ANXIETY DISORDERS

Agoraphobia

- Anxiety about being in places or situations from which escape might be difficult, or in which help would not be readily available in the event of a panic attack (shopping malls, social gathering, tunnels, and public transport).
- The situations are either avoided, endured with severe distress, or faced only with the presence of a companion.
- Symptoms cannot be better explained by another mental disorder.
- Functional impairment.

Social Phobia

- Marked irrational performance anxiety when a person is exposed to a possible scrutiny by others particularly unfamiliar people or authority figures leading to a desire for escape or avoidance associated with a negative belief of being socially inadequate.
- The problem leads to significant interference with functioning (social, occupational, academic…). The person has anticipatory anxiety.
- The response may take a form of panic attack (situationally- bound or situationally-predisposed).
- Common complaints: palpitation, trembling, sweating, and blushing.
- Examples: speaking in public (meetings, parties, lectures) - serving coffee or tea to guests- leading prayers.

Specific Phobia

- Persistent irrational fear of a specific object or situation (other than those of agoraphobia and social phobia) accompanied by strong desire to avoid the object or the situation, with absence of other psychiatric problems.

Generalized Anxiety Disorder (GAD)

Diagnostic Criteria

- ≥ 6 months' history of excessive anxiety occurring more days than not, about a number of events or activities (such as work or school performance).
- The person finds it difficult to control the worry.
- The anxiety and worry are associated with ≥ 3 of 6

1. *restlessness or feeling keyed up or on edge.*
2. *being easily fatigued.*
3. *difficulty concentrating or blank mind.*
4. *irritability.*

5. *muscle tension.*
6. *sleep disturbance.*

- The focus of the anxiety is not confined to features of an Axis I disorder.
- It causes significant distress or functional impairment in social/ occupational/ or other areas.
- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

Obsessive Compulsive Disorder (OCD)

- Recurrent obsessions or compulsions that are severe enough to be time consuming (> 1 hour a day) or causes marked distress or significant impairment.
- The person recognizes that the obsessions or compulsions are excessive and unreasonable.
- The disturbance is not due to the direct effect of a medical condition, substance or another mental disorder.
- Associated features / complications: **Anxiety** is an important component of OCD. Compulsions are done to reduce anxiety. Thus, reinforces obsessive compulsive behavior. **Severe guilt** due to a pathological sense of self blaming and total responsibility to such absurd thoughts especially in blasphemous, aggressive and sexual obsessions. **Avoidance** of situations that involve the content of the obsessions, such as dirt or contamination. **Depressive features** either as precipitating factor (i.e. primary), secondary to, or simultaneously arising with OCD.

Post-traumatic Stress Disorder (PTSD)

- Exposure to a traumatic threatening event (experienced, or witnessed) & response with horror or intense fear.
- Persistent re-experience of the event (e.g. flashback, recollections, or distressing dreams.
- Persistent avoidance of reminder (activities, places, or people).
- Increased arousal (e.g. hypervigilance, irritability).
- ≥ 1 month duration of the disturbance
- **Acute stress disorder:** similar features to PTSD but: -
  A- onset is within 1 month after exposure to a stressor (If symptoms appeared after one month consider post-traumatic stress disorder(PTSD).
  B- Duration: a minimum of 2 days and a maximum of 4 weeks (If symptoms continued more than one month consider PTSD).

Adjustment Disorders

- Maladaptive psychological responses to usual life stressors resulting in impaired functioning (social, occupational or academic).
- Symptoms develop within 3 months of the onset of the stressor (if more than 3 months it is less likely that the reaction is a response to that stressor).
- There should be a marked distress that exceeds what would be expected from exposure to the stressor.
- There should be a significant functional impairment.
- Symptoms vary considerably; there are several types of adjustment disorders: – With depressed mood/With anxiety/With mixed anxiety and depressed mood/With disturbance of conduct (violation of rules and disregard of others rights)/With mixed disturbed emotions and conduct/ Unspecified e.g. inappropriate response to the diagnosis of illness, such as social withdrawal without significant depressed or anxious mood, severe noncompliance with treatment and massive denial.
- In adults: depressive, anxious and mixed features are the most common.
- In children and the elderly: physical symptoms are most common.
- Disturbance of conduct occurs mainly in adolescents.
- Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.
- Adjustment disorder can be: Acute: if the disturbance lasts less than 6 months. Or Chronic: if the disturbance lasts for 6 months or longer (when the stressors or consequences continue).

