoxication
   f. Paranoid features in a psychotic patient
   g. Command violent auditory hallucinations—some but not all patients are at high risk
   h. Organic mental disorders, global or with frontal lobe findings; less commonly with temporal lobe findings (controversial)
   i. Patients with catatonic excitement
   j. Certain patients with mania
   k. Certain patients with agitated depression
   l. Personality disorder patients prone to rage, violence, or impulse dyscontrol
2. Assess the risk of violence
   a. Consider violent ideation, wish, intention, plan, availability of means, implementation of plan, wish for help.
   b. Consider demographics—sex (male), age (15–24), socioeconomic status (low), social supports (few).
   c. Consider past history: violence, nonviolent antisocial acts, impulse dyscontrol (e.g., gambling, substance abuse, suicide or self-injury, psychosis).
   d. Consider overt stressors (e.g., marital conflict, real or symbolic loss).

TREATMENT OF EMERGENCIES: PHARMACOTHERAPY

- Indications of immediate treatment:
  1. Violence
  2. Anxiety or panic
  3. Extrapyramidal reactions

CONT.

- Paranoid patients who are violent should be tranquilized with →
  1. IM Chlorpromazine (CPZ, ***Largactil***)
  2. Olanzapine
  3. Zuclopenthixol (***Clopixol – Acuphase***)
  4. ***Benzodiazepine***: diazepam (IV 5 – 10 mg), Lorazepam (2 – 4 mg), midazolam

CONT.

- Episodic outbursts of violence:
  - IM haloperidol
  - β blockers
  - Carbamazepine (***Tegretol***)
  - Lithium
- Inter – ictal psychosis: haloperidol
- Post – ictal psychosis: verbal de – escalation
- Anticonvulsants can also be used.

TREATMENT CONT.

- Psychotherapy: marital, family, supportive
  - To find out the precipitant factors so as to tailor interventions.
- Restraints & verbal de – escalation
  - Used when patients are dangerous to themselves or others, can be temporary to receive medication.
  - Preferably 5 or minimum of 4 persons
  - Leather restraints are safest

Table 23.2-5
Use of Restraints

Preferably five or a minimum of four persons should be used to restrain the patient. Leather restraints are the safest and surest type of restraint.

Explain to the patient why he or she is going into restraints.

A staff member should always be visible and reassuring the patient who is being restrained. Reassurance helps alleviate the patient's fear of helplessness, impotence, and loss of control.

Patients should be restrained with legs spread-eagled and one arm restrained to one side and the other arm restrained over the patient's head.

Restraints should be placed so that intravenous fluids can be given, if necessary.

The patient's head is raised slightly to decrease the patient's feelings of vulnerability and to reduce the possibility of aspiration.

The restraints should be checked periodically for safety and comfort.

After the patient is in restraints, the clinician begins treatment, using verbal intervention.

Even in restraints, most patients still take antipsychotic medication in concentrated form.

After the patient is under control, one restraint at a time should be removed at 5-minute intervals until the patient has only two restraints on. Both of the remaining restraints should be removed at the same time, because it is inadvisable to keep a patient in only one restraint.

Always thoroughly document the reason for the restraints, the course of treatment, and the patient's response to treatment while in restraints.

CONT.

- Disposition: *admit* (voluntary/ involuntary) or discharge
- Documentations:
  - Important positives & negatives, gaps in information & their reason should be mentioned, names, telephone numbers, provisional and differential diagnosis, treatment plan after history, MSE, diagnostic tests and medical evaluation

SUMMARY: MUST KNOW

- Conditions that present with violence.
- Medications that can be used in violent patients.
- Indications in the use of physical restraints.

C2.1. MANAGEMENT OF SUICIDE & PARASUICIDE 3RD/4/2019

BY: DR. NG'ANG'A

INTRODUCTION

- Suicide comes from a Latin word that means 'self murder'.
- It represents the person's wish to die.
- It is the act of a person willingly (at times ambivalently) taking his own life.
- Planning may take days, weeks or even years but other cases may be impulsive.

TERMINOLOGIES

- ***Chronic suicide***: deaths through alcohol & substance abuse & conscious, poor adherence to medical regimens for addiction, obesity & hypertension.
- ***Parasuicide***: injure themselves by self mutilation but do not wish to die.
- ***Cyber suicide***: suicide pact made between individuals who meet on the internet.
- ***Copy cat suicide ("Werther syndrome")***: a suicide within a peer group. Publicized suicide can serve as a model for next suicide in absence of sufficient protective factors.
- ***Anniversary suicide***: persons take their lives on the day a member of their family did.

SUICIDE

- Primary emergency.
- Usually there is underlying depression.
- Prime suicide site in the world is ***The Golden Gate Bridge in San Francisco,*** with 1600 suicides committed there since the bridge opened in 1937.

EPIDEMIOLOGY

- According to WHO:
  - >800,000 people die of suicide every year world wide.
  - In 2012, 2nd leading cause of death in 15 – 29 year olds.
  - In the US, it is the 10th leading cause of death for all ages.

CONT.

- Sex demographics
  - Suicide is 3X as common in men as in women; However, females make 2 – 3 times more suicide attempts than men do.
  - Related to method.
  - Females are more prone to go for medical & psychiatric help than men.
- Age related demographics
  - In general, suicide attempts increase with age, with a major spike in adolescents & young adults.
  - Geriatric suicide is extremely prevalent.
- Marital status: Rates lowest among married, increase progressively with never married, widowers, widows & divorced

CONT.

- Occupation related demographics
  - Higher in unskilled workers (social class v) followed by professionals (social class I).
  - Police & military personnel are at risk.
  - Physicians & dentists.
  - Prisoners especially when out on remand.
- Religion related demographics: Protestants tend to have a higher suicide rates than Catholics & Jews.

CONT.

- Method
  - Various methods reported globally
  - Regardless of culture, ***suicidality in women is most often expressed by ingestion***. If the ingestion acts slowly & is treatable, intended suicides may become attempts.
  - In US: availability of firearms
  - In Kenya: Pesticides, hanging

AETIOLOGY/ RISK FACTORS:
A NUMBER OF FACTORS CORRELATE WITH SERIOUS SUICIDE ATTEMPTS & COMPLETED SUICIDE

- Mental illness
  - 95% of those who commit suicide have a mental illness
  - Depression:
    - Hopelessness, helplessness & withdrawal
    - When a patient is coming out of a deep depression
  - Bipolar disorder
    - Profound & emotional oscillation between mania & depression
    - Men with bipolar are at increased risk for suicide.

CONT.

- Schizophrenia
  - Command hallucinations
  - Depression due to the illness
  - Physical comorbidity & substance abuse
- Anxiety disorders & OCD
  - Patients feel frightened, terrorised, isolated & paralysed by the symptoms
  - Associated depression

CONT.

- PTSD
  - Trauma survivors struggle with nightmares & flashbacks
  - War veterans (Iraq & Afghanistan) have high rates of suicide
- **Substance abuse**
  - Self destructive behaviour in all 3 phases of use: ***intoxication, withdrawal & chronic use***
  - Alcohol, LSD
  - Even those in recovery remain at risk

CONT.

- Delirium & dementia
  - The involved loss of memory, disorientation, hallucinations, delusions & poor judgement often lead to self – destructive behaviour
- Traumatic brain injury
- Bulimia
- Personality disorders

CONT.

- **Physical illnesses**
  - Especially chronic conditions: epilepsy, ESRD, cancer, HIV
- **Genetics**
  - Having a relative commit suicide is indeed a risk factor
  - ***Genes related to serotonin implicated in 2nd suicide attempts***

CONT.

- Social factors
  - Economic instability & status
  - Social fragmentation
  - Media & internet
  - Contagion
- Life experiences
  - Romance related losses
  - Job termination
  - Physical, emotional and sexual abuse
  - Victimisation by bullying
- Impulsivity: Lack of executive function in the form of poor impulse control

RISK FACTORS OF SUICIDE

- Gender: M>F
- Age: usually rare before puberty, men peak at 45yrs, women at 55yrs
- Race: > whites
- Religion: > protestants & Jews; < Catholics & Muslims
- Marital status: > single, never married & divorce
- Occupation: > people of high social status.

CONT.

- Physical health: loss of mobility, disfigurement, chronic intractable pain, drugs (***reserpine, corticosteroids, anti – HTN & anticancer agents***)
- Mental illness: depression, schizophrenia, dementia, alcohol disorders, other substance dependence & personality disorders (APD: increased cases in prisoners), Anxiety disorders (Panic Disorder & Social Phobia)

COMMON METHODS

- Pesticide
- Hanging: globally the MC form of suicide is by *hanging.*
- Firearms
- Drug overdose
- Fatal injuries
- Exsanguinations
- Suffocation
- Drowning.

STAGES OF SUICIDE

Ideation

Threatening

Attempting

CONT.

- Aim is to ***intervene between the stages of ideation & threatening.***

ASSESSING SUICIDE RISK: FOCUSED PATIENT ENQUIRY

- **Suicidal ideation**: determine whether the patient has any thoughts of hurting him/herself. Positive response requires further enquiry.
- **Suicide plans**: specific plans indicate greater danger
- **Purpose of suicide**: what the patient believes his/ her suicide will achieve
- **Potential for homicide**
- Additional questions related to family members, depression symptoms, psychosis, dementia, loss, substance abuse etc.

SIGNS & RISK FACTORS

- Patients with definite plans to kill themselves.
- Systematic pattern of behaviour indicating they are leaving life (goodbye to friends, making a will, suicide note).
- Strong family history of suicide.
- Presence of a gun (or means e.g. hoarding pills, pesticide).
- Being under the influence of alcohol or other mind altering drugs.
- Severe, immediate unexpected loss.
- Patient is isolated & alone.

CONT.

- Patient has ***depression*** of any type.
- Experiences ***command hallucinations***.
- Discharge from a psychiatric hospital.
- ***Anxiety*** in all forms: constant dread & tension proves unbearable for some
- Clinician's feelings: ***regardless of what the patient says or does, it matters if the clinician has a feeling that the patient is going to commit suicide***.

CONT.

- Other sources of information
- Family interviews
- Interviews with friends or co-workers

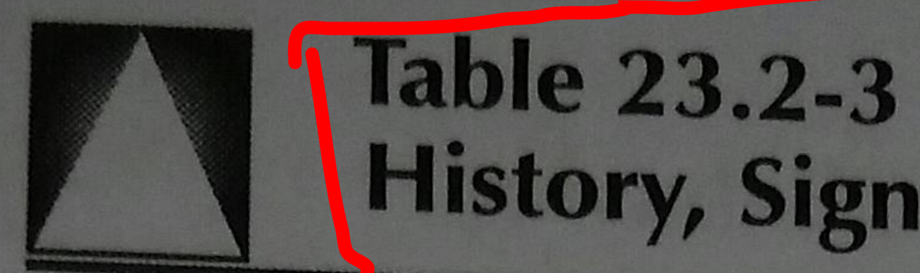


Table 23.2-3
History, Signs, and Symptoms of Suicidal Risk

1. Previous attempt or fantasized suicide
2. Anxiety, depression, exhaustion
3. Availability of means of suicide
4. Concern for effect of suicide on family members
5. Verbalized suicidal ideation
6. Preparation of a will, resignation after agitated depression
7. Proximal life crisis, such as mourning or impending surgery
8. Family history of suicide
9. Pervasive pessimism or hopelessness

PATIENT HISTORY

- A threat of suicide is associated with the completed act.
- Activities associated with committing suicide include:
  - Making a will
  - Getting house affairs in order
  - Unexpectedly visiting friends & family members
  - Purchasing a gun, rope, rat poison
  - Writing a suicide note
  - Visiting the primary care physician: within 3 weeks before the act, can come for a variety of medical problems.

SUICIDE RELATED CHARACTERISTICS

- Preoccupation with death
- A sense of isolation & withdrawal
- Few friends or family members
- Emotional distance from others
- Distraction & lack of humour
- Focus on the past: dwell on past losses, defeats & anticipate no future
- Dominated by helplessness (*cannot help themselves & no one can help them*)
- Hopelessness (*cannot foresee things ever improving*)

MSE

- Appearance
  - Dress & hygiene of depressed individuals.
  - Evidence of suicidal behaviour.
- Affect
  - Depression & anxiety.
  - Flat affect when describing thoughts & plans of suicidal behaviour.

CONT.

- Thoughts
  - Delusions: e.g. world would be better/ reuniting with loved one,
  - Obsessions: focus their lives on their suicide.
- Perceptual disturbances: ***Command hallucinations***

CONT.

- Suicide & homicide
  - The more specific the ideas & plans, the greater the possibility.
  - NB: ***Aggression turned inward is suicide, aggression turned outward is homicide***
  - Although infrequent, murder – suicides are a reality
- Judgement & insight
  - How a patient has handled stress & how they will handle it in the future are a concern.
  - ***Impaired decision making*** is related to suicidal behaviour in both adolescents & adults.
- Orientation & memory: Delirium & dementia

PRINCIPLES OF INTERVENTION

- First and foremost, ***the patient's safety must be assured***
  - The individual **must not be left alone**. They should be surrounded by hospital staff, family & friends.
  - **Remove anything that the patient may use** to hurt or kill him/ herself.
  - Treat initially in a secure, safe & highly supervised place (suicidal watch)
  - Remove **ligature points** (*places where things like ropes can be attached to*)

CONT.

- Put in place a management/ treatment plan
  - Address the underlying cause of the self destructive behaviour.
  - Regular review of the risks & plans.
- Pharmacologic therapy
  - Based on patient's underlying mental disorder.
  - Prescribe adequate but non – dangerous amount of drugs on discharge.
- ECT (Electro Convulsive Therapy)
- Early follow up

MANAGEMENT

- History & clinical examination (P/E, MSE)
  - Depression scales
- Group patient: high risk vs. low risk
- Decide on whether to manage as an inpatient or outpatient.

HIGH RISK PATIENTS FOR SUICIDE

- >45yrs.
- Male
- Divorced or widowed
- Unemployed
- Alcohol dependence
- Violent behavior
- Previous suicide attempt
- Previous psychiatric hospitalization
- Chronic illness
- Socially isolated
- Unresponsive family

CONT.

- Decision to hospitalize a patient depends on:
  - Diagnosis
  - Depression severity
  - Suicidal ideation
  - Patient’s living situation
  - Patient’s and family's coping ability
  - Availability of social support
  - Presence or absence of risk factors for suicide.
- A patient that can be managed as an outpatient should:
  - Have ***struck rapport with the doctor***
  - ***Be able to call when unable to control suicidal impulses (note patient's contacts)***

CLINICIANS PRACTICAL PREVENTIVE MEASURES FOR DEALING WITH SUICIDAL PERSONS

- Reducing the psychological pain by ***modifying the patients stressful environment***.
- Enlisting the aid of the spouse, employer or a friend.
- Building realistic support by ***recognizing that the patient may have a legitimate complaint.***
- Offering ***alternatives to suicide.***

PHARMACOTHERAPY

- **Antidepressants:** Fluoxetine
  - Watch out for **paradoxical suicide**.
- **Antipsychotics:** IM Flupenthixol 20mg for 6 months
- **Lithium**
- Treatment of the underlying condition.

PSYCHOTHERAPY

- **Individual therapy**: problem solving skills, distress tolerance skills.
- **Group therapy** & **family therapy.**

PARASUICIDE/ DELIBERATE SELF – HARM

- This describes patients who injure themselves by ***self mutilation*** e.g. cutting of the skin but **do not wish to die**.
- They cut themselves delicately usually in wrists, arms, thighs or legs.
- They experience no pain & are usually angry with themselves. The deliberate self harm is a ***form of tension relief***.

CONT.

- F:M = 3:1
- Age: 20s
- May be single or married
- Most have personality disorders: ***introverts, neurotic*** & ***hostile.***
- May have alcohol & other substance abuse disorders.

CONT.

- Self mutilation is viewed as ***localized self destruction***, with mishandling of aggressive impulses caused by a persons unconscious wish to punish himself or herself or an introjected object.

OVERLAP BETWEEN SUICIDE AND DELIBERATE SELF HARM

- Some people who had no intention of dying succumb to effects of overdose.
- Ambivalent: not sure whether they want to die or live.
- In those who have been involved in self harm, suicide in the subsequent one year is 100 times greater than in the general population.

METHODS OF DELIBERATE SELF HARM

- Laceration
- Burning
- Jumping from heights
- Jumping in front of a vehicle

EPIDEMIOLOGY OF DELIBERATE SELF HARM

- Epidemiology
  - 3 per 100000 per year (UK)
  - US: 15% of college students attempt once in their lifetime
  - Kenyan/ African data lacking
  - More common among younger people

CAUSES OF DELIBERATE SELF HARM

- Precipitating factors/ trigger
  - Stressful events e.g. recent quarrel with a spouse or significant other, illness of a family member, personal physical illness
- Predisposing factors
  - Familial & developmental factors: early parental loss, abuse
  - Personality variables: coping skills
- Psychiatric disorder: Depression, Substance use

MOTIVES

- To die
- To escape from unbearable anguish
- To get relief
- To change the behaviour of others
- To escape from a situation
- To show desperation to others
- To get back at other people
- To get help

MOTIVES (IN THEIR OWN WORDS)

- When I was younger (12 or 13) it was mainly because I was angry with people, but didn't know how to communicate my anger. I would get upset, but not wanting to lash out at others, I would attack myself instead.
- I began to struggle with depression & anxiety throughout the following years & I realized that self – Injury was a way to feel "better". I would think of suicide, but not wanting to actually kill myself, I realized that physically harming myself was an easier solution.
- I would feel completely empty & consumed by these painful emotions - self-injury gave me something REAL & tangible to feel... gave me something other than emotional pain to experience

CONT.

- I have so much emotional pain I can't deal with it; physical pain is so much easy to deal with, I cut enough so that the physical overpowers the emotional?
- Physical pain gives me a sense of control. when you're hurting inside, you feel lost, confused, etc. when you're cutting, you can say, ok, my arm hurts right here, I know that if I put a bandage on it, it will be better and the pain will stop.
- I do to my body what's been done to my soul

OUTCOME OF DELIBERATE SELF HARM

- Repetition of self harm
- Suicide – almost 3% eventually take their own lives

ASSESSMENT

- Assess patient to determine if they will be managed as an in – patient or out patient.
- Aims of assessment include:
  - Immediate risks of suicide.
  - Subsequent risk of further deliberate self harm.
  - Current medical or social problems.

MANAGEMENT

- Admit if severe self – mutilation or a high risk patient.
- **Psychotherapy is the mainstay.**
  - Main aim is to enable the patient to resolve the difficulties that led up to the act of self harm.
  - Deal with future crises without resolving to self harm (Interpersonal and coping skills)
  - The family can be involved.

C2.2. MANAGEMENT OF THE MANIPULATIVE & VIOLENT PATIENT

BY: DR. NG’ANG’A

OBJECTIVES

- Define & give signs of agitation.
- Causes of aggression.
- Recognition of the aggressive patient.
- Management of the aggressive patient.
- The delusional patient.
- Discharge & follow up.

AGITATION

- Agitation is ***excessive motor or verbal activity***
- Common examples include:
  - Hyper – activity
  - Assaultiveness
  - Verbal abuse
  - Vocal outbursts
  - Threatening gestures & language
  - Physical destructiveness

CAUSES

- Acute intoxication
- Metabolic disorder
- Infectious disease
- Intracranial disorder
- Acute withdrawal
- Trauma
- Psychiatric disorders etc.

COMMONEST PSYCHIATRIC DISORDERS THAT PRESENT WITH VIOLENCE:

- Psychotic disorders: schizophrenia, mania, paranoid states, ± hallucinations
  - Of violent people with schizophrenia 71% are substance abusers (*carries 12 times risk of violence*)
- Drug abuse: PCP, stimulants
- Alcohol abuse
- Organ brain syndromes (7 – 28%)

CONT.

1. Be aware of early Signs of impending violent behavior, such as ***agitation, abusive language & challenges to authority***.
2. Completely undress major trauma victims as soon as possible, removing any weapons on their persons.
3. Do not leave any instruments that can be used as weapons near a potentially violent patient

POSITIVE PREDICTORS OF VIOLENCE

- Male gender
- Prior history of violence
- Psychiatric illness
- Drug or ethanol abuse

SIGNS & SYMPTOMS

- Provocative behavior
- Angry demeanor
- Pacing
- Loud/ pressured speech
- Pounding walls
- Throwing items
- Gripping arm rails intensely
- Clenched fists

EARLY RECOGNITION

- Anger → resist authority → confrontational → combative

CONT.

- Important to recognize
- Aggression: An individual aiming to create fear
  - Eye contact: direct/ non – hostile
  - Personal space
  - Door position
  - Body language
  - Move chairs, hide scissors, remove lanyards etc.

CONT.

- First approach to any agitated patient should be **verbal de – escalation**.
- The physician should remind the patient that they are in a safe environment.
- Improving the patient's comfort.
- Stationing security officers may dissuade further inappropriate behavior.
- Most importantly, care providers must check their own emotions: Yelling back or exchanging threats with the patient only further escalates the situation

The Art of
Verbal De-escalation
D
DECIDE
Decide if a patient is appropriate for verbal de-escalation
Clues include a patient which is responsive.
Engaged in conversation.
Not an active threat to safety
E
ENSURE SAFETY
Ensure adequate backup
Clear area of potential weapons (loose objects, supplies).
Respect personal space
(two arms length between you and patient)
F
FORM RELATIONSHIP
Introduce yourself by name and title
Ask what they like to be called
Ask "Will you allow us to help?"
Use short sentences, simple vocabulary
U
UTILIZE INTERESTS
Identify patient's wants and feelings
Agree as much as possible, either in truth, principle, odds, or to disagree
Reinforce that you will let no harm come to patient
S
SET LIMITS
Speak matter of factly about consequences for bad behavior
Offer choices for behavior, even it's between oral and IV meds
Use repetition as needed until you are heard by patient
E
ENFORCE/EVALUATE
If aggression escalates and violence seems imminent, withdraw and mobilize help
Once situation defused, by either verbal de-escalation or medication, debrief staff and/or patient

PREVENTION

- Isolate from other provocative patients/friends/family
- Hospital gown
- Anticipate combativeness while talking with patient

MANAGEMENT OPTIONS

- Verbal de – escalation: done so as to try to bring the tension down.
- Physical restraints
- Chemical restraints

VERBAL DE – ESCALATION

- Calm, slow talking
- Be firm & assertive
- Avoid argumentative or condescending language

CONT.

- Indicate that you are capable of dealing with the patients capacity for violence.
- Convey that you are accustomed to the unpleasant as well as the pleasant patients.
- Convey that it is your job to help patient maintain control & to make sure that neither the patient nor anyone else is going to be hurt.
- Be in charge of the situation and do not assess the patient when you are alone

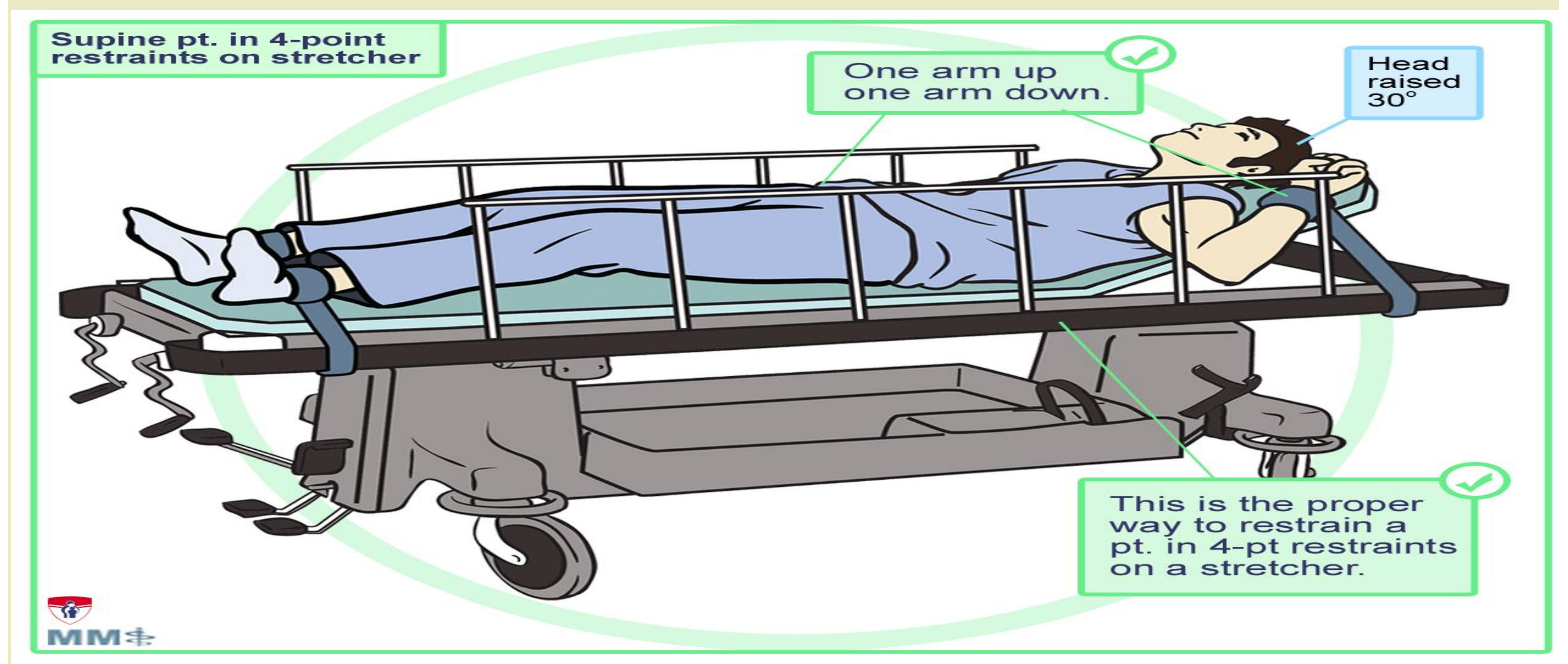
PHYSICAL RESTRAINTS

- Should not be applied for convenience or as a punitive measure.
- Should ensure safety for patient and others.

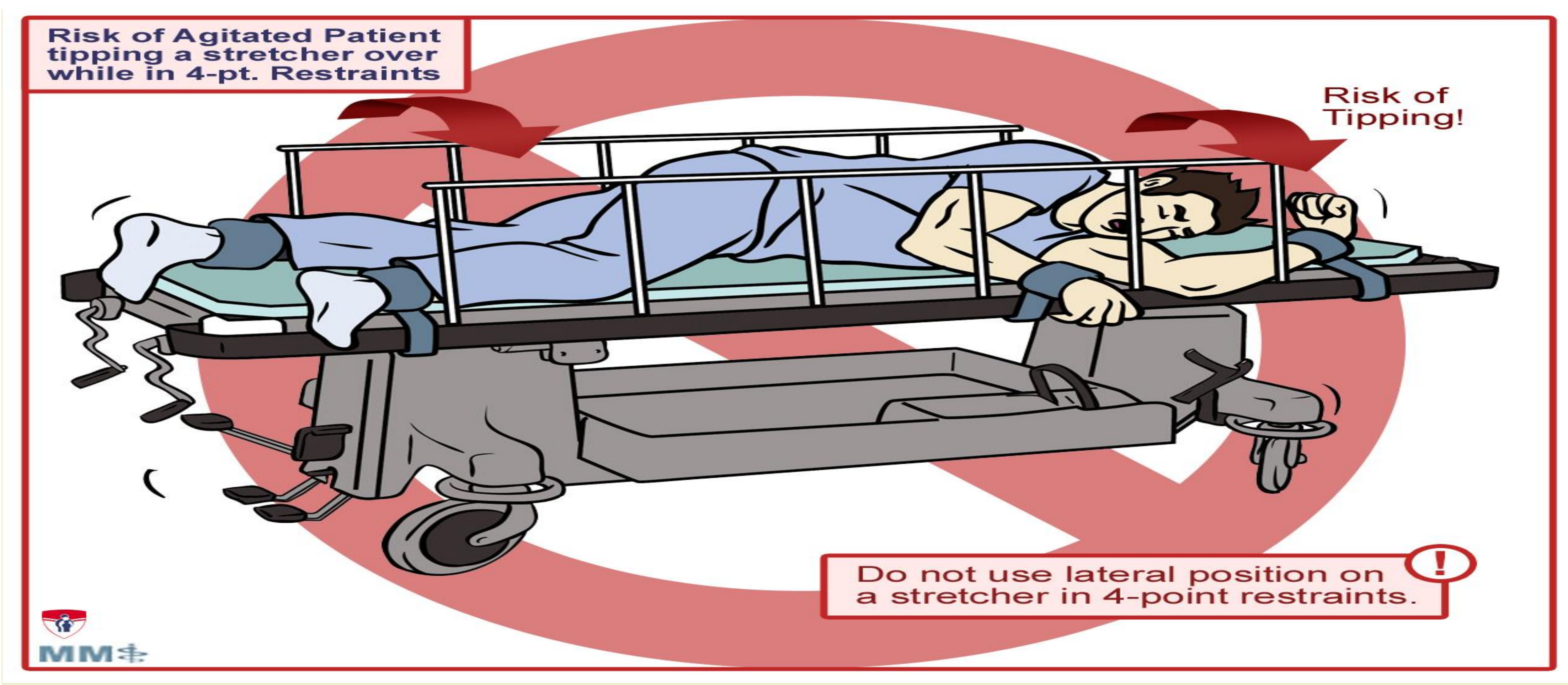
THE TEAM APPROACH

- 5 + people
- Team leader
- 1 person for each extremity

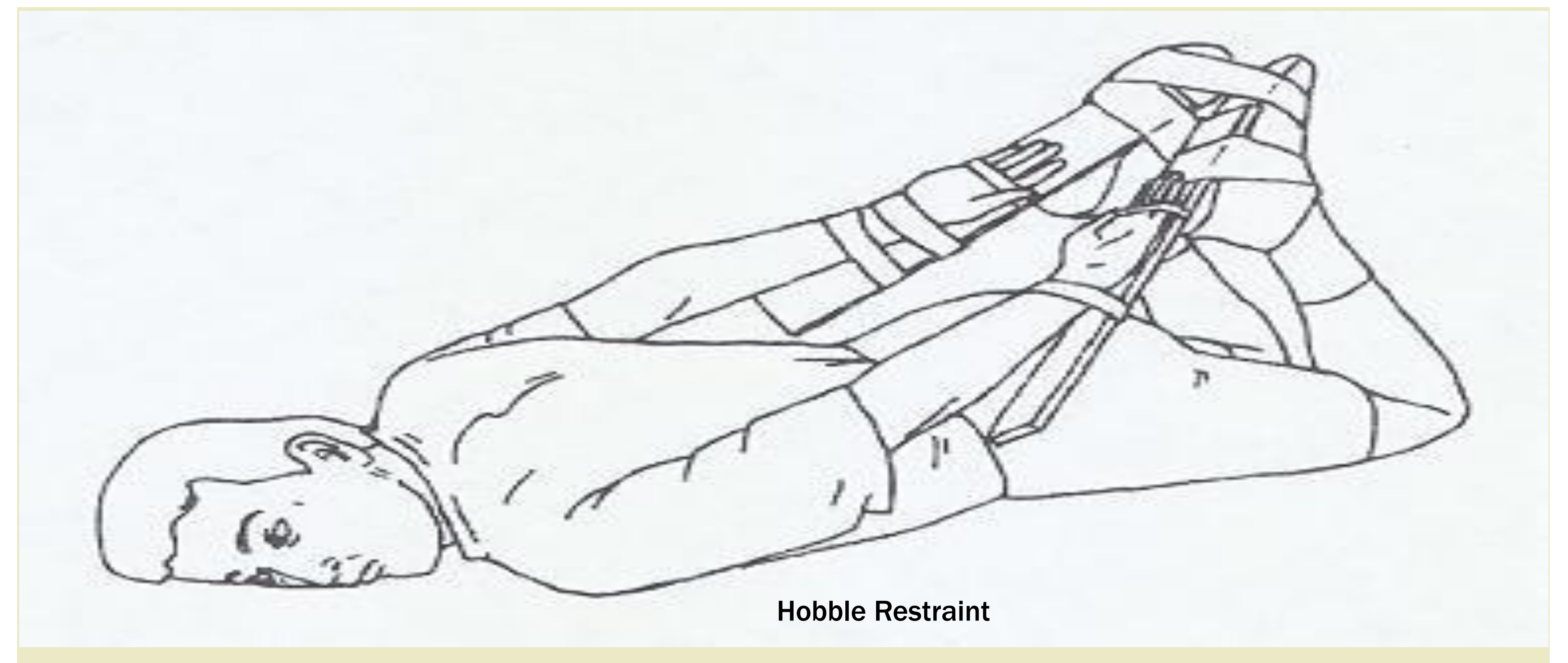
PHYSICAL RESTRAINTS



WHAT NOT TO DO



WHAT NOT TO DO: HOBBLE RESTRAINT



Hobble Restraint

CONT.

- Some patients are brought to the outpatient department while physically restrained either by policemen or relatives(e.g. in handcuffs or ropes).
- For such patients the following should be done.

CONT.

- Establish whether ***effective verbal contact can be made***.
- Establish the ***level of reality impairment***.
  - If the patient is not in touch with reality then ***the doctor may have to medicate patient before an interviewing is done.***
  - If reality testing is not severely impaired , however the next step is to ***decide whether it is safe to remove the physical restrain***.
- Sit preferable on a big table next to the exit whose doors open outwards.

CONT.

- Many psychiatrist prefer to leave the restrain on until at least some history is obtained & some rapport established.
  - If the patient is brought in tied, assess them that way.
- ***If considering release from restrain, your concern should be the safety of both the patient & others around him.***

REMOVING THE RESTRAIN

- If you make the decision to remove the restrain then you should monitor the reaction of the patient as the restraints are loosened.
- If patient remains calm & seems to be relieved, the process of removing the restrains can continue.
- If the patient acts in a way suggesting that removal will increase agitation, then the process should be stopped.

WHETHER A VIOLENT PATIENT HAS RESTRAIN OR NOT;

- He/she should not be interviewed alone.
- At least one other person should be present & in some cases that other person should be a guard or police.
- Leave the interviewer's room's door open.
- Sit between the patient & the door so that the interviewer has unrestricted exit should that be necessary
- Make it clear to the patient in a non angry manner that though he is free to say or feel anything he is not free to act in a violent way.

CONT.

- Such statement should be backed by:
  - Show of force, by a uniformed, calm, consistent staff presence; ensure that the patient understands that they are there to lend support in effort to control the patient including ability to subdue the patient physically if necessary.
  - Avoid confrontation
  - Avoid behavior that would be interpreted as demeaning or disrespectful by the patient.
  - ***Respect as much as possible patients need for space.***

SPECIFIC QUESTION TO ASKED REGARDING A VIOLENT PATIENT

- Has patient been violent before?
  - Trigger? How violent were they?
- Did patient experience violence in childhood?
- Under what specific condition does patient result to violence?
- Obtain collaborative history on the same from friend and relatives.

THE DELUSIONAL PATIENT

- Delusions may be thought of as the patient’s defensive & self protective though maladaptive strategy against overwhelming anxiety, lowered self esteem & confusion.
- ***They should never be challenged because the patients feels threatened to defend them.***
- ***Do not however pretend that you hold the same belief with the patient.***
- The more you respect their beliefs the more they are likely to open up to you.

MANAGEMENT

- Interviewing
- MSE: behavior, insight
- Protect patient: Sedation (if too aggressive)
  - BDZs IM: diazepam, midazolam, lorazepam
  - Chlorpromazine (Largactil) deep IM
  - Zuclopenthixol (Clopixol Acuphase)
  - Olanzapine IM
  - Combinational therapy: BDZ + haloperidol

CHEMICAL RESTRAINT

1. Benzodiazepines
2. Typical antipsychotics
3. Atypical antipsychotics
4. Combination therapy

IDEAL THERAPY

- Works rapidly
- Effective with multiple routes of administration
- Does not interact with other sedating agents
- Not addictive
- Immune to tolerance
- Minimal cardio respiratory depression
- Low side effect profile

BENZODIAZEPINES

- Diazepam
- Lorazepam
- Midazolam

DIAZEPAM

- PO
  - Dose: 5 – 10 mg
  - Onset: 1 – 2 hours
  - Half – Life: 30 – 60 minutes
- IV
  - Dose: 2 – 10 mg
  - Onset: 20 – 30 minutes

LORAZEPAM

- PO
  - Dose: 1 – 2 mg
  - Onset: 16 hours
  - Half – Life: 14 hours
- IM
  - Dose: 0.5 – 2 mg
  - Onset: 20 – 30 min
- IV
  - Dose: <2 mg/min
  - Onset: 5 – 20 min

MIDAZOLAM

- IM
  - Dose: 5 – 15 mg (q15 min)
  - Onset: 15 – 20 min
  - Half-Life: 2 – 6 hr
- IV
  - Dose: 1 – 2 mg (q2 – 3 min)
  - Onset: 1 – 5 min
  - Half-Life: 2 – 6 hr

TYPICAL ANTIPSYCHOTICS

- Haloperidol
- Droperidol

HALOPERIDOL

- PO
  - Dose: 5 – 10 mg
  - Onset: 2 – 6 hr
  - Half-Life: 12 – 18 hr
- IM
  - Dose: 5 – 10 mg
  - Onset: 30 – 60 min
- IV
  - Dose: 1 – 2 mg
  - Onset: 30 – 60 min

DROPERIDOL

- IM/IV
  - Dose: 0.625 – 1.25 mg
  - Onset: 30 min
  - Half-Life: 2 – 4 hr

ATYPICAL ANTIPSYCHOTICS

- Risperidone
- Olanzapine

RISPERIDONE

- PO
  - Dose: 1 – 3 mg
  - Onset: 30 – 60 min
  - Half-Life: 20 hr

OLANZAPINE

- PO
  - Dose: 10 – 20 mg
  - Onset: 5 – 8 hr
  - Half-Life: 20 hr
- IM
  - Dose: 5 – 10 mg q4 hr
  - Onset: 15 – 45 min

OTHER

- Ketamine
  - IM
    - Dose: 4 – 5 mg/kg
    - Onset: 4 – 5 min
    - Half-Life: 30 – 60 min
  - IV
    - Dose: 1 mg/kg
    - Onset: 1 min
    - Half-Life: 15 min

COMBINATION THERAPY

- BDZ + antipsychotic

	Lorazepam	Haloperidol	Combo
Decreased Agitation	+	++	++++
Cumulative Sleep	+++	++	+++

COMBINATION THERAPY - REGIMENS

- Lorazepam + Haldol
  - 2 mg Lorazepam
  - 5 mg Haldol
  - IM/IV
- Midazolam + Haldol
  - 5 mg Midazolam
  - 5 mg Haldol
  - IM/IV

CONT.

- Consider managing the underlying cause then discharge accordingly.

WHAT CAN THE HOSPITAL DO TO DECREASE THE RISK OF VIOLENCE?

- All unnecessary doors should be locked & access into the hospital limited to a few patrolled entrances.
- Metal detectors should be used to screen patients & visitors for weapons.
- Continuous-surveillance, closed-circuit television monitors help to ensure safety in the parking areas and the immediate grounds of the hospital.
- Multiple methods of summoning police or security must be available to the ED without having to go through the hospital operator.
- Responding police or security officers should be trained and equipped appropriately.
- Clear documentation in the medical record.
- A comprehensive program patterned after the critical incident stress debriefing model provides immediate and long-term psychological support.

C2.3 OTHER PSYCHIATRIC EMERGENCIES

BY: DR. KIGAMWA

A PSYCHIATRIC EMERGENCY

- Conditions in which ***prompt diagnosis & treatment is essential if full recovery is to be realized*** without unnecessary complications.

EPIDEMIOLOGY OF SOME PSYCHIATRIC EMERGENCIES

- Suicide: 20%
- Violence: 10%
- Common psychiatric diagnoses:
  - Mood disorders
  - Schizophrenia
  - Psychotic states due to medical conditions (***Alcohol dependence***)

OTHER PSYCHOTIC STATES DUE TO GENERAL MEDICAL CONDITIONS

- **Acute toxic confusional states (Delirium)**
  - Aggressive behaviour may be due to clouding of consciousness and decreased comprehension, perplexity and delusions of persecution.
  - Withdrawal states due to alcohol and other drugs may also present dramatically
- **Dementia:** in dementia there is decreased control due to cerebral damage. Catastrophic reactions (bursts of aggression, anxiety & crying) occur
- **Epilepsy**: aggression may occur in post – epileptic confusional states.

SCHIZOPHRENIA & OTHER PSYCHOSES

- Schizophrenia: violence may be due to →
  - Delusional beliefs, persecution
  - Auditory hallucinations
  - Catatonic excitement (the patients may be either aggressive or hyperactive).
- Patients with schizophrenia may experience a worsening in one or more of the chronic symptoms.

DRUG REACTIONS

- Acute dystonic reactions
- Neuroleptic malignant syndrome
  - Can occur anytime during course of ***antipsychotic treatment***
  - Symptoms are: motor, behavioral, autonomic instability
  - Laboratory: increased WBC, creatinine phosphokinase, liver enzymes
  - Management: **amantadine, bromocriptine, BDZ**

CONT.

- Other Hyper – thermic syndromes.
- SIADH secretion: caused by antidepressants
- Serotonin syndrome: similar to NMS

GENERAL STRATEGIES

- SELF PROTECTION
- HARM PREVENTION
- R/O ORGANIC DISORDERS
- R/O IMPENDING PSYCHOSIS

EVALUATION: GENERAL STRATEGIES

- Self – protection
  - If possible ***get some details about the patient before meeting***.
  - Use trained people to ***restrain the patient***.
  - Be alert to ***risks of impending violence***. (Slide 984)
  - Attend to the ***safety of physical surroundings.***
  - Have others nearby or be able to summon for help when needed.

CONT.

- Harm prevention
  - Prevent self – injury & suicide
  - Prevent violence towards others
- Rule out organic disorders
- Rule out impending psychosis

MANAGEMENT AN EXACERBATION OF PSYCHOTIC SYMPTOMS

- The history should be reviewed to detect any ***possible precipitants***.
- Review dose if necessary
- Lack of compliance is also often an important cause.
  - This may be due to side effects or lack of volition or acute psychosis.
  - Suitable alternatives are the ***depot medications.***
  - An ***explanation & discussion of the side effects*** would also increase the compliance.

DRUGS USED IN ACUTE PSYCHOTIC STATES

Oral medication

- Haloperidol (5 – 10 mg)
- Olanzapine (10 mg)
- Risperidone (2 mg)
- Above 3 plus ***lorazepam*** 1 – 2 mg

Intramuscular

- Lorazepam (1 – 2 mg)
- Haloperidol (5 mg)
- Olanzapine (5 – 10 mg)
- Ziprasidone (10 – 20 mg)
- IM chlorpromazine 100 mg (no longer used in some countries)

CONT.

- Intravenous
  - IV diazepam 10 mg slowly
  - IV midazolam
- Repeat after 30 minutes if no response
  - Clopenthixol Acuphase 100 mg every 2 days
  - ***IV antipsychotics are no longer recommended***

NON – DRUG INTERVENTIONS

- Talking down (verbal de – escalation)
- Distraction
- Seclusion
- Physical monitoring

ACUTE DRUG REACTIONS

- Acute dystonic reactions
  - Anticholinergics:
    - Oral trihexyphenidyl (benzhexol): 5 mg
    - IV/IM procyclidine (5mg/mL): 5 – 10mg
    - OR Benztropine (1mg/mL): 2 – 4mg
  - OR IV diazepam (5 – 10mg)

SEVERE DEPRESSION

- This may present as an emergency because of:
  - Suicidal attempts
  - Refusal to feed
  - Psychomotor retardation
  - Muteness
  - Immobility or inability to attend to their self – care.

MANAGEMENT: DEPRESSION

- Patients with depression may not readily acknowledge the need for help. One should proceed as follows.
  - Communicate in a clear & hopeful manner
  - Identify any stresses present & ***offer realistic reassurance***.
  - ***Supportive psychotherapy*** is often appropriate
- In severely depressed or psychotic patients, enlist the ***family support*** & other legal procedures for hospitalisation & management.

CONT.

- Contact the patients previous doctor if any.
- The patients ***may need to be admitted for prompt treatment usually by ECT***.
- Hospitalisation is indicated if:
  - Depressed patients express serious thoughts of suicide or self – destructiveness.
  - There is lack of social support or the patient lives alone.

SEVERE DEPRESSION

- ***Start on <u>antidepressants</u> only if you are able to monitor the response & follow up the patient.***
- Prescribe only the supply needed until the next review which ***should not be > 2 weeks***.
- **<u>Benzodiazepines</u>** can be used in anxious patients or to treat insomnia before the antidepressants take effect.

CONT.

- Neuroleptics such as **chlorpromazine** may be given if there are psychotic symptoms for example hallucinations, delusions or severe agitation
- **Electroconvulsive therapy (ECT)** often gives rapid response & should be considered in patients who are:
  - Mute
  - Suicidal
  - Severely retarded or agitated
  - Have paranoid delusions
  - Have poor response & medical contraindications to antidepressants.

MANIA

- Such patients may become angry or hostile if thwarted or obstructed.
- Indications for compulsory hospitalisation include:
  - Lack of insight.
  - Severe states of mania in which the patient runs the risk of exhaustion.
  - Destructive & irresponsible behaviour such as financial misadventures.

ANXIETY DISORDERS

- Acute attacks of anxiety or panic (***anxiety is most likely to present as an emergency if it takes the form of panic disorder***).
  - The patient experiences intense anxiety, which is beyond normal experience & is accompanied by physical symptoms such as palpitations, chest pains, sweating or restlessness.
  - The patient may express the fear that he is losing control or is going “mad”.
  - Such patients may present in casualty or emergency departments accompanied by equally distressed relatives who may think that the patient has some life – threatening physical disorder.

CONT.

- Medical conditions that have similar symptoms are:
  - Myocardial Infarction
  - Pulmonary Thromboembolism
  - Hyperthyroidism or hypothyroidism
  - Hypoglycaemia
  - Hyperparathyroidism
  - Phaeochromocytoma
  - Drug or alcohol withdrawal & drug intoxication

CONT.

- These should be considered & ruled out by appropriate history, P/E & laboratory investigations.
- It is also important to keep in mind that panic disorders can co – exist with other psychiatric syndromes.
- Management: ***IV diazepam 5 – 10 mg*** offers prompt relief before a more detailed assessment is made.

CONVERSION & DISSOCIATIVE DISORDERS (HYSTERIA)

- Cases of recent onset may present dramatically. These may manifest as:
  - Disorders of movement: paralysis, gait disturbances, tremors, aphonia, mutism, psychogenic convulsions
- Disorders of sensation: blindness, deafness
- Fugue states

CONVERSION & DISSOCIATIVE DISORDERS (HYSTERIA)

- Dissociation & conversion disorders may begin suddenly following an emotional stress.
- **Primary gain** is the respite, which results from the psychological conflict.

MANAGEMENT OF ANXIETY & CONVERSION – DISSOCIATIVE DISORDERS

- ***BDZs*** to allay anxiety, which is never entirely absent.
- ***Psychotherapy***: the aim of this is to help the patient ventilate his feelings & to talk to an understanding helper about the stressful situation.
  - ***Reassurance*** & ***suggestion*** are techniques that are commonly used.
- ***Abreaction therapy***: in which the patient is sedated by intravenous drugs (diazepam or phenobarbitone) just enough to lower his psychological defences & allow the subconscious conflict to surface. This may then be re-experienced and if accepted and remembered by the individual, the symptoms disappear.

CONT.

- ***The use of <u>irritants</u> (sniffing salts) or <u>physical punishment</u>, for example, slapping the patient to get him to snap out of his state & other somatic treatments are <u>not to be recommended</u>.***
- Only psychotherapy is expected to give lasting benefits, taking into consideration the fact that the underlying cause is a psychological conflict.

ADJUSTMENT DISORDERS

- *"A maladaptive reaction to an identifiable psychosocial stressor, that occurs within 3 months of the onset of the stressor"* (DSM IV)
- The clinical features are: ***agitation, disorientation, stupor or fugue, which may last for hours or days***.
- It is required that one rules out other mental disorders before making the diagnosis.
- Usually after difficult or threatening life events, every normal person is expected to show some emotional & behaviour changes.
- But if the suffering or dysfunction, which results is out of proportion to the degree of stress then it is considered pathological.

POST – TRAUMATIC STRESS DISORDER

- **PTSD** occurs after an unusually severe stress that is outside the range of normal experience.
- These cause helplessness and extreme danger to the victim. Examples are rape, wars, massacres, detention and natural catastrophes such as floods, earthquakes, and mass accidents among others.
- The clinical manifestations are **intrusive recollections of the events** (the victim acts as if he is reliving the events) **distressing dreams**, **insomnia**, **irritability**, **impaired concentration** and **emotional detachment**. **Explosive aggressive behaviour** may occur.

CONT.

- The picture may be complicated by alcohol and drug abuse as an attempt to cope with the unpleasant feelings.
- Anxiety and depressive illnesses may also be present.
- Organic mental disorders such as previous head injury causing long – term effects on mood & cognitive impairment or malnutrition should be excluded.
- ***In the acute cases, the victims may be sedated with anxiolytic drugs and allowed adequate rest***. After further assessment, ***psychotherapy*** can be commenced allowing the victim to explore the traumatic event & ventilate his feelings.

PREVENTION OF PTSD

- Helpful: Multiple session CBT in those with ASD
- Unknown effectiveness
  - Multiple CBT in all exposed to accidents
  - Single session debriefing
  - Propranolol
  - Temazepam
- Unlikely to be helpful
  - Supportive counselling
  - Single session individual debriefing (may increase risk of PTSD & depression)

PERSONALITY DISORDERS

- The disturbances are evident in interpersonal relationships & adjustment to society.
- These individuals are at a greater risk of developing other psychiatric disorders during personal stresses.
- Since the patients rarely view their behaviour as unacceptable, they are unlikely to present to the doctor directly.

CONT.

- **Antisocial personality disorder:** patients with this disorder may be referred because of violence or due to complications of drug or alcohol abuse.
- **Paranoid personality disorder** the patient's mistrust & hypersensitivity to trivial matters, feelings of shame etc. may get the patients into difficult social situations like frequent arguments and fights.

ACUTE GRIEF & DISASTER VICTIMS

- Grief, mourning or bereavement refers to the syndrome which occurs after significant loss.
- This may be loss of a loved one through death, loss of health or news of impending death after being diagnosed with cancer or HIV. Other factors include loss of a job or demotion.

NORMAL GRIEF REACTION

- Depends on cultural factors as well as the individual's character & coping skills.
- In most cases, the following stages are seen.

1. **Stage I**: shock, disbelief & numbness. Denial of loss may occur to protect the person from painful reality. This situation may last for hours to days.
2. **Stage II**: reality gradually returns; the thoughts of the loss occur repeatedly. ***Depression is common and may be accompanied by guilt, anger or shame***. This may last for several weeks or months.
3. **Stage III**: reorganisation occurs in this last phase as the loss & its consequences are fully accepted.

CONT.

- Most of the grieved people recover well without any complications & do not need psychiatric help.
- In a few cases however, the grieving process may not occur or is unduly prolonged.
- Grief may be prolonged because of an ***underlying psychiatric illness***.
- Alternatively, it could be that ***the patient is unable to grieve normally***. This can occur if the person is isolated or if he maintains a stoic stance. Guilt feelings may also interfere with the normal grief reaction.

MANAGEMENT OF UNCOMPLICATED GRIEF

- A ***full psychiatric assessment*** should be done, as the people who are overwhelmed by their feelings and seek help are prone to developing other psychiatric illnesses.
- The ***main differential diagnosis is major depression***. Severe vegetative states or suicidal behaviour would favour a diagnosis of major depression. Alcoholism, drug abuse and suicide are other problems, which may occur after bereavement.

CONT.

- In bereavement due to suicide particular attention should be paid as ***the risk of suicide is usually higher in these individuals***.
- Any ***underlying psychiatric disorder should be treated*** & the ***normal grieving process facilitated***.
- Generally, this will depend on the culture & some rituals that the patient needs to undergo. The ***help of relatives or one familiar with the patients culture may be enlisted***.

CONT.