Normal Grief

SHOCK

- Few hours – several days
- Numbness (lack of emotional response)
- Denial (disbelief or incomplete acceptance and feeling of unreality
- Searching for the lost person
- Anger
- Yearning

DISORGANIZATION

- A week – 6 months
- Despair, sadness, weeping
- Poor sleep & appetite
- Guilt toward deceased.
- Experience of presence of the dead person with illusions and pseudo hallucinations.
- Social withdrawal
- Somatic complaints with anxious mood.

REORGANIZATION

- Weeks – Months
- Symptoms subside and resolve gradually.
- Acceptance of the loss with new adjustment.
- Memories of good times.
- Often there is a temporary return of symptoms on the anniversary of the death.

Pathologic Grief

Abnormally Intense Grief

Symptoms are severe enough to meet criteria for major depression:

- Severe low mood.
- Death wishes with suicidal ideas.
- Psychomotor retardation.
- Global loss of self-esteem.
- Self-blame is global.
- Does not respond to reassurance.

Prolonged Grief*

- Grief lasting for ≥ 6months.
- Symptoms of the first and second stages persist.
- May be associated with depression.

Delayed Grief

- The first stage of grief does not appear until ≥ 2 weeks after the death.
- More frequent after sudden, traumatic or unexpected death.

Distorted Grief

- Features that are unusual e.g.: -marked overactivity. -marked hostility. -psychomotor features.

*Duration of normal grief varies with culture (average 6-12 months).

NEUROCOGNITIVE DISORDERS

Delirium

Definition: -
Acute transient reversible global cognitive impairment with impaired consciousness due to a medical problem.

- Consciousness is disturbed (i.e., awareness of the environment is impaired but patient is not in coma).
- Cognitive functions are impaired + / - perceptual disturbances (illusions or hallucinations). Acute onset with fluctuating symptoms (within hours during the day) & transient course (few days).
- Caused by a physical problem (e.g. hypoxia, hypoglycemia, infection…others see causes).

Dementia

Early stages

- A gradual loss of social and intellectual skills (first noticed in work setting where high performance is required).
- Mild memory impairment.
- Subtle changes in personality.
- Changes in affect (irritability, anger, …).
- Multiple somatic complaints and vague psychiatric symptoms.

Late stages

- Increasing memory impairment (esp. recent memory).
- Attention impairment.
- Disorientation: particularly to time, and when severe to place and person.
- Language: vague and imprecise speech with inappropriate repetition of the same thoughts (perseveration).
- Impaired judgment.
- Potential aggression (verbal & physical).
- Psychotic features: hallucinations and delusions.
- Emotional lability.
- Catastrophic reaction marked by agitation secondary to the subjective awareness of intellectual deficits under stressful circumstances.

Amnestic Syndrome

- Impairment in the short-term memory (retention of new information; temporal lobe function) due to a specific organic cause, in the absence of generalized intellectual impairment.
- It leads to social and occupational dysfunctioning.
- The patient may show confabulation (filling memory gaps with incorrectly retrieved information).
- The insight is partially impaired.

Wernicke – Korsakoff's Syndrome

Wernicke encephalopathy (Acute)

- Ophthalmoplegia.
- Ataxia.
- Impairment of memory.
- Impaired consciousness

Korsakoff psychosis (Chronic)

- Peripheral neuropathy.
- Chronic memory defect.
- Irritability.