- Reviewing the relationship with the deceased & encouraging the patient to talk about his feelings – sadness, anger or despair – concerning the deceased.
- The doctor should remain detached & not discourage angry feelings expressed by the patient & sometimes these may be directed to the hospital or the doctor himself.
- Reassure the patient that the symptoms experienced such as somatic distress, apathy & recurrent images of the deceased are normal & will gradually pass away with time.

CONT.

- ***Do not impose your philosophy of life or religious beliefs on the patient***. Allow the patient to experience & express any feelings setting appropriate limits. Avoid statements such as "Bear it like a man" or "Pull yourself together".
- **Use medications sparingly**. Attempts to over sedate the patient to sleep it over may be counter productive in the long run as they arouse guilt feelings later.
  - Benzodiazepines such as lorazepam (Ativan) 2 mg as needed may be used. Alcohol use should be discouraged.
  - ***Major tranquillizers such as chlorpromazine should not be used except perhaps to treat underlying psychiatric disorder.***

CONT.

- Do not allow the patient to remain isolated. Use family members, friends and other social support.
- The patient should be encouraged to ***return to work within 3 – 6 weeks after the bereavement***
- Follow up & further appointments should be arranged as necessary

CRITICALLY ILL PATIENTS

- Distraught relatives & friend of patients who are critically ill should be made comfortable in a private setting if feasible.
- One of the staff or the doctor looking after the patient should be available to answer their questions.
- The questions may be repetitive but one has to bear in mind the fact that ***registration & recall is often poor in anxious persons***.
- They should be allowed free access to the patient so long as they do not interfere with treatment or resuscitation procedures. Request for prayers or last rites should be granted.

CONT.

- If the patient is already dead, the relatives may be allowed to view the body but ***any equipment used for resuscitation should be removed***.
- Generally, ***the body should be covered leaving only the face and the hands exposed. The viewing should not take more than 15 minutes in the emergency room.***

MASS DISASTERS

- In cases of mass disaster such as mass accidents, ***most attention will naturally be paid to the severely physically injured but the uninjured survivors also need to be offered counselling*** as they may have considerable psychological morbidity.
- The relatives of the victims also need to be ***informed sympathetically but accurately*** about the victims' conditions.
- The disaster workers should be helped to overcome any psychological trauma they may have had.
- Feelings of frustration, guilt or helplessness are common among them. ***"Debriefing sessions"*** would give them an opportunity to reflect on & share their experiences.

C3. PSYCHOSOMATIC MEDICINE

BY: PIUS KIGAMWA

- Psychosomatic medicine is an area of scientific investigation concerned with ***the relation between psychological factors & physiological phenomena in general and disease pathogenesis in particular.***
- Integrates mind & body into a psychobiological unit; to study psychological & biological processes as **dynamic interacting systems**.
- It emphasizes the **unity of mind & body** & the interaction between them.
- It encourages a **holistic** approach to medicine.

- Two basic assumptions:
    - There is a **unity of mind & body** (reflected in the term mind – body medicine).
    - Psychological factors must be taken into account when considering all disease states.
- Emphasis on examining & treating **the whole patient**, not just his or her disease or disorder.

- The concepts of psychosomatic medicine also influenced the field of behavioral medicine which integrates the behavioral sciences & the biomedical approach to the prevention, diagnosis & treatment of diseases.
- Psychosomatic concepts have contributed greatly to those approaches of medical care.

Biomedical Model:

- The application of biological science to maintain health & treating disease.
- ***Engel (1977)*** proposed a major change in our fundamental model of health care.
- The new model continues the emphasis on biological knowledge, but also encompasses the utilization of psychosocial knowledge, i.e., the ***biopsychosocial model***.

STRESS THEORY

- Stress can be described as a ci***rcumstance that disturbs, or is likely to disturb, the normal physiological or psychological functioning of a person***.
- The body reacts to stress in this sense.
- Stress is therefore defined as anything (real, symbolic, or imagined) that threatens an individual's survival by putting into motion a set of responses that seeks to diminish the impact of the stressor & restore homeostasis.

THE STRESS MODEL

- A psychosomatic framework.
- Two major facets of stress response.
  - "**Fight or Flight**" response is mediated by ***hypothalamus***, the ***SNS*** & the ***adrenal medulla.***
    - If chronic, this response can have serious health consequences.
  - The ***hypothalamus***, ***pituitary gland***, the ***adrenal cortex*** mediate the second facet.

NEUROTRANSMITTER RESPONSES TO STRESS

- Stressors activate **noradrenergic** systems in the brain & cause release of ***catecholamines*** from the SNS.
- Stressors also activate **serotonergic** systems in the brain, as evidenced by increased serotonin turnover.
- Stress also increases **dopaminergic** neurotransmission in ***meso-pre-frontal pathways***.

ENDOCRINE RESPONSES TO STRESS

- **CRF** is secreted from the hypothalamus & it acts at the anterior pituitary to trigger release of **ACTH.**
- ACTH acts at the adrenal cortex to stimulate the synthesis and release of ***glucocorticoids***.
- Glucocorticoids:
  - Promote **energy use**
  - Increase **cardiovascular activity**
  - Inhibit functions such as **growth, reproduction & immunity.**

IMMUNE RESPONSE TO STRESS

- Inhibition of immune functioning by glucocorticoids.
- Stress can also cause immune activation through a variety of pathways including the ***release of humoral immune factors (cytokines) such as IL – 1 & 6***.
  - These cytokines can themselves cause further release of CRF, which in theory serves to increase glucocorticoid effects & thereby self-limit the immune activation.

- High level of Cortisol results in suppression of immunity which can cause ***susceptibility to infections and possibly also in many types of cancer***.
- Changes in the immune system in response to stress are now very well established.

- Note that: ***immune suppression in response to stress occurs even after removal of the adrenal gland !!!.***
- There appears to be an alternative path, other than through the adrenals, for the brain to influence the immune response i.e. ***psychoneuroimmunology***

DSM-IV DIAGNOSTIC CRITERIA FOR PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION

A. General medical condition (coded on Axis III) is present.

B. Psychological factors adversely affect the general medical condition in one of the following ways:

1. The factors have ***influenced the course of the general medical condition*** as shown by a *close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the general medical condition*.
2. The factors interfere with the treatment of the general medical condition.
3. The factors constitute additional health risks for the individual.
4. Stress – related physiological responses precipitate or exacerbate symptoms of a general medical condition.

- ***Mental disorder affecting medical condition*** (e.g., an Axis I disorder such as major depressive disorder delaying recovery from a myocardial infarction).
- ***Psychological symptoms affecting medical condition*** (e.g., depressive symptoms delaying recovery from surgery; anxiety exacerbating asthma)
- ***Personality traits or coping style affecting medical condition*** (e.g., pathological denial of the need for surgery in a patient with cancer, hostile, pressured behavior contributing to cardiovascular disease)
- ***Maladaptive health behaviors affecting medical condition*** (e.g., lack of exercise, unsafe sex, overeating)
- ***Stress-related physiological response affecting general medical condition*** (e.g., stress-related exacerbations of ulcer, hypertension, arrhythmia, or tension headache)
- ***Other unspecified psychological factors affecting medical condition*** (e.g., interpersonal, cultural, or religious factors)

- The essential challenge in psychosomatic-psychobiological research is to ***delineate the mechanisms by which experiences cause certain types of physiological reactions that result in disease states***.

CARDIOVASCULAR SYSTEM

- Psychological factors have been closely studied as part of the pathogenesis of the cardiovascular diseases.
- ***Depression***
  - It is an independent risk factor for the development of coronary artery disease.
  - It increases mortality rates following myocardial infarction (MI).
- Hyperactivity of the HPA axis, immune activation with release of pro-inflammatory cytokines & activation of the SNS & of CRF pathways in the central nervous system (CNS).

GASTROINTESTINAL CONDITIONS

- Functional disorders represent 50% of complaints in GI clinics.
- There is a strong & consistent association between functional gastrointestinal disorders and psychological factors.
- IBS is the MC.
- Brain-Gut axis
- Hypersensitivity of GI tract
- Role of stress

SOMATOFORM DISORDERS

- 3 enduring clinical features:
  - Somatic complaints that suggest major medical problems.
  - Psychological factors & conflicts that seem important.
  - Symptoms or magnified health concerns that are NOT under the patient's conscious control.
- They include:
  - Somatization disorder
  - Conversion disorder
  - Pain disorder
  - Hypochondriasis
  - Body Dysmorphic Disorder

SOMATIZATION DISORDER

- The essential feature of somatization disorder is ***recurrent, multiple somatic complaints requiring medical attention but not associated with any physical disorder***.
- Somatization disorder is the expression of personal and social distress in bodily complaints.
- Multiple symptoms of multiple systems for several years.
- Chronic relapsing condition with no known cure.

CONVERSION DISORDER

- A disturbance of body functioning ***(usually neurological)*** that does not conform to current concepts of the anatomy & physiology of the central or the peripheral nervous system.
- It ***typically occurs in a setting of stress & produces considerable dysfunction***.
- Involuntary movements, tics, seizures, abnormal gait, paralysis, weakness etc.

HYPOCHONDRIASIS

- Preoccupation with ***the fear of developing a serious disease or the belief that one has a serious disease***.
- The fear is based on ***the patient's interpretation of physical signs or sensations as evidence of disease even though the physician's physical examination does not support the diagnosis of any physical disorder***.
- However, ***the belief does not have the certainty of delusional intensity***.

PAIN DISORDER

- Preoccupation with pain is consuming and to some extent disabling.
- That is, ***pain becomes the predominant focus of the clinical presentation and the pain itself causes clinically significant distress or impairment and the patient's life becomes organized around the pain***.
- Psychological factors are judged to play a role in this disorder.

BODY DYSMORPHIC DISORDER

- Preoccupation with ***an imagined defect in appearance***. If a slight physical anomaly is present, the person's concern is markedly excessive.
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

MANAGEMENT

- Caring rather than curing
- Management is ***more realistic than treatment***
- Therapeutic relationship
- Nature of symptoms in psychosomatic context
- ***Rule out depression and anxiety disorders***
- Avoid investigations without indications
- Pharmacotherapy
- Coping skills
- Lifestyle changes

C4. MANAGEMENT OF SOMATOFORM DISORDERS

BY: DR. RACHEL KANG'ETHE

OBJECTIVES

- Describe principles of assessment, treatment & management of somatoform disorders.
- Outline assessment & diagnosis of somatoform disorders.
- List treatment methods used to manage somatoform disorders.

INTRODUCTION:

- In middle ages, somatoform disorders were believed to be due to demonic possession.
- 17th C, Sydenham "hysteria could simulate any medical disease".
- 19th C, ***Briquet, Reynold, Charcoat*** believed hysteria to be a CNS disease.
- 1893-95 ***Breur and Freud*** gave new insights. Freud - hysteria = "conversion of emotional distress to physical symptoms".
- "Soma" Greek term for body. Later, hysteria termed 'somatization' by Stekl to denote "expression of emotional distress as bodily symptoms".
- St Louis group Perley, Guze described Briquet's syndrome as "chronic multiple somatic symptoms, with no identifiable organic cause".
- First introduced 30yrs ago in DSM-III as Somatoform Disorder.
- DSM-IV – concept of medically unexplained symptoms introduced.
- Somatoform disorders are a clinical & public health problem & they often leads to social dysfunction, occupational difficulties & increased healthcare use. So understanding somatoform disorders is important.

Characteristics of somatoform disorders

- **Somatic complaints:**
  - Somatoform disorders are experienced by patients as ***somatic [physical] symptoms***. The hallmark of somatoform disorders is ***the presence of physical symptoms without demonstrable medical illness*** - initiated, exacerbated & maintained by psychological conflicts.
  - Physical exam & lab tests do not explain the patient's vigorous & sincere complaints.
  - The symptoms are ***not adequately explained by medical illness, substances or another psychiatric disorder*** yet they cause significant distress or impairment in occupational, social or other areas of functioning.

- **Morbid bodily preoccupation:** anxiety often present & may justify specific Rx.
- **Not intentional:**
  - Somatization is essentially an expression of psychological pain via unexplained somatic symptoms or bodily preoccupation. IT IS NOT CONSCIOUS DECEPTION BY THE PATIENT.
  - The physical complaint, generally is the result of the following three processes:
    - Experience of an emotion, e.g. anxiety.
    - Expression of a bodily aspect of the emotion, e.g. a racing pulse resulting from anxiety.
    - An attribution or thought arising from the bodily experience, e.g., the implication that the patient is ill as a result.

- **Diagnoses of exclusion:**
  - R/O medical causes, other psychiatric illness, intentional feigning (as in **factitious disorder** or **malingering)**
- **No cured but can be managed**.
  - Treatment – focus is on:
    - Stress reduction
    - Reduction in help – seeking behavior
    - Teaching to control symptoms
    - Finding things that make the symptoms worse
    - Eliminating reinforcers
    - Helping persons with somatoform disorders to live the most normal life possible.

. Clinical features suggesting somatoform morbidity

- Patient presenting with variable physical symptoms, or a conviction that they suffer from a certain condition that is inconsistent with physical findings or established medical knowledge
- Refusal to accept advice or reassurance given
- Significant social or family dysfunction attributable to complaint
- Complaint may relate to organ systems with significant autonomic innervation, eg cardiovascular, respiratory, gastrointestinal or reproductive systems
- Evidence of exaggeration, or complaints regarding a perceived deficit in care received
- Presentation not consistent with established medical knowledge

Predisposing factors

- Early life trauma
- Childhood illness
- Childhood experience of parental ill health and somatisation
- Potential source of secondary gain (NB. use caution in considering this value-laden matter, as many illnesses have secondary gain)
- History of depression and anxiety
- Personality dysfunction: antisocial, borderline and hysterical personality disorder

CONT.

- It is essential to exclude depression or anxiety disorders as this are treatable & they may contribute to the presentation.
- Awareness of risk factors should enable early identification of somatoform disorders, thereby limiting the expense & harm of unnecessary investigations.
- Acknowledge reality of the problem for the patient.
- Identify & acknowledging the significance of perpetuating emotional & social factors & develop, a ***biopsychosocial model management plan*** to improve function & ameliorate distress.

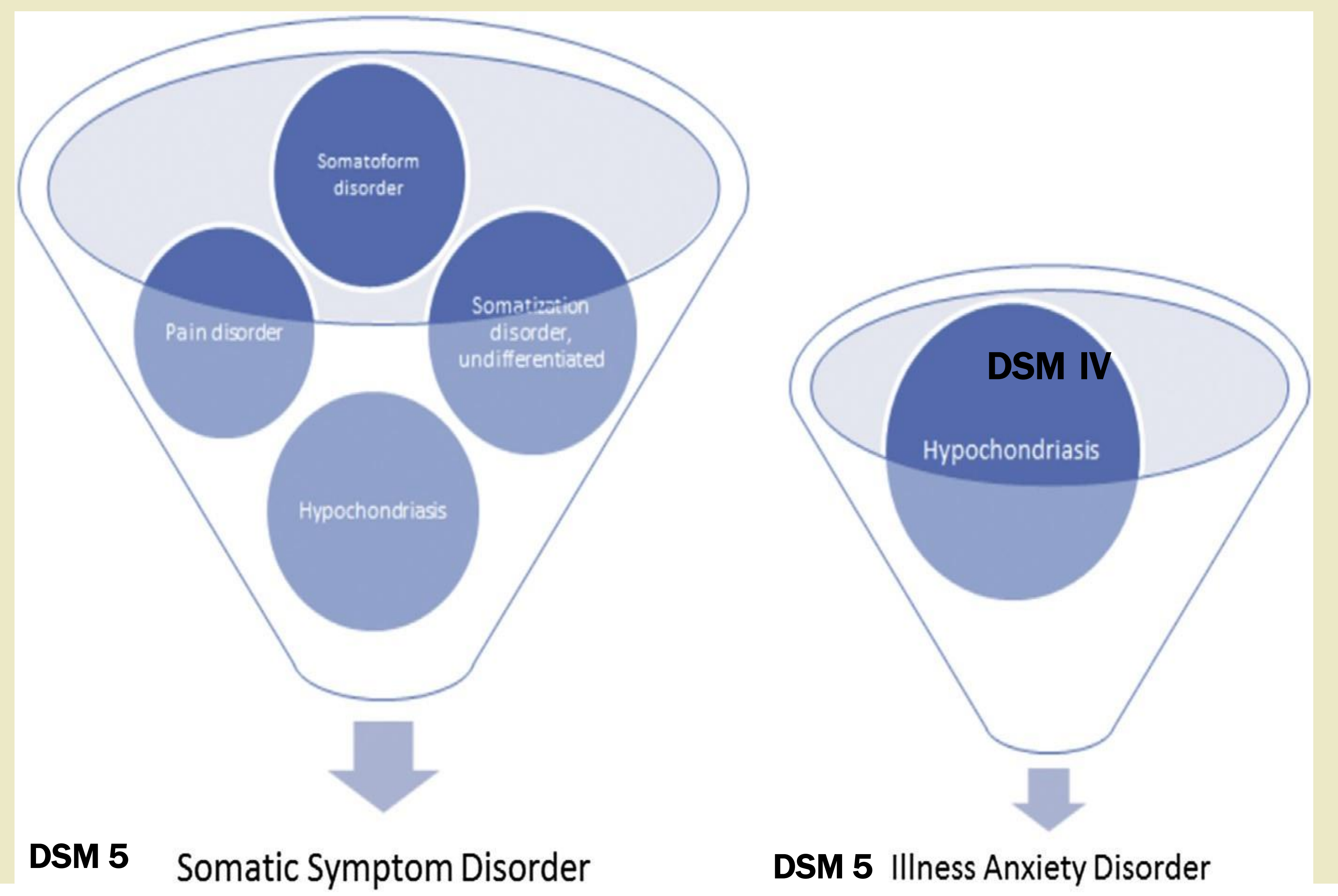
SOMATOFORM DISORDERS DSM IV

- Somatization Disorder
- Conversion Disorder
- Hypochondriasis
- Pain Disorder
- Body Dysmorphic Disorder
- Undifferentiated Somatoform Disorder
- Somatoform Disorder NOS

SOMATIC SYMPTOM DISORDER & RELATED DISORDERS (DSMV)

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder
- Psychological disorders affecting medical condition
- Factitious Disorder
- Nonspecific somatic symptom disorders
- Other specific somatic symptom disorders

DSM IV
Somatoform Disorder



Conceptualizing Somatoform Disorders

- A way of responding to stress
- Somatosensory amplification, where somatic symptoms are experienced as intense, noxious or disturbing e.g.
  - Hypervigilance to bodily sensations
  - Selecting out some sensations
  - Intensification by cognition & affect hence making them more alarming.
- Masked depression or anxiety or other psychiatric disorders or amplified personal perceptual style due to personality trait or abnormal neuropsychological information processing or as seeking care for emotional distress or as a response to health care incentives.

Somatoform Disorders: Etiological considerations

- **Physiological:** autonomic arousal, muscle tension, hyperventilation, vascular changes, cerebral information processing, sleep disturbance
- **Psychological:** perceptual factors, beliefs, mood, personality factors]
- **Interpersonal pathophysiological mechanisms:** reinforcing actions of relatives & friends, health care system, disability benefits
- **Others**: Genetic factors, developmental factors, cognitive theories, Personality characteristics, psychodynamic factors, Sexual/physical abuse, socio-cultural factors, gender & iatrogenesis.

- **What is somatization?** The process of using one's body or manifestations of illness in the absence of medical cause for psychological gain or personal benefit.
- **What is the difference between somatoform disorders & factitious disorders?**
  - Somatoform = **unconscious** production of physical signs & symptoms of illness.
  - Factitious = **conscious** production of complaints to assume "sick role".
- **What is the difference between factitious disorders and malingering?**
  - Goal of factitious disorders = primary gain
  - Goal of malingering = secondary gain
- **What is primary gain?** Assuming sick role to obtain the **psychological benefit** of being cared for & receiving attention from nurturing, authoritative figures.

- **What is secondary gain?** Some <u>**external benefit**</u> arising from being ill.
- **Secondary gain examples:**
  - Financial benefit in form of disability pay, Medications e.g. narcotics, decisions made by healthcare workers to support pending legal cases & avoidance of commitments or obligations.
- **When patient presents with somatoform disorders what underlying problems are investigated?**
  - Underlying psychiatric syndrome
  - Coexisting personality disorder
  - Psychosocial stressor e.g. sexual abuse.
- **What elements of history suggest somatoform disorders?**
  - Several unconnected, exaggerated, often strange medical complaints that have been worked up by numerous physicians in the past without clear cause.
- **What elements of exam, laboratory tests suggest somatoform disorders?**
  - Anxiety about these complaints, strange indifference to significant medical complaints (La belle indifference), inconsistent physical examination or lab findings.

ASSESSMENT

- Testing should only be performed for diagnoses that are supported by a carefully performed history & P/E.

Somatoform Disorders: Assessment

1. ***R/O physical illness***: Initial evaluation of somatic symptoms thorough medical assessment directed at R/O physical illness.
2. ***Psychiatric assessment***: If apparent physical symptoms psychogenic in origin, a complete psychiatric assessment is required.
3. ***Diagnosis:*** Use DSM-criteria to make specific somatoform disorder diagnosis: assess symptoms' duration, severity & psychosocial impact.
4. ***Identify psychiatric co – morbidities***: Assess for psychiatric disorders e.g., depression, anxiety, schizophrenia, SUDs, as these may masquerade as vague physical symptoms that pts repeatedly seek medical attention for.
5. ***Biopsychosocial formulation***: understanding of patient & their symptoms; familial, temperament vulnerabilities; symbolic meaning ascribed to symptoms, how this connects with formative & current life experiences; stressful life circumstances role; role of learning, as it applies to reinforcement of pathological illness behavior; broader overarching social & cultural context influence.
6. These assessments will determine the choice of a definitive treatment strategy, specifically tailored for each individual patient.

Comorbidity with somatoform disorders

Somatic presentations of underlying mental disorder or distress are extremely common in general practice with somatisation frequently being a way of presenting anxiety and depression[388]. Many of these presentations are easy to sort out for the clinician, with the underlying stressor or disorder quickly coming to the fore and the patient willing to attribute the physical symptoms to the underlying problem.

There is a linear relationship between the severity of anxiety and depression and frequency and severity of somatic symptoms[389-392].

There is a high degree of comorbidity with depression and anxiety amongst people with somatoform disorders[389, 392-398]. A combination of anxiety and depression and a somatoform disorder results in more somatic symptoms than if anxiety or depression alone occurs with the somatoform disorder[392, 396, 398]. Individuals with somatoform disorders and comorbid depression may use both organic and psychological explanations for their symptoms[399].

Overlap of symptoms of diagnostic criteria for somatoform disorders and anxiety and depression may explain the high prevalence of somatic symptoms in those with anxiety and depression[392, 400].

Anxiety and depression are more likely than somatoform disorders to be the source of medically unexplained symptoms[401]. Regardless, depression and anxiety make pain feel worse and individuals present with a higher level of functional somatic symptoms[392, 402].

There is obvious scope for inappropriate substance use in these individuals as the medical practitioner attempts to deal with some of the symptomatology before the correct diagnosis is recognised[377, 403].

There are strong correlations between pain disorders and opioid dependence and misuse. However, this does not suggest that all people with pain and opioid dependence have a somatoform disorder.

Somatoform disorders also correlate with alcohol and benzodiazepine dependence and misuse[379, 404].

Delay in diagnosing these disorders may result in the individuals being prescribed opioids or benzodiazepines with subsequent increased risk of dependence[404].

IDENTIFYING SOMATOFORM DISORDERS

1. Do a thorough history & detailed physical assessment
2. Rule out **medical illness**
3. Consider **medication side effects**
4. Identify ability to meet basic needs
5. Identify **secondary gains**
6. Identify ability to communicate emotional needs
7. Build therapeutic alliance with the patient
8. Screening tools for somatoform disorders e.g. **PHQ-15**
9. Identify **psychiatric comorbidities** e.g., substance use disorder, depression, anxiety

THE BATHE TECHNIQUE

- **Background** – What brings you here today?
- **Affect** – How do you feel about that?
- **Trouble** – What bothers you most about this situation?
- **Handling** – How are you handling that?
- **Empathy** – That must be very difficult for you.

ASSESSING PATIENTS WITH SSD USING S4 MODEL

1. **S**tress recently (last week) → yes/no
2. **S**ymptom count (checklist of 15 somatic symptoms; scored as positive if $>$ 5 symptoms)
3. **S**elf – rated overall health poor or fair on a 5-point-scale [excellent, very good, good, fair, poor]; scored as positive or poor responses.
4. **S**elf – rated severity of symptoms from 0 (none at all) to 10 (unbearable) scale, scored as positive for responses $\geq$ 5

SOMATOFORM DISORDER DIAGNOSIS

① Building alliance with patient.

② Collaborating with referral source.

③ Reviewing medical records.

④ Gathering collateral information from others.

⑤ Psychiatric examination, MSE, physical examination.

⑥ Use DSM-criteria to make specific somatoform disorder diagnosis

PHQ-15 - SCREENING FOR SOMATOFORM DISORDERS

		Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a.	Stomach pain	☐	☐	☐
b.	Back pain	☐	☐	☐
c.	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d.	Menstrual cramps or other problems with your periods	☐	☐	☐
WOMEN ONLY				
e.	Headaches	☐	☐	☐
f.	Chest pain	☐	☐	☐
g.	Dizziness	☐	☐	☐
h.	Fainting spells	☐	☐	☐
i.	Feeling your heart pound or race	☐	☐	☐
j.	Shortness of breath	☐	☐	☐
k.	Pain or problems during sexual intercourse	☐	☐	☐
l.	Constipation, loose bowels, or diarrhea	☐	☐	☐
m.	Nausea, gas, or indigestion	☐	☐	☐
n.	Feeling tired or having low energy	☐	☐	☐
o.	Trouble sleeping	☐	☐	☐

GENERAL MANAGEMENT APPROACHES FOR SOMATOFORM DISORDERS

1. A central feature of definitive treatment strategy is the **doctor-patient relationship**. Repeatedly demonstrated the most helpful intervention for somatoform disorder patients, is ***stable, ongoing relationship with a caring, reassuring, supportive doctor who can empathetically understand & validate their physical & emotional distress***.
2. Clarify limits of interventions on offer & schedule appointments strictly.
3. **Multidisciplinary team**: Due to impact on social functioning, useful to offer couple or family interventions & assistance multidisciplinary team - e.g., social worker, OTs, psychologists,

CONT.

- Pharmacological treatments
  - Treat identified comorbid psychiatric disorders.
  - Medications to treat anxiety & depression: SSRIs
  - Short term use of anxiety meds (***dependence is a risk***)
- Non – pharmacological interventions e.g. **CBT & Integrative therapy**

MANAGEMENT STRATEGY

- **Proactive not reactive**: arrange to see patients at regular, fixed intervals.
- **Broaden agenda**: establish a problem list & let patient discuss relevant problems.
- **Minimize providers** to one or two to reduce iatrogenic harm.
- **Co – opt a relative**, this is a therapeutic ally to help implement, monitor management plan.
- **Cope not cure:** ***cure is an unrealistic expectation***, instead aim for containment & damage limitation & remind patient at each consultation.

TREATMENT AIMS

1. Treatment focus should be on ***coping with symptoms & impairment rather than on symptomatic cure***.
2. Target ***perpetuating factors***:
   - Depression, anxiety or panic disorder
   - Chronic marital or family discord
   - Dependent or avoidant personality
   - Occupational stress
   - Abnormal illness beliefs
   - Iatrogenic factors
   - Pending medical legal claim

TREATMENT PRINCIPLES

- Validate patient experience, e.g., explain that the symptoms real & familiar to doctor
- Provide framework, e.g., ***describe how psychological factors [ABC] may exacerbate somatic symptoms***
- Offer opportunity for discussion of patient's worries at earliest opportunity
- Give practical advice on coping with symptoms & encourage return to normal activity as soon as possible.
- Discuss & agree a treatment plan that includes a planned follow up & review.
- Encourage specific tasks before next meeting, e.g., identify 3 situations that worsen condition.

MANAGEMENT OF SUBTYPES OF SOMATOFORM DISORDERS: SOMATIZATION DISORDER

- A ***poly symptomatic disorder***, starting before age 30, extending over a period of years. It is characterized by ***multiple symptoms in a combination of pain, gastrointestinal, sexual and pseudo neurological symptom areas***.
- **Comprehensive assessment**: medical history of illnesses, surgeries, pain, fatigue; distress produced by symptoms; current medications; abused substances; psychiatric symptoms & comorbid disorders; stressors – past, present, typical response to stress; use additional informants, review medical records.
- Note that: **clinical presentation is considered in context of psychosocial factors, both current & past**.
- Determine if any coexisting or underlying psychiatric disturbance, significant personality features, self-destructive risk, addictive potential.
- Base diagnostic procedures on objective findings & minimize use.
- Patient dialogue, assessment & exam of new symptoms or signs primarily address somatic rather than psychological complaints.

TREATMENT

- No well – established treatment.
- Guiding principle is: "Do no harm". ***Harm may be done by: not considering possible medical basis, unnecessary medical treatment or inadequate treatment for valid medical conditions***.
- Management rather than cure is the goal of treatment. A **therapeutic alliance** should be fostered & maintained**. Social suppor**t & relevant life quality domains carefully reviewed at each patient contact.
- **Psychotherapy***:* Long term individual & group supportive: provide reassuring, sympathetic relationship; use brief, regularly scheduled, widely – spaced sessions, to help cope with their symptoms, to develop alternative strategies for expressing their feelings, ***avoid providing attention only when patient is complaining***.
- **Pharmacotherapy***:* **psychotropic/antidepressants** to treat coexisting or underlying depression & anxiety. Monitor medication.

CONVERSION DISORDER

- Involves unexplained symptoms or deficits **affecting voluntary motor or sensory function suggesting a neurological or medical condition**. psychological factors are judged as being associated with the symptoms or deficits.
- **Primary gain**: internal conflicts remain outside awareness.
- **Secondary gain:** tangible advantages & benefits as a result of being sick.

DIFFERENTIALS

- **Neurological/medical disorders**: dementia, brain tumors, SDH, basal ganglia disease, myasthenia gravis, MS, myopathies, optic neuritis, SLE, acquired, hereditary and drug – Induced dystonia.
- **Psychiatric**:
  - Schizophrenia: hallucinations presenting with conversion disorder generally present w/o other psychotic symptoms & often involves more than one sensory modality w/vague or fantastic content.
  - Anxiety disorder: consider high anxiety states with phobia, panic attack associated w/somatic c/o.
  - Depression

MANAGEMENT

- **Assess:** physical symptoms, meds, substances, psychiatric symptoms, stressors
- **R/O** medical conditions or if may be intentionally feigning symptoms.
- **Treatment Considerations**
  - Address current psychosocial stressors with ***environmental manipulation***, ***support***, ***advice***, ***coping skills***, ***reduce any reinforcers***, ***sources of secondary gain***, ***supportive consequences***, *talk of physical symptoms*.
  - ***Insight – oriented therapies not indicated.***

COURSE & PROGNOSIS

- <u>Acute</u>: positive expectation to recover; physical therapy face-saving way for patient to recover.
- <u>Chronic</u>: physical rehab, suggestion, psychotherapy.
- <u>Good prognosis predictors:</u>
  - Good premorbid adjustment
  - Sudden onset
  - Identifiable stressor
  - Short duration
  - No comorbid psychiatric/medical disorders
  - Above average IQ
  - No ongoing litigation
  - Short interval from onset to treatment initiation
  - Paralysis
  - Aphonia
  - Blindness
- <u>Poor prognosis predictors:</u> tremor, seizures

PAIN DISORDER

- Pain is the predominant focus of clinical attention, also, psychological factors judged to play important role in its onset, severity, exacerbation & maintenance.
- **Assessment**: Collect information regarding physical symptoms, medical conditions, substances, psychiatric symptoms, stressors & conflicts.
- Identify & treat comorbid disorders
- R/O factitious disorder or malingering.

CONT.

- **Pain management**: Target physical, psychological chronic pain. ***Validate patient's pain, don't challenge***.
- **Pharmacotherapy**:
  - ***Analgesics, nerve blocks → not helpful***
  - **Antidepressants** useful; effective even with low dosages
  - Teach pain coping & participating in regularly scheduled activities despite pain
  - Adapting to a potentially chronic condition; not let the pain to become the determining factor in one's lifestyle.
- **Psychotherapy:** Patient's pain validation, examine interpersonal ramifications in patient's life; relaxation, reinforce shift of focus away from pain, develop a solid therapeutic alliance; gain sense of control over pain, develop ability to cope with stress, **Biofeedback** helpful; **hypnosis**.
- **CBT techniques:** distraction, stress management, restructuring, activity pacing, sleep management, log activities attempted & pain level associated with each.

BODY DYSMORPHIC DISORDER (BDD): TREATMENT:

- Distinguish BDD from normal concerns about appearance or overvaluing of appearance (delusional, resistant to reality testing /reassurance; significant distress or impairment).
- Assess for any patient with a coexisting mental disorder, such as depressive or anxiety disorder, ***coexisting disorder should be treated with appropriate pharmacotherapy and psychotherapy***.

CONT.

- **Medications: SSRI's** that work for OCD – effective in 50% pts.
  - SSRI's at higher doses and for longer duration.
- **TCAs**, **Pimozide** useful.
- **CBT**: exposure, response prevention, self – esteem building, coping strategies & modifying distorted thinking.

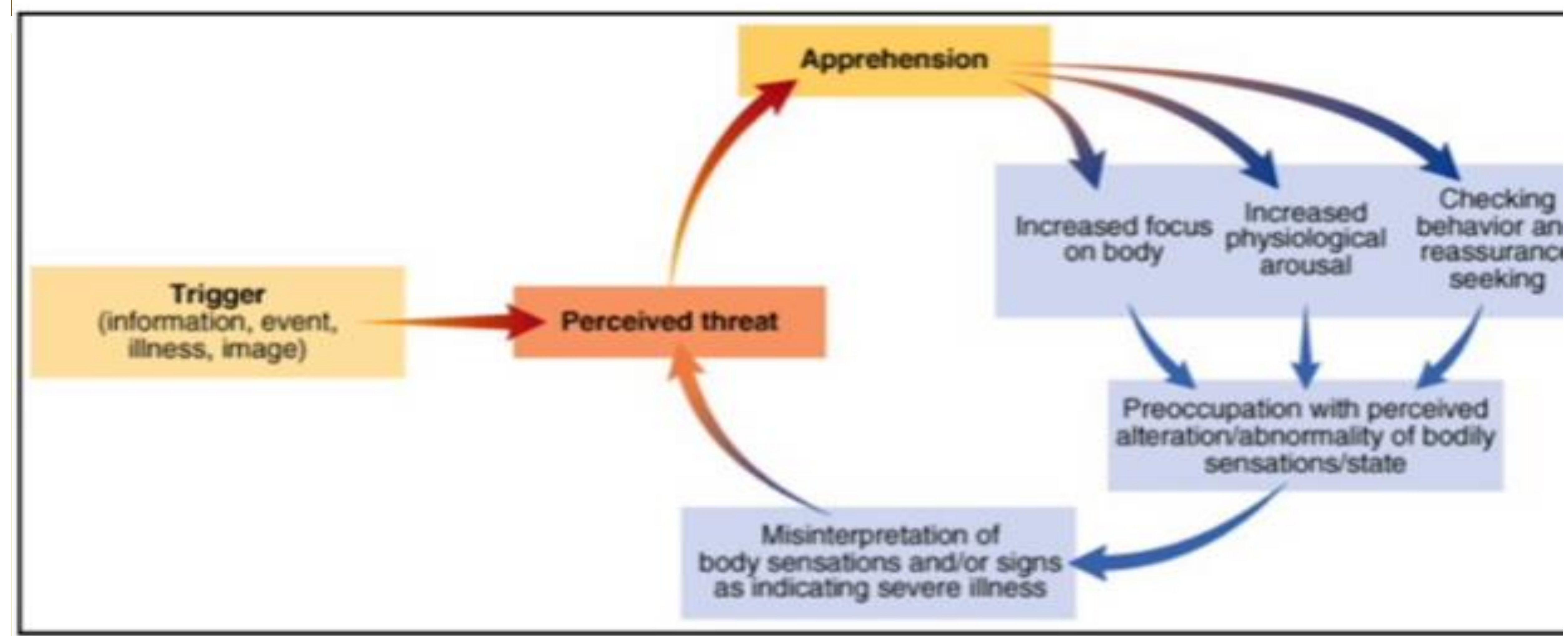
HYPOCHONDRIASIS TREATMENT

- Hypochondriasis pts tend to resist psychiatric Rx or accept if it given in a medical setting, focuses on ***stress reduction & chronic illness coping education***.
- ***Group therapy is the modality of choice***; its social support/ interaction reduces anxiety.
- Frequent, regularly scheduled physical exams reassure pts, c/o taken seriously. Do invasive diagnostic/ therapeutic procedures only, if objective evidence calls for them and refrain treating incidental physical exam findings.

CONT.

- **CBT:** Pts shown how to create symptoms by focusing attention on certain body areas, reduce excessive attention to sensations, identifying, challenging illness-related misinterpretations of bodily sensations and negative perceptions about sensations. Reassurance, education regarding symptoms origins. ***Discourage reassurance seeking from medical professionals***.
- **Pharmacotherapy:** ***Medication alleviates hypochondriacal symptoms only if there is underlying drug-responsive condition***, e.g., anxiety or depression. If secondary to another primary mental disorder, that disorder treated in its own right. If it is transient situational reaction, help pts cope with stress without reinforcing use of the sick role or illness behavior as a solution to their problems.

- Causes of hypochondriasis



Cognitive-Behavioral Tx of Hypochondriasis

- Results:
  - 36.5% no longer had DSM-IIIR Hypochondriasis
  - Hyp sample has less hyp and somatiz than at base
  - Less disease conviction & somatiz at baseline were associated with loss of Hyp dx at follow-up
  - Sig more medical illness during FU interval occurred in those patients who were no longer Hyp

REFERENCES

1. The African textbook of psychiatry & mental health by Ndetei et al 2006
2. Kaplan & Saddocks Synopsis Psychiatry: Clinical Psychiatry , 2007

C5. SEXUAL DISORDERS & PSYCHOSEXUAL THERAPY

BY: DR. M. MATHAI

OBJECTIVES OF LECTURE

- To familiarise students with sexual conditions that they may encounter as doctors.
- Reduce the feelings of embarassment & helplesnness when encountered with this area of human function.
- Introduce some skills that can be relevant in dealing with sexual disorders.

SEXUAL DISORDERS- INTRO

- DSM IV- looks at Sexual disorders in 3 categories

1. Sexual dysfunctions: failure of function
2. Paraphilias: unusual forms of sexual expression
3. Sexual identity disorders: ***subjective awareness of sexual self (read up)***

COMMON DYSFUNCTIONS INCLUDE

- Lack or loss of interest
- Sexual aversion
- Lack of sexual enjoyment
- Failure of genital response: vaginal dryness in females, erectile failure in men
- Orgasmic dysfunction
- Premature ejaculation
- Non organic vaginismus
- Non organic dyspareunia

SEXUAL DYSFUNCTIONS – CLASSIFICATIONS DSM IV

Sexual desire disorders

- ***Hypoactive sexual desire***: persistent or recurrent **deficient or abscent sexual fantasies & desire** for sexual activity.
- ***Sexual aversion disorder***: persistent or recurrent **extreme aversion to & avoidance of all or almost all genital sexual contact** with a sexual partner.

SEXUAL AROUSAL DISORDER

- **Female sexual arousal disorder**: persistent or recurrent inability to attain, or maintain untill completion of sexual activity, an **adequate lubrication – swelling reponse** of sexual excitement.
- **Male erectile disorder**: persistent or recurrent inability to attain or maintain until completion of the sexual activity, **an adequate erection**.

ORGASMIC DISORDERS

- Female & Male: persistent or recurrent delay in, or **absence of, orgasm** following a normal sexual excitement phase (***in females age, experience and adequacy of sexual stimulation should be taken into account***).
- Premature ejaculation: persistent or recurrent **premature ejaculation** with the minimal sexual stimulation before on or shortly after penetration & before the person wishes it.

SEXUAL PAIN DISORDERS

- **Dyspareunia** not due to general medical condition: persistent or recurrent **genital pain** associated with sexual intercourse in either male or female.
- **Vaginismus**: persistent or recurrent **involuntary spasm of the musculature of the outer third of the vagina** that interferes with sexual intercourse.

IMPORTANT FACTORS IN DIAGNOSIS INCLUDE:

- The disturbance causes **marked distress** or **interpersonal difficulty.**
- The disturbance is **not** accounted for by a **general medical condition** or the physiological effects of a substance.
- In some of the dysfunctions factors that affect sexual functioning like **age & context** of the person's life must be taken into account.

SUBTYPES

- **Lifelong (primary)** or Acquired type **(secondary)**
- **Generalised** or **situational**
- Due to psychological factors or Due to combined factors

ORGANIC SEXUAL DYSFUNCTIONS

- Sexual dysfunctions due to a general medical condition
- Substance – induced Sexual dysfunction

II. PARAPHILIAS CLASSIFICATIONS DSM IV

- Check DSM IV classification

NORMAL & ABNORMAL?

- There is immense cultural variation in sexual behaviour across culture and times.
- So what is implied by normality, abnormality, natural or unnatural, immoral sex?
- How do we decide what is normal sex?
- **The guidelines for determining our normality is based on what friends or relatives reveal as normal and what is depicted in the media.**

SEXUAL DIVERSITY

- Sexual diversity can be viewed as existing in a **continuum** with the frequency that individuals engage in different types of sexual practices ranging from never to always.
- Under this understanding of sex ***there is no normal or abnormal***.
- One can then talk about an individuals behaviour being **more or less typical** or **atypical** of the group average to which he/she belongs.

DEFINITION

- Paraphilias are frequent, intense, sexually arousing fantasies or behaviors that involve **inanimate objects, children or nonconsenting adults, or suffering or humiliation of oneself or the partner.**

NORMALITY OR PERVERSION?

- Some degree of variety in sexual activity is very common in healthy adult sexual relationships & fantasies.
- Mutual agreement to engage in noninjurious sexual behaviors of an unusual nature may be part of a loving & caring relationship.
- When taken to the extreme, however, such sexual behaviours are perverted.

CT

- Partners of people with a paraphilia may feel like an object or as if they are unimportant or unnecessary in the sexual relationship.
- Paraphilias cause significant distress & interfere with functioning.
- Distress may result from, criminal elements of some paraphilias, other people's reactions or from guilt about doing something socially unacceptable.

DSM IV CLASSIFICATION

- Exhibitionism
- Fetishism
- Frotteurism
- Pedophilia
- Sexual masochisim
- Sexual sadism
- Transvestic fetishism
- Voyeurism
- Paraphilias not otherwise specified

DSM IV CRITERIA

- Period: ***6 months***
- Acting on the urges or that the urges cause ***marked distress or interpersonal difficulties or social-occupational impairment or impairment in other important areas of functioning***.

EXHIBITIONISM

- **Recurrent intense sexually arousing fantasies, sexual urges or behaviours to expose ones genitals to strangers**
- Exhibitionists are usually males who expose their genitals, usually to unsuspecting strangers & become sexually excited when doing so. The victim is almost always a woman or a child of either sex. Actual sexual contact is almost never sought.
- Exhibitionism usually starts when people are in their mid 20s. Most exhibitionists are married, but the marriage is often troubled.

FETISHISM

- **Recurrent intense sexually arousing fantasies, sexual urges or behaviours involving the use of non living objects for sexual satisfaction (*does not include sex toys*).**
- People with fetishes may become sexually stimulated & gratified by wearing another person's undergarments, wearing rubber or leather, or holding, rubbing, or smelling objects, such as shoes.
- People with this disorder may not be able to function sexually without their fetish. The fetish may replace typical sexual activity with a partner or may be integrated into sexual activity with a willing partner.

FROTTEURISM

- Recurrent intense sexually arousing fantasies, sexual urges or behaviours involving touching & rubbing against a non – consenting person

PEDOPHILIA

- Recurrent intense sexually arousing fantasies, sexual urges or behaviours involving sexual activity with a prepubescent child or children- generally children under 13 (may not correspond to definition of statutory rape)
- The person is at least 16 years and at least 5 years older than the victim
- Specifications- attracted to males, females or both
- May be limited to incest
- May be exclusive type (attracted only to children or non exclusive)

SEXUAL MASOCHISM & SADISM

- Recurrent intense sexually arousing fantasies, sexual urges or behaviours involving the act (real or simulated) of being humiliated, beaten, bound, or otherwise made to suffer
- Recurrent intense sexually arousing fantasies, sexual urges or behaviours involving the act (real or simulated) in which the psychological or physical suffering (including humiliation of the vicitm is sexually exciting to the person
- Some amount of sadism and masochism is commonly play-acted in healthy sexual relationships, and mutually compatible partners often seek one another out. This may not be considered a disorder.
- In contrast, the disorder of sexual masochism or of sexual sadism takes these acts to an extreme or involves nonconsenting victims (and thus constitutes a crime). Some acts result in severe bodily or psychologic harm and even death.

TRANSEVESTIC FETISHISM

- **Recurrent intense sexually arousing fantasies, sexual urges or behaviours in a heterosexual male involving cross dressing.**
- In transvestic fetishism (cross-dressing), men prefer to wear women's clothing, or, far less commonly, women prefer to wear men's clothing. However, they do not wish to change their sex, as transsexuals do. Cross-dressing may not hurt a couple's sexual relationship, although if a partner is not cooperative, transvestites may feel anxious, depressed & guilty and ashamed about their desire.
- Some men who appear to be transvestites only in their teens & twenties develop gender identity disorder later in life & may seek to change their body through hormones and genital surgery.

VOYEURISM

- **Recurrent intense sexually arousing fantasies, sexual urges or behaviours involving acts of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity**
- As a disorder, voyeurism is much more common among men. Voyeurs spend a lot of time seeking out viewing opportunities. It may become the preferred method of sexual activity & consume countless hours of watching.

PARAPHILIAS NOT OTHERWISE SPECIFIED

- Telephone obscenity
- Necrophilia
- Zoophilia
- Coprophilia
- Klismaphilia(enema)
- Urophilia

TREATMENT OF PARAPHILIAS

- Most paraphilias are ***very resistant to treatment***
- Rarely do people suffering from paraphilias seek treatment voluntarily- ***usually being forced to seek treatment after being arrested***
- Treatment includes:
  - Psychotherapy
  - Support groups
  - Antidepressants (esp. SSRIs)
  - Drugs that alter the sex drive & reduce testosterone levels in males.

MANAGEMENT OF PSYCHOSEXUAL DYSFUNCTIONS

- ***Sex therapy (Psychosexual therapy)*** Refers to the psychological treatment of non organic sexual dysfunctions.
- Often closely related to ***relationship couple therapy***.

HISTORICAL DEVELOPMENT

- Interest in sexuality in modern times:
  - **Freud** Psychosexual development &the psychoanalysis.
  - **Alfred Kinsey**: Sexual behaviour in the Human Male (1948); Sexual behaviour in the Human Female (1953).
  - **Masters & Johnson:** Human sexual response (1966)

LEVELS OF PSYCHOSEXUAL INTERVENTION: THE PLISSIT MODEL

- **P**ermission: acknowledging human sexuality & possible dysfunctions.
- **LI**mited information: basic information/ Psychoeducation
- **S**pecific **S**uggestions: making specific suggestions, exercises & strategies
- **I**ntensive **T**herapy: requires referral to a psychosexual therapist

THERAPIST'S ATTRIBUTES

- Feeling comfortable talking about sex
- Being conversant with the local language of sex
- Being conversant with cultural aspects related to sexuality- beliefs, myths, attitudes, practices
- Having the basic knowledge about sex & sexuality to give education
- Attitude- ability to listen, empathy, non-judgmental, non moralistic

INITIAL SESSION: A COMPREHENSIVE MEDICAL & PSYCHIATRIC HISTORY & AN MSE

1. Important in all cases to rule out organic conditions
2. Detect other related psychiatric disorders or comorbidity
3. Embarrassment about talking about sex & admitting to a sexual problem are big hindrances and therefore asking about sexual history is important even if this is not part of the presenting complaints- particularly in medical and psychiatric conditions where sexual dysfunctions are suspected
4. Decision should be made whether to include partner in therapy

WITH OR WITHOUT PARTNER

With Partner

1. Allows observation of couple interaction & communication
2. Partner as informant
3. Avoids stress & anxiety when patient comes home with new strategies or behaviour after therapy
4. Reduction of potential threat & conflict in the relationship & increases support of the afflicted partner
5. Enhances sexual satisfaction

Without Partner

- Treatment of individuals without partners follows a different approach that takes into account the reasons for lack of partner.

IMPORTANT STAGES IN THERAPY

- Determining whether the problem is ***primary or secondary*** has the problem always been there or has it developed over time
- Is the problem ***total or situational***
- What are the related ***psychosocial factors*** ie., relationship, tiredness, lack of privacy, fear of pregnancy or infections.

SOME FORMS OF THERAPY

- Basic psychoeducation & reassurance
- Behavioural therapy
- Combined

THE STAGES OF THE SEXUAL RESPONSE CYCLE IN MALES & FEMALES BY MASTERS AND JOHNSON

1. Desire
2. Excitement: characterised by physiological changes in the genitals
3. Plateau: ↑ HR, BP, RR, Muscle tension
4. Orgasm: single or multiple rhythmic muscular contractions & ejaculation in males
5. Resolution

Read more on this- Getting the most out of psychosexual therapy- understanding the sexual response (PDF)-Written by ROSE WHITELEY for the Porterbrook Clinic, Sheffield

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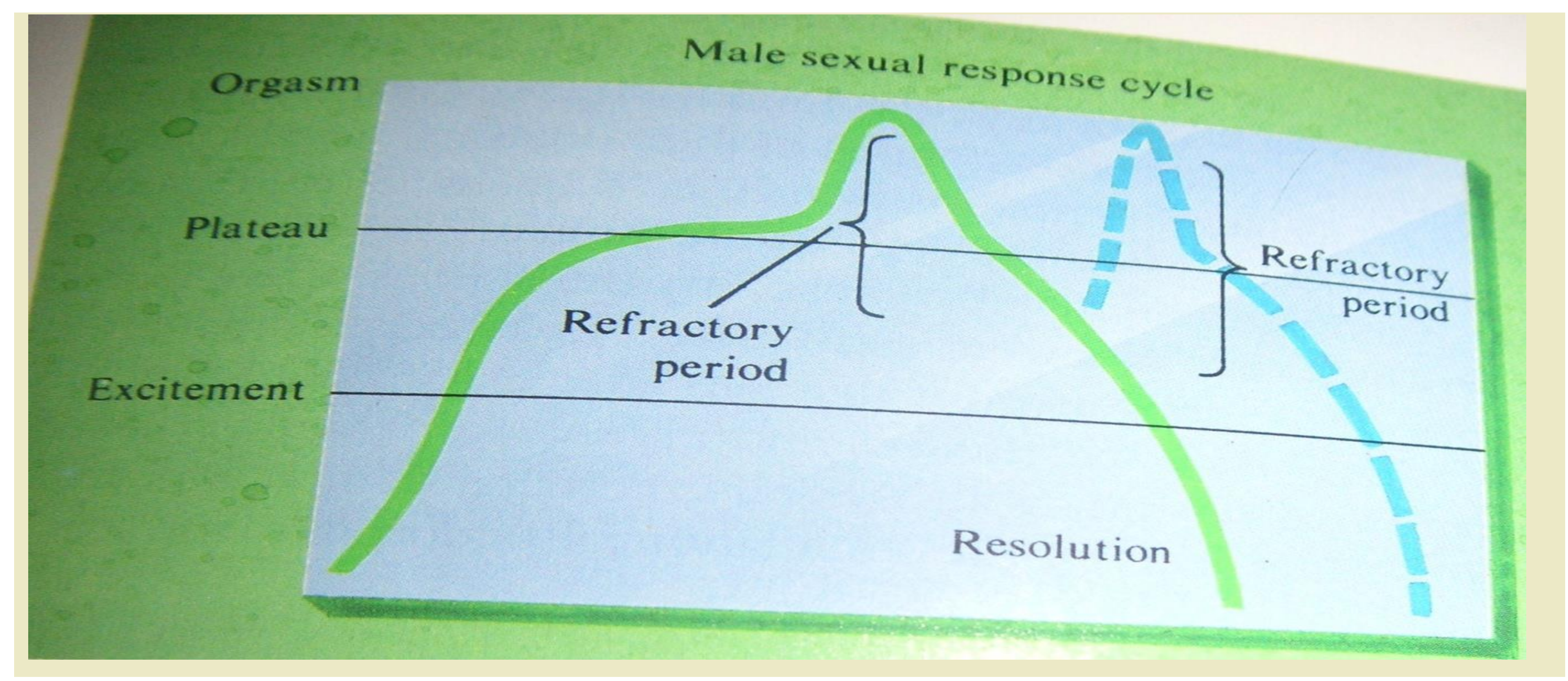
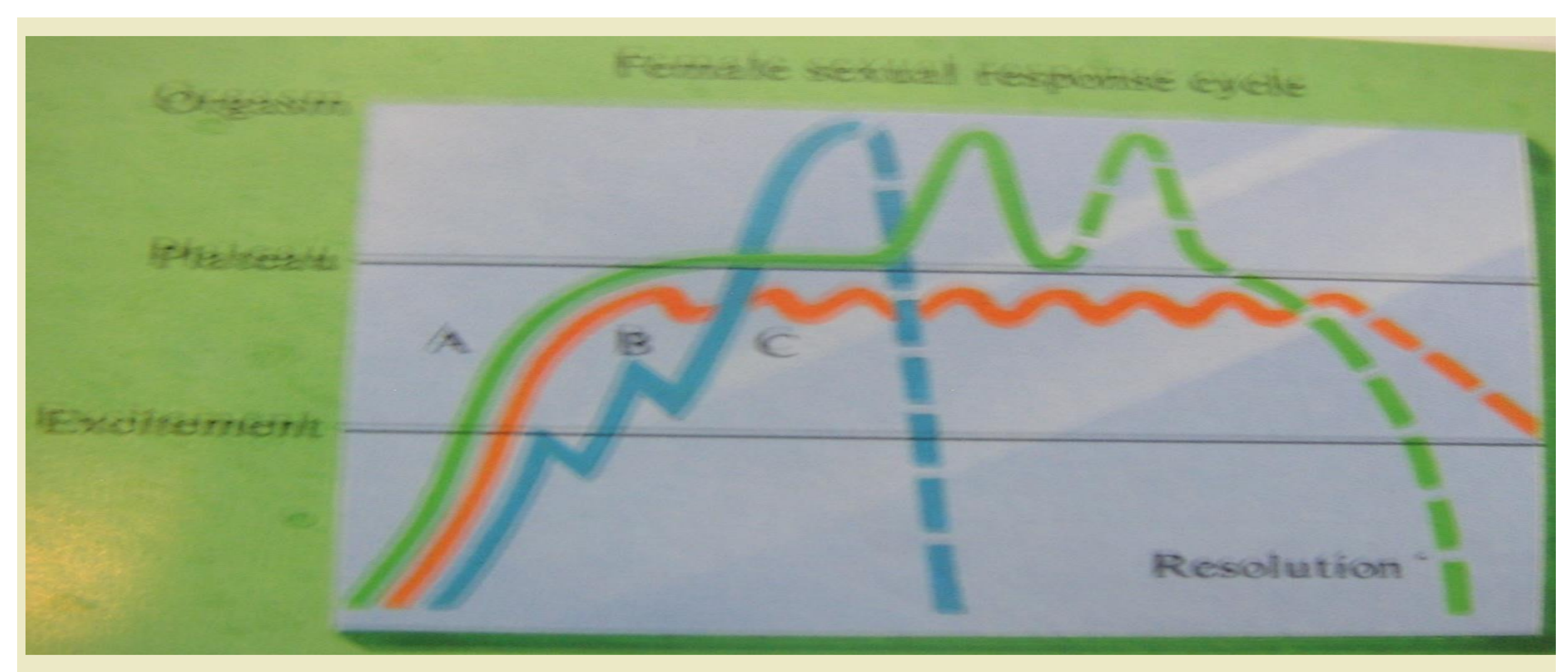
MALE SEXUAL RESPONSE CYCLE



FEMALE SEXUAL RESPONSE CYCLE



SPECIFIC SUGGESTIONS/STRATEGIES

- Behaviour therapy
- Self Exploration & directed masturbation
- Sensate focus for couples
- Kegel's Pelvic floor exercises
- Sexual fantasies
- Lubricants

THERAPY OF SOME COMMON CONDITIONS: FAILURE OF GENITAL RESPONSE IN WOMEN

- Investigate factors that may inhibit arousal: Partner Arousal techniques, Lack of privacy, tiredness, beliefs and cultural practices (FGM)
- Psychoeducation: female sexual and physiological anatomy, the female sexual response cycle, the use of lubricants
- Use of erotic material

THERAPY OF SOME COMMON CONDITIONS: FAILURE OF GENITAL RESPONSE IN MEN

- Erectile failure
- Investigate: childhood- socialisation religious moralistic sexual attitude- punishment for sexual play,
- Adolescence sexual experiences
- Performance anxiety may be related to premature ejaculation
- Psychosexual education
- Self and partner stimulation
- Use of erotic material
- The use of Viagra: cause a relaxation of penile blood vessels and increasing blood flow
- Other forms of physical treatment: ***penile prosthesis***, ***prostaglandin E1 injection***

ORGASMIC DYSFUNCTION IN WOMEN

- Treatment: rule out other sexual disorders
- Psycho-education: female sexual response cycle
- Behaviour therapy: Exercises → directed masturbation
- Sensate focus for couples
- Kegel Pelvic floor exercises
- Sexual fantasies

SENSATE FOCUS FOR COUPLES – PARTNER EXPLORATION

- Starts with non genital caressing progresses to genital & eventually sexual intercourse
- Concentration should be on pleasurable feelings rather than striving for erections and orgasms.

KEGEL'S PELVIC FLOOR EXERCISES

- Repeated contraction, holding & relaxation of the pelvic muscles
- Strengthens the pelvic floor muscles & increase womens' ability to recognise sensations in this area

FANTASY

- Permission giving in the use of sexual fantasies
- Use of erotic literature and media material

PREMATURE EJACULATION

- Inability to control ejaculation adequately for both partners to enjoy sexual interaction → ejaculation before or just after penetration
- Usually primary – men who never learnt how to control ejaculation
- ***May be a history of rapid frequent masturbation associated to guilt.***
- Reaction – anger, frustration, accusations/ condemnations which make condition worse
- Happens to all men sometimes & is normal.
- Can also be secondary in times of stress, anxiety or long periods of abstinence

PREMATURE EJACULATION – THERAPY

- Psycho – education: myths & beliefs → issues that contribute to performance anxiety
- Specific exercises

1. ***Seman's technique***: stop start technique (arousal and pauses) with graded approach starting with sensate focus – genital stimulation & eventually penetration.
2. The squeeze technique: can be started at failure of above squeeze the head of penis 10 – 20 seconds until the urge to ejaculate goes down.
3. Sensate couple focus.

NON ORGASMIC VAGINISMUS

- Penetration is impossible or painful because of a spasmodic contraction of the vaginal muscles- pelvic floor muscles
- Causes fear of penetration and anticipation of pain
- Previous sexual trauma
- Religious & cultural beliefs → causing fear or guilt
- Childhood punishment for masturbation
- Fear of pregnancy or painful labour
- In Vaginismus → penetration causes pain → vicious cycle or complete abstinence

VAGINISMUS- THERAPY

Psychosexual education:

- Treatment of underlying psychological disorders & dispelling myths
- Giving permission to enjoy sex
- Relaxation technique → progressive muscle relaxation → reduces generalised muscular tension
- Kegel's exercise → to teach control of the pelvic muscles

TEACHING SPECIFIC STRATEGIES

- Gradual progression from self exploration to sexual penetration
- Self exploration
- Insertion of graded trainers
- Sensate couple focus
- Graded penetration from object to penile
- Sexual position: position in which woman can control penetration

NON ORGANIC DYSPAREUNIA

- In men usually related to physical causes: common in men infections, scarring tight foreskin
- In women may also be related to physical conditions or poor arousal response
- Psychoeducation on arousal- important
- Modification of intercourse positions- use positions with less penetration

C6. GENDER BASED SEXUAL VIOLENCE & MANAGEMENT

BY: DR. M. MATHAI

WiLDAF
SCREAM
End the plague of sexual violence in Kenya.

OBJECTIVES OF THIS LECTURE

By the end of this lecture Student should be able to:

- Define gender based sexual violence (SGBV)
- Describe the magnitude of the problem
- Discuss the socio-cultural factors associated with SGBV
- Describe the impact of SGBV on Mental health
- Describe Sexual violence/defilement in children
- Discuss the concept of "one stop centers" in the management of Sexual Violence
- Outline the management of sexual violence
- Outline the steps in the collection of forensic evidence in cases of SV

GENDER BASED SEXUAL VIOLENCE AND GBV INTRODUCTION I

- GBSV is one component of GBV
- What is – gender?
- the term "gender" is used to refer to the <u>social and cultural constructions</u> of masculinities and femininities. It does not refer to biological difference, but rather cultural difference.

GENDER BASED VIOLENCE- INTRODUCTION II

What acts of violence are referred to under GBV

- Physical and emotional violence based on gender of victim
- domestic violence
- Sexual violence
- Cultural violence like Female Genital Cutting

SEXUAL VIOLENCE

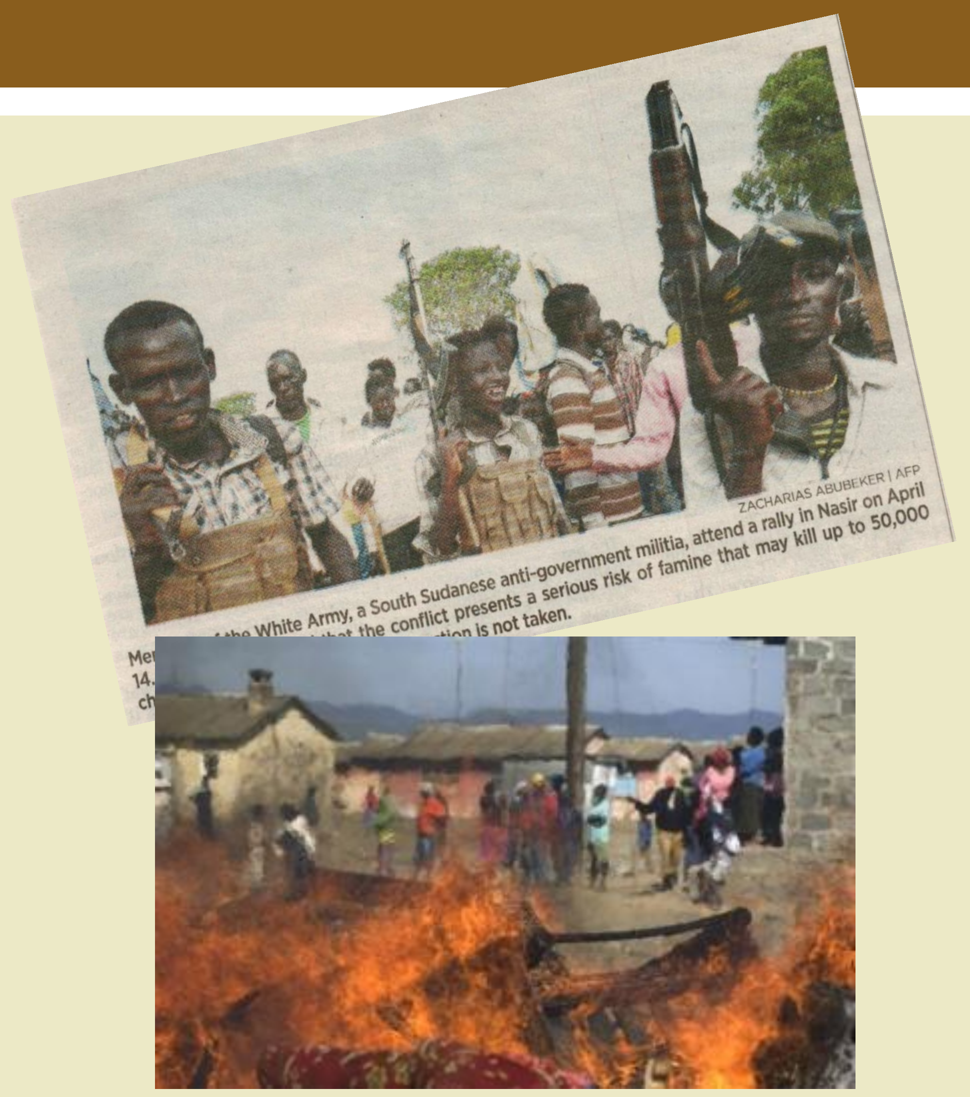
- WHO def: „any **sexual act**, **attempt to obtain a sexual act**, **unwanted sexual comments** or **advances** or acts to **traffic women‘s** sexuality using coercion, threats of harm or physical force, by any person regardless of relationship to victim, in any setting including but not limited to home and work“
- Sexual abuse refers to a range of sexual activities- **non consensual between adults** or even **consensual when a minor is involved.**

PREVALENCE OF GBV- SEXUAL VIOLENCE

- On average it has been estimated that out of every 10 women born in a country 4 will be raped during their life time
- Police statistics indicate a rape case every 26 minutes- 58 per day in Kenya
- Increase in conflict situations: Humanitarian groups reported between 1000-1500 cases of sexual violence during the post election Violence 2007

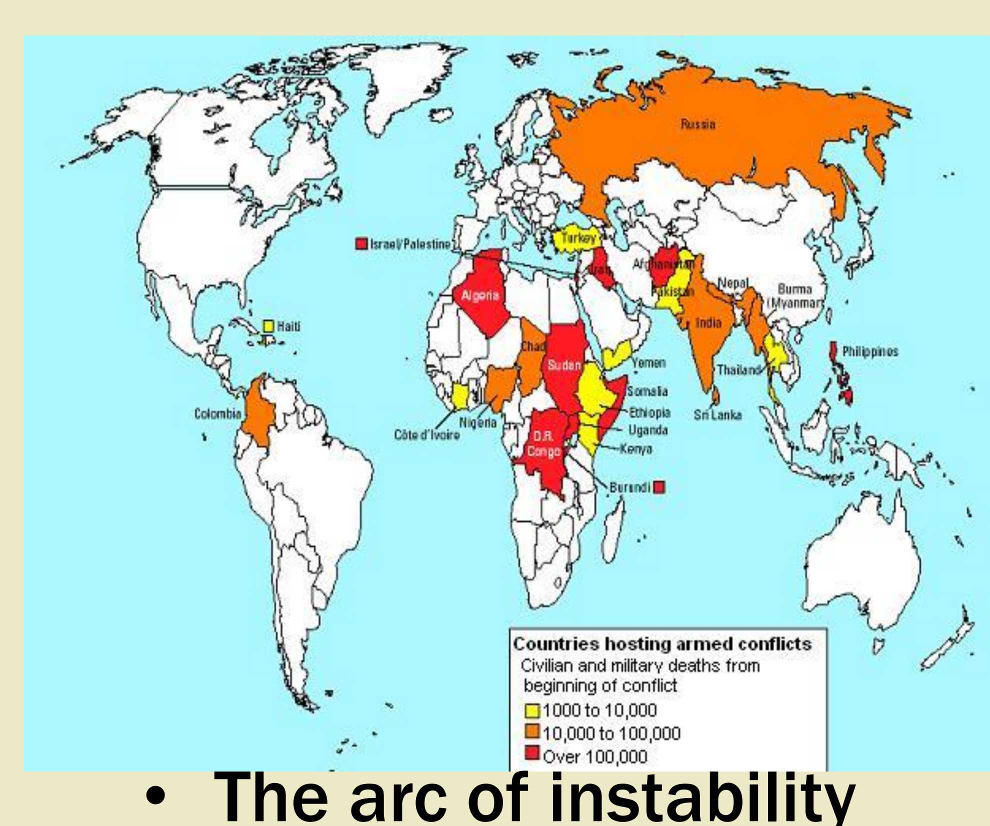
SEXUAL VIOLENCE IN ARMED CONFLICT

- “Sexual violence in warfare is among the darkest legacies of the 20th century, and it continues to ravage societies in the new millennium”. Leatherman 2012, pg 2



CONT.

- **It is estimated that more than 150 million women and girls and 73 million boys experience sexual violence every year (WHO 2002).**
- Systematically organized rape as a weapon of war is as old as history.

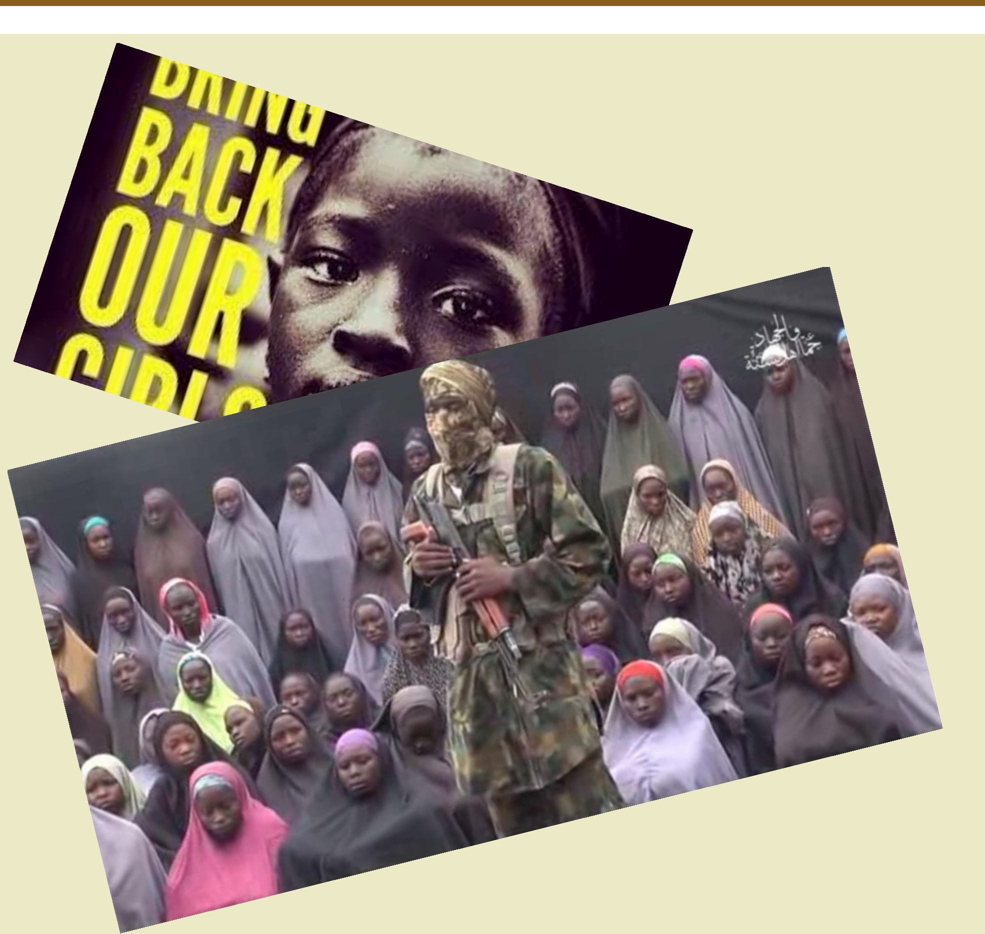


- The arc of instability

ATROCITIES AGAINST WOMEN'S BODIES

The horror stories!

- Rape and gang rape
- Sexual humiliation and mutilation
- Forced Incest
- Forced prostitution and sexual enslavement
- Kidnap and Forced marriages
- Violent abortion of fetuses in pregnant victims
- Forced pregnancy.
- Deliberate infection with STIs and HIV.



GENDER BASED VIOLENCE- INTRODUCTION III

- The rape of women is not about sexual pleasure
- The rape of women is about the exercise of power and control
- Acts of violence in most cultures are perpetrated against women by men by virtue of the female gender being:
  1. Weaker physical strength
  2. Low status in society
  3. Lack of resources
  4. Dependency
  5. Socio-cultural norms

SEXUAL OFFENCES ACT

SOA of 2006 includes:

- Includes 12 forms of sexual violence

SEXUAL OFFENCES ACT

SOA of 2006 includes:

- **Rape:** penetration with his/her genital organs-No consent or consent obtained through force
- **Attempted rape**
- **Sexual assault**
- Induced **indecent acts**- contact with private parts/ use of objects, bestiality

SEXUAL OFFENCES ACT CONT

- Defilement- Penetration with child
- Pornography- manufacture/distributes/supplies/display
- Child trafficking
- Sex tourism
- Child prostitution
- Prostitution of persons with mental disabilities
- Incest
- Sexual harassment- Unwelcome Sexual advances

PSYCHOLOGICAL EFFECTS OF SEXUAL ABUSE

- Include:
  - Anxiety disorders- any and particularly: Acute stress disorder and PTSD
  - Somatoform disorders/ somatic syndrome disorders
  - Dissociative disorders
  - Depression
  - Substance abuse
  - Can provoke the onset or relapse of psychotic disorders

RAPE AND PTSD

- Rape has been found to be the most adverse single event in the causation of PTSD (also referred to as ***rape trauma syndrome***)- leading to PTSD in about half of the survivors.

SEXUAL ABUSE IN CHILDREN

- Defined:- Sexual behavior between a child and an adult
- Between 2 children when one of them is significantly older and / or uses coercion
- In the SOA referred to as defilement.

CHILD SEXUAL ABUSE- CONT.

- Child sexual abuse is usually associated with high levels of both physical and psychological damage
- Psychological sequalae are worsened by the inability of the child to relate the event or the inatentiveness of important others
- The trauma of abuse in children may result in permanent neurobiological damage of the brain
- Most children are abused by known and even trusted people
- Most children are repeatedly abused

COMMON PSYCHOLGICAL SEQUALAE INCLUDE:

- Inability to trust
- Depression
- Anger
- Guilt
- Fear
- Damaged good syndrome
- Decreased Self esteem
- Blurred boundaries and role confusion
- Pseudo maturity/ precocious sex behavior
- PTSD

PART II: MANAGEMENT OF GENDER BASED SEXUAL VIOLENCE

- The management of gender based violence particularly rape should follow a multidisciplinary and multisectoral approach
- It is therefore important that health workers and others in the first line of contact be well trained in different aspects of management
- The trend now is towards setting up ‚one-stop centres' at all levels of health care

ONE STOP CENTRES

- The concept of one-stop centres tries to incoorporate all post rape care services under one roof
- These include:

1. Gynecological
2. Psycho-social
3. Surgical
4. Paediatric
5. Laboratory
6. Law enforcement and Legal

PRESENTATION OF CASES

- Acute
- A few days later
- Sometimes months or years
- Acute presenting picture may vary from calm to shock, tearful, mute, to severely agitated
- Some calm presenting clients may develop severe psychiatric problems later

EMERGENCY TREATMENT

- Physical examination and repair of any damaged tissues.
- Emergency prophylaxis: ***PEP, ECP, STIp, Analgesics***
- Post rape trauma counselling/crisis intervention

COLLECTION OF FORENSIC EVIDENCE

- Patient should not wash before examination and Collection specimens
- Special PR kit should be used- if not present improvise- do NOT use Plastic bags to store specimens (paper/karatasi bags) Include- perineal/vaginal/Anal/oral swabs, pubic hairs (combed through) Clothes (underwear),
- Post Rape Care form 2 /P3 be very specific, detailed and precise
- Material should be handed over to a law enforcement agent who should sign for it

PSYCHIATRIC MANAGEMENT

- Psychiatric management includes treatment at contact and follow-up

1. Pharmacotherapy
2. Psychotherapy
3. Sociotherapy

PHARMACOTHERAPY

- ***Sedatives-*** short term or if needed for longer periods low doses of Major tranquilizers
- ***Anti depressants***: Selective serotonin reuptake inhibitors (SSRIs) or Tricyclic antidepressants
- ***Mood stabilizers*** like the anti – convulsants

PSYCHOTHERAPY

- Can be individual, group or family or a combination of all three.
- Psychological First Aid (PSA) =Crisis intervention with support, education and development of coping mechanisms- relaxation exercises
- Trauma based CBT- follow-up
- NOTE: Debriefing has been found to result in retraumatisation.

SOCIOTHERAPY

- One of the challenges in management include protection of survivors by providing safe refuge
- This is particularly important in children where the perpetrators are family members or primary care givers

ROLE OF MH WORKERS IN PREVENTION

- Early diagnosis and treatment of survivors
- Treatment of psychiatric disorders
- Education- community, schools, parents
- Creating environments that ensure the safety of women and children, at home, work/school and during conflicts and migration
- Laws-both local and international

ROLE OF POLITICS

C7. MANAGEMENT OF PERSONALITY DISORDERS

BY: DR.
RACHEL
KANG'ETHE

LEARNING OBJECTIVES

1. To learn about different management options of specific personality disorders
2. List & describe some current treatments for personality disorders.

Review: Basic information about personality disorders [PDs]:

The word **'Personality'** derived from Latin word **'Persona'.** In ancient Greek 'Persona' used to describe theatrical mask, Greek actors used to wear on their face before coming to the stage to act. So, in olden days 'personality' used to depict outward appearance of a person. Today the term personality is explained in various ways. >50 different definitions of personality!

"Personality arises from within the individual; remains fairly consistent throughout life & is defined as the characteristic patterns of thoughts, feelings, behaviors that make a person unique.'

Even though, it is difficult to say exactly what "personality" is, we do recognize different personality types: some people are shy, some bold, some serious, some light-hearted.

Personality is the sum total of all the ways of thinking, feeling and acting that make a person unique.

Everyone has a personality, but not all have a PD. People react differently to different situations due to their personalities, but still we expect them to behave within a range of commonly accepted ways.

- **People with PDs are often those whom others regard as "difficult" people.**

What are Personality Disorders [PDs]?

- PDs characterized by problematic thinking patterns; emotional dysregulation/difficulty with impulse control. The most defining feature of PDs is their negative effect on interpersonal relationships.
- DSM defines **PD** as "an enduring pattern of inner experience and behavior that deviates markedly from the person's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment."
- PDs not diseases in the usual medical disease sense but represent varied patterns where the personality system functions maladaptively in relation to its environment.

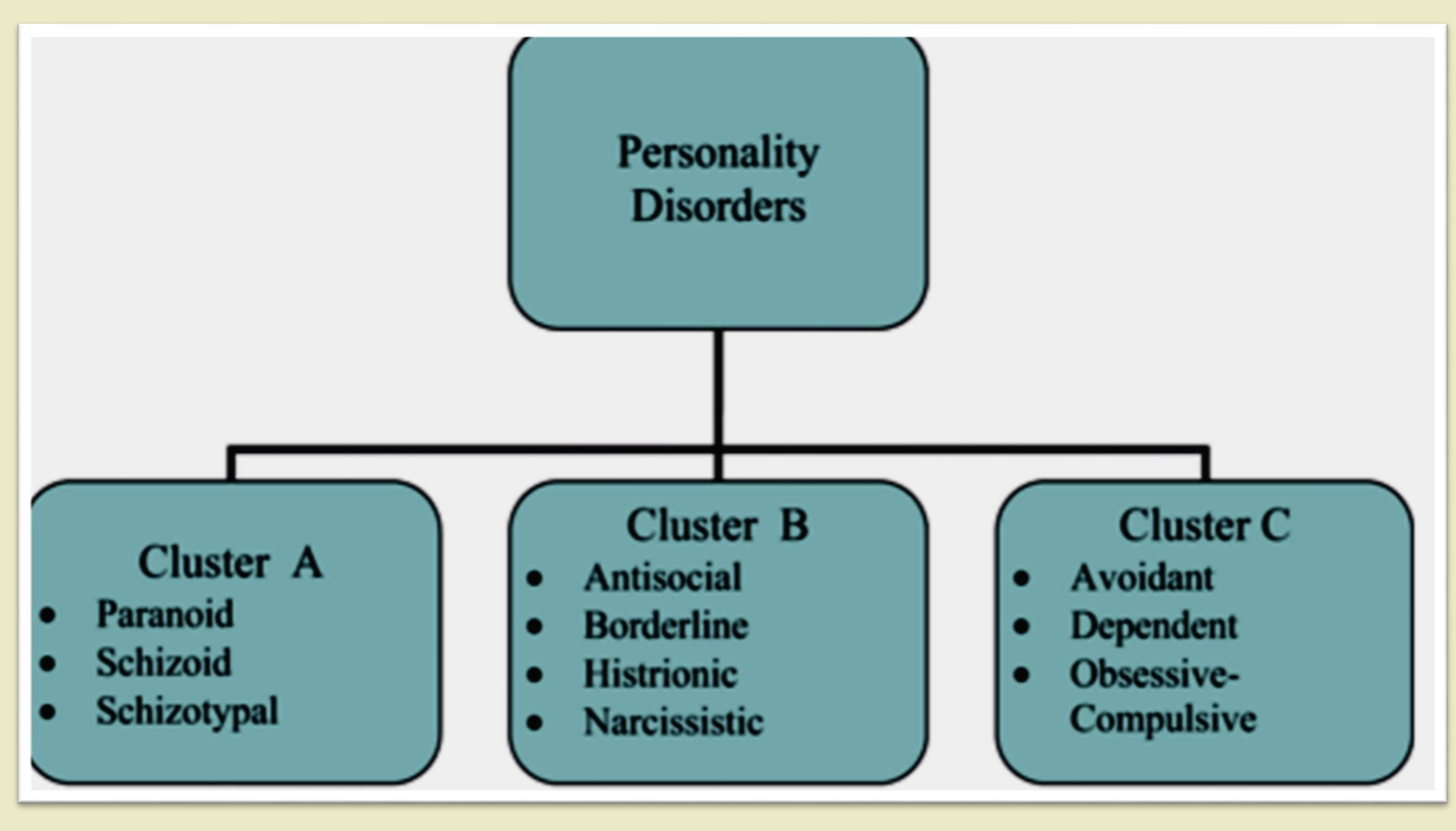
When personality patterns/traits [such as impulsivity, dissocial behavior, aggression, psychasthenic symptoms], are **rigid** & **self-defeating**, they may **interfere with functioning** & lead to psychiatric symptoms, cause more or less **suffering** of individual or other people or both & lead to **maladaptation** in relations, family and work.

3 P's-of-Personality Disorders [PDs]:

1. **P**ersistent: happens frequently
2. **P**ervasive: across many circumstances
3. **P**roblematic-for selves/others

*50% comorbidity among PDs *Comorbidity makes management difficult.

*PDs also ***predisposing factor for many other psychiatric diseases*** e.g., suicide, substance use disorders, mood disorders, impulse-control disorders, eating disorders and anxiety disorders.


Personality Disorders
Cluster A
Paranoid
Schizoid
Schizotypal
Cluster B
Antisocial
Borderline
Histrionic
Narcissistic
Cluster C
Avoidant
Dependent
Obsessive-Compulsive

CLUSTER	PERSONALITY DISORDER	CHARACTERISTICS
A ODD BEHAVIOUR	†Paranoid	Irrational suspicions and mistrust of others
	†Schizoid	Lack of interest in social relationships
	Schizotypal	Odd behaviour or thinking
B DRAMATIC	Antisocial	Pervasive disregard for the law and rights of others; may account for half of prison population in some countries
	Borderline	Instability in relationships, self-image, identity and behaviour
	†Histrionic	Pervasive attention-seeking behaviour: shallow or exaggerated emotions
	Narcissistic	Pervasive pattern of gradiosity: need for admiration and lack of empathy
C ANXIOUS	Avoidant	Social inhibition; feelings of inadequacy
	†Dependent	Pervasive psychological dependence on others
	Obsessive-compulsive	Rigid conformity to rules and moral codes; excessive orderliness

- PDs are “syndromes”, each of the ten DSM-5|DSM-IV PDs is a constellation of maladaptive personality traits, rather than just one particular personality trait.
- People with PDs believe others should change to accommodate them/their wishes & view their features acceptable and not in need of change, i.e. ***“alloplastic defenses”*** experience less distress as direct result of PDs than might be expected.

Which person shows signs that he or she may have a PD?

A Mary, age 36, has been out of work for four years. She has lived with her parents off and on since high school. Every time her roommates did something to hurt her feelings she would move back home. A family friend recently offered her a job as a clerk, but Mary turned it down. She was insulted he didn't offer her a higher position. Last night Mary told her parents they should sell their house and move into an apartment, then give her the extra cash so she can get her own place. She got very upset when they said no.

B Mario, age 36, moved back in with his parents after the company he worked for shut down without warning. He's embarrassed to be living with his parents at his age. Mario has been looking for a job for five months and was starting to worry that he would never find one. A bunch of his pals took Mario out for dinner and told him to keep looking - he would find a job eventually. When he got home he was feeling much better and decided he would send out another bunch of job applications the next day.

PARENTS FROM HELL - Parents with extremely severe personality disorders.

- **Ed Sexton:** When Ed Sexton was young, he killedcats and dogs, torture neighborhood children and set fires. Ed had 11 children by his wife, Estella-May, whom he married just after being released from prison. Ed would humiliate his sons by making them stand naked in front of the whole family while Ed whipped them. All were warned that Ed would kill them if they talked to outsiders. Ed had incestuous relations with all five daughters. Ed encouraged his own children to have sex with one another and usually remained naked while at home, ready to have sex with whomever he pleased. His daughter Pixie became pregnant by her father. He then made her marry Joel, to make it appear as though the child was not born of incest. After she gave birth to Chris, Ed killed Joel, and Pixie killed Chris. Finally Ed was arrested for the murder of his son-in-law.

- **Dr. Debora Green,** another parent with narcissistic, sadistic characteristics plus psychopathic traits, was given to outbursts of rage that were exacerbated by her alcoholism. When her husband spoke of divorce, Debora tried to poison him with ricin, which led to his being hospitalized 11 times before it became clear that she was trying to kill him. She then threatened suicide, at which point her husband committed her to the Menninger Clinic. While at the Menninger Clinic, she had fantasies of becoming a psychiatric resident, seemingly unaware that she lacked even the characteristics of a workable psychiatric patient, let alone those of a psychiatrist. She signed out after 4 days and warned her husband, “You’ll get those kids over our dead bodies.” She spread accelerant over their house and set fire to it, killing two of her three children.

- **Mary Bell:** Betty, mother of Mary Bell, a girl who murdered two young boys in England, was a neglectful prostitute, who forced her daughter from age 5 years to have sex with various men she brought home. Betty tried to kill Mary many times during her first year. When Mary was 8 years old, her mother tried to drown her by pushing her head underwater. Betty often throttled her daughter till she was unconscious. Mary re-enacted this behavior herself, in that, when by Mary was 11 years old, she strangled birds and cats and then two boys (each was 2 years old), for which she was sent first to a reformatory and, later, to prison. As time went on, she rehabilitated, morally and spiritually. She now lives under a different name and has married and has a child of her own. This is an example of "parents from hell", whose depraved treatment of their children so warps the children's developing personalities as to predispose them to commit murderous acts. Meanwhile, the offending parents continue with their lives, remaining very much in the background, never being arrested for any crime and never being compelled by any authorities to undergo psychiatric examination or treatment. The sadistic psychopath in Mary's family was her mother, Betty, who was never brought to justice.

Personality Disorders Management Plan Outline

A. Investigations - biopsychosocial
   1. physical
   2. psychological
   3. social

B. Treatment - biopsychosocial
   1. physical
   2. psychological
   3. social

- Treatment of Personality Disorders, specifically tailored to individual patient's type of personality disorder, personality psychopathology domains involved, severity of their illness and the presence of comorbid psychiatric disorders.
- Manage comorbid conditions in standard manner.

Assessment of Personality Disorders

Management planning starts with assessment ; interview patient and an informant (~ 2-3 interviews) as follows:

- ***History***.
  - Subjective information taken through history may not provide accurate data with patients suffering from a PDs.
  - Responses may be falsified, either purposively or unintentionally.
  - History- taking still offers information into patient's disorder.
  - Key points include medical/psychiatric history, family history, work and school history, substance use, nutrition & established interpersonal relationships.
- ***Physical assessment***
  - Physical assessment can provide valuable information eg, evidence of self-mutilation or suicide attempts. Laboratory studies can demonstrate substance use, nutritional status, and sexually transmitted diseases that can result from patient's PD.

- **Use of Questionnaires and Tools.**
  - Questionnaires are available for assessment of PDs such as:
  - Minnesota Multiphasic Personality Inventory-2 (MMPI-2).
  - Personality Inventory for DSM-5, available in both long and short version to assess personality traits.
- **Personality Disorders – MSE**
  - Observations during an interview or interaction with the patient can afford pertinent clues. Observe patient's general appearance, speech pattern, affect & behavior. Blunt affect or guarded behavior common with Cluster A personality disorders. Communication may be tangential or difficult to follow. Patients may exhibit behaviors indicating paranoia or hallucinatory in nature. Abrupt behavior demonstrates lability of emotions is typical with Cluster B and C personality disorders. Cognitive functions and thought process not usually impaired in PDs. Questions regarding judgment are important for insight.

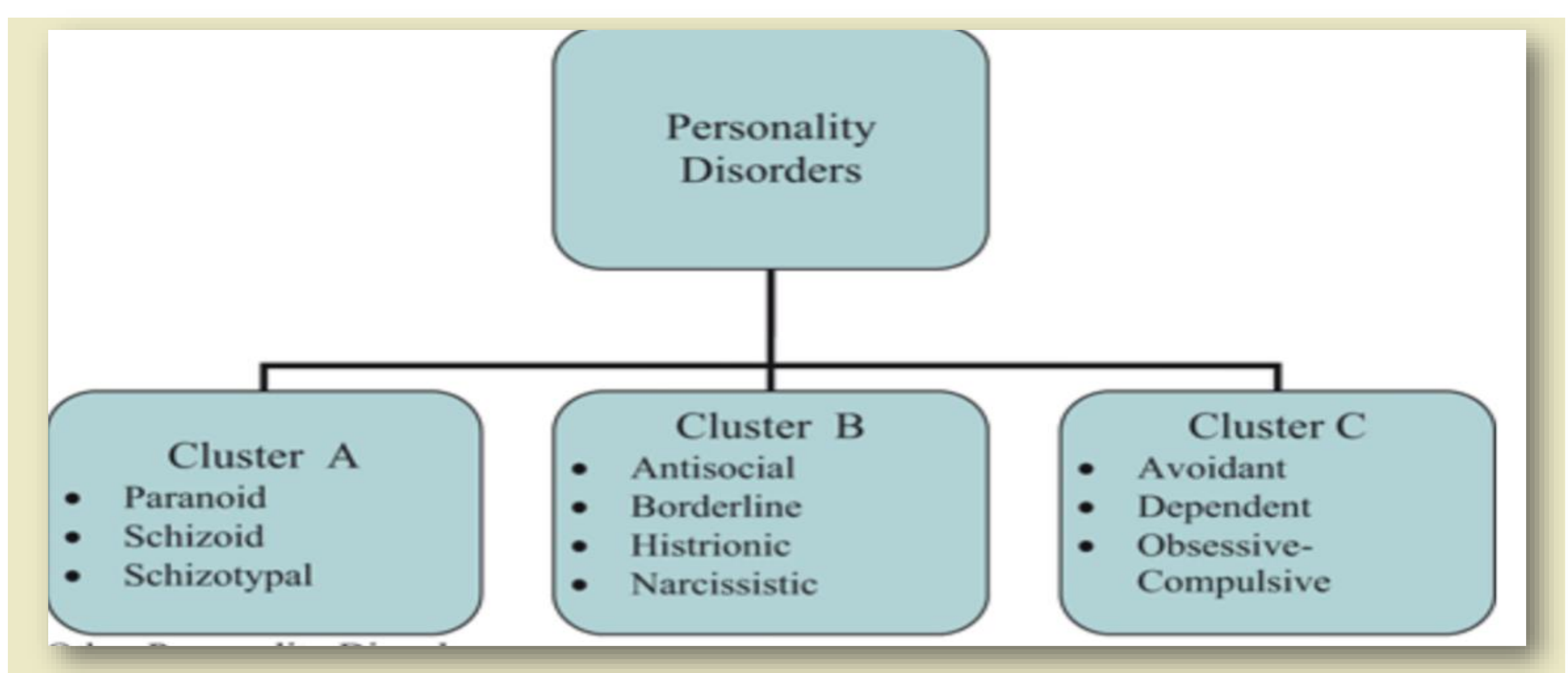
- **Risk to Self and Others.**
  - Assessment for risk and harm to self or others is important with patients diagnosed with personality disorders. Ask directly about potential for harm to self or others. Current ideation and intent are vital to determine lethality or severity of risk. The objective reactions to these questions can be just as informational as the actual answers given. If patient states he/she has had thoughts of harming self or others, this needs to be further explored.
  - Risk factors to be assessed include: history of past suicidal ideation, suicide attempts, self-mutilation, poor impulse control. Mood and affect should also be incorporated – depressed, angry or labile mood can indicate higher risk.
  - Protective factors should also be reviewed such as methods of coping and spiritual beliefs.
- **Formulate** pt’s psychopathology, circumstances that led to current problems [what, why, how, when], strengths; construct treatment plan and negotiate treatment contract.

Assessment Summary:

1. Interview patient and informant (s).
2. Establish a diagnosis of personality disorder.
3. Evaluate personality patterns, describe problems across domains of psychopathology-symptoms [psychological distress, self-harming, dysphoria, cognitive disorganization, dissociative behavior, cognitive -perceptual and neuropsychological symptoms], interpersonal function, social function [work history, inner experience]
4. Delineate any comorbidity.
5. Formulate the individual patient's psychopathology, circumstances that led to current problems and construct treatment plan; feedback to patient and negotiate treatment contract.

- **However, in emergency crisis evaluation/serious self-harming, suicidal behavior or serious clinical disorder symptoms; more focused assessment appropriate to get information to ensures patient's safety and manage immediate problems.**

DSM IV DIAGNOSTIC CRITERIA OF PERSONALITY DISORDERS



<u>Diagnosis and assessment of PD</u> is approached in two steps.

1. First, evaluation for presence of PD based on adaptive failure or diagnostic criteria core pathological personality features –present / pervasiveness, long-term duration & interpersonal difficulties.
2. Second, assessment of individual differences in PD, using dimensional model such as the 4 patterns and component traits.

DIAGNOSIS OF PERSONALITY DISORDER: <u>DSM-5_PDs Diagnostic criteria</u>:

- Each PD has own set of diagnostic criteria. However, generally diagnosis of a PD includes: [1]. long-term marked deviation from cultural expectations that leads to [2]. significant distress or impairment in at least two of these areas: {a}. way perceive and interpret self, other people and events and {b}. impulse control, appropriateness of emotional responses and functioning when dealing with other people and in relationships.
- Sometimes it can be difficult to determine the type of PD, as some PDs share similar symptoms and more than one type may be present.
- Other disorders such as depression, anxiety or substance abuse may further complicate diagnosis of PDs.

How to diagnosis a personality disorder:

PD diagnosis: PD diagnosis and assessment approached in 2 steps-

[1]. First is evaluation for presence of PD based on adaptive failure or diagnostic criteria for PD_ longstanding, pervasive PD_defining features; presence since adolescence or early adulthood and adversely impacting individual's life and functioning.

[2]. Second is assessment of individual PD psychopathology differences, using patterns and component traits dimensional model.

- ***Differentiation from other mental disorders*:**

PDs may be primary diagnosis or comorbid condition; also possible presenting problems solely due to clinical disorder with Rx|outcome. [1]. Differentiation begins by evaluating extent pt meets PD criteria & r/o cognitive disorder. [2]. Differentiation of PD vs. PDs comorbidity-SUD, anxiety, depression & bipolar disorders.

- PD vs. mood disorders differentiation hard, as 2 often comorbid, plus PD & mood symptoms overlap, so it is hard to determine if presenting symptoms reflect mood disorder, PD or both. Common errors-mood disorder diagnosis instead of PD or failure to diagnose comorbid PD & attribute clinical features to mood disorder.

Differentiation of PDs - related quasipsychosis from psychotic disorders not hard, as, PD symptoms more transient, less pervasive & no loss of insight as typical with psychotic conditions. PDs’ pseudohallucinations “voices” often linked to voice of abusive person from PD_pt’s past but if persist $\geq$ a week, PD diagnosis reviewed, unless the PD is schizotypal PD.

Accurate diagnosis leads to adequate treatment of all presenting disorders, reduced suicide risk & improved personality functioning.

If not able to differentiate other disorders vs. PD - symptom clusters targeted with specific pharmacological or psychotherapy.

TREATMENT FOR THE 'UNTREATABLE'

➡Prior 1990s, treatment for PDs often not provided or if offered, seen as a "heroic effort" based on belief PDs treatment taxed clinician with little hope for a promising outcome. PDs treatment then dominated by psychoanalytical therapies and therapeutic nihilism prevailed. People with PDs viewed as difficult patients resulting in negative thoughts and feelings about them in **care providers–counter transference**!

➡Reflexive acts rarely help. Reinforce fears of abandonment, rejection – leading to increased efforts to remain attached. More phone calls, hospital visits, noncompliance to "stay sick".

➡Even though, research in that era, led to understanding of importance of structured approach, consistency, treatment contract and treatment alliance in the formulation implementation of treatment plans.

Are PDs Untreatable? NOT TRUE Now there is evidence PDs treatable with specialized psychotherapies and various medications.

Treatment planning involves five broad decisions:

1. Treatment setting: inpatient, day hospital or outpatient
    a. **Opt for the least restrictive safe treatment setting**
    b. Focus on helping patients cope in their natural environment
    c. Hospitalization vehicle for maintaining safety; consider if risk of suicide outweighs risk of inappropriate hospitalization
2. Treatment format: individual, group, family or combotherapy
3. Major strategies/techniques to use, sequence of interventions, theoretical models: psychodynamic, cbt or psychoanalytic.
4. Treatment duration & frequency: crisis intervention, short or long-term therapy and frequency of appointments;
5. Use of medication & way it's combined with other interventions.

Together, these 5 categories provide a comprehensive way to plan treatment that is consistent with the tailored approach advocated.

Key interventions and actions when interacting with PDs patients:

1. Maintain safe environment. Take precautions to reduce risk of harm to self or others. Remove items that may be used as weapon.
2. Establish a written contract with patient discussing expected behaviors of patient and that patient will not harm self or others, and will notify a member of the team if feelings to do so develop.
3. Establish therapeutic relationship with patient. Be straightforward in communications. Empathy and non-judgmental attitude is vital.
4. Establish a therapeutic relationship with patient.
5. Maintain objectivity & consistency amongst healthcare team Consistent information & interactions with patient can be assured by developing an interdisciplinary plan of care and ensuring communications between healthcare team is consistently updated. Maintain objectivity and consistency.
6. Set behavioral limits Let patient know what behaviors acceptable, which are not and outline consequences for inappropriate behavior.

TREATMENT

Treatment depends on nature of PDs, patient willingness to engage in treatment and the available resources.

- **Psychotherapy (Mainstay):**

A. General Principles

- Focus on pt-therapist relationship in "here & now"
- Utilize countertransference to explore relationship
- Educate patients to recognise their affective reactions and what triggers them. Connect actions with thoughts and feelings, aiming to examine and to improve perceptions and responses.

B. Primary treatment for PDs is psychotherapy. Psychotherapy Types :

- Dialectical Behavior Therapy (DBT)
- Transference-based psychotherapy
- Mentalization-based psychotherapy
- Schema-focussed therapy
- Cognitive-Behavioral Therapy

PD PSYCHOEDUCTION: *Increases hopefulness on change possibility & encourages active participation in treatment planning.

MOTIVATIONAL INTERVIEWING:

*Ask for permission to discuss the problem – raise awareness.
*Elicit talk about change, change possibilities advantages/ disadvantages and taking the first step. *Ability check (1-10) – pt's confidence in ability to change, elicits possible barriers. End with summary of discussion points, what agreed and what uncertain.

PROBLEM SOLVING:

*Identify the problem –specify, define; brainstorm possible solutions /alternatives, their pros and cons, choose most suitable ones.
*Seek commitment with specific details; summarize, schedule follow up, acknowledge further barriers may be encountered and that solutions for these will also be found.

Specific manualized therapies for Personality Disorders:

- Second era of PDs treatment marked by development of several evidenced-based effective treatments for PDs including: *Cognitive-behavioral therapy (CBT); *Mentalization based therapy (MBT); *Dialectical behavior therapy (DBT); *Transference focused therapy (TFP); *Schema therapy. Now there is hope for people affected by PDs, including their family members and loved ones

Cognitive Therapy

- This is a modification of standard cognitive and behaviour therapy that is goal directed and focused more on altering underlying belief structures rather than reduction of symptoms
- It is likely to take up to 30 sessions of treatment of which the initial ones help to define the areas of intervention by identifying what are the fundamental structures of past, present and future experiences
- The therapist and patient maintain a collaborative therapeutic alliance throughout treatment and include homework and testing of core beliefs and structures

Mentalisation Based Therapy (MBT)

- A mixed group and individual therapy based on psychoanalytic principles
- Treatment typically lasts 18 months
- Directed towards developing the ability to mentalise, that is to interpret the actions of oneself and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons)

Dialectic Behaviour Therapy (DBT)

- This is a special adaptation of cognitive therapy, originally used for the treatment of women with borderline personality disorder who harmed themselves repeatedly
- DBT is a manualised therapy including functional analysis of behaviour, skills training and support (empathy, validation of feelings, management of trauma)
- Directed at reducing self-harm

Cognitive Analytical Therapy

- Postulates that a set of partially dissociated 'self-states' account for the clinical features of
- borderline personality disorder
- Rapid switching between these self-states leads to dyscontrol of emotions including intense expression and virtual absence (depersonalisation)
- Therapy aims to formulate these processes collaboratively,examining them as they occur in treatment as well as in life experiences

Dynamic psychotherapy

- This is based on a developmental model of personality
- Treatment is generally long term
- The aim of therapy is to understand the way in which the past influences the present with the use of interpretation
- Treatment focuses on the therapeutic alliance between patient and therapist, the individual's emotional life, and defences
- Therapy uses the relationship between patient and therapist (transference) as a way to understand how the internal world of the individual affects relationships

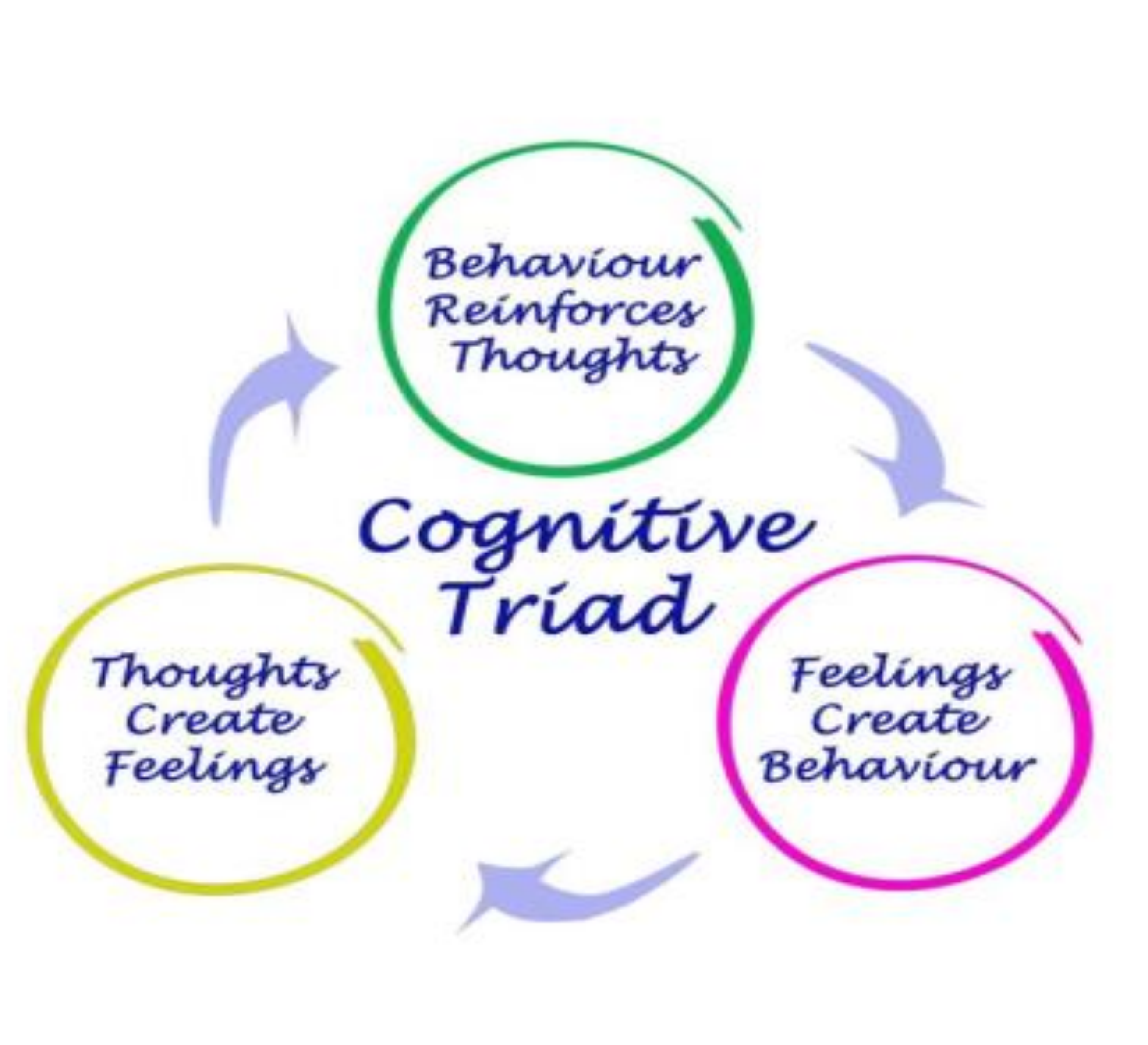
Cognitive Behavior Therapy [CBT], developed in 1960s by ***Dr. Aaron Beck***, was initially used to treat
depression. The underlying concept behind CBT is thoughts, feelings and behavior are interconnected; and that thoughts determine our feelings which then determine our behavior.