SOMATIC SYMPTOMS & RELATED DISORDERS

Somatic Symptom Disorder

- Multiple somatic symptoms (affecting multiple organ system) that cannot be explained adequately based on physical examination and laboratory investigations.
- The symptoms are not intentionally produced.
- The disorder is chronic.
- It is associated with excessive medical help-seeking behavior.
- It leads to significant distress and functional impairment (social, occupational…).
- The focus is on the symptoms and not on the over-concern with a disease. (In contrast to hypochondriasis).

Etiology

- Faulty perception and assessment of somato-sensory inputs due to characteristic attention impairment.
- Displacement of unpleasant emotions into a physical symptom.
- Alleviation of guilt through suffering.
- To obtain attention or sympathy.

Illness Anxiety Disorder (Hypochondriasis)

- Intense prolonged over-concern and preoccupation with physical health and/or excessive worry about having a serious physical disease (e.g. cancer, organ failure, AIDS, etc.).
- The preoccupation persists in spite of medical reassurance.
- It is not delusional in intensity.
- It causes social or occupational dysfunctioning.

Etiology

- The patient amplifies his normal somatic sensations due to unrealistic interpretation of physical complaints, and misattributes pathological meaning (e.g., minor usual muscular chest pain is interpreted as a sign of cardiac disease).
- Most of such patients have obsessional and anxiety personality traits.

Functional Neurological Symptom Disorder (Conversion Disorder)

- Symptoms are related to the neurological system.
- **Sensory:** paraesthesia - partial blindness - deafness
- **Motor:** paralysis – paresis - aphonia
- **Pseudoseizures and fainting**: Pseudoseizures usually lack a number of features of the true epileptic seizures e.g. aura, cyanosis, physical consequences of seizure (tongue bite, trauma, incontinence) and do not occur in sleep. EEG findings are normal. Prolactin level usually increases within 3 hours of a true seizure but not a pseudoseizure.
- Patient may be unconcerned about his symptoms (denial of affect) this is called “La belle indifference” or may also present in a dramatic or histrionic fashion.
- Primary gain: the reduction of inner tension and intrapsychic conflict after developing the physical disability through conversion.
- Secondary gain: the advantage that the patient gains, e.g. avoiding unpleasant duties.

SUBSTANCE-INDUCED DISORDERS

Alcohol

Intoxication

- **Early intoxication** includes a sense of well-being, liveliness and a smell of alcohol on the breath, grading into emotional lability, irritability, and incoordination, which grades into apathy, ataxia, and slurred speech.
- **Heavy intoxication** (blood alcohol level above 300 mg/ml) can lead to alcoholic coma. Alcohol acute intoxication may mimic many psychiatric conditions (panic attacks, depression, and acute psychosis with delusions +/- hallucinations).

Withdrawal

- **6 - 8 hours | Autonomic hyperactivity: -** tremor, agitation, diaphoresis, anxiety, tachycardia, nausea, vomiting, anorexia, headache, insomnia, and craving for alcohol.
- **10 - 30 hours | Perceptual disturbances: -** Hallucinations (auditory or visual, tactile, olfactory or mixed), illusions, + autonomic hyperactivity of stage 1.
- **12 - 48 hours | Grand mal seizures**; 3-4% of untreated patients progress to stage 3; more than 50% have multiple seizures; >30% have Delirium Tremens if untreated.
- **≥ 2 - 3 days | Delirium tremens** (DTs).

Anxiolytics, Sedatives & Hypnotics. (e.g. Benzodiazepines)

Intoxication

Similar to alcohol intoxication

- Slurred speech – incoordination - unsteady gait - nystagmus / ataxia.
- Impaired attention or memory - stupor or coma.

Withdrawal

Similar to alcohol withdrawal

- Autonomic hyperactivity (e.g. sweating, tachycardia).
- Nausea, vomiting, anorexia. - Insomnia. - Anxiety / agitation.
- Perceptual disturbances (e.g. illusions…).
- Seizures.
- Delirium.