CBT is primarily focused on the belief that the way we think is what causes us pain and if we can change that, it will significantly improve our overall well-being.

Individuals who suffer from mental disorders have distorted & irrational thinking – which may cause maladaptive behavior.

E.g., **‘Cognitive Triad’ in Beck’s Model of Depression.**

These automatic thoughts or thought distortions, are what Dr. Beck wanted to pinpoint with patients so that they could work on cognitively restructuring their self-defeating thoughts to positive and healthy thoughts. CBT is focused primarily on reconstructing thoughts so that feelings and behavior are not self-destructive. By challenging the pre-existing cognitive beliefs, the patient is psycho-socially supported to bring positive changes in thoughts and behavior. One of the greatest benefits of CBT is that it helps the client develop skills that can be useful both now and in the future.

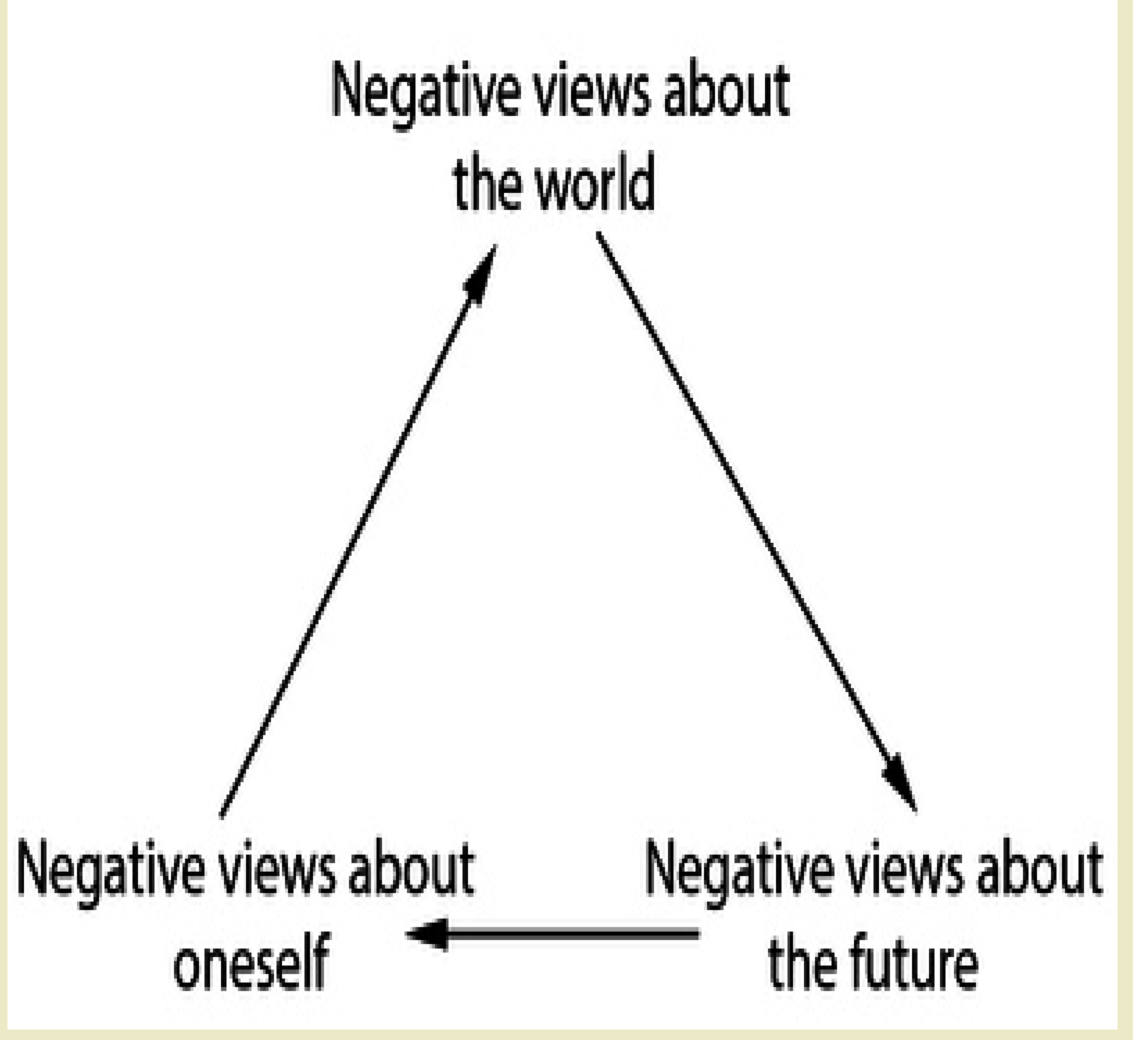

Behaviour Reinforces Thoughts
Cognitive Triad
Thoughts Create Feelings
Feelings Create Behaviour

THOUGHTS

BEHAVIOR

FEELINGS

Cognitive Behavioral Therapy



CBT FOR PERSONALITY DISORDERS

- CBT for PDs derives from traditional CBT, a highly effective, evidence-based therapy.
- People with PDs have characteristic patterns of thinking that tends to be somewhat extreme, inflexible, and distorted gets them into trouble.
- CBT is helpful for people with PDs due to its emphasis on identifying and changing dysfunctional thinking patterns.
- CBT conceptualizes all 10 PDs as dysfunctional core beliefs about the self, others and the world. The cognitive therapist helps those with PDs learn identify and change these core beliefs.
- A challenge for CBT therapist is that pts with PDs do not come into therapy ready to trust.

Cognitive model of personality disorders

Biological factors
Temperament of child

Childhood experiences
(e.g. attachment to caregivers,
trauma, social environment)

Formation of schemas

Core beliefs
Self Others

Overdeveloped
behavioural strategies

Underdeveloped
behavioural strategies

DIALECTICAL BEHAVIOR THERAPY (DBT) FOR PDS

- DBT, based on biosocial theory of mental illness, is a modified form of CBT, that was developed by Marsha Linehan. DBT is a comprehensive, multimodal treatment that combines CBT techniques for emotion regulation, social skills, exposure, empathy & reality-testing with concepts of distress tolerance, problem solving with acceptance & mindful awareness meditative practice and emphasises the patient-therapist connection. DBT aims is to reduce ineffective action patterns

DBT Skill Sets at a Glance

Core Mindfulness

What Skills

Observe
Describe
Participate

How Skills

One-mindfully
Non-judgmentally
Effectively

Reality Acceptance

Radical Acceptance
Turn the Mind
Willingness
Notice Willfulness

Interpersonal Effectiveness

Describe
Express
Assert
Reinforce

Mindful
Appear Confident
Negotiate

Gentle
Interested
Validate
Easy Manner

Fair
no Apologies
Stick 2 Values
Truthfulness

Emotion Regulation

Accumulate positive experiences
Build mastery
Cope ahead of time

treat Physical Illness
Eat balanced meals
Avoid mood-altering drugs
Sleep balanced
Exercise

Validate
Imagine
Take small steps
Applaud yourself
Lighten your load
Sweeten the pot

- ★ Mindful to emotion
- ★ Behavior chain analysis
- ★ Opposite Action
- ★ Pros and Cons

Distress Tolerance

Activities
Contributing
Comparisons
Emotion opposites
Pushing away
Thoughts
Sensations

Imagery
Meaning
Prayer
Relaxation
One thing at a time
Vacation
Encouragement

Temperature
Intense physical exertion
Paced breathing

Interpersonal effectiveness

Emotion regulation

Mindfulness

Distress tolerance

Dialectical Behavior Therapy

CBT	VERSUS	DBT
Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty,thinking patterns cause maladaptive behavior and negative emotions		Dialectical Behavioral Therapy is a specific type of cognitive-behavioral psychotherapy which was originally developed to help better treat borderline personality disorder and chronically suicidal individuals
Anxiety, depression, and substance abuse can be treated with CBT		Suicidal or self-harm motives and multiple, complex difficulties in life can be treated with DBT
A short term, goal-oriented therapy		A long term process
Helps to identify, analyze and re-organize unhealthy and negative thoughts in people		Positive interpersonal relationships, stress management, accepting the reality and proper control of emotions are targeted

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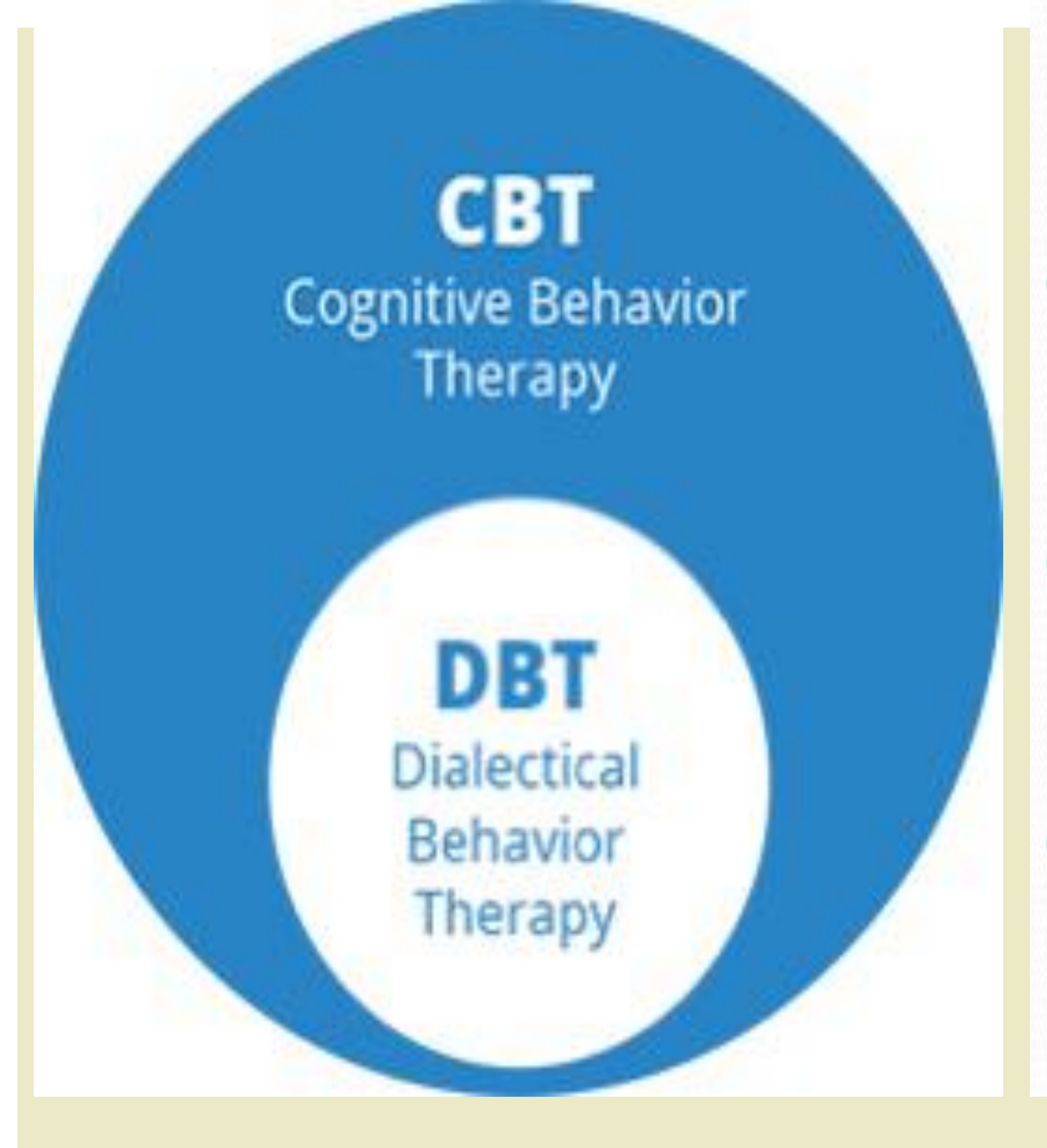
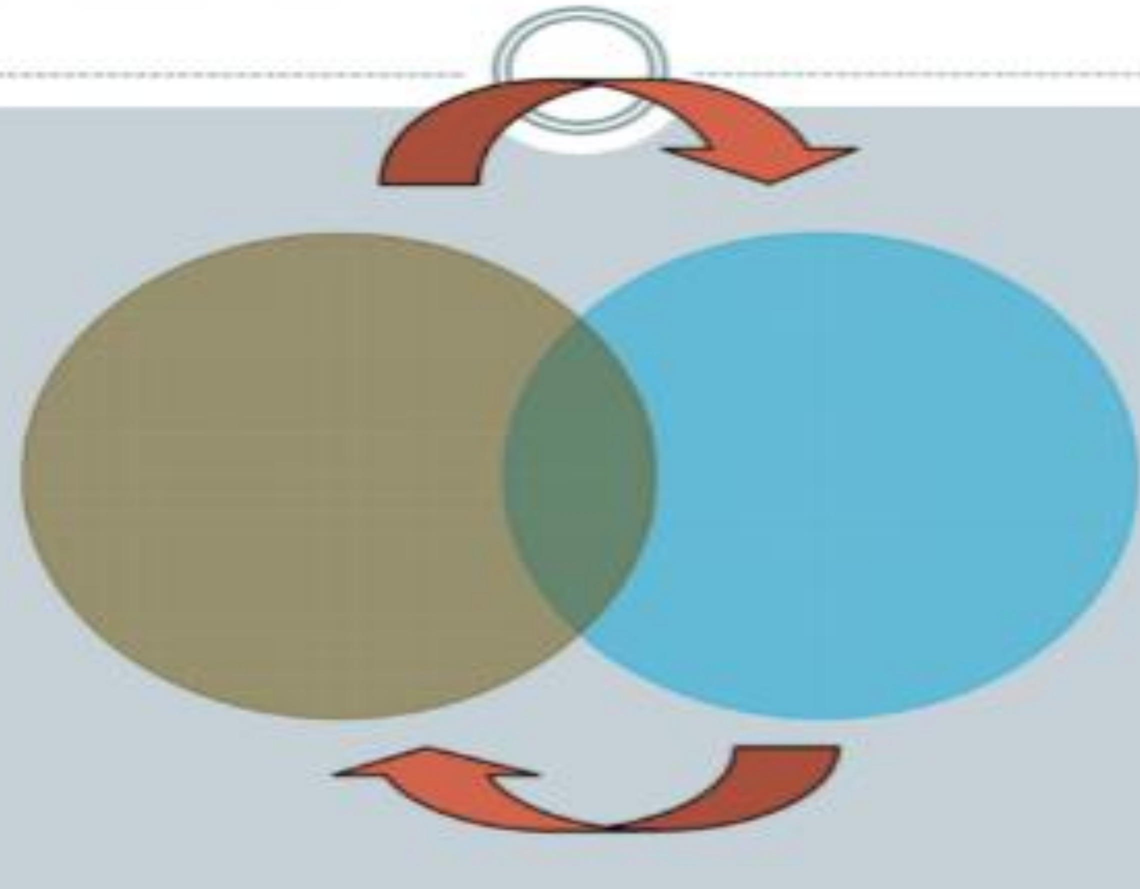


CBT	DBT
• Focus on change	• Dialectic of acceptance and change
• Exposure to distress	• Exposure to distress with acceptance of distress
• Problem focus: specific	• Problem focus: broad, inclusive and use of hierarchy

MENTALIZATION BASED TREATMENT (MBT)

- MBT founded by ***Bateman & Fonagy***, originates from attachment theory. Mentalization is insightful understanding of what one is feeling and why. The ability to mentalize vital for self organization and affect regulation. Mentalizing is like "hitting a pause button"- giving ability to briefly tolerate the feeling, to stop and reflect upon it, slowing down & deterring from acting on destructive impulses/urges. Difficulties with emotional regulation is a hallmark features of PDs. Insecure attachments limit the development of this important skill. MBT proposes this highly necessary skill must be learned in order to correct interpersonal difficulties and so, seeks to assist pts to develop it. MBT begins with developing a warm, empathic therapeutic alliance, which provides a context to learn mentalization.

Mentalization: Two People



SELF

Feelings
Thoughts
Motives
Intentions
Beliefs
Desires
Needs

OTHER

Feelings
Thoughts
Motives
Intentions
Beliefs
Desires
Needs

Imagination
Interaction

- To see ourselves from the outside and others from the inside
- Understanding misunderstanding
- Having mind in mind
- Introspection for subjective self-construction – know yourself as others know you but also know your subjective self (your experience)

Benefits of Mentalizing

- Connection through shared understanding.
- A “meeting of minds”.
- Leads to better interpersonal functioning, and therefore, better chance at getting objectives met in life & relationships.
- Being misunderstood is aversive, it can lead to painful emotions.
- Many BPD difficulties can result from the temporary loss of mentalizing.

TRANSFERENCE FOCUSED PSYCHOTHERAPY (TFP)

- TFP developed by ***Dr. Otto Kernberg***; in response to psychoanalysis' failure to Rx
- PDs. TFP developed by modifying, tailoring psychoanalytic therapy techniques for
- PDs Rx. TFP is based on object relations theory. Object relations theory, posits that
- during infancy, we develop internal representations of "self" & other people as
- "objects“, initially split-off, positively & negatively-toned; later integrated into a
- single, cohesive whole. However, when good & bad representations remain split-off
- & separate, result PD-disintegrated personality organization. TFP therapist
- identifies nature of the structural problem and develops a strategy to repair it.

Self
Other
Affects
The Object Relations Dyad

TFP VS TRADITIONAL PSYCHOANALYSIS

- TFP differs from psychoanalysis of free-
- association, in [1]. First, there is a very specific agenda. Therapy, starts with
- extensive evaluation and diagnosis made. Therapist & pt then discuss and agree
- upon a treatment contract together. Therapy contract addresses boundaries of
- therapy – sessions frequency /duration, phone calls, emergency procedures etc.
- [2]. 2nd, therapist is not simply a passive listener. [3]. 3rd, focus on here-&-now,
- present-day relationships. Therapist takes on a very active role in therapy- asking,
- pointing, clarifying questions, challenging self-destructive /negative behaviors.

Mechanism of Change in TFP

- In successful treatment, the patient goes from intense, split, negative conceptions of self and others to affectively and cognitively nuanced and complicated conceptions of self and others
- This process of change is experienced in the evolving conception of the therapist and self in the treatment relationship
- This process of change is captured in the Reflective Functioning scale

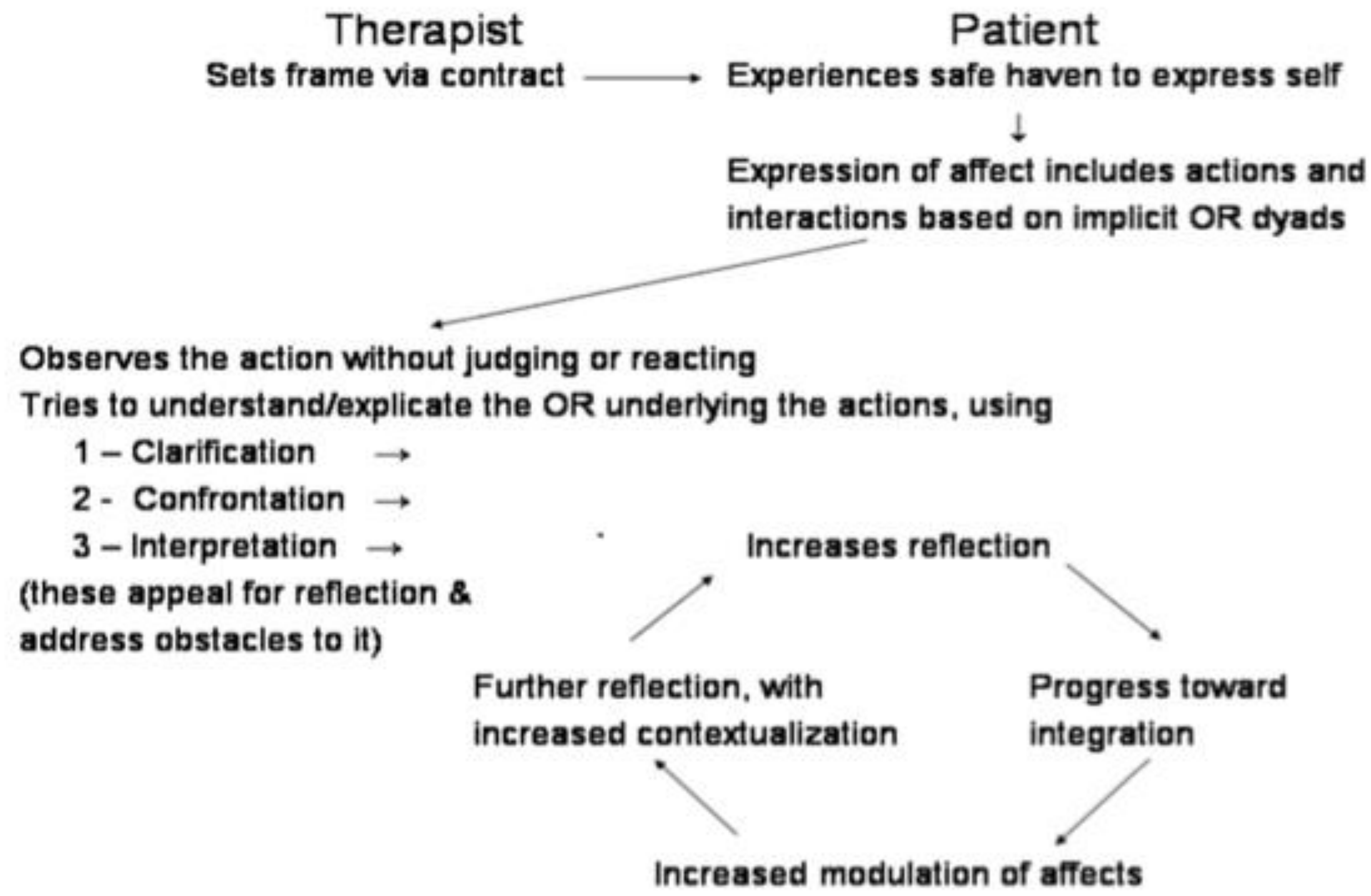


Figure 3. Mechanisms of change in transference-focused psychotherapy.

SCHEMA THERAPY [YOUNG, 1990]

- Developed to treat PDs who failed to respond to CBT. Schema Therapy is a broad, integrative model that shares commonalities with object relations therapy, experiential therapy, DBT, interpersonal therapy as well as CBT. Schema Therapy differs from these approaches regarding nature of therapy relationship, therapist's general style, stance, degree of activity and directiveness.

SCHEMA THERAPY-CONCEPTS

- Early maladaptive schemas [EMS]
- Schema domains
- Coping styles &
- Schema modes.

CONT.

- EMS-dysfunctional pervasive patterns about oneself and one's relationships with others, are triggered by encounters of environments reminiscent of childhood environments that produced them. When this happens, individual is flooded with intense negative affect. 18 EMS, due to childhood abuse, neglect, and trauma in early life-related unmet core emotional needs, plus temperament and cultural factors, delineated.

Schema Therapy vs Cognitive Therapy

- Greater emphasis on the therapeutic relationship
- More emphasis on affect and mood states
- More discussion of childhood origins and developmental processes
- More emphasis on lifelong coping styles
- More emphasis on core themes

SCHEMA THERAPY STAGES

- Emotional bonding
- Get around Detached Protector
- Heal Abandoned Vulnerable Child
- Banish Punitive Parent
- Channel Angry Child effectively
- Develop Healthy Adult

In schema therapy, schemas refer to early maladaptive schemas. These are self defeating emotional and cognitive patters established from childhood and repeated throughout life.

These can be made up of emotional memories of past hurt, tragedy, fear, abuse neglect, abandonment, or lack of normal human affection.

The 18 Early Maladaptive Schemas

Disconnection & Rejection

- Emotional Deprivation
- Abandonment
- Mistrust/Abuse
- Social Isolation
- Defectiveness

Impaired Autonomy

- Failure
- Dependence
- Vulnerability

Impaired Limits

- Entitlement
- Insufficient Self-Control

Other-Directedness

- Subjugation
- Self-Sacrifice
- Approval Seeking

Overvigilence & Inhibition

- Emotional Inhibition
- Unrelenting Standards
- Negativity/Pessimism
- Punitiveness

GOALS OF SCHEMA THERAPY WITH PDS

A. Identify early maladaptive schemas to validate the client's unmet emotional needs,
B. To change dysfunctional beliefs and maladaptive schemas to more functional ones.
C. To change maladaptive life patterns and coping styles
D. To provide an environment for learning adaptive skills.

2 PHASES OF SCHEMA THERAPY

1. ***Assessment & education phase***: In this phase, therapists help pts identify their schemas, understand the origins of their schemas in childhood, and relate their schemas to their current problems.
2. ***Change phase:*** In the change phase, therapists integrate several interventstions, including cognitive, experiential, behavioral, and interpersonal strategies, to heal schemas and replace maladaptive coping styles with healthier behaviors

MEDICATIONS

- Medications may be prescribed with psychotherapy, based on the symptoms demonstrated in relation to PDs diagnosed.
  - **Antidepressant** ***medications*** e.g., sertraline, fluoxetine for depressed mood, anger, irritability or impulse control.
  - **Mood-stabilizing medications** for emotional lability, irritability, aggression & impulse control – e.g., valproic acid, lithium.
  - **Anti-anxiety medications** to reduce anxiety, agitation or insomnia.
  - **Antipsychotic medications** *e.g.,* risperidone, quetiapine, olanzapine, to treat psychotic symptoms, anger and anxiety.

PHARMACOTHERAPY/MEDICATIONS FOR PDS SYMPTOMS

Dysphoria: SSRI, low dose atypical AP

Depression-SSRI, atypical antipsychotic AP;

Anxiety: SSRI, low dose AP, Buspirone;

Acute anxiety/agitation: benzodiazepines

Emotional instability-low dose AP, lithium, anticonvulsants;

Aggression-lithium, AP

Impulsivity-SSRI, lithium, low dose AP, anticonvulsants;

Emotional flatness - atypical AP, SSRI

Psychotic - AP

CONT.

Dependent PD
- Anxiety disorders and depression common
- Need long term support and structure/ CBT

Avoidant PD
- CBT | SSRI's, SNRI and RIMA's

Obsessive-compulsive PD
- Thorough approach but avoid focus on uncertainties & variables
- Treat anxiety: psychotherapy; SSRI

Treatability of Antisocial Personality disorders
- Many treatment models useful to some degree
- Anger management, CBT approaches, therapeutic community

COMORBIDITY

- Many times, personality-disordered patients seek psychotherapy or medication treatment, not because of PDs symptoms themselves, but due to comorbid condition such as Depression, Panic Disorder, Generalized Anxiety Disorder, other disorders.
- The comorbid condition may be not only causing more dysphoria, but also exacerbating PDs symptomatology. As such, pharmacological treatment can be more parsimonious if an agent treats the comorbid condition and core features of that patient's PD pathology.

- **Hospitalization** has little value for patients with PD in crisis and may negatively influence suicidal behavior in some. Pts admitted may become dependent on the locked hospital environment and be viewed as low risk by staff who sanction discharge when the patient is in fact still at high risk. For many patients, admission to in-patient care is likely to be ineffective and counterproductive.

➡**Therapeutic community** (TC) treatment used for many years in an effort to help people with PDs. TC is a psychosocial intervention in which participants come together to a communal, ordinarily residential set ting. Staff provide safe containment and a psychotherapeutic framework. Personal accountability and democratic decision-making are highly valued: the treatment is conceptually 'delivered' by other community members, whose analysis of individual functioning has the legitimacy of peer insight. Oct 9, 2013 – Gasket al; state that there is no evidence for the effectiveness of TC in the treatment of PDs.

PERSONALITY DISORDERS
INTEGRATED MODULAR TREATMENT [IMT]

- Patients with personality disorders present with unique array of problems spanning multiple domains of functioning and treatment should utilize an integrated array of strategies and techniques to address the diverse impairments - symptoms, emotion and impulse regulation problems, interpersonal patterns and self-identity problems and overall severity of dysfunction, rather than focusing on a more globally conceptualized categorical disorder.

CONT.

- Currently, PDs Rx characterized by greater concern with integrating Rx principles and methods across therapies, use of eclectic & pragmatic treatment strategies and emergence of more modular| transdiagnostic approaches focusing on specific domains of personality pathology rather than global diagnoses-integrated modular treatment [IMT] approach combines an eclectic array of treatment principles, strategies & methods drawn from all effective treatments, targeted in a way to treat specific impairments.

INTEGRATED APPROACH TO PDS TREATMENT

- Several treatments are effective in treating PDs and outcome does not differ substantially across treatments.
- So an integrated, eclectic treatment using an array of interventions drawn from different treatment modes and delivered in an integrated way is consistent with current empirical evidence on treatment efficacy and the limitations of current treatments.

4 KEY STRATEGIES FOR ORGANIZING & COORDINATING RX INTERVENTIONS.

1. First, treatment is based on generic change mechanisms.
2. Second, interventions divided to general & specific Rx strategies.
   A. General Rx strategies used throughout Rx to build alliance| motivation, ensure therapeutic consistency and validation.
   B. Specific interventions to treat specific problems - PRN
   C. Third, treatment conceptualized as a series of phases, each addressing different problems and domains of psychopathology.
3. Finally, specific behaviors change described using stages of change model providing an orderly way to combine interventions.

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2. The African textbook of psychiatry and mental health by Ndetei et al 2006

C8. CHILD PSYCHIATRY

COMPILED BY
NAILA KAMADI

OUTLINE

A. CHILDHOOD PSYCHIATRIC DISORDERS - Slide 1297
B. MENTAL RETARDATION
C. LEARNING DISORDERS
D. CHILDREN REACTION TO ILLNESS/ DEATH
E. ATTACHMENT, SOCIAL & DEPRIVATION SYNDROMES IN CHILDREN & ADOLESCENTS
F. DEVELOPMENTAL LANDMARKS IN CHILDREN & ADOLESCENTS

C8A. MANAGEMENT OF CHILDHOOD PSYCHIATRIC DISORDERS 28/2/2019

BY: DR. JUDY KAMAU

OVERVIEW OF PSYCHIATRIC DISORDERS OCCURING IN CHILDREN AND ADOLESCENTS

DISORDERS

- Mental retardation
- Pervasive developmental disorders
  - Autistic disorder
  - Childhood disintegrative disorder
  - Retts disorder
  - Pervasive developmental disorder NOS
- Disruptive behaviour disorders
  - Attention Deficit Hyperactivity disorder
  - Oppositional defiant disorder
  - Conduct disorder

DISORDERS

- Anxiety disorders of childhood and adolescence
  - Separation anxiety disorders
  - Generalised anxiety disorder
  - Social phobia
  - Panic disorder
  - PTSD
  - OCD
  - Selective mutism

CONT.

- Mood disorders in children and adolescent
  - Major depressive disorders: manifests in children as irritability
  - Dysthymic disorder
  - Bipolar disorder
  - Cyclothymia

DISORDERS

- Psychotic disorders in children and adolescence
  - Very early onset at the age of 10
  - Early onset schizophrenia at age of 13
- Tic disorders
  - Tourette's disorder
  - Chronic motor or vocal tic disorder
  - Transient tic disorder

CONT.

- Sexual and other forms of child abuse
- Eating disorders
  - Anorexia nervosa
  - Bulimia nervosa: onset at adolescence
  - Pica
  - Rumination disorder
  - Feeding disorder of infancy or early childhood

DISORDERS

- Sleep disorders
  - Parasomnias
  - Narcolepsy
- Elimination disorders
  - Enuresis: diagnosed from around age of 5
  - Encopresis: diagnosed from around age of 4

CONT.

- Learning disabilities
- Motor skills disorders
- Developmental communication disorders
- Developmental coordination disorder

PREVENTION & TREATMENT

PREVENTIVE APPROACHES

- Primary prevention
  - Action taken to prevent the development of the disorder in the first place by removing the cause
- Secondary prevention
  - Action taken to identify the disorder at its onset, or as early as possible thereafter , so as to prevent extension and minimise the duration
- Tertiary prevention
  - Action taken to limit further the avoidable disability arising from an established condition

PREVENTIVE APPROACHES

- The presence of risk factors implies that the individual is at risk of developing a disorder
- Protective factors are those that reduce the individual's likelihood of developing a disorder in the presence of risk factors
- Vulnerability factors are those that increase the risk of disease
- Action to decrease risk and vulnerability factors and to enhance protective and resilience may result in successful prevention

PREVENTIVE PRINCIPLES IN MANAGEMENT

- Concern for the whole child and family
- Knowledge about and respect for associated services
- Communication between professionals
- Availability of mental health consultation
- Emphasis on parental involvement in decision making
- Encouragement of voluntary activity

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

Behaviour therapy

- Are directed towards the development and encouragement of an increased frequency and intensity of desirable behaviours and the the removal / reduction in frequency of undesirable or challenging behaviour
- Based on learning theory
- With children, parents, teachers and other involved individuals are used as agents of behavioural change and maintenance

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

Behaviour therapy

- General principles of assessment
  - Define problem to be treated
  - Define the circumstances of the problem behaviour
  - Undertake a functional analysis of behaviour
    - ABC: antecedents → behaviour → consequences
    - Antecedents: settings and triggers; actions; responses
  - Baseline recordings
  - Evolve a plan collaboratively

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

- **Operant methods**
- Pioneered by Skinner
- Indicates that the likelihood of a behaviour recurring depends on the significance of the event immediately following it to the person showing the behaviour
- If the event following the behaviour is is positively reinforcing or rewarding, then the behaviour is likely to occur with increasing frequency and intensity
- If it is not reinforced or is punished, it is less likely to recur and will eventually stop completely (extinction)

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

- Operant methods
- Indications
  - Conduct problems: reward good behaviour & punish bad behaviour.
  - Anxiety related problems
  - Feeding difficulties: reward when the child finishes the food.
  - Hyperactivity
  - Enuresis and encopresis
  - Mutism

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

- **Desensitization**
- Fear and avoidance are thought of as emotional, cognitive and behavioural responses that can be learned and unlearned
- Cautious but sustained approach towards the source of the fear until the situation has been mastered and the fear conquered.
- At each stage the person must be feel confident and reassured before proceeding further
- Indications: Phobias

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

- Desensitization
- Application:
  - Establish a hierarchy of feared situations
  - Graded exposure
    - In vivo desensitization
    - Covert sensitization
  - Relaxation
    - Deep breathing exercises
    - Positive imagery
    - Muscular relaxation

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

Other behavioural techniques

- Classical conditioning (Pavlov)
- Flooding: Discouraged
- Response prevention
- Aversion therapy: not used as much.
- Social skills training

TREATMENT: BEHAVIOUR AND COGNITIVE PSYCHOTHERAPIES

Cognitive psychotherapy

- Psychological change can be brought on by attention to and and attempts to alter the thought processes (cognitions) of the individual
- The patient has maladaptive cognitions that that result in the development of inappropriate states of mind and detrimental behavioural patterns
- Antecedent event → belief → emotional & behavioural consequence
- Maladaptive believes can either be about oneself, the future or one's surrounding environment

INDIVIDUAL PSYCHOTHERAPY

- Psychotherapeutic techniques involve understanding the internal worlds of the child or adolescent in order to help resolve internal conflicts and therefore master developmental tasks
- Help the child or adolescent become aware of the meaning of the symptoms to themselves and to other people so that they can if they wish, change their behaviour

FAMILY THERAPY

- Attempts to understand a presenting problem within the context of family relationships rather than locating it's source in any one individual
- An attempt is made to to enable family members to see presenting problems as arising from their interactions and to improve communication between family members thus indirectly reducing individual symptomatology

GROUP THERAPY

- A form of psychotherapy in which a group of patients meet to describe and discuss their problems together under the supervision of a therapist.
- Indications:
  - Children with difficulties in their social relationships
  - Antisocial children may benefit from behavioural techniques applied in a group setting
  - Children and adolescents who have suffered similar traumatic experiences

DRUG THERAPY

- Medication has a limited but increasing role in the treatment of psychiatric disorders in children and adolescence
- Can produce highly beneficial effects especially when combined with other forms of psychological, educational, familial and social interventions
- Doses should be given appropriate to the child's body weight
- Therapeutic doses may vary greatly from person to person
  - More active hepatic metabolism of certain drugs in young people
  - Increased neuro – receptor sensitivity in immature brains

DRUG THERAPY

- General principles
- Medication should never be the initial course of intervention. Consider educational, psychological, social and family approaches first
- Thorough multidisciplinary assessment must be undertaken before prescription
- Other interventions should usually have been tried
- If problems persist, consider adding meds as an adjunct to to above approaches
- Treat symptoms (e.g. aggression, over activity, self injury) not a syndrome (e.g.) autism

DRUG THERAPY

- General principles…
- Undertake a clinical trial of medication. Does it work or not? Are there side effects?
- Consider the cost-benefit ratio. What is the likelihood of improvement? how important is this? What is the likelihood of side effects? How serious might they be?
- Increased risk of side-effects in people with ID and neurodevelopmental disorders
- If medication is ineffective, stop it
- If it does work, give it for the minimum time possible with frequent monitoring

DRUG THERAPY

Stimulants

- Methylphenidate, Dextroamphetamine & pemoline
- Indicated for ADHD, Narcolepsy

Antidepressants

- Indicated for OCD, depression, anxiety disorders, trauma related symptoms, bulimia, enuresis, smoking cessation

DRUG THERAPY

- Anxiolytics (rarely used; relaxation techniques & CBT are preferred)
  - Benzodiazepines
  - Azapirones (buspirone)
  - Antihistamines (hydroxyzine)
- Antipsychotic medication
- Indications
  - Haloperidol: aggression and tic disorders
  - Second generation antipsychotics: acute mania and schizophrenia in the youth (risperidone, aripiprazole, olanzapine)
  - For children: risperidone is preferred.

DRUG THERAPY

- Mood stabilizers
- Agents that can stop the cycling between depression and euphoria in bipolar mood disorder
- Lithium (youth over 12 years old)
- Anti epileptic drugs e.g. carbamazepine, sodium valproate

DRUG THERAPY

- Other psychotropic medications
  - Atomoxetine (norepinephrine re-uptake inhibitor)
  - Clonidine & guanfacine (central alpha 2 adrenoceptor agonists)
  - Diphenhydramine (antihistamine)
  - Melatonin
  - Amantadine

OTHER THERAPIES

- ECT
- Dietary treatments

- That which offends you only weakens you. Being offended creates the same destructive energy that offended you in the first place – so transcend your ego and stay in peace.
- - Wayne Dyer

C8B. INTELLECTUAL DISABILITY/ MENTAL RETARDATION 14TH/10/2019

BY: DR. J. KAMAU

INTRODUCTION

- Intelligence
  - Sum of those aspects of mental life that relate to general cognitive abilities necessary for appraising and adapting to the environment.
  - Intelligence seems to be normally distributed within the population.
  - Is under both genetic and environmental control.
- Neurodevelopmental disorders
  - Starts early in infancy and childhood.
  - impairment and delay in central nervous system.
  - the course is fairly stable compared to other mental disorders which can remit and escalate.
  - Include:
    - Intellectual disability.
    - Autism spectrum disorders.
    - Attention Deficit Hyperactivity disorder.

ID DEFINITION

- Abnormal intellectual development may be due to slowness in development (retardation, delay) or distortions in development, or both.

- Intellectual disability is a consequence of intellectual impairment.

- Intellectual disability is a "disability characterized by significant limitations in both **intellectual functioning** and in **adaptive behaviour,** which covers many everyday social and practical skills".

ID DEFINITION

- Adaptive functioning/skills.
- There are three sets of adaptive skills;
  - Conceptual skills → reading, numbers, money, time, and communication skills.
  - Practical life skills → feeding, bathing, dressing, occupational skills, and navigational skills.
  - Social skills → understanding and following social rules and customs, obeying laws, and detecting the motivations of others in order to avoid victimization and deception.

ID DEFINITION

- The impairment should be global, of early onset and long term.
- The child's IQ should be less than 70.
- The child should be functionally impaired in every day life skills.
- IQ tests are standardized tests, designed to have a mean of 100 and a standard deviation of 15.

CLASSIFICATION OF INTELLECTUAL DISABILITY BY IQ.

- Mild → 50- 55 to 70 (account for 85 % of ID).
- Moderate → 35- 40 to 50- 55 (10% of ID).
- Severe → 20-25 to 35-40 (3-4% of ID).
- Profound → below 20 or 25 (1-2% of ID).

PREVALENCE

- 2-3% of the general population score in the mild ID (IQ 50-70)
- Moderate to profound (IQ<50) occurs in 3-4 per 1000 children
- More boys than girls in special schools for learning disabilities

AETIOLOGY

- GENETIC
  - Chromosomal abnormalities
    - Trisomy 21
    - Trisomy 13
    - Trisomy 18
    - Cri-du chat syndrome
  - Metabolic disorders
    - Phenylketonuria
    - Galactosemia

AETIOLOGY

- PRENATAL
  - Maternal illnesses
    - Rubella, syphilis, toxoplasmosis
    - Endocrine disorders
    - malnutrition
  - Toxins
    - Lead, alcohol
  - Placental dysfunction
- PERINATAL CAUSES
  - Birth asphyxia
  - Prematurity complications
  - Kernicterus

AETIOLOGY

- POST-NATAL
  - Head Injury (accidental / non- accidental)
  - Toxins
  - CNS infections
  - Seizures
  - Environmental deprivation

- IDIOPATHIC

CLINICAL FEATURES

- First identified or suspected ante-natally if there is known family history of a genetic disorder associated with ID, or both parents have ID.
- May be identified soon after delivery when a condition known to be associated with ID is identified e.g. Down Syndrome.
- Biochemical screening identification soon after birth can identify children with hypothyroidism, phenylketonuria.

CLINICAL FEATURES

- Diagnosis may be delayed at times for several years until the consequences of generalised development become obvious.
  - e.g. where physical features are subtle and degree of impairment is mild or moderate (autism, fragile X syndrome)

- Severity of ID, social circumstances and sometimes underlying aetiology influence mode of presentation

CONT.

- Features include:
  - Delayed gross motor milestones in the first year of life (*can be unreliable influenced by familial and cultural factors
  - Delayed social milestones such as smiling, attachment behaviour
  - Speech and language delay
  - Deafness may be suspected due to lack of response to sound, lack of appropriate words
  - Failure to make educational progress

CLINICAL FEATURES

- Clinical features will depend more especially on:
  - Severity of the impairment
  - Associated physical and psychiatric conditions
  - Quality of care and education received
  - Aetiology of the intellectual disability

CLINICAL FEATURES

- Mild → Appearance unremarkable, normal language, can live independently as adults, need help coping with family responsibilities.
- Moderate → Language is affected with simple speech. Activities of daily living acquired over time e.g. dressing, feeding, attention to hygiene. Problems with extended activities like handling money and directions.
- Severe → Development greatly slowed. Look after themselves eventually after close supervision. Engage in simple social activities.
- Profound →Dependent even for simple activities of daily living.

ASSESSMENT

- Four components
- Assessment is not a-once-and-for-all exercise.

1. Investigation of the cause
    - Frequently not possible
    - Basic right to know
    - Provide relief
    - Assists in focusing towards the future
    - A treatable cause may be found
    - Amniocentesis, routine biochemical tests, physical examination may reveal stigmata consistent with an obvious chromosomal abnormality

ASSESSMENT

2. Identification of associated physical and psychiatric problems
   - Sensory disorders are common in children with ID
   - General physical and neurological examination. Cerebral palsy can occur in 25% of children with moderate to severe ID
   - Behavioural and emotional problems: ADHD (10% of mod-severe ID), Autism spectrum disorders,
   - Self injurious behaviour (10-15% of severe ID)
     - Conditions associated with self-injurious behaviour include:
       - Lesch Nyhan, Fragile X, Prader Willi, Smith-Magnesis.

ASSESSMENT

3. Determination of level of functioning
   - General intelligence
   - Speech and language
   - Gross and fine motor development
   - Sensory issues
   - Social and personal development

ASSESSMENT

4. Assessment of family functioning, care, expectations and coping capacity
   - A major source of difficulty is mismatch between the child's abilities and potential, and parental perceptions of what the child is and is capable of.

MANAGEMENT

Important components

- Breaking the news
  - Nature
  - Likely causes
  - Likely further developments
  - Break news as soon as possible to both parents
  - Arrange for subsequent follow-up meetings
  - Psycho-educational: genetic counselling where available, likely implications on the child in the future, future parental pregnancies
  - Psychotherapeutic: sympathetic and supportive listening, moving family towards practical solutions

CONT.

- Counselling on promotion of development
  - Child will need more help in the acquisition and retention of new skills from parents and teachers.
  - Help needs to be provided at an appropriate level for the child
  - Early intervention programs
  - Link up parents with various professionals as early as possible.

CONT.

- Dealing with associated disabilities and behavioural problems
  - Common physical deficits: impairment of vision, hearing, epilepsy, cerebral palsy.
  - Cerebral psychiatry deficits: ADHD, Autism spectrum disorders.
  - Other psychological problems: Aggression, Self-injury, Obsessive Compulsive Behaviour

- Advising on appropriate education
  - Provide information on medical matters (meds, physiotherapy, hearing aids, spectacles).
  - Child's attention span, persistence, level of activity, capacity to form relationships, language and communication skills.

CONT.

- Genetic counselling where applicable.

- Providing social and emotional support
  - Parents get support from various sources → relatives, friends, neighbors, friends, social workers, teachers.
  - Regular examinations and healthy checks

C8C. MANAGEMENT OF LEARNING DISORDERS

BY: DR. JUDY KAMAU

BACKGROUND

- Learning disabilities are frequently diagnosed in children.
- Learning disabilities can occur for a variety of reasons and often require a multidisciplinary approach to address some of the more complex problems that can surround the diagnosis.
- Early diagnosis and referral to qualified educational professionals for evidence-based assessments and therapies offers the best chance for an improvement in quality of life.

BACKGROUND

- A child struggling in school causes concern.
- Difficulties with school tasks can leave children frustrated and parents and teachers wondering about the barriers that are preventing learning.
- Underachievement may however be a symptom of any number of cognitive, emotional and social difficulties.
- Children with difficulties fall along a continuum, some show less difficulty and others more
- Learning disabilities can be present with other co-occurring problems or co- morbidities. Examples of co-morbid problems include speech and sound disorders, attention deficit disorders and emotional disorders.

BACKGROUND

- The manifestations of a learning difficulty can change over development. What appears to be mild at one age can become a significant problem in another life stage.

Disorders include

- Reading Disorder
- Mathematics Disorder
- Disorder of Written Expression
- Learning Disorder NOS

READING DISORDER

Includes possible deficits in:

- Word reading accuracy:
  - The ability to correctly decode the written language, especially when reading aloud.
- Reading rate or fluency:
  - The ability to read quickly, accurately and effortlessly, with appropriate expression and meaning.
- Reading comprehension
  - Knowledge and understanding derived from text.
- Dyslexia is a developmental disorder affecting the skills involved in the reading and spelling of words, in the absence of any intellectual impairment.

MATHEMATICS DISORDER

- Mathematical disorder also known as dyscalculia is a term used for a wide range of disorders caused by abnormalities in one or more of the basic psychological processes involved in understanding or use of math.
- Several manifestations of the disorder may occur throughout the life of the individual.
- Mathematics disorder does not include children who have learning problems caused primarily by
  - visual, hearing, or motor impairments
  - mental retardation
  - emotional disturbance
  - environmental, cultural, or economic disadvantage

DISORDER OF WRITTEN EXPRESSION

- Proficiency in written expression skills can be viewed as the culmination of a child's education.
- Along with reading, expressing oneself in writing is an essential accomplishment of childhood that facilitates the necessary and rewarding tasks of adult life.
- The ability to write at an age-appropriate level is required for all academic progress and for some children, the acquisition of written expression skills is a difficult and enduring problem.
- Disorders of written expression often accompany reading or other learning difficulties

DISORDER OF WRITTEN EXPRESSION

- Disorder of written expression includes possible deficits in:
  - Spelling accuracy
  - Grammar and punctuation accuracy
  - Clarity or organization of written expression

HISTORY & PRESENTATION

- Falling behind in class
- Delayed early language development
- Difficulty segmenting words or recognizing the differences between similar sounds
- Family history of reading disability all indicate a potential learning problem.
- Frequently, learning disorders are comorbid with behaviour disorders, most frequently ADHD and oppositional defiant disorder.

ASSESSMENT

- Testing for intellectual or cognitive potential
- Testing for information processing or sensory motor abilities that are indicative for a learning disability
- Assessment of current educational achievement
- A prudent approach would be to *collect information from multiple sources* rather than depending on a single source or test.
- A diagnosis of one of the specific learning difficulties is heavily dependent on the educational, socio-economic and socio-cultural context.

ASSESSMENT

- Informal
- Formal psycho-educational assessment

ASSESSMENT

Informal

- Class room assessment
- Systemic observation
- File/ report reviews & interviews
- Get corroborative information from family, other teachers, ± counsellors, relevant medical reports
- Identify strengths and weaknesses

ASSESSMENT

Formal assessment (psycho-educational)

- Mainly conducted by psychologists
- May reveal difficulties in:
  - Perceptual and information processing
  - Language and auditory processing
  - Attention and other areas of executive function
  - Motor abilities
  - Social skills
  - Reading, written language, math

DIFFERENTIAL DIAGNOSIS

- Visual or hearing problems
- Intellectual disability (Mental retardation)
- Psychological or mental health problems
- Environmental or cultural factors
- Medical disorders (seizures, sleep disorders

COMMON CO-MORBIDITIES

- Other learning disabilities
- Developmental or acquired language disorders
- ADHD
- Disruptive behavioural disorders
- Mood disorders
- Anxiety disorders
- Environmental/cultural factors
- Medical disorders e.g. seizures, sleep disorders

OTHER ASSOCIATIONS

- Self esteem problems
- Substance use
- Drop out of school
- Suicide

MANAGEMENT

- Rule out other disorders
- Manage comorbidities

INTERVENTIONS

- School based
- Accommodation/ modifications
  - Use less difficult/ lengthy words with written instructions
  - Decrease amount of items students are expected to learn/ complete
  - Ample time for students to read content
  - Give instructions/ directions aloud to student
  - Occasionally substitute pictures/graphics for words
  - Allow students to voice responses rather than write

INTERVENTIONS

- Mastery model
  - Learners work at their own pace
  - Gain fundamental skills before moving to the next level
- Direct instruction
  - Highly structured intensive instruction
  - Interactions between teachers and student
  - Mistakes corrected immediately
  - Frequent progress assessment

INTERVENTIONS

- Classroom adjustment
  - Special seating assignment
  - Quiet environment
- Special equipment
  - Word processors with spell check and dictation
  - Talking calculators
  - Books on tape
  - Computer based activities

INTERVENTIONS

- Class room assistants
  - Note takers
  - Readers
  - Proof readers
  - Scribes
- Special education
  - Prescribed resource room hours
  - Individualised treatment plan

PROGNOSIS

- Children with learning disabilities can achieve academic success through a multidisciplinary approach that targets and manages the complex aspects associated with the condition.
- Children with learning disabilities can be challenging, and addressing the issues is not always simple.
- With appropriate accommodations and support, children with learning disabilities can achieve academic progress.

C8D. CHILDREN'S REACTION TO DEATH

BY: DR. T. MUTAVI

INTRODUCTION

- Almost every child or adolescent faces the death of someone close (a relative, friend, or even a pet) at some point in his or her life and are affected in some way.
- It is estimated that about 6 percent of children under age 15 will lose a parent.

- In most cases children are left out in the discussions about the death.
- When children are left out and not told any thing, they may feel anxious, bewildered, and alone.
- Young children may not verbalize or understand explanations.
- Regardless of this ability or inability to express themselves, children do grieve, often very deeply.

REACTION TO DEATH

- Children in many ways react to death like adults.
- **Shock.** The child may not believe the death really happened and will act as though it did not. This is usually because the thought of death is too overwhelming.
- **Physical Symptoms.** The child may have various complaints, such as headache or stomach-ache, and may fear that he too will die.

- **Anger.** The child may be angry at the person who died because he feels he has been left "all alone," or that God didn't "make the person well.“
- **Sadness.** The child may show a decrease in activity - being "too quiet.“
- **Regression.** The child may revert to behaviors he had previously outgrown, such as bed-wetting or thumb-sucking.

- **Guilt.** The child may think that he caused the death by having been angry with the person who died, or he may feel responsible for not having been "better" in some way.
- **Anxiety and Fear.** The child may wonder who will take care of him now, or fear that some other person he loves will die.

- **Dependency.** Become clingy and over-dependent on the adults around them as a way to cope with their sadness and grief.
- They may imagine or pretend that they are dying, or exhibit curiosity about the funeral coach, casket and grave.
- **Depression.** Children can just as easily become depressed as adults do.

- Many children become restless and overactive in response to grief.
- In short, there is no “normal” or correct way for children to grieve.
- It is a uniquely personal process.

- All the reactions outlined above are normal expressions of grief in children up to about six months.
- If the child's reaction seems to be prolonged, seeking professional advice of those who are familiar with the child (e.g., teachers, pediatricians, clergy) may be helpful.

DEVELOPMENTAL STAGES AND REACTION TO DEATH

- ***Age 2-5years***
  - Will be restless, have sleep disturbances, or frightening dreams.
  - They will sometimes revert to behaviors they had at a younger age, such as wetting the bed or thumb sucking.
  - Blame themselves since they do not fully understand the concept of death.

❑ *School-aged children*

- Physical symptoms, such as stomachache, headache and unusual complaint of tiredness.
- Behavior change e.g. reluctance to go to school, daydreaming in class, or a decline in academic performance
- Children of this age usually need extra time for physical activity to work off some of the physical tensions connected with mourning.

- ***Teenagers***
  - Understand more as an adult does, but find it difficult than younger children to deal with their sorrow.
  - Behavior problems
  - Dropping out of school
  - Physical complaints such as headache or chest pain.
  - Sexual promiscuity
  - Suicide attempts may result from their feelings of pain and loss.

- Often, teenagers are reluctant to talk to adults who could help them through their grief.
- Some adolescents may become angry with rage at the world for letting death take a loved one
- Adolescents can also feel very vulnerable. Some express the need to feel like a child again, to be taken care of and protected, to feel secure in a safe world.

INTERVENTION

- **WHAT PARENTS OR CARE GIVERS CAN DO.**

1) ***Handling a Child's Questions About Death and Dying***

- Children are generally curious and would want to ask a lot of questions.
- Preschoolers may ask questions such as, when is grandma coming back?

- Between age 5 and 10 children learn that death is final but may demand to know why young people also die.
- Listen to the child’s questions; answer them as simply as possible.
- Be direct, not trying to over explain or interpret their questions
- Be honest. Telling a child that “Grandpa is just sleeping,” may cause fear in them of falling asleep and never waking.

- Answering the child's questions as honest as possible helps minimize the child's fears.

2) Discussing Death with Children

a) Warn children of grave illnesses.

- Discuss serious illness in the family with the children before death occurs
- Children/child will be prepared – not a shock or surprise to them.

- Children have to know why the parents are sad and acting differently.

b) Talk to children soon after a death occurs.

- Children have to go through grieving process just as adults so they have to be told about the loss immediately.
- Discuss the loss with the children and not with others.

c) **Define "dead" in clear and simple terms**

- They have to understand that the dead person will not be able to do what they used to do e.g. walk, talk and breathe.
- The child should be told the dead person will never return and that the body will be buried in the ground or burned to ashes.

c) Avoid casual explanations

- Telling children that someone died because he was sick may lead them to believe that they themselves will also die when they are sick.

- Telling children that "Grandma went to sleep and will not wake up" will likely cause children to be afraid to go to sleep for fear that they will never wake up.
- "It is God's will." The child will not understand a God who takes a loved one because He needs that person Himself; or "God took him because he was so good." The child may decide to be bad so God wont take him, too.

- "John was sick and went to the hospital where he died. " The child will need an explanation about 'little" and "big" sicknesses. Otherwise, he may be extremely fearful if he or someone he loves has to go to the hospital in the future.
- Use words like "dead," "stopped working," and "wore out." These are simple words that help establish the fact that the body is biologically dead.

d) Fit the explanation to the children.

- Understanding a child's developmental stages helps parents, teachers, and caregivers provide appropriate responses and support for the child.
- For example level of development and understanding of death.

i) Two to six years

- Do not understand the finality of death so may appear unaffected by death.

- Parents should know the feelings of children about death and given reassurance when necessary.

ii) Six to nine years

- Children begin to understand that death is final thing though the understanding is not complete.
- May see death as something that only happens to old people and other people.

iii) Nine to twelve years

- At this age the children understand death but may not be able to handle all the details
- May regress if given too much.

iv) Teens.

- By the time children reach the teenage, they probably understand death and its finality as an adult.
- Even though they have this understanding, they still need lots of support from parents and loved ones.

3) Supporting Children

a) Include the children.

- Parents should allow their children to grieve with the family and those who care about them instead of sending them away to grieve alone.

b) Try not to alter the daily routine.

- Parents should keep life going as normal as possible
- Disruption of daily routines can be very upsetting to children.

- The more stable daily life remains for children, the easier things will be for them.

c) **Allow children to grieve in their own way.**

- Allow children to mourn. Be supportive and reassuring to them.
- Parents should encourage their children to express their feelings, whatever they are.

d) Don't hide your own grief.

- Parents should not hide their feelings from children.
- Parents should not turn to children for emotional support.
- Children must be allowed to grieve without feeling responsible for supporting grieving parents.

e) **Reassure.**

- At time of death children may think of their own death.

- Should be told that though no one knows for sure when they will die, they will probably not die for a very, very long time.
- Reassurance must be realistic
- If a child has lost a parent, reassure him that the other parent will still be here.
- For the present, the child will still live in the same house, sleep in the same bed, and go to the same school

- Often children conclude that they somehow caused the death.
- Tell the child it is not his/her fault that their friend or loved one died.
- If death occurred due to illness, reassure the child that he or she is healthy and will not die of the same disease

*4) **Attending the Funeral***

- When deciding whether a child should attend the funeral or not the parent should consider:

- Often children conclude that they somehow caused the death.
- Tell the child it is not his/her fault that their friend or loved one died.
- If death occurred due to illness, reassure the child that he or she is healthy and will not die of the same disease

*4) **Attending the Funeral***

- When deciding whether a child should attend the funeral or not the parent should consider:

1) The age of the child.
2) What the service will include.
3) How emotional the service will be.
4) The children's relationship to the person who died.

- This will apply to children younger than 7 years.
- Children should be allowed to attend the funeral, if it is their wish.

- Prior to the funeral someone should explain to children what is likely to take place, who will be there, and how people are likely to react.
- The choice of whether to view or touch the deceased should be left up to the child.
- Attending the funeral will provide children with the opportunity to express grief and to say good-bye to the deceased.

- **PROFESSIONAL INTERVENTION**

1) Counseling

- This may be necessary in pathological grief reaction.
  - Be loving, accepting, truthful, and consistent.
  - Let the child know about illness or death
  - Let the child express grief

- Reassuring the child that you will be there for them

2) Psychotherapy

- Family therapy

3) Social support

- Providing support to the family to help cope with stresses.
- Group support

4) Pharmacotherapy

- Some children may require drugs for depression, anxiety, phobias, psychosis etc.

- ***Developmental Phases of Grief Resolution***
  - These phases are the same for children and adults; they are not discrete phases and some overlap may occur; and the length and intensity of each phase is dictated by the seriousness of the loss.
- *Phase One*:
  - Characterized by shock and numbing followed by a reaction of alarm.

- The alarm is centered around questions of who is going to care for the child.
- Denial and disbelief may also be exhibited during this initial stage.
- *Phase Two*:
- Characterized by yearning, searching, disorganization, despair, and ultimately reorganization

- This phase is also characterized by strong feelings of sadness, anger, guilt, and shame.
- *Phase Three*:
- This phase involves the integration of loss and grief where the child begins to reorganize daily activities.
- Less frequent and less intense crying is seen. The child is also able to verbalize an awareness of the loss

C8E. ATTACHMENT, SOCIAL AND DEPRIVATION SYNDROMES IN CHILDREN & ADOLESCENTS
27/2/2019
LEVEL VI MBCHB

BY: DR. JUDY KAMAU

CHILD MALTREATMENT

- The definition of child maltreatment varies across continents and cultures but the focus is similar salient points.
- Ill treatment (i.e. the opposite to nurturing).
- The potential to cause harm to the child, including threats to harm as well as neglect (failure to provide the basic necessities required for normal development).
- Usually involves parents or other people in the context of a relationship of responsibility, trust or power (this includes teachers, religious leaders etc.).
- Exposure to (witness) violence, esp. between parents.

EPIDEMIOLOGY

- Globally there is a lack of reliable estimates of the prevalence of child maltreatment, esp. for low and middle income countries
- ~ 40M children globally are estimated to suffer abuse each year (WHO, 2001)
- Children's rights: The convention on the rights of the child states that children everywhere are entitled to basic human rights which include the right to:
  - Survival
  - Develop to the fullest
  - Protection from harmful influences, abuse and exploitation
  - Participate fully in the family, cultural and social life.

TYPES OF MALTREATMENT (WHO)

- Physical abuse: physical harm or injury
- Sexual abuse: involvement of a child in sexual activity that he (by virtue of his age or stage of development)
  - Does not fully comprehend
  - Is unable to give informed consent
  - Is not developmentally prepared for
- Sexual abuse may be by adults or children (under the age of 18 who have responsibility over the child) who are in a position of responsibility, have obtained children's trust, or have power over the victim.

CONT.

- Emotional abuse: failure to provide developmentally appropriate supportive emotional environment which results in impairment of a child's emotional development or sense of self worth
- Exploitation: use of children in work or other activities for the benefit of others, for financial gain e.g. child labor
- Neglect and negligent treatment: failure to provide for a child's basic needs and development in all spheres.

ATTACHMENT

- The absence of typical caregiving, including warm and responsive parenting, has been suggested to significantly affect the young child's ability to form adaptive relationships with adults and peers
- John Bowlby's (1952) original thesis was infants required responsive, individualized and loving care and that the presence of such caregiving allowed infants to develop a sense of security and trust in the world around them.
- It provided the foundation for the development of social relationships with others
- These first relationships between caregivers and infants were prototypical of what the child might expect as he or she got older and what she expects from adult relationships.

NEGLECT & NEGLIGENT TREATMENT

- Children need a safe and secure environment that they call home
- Besides providing shelter, home needs to be ab place of both physical and emotional safety where children can find comfort, protection and security. Thus optimum development depends on the interaction of positive environmental influences and inherent genetic disposition starting even prenatally (Shonkoff et. Al. 2000)
- However, in many parts of the world today, 8M abandoned or orphaned children are still being raised in socially depriving institutions (UNICEF 2007)
- Children exposed to early institutional rearing are at risk of developing psychopathology.

RISK FACTORS FOR CHILD MALTREATMENT

- Child
  - Younger age
  - Constitutional vulnerabilities e.g. CP, mental retardation, prematurity etc.
  - Difficult temperament
  - Chronic illness
  - Gender: for school aged children, female gender higher risk for sexual abuse while male gender higher risk for physical abuse.

CONT.

- Family
  - Low SES status (poverty, unstable housing, low education, unemployment, single parenthood, young parental age)
  - Criminal history
  - Substance abuse
  - Chronic physical illness and disabilities
  - Psychosocial factors (mental health problems, poor coping skills, lack of support from spouse, family community, marital disharmony, domestic violence)
  - Parents who were victims of abuse
  - Violence within the family

CONT.

- Society
  - High local unemployment
  - Social isolation
  - Sociocultural
  - Legal aspects
  - Disasters: natural or man - made

ASSESSMENT OF CHILD ABUSE AND NEGLECT

- Information from multiple informants: parents, children, child protective services workers, teachers
- Imaging
- Health care providers are mandated reporters of suspected or confirmed child maltreatment

CONSEQUENCES OF MALTREATMENT

- For child survivors of maltreatment the suffering happens not just at that point in time the deleterious impact, without adequate intervention, lingers on decades later into adulthood
- Certain types of abuse may cause long term injuries e.g. when the brain is directly damaged as in the Shaken Baby Syndrome. Maltreated children with bone fractures may have a higher risk of developing cancer later.

SEQUELAE OF MALTREATMENT

- Attachment difficulties
- Affect regulation ability to modulate or control the intensity of emotions
- Self esteem
- Peer problems
- Language development problems esp. those who have been neglected
- School adjustment and performance
- Cognitive problem: social and behavioral problems

CONT.

- Sexual behavior problems (esp. related to child sexual abuse)
  - ***Putting mouth to sex parts; asking to engage in sexual acts; masturbates with objects or inserting objects into the vagina or anus
  - **Talks about sexual acts; wants to watch movies that show nudity; knows more about sex than other children their age
  - *Talks flirtatiously, masturbates by hand; touches sex parts at home; tries to look at nude pictures or people undressing
- Intergenerational transmission of abuse

PSYCHIATRIC SEQUELAE

- Psychiatric diagnosis and symptomatology
- Child maltreatment is a risk factor for multiple forms of psychopathology which increased rates of:
  - PTSD
    depression
  - Reactive attachment disorders
  - Disinhibited social engagement disorders
  - Dissociative symptoms
  - Suicidality
  - Self destructive behavior, borderline traits
  - Drug and alcohol problems
  - Eating disorders
  - Oppositional defiant disorder and conduct disorders

CONT.

- Management can be challenging with high rates of diagnostic comorbidities and co – occurring family and social problems.

PROMOTING RESILIENCE AND RECOVERY

- Promoting the development and maintenance of positive attachment relationships
  - Availability of + stabile social supports
- Providing enrichment opportunities: sports, music training – promote development of self esteem
- Child and birth focused clinical interventions
  - Trauma informed systems of care; PTSD treatments; parent focused interventions
- Treatment of any emerging or resulting psychopathology

C8F. HUMAN DEVELOPMENT: LANDMARKS OF GROWTH AND DEVELOPMENT OF CHILDREN THROUGH ADOLESCENTS

BY: LINCOLN KHASAKALA

SPECIFIC OBJECTIVES:

By the end of this lecture, the student will be able to:

- Identify the importance of growth and development.
- Define growth and development.
- Mention the principles of growth and development.
- List factors affecting growth and development.
- Mention types of growth and development.
- Identify the stages of development.

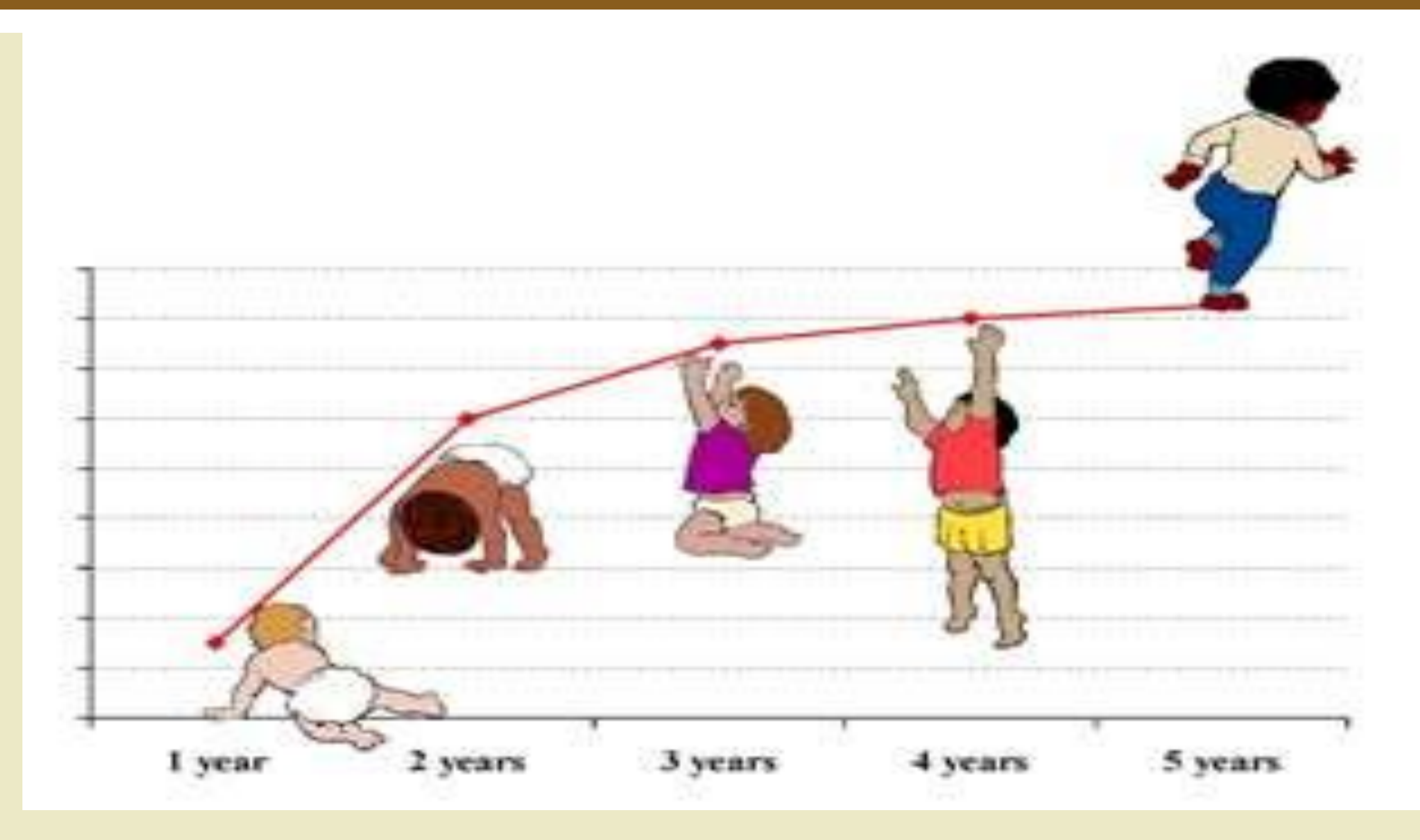
GROWTH

Growth refers to an increase in physical size of the whole body or any of its parts.

It is simply a quantitative change in the child's body.

It can be measured in Kg, pounds, meters, inches, ….. etc

CHILD GROWTH (IMAGE: WHO)



CHANGES IN BODILY PROPORTIONS WITH AGE.

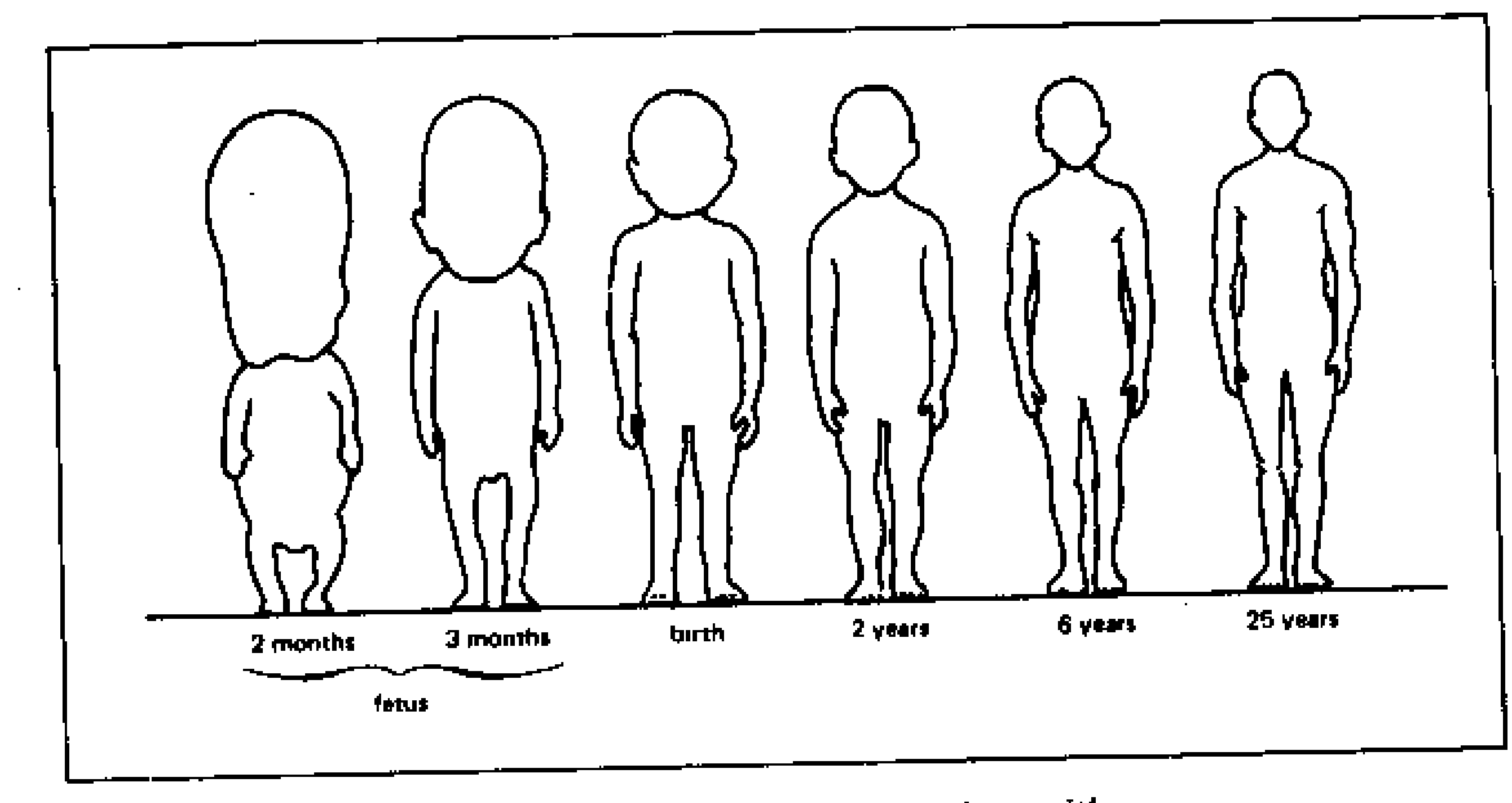


Figure 9. Changes in bodily proportions with age

DEVELOPMENT

- Development refers to a progressive increase in skill and capacity of function.
- It is a qualitative change in the child's functioning.
- It can be measured through observation.

BY UNDERSTANDING WHAT TO EXPECT DURING EACH STAGE OF DEVELOPMENT ,PARENTS CAN EASILY CAPTURE THE TEACHABLE MOMENTS IN EVERYDAY LIFE TO ENHANCE THEIR CHILD'S LANGUAGE DEVELOPMENT, INTELLECTUAL GROWTH,

SOCIAL DEVELOPMENT AND MOTOR SKILLS

MATURATION

- Increase in child's competence and adaptability.
- It is describing the qualitative change in a structure.
- The level of maturation depends on child's heredity.

IMPORTANCE OF GROWTH AND DEVELOPMENT IN CHILDREN

- Knowing what to expect of a particular child at any given age.
- Gaining better understanding of the reasons behind illnesses.
- Helping in formulating the plan of care.
- Helping in parents' education in order to achieve optimal growth & development at each stage.

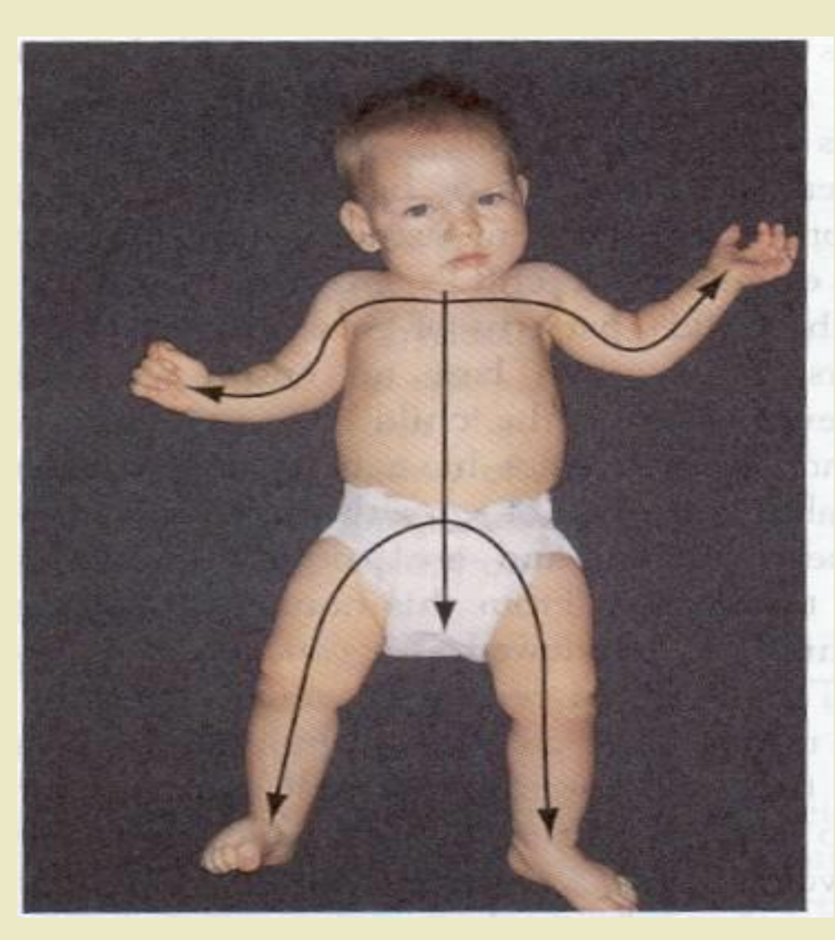
PRINCIPLES OF GROWTH & DEVELOPMENT

- Continuous process
- Predictable Sequence
- Don't progress at the same rate (↑ periods of GR in early childhood and adolescents & ↓ periods of GR in middle childhood)
- Not all body parts grow in the same rate at the same time.
- Each child grows in his/her own unique way.
- Each stage of G&D is affected by the preceding types of development.

PRINCIPLES OF GROWTH & DEVELOPMENT

- Growth and development proceed in regular related directions:
  - Cephalo – caudal (head down to toes)
  - Proximo distal (center of the body to peripheral)
  - General to specific.

GROWTH PATTERN



GROWTH PATTERNS

The child's pattern of growth is in a head-to-toe direction, or **cephalocaudal**, and in an inward to outward pattern called **proximodistal**.

FACTORS AFFECTING GROWTH AND DEVELOPMENT

- Hereditary factors
- Environmental factors
  - Prenatal environment:
    - Factors related to mothers during pregnancy: nutritional deficiencies, diabetic mother, exposure to radiation, infection with German measles, smoking, use of drugs.

CONT.

- Factors related to fetus
  - Malposition in uterus
  - Faulty placental implantation
- Postnatal environment
  - External environment: SES of family, child's nutrition, climate & season, child's ordinal position, number of siblings in the family, family structure (single parent or extended family)
  - Internal environment: child's intelligence, hormonal influences, emotions

TYPES OF GROWTH & DEVELOPMENT

Types of growth:

- Physical growth (Ht, Wt, head & chest circumference)
- Physiological growth (vital signs)

Types of development:

- Motor development
- Cognitive development
- Emotional development
- Social development

STAGES OF GROWTH & DEVELOPMENT

- Prenatal
  - Embryonic (conception- 8 w)
  - Fetal stage (8-40 or 42 w)
- Infancy
  - Neonate
    - Birth to end of 1 month
  - Infancy
    - 1 month to end of 1 year

CONT.

- Early Childhood
  - Toddler: 1-3 years
  - Preschool: 3-6 years
- Middle Childhood
  - School age 6 to 12 years
- Late Childhood
  - Adolescent: 13 years to approximately 18 years

NEWBORN STAGE

Newborn stage is the first 4 weeks or first month of life. It is a transitional period from intrauterine life to extra uterine environment.

NORMAL NEWBORN INFANT

Physical growth

- Weight = 2.700 – 4 kg
- Wt loss 5% -10% by 3-4 days after birth
- Wt gain by 10th days of life
- Gain ¾ kg by the end of the 1st month

Weight:

They loose 5 % to 10 % of weight by 3-4 days after birth as result of :

- Withdrawal of hormones from mother.
- Loss of excessive extra cellular fluid.
- Passage of meconium (feces) and urine.
- Limited food intake.

HEIGHT

- Boys average Ht = 50 cm
- Girls average Ht = 49 cm
- Normal range for both (47.5- 53.75 cm)

Head circumference

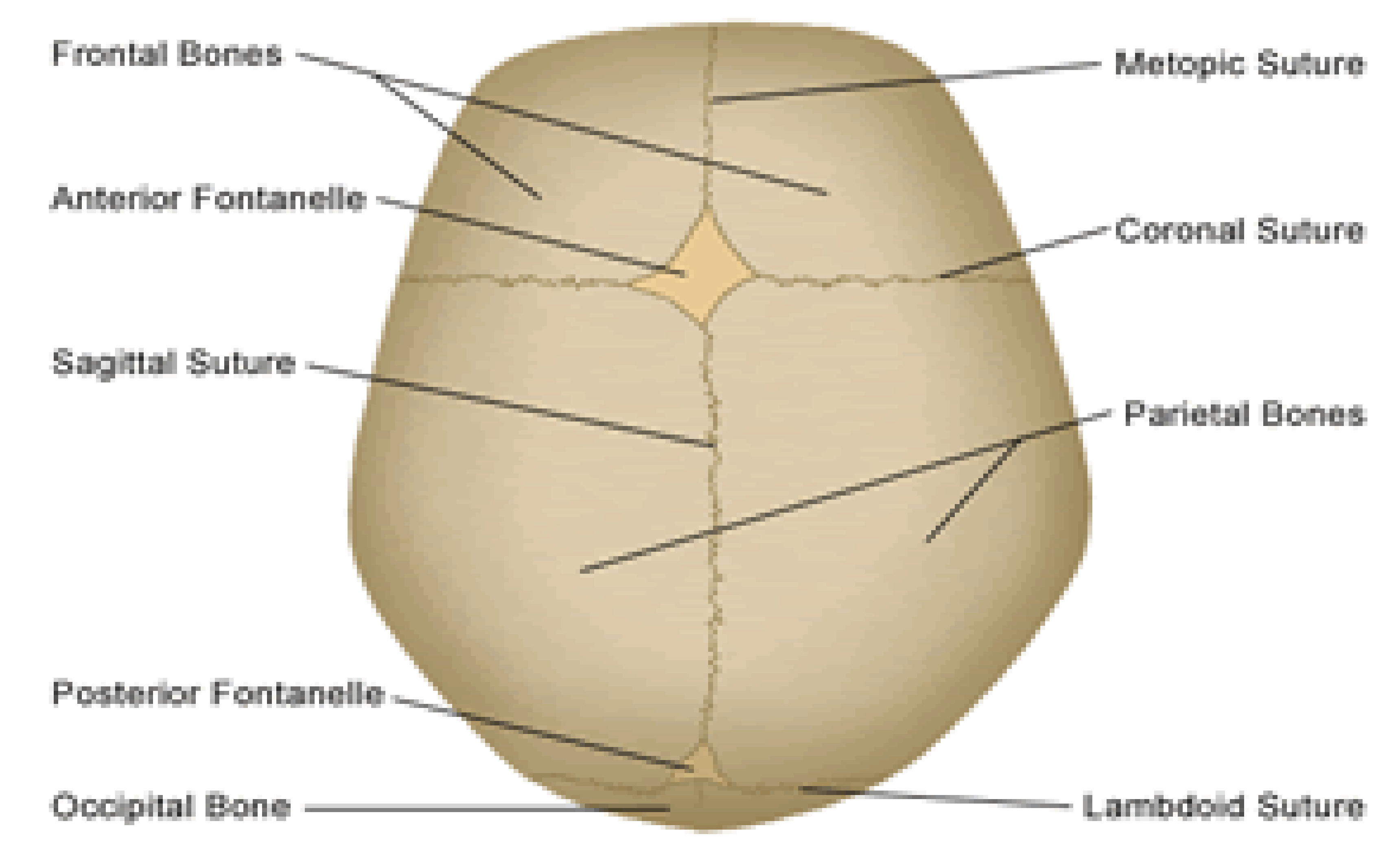
33-35 cm

Head is ¼ total body length

Skull has 2 fontanels (anterior & posterior)

ANTERIOR FONTANEL

- Diamond in shape
- The junction of the sagittal, corneal and frontal sutures forms it
- Between 2 frontal & 2 parietal bones
- 3-4 cm in length and 2-3 cm width
- It closes at 12-18 months of age


Normal Skull of the Newborn
Frontal Bones
Metopic Suture
Anterior Fontanelle
Coronal Suture
Sagittal Suture
Parietal Bones
Posterior Fontanelle
Occipital Bone
Lambdoid Suture

POSTERIOR FONTANEL

- Triangular
- Located between occipital & 2 parietal bones
- Closes by the end of the 1st month of age

CHEST CIRCUMFERENCE

It is 30.5 to 33cm (usually 2–3cm less than head circumference).

PHYSIOLOGICAL GROWTH

- Vital signs

  - Temperature (36.3 to37.2°C).
  - Pulse (120 to 160 b/min).
  - Respiration (35 to 50C/min) .

Axillary

Rectal

RESPIRATION

Normal Variations

30 to 60 respirations per min
Average - 40 respirations per min

HEART RATE (APICAL)

Normal Variations

100 to 160 beats per min
100 while sleeping
160 while crying

TEMPERATURE

Rectal

90.0° F to 99.5° F
(35.6° C to 37.5° C)

Axillary

97.6° F to 98.6° F
(36.5° C to 37.0° C)

BLOOD PRESSURE (AT BIRTH)

Average

75/42

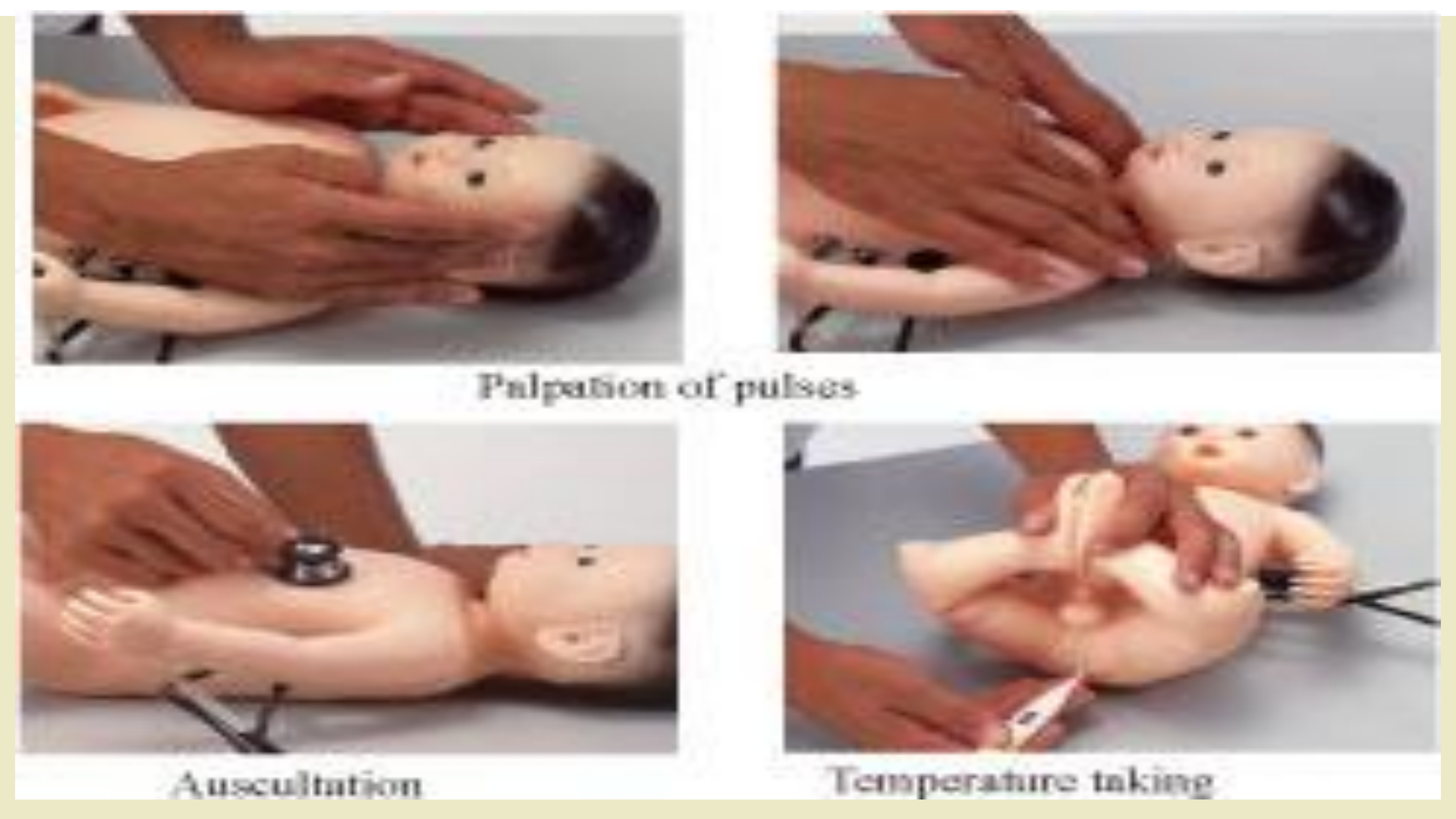
Systolis

60 to 80 mm Hg

Diastolic

40 to 50 mm Hg

SIMULATION FOR VITAL SIGNS



APGAR SCORING CHART

SIGN	0	1	2	1 min	5 min
Heart Rate	Absent	Less Than 100	Over 100	2	2
Respiratory Effort	Absent	Slow, Irregular	Good Cry	1	2
Muscle Tone	Limp	Some Flexion	Active Motion	1	2
Reflex Irritability	No Response	Grimace	Cry	1	2
Color	Pale	Body Pink, Extr. Blue	All Pink	1	2
TOTAL SCORE				6	10

The Apgar score rates:
Respiration, crying
Reflexes, irritability
Pulse, heart rate
Skin color of body
and extremities
Muscle tone
A.D.A.M.

NEWBORN SENSES

- Senses

  - Touch
  - Vision
  - Hearing
  - Taste
  - Smell

TOUCH

- It is the most highly developed sense.
- It is mostly at lips, tongue, ears, and forehead.
- The newborn is usually comfortable with touch.

VISION

- Pupils react to light
- Bright lights appear to be unpleasant to newborn infant.
- Follow objects in line of vision

HEARING

- The newborn infant usually makes some response to sound from birth.
- Ordinary sounds are heard well before 10 days of life.
- The newborn infant responds to sounds with either cry or eye movement, cessation of activity and / or startle reaction.

TASTE

Well developed as bitter and sour fluids are resisted while sweet fluids are accepted.

Smell

Only evidence in newborn infant's search for the nipple, as he smell breast milk.

NORMAL NEWBORN INFANT

GROSS MOTOR DEVELOPMENT

Motor development:

The newborn's movement are random, diffuse and uncoordinated. Reflexes carry out bodily functions and responses to external stimuli.

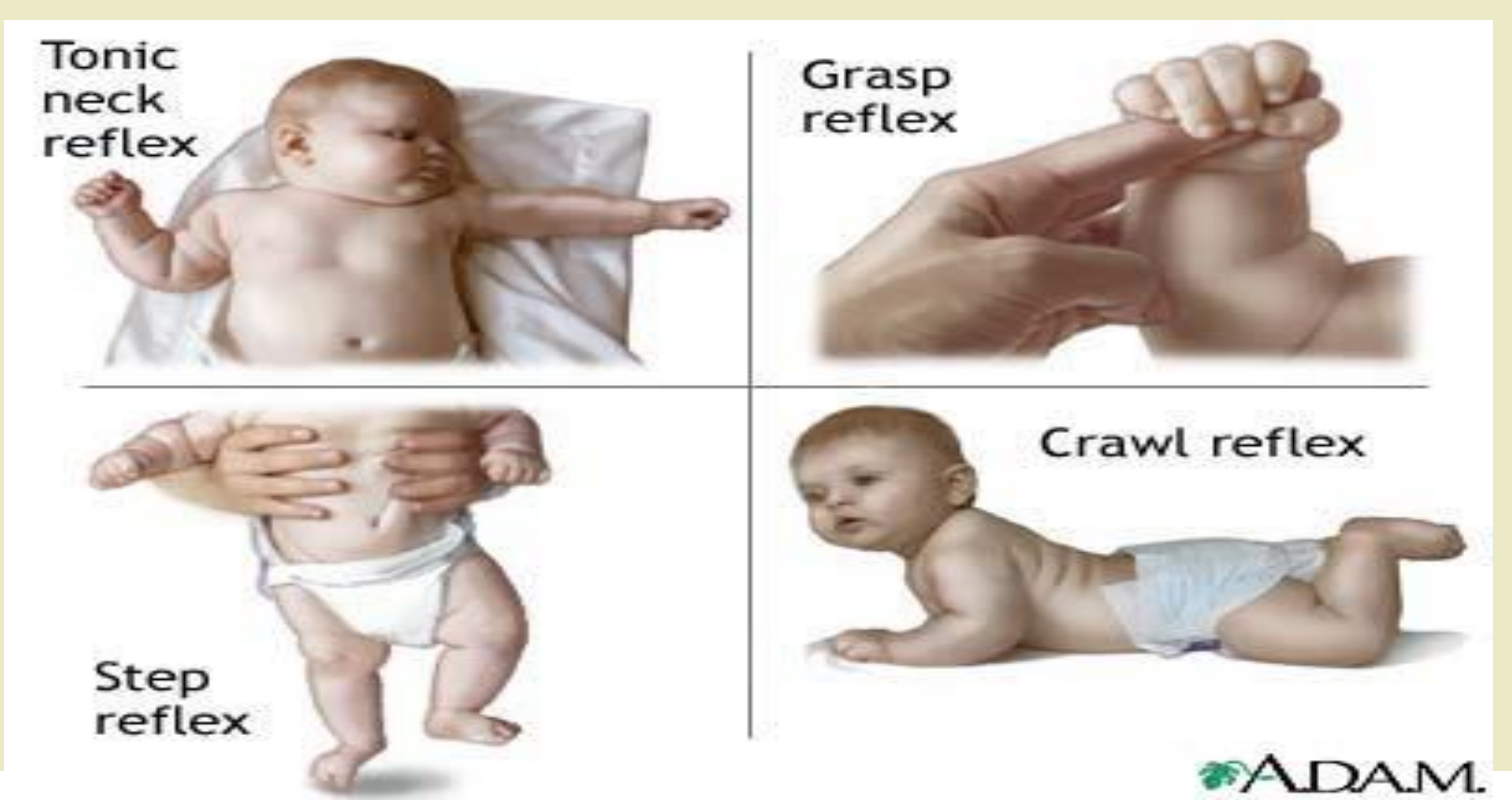
FINE MOTOR DEVELOPMENT

- Holds hand in fist
- When crying, he draws arms and legs to body

REFLEXES

- Swallowing
- Gagging
- Sucking
- Grasp
- Tonic-neck

ONE MONTH-REFLEXES



COGNITIVE DEVELOPMENT

The cognitive development of newborn infant is difficult to understand or observe it.

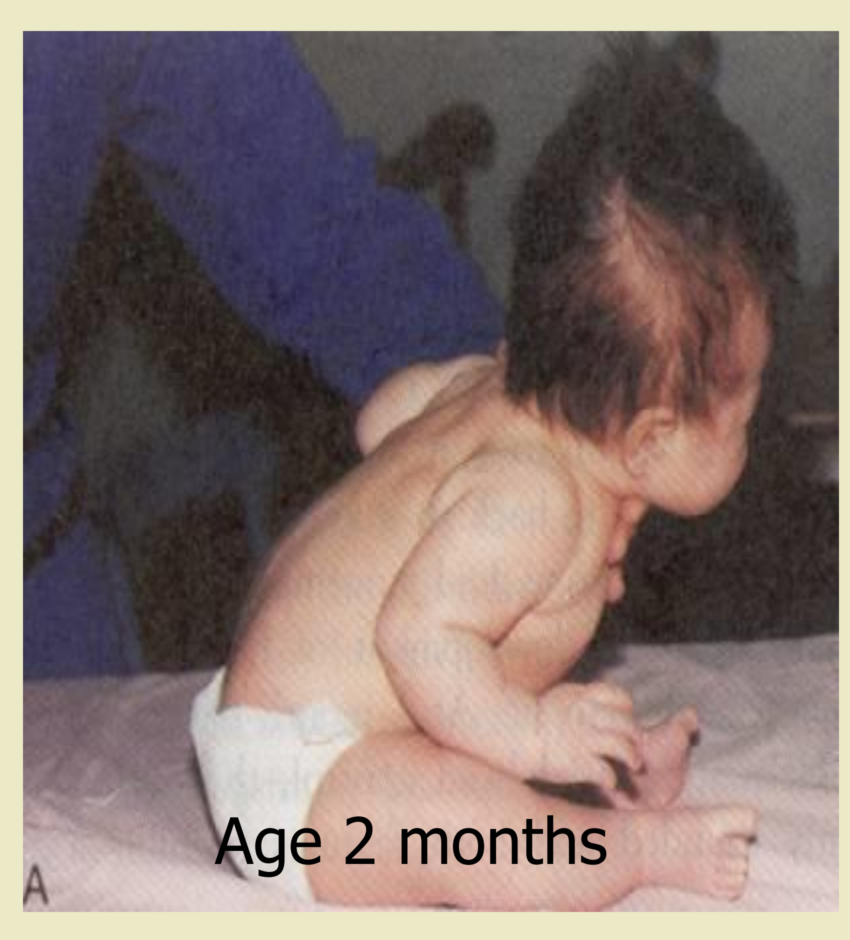
EMOTIONAL DEVELOPMENT

The newborn infant expresses his emotion just through cry for hunger, pain or discomfort sensation

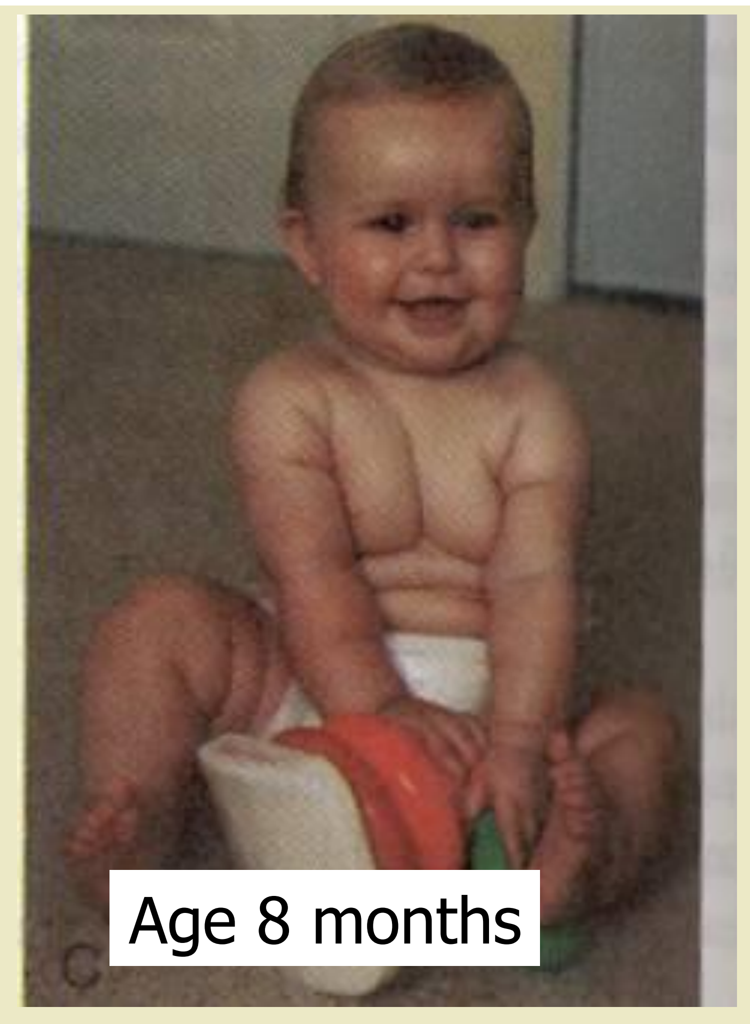
SOCIAL DEVELOPMENT

INFANCY

SITTING UP

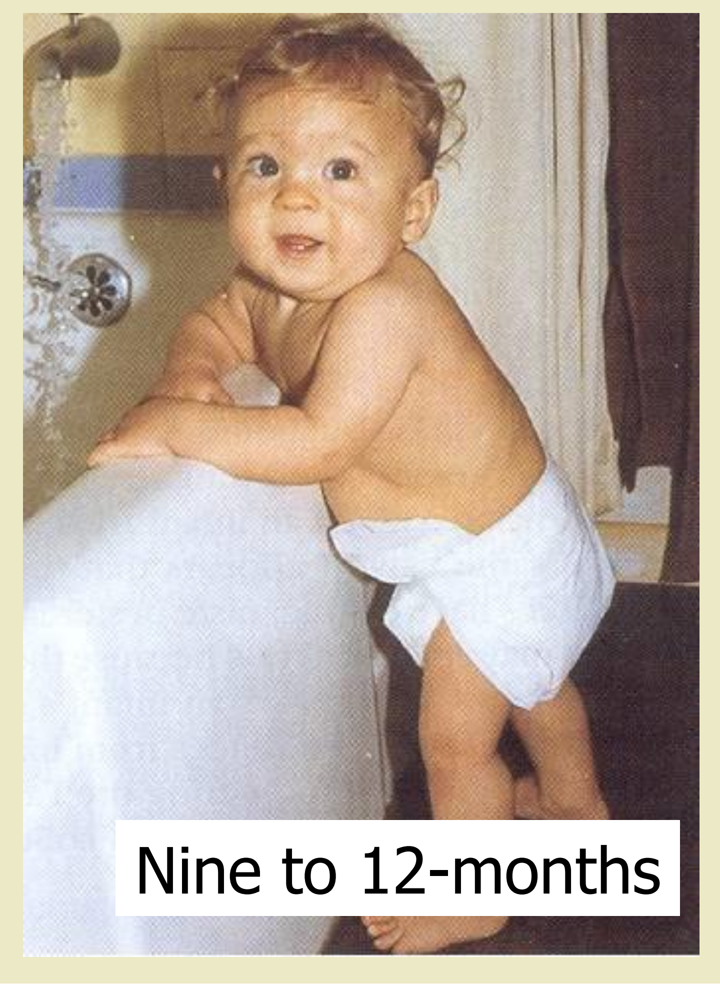


Age 2 months

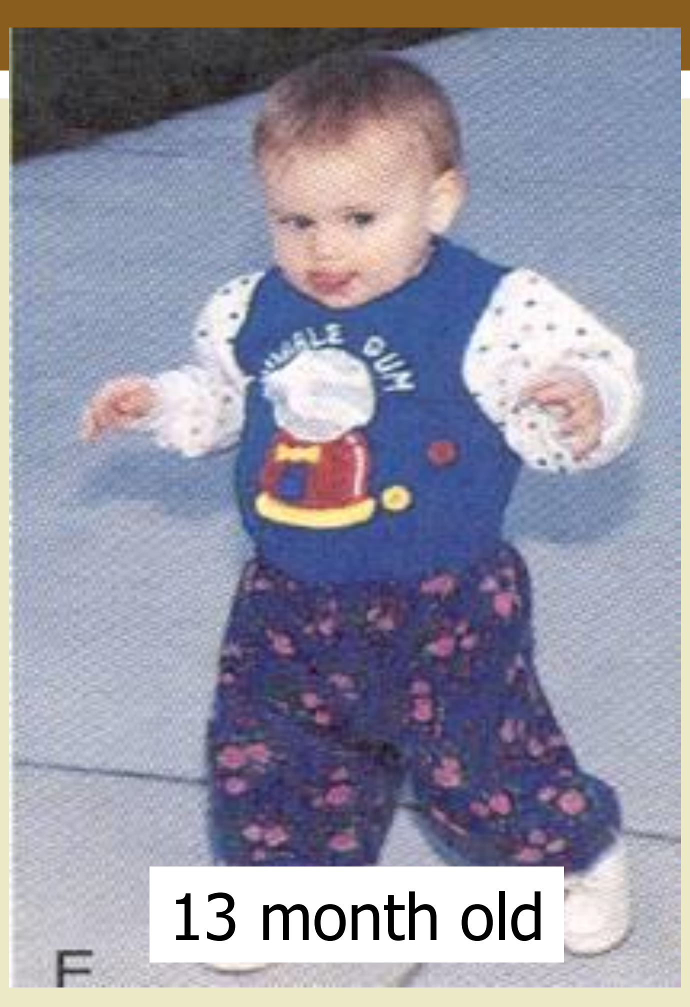


Age 8 months

AMBULATION



Nine to 12-months



13 month old

FINE MOTOR DEVELOPMENT IN INFANCY

DEFINITION OF NORMAL INFANT:-

It is the period which starts at the end of the first month up to the end of the first year of age. Infant's growth and development during this period are rapid.