Inhalants (Volatile Solvents)

Intoxication

Symptoms of mild intoxication are similar to intoxication with other brain suppressants (e.g. alcohol).

- **In small doses**, these agents produce the attracting features: euphoria, excitement, pleasant floating sensations, and disinhibition.
- **High doses** can cause: disturbed consciousness, perceptual disturbances, impulsiveness, assultiveness, impaired judgment, sedation, slurred speech, nystagmus, ataxia, incoordination, nausea, and vomiting.

Opioids

Intoxication

- **Initial Phase:** euphoria, analgesia, and relaxation.
- **Then:** apathy, dysphoria, drowsiness, slurred speech, psychomotor retardation (or agitation), disturbed consciousness, impairment in attention, memory, and judgment.
- Sexual desire diminishes with repeated use.
- Opioids effects on the pupils; Pupillary constriction.
- In severe overdose: Pupillary dilatation.

Withdrawal

- Rhinorrhea (runny nose).
- Lacrimation.
- Pupillary dilation.
- Yawning.
- Insomnia.
- Fever / sweating / piloerection.
- Muscle / joint aches.
- Nausea or vomiting / Diarrhea.
- Dysphoric mood.
- Craving (desperate searching for opioids).

CNS Stimulants (Amphetamine, Cocaine)

Features: -

- Hypervigilance / Hyperactivity / Agitation
- Suspiciousness >>>>>>> paranoid delusion.
- Overconfidence >>>>>> grandiosity.
- Aggression & violence.

- Insomnia.
- Euphoria or irritable mood.
- Hallucinations (visual more than auditory).
- Confusion and incoherence.
- However, it can be indistinguishable from functional psychosis (e.g. brief psychotic disorder, schizophreniform and schizophrenia) and only the resolution of the symptoms in a few days or a positive finding in a urine drug screen test eventually reveals the diagnosis.

Cannabis (marijuana/hash/ hashish)

Features: -

- Euphoria / heightened perception / talkativeness / sensation of slowed time & disinihibition.
- Physical effects: Red conjunctiva / dry mouth / mild tachycardia/ increased appetite respiratory tract irritation & impaired motor coordination.
- Impaired cognitive functions & judgment.
- Anxiety +/- panic attacks with depersonalization and derealization (in high doses).
- Brief psychosis (transient paranoid ideation is more common than florid sustained psychosis). Features may be correlated with preexisting personality traits (e.g. borderline / paranoid/…).
- Cannabis may trigger anxiety / panic attacks & can induce delirium.
- Following discontinuation of cannabis, some patients may develop depressive features. Chronic use of cannabis can lead to a state of apathy and amotivation (amotivation syndrome) but this may be more a reflection of patient's personality structure than an effect of cannabis.

PSYCHOTIC DISORDERS

Brief Psychotic Disorder

- Acute and transient psychotic condition that lasts ≥ 1 day but ≤1 month and not induced by an organic cause.

Features: -

- Paranoid delusions, hallucinations, emotional volatility, odd behavior, & screaming.

Schizophreniform Disorder

- Similar features to those of brief psychotic disorder but the duration is > 1 month & < 6 months

Delusional Disorders

Diagnostic Criteria

- ≥ 1- month systematized delusion(s) (such as being persecuted, followed, loved at a distance, or deceived by spouse).
- Patients usually do not have prominent or sustained hallucinations.
- Patients' moods are consistent with the content of their delusions(a patient with grandiose delusions is euphoric).

Types:

- Persecutory type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way.
- Grandiose type: delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
- Jealous type: delusions that the individual's sexual partner is unfaithful.
- Erotomanic type: delusions that another person, usually of higher status, is in love with the individual.
- Somatic type: delusions that the person has some physical defect or general medical condition.
- Mixed type: delusions characteristic of more than one of the above types but no one theme predominates.
- Unspecified type.