PHYSICAL GROWTH OF NORMAL INFANT

Weight : the infant gains :

- Birth to 4 months → ¾ kg /month
- 5 to 8 months → ½ kg / month
- 9 to 12 months → ¼ kg /month

The infant will double his birth wt by 4-5 months and triple it by 10-12 months of age

CALCULATING INFANT'S WEIGHT

- Infants from 3 to 12 months:
- Weight = $\frac{\text{Age in months+9}}{2}$
- Hence: weight of 7 month old infant is:
  - $\frac{7+9}{2} = 8\text{Kg}.$

HEIGHT

- Length increases about 3 cm /month during the 1st 3 months of age,
- then it increases 2 cm /month at age of 4-6 months,
- Then, at 7 – 12 months, it increases 1 ½ cm per month

HEAD CIRCUMFERENCE

- It increases about 2 cm /month during the 1st 3 months,
- Then, ½ cm/month during the 2nd 9 months of age.
- Posterior fontanel closes by 6-8 w of age.
- Anterior fontanel closes by 12-18 months of age.

CHEST CIRCUMFERENCE

- By the end of the 1st year, it will be equal to head circumference.
- Physiological growth of infants:-
  - Pulse 110-150 b/min
  - RR 35 ± 10 c/min
  - Breath through nose.
  - Blood pressure 80/50 ± 20/10 mmHg

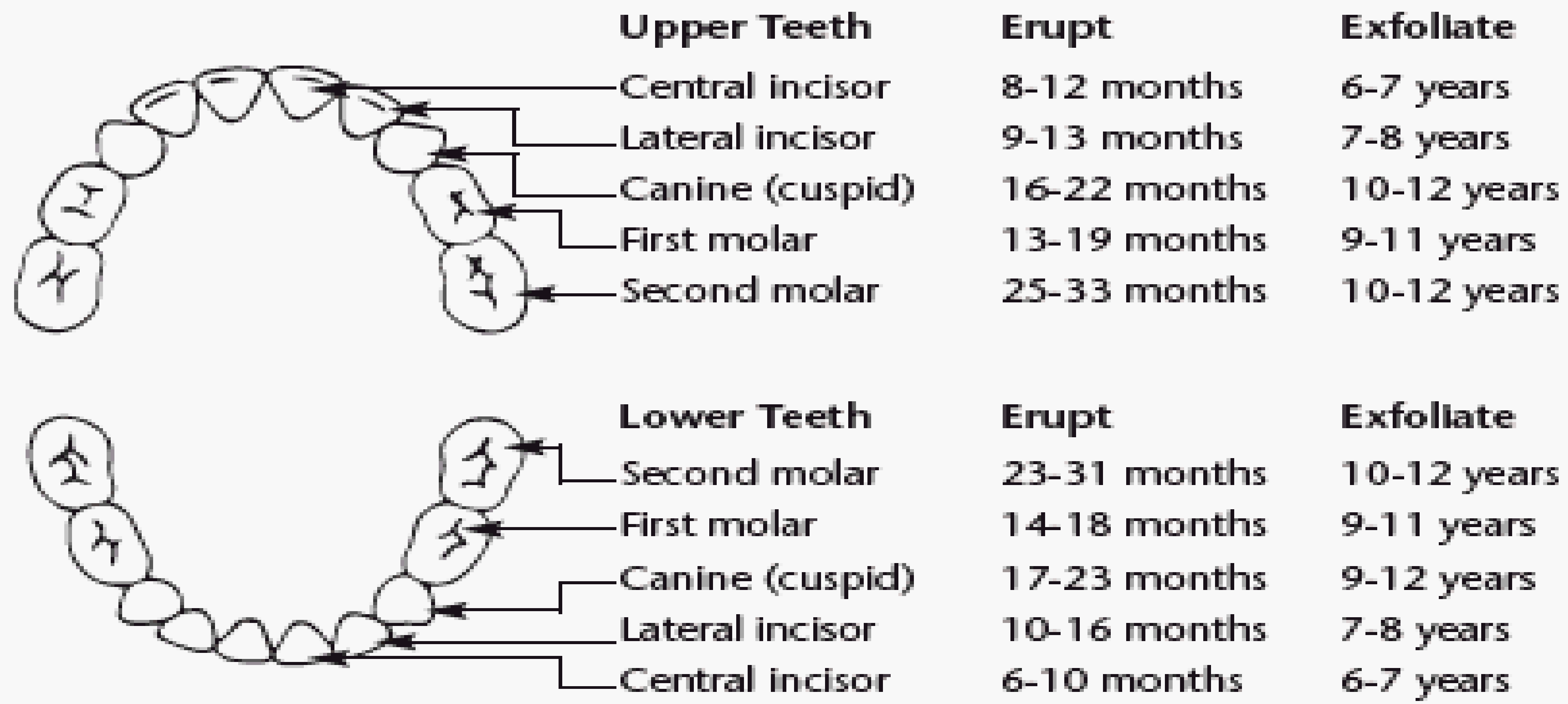
Eruption of the Primary Teeth*

Tooth	Upper Jaw †	Lower Jaw †
Central incisor	8-12 months	6-10 months
Lateral incisor	9-13 months	10-16 months
Cuspid	16-22 months	17-23 months
First molar	13-19 months	14-18 months
Second molar	25-33 months	23-31 months

*Compiled from information furnished by the American Academy of Pediatric Denistry

†These eruption times are average and can normally vary by two months.

PRIMARY DENTITION



Upper Teeth	Erupt	Exfoliate
Central incisor	8-12 months	6-7 years
Lateral incisor	9-13 months	7-8 years
Canine (cuspid)	16-22 months	10-12 years
First molar	13-19 months	9-11 years
Second molar	25-33 months	10-12 years

Lower Teeth	Erupt	Exfoliate
Second molar	23-31 months	10-12 years
First molar	14-18 months	9-11 years
Canine (cuspid)	17-23 months	9-12 years
Lateral incisor	10-16 months	7-8 years
Central incisor	6-10 months	6-7 years

DENTITION:

Eruption of teeth starts by ***5 – 6 months of age***. It is called "Milk teeth" or "Deciduous teeth" or "Temporary teeth".

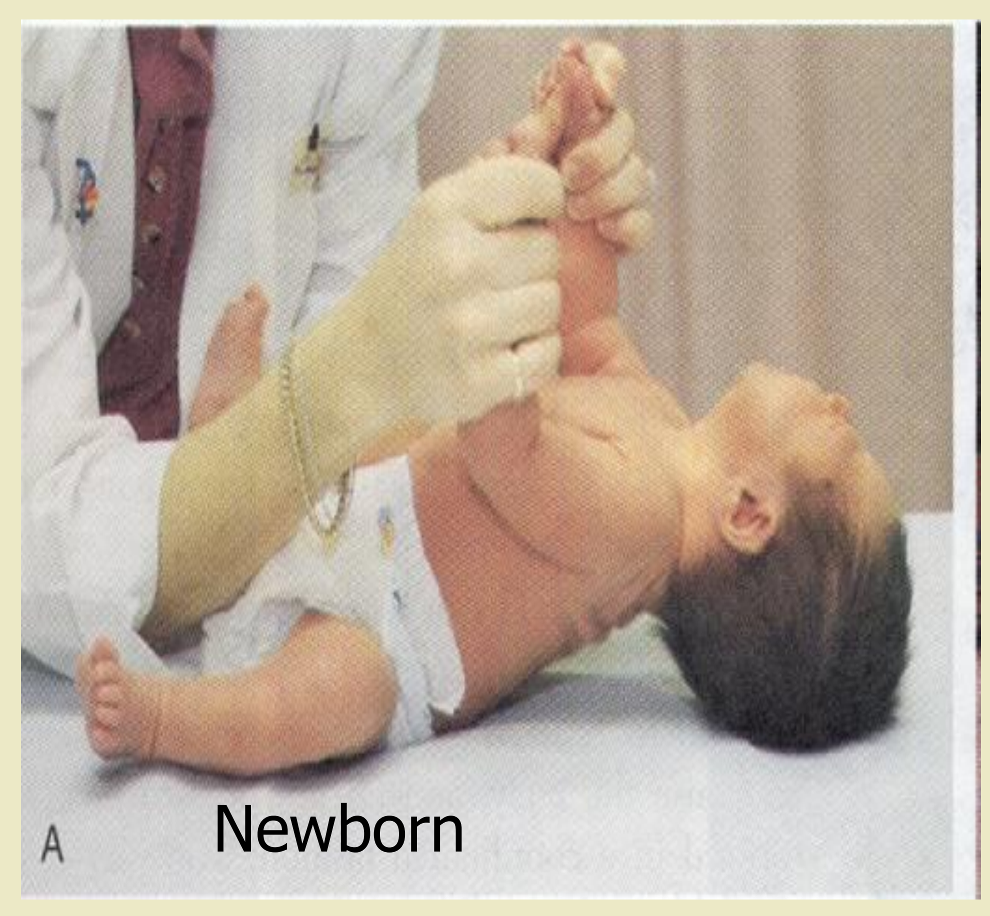
AVERAGE AGE FOR TEETH ERUPTION IN MONTHS:

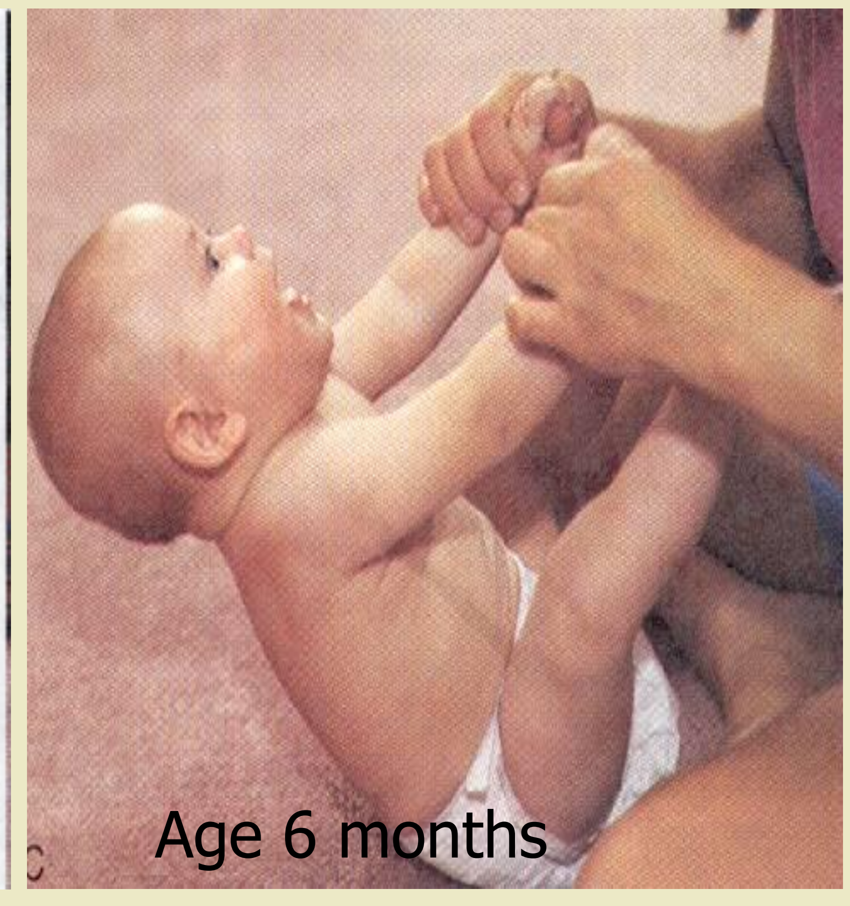
- Lower central incisors → 6
- Upper central incisors → 7.5
- Upper lateral incisors → 9
- Lower lateral incisors → 11
- Lower first molars → 12
- Upper first molars → 14
- Lower cuspids → 16
- Upper cuspids → 18
- Lower 2nd molars → 20
- Upper 2nd molars → 24

MOTOR DEVELOPMENT

- **At 2 months**
  - Hold head erects in mid-position.
  - Turn from side back.
- **At 3 months,** the infant can
  - Hold head erects and steady.
  - Open or close hand loosely.
  - Hold object put in hand

HEAD CONTROL





AT 4 MONTHS, THE INFANT CAN:

- Sit with adequate support.
- Roll over from front to back.
- Hold head erect and steady while in sitting position.
- Bring hands together in midline and plays with fingers.
- Grasp objects with both hands.

AT 5 MONTHS, THE INFANT CAN:

- Balance head well when sitting.
- Site with slight support.
- Pull feet up to mouth when supine.
- Grasp objects with whole hand (Rt. or Lt.).
- Hold one object while looking at another

AT 6 MONTHS, THE INFANT CAN:

- Sit alone briefly.
- Turn completely over (abdomen to abdomen).
- Lift chest and upper abdomen when prone.
- Hold own bottle.

AT 7 MONTHS, THE INFANT CAN:

- Sit alone.
- Hold cup.
- Imitate simple acts of others.

AT 8 MONTHS, THE INFANT CAN:

- Site alone steadily.
- Drink from cup with assistance.
- Eat finger food that can be held in one hand.

AT 9 MONTHS, THE INFANT CAN:

- Rise to sitting position alone.
- Crawl (i.e., pull body while in prone position).
- Hold one bottle with good hand-mouth coordination

AT 10 MONTHS, THE INFANT CAN:

- Creep well (use hands and legs).
- Walk but with help.
- Bring the hands together.

At 11 months , the infant can:

- Walk holding on furniture.
- Stand erect with minimal support

AT 12 MONTHS , THE INFANT CAN:

- Stand-alone for variable length of time.
- Site down from standing position alone.
- Walk in few steps with help or alone (hands held at shoulder height for balance).
- Pick up small bits of food and transfers them to his mouth

AMBULATION(MOTOR GROWTH)

- 9 month old: crawl
- 10 month old: creep
- 1 year: stand independently from a crawl & creep position

- 13 month old: walk and toddle quickly

- 15 month old: can run

EMOTIONAL DEVELOPMENT:

- His emotions are instable, where it is rapidly changes from crying to laughter.
- His affection for or love family members appears.
  - **By 10 months**, he expresses several beginning recognizable emotions, such as anger, sadness, pleasure, jealousy, anxiety and affection.
  - **By 12 months** of age, these emotions are clearly distinguishable.

SOCIAL DEVELOPMENT

- He learns that crying brings attention.
- The infant smiles in response to smile of others.
- The infant shows fear of stranger (stranger anxiety).
- He responds socially to his name.
- According to Erikson, the infant develops sense of trust. Through the infant's interaction with caregiver (mainly the mother), especially during feeding, he learns to trust others through the relief of basic needs.

AS AN INFANT'S VISION DEVELOPS, HE OR SHE MAY SEEM PREOCCUPIED WITH WATCHING SURROUNDING OBJECTS AND PEOPLE

SPEECH MILESTONES

- 1-2 months: coos
- 2-6 months: laughs and squeals
- 8-9 months babbles: mama/dada as sounds
- 10-12 months: "mama/dada specific
- 18-20 months: 20 to 30 words – 50% understood by strangers
- 22-24 months: two word sentences, >50 words, 75% understood by strangers
- 30-36 months: almost all speech understood by strangers.

HEARING

- BAER hearing test done at birth
- Ability to hear correlates with ability enunciate words properly
- Always ask about history of otitis media – ear aiding devices.
- Early referral to MD to assess for possible fluid in ears (effusion)
- Repeat hearing screening test
- Speech therapist as needed

RED FLAGS IN INFANT DEVELOPMENT

- Unable to sit alone by age 9 months
- Unable to transfer objects from hand to hand by age 1 year
- Abnormal pincer grip or grasp by age 15 months
- Unable to walk alone by 18 months
- Failure to speak recognizable words by 2 years.

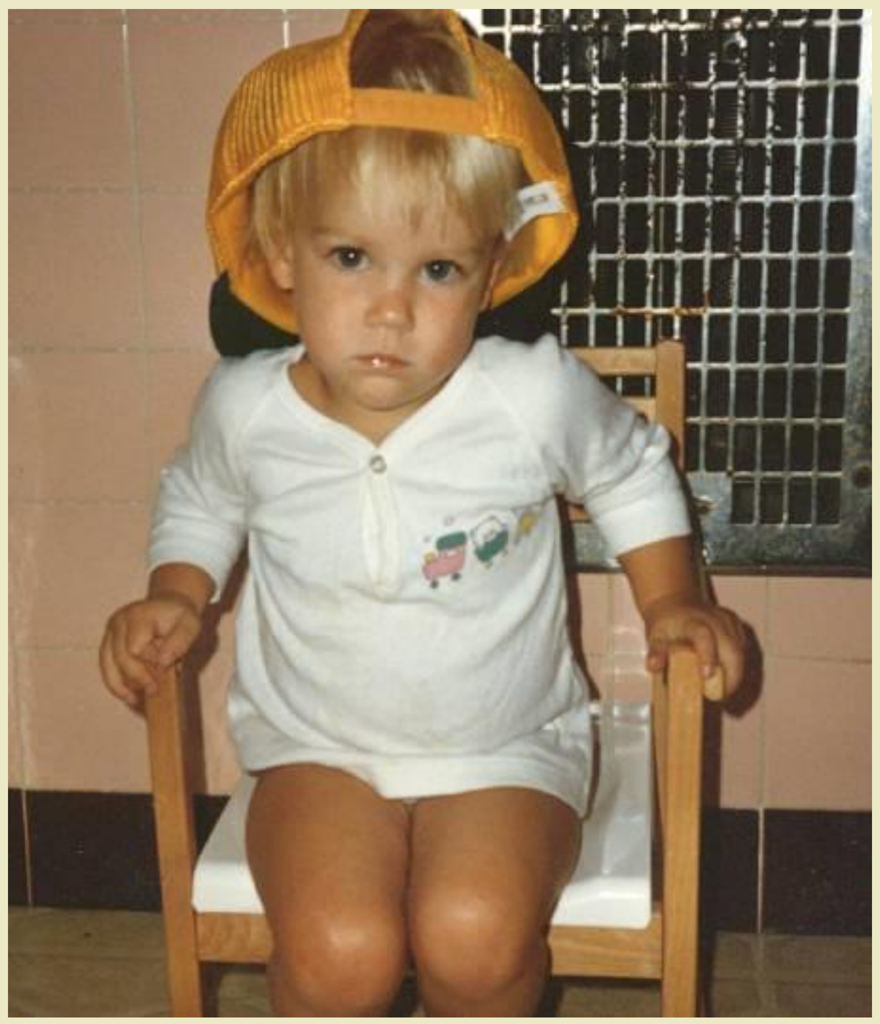
VISION IN TODDLER AGE

TODDLER

Safety becomes a problem as the toddler becomes more mobile.

Pilliterri, Lippincott

TODDLERS



NORMAL TODDLER:

Toddler stage is between 1 to 3 years of age. During this period, growth slows considerably.

PHYSICAL GROWTH

Weight:

- The toddler's average weight gain is ***1.8 to 2.7 kg/year.***
- Formula to calculate normal weight (Kg) of children over 1 year of age is
  - [Age in years X 2] + 8
  - E.g., The weight of a child aging 4 years

    = 4 X 2 + 8 = 16 kg

HEIGHT:

- During 1–2 years, the child's height increases by 1cm/month.
- The toddler's height increases about 10 to 12.5cm/year.

FORMULA TO CALCULATE NORMAL HEIGHT IN CM

- [Age in years X 5] + 80
- E.g., the length of 2 years old child:
  - 2 X 5 + 80 = 90cm

HEAD AND CHEST CIRCUMFERENCE:

- The head increases 10 cm only from the age of 1 year to adult age.
- During toddler years, chest circumference continues to increase in size and exceeds head circumference.

TEETHING:

- By 2 years of age, the toddler has 16 temporary teeth.
- By the age of 30 months (2.5 years), the toddler has 20 teeth

PHYSIOLOGICAL GROWTH:

Pulse: 80–130 beats/min (average 110/min).

Respiration: 20–30C/min.

Bowel and bladder control:

Daytime control of bladder and bowel control by 24–30 months.

FINE MOTOR - TODDLER

- 1 year old: transfer objects from hand to hand
- 2 year old: can hold a crayon and color vertical strokes
  - Turn the page of a book
  - Build a tower of six blocks
- 3 year old: copy a circle and a cross – build using small blocks

GROSS - MOTOR OF TODDLER

At 15 months, the toddler can:

- **Walk alone.**
- Creep upstairs.
- Assume standing position without falling.
- Hold a cup with all fingers grasped around it.

At 18 months:

- **Hold cup with both hands.**
- Transfer objects hand-to hand at will.

CONTINUOUS

At 24 months:

- Go up and down stairs alone with two feet on each step.
- **Hold a cup with one hand.**
- Remove most of own clothes.
- Drink well from a small glass held in one hand.

At 30 months: the toddler can:

- Jump with both feet.
- Jump from chair or step.
- Walk up and downstairs, one foot on a step.
- Drink without assistance.

ISSUES IN PARENTING – TODDLER (EMOTIONAL DEVELOPMENT)

- ***Stranger anxiety*** – should dissipate by age 2 ½ to 3 years
- ***Temper tantrums***: occur weekly in 50 to 80% of children – peak incidence 18 months – most disappear by age 3
- ***Sibling rivalry***: aggressive behavior towards new infant: peak between 1 to 2 years but may be prolonged indefinitely
- ***Thumb sucking***
- ***Toilet Training***

COGNITIVE DEVELOPMENT:

- Up to 2 years, the toddler uses his senses and motor development to different self from objects.
- The toddler from 2 to 3 years will be in the pre-conceptual phase of cognitive development (2-4 years), where he is still egocentric and can not take the point of view of other people.

SOCIAL DEVELOPMENT:

- The toddler is very social being but still egocentric.
- He imitates parents.
- Notice sex differences and know own sex.
- According to **Erikson,**
    - The development of autonomy during this period is centered around toddlers increasing abilities to control their bodies, themselves and their environment i.e., "I can do it myself".

PRE-SCHOOL

PRESCHOOL STAGE

Definition:-

It is the stage where child is 3 to 6 years of age. The growth during this period is relatively **slow.**

Physical growth:-

Weight: The preschooler gains approximately 1.8kg/year.

Height: He doubles birth length by 4–5 years of age.

Physiological growth

- **Pulse:** 80-120 beat/min. (average 100/min).
- **Respiration:** 20-30C/min.
- **Blood Pressure:** 100/67±24/25.

FINE MOTOR – OLDER TODDLER

- 3 year old: copy a circle and a cross – build using small blocks
- 4 year old: use scissors, color within the borders
- 5 year old: write some letters and draw a person with body parts

FINE MOTOR AND COGNITIVE ABILITIES PRE-SCHOOL

- Buttoning clothing
- Holding a pencil
- Building with small blocks
- Using scissors
- Playing a board game
- Have child draw picture of himself

COGNITIVE DEVELOPMENT

Preschooler up to 4 years of age is in the **pre-conceptual phase**. He begins to be able to give reasons for his belief and actions, but not true cause-effect relationship.

EMOTIONAL DEVELOPMENT OF PRESCHOOLER

- Fears the **dark**
- Tends to be **impatient and selfish**
- Expresses **aggression** through physical and verbal behaviors.
- Shows signs of **jealousy of siblings**

SOCIAL DEVELOPMENT IN PRESCHOOLERS

- Egocentric
- Tolerates short separation
- Less dependent on parents
- May have dreams & night-mares
- Attachment to opposite sex parent
- More cooperative in play

SOCIAL DEVELOPMENT

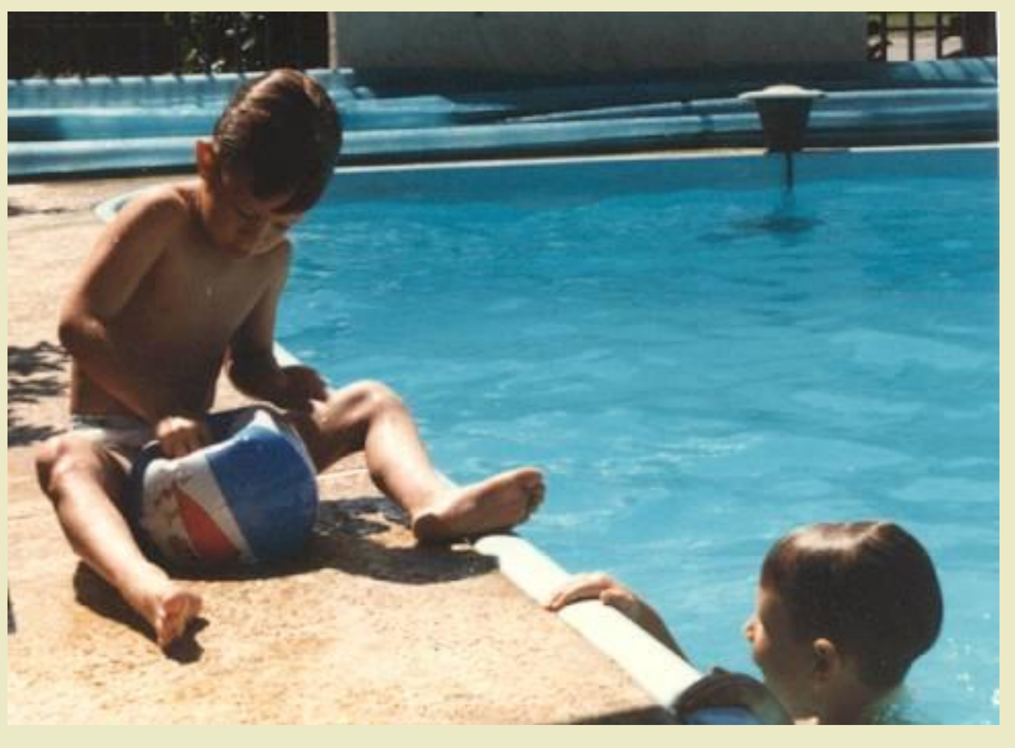
According to **Erikson theory:**

- The preschooler is in the stage where he **develops a sense of initiative**, Where he wants to learn what to do for himself, learn about the world And other people.

RED FLAGS: PRESCHOOL

- Inability to perform self-care tasks, hand washing simple dressing, daytime toileting
- Lack of socialization
- Unable to play with other children
- Unable to follow directions during exam

POOL SAFETY



SCHOOL-AGE

NORMAL SCHOOL-AGE CHILD:

- School-age period is between the age of 6 to 12 years. The child's growth and development is **characterized by gradual growth.**

PHYSICAL GROWTH

Weight:

- School–age child gains about **3.8kg/year.**
- Boys tend to gain slightly more weight through **12 years.**
- **Weight Formula for 7 - 12 yrs.**
  - $\frac{[\text{Age in years X } 7] - 5}{2}$

Height:

- The child gains about 5cm/year.
- Body proportion during this period: Both boys and girls **are long-legged**.

Dentition:

- **Permanent teeth** erupt during school-age period, **starting from 6 years**, usually in the same order in which primary teeth are lost.
- The child acquires permanent molars, medial and lateral incisors.

PHYSIOLOGICAL GROWTH:

- **Pulse:** 90±15 beats/min (75 to 105).
- **Respiration:** 21±3C/min (18-24).
- **Blood Pressure:** 100/60±16/10.

SCHOOL YEARS: FINE MOTOR

- Writing skills improve
- Fine motor is refined
- Fine motor with more focus
  - Building: models – logos
  - Sewing
  - Musical instrument
  - Painting
  - Typing skills
  - Technology: computers

MOTOR DEVELOPMENT

- **At 6-8 years,** the school-age child:
  - Rides **a bicycle.**
  - Runs Jumps, climbs and hops.
  - Has improved eye-hand coordination.
  - Prints word and **learn cursive writing.**
  - Can brush and comb hair.

At 8–10 years, the school–age child:

- Throws balls skillfully.
- Uses to participate in organized sports.
- Uses both hands independently.
- Handles eating utensils (spoon, fork, knife) skillfully.

At 10–12 years, the school–age child:

- Enjoy all physical activities.
- Continues to improve his motor coordination.

SCHOOL AGE: GROSS MOTOR

- 8 to 10 years: **team sports**
- Age ten: **match sport** to the physical and emotional development

SCHOOL PERFORMANCE

- Ask about favorite subject
- How they are doing in school
- Do they like school
- By parent report: any learning difficulties, attention problems, homework
- Parental expectations

SCHOOL AGE

SCHOOL AGE: COGNITIVE DEVELOPMENT

At 7-11 years, the child now is **in the concrete operational stage of cognitive development.** He is able to function on a higher level in his mental ability.

Greater ability to concentrate and participate in self-initiating quiet activities that challenge cognitive skills, **such as** reading, playing computer and board games.

EMOTIONAL DEVELOPMENT

The school-age child:

- Fears **injury to body** and fear of **dark.**
- **Jealous** of siblings (especially 6-8 years old child).
- **Curious** about everything.
- Has **short bursts of anger by age of 10 years but able to control anger by 12 years.**

SOCIAL DEVELOPMENT

The school-age child is :

- Continues to be egocentric.
- Wants other children to play with him.
- Insists on being first in every thing
- Becomes peer oriented.
- Improves relationship with siblings.
- Has greater self-control, confident, sincere.
- Respects parents and their role.
- Joints group (formal and informal).
- Engage in tasks in the real world.

RED FLAGS: SCHOOL AGE

- School failure
- Lack of friends
- Social isolation
- Aggressive behavior: fights, fire setting, animal abuse

13 TO 18 YEAR OLD

ADOLESCENT AGE

- Physical growth
- Physiological growth
- Secondary sex characteristics
- Cognitive development
- Emotional development
- Social development

DEFINITION OF ADOLESCENT:

Adolescence is a transition period from childhood to adulthood. Its is based on childhood experiences and accomplishments.

It begins with the appearance of secondary sex characteristics and ends when somatic growth is completed and the individual is psychological mature.

Physical growth:

Weight:

- Growth spurt begins earlier in girls (10–14 years, while it is 12–16 in boys).
- Males gains 7 to 30kg, while female gains 7 to 25kg.

Height:

- By the age of 13, the adolescent triples his birth length.
- Males gains 10 to 30cm in height.
- Females gains less height than males as they gain 5 to 20cm.
- Growth in height ceases at 16 or 17 years in females and 18 to 20in males

PHYSIOLOGICAL GROWTH:

Pulse: Reaches adult value 60–80 beats/min.

Respiration: 16–20C/minute.

NB: The sebaceous glands of face, neck and chest become more active. When their secretion accumulates under the skin in face, **acne will appear.**

APPEARANCE OF SECONDARY SEX CHARACTERISTICS

1- Secondary sex characteristics in girls:

- Increase in transverse diameter of the pelvis.
- Development of the breasts.
- Change in the vaginal secretions.
- Growth of pubic and axillary hair.
- Menstruation (first menstruation is called menarche, which occurs between 12 to 13 years).

BODY IMAGE

2- Secondary sex characteristics in boys:

- Increase in size of genitalia.
- Swelling of the breast.
- Growth of pubic, axillary, facial and chest hair.
- Change in voice.
- Rapid growth of shoulder breadth.
- Production of spermatozoa (which is sign of puberty).

ADOLESCENT

- As teenagers gain independence they begin to challenge values
- Critical of adult authority
- Relies on peer relationship
- Mood swings especially in early adolescents

Cognitive development:

Through formal operational thinking, adolescent can deal with a problem.

Emotional development:

This period is accompanied usually by changes in emotional control. Adolescent exhibits alternating and recurrent episodes of disturbed behavior with periods of quite one. He may become hostile or ready to fight, complain or resist every thing.

Social development:

He needs to know "who he is" in relation to family and society, i.e., he develops a sense of identity. If the adolescent is unable to formulate a satisfactory identity from the multi-identifications, sense of self-confusion will be developed according to **Erikson:-**

Adolescent shows interest in other sex.

He looks for close friendships.

ADOLESCENT BEHAVIORAL PROBLEMS

- Anorexia
- Attention deficit
- Anger issues
- Suicide

ADOLESCENT TEACHING

- Relationships
- Sexuality – STD's / AIDS
- Substance use and abuse
- Gang activity
- Driving
- Access to weapons

DEVELOPMENTAL THEORIES

1. Freud theory of sexual development
2. Piaget theory of cognitive development
3. Erikson theory of psychosocial development

PSYCHOANALYSIS & THE UNCONCIOUS, SIGMUN FREUD (1856 – 1939)

- Psychoanalytical theory ***emphasises the importance of early childhood experiences to shape personality***.
- Described the 3 instances of the psyche, i.e., ***the id, the ego & the super ego***
- And the structural psyche: ***concious***, ***subconcious*** & ***unconcious***.

FREUD'S STAGES OF PSYCHOSEXUAL DEVELOPMENT

- Children pass through a series of age – dependent stages during development.
- Each stage has a designated "**pleasure zone**" and "**primary activity**".
- Each stage requires resolution of a particular conflict/task.

PSYCHOSEXUAL STAGES

- Failure to successfully navigate a stage’s particular conflict/ task is known as **Fixation**
  - Leaving some energy in a stage
- Specific problems result from Fixation, depending on which stage is involved
  - Fixation may result from environmental disruption.

PSYCHOSEXUAL STAGES

- Freud's stages are based on clinical observations of his patients
- The Stages are:
  1. Oral – sensory (infancy)
  2. Anal (toddler)
  3. Phallic (preschool)
  4. Latency (school)
  5. Genital/ pubertal (adolescence)

ORAL STAGE

- Birth to 18 months
- Pleasure Zone: Mouth
- Primary Activity: Nursing
- Basic conflict: Oral stage weaning

CONT.

- Goal/ achievement: trust & comfort
- Fixation results in: ***difficulties with trust, attachment & commitment***
- Fixation may also manifest: as ***eating disorders, smoking, drinking problems, dependency, aggression***

ANAL PHASE

- 18months – 2 yrs.
- Pleasure Zone: Anus
- Primary Activity: Toilet training
- Basic conflict: controlling bodily needs
- Goal/ achievement: sense of accomplishment and independence.
- Failure to produce on schedule arouses parental disappointment

ANAL PHASE

- Parental disappointment, in turn, arouses feelings in child of anger & aggression towards caregivers, which are defended against
- Fixation may result in either:
  - Anal retentiveness: perfectionism, obsessive-compulsive tendencies
  - Anal expulsive: sloppy, messy, disorganized

PHALLIC (OEDIPAL) PHASE

- Ages 3-6
- Pleasure Zone: Genitals
- Primary Activity: Genital fondling
- Goal or achievement: identify with same – sex parent
- Must successfully navigate the Oedipal Conflict

OEDIPAL CONFLICT

- Boys want to marry mom and kill father, aka Oedipal Complex, but fear retaliation from father (castration anxiety); ultimately resolved through identification with father.
- Girls have penis envy, want to marry dad, aka "***Electra Complex***"; identify with mom to try to win dad's love

PHALLIC (OEDIPAL) PHASE:

- Resolution of the Oedipal Conflict results in ***formation of the Superego.***
- Fixation results in ***attraction to unattainable partners, inferiority.***

LATENCY PHASE

- Ages 6 – 11
- Basic conflict: ego & superego
- Pleasure Zone: Sex drive is rerouted into socialization and skills development
- Goal or achievement: intellectual pursuits & social interactions

CONT.

- Primary Activity: Same sex play; identification of sex role
- Don’t like opposite sex (has “cooties”)
- Fixation results in lack of initiative, low self esteem; environmental incompetence

GENITAL PHASE

- Ages 13 - young adulthood
- Pleasure Zone: Genitals
- Basic conflict: sexual interest
- Primary Activity: Adult sexual relationships
- Fixation results in regression to an earlier stage, lack of sense of self

JEAN PIAGET (1896 – 1980)

- Swiss psychologist & genetic epistemologist known for his theory of **cognitive development** that looked at how children develop intellectually throughout the course of childhood.

4 COGNITIVE STAGES FOR CHILD DEVELOPMENT AS DEFINED BY JEAN PIAGET

Sensorimotor stage (birth - ~2 yrs.): children learn about the world through their senses and manipulation of objects.

Preoperational stage (2 – 7 yrs.): children develop *memory* & *imagination*. They are able to understand things symbolically & to understand the ideas of past & future.

Concrete operational (7 – 11 yrs.): children become more aware of external events as well as feelings other than their own. They become less egocentric & begin to understand that not everyone shares their thoughts, beliefs or feelings.

Formal operational stages (11 & older): children are able to use logic to solve problems, view the world around them & plan for the future.

Piaget's Theory

Stage	Age Range	Description
Sensorimotor	0-2 years	Coordination of senses with motor response, sensory curiosity about the world. Language used for demands and cataloguing. Object permanence developed
Preoperational	2-7 years	Symbolic thinking, use of proper syntax and grammar to express full concepts. Imagination and intuition are strong, but complex abstract thought still difficult. Conservation developed.
Concrete Operational	7-11 years	Concepts attached to concrete situations. Time, space, and quantity are understood and can be applied, but not as independent concepts
Formal Operations	11+	Theoretical, hypothetical, and counterfactual thinking. Abstract logic and reasoning. Strategy and planning become possible. Concepts learned in one context can be applied to another.

CONT.

- Sensorimotor: infancy stage up to 2 years,
- Pre – conceptual phase:
  - Toddler stage: 2 – 3 years.
  - Pre school age stage up to 4 years.
- Concrete – operational:
  - School age stage: 7 – 12 yrs.
- Preoperational formal operations
  - Adolescence stage: 12 – 15 yrs.
- Formal operations
  - Adolescence stage 15 years through life

ERIK ERIKSON (1902 – 1994)

- Described identities as personal & developing from heritage & history.
- He described identity as developing through stages of ***crisis and resolution***, i.e., 8 stages of psychosocial development.

8 STAGES OF PSYCHOSOCIAL DEVELOPMENT

- Trust vs. mistrust
- Autonomy vs. shame & doubt
- Initiative vs. guilt
- Industry vs. inferiority
- Identity vs. identity confusion
- Intimacy vs. isolation
- Generativity vs. stagnation
- Integrity vs. despair

ERICKSON'S PSYCHOSOCIAL STAGES

Stages	*Crisis*	*Favorable Outcome*	*Unfavorable Outcome*
Childhood			
1st year of life	*Trust vs. Mistrust*	Faith in the environment and future events	Suspicion, fear of future events
2nd year	*Autonomy vs. Doubt*	A sense of self-control and adequacy	Feelings of shame and self-doubt
3rd through 5th years	*Initiative vs. Guilt*	Ability to be a "self-starter," to initiate one's own activities.	A sense of guilt and inadequacy to be on one's own
6th year to puberty	*Industry vs. Inferiority*	Ability to learn how things work, to understand and organize.	A sense of inferiority at understanding and organizing.
Transition years			
Adolescence	*Identity vs. confusion*	Seeing oneself as a unique and integrated person.	Confusion over who and what one really is.
Adulthood			
Early adulthood	*Intimacy vs. isolation*	Ability to make commitments to others, to love.	Inability to form affectionate relationship.
Middle age	*Generativity vs. self-adsorption*	Concern for family and society in general.	Concern only for self—one's own well-being and prosperity.
Aging years	*Integrity vs. despair*	A sense of integrity and fulfillment; willingness to face death.	Dissatisfaction with life; despair over prospect of death.

FREUD'S PSYCHOSEXUAL & ERIKSON'S PSYCHOSOCIAL THEORY

Freud	Erikson
Oral stage	Trust vs. mistrust
Anal stage	Autonomy vs. doubt
Phallic stage	Initiative vs. guilt

ERIKSON THEORY (PSYCHOSOCIAL DEVELOPMENT)

- Infancy stage → trust vs. mistrust
- Toddler stage → autonomy & self esteem vs. shame & doubt
- Preschool stage → initiative vs. guilt
- School age stage → industry vs. inferiority
- Adolescence stage → identity and intimacy vs. role confusion

C9. MATERNAL PSYCHIATRY

COMPILED BY
NAILA KAMADI

OUTLINE

A. ATTITUDE TOWARDS AND PSYCHOLOGICAL ASPECTS OF PREGNANCY (slide 1586)
B. MATERNAL STRESS & NEGLECT (slide 1621)
C. PREPARATION FOR PREGNANCY, BIRTH & PREMATURE BIRTHS (slide 1648)
D. POST PARTUM BLUES (slide 1679)
E. POST PARTUM PSYCHOSIS (slide 1694)

C9A. ATTITUDE TOWARDS AND PSYCHOLOGICAL ASPECTS OF PREGNANCY

BY: PROF. OBONDO

INTRODUCTION

- Conception is positive because reproduction is one of the most important aspects of marriage.
- It is basic to the family to the extent that some marriages break down due to childlessness.
- In some societies childlessness was and is enough grounds for divorce.
- In traditional African societies barrenness resulted in second or third wife being brought.

- In other societies women married other women to produce children for them.
- Childlessness contributed to distress in the woman because of fear of loss of respect in her community and fear of losing her husband.

ATTITUDE TOWARDS PREGNANCY

- ***The expectant mother***

- Received with mixed reactions e.g. with joy and eagerness or in other instances with anger, depression and fear.
- Reaction to unwanted pregnancy may be negative in the form of depression, anger and fear.
- For example, a teenager who is not married or a married woman who feels she has enough children, may react negatively.

- Children born out of such pregnancy may be rejected and rejected children may develop antisocial behavior or other psychological disorders.
- Wanted pregnancy is received with joy and eagerness
- Every pregnancy should therefore, be planned or wanted

❑ ***The father –to – be***

- Married men’s responses to pregnancy are generally positive.

- Some fathers distance themselves while others get involved in the pregnancy and parenting
- A study found that first time expectant fathers were initially ambivalent .
- In some studies fathers prepare for fatherhood e.g. attending parent classes, planning father-child activities, observing and talking to other fathers and baby dreaming about the baby.

- Such fathers end up doing best in the father role after the baby is born.

❑ ***Children***

- Small children react to mother's pregnancy with curiosity about the origin of babies, particularly where the baby will exit and how it originally got there.

PSYCHOLOGICAL ASPECTS OF PREGNANCY

- Adjustment to pregnancy i.e. the varies phases of prenatal development.
- Adjustment to problem pregnancies.

❑ Social support

- Supportive relationship e.g. mothers presence, supportive cohabiting partner or husband.
- Financial security

PRENATAL DEVELOPMENT

- Three major phases of prenatal development include:
- **First trimester (first 12 weeks)**
- ***Physical changes***
- Missed periods
- Changes in the bodily temperature
- Frequent urination
- Nausea and vomiting (morning sickness)
- Breast tenderness – due to high level of progesterone

- Feelings of fatigue and sleepiness due to high levels of progesterone
- The need for more sleep
- Increase in vaginal discharge – due to increased hormone level

❑ ***Psychological changes***

- Anxiety may be evident in a woman who does not desire the pregnancy.
- Anxiety about miscarriage

- Financial difficulties may result in depression
- Availability of support serves as a buffer against stressful events.
- Fatigue and lack of energy in this stage may be distressing to a woman who has been active prior to pregnancy.
- Unplanned pregnancy results in overall negative emotions.
- There is also ambivalence.

2) **The second trimester (13 – 26 weeks)**

❑ ***Physical changes***

- Awareness of fetus movement in the 4th month – exciting to a woman.
- Awareness of the pregnancy due to the expanding belly
- Constipation and nose bleeding is common.
- Edema in hands, face, wrists, ankle and feet may be a problem.
- Breasts become fully developed for nursing..

❑ *Psychological changes*

- A period of calm and well-being – no discomforts.
- Fear of miscarriage diminishes as fetal movements reassures the mother.
- Tension associated with labor and delivery are not yet
- Women who have had other children may be more distressed than those who have not because of the demands associated with the care of other children.
- Feelings of nurturance or maternal responsiveness to the infant increase steadily.

3) **The third trimester (27 – 36 weeks)**

❑ ***Physical changes***

- Uterus becomes very big and hard. The fetus is active and the woman becomes aware of its somersaults and hiccups.
- Shortness of breath due to the size of the uterus.
- Weight gain continues - not good – high blood pressure, heart problems and back pain.
- Physical exercise may be necessary for physical and psychological well-being of the woman. Also good for labor.

Psychological changes

- Psychological well-being is greater among women who have social support e.g. a cohabiting husband or partner.
- Mothers who have high levels of affection with their husbands have lower levels of anxiety in the 3rd trimester.
- Depression was reported to be higher in single women than married women.
- Women with high income, of middle class do not experience associated stressful events they experience psychological well-being.

PROBLEM PREGNANCIES

❑ ***Ectopic pregnancy***

- In ectopic pregnancy the fertilized egg implants outside the uterus e.g. in the fallopian tube, abdominal cavity, the ovary or the cervix.
- It may be due to the obstruction of the tubes as a result of gonorrheal disease.
- Symptoms are sharp abdominal pain, vaginal bleeding and pain in the shoulder.
- If rapture occurs the woman may die.

False pregnancy (pseudocyesis)

- The woman believes she is pregnant and shows signs and symptoms of pregnancy but not pregnant.
- The woman stops having menses and have morning sickness, weight gain, and the abdomen bulges.
- This condition may disappear spontaneously or through psycho-therapy. Rarely does it persists into labor.

- ***Preterm birth***
  - Premature labor and birth due to poor nutrition, poor health, heavy smoking, cocaine use and syphilis.
- ***Infertility***
  - Psychological stress in infertile couple
  - Result in conflict between the couple since it does affect the couple's sexual relationship e.g. reduces spontaneity and is associated with lower sexual satisfaction.

- All these problems create a negative attitude towards pregnancy by both the father and mother
- For example, premature birth which may have ended in birth defects may result in the mother having anxiety getting pregnant again.
- Also a mother who had previous ectopic pregnancy may not want to get pregnant for fear of having another ectopic pregnancy.

TEENAGE PREGNANCY AND MOTHERHOOD

- Teenage pregnancy is a major social problem because of the psychosocial factors involved:
  - Single motherhood
  - Teenage mothers are disadvantaged economically due to unemployment
  - School drop-out
  - Children are born with low birth weight which leads to a variety of problems e.g. poor academic performance and behavior problems.

- Suffer from anxiety and anger due to unwanted pregnancy
- May be caught up in conflicting conclusions about the pregnancy e.g. Whether to keep the fetus or not.
- In summary, teenage pregnancy is a serious problem but not unresolved one.

THE FATHERS ROLE IN PREGNANCY

- *The couvade syndrome (male pregnancy symptoms)*
- Some men experience the couvade syndrome whose symptoms include:

a) Indigestion
b) Gastritis
c) Nausea
d) Lack of appetite and headaches

- These symptoms help men prepare for fatherhood.

❑ *Couvade ritual:*

- Husband retires to bed while the wife is in labor, suffers all the pain of delivery, mourning and groaning as the wife does.
- Couvade is still practiced in parts of Asia, North and South America and Oceania (Mead &Newton, 1967)

TERMINATION OF PREGNANCY

- **Medical**
  - To preserve the health and life of the mother.
- **Eugenic**
  - Due to risk of congenital abnormality.
  - Producing intelligent children to improve the human race.
- **Psychiatric**
  - Due to the possibility of a similar problem in the offspring.

- **Social**
  - When pregnancy is untimely and disruptive.
- **Humanitarian**
  - When pregnancy has resulted from rape or incest.
- **Miscarriages**
- **Stillbirth, neonatal death, and infant death**

THE DO'S AND DON'TS DURING PREGNANCY

- ***Sex during pregnancy***
- Sex during pregnancy is traditionally believed to:
1) Cause infection
2) Precipitate labor prematurely
3) Cause a miscarriage
- Current medical opinion is that:
- Intercourse can continue until 4 weeks before due date.

- Not associated with preterm labor or miscarriage.
- In the later stages of pregnancy side-to-side position is the most suitable.
- Hand genital stimulation or oral sex may be good alternative

❑ ***Nutrition during pregnancy***

- Good nutrition is good during pregnancy because a healthy mother = a healthy baby.

- It is important that pregnant women get enough:

1) Protein good for tissue building.
2) Folic acid – important for growth
3) Calcium – deficiency leads high blood pressure and premature birth.
4) Magnesium – deficiency leads to premature birth.

- For these reasons food supplements are recommended for pregnant women

- ***Drugs during pregnancy***
- The following drugs are dangerous during pregnancy.

a) Antibiotics – long term use may cause damage to the fetus.

b) Alcohol – may result in fetal alcohol syndrome (FAS) characterized by prenatal and postnatal growth deficiencies, small brain, heart malfunctions or mental retardation.

- Cocaine – associated with premature birth and low birth weight and small head circumference (micro cephalic).
- Steroids – associated with low birth weight, cleft palate and stillbirths.
- Smoking – associated with low birth weight, hyperactivity and impulsivity
- Psychoactive substances (marijuana, imipramine and amitriptyline) – are associated with birth defects.

- **Father and drugs**
  - Studies found that drugs taken by men before conception cause birth defects probably because they damage sperms and their genetic contents.
  - Smoking may result in cancer in the child in childhood.

INTERVENTIONS

- ***Social treatments***
  - Programs to prevent further pregnancies and births e.g. school programs that may help adolescents finish school.
  - Child care programs for mother while they attend school.
  - Information and access to contraception.
  - Social support may also be useful.

- Education of expectant mothers and fathers on good habits that will not interfere with the normal development of the child e.g. good nutrition, and avoid drugs and alcohol during pregnancy.

- ***Psychotherapy***

- Counseling to help the teenager accept and cope with the situation.
- Incase of negative attitude the couple requires counseling to help them accept the pregnancy and cope with it.

- Depressed mothers may require psychotherapy and drug treatment.
- Helping a mother who has miscarried involves grief therapy in which her intense distress is shared and sadness, guilt and anger ventilated with support.
- Genetic counseling may necessary when there is genetically based disorder in the family.
- A bereaved need to share her distress e.g. reasons for the baby's death, next pregnancy, grieving children and adoption.

- Follow-up counseling should be continued for at least six months.

- ***Pharmacotherapy***

- Antidepressants should be avoided during the last trimester however, ECT is safe provided the mother is completely oxygenated during the brief period of the therapy.
- Phenothiazines and anxiolytics are relatively safe in pregnancy particularly in the last semester.

C9B. MATERNAL STRESS & NEGLECT

BY: PROF. OBONDO

INTRODUCTION

- All living things suffer from stress at one point or another in their lives.
- For example, mothers feel stressed when their children fall ill, teachers feel stressed just before national examinations, politicians feel stressed just before an election etc.

- This inability to cope with tension and anxiety may result in an emotional upset which one may be unable to cope with hence a crisis is felt.
- Stress has been shown to directly or indirectly contribute to diseases such as cancer, stroke, asthma, migraine and many other diseases.

Definition of stress

- The oxford companion to medicine defines stress as “the total physiological reaction to an adverse or threatening stimulus”.

- It has been shown conclusively, that stressful events are important causes of stress in millions of people all over the world.

Maternal stress

- Distress in a mother as a result of physiological, psychological or unfavorable environment circumstances.

- The stress may be evident during pregnancy, at delivery or during the child's development.

- Results in a mother's inability to take care of her children.

FACTORS CONTRIBUTING TO MATERNAL STRESS

- **Physiological**
  - Physical illness e.g. diagnosis of Aids and obstetric complications (pregnancy and birth complications) such as hypoxia
  - Physiological changes during pregnancy./ Unwanted pregnancy
  - Hormonal imbalances.

Environmental circumstances

- The strains and stresses of everyday life such as poverty, stressful living e.g. overcrowding
- Lack of social support
- Multiple roles a mother plays e.g. homemaker, employment etc.
- These places a lot of extra stress on the mother resulting in neglect or rejection of children.
- Martin and Walters found that neglectful families not only had financial problems but also lived in crowded inadequate areas.

Life events

- Natural or unnatural disasters e.g. floods, earthquakes, cyclone or war, burning down of peoples dwelling places as happens in slum areas etc.
- Being Raped
- Bereavement e.g. loss of a loved one

Psychological

- Insecure attachment
- For example, a depressed mother may not be able to form secure attachment
- This is because depressed mothers are less sensitive and responsive to their infants.

OTHER FACTORS

Characteristics of the child

- Temperamentally difficult infant or child.
- Children with failure to thrive syndrome.
- Children who cry frequently, who are irritable and demanding, difficult to feed children and sickly babies.

- Premature babies and those with low birth weight and birth defects and prenatal loss.
- **Factors in marriage**
  - Youthful marriage and parenthood
  - Family discord
  - Separation and divorce
  - Failure of husband to support wife
  - Single parenthood

CONSEQUENCES OF MATERNAL STRESS

Prenatal problems

- Maternal distress during pregnancy increases the intrauterine level of glucocorticoids (cortisol), which may have long-term health consequences for the child. Talge et al (2007)
  - Spontaneous abortion

- Structural malfunctions e.g. occurrence craniofacial and birth defects
- Preterm delivery – during the 3rd trimester
- Birth weight – result in reduced birth weight and smaller head size

- Emotional or cognitive problems, including an increased risk of attentional deficit/hyperactivity, anxiety, and language delay
- Such children may also suffer from Chronic diseases such as heart problems, hypertension and diabetes

- **Maternal neglect**
  - Studies have shown that depressed mothers may spend very little time with their babies. Talge et al (2007)
  - Neglect results in failure to thrive syndrome, malnutrition, poor skin hygiene, irritability and withdrawal

- Such children developmentally delayed and emotionally disturbed.
- Psychological dwarfism (an extreme failure to thrive syndrome) is evident
- Maternal stress → maternal neglect → negative emotional and social development in children.

Emotional bonds and relationships

- Secure attachment is formed with a mother who is responsive to the child's needs.
- Is important for social and emotional development of the child
- Stress leads to insecure attachment which results in negative or lack of bonding

- This lack of or negative relationship is associated with increased risk of schizophrenia in the child.

Maternal deprivation

- Maternal deprivation due to stress can be distressing to the child.
- According to Bowlby (1951), maternal deprivation may lead to:
  - Acute distress due to disruption in the bonding process.

- Failure to thrive syndrome as a result of poor nutrition
- Developmental delay and intellectual impairment due to lack of perceptual and linguistic stimulation
- Enuresis which is a reaction of early stress.

Maternal rejection

- This is closely related to maternal deprivation and is shown in various ways:
  - Distorted or inadequate care of children
  - Denial of love and affection

- Lack of interest in the child’s activities and achievements.
- Cruel and abusive treatment of the child.

- Maternal rejection is associated with:
  - Overt aggression and impulsive behavior in children

- Lack of capacity to form meaningful relationships
- Suffer from diminished intellectual functioning, excessive fears, and running away from home.

MANAGEMENT

- **Before birth**
  - Planned pregnancy
  - Good Social support network
- **Postnatal**
  - Social support

- Removal of child from the damaging environment to a place of safety
- Deal with the child’s fears, anxieties and self –esteem by building a trusting relationship in which the child will not be abused.
- Rehabilitate the mother after assessing her weaknesses and strengths by:

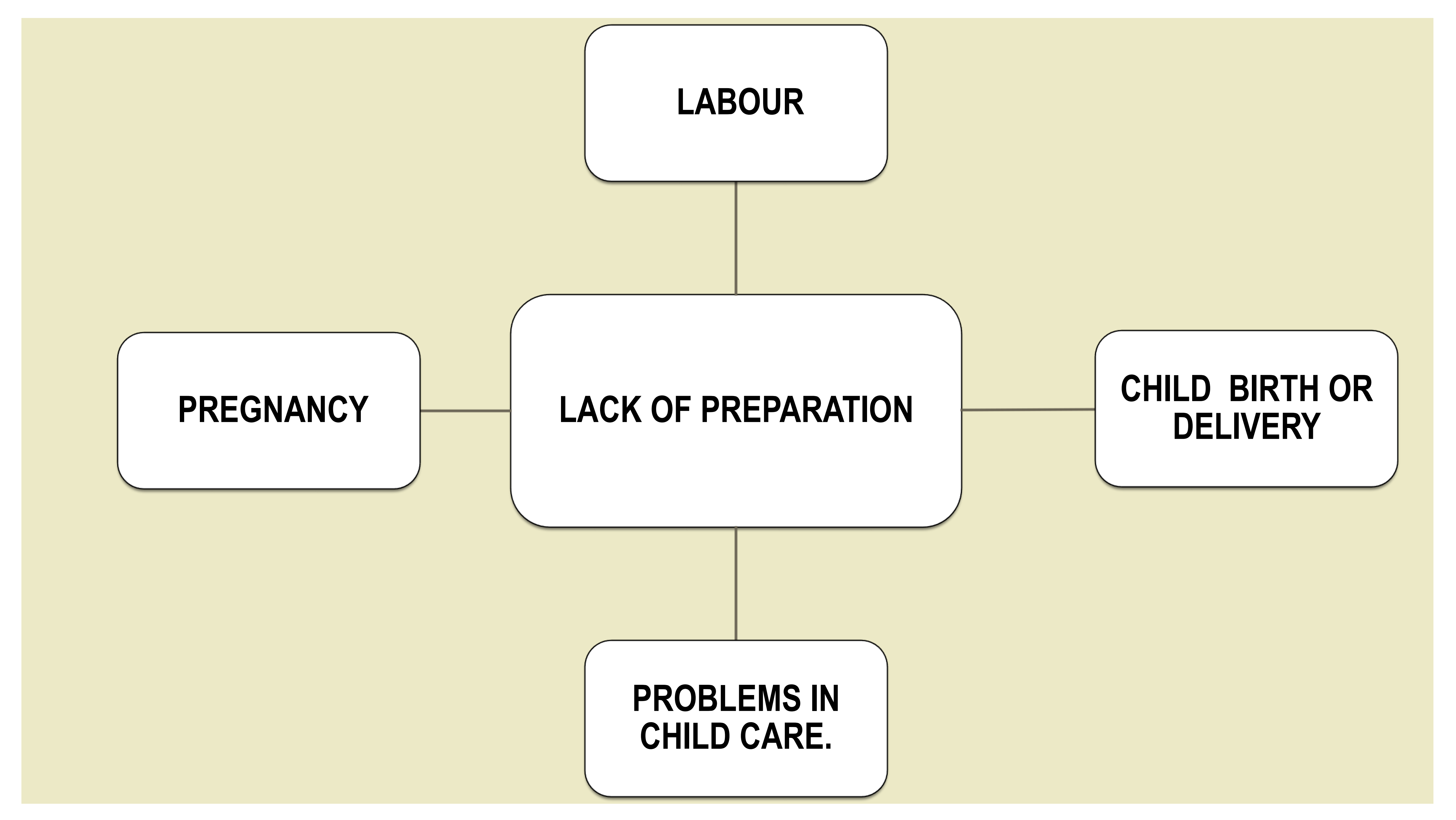
- Eliminating social environmental stresses
- Reduce the demand on the mother to a level that is within her capacity e.g. provision of a housekeeper or placement of child in day care.
- Provide emotional support, encouragement, empathy and instruction on maternal care.

- Psychotherapy (individual and family therapy)
- Relevant social department or child protection unit may be involved.
- Use of medication (***hypnotic drugs***- to help with sleep and ***anxiolytic*** drugs - to help anxiety) and ***relaxation techniques*** to help reduce stress.

C9C. PREPARATION FOR PREGNANCY, BIRTH & PREMATURE BIRTHS

INTRODUCTION

- Preparation begins before pregnancy
- Important because:
  - It alleviates anxiety
  - Results in less complications or none and easy child birth
  - Result in good health of both mother and baby
  - Healthy mother = Healthy baby


LABOUR
PREGNANCY
LACK OF PREPARATION
CHILD BIRTH OR DELIVERY
PROBLEMS IN CHILD CARE.

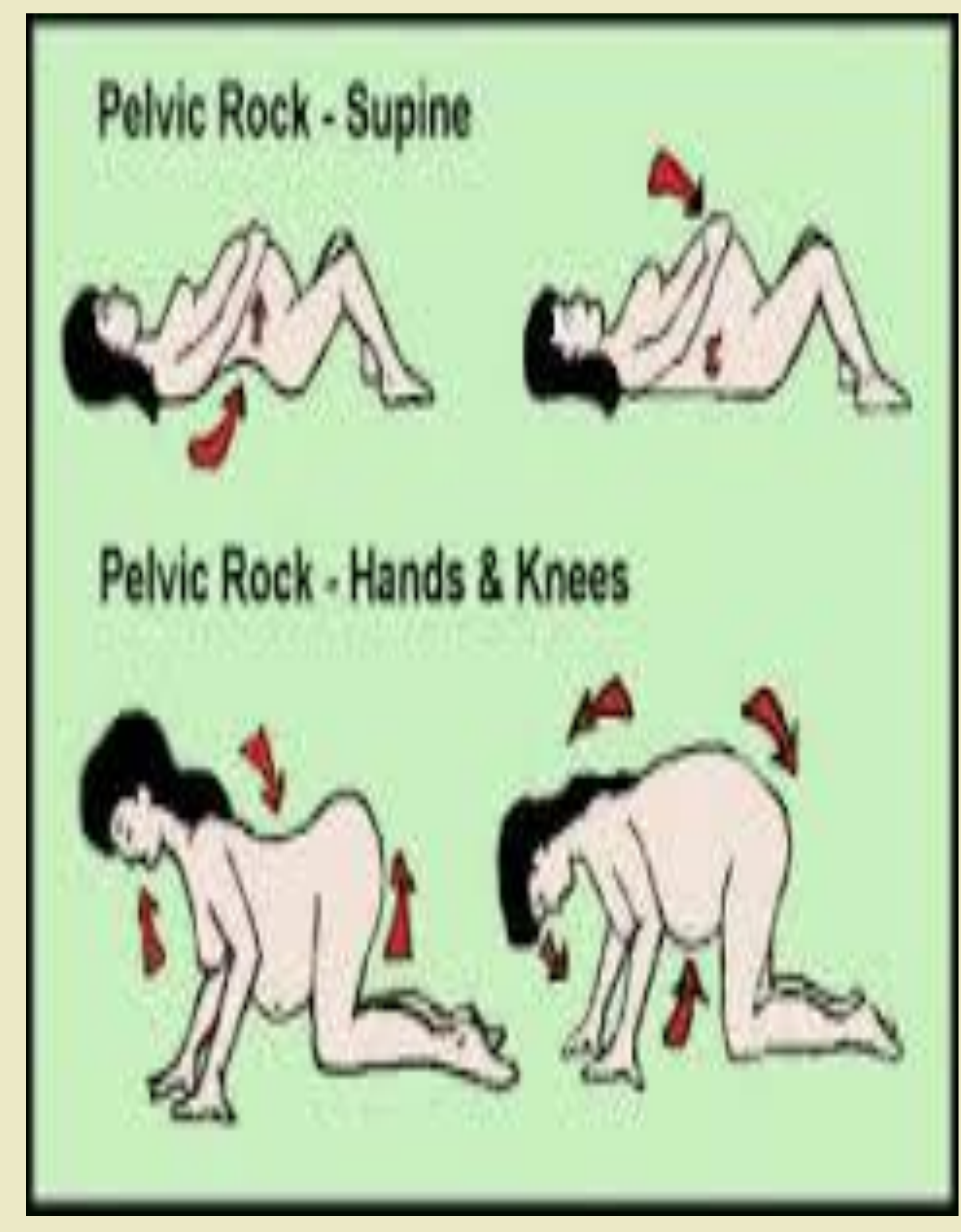
PLANNING PREGNANCY AND DELIVERY

- Planned pregnancy
  - Decide whether you want a child
  - To avoid rejection of the child if unplanned
- Normal weight – BMI
  - Achieve normal weight
  - Being below or above normal weight may interfere with pregnancy
  - Visit the clinic for antenatal care

EXERCISE AND GOOD NUTRITION

REGULAR EXERCISES

- Should exercise ***four to five times per week for at least 30 minutes***
  - Pelvic muscle exercises – pelvic rocking and squatting
- These exercises will ease pain during labour
- Prevent and reduce stress.
- Help avoid big baby



Squatting- can strengthen the body and prepare it for labor and birth

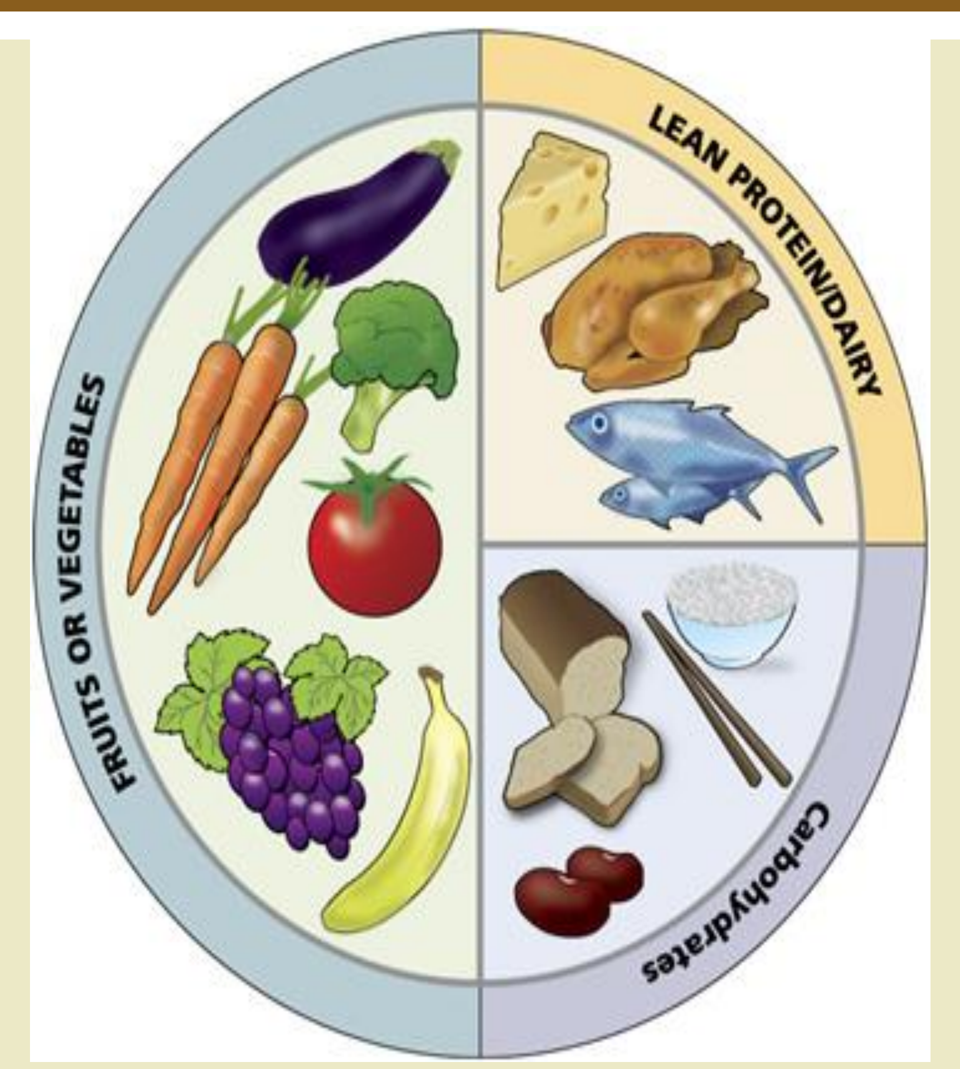
www.BirthBootCamp.com

Prenatal Yoga

- Encourages gentle stretching
- Focus on breath to relax the mind.
- Emphasizes good posture
- Strengthens and conditions the vital muscle groups to ease pregnancy, labor and recovery.
- Certain series like the modified Cat-Cow can position the baby for delivery
- Twists encourage blood flow to reproductive organs to correct hormonal imbalances

GOOD NUTRITION

- Have a balanced diet that includes:
  - Protein
  - Whole grain
  - Green leafy vegetables & fruits
- Folic acid supplement ***400mg***
- Omega 3 fatty acids, calcium & iron.



Good Nutrition

- Well-developed body
- Ideal weight for body composition
- Good muscle development
- Smooth skin, glossy hair, clear and bright eyes
- Mental and physical alertness
- Ability to resist disease
- Increased life span

WHAT TO AVOID DURING PREGNANCY

- Stresses
  - Avoid worries about the pregnancy, being a mother, financial worries etc.
  - Reduce stress by doing yoga/meditation and getting support from loved ones and friends.

ENVIRONMENTAL TOXINS

- Wear gloves when gardening to avoid ***Toxoplasmosis***.
- Avoid unpasteurized milk because may contain ***Listeria***.
- Avoid tuna & other large fish because of ***mercury***.

What foods are risky?

When it comes to *Listeria*, some foods are more risky than others. Meet some of the other foods where *Listeria* is known to hide.

Sprouts

Raw Milk
(unpasteurized)

Soft Cheeses

Deli Meats and Hot Dogs
(cold, not heated)

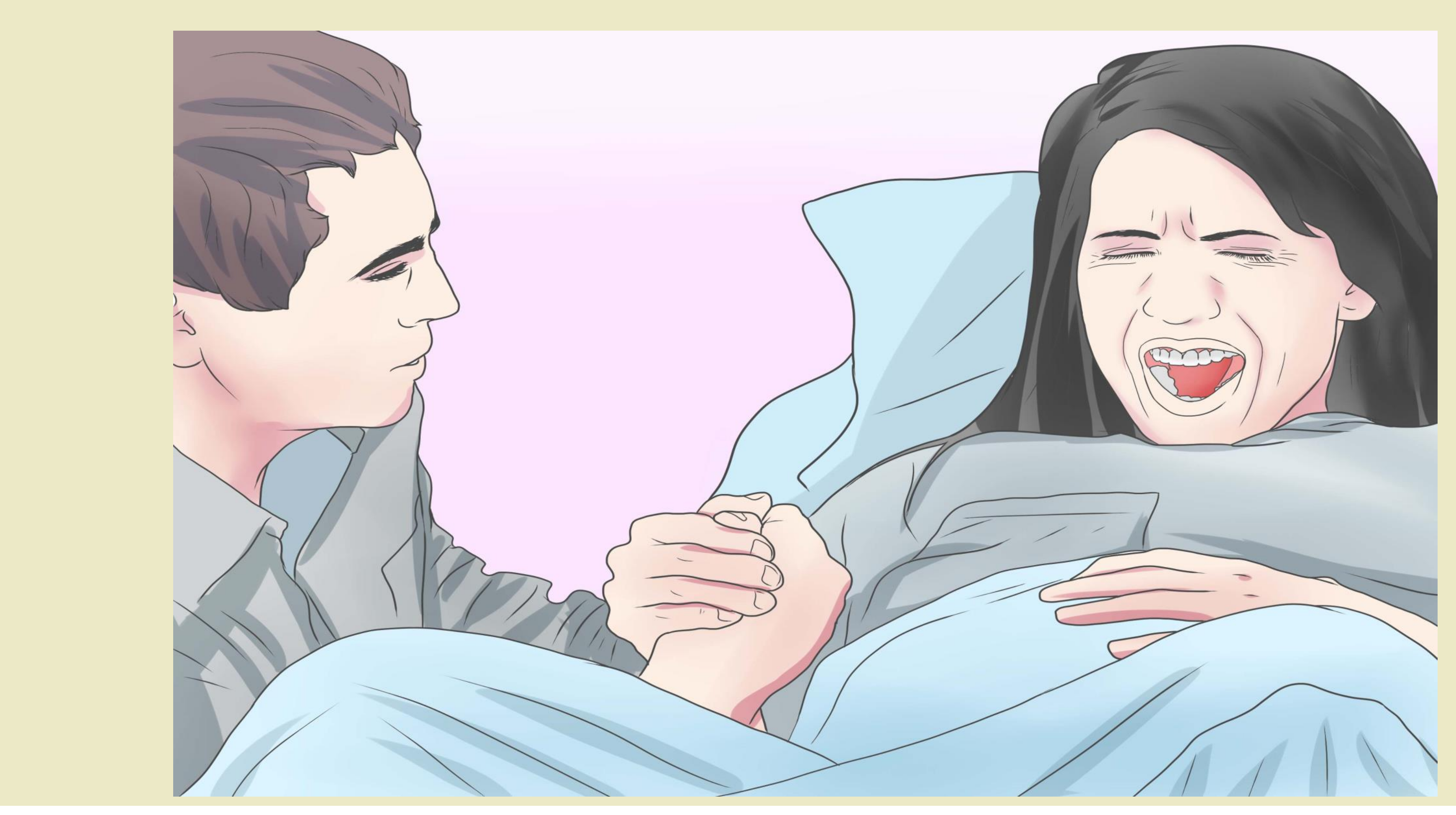
Smoked Seafood

CONT.

- The workplace: Some jobs present specific risks to the developing baby
- Hot tubs/saunas: Excessive heat can affect the developing baby's CNS.
- Alcohol & Tobacco
  - No amount of alcohol is safe during pregnancy and can contribute to **fetal alcohol syndrome**.
  - Tobacco use can affect the baby's growth and adversely affect the mothers blood pressure.

- Medications
  - Avoid medications, supplements & herbs unless recommended by health care provider.
- Viruses: Regular hand washing can help exposure to Fifth's disease, CMV, chicken pox & rubella.
- Pap smear, dental, STIs, mental illness should be addressed before pregnancy – can be harmful.
- Many complications & health risks can be avoided by taking good care during pregnancy

PREPARATION FOR LABOUR



- 3rd trimester is approached with a mixture of apprehension & excitement as well as & often fear.
- The following will help overcome anxieties in an expectant mother
  - Balanced diet & exercise
  - Regular exercises e.g. Yoga, swimming, walking, dancing & low – impact aerobics
  - Attaining & maintaining healthy weight

- Attending childbirth parenting classes help deal with fears & anxieties about labour.
- Being in contact with the doctor helps alleviate stress or anxiety about labour and delivery
- The result is uncomplicated birth and a healthy baby

STAGES OF LABOUR: WHAT TO EXPECT

- 1st stage: cervical dilation - fully dilate to 10 centimetres.
- 2nd stage: voluntary push of the baby down the birth canal with contractions lasting 60 seconds → culminates into birth
- 3rd stage: Comes after birth and continuous through to the delivery of the placenta
- 4th stage: Begins after the birth of the baby and the delivery of the placenta, and lasts for about an hour - bonding

BONDING OF MOTHER WITH BABY – 4TH STAGE.

PAINLESS LABOUR

- Medical pain-relief strategies
  - Analgesics, epidural
  - Medicalized childbirth may be risky because of the effect on the baby.
- Nonmedical pain – relief strategies
  - Relaxation techniques, movement, massage, hydrotherapy
- Acupuncture - The insertion of tiny needles into nerve centres to block pain.

ROSSATO – BENNETT (2011), SUGGESTS THE FOLLOWING:

1. Get active daily
   - Take stairs instead of the elevator
   - Take a 10 minute walk once everyday
   - Always sit upright. “Do not slouch”. Will help in the position of the foetus
2. Get your beauty rest: Get enough rest for stamina during labour
3. Relax your body and mind: Meditation, taking a warm bath, and practicing breathing techniques are all helpful in falling asleep.

DELIVERY OR BIRTHING

PREPARATION FOR DELIVERY

- Things to do before delivery
  - Preregister with a hospital
  - Know the number of your doctor
  - Have transportation available
- Supplies you will need for the newborn
  - Breastfeeding supplies, such as a nursing bra and pads

- Baby bottles and nipples
- Sweater and a cap for your baby
- Diapers
- Cotton balls, mild soap, diaper rash ointment, hair brush, and thermometer
- Infant car seat as required by law

WHAT TO PACK TO THE HOSPITAL

- Medical coverage information
- Nursing bra and breast pads
- Socks and slippers
- Lip balm
- Music CDs to listen to during labour
- Loose fitting clothes to wear home

LABOR BAG
wikiHow

- Toothbrush, toothpaste, and hairbrush or comb
- Telephone numbers of family and friends
- Infant sleeper with legs or T-shirt and a diaper for baby to wear home
- Baby blanket
- Camera

WHY IS IT IMPORTANT TO PREPARE FOR PREGNANCY, LABOUR AND BIRTH

- To avoid unwanted pregnancy – can result in rejection of the baby.
- To avoid pregnancy and birth complications which may result in birth defects – by receiving education on the do's and don'ts from a professional.

- To alleviate fears and anxieties about pregnancy and child birth
- To help expectant mothers cope with pregnancy
- Contribute to a healthy mother and hence a healthy baby

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C9D. POSTPARTUM BLUES

BY: DR. WANGARI KURIA

OBJECTIVES

- Define postpartum blues
- Understand epidemiology
- List the clinical features
- Discuss management

DEFINITION

- This is an emotional change that occurs in women after delivery.

ONSET AND DURATION

- The Postpartum blues can happen in the ***days right after childbirth and normally go away within a few days to a week***

EPIDEMIOLOGY

- Half to 2/3 of women who deliver normal babies experience postpartum blues also known as maternity blues.
  - Peak onset is on the ***3rd – 4th postpartum day***

EPIDEMIOLOGY

- Postpartum Blues are more frequent
  - Among primigravida.
  - It is not related to delivery complications or use of anesthesia.
  - Women developing postpartum blues ***have often experienced depressive symptoms in the last trimester of pregnancy.***
  - Often have history of premenstrual tension.

EPIDEMIOLOGY

- Both the frequency of the emotional changes & their timing suggest that ***postpartum Blues may be related to readjustments in hormones after delivery***.
  - Progesterone and estrogen increase greatly during late pregnancy & fall after birth.

CLINICAL FEATURES

- New mother
- Sudden mood swings esp. to spouse
- Sadness
- Anorexia
- Sleeping problems

CLINICAL FEATURES

- Irritability
- Restlessness
- Anxiety
- Loneliness
- Tearfulness.

CLINICAL FEATURES

- Fatigue
- Begins shortly after childbirth
- Severity lessens over the course of a week
- It is self limiting

CLINICAL FEATURES

- Lability of mood: alterations between euphoria and misery
- Episodes of crying (***may not be feeling depressed***)
- Patients complain that they are confused but cognitive functions are normal

TREATMENT

- Symptoms are not severe & ***pharmacotherapy treatment is not needed***.

PSYCHO EDUCATION

- ***Psycho education*** is important long before delivery to inform the pregnant mother on the psychological aspects of pregnancy and child birth.
- Advice mother to ***join a support group of new mothers or talk with other mothers***

MANAGEMENT

- But there are things the mother can do to feel better.
- Nap when the baby does.
- Ask for help from your spouse, family members & friends.

CONCLUSION

- Postpartum blues is a short lasting self limiting condition that does not require pharmacotherapy.

C9E. POSTPARTUM PSYCHOSIS

BY: PROF. WANGARI KURIA

OBJECTIVES OF THE LECTURE

- Etiology
- Classification of disorder as per DSMIV
- Clinical features
- Diagnosis
- Management

DSMIV

- This is an example of psychotic disorder not otherwise specified.
- It is a psychiatric emergency.
- Though the prevalence is lower than for the postpartum blues and depression, the catastrophic results of condition dictates urgent management of the patient.

INTRODUCTION

- Literature indicates that postpartum psychosis is basically a Bipolar mood disorder.
- The strong link between bipolar mood disorder and postpartum is suggested by evidence of clinical presentation, longitudinal course and family history
- Onset coincides with tremendous hormonal shifts after delivery.

EPIDEMIOLOGY

- Incidence -1per 1,000 childbirths- 2 per 1000 births.(0.1%- 0.2% of the general population
- 50-60% of affected woman have just had their 1st child.
- 50% of the cases involves deliveries with perinatal complication.
- 50% of affected women have a family history of mood disorder.

EPIDEMIOLOGY

- Women with known schizophrenia have a 25% risk of puerperal exacerbation
- Postpartum psychosis occurs in 20 – 30% of women with history of bipolar disorder
- Women with bipolar mood disorder and family history of postpartum psychosis in first degree relative have 70% risk of developing postpartum psychosis

CONT'D

- It is fundamentally a disorder of women but some rare cases affect fathers.
- In those rare instances the husband may feel displaced by the child and may be competitive for the mothers love and attention.
- However the father probably has a coexisting major mental disorder that has been exacerbated by stress of fatherhood.

- Risk of recurrence in subsequent pregnancies can exceed 50%
- The validity of the diagnosis is usually verified in the year after birth when as many as 2/3 of the patients may have a second episode of the underlying disorder.
- Women who receive pharmacotherapy may remain symptomatic 1yr after delivery

CONT'D

- The delivery is a nonspecific stress perhaps through a major hormonal mechanism
- A few cases of postpartum psychosis result from general medical condition associated with perinatal events such as
  - **Infection**
  - **Drug intoxication**
  - **Toxemia**
  - **Blood loss**
- The sudden fall in estrogen and progesterone concentration immediately after delivery may also contribute. However treatment with those hormones has not been effective.

PSYCHOSOCIAL FACTORS

- The psychosocial etiology is justified by researchers on the basis of:
  - Preponderance of primiparous mothers.
  - Association between postpartum psychosis and relevant stressful events.

PSYCHODYNAMIC THEORIES ON ETIOLOGY

- This is justified by:
  - Presence of conflicting feelings in the mother about her mothering experience
  - Unwanted pregnancies
  - Increased prevalence in those with marital discord and feeling trapped in unhappy marriage.

CLINICAL FEATURES OF POSTPARTUM PSYCHOSIS

- Symptoms begin within days of delivery.
- Mean time onset is 1 – 4 weeks after childbirth (but almost always within eight weeks of delivery).

CLINICAL FEATURES

- Fatigue
- Insomnia
- Restlessness
- Episodes of fearfulness
- Emotional lability

CLINICAL FEATURES

- Cognitive deficits/ impairment
- Motility disturbances
- Mood abnormalities
- The patient may develops frank psychosis.
- Grossly disorganized behavior

CLINICAL FEATURES

- Suspiciousness
- Confusion
- Incoherence
- Obsessive concern about baby's health &welfare.
- Irrational statements
- Delusions present in 50% of patient (many involve death of baby or being defective)

CONT'D

- Hallucination " 25% "(voices telling her to kill the baby)
- Inability to move stand or walk is common.
- Feeling of not wanting to care for the baby
- Not loving the baby
- Wanting to harm baby or self or both
- Denial of birth
- Thought of being unmarried and persecutory delusion

CONSEQUENCES

- The disturbances and lack insight can result to devastating consequences in which the safety and well-being of the affected mother and her offspring are jeopardized

DIFFERENTIAL DIAGNOSIS

- Other psychotic due to general medical condition or substance induced:
  - Psychotic disorder
  - General medical condition e.g. hypothyroidism Cushing syndrome
  - Substance induced psychosis
  - Infections, toxemia
  - Neoplasm

TREATMENT

- Treatment is dictated by;
  - The underlying diagnosis, bipolar disorder, and guided :
    - By the symptom profile
    - Patient's response to past treatments
    - Drug tolerability
    - And breastfeeding preference.

SOMATIC THERAPIES INCLUDE:

- Anti manic agents
- Atypical antipsychotic medications: Carbamazepine, Sodium valproate
- ECT.
- Estrogen prophylaxis remains purely investigational.

OTHER MANAGEMENTS

- Do not breastfeed when on medication that affects the baby
- Suicidal caution may be necessary to transfer to psychiatric unit.
  - Suicidal caution is prescribed on the T sheet & the patient is assigned a nurse for charted monitoring 24 hrly.
- Maintain mother to baby contact but supervise

PYCHOTHERAPY

Psychotherapy indicated after period of acute psychosis address various conflicts in patient life including;

- Acceptance of mothering role.
- Changes in environmental factors may be indicated.
- Increased husband and other person support to patient to reduce stress.

COURSE

- The course of syndrome is similar to that seen in patients with mood disorders.
- Patients may experience another episode of symptoms with 1-2 years of the birth.
- In 50% Subsequent pregnancies are associated with an increased risk of having another episode.

COURSE

There are high rates of recovery from acute illness but in one study:

- 5% of patients committed suicide
- and 4% committed infanticide.

PROGNOSIS

A good prognosis is associated with;

- Good pre morbid adjustment
- Supportive family network
- Absence of family history of mental illness

CONCLUSION:

- **The rapid and accurate diagnosis of postpartum psychosis is essential to expedite appropriate treatment and to allow for quick, full recovery, prevention of future episodes, and reduction of risk to the mother and her children and family.**
- **Always treat as an emergency**

D. MISCELLANEOUS TOPICS ☺ LEVEL VI MBCHB 2019

COMPILED BY NAILA KAMADI

D. MISCELLANEOUS TOPICS ☺ (SLIDE 1721) OUTLINE

- HANDLING DIFFICULT SITUATIONS IN LIFE (Slide 1723)
- ORGANIZATION OF MENTAL HEALTH SERVICES (Slide 1746)
- ETHICS IN PSYCHIATRY
- COMMUNITY PSYCHIATRY MENTAL HEALTH SERVICES
- VOLUNTARY COMMUNITY ORGANIZATIONS (slide 1771)
- MENTAL HEALTH INSTITUTION AND MODES OF ADMISSION FOR THE MENTALLY ILL
- DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS: CAUSES AND CONSEQUENCES (slide 1794)
- MENTAL HEALTH TREATMENT ACT
- CRIME, DEVIANCE & IMPLICATIONS ON HEALTH (slide 1814)
- FITNESS TO PLEAD, TESTAMENTARY CAPACITY & CRIMINAL RESPONSIBILITY
- LIAISON PSYCHIATRY (slide 1850)
- GENETIC COUNSELING

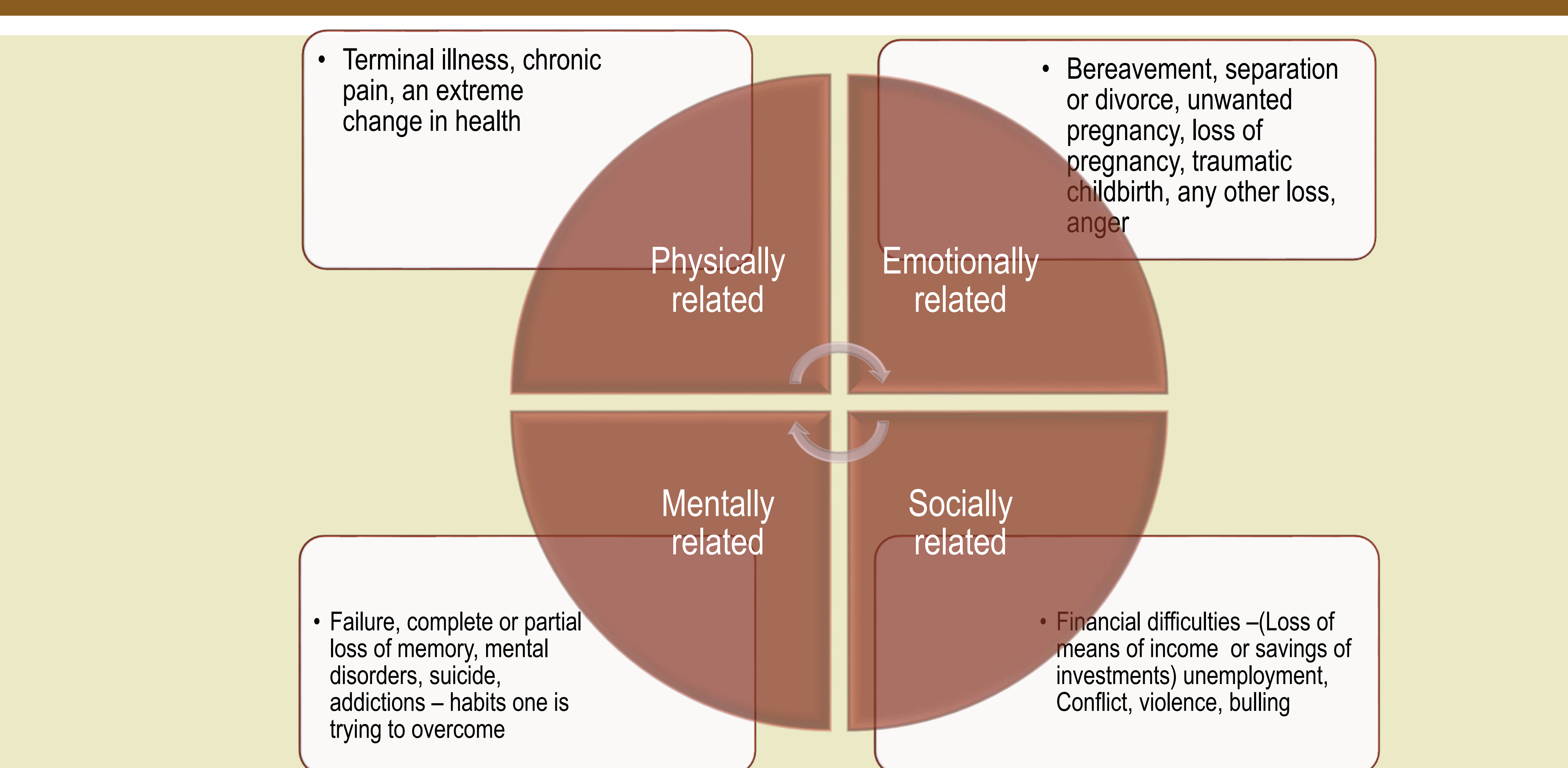
HANDLING DIFFICULT SITUATIONS IN LIFE

BY: PROF. OBONDO

INTRODUCTION

- As human beings we like to be happy and peaceful
- But sometimes go through challenges at different points in our lives due to:
  - relationship problems
  - problems with studies
  - work problems
  - loneliness
  - financial etc.
- These problems make us feel anxious and stressed.
- Successful resolution make us feel happy

EXAMPLES OF DIFFICULT SITUATIONS IN LIFE



TOP 10 MOST DIFFICULT LIFE SITUATIONS ACCORDING TO SHIKHA NAIN (2014)

Losing self confidence

- Losing hope in life, means one does not believe in themselves and getting out of this can be tough but nothing goes on for ever.

Lack of support in your old age

- Parents do all they can for their children but when they grow old, the children see them as a burden
- It becomes a difficult situation for the elderly

Losing all that you have in a natural calamity

- Natural calamities such as earthquake, hurricane, floods and any other, cause destruction and massive loses that lead to devastation in the individual

Divorce

- Divorce refers to splitting up of a married couple due to unavoidable circumstances
- In this case it is not only the couple that goes through rough time but also the child/children
- Dealing with divorce requires a lot of strength

Being handicapped

- Being handicapped restricts a person's ability to function physically, mentally and socially.
- This is a difficult situation to deal with because it is so disheartening.

Loss of job

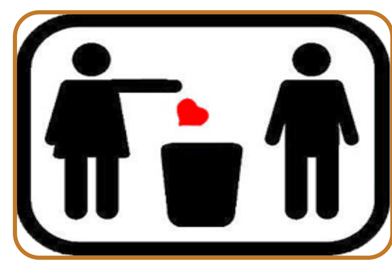
- Losing a job feels hopeless.
- It leads to unemployment, insecure future, mental tension and the option of looking for another job which may not be forthcoming

Loss of child

- A child is the most beautiful gift to parents by God
- The loss of a child is the most devastating experience a parent can face . Parents become lonely

Failure

- Trying to do something useful in life and not succeeding is a failure in life
- It comes with disappointments and lack of hope for the future – hence disheartening situation



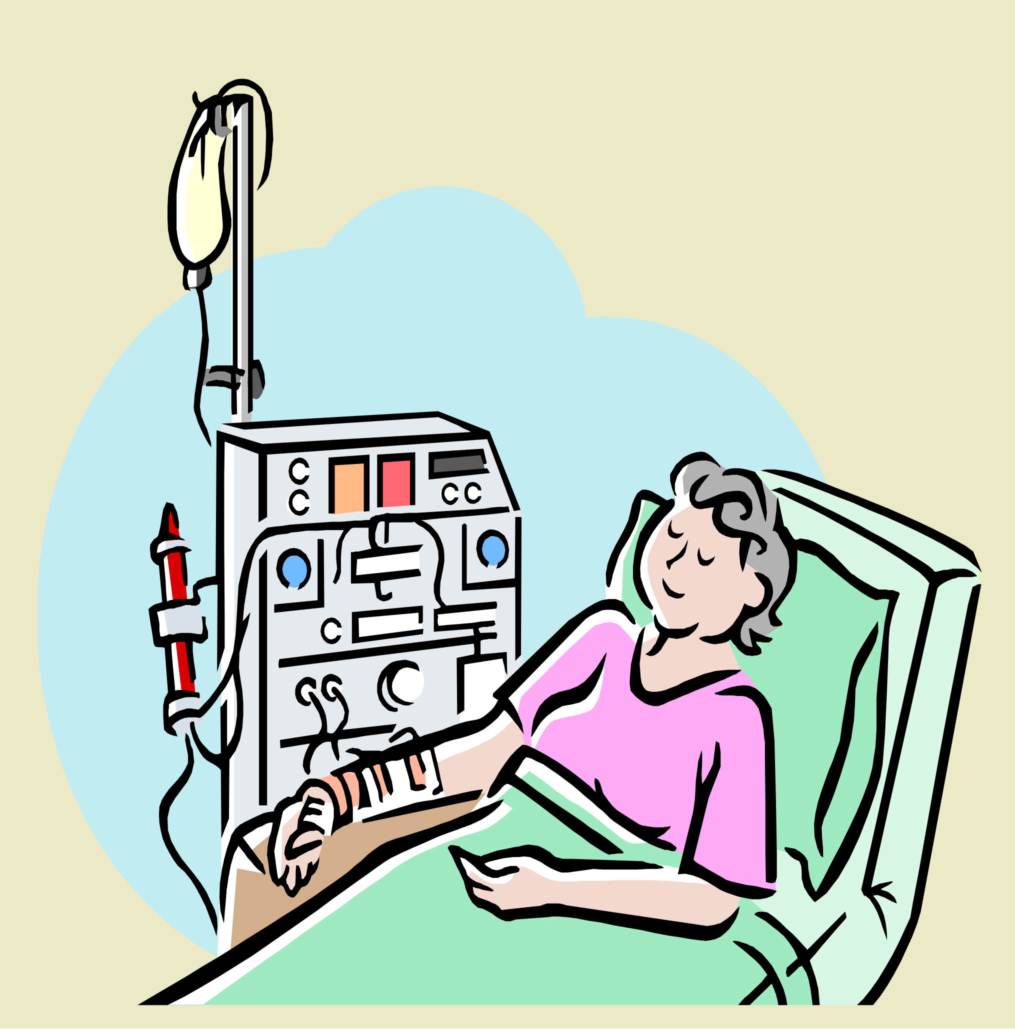
Break up

- Falling in love and falling out of love is part of life.
- When this happens the individual is devastated because they cant imagine being apart from the one they love.

Death of a loved one

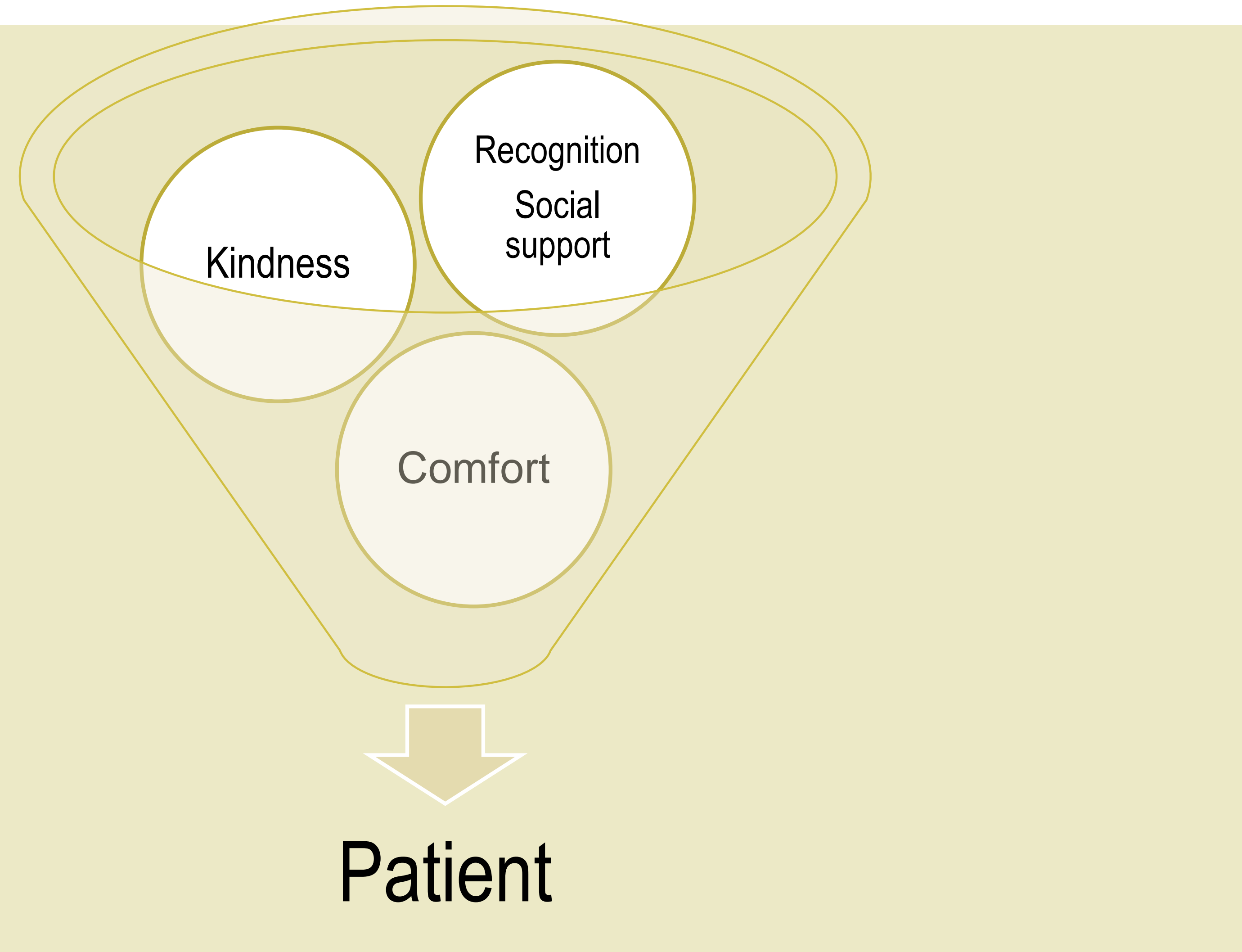
- The loss of a loved one turns one's life upside down
- This is a traumatic situation that people find difficult to deal with
- Not knowing how to react may result in depression

WORKING WITH DIFFICULT PATIENTS



- A patient with renal disease has many challenges including:
  - digestive and neurological disorders, bone disease, Anemia, family problems, loss of job, decreased mobility, loss of sexual function and cognitive impairment (Kimmel, MD & Peterson, MD., 2005)
    - It is not an easy life
- Sometimes this causes denial, anger and behavior issues

WHAT THE PATIENT NEEDS



COMMON PROBLEMS

- Becoming personally involved
  - Lose ability to respond objectively
  - React emotionally
- Gifts
  - Protects pts from feeling that they need to pay extra for quality by not receiving gifts from patients
  - Protects staff from feeling they need to give extra attention
- Showing favoritism
  - Do not favor some patients over the others
- Dual relationships
  - Do not exchange goods and services

- An addiction to alcohol is characterized by:
  - Compulsive and continued use of alcohol in spite of adverse consequences such as illness, job loss, or family problems.

- Reduced physical functioning
- Decreased interest in life activities, including work
- Memory loss
- Mood swings, irritability, aggressive behavior
- Preoccupation with drinking and making life decisions which enable drinking
- Distorted thinking and inability to make sound decisions
- Increased incidents of absenteeism
- Getting arrested
- Deteriorating relationships with colleagues at wotk
- Unsteady gait, clumsiness
- Work injuries and accidents
- Poor family relationships

MANAGING AN ALCOHOLIC

- Educate then on the consequences of heavy alcohol consumption
  - Making it clear that alcohol abuse is interfering with their work and drinking on the job will result in the job loss.
  - Financial problems they are having is due to heavy drinking
  - That their physical and mental health issues are as a result of drinking.
  - That their marriage has broken down because of drinking
  - Frequent arrests are due to drinking
  - Memory loss
- Help the person get help – either from hospital, rehab or support group.

GENERAL TIPS ON HOW TO HANDLE DIFFICULT PATIENTS

- Difficult patients can be needy, demanding and question everything you do
- You can be frustrated if you do not know how to deal with them
- In the table below are tips that can help you handle difficult patients

TABLE

How to handle difficult patient encounters

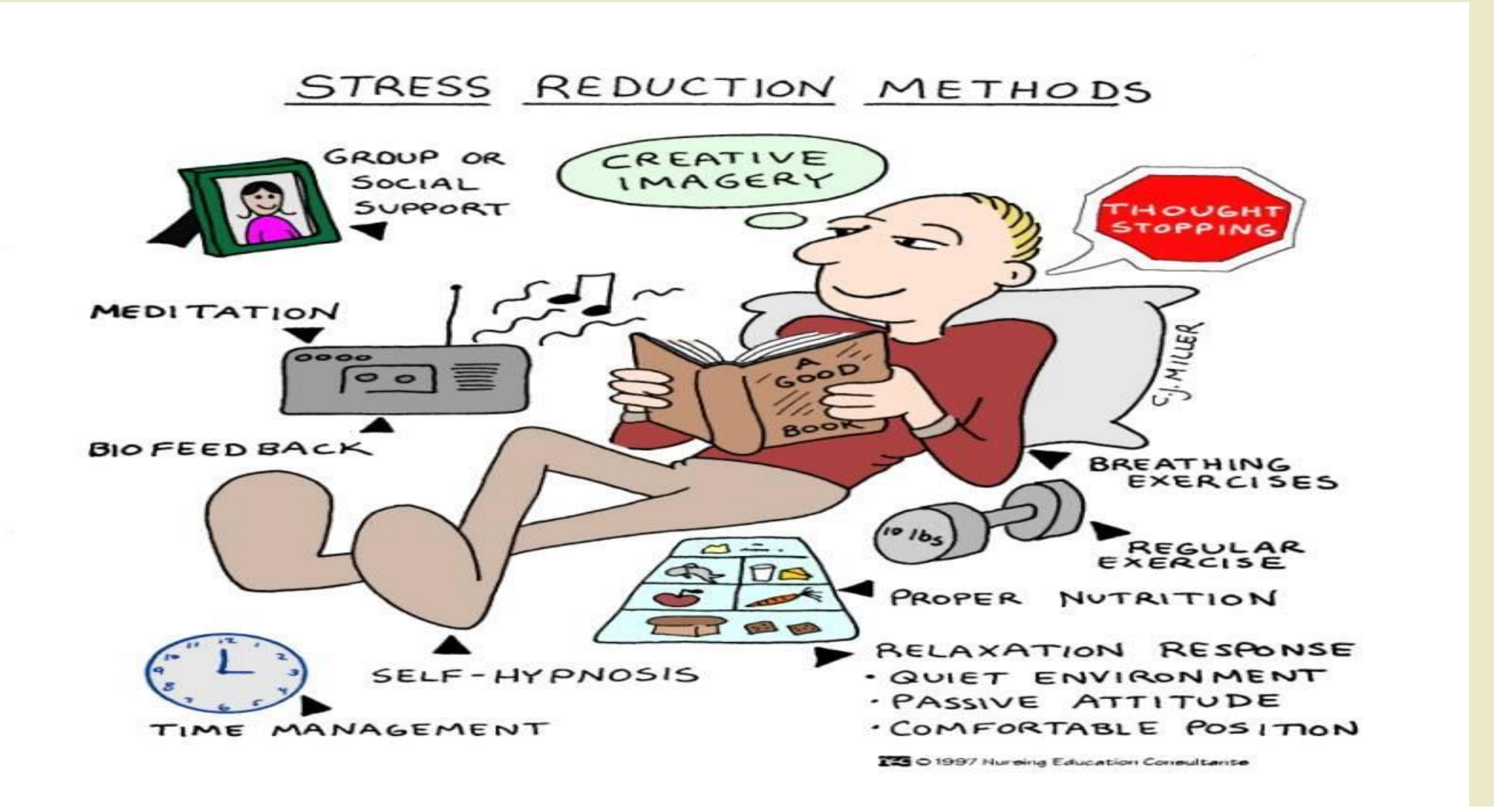
Core principles	Communication techniques	Visit structure
Make your relationship with the patient, not the "disease," the target of change	Elicit emotions via direct and indirect questioning. • Directly question *"How does that make you feel?"* • Inquire about impact on life *"With all of these headaches, I'm wondering how you are handling things."* • Seek patient explanatory model *"Do you have any thoughts on what's behind these headaches?"* • Self-disclose *"My sister struggled with migraines for years, too, but eventually she found the right treatment."*	Schedule frequent, regular, brief appointments in advance
Focus the discussion on the patient's emotional experience	Offer support and empathy. • Name the affect *"You sound sad."* • Validate *"You've lost your wife and have pain all over your body. That's a lot for anyone to cope with."* • Align *"I want to do everything in my power to help you get your pain down so you can get back to work."*	Set the agenda at the beginning of the appointment
Allow the patient's perspective to guide the clinical encounter	Use nonverbal behaviors that convey attentive listening. • Thoughtful nodding • Occasional silence	De-emphasize diagnostics and prescriptions for patients with medically unexplained symptoms and instead explore personal stressors

How do you handle difficult *patients* or *co-workers*?