Schizoaffective Disorder

- Concurrent presence of mood disturbance (depressive or manic episodes) and psychotic features (delusions or hallucinations, for at least 2 weeks in the absence of prominent mood symptoms during some phase of the illness).
- Course: -
- Normal Mood -> Mania -> 2 weeks (Delusion or Hallucinations) -> Depression -> Normal Mood

Schizophrenia

Diagnostic Criteria

- ≥ 6 months' duration of disturbance (including the prodromal and residual phases).
- ≥ 1month period of psychotic features with 2 out of 5: -
- Delusions / hallucination / disorganized speech (e.g. incoherence) / or disorganized behavior/ catatonic features or negative features (e.g. flat affect).
- Significant functional impairment (occupational, social, academic...etc.).
- Exclusion of other psychotic disorders (see above; the differential diagnosis).

Features: -

Acute Schizophrenia

- Presence of **active/positive features**:
- Prominent Delusions (paranoid - bizarre)
- Prominent Hallucinations: (3rd or 2nd but with derogatory content)
- Disorganized thinking and speech.
- Disturbed behavior +/- aggression.
- Incongruity between affect thinking and behavior.

Chronic Schizophrenia

- Presence of **negative features:**
- Poor self-care and hygiene.
- Lack of initiative and ambition.
- Social withdrawal.
- Poverty of thought and speech.
- Restricted or apathetic affect.
- Cognitive deficit.
- Loose association >>> Word salad.
- Delusions and hallucinations become less prominent

MOOD DISORDERS

Episodes

(Discrete periods of abnormal mood; low, high, or mixed mood)

Major depressive episode (MDE)

- ≥ 5 of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either no.1 or no.2:

1. ***Low mood.***
2. ***Loss of interest in pleasurable activities (anhedonia).***
3. *Appetite or body weight change (increased or decreased).*
4. *Insomnia or hypersomnia.*
5. *Psychomotor agitation or retardation.*
6. *Fatigue or loss of energy.*
7. *Feelings of worthlessness or excessive guilt.*
8. *Diminished concentration.*
9. *Recurrent thoughts of death or suicide.*

- Significant distress or impairment in functioning.
- The symptoms do not meet criteria for a mixed episode.
- Not due to substance abuse, a medication or a medical condition (e.g., hypothyroidism).

Manic episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week.
- During the period of mood disturbance ≥ 3 of the following (4 if mood is irritable):

1. *Inflated self-esteem or grandiosity.*
2. *Decreased need for sleep.*
3. *Pressured speech.*
4. *Racing thoughts or flight of ideas.*
5. *Distractibility (reduced concentration).*
6. *Increase in goal-directed activity (socially, at work, or sexually).*
7. *Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).*

- The symptoms do not meet criteria for a mixed episode.
- Significant distress or impairment in functioning.
- Not due to substance abuse, a medication or a general medical condition (e.g., hyperthyroidism).

Mixed episode

- ≥ 1 week of both manic and depressive symptoms occurring simultaneously nearly every day (e.g. overactive overtalkative patient may have at the same time profound depressive thoughts including suicidal ideas)

Alternating Affective Sates

- Manic and depressive features follow one another in a sequence of rapid changes in a short time (e.g. a manic patient may be intensely depressed for few hours and then quickly becomes manic)

Hypomanic episode

- ≥ 4 days less severe elevated mood
- Not severe enough to cause marked impairment in social or occupational functioning
- No psychotic features (hallucinations/delusions).

Disorders

(Longitudinal view / diagnostic term)

Bipolar I disorder

- Patient has met the criteria for a full manic or mixed episode, usually sufficiently severe to require hospitalization.
- Depressive episodes may/may not be present.