1. Don't try to change them.
2. Set firm boundaries.
3. Acknowledge their feelings.
4. Hold your ground.
5. Use fewer words.

DEALING WITH OTHER DIFFICULT LIFE SITUATIONS

Managing stress

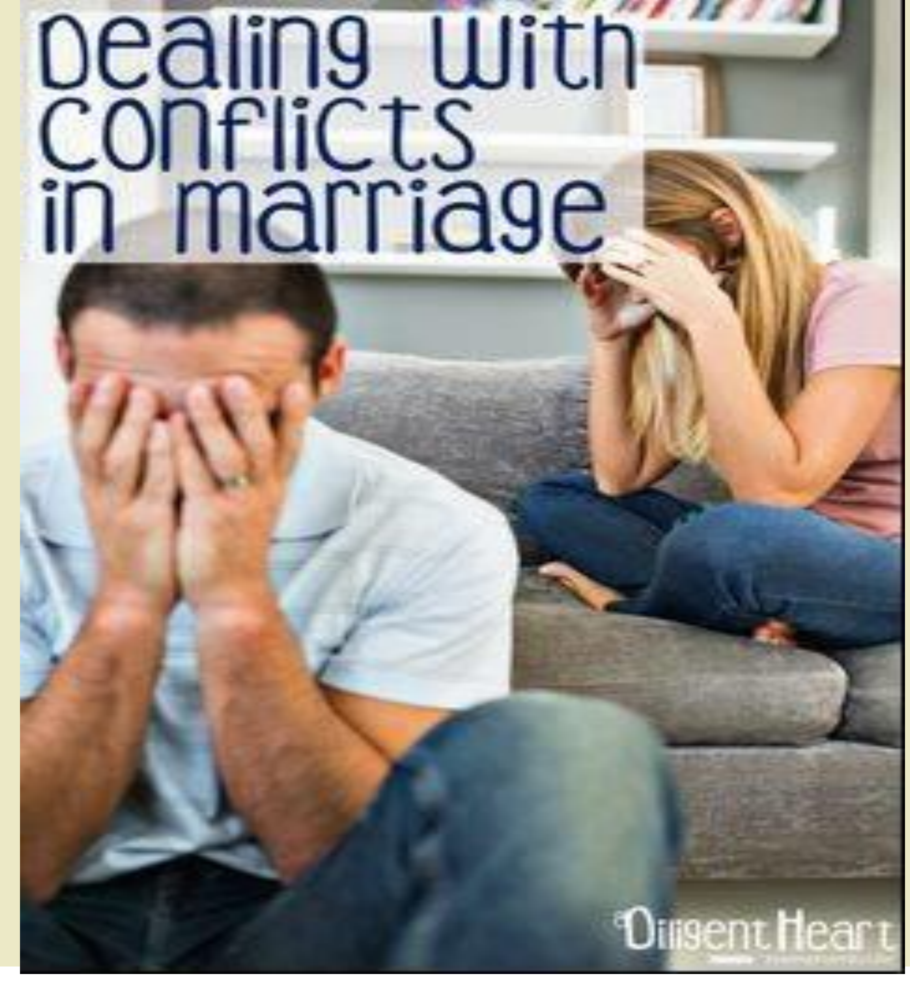


Dealing with an angry customer (Shushmul, 2005)

DEALING WITH CONFLICTS

Conflict resolution model

Example



CONFLICT RESOLUTION MODEL

Create a calm environment

ed to be aware of the physical environment and sources of conflict

Understand others

Acknowledge the perspectives and feelings of the other individual(s) involved

Need a non judgemental approach

Have to remain objective in dealing with conflict. Should not be judgemental

Focus on the theme

Focus on the matter at hand with a focus on positive outcomes

Look for solutions

Not all conflicts can be resolved, but working in collaboration with other will improve the likelihood of a positive outcome

Implementing agreement

Showing respect for your fellow person helps the process go a long way and lessen the opportunity for a position of defense.

Continue to communicate

Follow up is extremely important. It allows you to monitor the progress being made and demonstrates to the individual your commitment to resolving the conflict.

Take Another look

Revisiting the matter occasionally is a good way to prevent future reoccurrences, it is important that this follow up be made with preserving the dignity and respect for the patient.

HEALTHY LIVING

- Take charge of your life.
- Act appropriately -don't simply react to stressful situations
- Find balance in all that you do.

THE ORGANIZATION OF MENTAL HEALTH SERVICES IN KENYA 8/5/2019

BY: DR. MBURU

THIS ACT MAY BE CITED AS THE MENTAL HEALTH ACT, 2013. ARRANGEMENT OF CLAUSES

- **PART I—PRELIMINARY**
- **PART II—ACCESS TO MENTAL HEALTH CARE**
- **PART III—DETERMINATION OF MENTAL ILLNESS**
- **PART IV—RIGHTS OF PERSONS WITH MENTAL ILLNESS AND DUTIES OF MENTAL HEALTH CARE PROVIDERS**
- **PART V—PROVISIONS ON ADMISSION AND TREATMENT**
  - Voluntary admission
  - Informed consent
  - Involuntary admission
  - Emergency admission and treatment
  - Considerations for emergency cases
  - Duration of emergency treatment

CONT.

- **PART VI—MENTALLY ILL OFFENDERS:** Facilities for mentally ill offenders
- **PART VII—SECLUSION AND RESTRAINT**
- **PART VIII—REVIEW, APPEALS, DISCHARGE AND TRANSFER OF PERSON WITH MENTAL ILLNESS**
- **PART IX—CARE AND ADMINISTRATION OF PROPERTY OF PERSONS WITH MENTAL ILLNESS**
- **PART X—MENTAL HEALTH BOARD**
- **PART XI—FINANCIAL PROVISIONS**
- **PART XII—MISCELLANEOUS PROVISIONS**

STUDENTS TO READ THE ACT IN FULL SO AS TO GET ALL DETAILS.

WORLD HEALTH ORGANIZATION (WHO) DEFINITION OF HEALTH

- HEALTH POLICIES ON THE 21ST CENTURY WILL NEED TO BE CONSTRUCTED FROM A KEY QUESTION…
- "WHAT MAKES PEOPLE HEALTHY?" (KICKBUSCH, QUOTED IN WHO: 2005, P.2)
- THE WORLD HEALTH ORGANIZATION (WHO) DEFINES HEALTH AS
- *"NOT MERELY THE ABSENCE OF DISEASE OR INFIRMITY', BUT RATHER, "A STATE OF COMPLETE PHYSICAL, MENTAL AND SOCIAL WELL-BEING"* (2001: 3).

MENTAL HEALTH—DEFINITION.

A STATE OF WELL BEING WHERE BY INDIVIDUALS

- RECOGNIZE AND
- REALIZE THEIR ABILITIES,
- ARE ABLE TO COPE WITH THE NORMAL STRESSES OF LIFE,
- WORK PRODUCTIVELY AND FRUITFULLY,
- AND MAKE A CONTRIBUTION TO THEIR COMMUNITIES (WHO 2003)

THE MENTAL HEALTH BILL, 2013

THIS BILL NOW AN ACT OUTLINES HOW MENTAL SERVICES ARE STRUCTURED

- **PART I—PRELIMINARY**
- 1—Short title
- 2—Interpretation
- 3—Objects and purposes of the Act

THE MENTAL HEALTH BILL, 2013

A BILL NOW AN ACT OF PARLIAMENT TO

1. PROVIDE FOR THE PREVENTION OF MENTAL ILLNESSES,
2. PROVIDE FOR CARE,
3. PROVIDE FOR TREATMENT AND REHABILITATION OF PERSONS WITH MENTAL ILLNESS;
4. TO PROVIDE FOR THE PROCEDURES FOR ADMISSION,AND TREATMENT
5. PROVIDE FOR GENERAL MANAGEMENT OF PERSONS WITH MENTAL ILLNESS;
6. TO PROVIDE FOR THE ESTABLISHMENT OF THE MENTAL HEALTH BOARD AND FOR CONNECTED PURPOSES

(*ENACTED BY THE PARLIAMENT OF KENYA*)

POSITIVE MENTAL HEATH

IS A CRUCIAL DETERMINANT OF OVERALL HEALTH AND SOCIO-ECONOMIC DEVELOPMENT

IT INCLUDES

- GOOD EMOTIONAL STATE,
- GOOD COGNITIVE FUNCTIONS ,
- GOOD SOCIAL FUNCTIONING AND COHERENCE

‘***‘THERE IS NO HEALTH WITHOUT MENTAL HEALTH’’***

MENTAL HEALTH POLICY (2015-2030)

GOAL

- TOWARDS ATTAINING THE HIGHEST STANDARDS OF MENTAL HEALTH

THE MENTAL HEALTH POLICY-IMPLEMNTATION

IN LINE WITH

- CONSTITUTION OF KENYA (2010)
- KENYA VISION 2030
- KENYA HEALTH POLICY OF 2014-2030

AND

- THROUGH MULTISECTORAL APPROACH-INCLUDING ALL HEALTH SECTORS
- WILL BE IMPLEMENTED THROUGH 5-YR STRATEGIC PLANS

ROLE OF NATIONAL GOVERNMENT

DEVELOP

1) POLICY,NOW IN OPERATION
2) LEGISLATION,
3) STANDARD SETTING
4) REGULATION,
5) CAPACITY DEVELOMENT,
6) COORDINATION,
7) MONITORING AND EVALUATION
8) AND OFFERING TECHINICAL ASSISTANCE TO THE COUNTIES

THE ROLE OF MINISTRY OF HEALTH

FACILITATE

1) POLICY IMPLEMENTATION,
2) ADEQUATE FINANCES,
3) HUMAN RESOUCES,
4) COMMODITY SUPPLY,
5) HEALTH INFORMATION AND INFRASTRCTURE

THE ROLE OF DIRECTORATE OF MENTAL HEALTH AND SUBSTANCE ABUSE

- PROVIDE STRATEGIC LEADERSHIP IN IMPLEMENTATION OF THE POLICY THROUGH
- INTERGRATED STRATEGIC PLAN,
- PROGRAMMES AND GUIDELINES

THE ROLE OF KENYA BOARD OF MENTAL HEALTH

SHALL PROVIDE CRITICAL OVERSIGHT ON THE

IMPLENTATION OF POLICY

THE ROLE OF THE GOVERNMENT

WILL PROVIDE AN ENABLING ENIVIRONMENT

FOR THE ENHACEMENT OF PRIVATE/PUBLIC

SECTOR PARTENERSHIPS

THE ROLE OF COUNTIES

INCLUDE MENTAL HEALTH IN

- THE COUNTY INTERGRATED DEVELOPMENTS PLANS,
- STRATEGIC PLANS
- AND ANNUAL IMPLEMENTATION PLANS
- RESOURCE MOBILIZATION
- CAPACITY BUILDING
- EFFECTIVE IMPLEMENTATION

ROLES AND RESONSIBILITIES OF HEALTH REGULATORY BODIES

REGULATE HEALTH PROFFESIONALS

REGISTER

LICENCE

FACILITATE CONFLICT RESOLUTION

DISPLINE ANY CASE OF PROFESSIONAL MISCONDUCT

RESPONSIBILTIES AND ROLES OF NON STATE ACTORS

- EXPAND COVERAGE OF MENTAL HEALTH
- IMPROVE ACCESS
- FORMULATE, FINANCE, IMPLEMENT MONITOR AND EVALUATE PROGRAMS
- ADVOCACY FOR PROMOTION MENTAL HEALTH CARE

ROLES AND RESONSIBILITIES OF MEDIA

- POSITIVE ADVOCACY
- PROMOTION OF MENTAL HEALTH
- AND CARE

ROLES AND RESONSIBILITIES OF INVIDUALS, FAMILIES, AND COMMUNITIES

- PROMOTION OF MENTAL HEALTH
- PREVENTION
- TREATMENT
- REHABILITATION OF PEOPLE WITH MENTAL NEUROLOGICAL AND SUBSTANCE USE

THE ROLE OF DEVELOPMENT AND IMPLEMENTATION PARTNERS

- SUPPORT
  - MENTAL HEALTH POLICY IMLEMENTATION,
- THROUGH
  - HEALTH SECTOR PARTNERSHIP AND
  - EMPHASIS MENTAL HEALTH PRIORITIES
  - AND PLANS

THE ROLE OF TRAINING AND RESEARCH INSTITUTES

- MENTAL HEALTH TO BE INCLUDED IN THE CURRICULUM
- CURRICULUM TO MEET INTERNATIONAL STANDARDS
- PROVIDE EVIDENCE BASED APPROCHES AND PRACTICES TO MENTAL HEALTH ISSUES
- CONDUCT SCIENTIFIC MENTAL HEALTH RESEARCH AND
- SHARE INFORMATION TO INFORM THE POLICY IMPLEMENTATION

PROFFESSIONAL BODIES

- PROVIDE TECHNICAL ADVISE,AND PROFFESSIONAL EXPERTISE
- ENSURE/FACILITATE PROFFESSIONAL GROWTH
- MAINTAIN ETHICS
- WELFARE OF THE MEMBERS

POLICY MONITORING AND EVALUATION

- FIVE YEAR MENTAL HEALTH STRATEGIC PLANS
- FIVE YEAR MENTAL HEALTH POLICY EVALUATION EG(2015-2030 ONE)
- MEDIUM-TERM OUTCOMES

REFERENCES

1. KENYA MENTAL HEALTH POLICY 2015-2030

- http://www.health .go.ke
- Published by ministry of health- august 2015

2. MENTAL HEALTH ACT, 2013

VOLUNTARY COMMUNITY SERVICE ORGANIZATIONS IN MENTAL HEALTH

BY: DR. MBURU

VOLUNTARY SERVICE ORGANIZATIONS IN MENTAL HEALTH

- The aim of VSO in mental health is to support patients as well as the care givers and also educate the public what is required in the management of that particular disorders
- Most of the VSO address a particular disorder

INCLUDE

- Autism Society of Kenya
- Schizophrenia Foundation of Kenya
- Kenya Association for the welfare of epilepsy
- Alcoholic Anonymous
- Alzheimer's Association of Kenya

AUTISM SOCIETY OF KENYA

- Is a parent driven initiative founded in the year 2003

OBJECTIVES OF ASK

- Create awareness of the existence of Autism in Kenya and establish its management procedures

SERVICES

- Dietary services
- Integration therapy, sensory integration carried out by occupation therapist where they do
- 1. individualised learning
- 2. Motor skills development
- 3. Hydrotherapy
- 4. Vestibular stimulation
- 5.Sensory integration
- 6. Spiritual development

SERVICES

- Trainings for parents and care givers to create awareness and build their capacity and impact on them skills so that they are more skilled, motivated and prepared to play the supportive role.
- Trainings for occupational therapy students to enhance capacity and skills for the management of the disorder

SERVICES

- Awareness walks which serve as a channel to create community awareness as well as build the capacity of the caregivers

THE SCHIZOPHRENIA FOUNDATION OF KENYA (SFK)

- a voluntary organization helping families, friends and people with schizophrenia and related disorders
- The goal of the SFK is awareness creation and support families' participation in dealing with schizophrenia and related disorders

KENYA ASSOCIATION FOR THE WELFARE OF EPILEPSY

- **Goal**- To improve the quality of life of people living with epilepsy, empowering them to realize their full potential.
- To develop and sustain a comprehensive and integrated epilepsy program that is affordable and accessible to all people suffering from epilepsy countrywide.

SERVICE OFFERED BY KENYA ASSOCIATION FOR THE WELFARE OF EPILEPSY

- Promotive
- Curative
- Preventive
- Education

ALCOHOLIC ANONYMOUS

- AA is a support network of recovering alcoholics who adopt, and live by a programme that addresses the physical, mental, emotional, social, and spiritual dimensions of alcohol abuse. The programme is based on 12 "steps" designed to transform the alcoholic's mind and heart so that he or she will be able to resist the lure of the bottle.

12 STEPS IN AA

- The first three steps are foundational and recognize that "we don't get messed up alone, and we don't go into recovery mode alone’’
- The next three deal with "an honest and fearless moral inventory of all of our faults,"

12 STEPS OF AA

- The last three steps focus on relationships, directing the alcoholic to make a list of people they have wronged and come up with ways to make amends for those wrongs.
- The final three steps are "maintenance strategies" that urge people to make a "daily moral inventory" of their lives so that they may immediately correct any mistakes, to deepen their relationship with God, and to reach out and support others who are going through similar struggles

12 STEPS OF AA

- In addition to supporting one another at meetings, AA members also have sponsors who are "honest, firm, and understanding" people of the same sex whom they contact any time when they feel tempted to take a drink.

12 STEPS OF AA

- The recovery process--especially for hard-core or long-term alcoholics--usually begins with time spent in a detoxification centre where, under the supervision of a doctor, After this they can check into a residential centre (rehabilitation centres).

12 STEPS OF AA

- Patients stay there from three to six months and undergo extensive therapy. It is here where they receive a "crash course" in AA and the 12 steps. Once they check out, recovering alcoholics are urged to continue with AA and the 12 steps.

ALZHEIMER'S ASSOCIATION OF KENYA

- Alzheimer's Association of Kenya (AAK) is a non-profit Alzheimer association that supports people with dementia and their families. The association was registered in the year 2007 with most of the founding members being individuals who, affected by Alzheimer's, felt the need to come together and support others in a similar situation; especially care givers.

CONT.

- **Aims of the association**
- The primary aim is to support people with dementia and their care givers.
- **Our work**
- **Advocacy**
- They conduct advocacy through:

- Creating Public awareness for Alzheimers through:
  - Newspapers- Articles on members' experiences
  - Television – Televised interviews with caregivers
  - Brochures – Explaining the disease and services rendered by the Association (Translated in different local languages to reach different communities)
  - Wrist bands to identify members and patients

- **Providing public education on Alzheimer's**
- Target groups:
- The police
- Nurses
- The general public (via public transport)
- We focus on educating on:
- Signs and symptoms of Alzheimer’s
- Referral mechanisms/procedures

- **Support for caregivers**
- We offer support to caregivers by:
- Encouraging and allowing them to talk about what they are going through
- Assisting with counseling if required (for the caregivers)
- Home visits for people with Alzheimer’s patients for moral support

- **Resource center**
- A resource center was developed to provide more information about Alzheimer's
- **Research and documentation**
- In collaboration with Africa Mental Health Foundation, they are engaged in research and documentation of Alzheimer's in Kenya to inform policy and practice as well as advocate for the provision of services for the affected.

DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS: CAUSES AND CONSEQUENCES

BY: DR. MBURU

INTRODUCTION

- IS THERE A GROUP OF CITIZENS MORE DESERVING OF SAFETY AND REFUGE THAN PEOPLE WITH SEVERE MENTAL ILLNESS (SMI)? WHO HAVE TRADED ONE LEVEL OF CONFINEMENT IN
  - STATE MENTAL HOSPITALS
  - NURSING HOMES,
  - INTERMEDIATE CARE FACILITIES,
  - JAILS, AND PRISONS—
  - OR, WORSE, BECOME HOMELESS?

INTRODUCTION 2

- THIS LECTURE

- REVIEWS TRENDS IN THE TRANSINSTITUTIONALIZATION OF PEOPLE WITH SMI AND PROPOSES THAT IT IS TIME WE OFFER ASYLUM, IN THE BEST SENSE OF THE WORD, TO THE MOST VULNERABLE OF THE PEOPLE WITH SEVERE MENTAL ILLNESS.
- AND NOT DEINSTUTIONALIZE THEM.

ASYLUM---DEFINATION

- CONCEPT OF ASYLUM ORIGINATED IN ANCIENT GREECE AND ROME
- IT WAS A PLACE WHERE THOSE WHO WERE PERSECUTED COULD SEEK SANCTUARY AND REFUGE.
- THOSE PERSONS INCLUDED
  - DEBTORS,
  - CRIMINALS,
  - MISTREATED SLAVES,
  - AND INHABITANTS OF OTHER STATES

MODERN MENTAL HEALTH HOSPITALS

- THE MENTALLY ILL IN EARLY AMERICAN COMMUNITIES WERE GENERALLY CARED FOR BY FAMILY MEMBERS, HOWEVER, IN SEVERE CASES THEY SOMETIMES ENDED UP IN ALMS HOUSES OR JAILS.
- MENTAL ILLNESS WAS GENERALLY THOUGHT TO BE CAUSED BY
  - A MORAL OR
  - SPIRITUAL FAILING,
    - PUNISHMENT AND SHAME WERE OFTEN HANDED DOWN TO THE MENTALLY ILL AND SOMETIMES THEIR FAMILIES AS WELL.

By 1773. TO DEAL WITH MENTALLY DISTURBED PEOPLE WHO WERE CAUSING PROBLEMS IN THE COMMUNITY A MENTAL HOSPITAL WAS STARTED IN AMERICA

- **By 1792.** The New York Hospital opened a ward for "curable" insane patients.
- THIS TREND BECAME UNIVERSAL

BEGINNING OF MENTAL HOSPITALS

- Locally
- MATHARI HOSPITAL WAS FOUNDED IN 1910 .
- A SMALLPOX ISOLATION CENTRE WAS REDESIGNED AND BECAME THE NAIROBI LUNATIC ASYLUM.
- THE FACILITIES WERE SEGREGATED
  - WITH AFRICAN PATIENTS, WHO CONSTITUTED 95% OF THE PATIENTS, BEING KEPT IN THE WORST CONDITIONS. THEY LIVED IN VERY OVERCROWDED *BOMAS*, WHICH WERE THE TRADITIONAL FORM OF HOUSING IN KENYA.[2]
  - ASIAN FACILITIES WERE SOMEWHAT BETTER
  - WITH THE BEST CONDITIONS BEING RESERVED FOR EUROPEANS

UP UNTIL INDEPENDENCE ALL PSYCHIATRISTS, SENIOR DOCTORS AND NURSES EMPLOYED AT THE HOSPITAL WERE EUROPEAN.

MATHARI HOSPITAL

- IS A SPECIALIZED NATIONAL REFERRAL, TRAINING AND RESEARCH PUBLIC INSTITUTION IN MENTAL HEALTH IN KENYA.
- IT'S LOCATED ALONG WEST OF NAIROBI ALONG NAIROBI-THIKA ROAD.
- MATHARI HOSPITAL, WHICH HAS A BED CAPACITY OF 600 IS KENYA'S PREMIER PSYCHIATRIC HOSPITAL,
- AND IS THE NATIONAL PSYCHIATRIC TEACHING AND REFERRAL HOSPITAL.
- THE INSTITUTION ADMITS PATIENTS WITH SEVERE PSYCHIATRIC DISORDERS WHO CANNOT AFFORD PRIVATE SERVICES AND ARE CONSIDERED TOO DISTURBED TO BE MANAGED IN OTHER PUBLIC FACILITIES OR IN THE COMMUNITY.
- ITS CATCHMENT AREA IS LARGELY THE NAIROBI URBAN AREA WHERE THE FACILITY IS LOCATED, TOGETHER WITH THE CLOSE RURAL AND URBAN ENVIRONS TO THE CITY.
- SOMETIMES PATIENTS ARE REFERRED FROM ALL PARTS OF KENYA FOR SERVICES ESPECIALLY FORENSIC.

IS DEINSTUTILIZATION AN OPTION?

- **NO**
- WHY
- PEOPLE WITH SEVERE MENTAL ILLNESS (SMI)

DESERVE

- SAFETY AND REFUGE
- END UP
  - *IN STATE MENTAL HOSPITALS*
  - *NURSING HOMES,*
  - *INTERMEDIATE CARE FACILITIES,*
  - *JAILS, AND PRISONS*
  - *OR, WORSE, BECOME HOMELESS?*

IT IS TIME WE OFFER ASYLUM, IN THE BEST SENSE OF THE WORD, TO THE MOST VULNERABLE OF THE PEOPLE WITH SEVERE MENTAL ILLNESS.

PREVALENCE OF SMI

- IN KENYA PREVALENCE OF MENTAL ILLNESS RANGES---------------------------

- ACCORDING TO THE NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH),

IN USA

- 6.3 PERCENT OF THE POPULATION SUFFERS FROM SEVERE MENTAL ILLNESS
- DEFINED AS
  - LONGSTANDING MENTAL ILLNESSES, TYPICALLY PSYCHOSIS, THAT CAUSE MODERATE-TO-SEVERE DISABILITY OF PROLONGED DURATION

- IN KENYA MANY WHO NEED RESIDENTIAL TREATMENT CANNOT OBTAIN IT.
- THE PERCENTAGE OF PEOPLE WITH SEVERE MENTAL ILLNESS IN PRISONS AND JAILS IS GENERALLY ESTIMATED TO BE HIGH---------------

- INCARCERATED PERSONS HAVE SEVERE MENTAL ILLNESS

HOW DID WE GET HERE?THE AMERICAN EXAMPLE

- DEINSTITUTIONALIZATION AS A POLICY FOR STATE HOSPITALS BEGAN
  - IN THE PERIOD OF THE CIVIL RIGHTS MOVEMENT WHEN MANY GROUPS WERE BEING INCORPORATED INTO MAINSTREAM SOCIETY.
  - THREE FORCES DROVE THE MOVEMENT OF PEOPLE WITH SEVERE MENTAL ILLNESS FROM HOSPITALS INTO THE COMMUNITY:
  - 1.THE BELIEF THAT MENTAL HOSPITALS WERE CRUEL AND INHUMANE;
  - 2.THE HOPE THAT NEW ANTIPSYCHOTIC MEDICATIONS OFFERED A CURE;
  - 3.AND THE DESIRE TO SAVE MONEY

ROLES OF STATE HOSPITALS

- HISTORICALLY, STATE HOSPITALS FULFILLED MANY NEEDS FOR PEOPLE WITH SEVERE MENTAL ILLNESS WHICH INCLUDED
- THERAPY,
- MEDICATION,
- MEDICAL TREATMENT,
- WORK AND VOCATIONAL TRAINING,
- AND A SENSE OF COMMUNITY.

2. ROLES OF STATE HOSPITALS

- PRIOR TO 1950S
- STATE HOSPITALS PROVIDED
  - A WORK ENVIRONMENT.
  - THERE WERE OFTEN WORKSHOPS AND FARMS TO MAKE OR GROW SOME OF THEIR OWN NEEDS.
  - THIS WAS PARTICULARLY TRUE AT THE END OF THE NINETEENTH CENTURY
  - BEFORE ENTREPRENEURS REALIZED THERE WAS A PROFIT TO BE MADE IN THE STATE HOSPITAL SYSTEM AND SLOWLY BEGAN SELLING GOODS AND SERVICES TO THE HOSPITALS, REDUCING "THE AMOUNT OF WORK AND INCREASING THE AMOUNT OF IDLENESS IN THE SYSTEM"

INSTUTILIZATION OF PEOPLE WITH SMI AND LAW-1

- ABILITY OF STATE FACILITIES TO CONFINE PEOPLE IN HOSPITALS AGAINST THEIR WILL HAS MET MANY OBSTACLES
  - THER ARE LAWS INTENDED TO PRESERVE LIBERTY AND PREVENT WRONGFUL HOSPITALIZATION, ON THE ONE HAND,
  - AND THE NEED TO IDENTIFY AND TREAT PEOPLE EARLY IN THEIR DISEASES, ON THE OTHER.
  - ALTHOUGH PRESERVING THE RIGHTS OF PEOPLE WITH SEVERE MENTAL ILLNESS TO BE TREATED IN THE LEAST RESTRICTIVE SETTINGS IS NOBLE,

INSTUTILIZATION OF PEOPLE WITH SMI AND LAW-2

- IT HAS ALLOWED MANY PEOPLE WITH SMI TO "FALL THROUGH THE CRACKS" IN THE SYSTEM OR BE REHOSPITALIZED IN WHAT HAS BEEN TERMED THE "REVOLVING DOOR" OF ACUTE HOSPITAL ADMISSIONS

- DIFFICULTY BEING ADMITTED TO A HOSPITAL LEADS TO
  - THE HOMELESSNESS OF PEOPLE WITH SEVERE MENTAL ILLNESS,
  - THEY WANDER THE STREETS IN MAJOR CITIES,
  - BEING ARRESTED OR DYING.

- RESULTING IN
  - THE TERM "DYING WITH ONE'S RIGHTS ON" WAS COINED BY DAROLD TREFFERT IN 1973 TO DESCRIBE HOW THE LAWS HAVE GONE TOO FAR IN PROTECTING THE RIGHTS OF INDIVIDUALS AT THE EXPENSE OF THEIR SAFETY AND WELL-BEING

IS IT POSSIBLE FOR PEOPLE WITH SMI TO LIVE IN THE COMMUNITY,

- *THERE ARE REDUCED BEDS IN STATE FACILITIES*
- COMMUINTY PSYCHIATRY INTENDED TO PROVIDE TREATMENT IN THE COMMUNITY---IN KENYA SUCH MOVEMENT WAS STARTED
- MANY PEOPLE WITH SMI STILL CANNOT SURVIVE IN ANY DIGNIFIED OR INDEPENDENT MANNER GIVEN THAT THEY LIVE BELOW THE POVERTY LEVEL

SMI AND CRIME 1

WHY ARE SO MANY PEOPLE WITH SEVERE MENTAL ILLNESS PLACED INAPPROPRIATELY IN JAILS AND PRISONS?

MAJORITY OF PEOPLE WITH SMI

- EITHER POOR
- OR HAVE MORE SEVERE ILLNESS

WITH INADEQUATE SERVICES AND A MORE DIFFICULT TIME INTEGRATING INTO A COMMUNITY.

FACTORS SUCH AS

HIGH ARREST RATES FOR DRUG OFFENDERS,

LACK OF AFFORDABLE HOUSING,

UNDERFUNDED COMMUNITY TREATMENTS MIGHT BETTER EXPLAIN THE HIGH RATE OF ARRESTS OF PEOPLE WITH SEVERE MENTAL ILLNESS

SMI AND CRIME 2

EMERGENCY ROOMS ARE CROWDED WITH

- THE ACUTELY ILL PATIENTS WITH LONG PSYCHIATRIC HISTORIES
- PATIENTS WHO ARE VIOLENT,
- HAVE CRIMINAL HISTORIES
- ARE CHRONICALLY SUICIDAL,
- HAVE HISTORY OF DAMAGE TO PROPERTY,
- OR ARE DEPENDENT ON DRUGS CANNOT BE EASILY PLACED.

THEY ARE OFTEN DISCHARGED BACK TO THE STREETS WHERE THEY STARTED.

WHAT IS NEEDED OF MENTAL HOSPITALS?

- MENTAL HOSPITALS MUST
  - FUNCTION AS ENTRY POINTS TO THE MENTAL HEALTH SYSTEM FOR MOST PEOPLE WITH SEVERE MENTAL ILLNESS WHO OTHERWISE WILL WIND UP IN A JAIL OR PRISON.
  - MENTAL HOSPITALS ARE ALSO NECESSARY FOR INVOLUNTARY COMMITMENT.
  - MOST HEINOUS CRIMES ARE COMMITTED BY PEOPLE WITH SMI (CASES COULD BE QOUTED LOCALLY)
  - USA EXAMPLES
    - IN COLORADO, WHERE JAMES HOLMES KILLED OR WOUNDED 70 PEOPLE,
    - ARIZONA, WHERE JARED LOUGHNER KILLED OR WOUNDED 19 PEOPLE,
    - AND CONNECTICUT, WHERE ADAM LANZA KILLED 28 INCLUDING CHILDREN AS YOUNG AS 6 YEARS OLD.
    - ALL OF THESE KILLERS ARE THOUGHT TO HAVE HAD SEVERE MENTAL ILLNESS AT THE TIME OF THEIR CRIMES.

ANYWHERE ELSE WILL THOSE SERVICES BE INITIATED EXCEPT IN MENTAL HOSPITAL?

EVIDENCE FOR MENTAL HOSPITALS

- TWO STUDIES IN US BY

1 GUDEMAN AND SHORE

- THEY ESTIMATED THAT
  - 15 PERSONS OUT OF 100,000 IN THE GENERAL POPULATION WOULD NEED LONG-TERM CARE

2. TRUDEL AND COLLEAGUES CONFIRMED THIS APPROXIMATION WITH
  - A STUDY OF THE LONG-TERM NEED FOR CARE AMONG PEOPLE WITH THE MOST SEVERE AND PERSISTENT MENTAL ILLNESS IN A SEMI-RURAL AREA IN CANADA, WHERE THEY ESTIMATED A NEED OF 12.4 BEDS PER 100,000

- **AFTER THE INITIAL TREATMENT IN STATE HOSPITALS, MANY PEOPLE WILL STILL BE IN NEED OF LONG-TERM TREATMENT, AS NOTED ABOVE, IN A REAL ASYLUM SUCH AS THE ANCIENTS IMAGINED.**

CONCLUSION

- WE CANNOT DEPEND ON
  - CURRENT OUTPATIENT FACILITIES TO PROVIDE THE SUPPORT THAT IS NEEDED TO PREVENT UNNECESSARY HOMELESSNESS OR ADMISSIONS TO JAILS AND PRISONS AMONG THE MOST VULNERABLE PEOPLE WITH SMI.
  - REVISED LAWS FOR ACCESS TO THOSE SERVICES, TO APPROPRIATELY CARE FOR THIS POPULATION.
- THE IDEA OF AN ASYLUM AS IDEALIZED BY THE ANCIENTS MIGHT BE A WELCOMED ALTERNATIVE TO DEINSTUTILIZATION.

CRIME, DEVIANCE AND IMPLICATION ON MENTAL HEALTH

BY: DR. MATHAI MUTHONI

OBJECTIVES

- At the end of this lecture the student should be able
- To define and differentiate - deviant behavior and criminal behavior
- Describe types of behavior that falls under the above categories in our society
- Discuss some common psycho-sociological theories in aetiology of deviant behavior
- Discuss deviant theory and crime in relation to common mental disorders

INTRODUCTION

- What kind of behaviour would you term deviant
- What kind of behaviour would you term criminal

DEVIANT BEHAVIOUR

- Deviant behaviour can be defined as behaviour that violates social norms and role expectation and especially when the community feels strongly enough about it to institute sanctions to prevent or otherwise control deviant behaviour

DEVIANT BEHAVIOUR AND CRIME

- Deviance may constitute informal violations of social norms with resultant rebuke or disapproval
- OR- Deviant actions may violate **formally-enacted rules** and are hence referred to a criminal acts- punishable by the laws of the land

DEVIANT BEHAVIOUR AND CRIME- COMMON OBSERVATIONS

- Most ‚deviant' behaviour has social roots- being found more commonly in certain social economic groups particularly in city slums.
- Deviant behaviour and delinquency have been closely related to family structure
- Among the general categories of behaviour usually designated as deviant are: Crime, prostitution, certain forms of sexual behaviour, mental illness, suicide, alcoholism, and drug use
- Deviant behaviour has cultural dimensions

AETIOLOGY OF DEVIANCE AND CRIME

- The causation of crime is a complex interaction between the individual's intelligence, temperament and personality structure on one hand and his socio-cultural background on the other hand

AETIOLOGY II

- Several schools of thought have been engaged in trying to understand and explain deviance and criminal behaviour. These include:
- Sociologists
- Psychologists
- Criminalogists
- Psychiatrists

SOCIOLOGICAL THEORIES OF DEVIANCE

- No single theory can explain deviant behaviour
- The sociology of deviance contains a number of theories that seek to describe trends and patterns of behaviour that lie within social deviance.
- These can be broadly classified into 2 or 3 major categorie: Structural functionalism, Symbolic interaction and Conflict theories*

STRUCTURAL FUNCTIONALISM

- A Structural-Functionalist perspective believes that deviations come from the **formation of norms and values** which are enforced by institutions.
- Deviations are not deviant by nature, but are the results of institutional definition of certain behaviour as deviant
- Therefore, deviation is simply **what is defined as not normal by norms, values, or laws**

ÈMILE DURKHEIM‘S- ANOMIE THEORY

- Èmile Durkheim in his study on suicide came up with the concept of two dimensions of social bonding- social integration and social regulation.
- Social integration is the attachment to groups and institutions, while social regulation is the adherence to the norms and values of the society.
- The state of poor regulation he termed anomie
- Deliquency, crime and suicide are reactions to anomie

ÈMILE DURKHEIM AND ROBERT MERTON

- Anomie or the lack of norms in society is a condition of instability resulting from a breakdown of standards and values or from a lack of purpose or ideals
- Robert Merton in addition found that anomie is severest in people who lack an *acceptable means of achieving their personal goals. And who consequently fall back on illegitimate means
- *Accepatable means refer to those means acceptable according to the standards of society

MERTON'S STRAIN THEORY

- Merton described a continuum of response to anomie- conformity, social innovation, ritualism, retreat, rebellion

MERTON'S CONTINUUM

- **Conformity**- When an individual accepts the goals and means together example:- White collar employee who holds a job to support a family.
- **Innovation**- When an individual accepts the goals but uses illegitimate means in order to achieve them: Example- Drug dealer who sells drugs to support a family
- **Ritualism**- An individual may lose faith in cultural goals but still feel obligated to work under the routines of legitimate daily life.

MERTON'S CONTINUUM CT

- **Retreat**- Individuals may also reject both goals and means: Example: Drug addicts who have stopped caring about the social goals and use drugs as a way to escape reality
- **Rebellion**- individual rejects the cultural goals and the institutionalized means, but seeks to redefine new values for society: Example: Radicals

SYMBOLIC INTERACTIONISM

- Deviance is the result of learnt deviant behavior.
- The deviant may grow up alongside other deviants or may learn to give excuses for deviance.
- The focus is upon the consciousness and the mind of the individual as opposed to the institutions from where the norms come from.
- Basic points in this theory, is the idea that learning comes from the interactions between individuals and groups, using communication of symbols and ideas. When the symbols and ideas about deviation are much more favorable than unfavorable, the individual tends to take a favorable view upon deviance and will resort to more of these behaviors.
- *(Sutherland)*

NEUTRALIZATION THEORY-GRESHAM SYKES AND DAVID MATZA

- Neutralization theory explains how deviants justify their deviant behaviors
- Characterised by adjusting the definitions of their actions and by explaining to themselves and others the lack of guilt of their actions in particular situations.
- There are five different types of rationalizations: the denial of responsibility, the denial of injury, the denial of the victim, the condemnation of the condemners, and the appeal to higher loyalties.

RATIONALIZATIONS-IN NEUTRALISATION THEORY

- **Denial Of Responsibility**: Propelled helplessly into crime.
- **Denial Of Injury**: Crime does not hurt anyone, not morally wrong.
- **Denial Of The Victim**: Victim did not receive injury but rather, rightful force.
- **Condemnation Of The Condemners**: Condemners are hypocrites, deviants as well.
- **Appeal To Higher Loyalties**: Loyalty to a higher power than law, like friendship.

PRIMARY AND SECONDARY DEVIATION- EDWIN LEMERT

- An extension way to labeling is the idea of primary and secondary deviation.
- Primary deviance is any general deviance before the deviant is labeled as such
- Secondary deviance is any action that takes place after primary deviance as a reaction to the institutions (like imprisonment).
- Secondary Deviation is what causes people to become harder criminals.

CT.

The steps to becoming a criminal are:

1. Primary deviation.
2. Social penalties.
3. Secondary deviation.
4. Stronger penalties.

CT

5. Further deviation with resentment and hostility towards punishers.
6. Community stigmatizes the deviant as a criminal.
7. Strengthening of deviant conduct because of stigmatizing penalties.
8. Acceptance as role of deviant or criminal actor.

THE CONTROL THEORY- HIRSCHI

- A theory that stresses the bonds between the individual and society
- This theory asks why people refrain from criminal behavior, instead of why people commit criminal behavior.
- People will conform to a group when they believe they have more to gain from conformity than by deviance. If a strong bond is achieved there will be less chance of deviance than if a weak bond has occurred.

CT

- A person follows the norms because they have a bond to society. The bond consists of four factors: commitment, attachment, belief, and involvement, these are positively correlated.
- When any of these bonds are weakened or broken they will be more likey to become deviant

FAMILY STRUCTURES AND CONTROL THEORY

- According to Elliot, Huizinga, & Ageton (1985), weak social control may be due to:

- (1) "the failure to develop internal controls during childhood;
- (2) the breakdown of previously established internal controls, particularly during adolescence; and
- (3) social disorganization, in particular social units (i.e., family) that results in weak external controls."

CT

- Thus, the family is an important source of both internal and external control.
- Not only is it important in defining norms for conventional behavior, but family relationships provide an external source of social control (Hirschi, 1969; Nye, 1958).

FAMILY STRUCTURES AND DEVIANCE

- It can discourage risk-taking behaviors.
- The lack of family roles and relationships implies an absence of control which increases the probability of engaging in compromising behaviors.
- self-control develops with the internalization of social constraints.
- Members of a family are more likely to conform to norms because deviation threatens the relationship.
- The structure of family life and the quality of parental attachment determines the likelihood of adolescent engagement in deviant behavior.

LABELING THEORY- FRANK TANNENBAUM AND HOWARD BECKER AND THE CONFLICT THEORY

- "social groups create deviance by making the rules whose infraction constitutes deviance."
- Labeling theory suggests that deviance is caused by the deviant person being negatively labeled, internalizing the label, and acting according to the label.
- In the next stage "deviant" takes on traits that define what a real deviant is supposed to do- *give a dog a bad name*
- The dominant social group in this theory has the power to decide what is deviant and acceptable.

PSYCHOLOGICAL THEORIES OF CRIME

- Psychological theories of crime begin with the view that individual differences in behavior may make some people more predisposed to committing criminal acts. These differences may arise from personality characteristics, biological factors, or social interactions.

PSYCHOLOGICAL AND CONSTITUTIONAL FACTORS

- The XYY karyotype males were found to be significantly represented in penal institutions- this theory has however been put in question- the prevalence of XYY in the general populations is not well studied
- Other studies found abnormal EEGs in habitual aggresive criminals as opposed to single episode criminals
- Studies of aggressive crime found 2 broad categories: Habitual- with undercontrolled aggression and solitary crimes with overcontrolled aggression

PSYCHOLOGICAL THEORIES

- Psychoanalytic- socialization and the development of inner controls
- Cognitive- criminal behavior results from the way in which people organize their thoughts about morality and the law *(Kohlberg 1958)*
- Learning- based upon the principles of behavioral psychology. Behavioral psychology posits that a person's behavior is learned and maintained by its consequences, or reward value.

DEVIANCE, CRIME AND MENTAL ILLNESS

- Mental Health issues and deviant behaviour are seen as strongly interrelated.
- If we define deviant behaviour as a recurrent violation of socially prescribed patterns of behaviour, deviant behaviours such as delinquency, drug abuse or Psychosis can be also approached in terms of interventions aimed at preventing or treating these behavioral problems.
- A certain small percentage of persons with Mental illness commit criminal acts because of their mental disorders

CRIME AND PSYCHIATRIC DISORDERS

- Although constitutional as well as psychological factors have ben recognised to be important in the make up of some criminals only about 20% can be said to require Psychiatric treatment

CRIME AND PSYCHIATRIC DISORDERS

- Of those with recognisable mental disorders only about 1-3% have been diagnosed with a major mental disorder (psychosis or mental subnormality
- Most of these are petty crimes but ocassionally serious crimes like severe injury, sexual assault, arson, and homicide are committed by Mentally disordered
- Some studies seem to indicate that the prevalence of sexual offenders among people with Psychiatric morbidity is higher than in the general population

PSYCHOPATHOLOGY AND CRIME IN MENTALLY DISORDERED

- Intellectual backwardness and poor judgement may lead to petty crimes
- Frustrations and irritable moods- acts of aggression
- Poor understanding and inability to to make adult sexual realtionships- Sexual offences –
- Organic psychosis with failing intellectual capacities and disinhibitions may lead to acts of fraud and minor sexual offences
- Epileptics have been associated with sponteuos unprovoked acts of violence

CT

- Schizophrenics with distorted view of the world may commit minor and even serious crimes
- Depression- agression against self- suicide or close ones- homicide. Depression has also been associated with shop-lifting
- Manic- intolerance and aggression, breach of peace, financial crimes, lack of judgement crimes
- Alcoholics and other drug abusers- crimes under influence or to acess money
- Personality disorders- constitute the most difficulty - The aggressive and sadistic antisocial (psychopaths) having been described as consituting one of the most dangerous criminal types

WHAT HAPPENS TO THE MENTALLY DISORDERED CRIMINAL?

- Normally persons are held responsible for any criminal act they may commit and are liable to punishment for it
- In most countries a person can not be guilty of a crime if he has not the wit to form a criminal intent- mens rea test.
- This absolves children and many mentally disordered person from guilt

CONSULTATION AND LIAISON PSYCHIATRY

BY: PIUS KIGAMWA

DEFINITION

- Consultation-Liaison Psychiatry is a sub-specialty of psychiatry that incorporates clinical service, teaching, and research at the borderland of psychiatry and medicine. (Lipowski, 1983)

WHAT IS CONSULTATION-LIAISON PSYCHIATRY?

- **Liaison psychiatry**, also known as **consultative psychiatry** or **consultation-liaison psychiatry** (also, **psychosomatic medicine**) is the branch of psychiatry that **specialises in the interface between other medical specialties and psychiatry**, usually taking place in a **hospital or medical setting.**
- "Consults" are called when the primary care team has questions about a patient's mental health, or how that **patient's mental health is affecting his or her care and treatment.**

•The psychiatric team works as a "liaison" between the medical team and the patient. **Issues that arise** include

• **capacity to consent** to treatment,

•**conflicts** with the primary care team

•**intersection of problems** in both physical and mental health

•patients who may report physical symptoms as a result of a mental disorder (Wikipedia)

WHAT IS CONSULTATION-LIAISON PSYCHIATRY'S PRESENT POSITION?

- **The American Board of Psychiatry and Neurology: recommended subspecialty for Consultation-Liaison Psychiatry renaming it Psychosomatic Medicine**
- **June 2001: American Psychiatric Association Board of Trustees supported application**
- **2003: American Board of Medical Specialties approved the recommendation**

- ***Psychosomatic Medicine became the 7th subspecialty in Psychiatry***

ASSESSMENT

- The consultant should establish the URGENCY of the consultation (i.e., emergency or routine—within 24 hours).

  Commonly, requests for psychiatric consultation fall into several general categories:

1. Evaluation of suspected psychiatric disorder

- psychiatric history
- use of psycho-tropic medications

2. Evaluation of a patient who is acutely agitated.
3. Evaluation of a patient who expresses suicidal or homicidal ideation.

REQUESTS FOR PSYCHIATRIC CONSULTATION

- 4. Evaluation of a patient who is at high risk for psychiatric problems by virtue of serious medical illness.
- 5. Evaluation of a patient who requests to see a psychiatrist.
- 6. Evaluation of a patient with a medico-legal situation (capacity to consent)
- 7. Evaluation of a patient with known or suspected substance abuse.
- 8. Breaking of news

COMMON PSYCHIATRIC SYMPTOMS AS REASONS FOR CONSULTATION

- Depressed mood
- Agitation
- Disorientation
- Hallucinations
- Anxiety
- Sleep disorder
- Suicide attempt or threat
- Behavioural disturbance

FUNCTIONAL SOMATIC SYNDROMES

Gastroenterology	Irritable Bowel Syndrome
Functional dyspepsia	
Cardiology	Atypical chest pain
Neurology	Common Headache
Chronic fatigue syndrome	
Rheumatology	Fibromyalgia
Complex regional pain syndromes (Reflex sympathetic dystrophy)	
Gynaecology	Chronic pelvic pain
Orthopaedics	Chronic back pain

CHARACTERISTICS OF EFFECTIVE PSYCHIATRIC CONSULTANT (GOLDMAN, LEE, RUDD, 1983)

1. Talks with the referring physician, nursing and other staff before and after consultation. Clarifying the reason for the consultation is the initial goal

- 2. Establishes the level of urgency.
- 3. Reviews the chart and the data thoroughly.
- 4. Performs a complete mental status exam and relevant portions of a history and physical exam.

CHARACTERISTICS OF EFFECTIVE PSYCHIATRIC CONSULTANT (GOLDMAN, LEE, RUDD, 1983):

- 5. Obtains medical history from family members or friends as indicated.
- 6. Makes notes as brief as appropriate.
- 7. Arrives at a tentative diagnosis.
- 8. Formulates a differential diagnosis.
- 9. Recommends diagnostic tests.

CHARACTERISTICS OF EFFECTIVE PSYCHIATRIC CONSULTANT (GOLDMAN, LEE, RUDD, 1983):

- 10. Has the knowledge to prescribe psychotropic drugs and be aware of their interactions (with somatic therapies).
- 11. Makes specific recommendations that are brief, goal oriented and free of psychiatric jargon and **discusses findings** and recommendation with consultee – **In person** whenever possible.
- 12. Respects patient's rights to know that the identified "customer" is the consulting physician. (maintaining absolute Doctor-Patient confidentiality is not possible for a psychiatric consultant)

CHARACTERISTICS OF EFFECTIVE PSYCHIATRIC CONSULTANT (GOLDMAN, LEE, RUDD, 1983):

- 13. Follows – up patient until they are discharged from the hospital or clinic or until the goals of the consultation are achieved. Arranges out-patient care-if necessary.
- 14. Does not take over the aspects of the patient's medical care unless asked to do so.
- 15. Follows advances in the other medical fields and is not isolated from the rest of the medical community.

FOLLOW-UP

- At least daily follow-up should be considered for several types of patients:
- Those in **restraints**
- **Agitated, potentially violent, or suicidal**
- **Delirium**
- **Psychotic or psychiatrically unstable.**
- Acutely ill patients started on psychoactive medications should be seen daily until they have been stabilized.

IMPORTANT FIELDS OF C-L ACTIVITY

- Non compliance
- Delirium
- Dementia
- Transplantation medicine (Bone marrow, heart and lung, liver, kidney, living donations)
- Oncology
- Legal issues (competency)
- HCV, HIV, AIDS
- Addictions
- Perinatal mental health

Unless we lose ourselves in service to others, there is little purpose to our own lives.

-Thomas S. Monson

#In_The_Steps_Of_The_Great_Physician

#Glory_To_Jesus_Christ