Bipolar II disorder

- Patient has at least one major depressive episode and at least one hypomanic episode, but no manic episode.
- If there has been a full manic or mixed episode even in the past, then the diagnosis is bipolar I disorder, not bipolar II.
- Features are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder. T
- he symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

SEASONAL AFFECTIVE DISORDER

- Recurrent major depressive episodes that come with shortened day light in winter and disappear during summer (may be followed by hypomania).
- Absence of clear-cut seasonally changing psychosocial variables.
- Characterized by atypical features of depression: hypersomnia, hyperphagia (carbohydrate craving), weight gain, increased fatigue.
- It may occur as part of bipolar I or II disorders.

Rapid Cycling Bipolar I or II Mood Disorders

- ≥ 4 alternating mood episodes (MDE, Manic, Hypomanic or Mixed) in the previous 12 months, separated by intervals of 2-3 days.
- It is usually more chronic than non-rapid cycling disorders.

Major depressive disorder (MDD)

- Presence of major depressive episode (s).
- Not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
- There has never been a manic episode, a mixed episode, or a hypomanic episode.
- If the full criteria are currently met for a major depressive episode, specify its current clinical status and/or features: Mild, moderate, severe without psychotic features/severe with psychotic features Chronic - With catatonic features - With melancholic features - With atypical features - With postpartum onset.

Dysthymic disorder

- ≥ 2 years' history of chronic low mood.
- No remission periods more than two months.
- During low mood there should be ≥ 2 out of the following:

1. *Low energy or fatigue.*
2. *Low self-esteem.*
3. *Feeling of hopelessness.*
4. *Insomnia (or hypersomnia).*
5. *Poor appetite (or overeating).*
6. *Poor concentration or difficulty in making decisions.*

- Not better accounted for by any other psychiatric or medical diseases (e.g. major depression, hypothyroidism).
- It leads to impairment in functioning or significant distress.

Cyclothymic disorder

- Less severe bipolar mood disorder with continuous mood swings; alternating periods of hypomania and moderate depression.
- It is non-psychotic chronic disorder.
- It starts in late adolescence or early adulthood.

CHILD DISORDERS

Intellectual Disabilities (Mental Retardation)

Diagnostic Criteria

- **Significantly sub average intellectual functioning:** an IQ of approximately 70 or below on an individually administered IQ test.
- Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in **at least two of the following area**s:
  Communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- The onset is before age 18 years.

Pervasive developmental disorders (PDD)

- Affect multiple areas of development (social, language, emotional, & behavioral).
- They emerge before the age of 3 years and cause persistent dysfunction.
- **PDDs includes five disorders:**

1.Autistic Disorder (AD)

AD is a severe pervasive disorder of emotions, speech and behavior starting in early childhood after a brief period of normal development (before 30 months of age).

Features: –

- Impaired reciprocal social interactions (even with parents).
- Gaze avoidance is a characteristics feature.
- Impaired emotional responses (emotions toward parents, strangers and inanimate objects are almost the same).
- Impaired language development (interpersonal verbal communication is markedly affected). Restricted behavioral repertoire.
- Other features:
  - Resistant to change the routine and transition (e.g. having breakfast before a bath when the reverse was, may evoke temper tantrums).
  - Preoccupation with certain objects and rituals with resistance to change (e.g. the same dress, food,).
  - Labile mood and non-specific anger and fear.
  - Stereotypies, mannerisms, and grimacing.
  - Disturbed sleep.

2.Childhood Disintegrative Disorder(CDD)

Heller's syndrome-:

- Marked regression in several areas of functioning after at least 2 years of normal development.
- Deterioration over several months of intellectual, social, and language function occurring in 3- and 4-year-olds with previously normal functions.
- After the deterioration, the children closely resembled children with autistic disorder

3.Asperger's Disorder

although it is a PDD, no significant delays in language, cognitive development, or self-help skills.

Features: -

Impairment in social or emotional reciprocity interaction (eye contact, facial expression).

4.Rett's disorder

A progressive PDD.

It has its onset after some months of normal development.

Features: -

- Impaired speech, communicative and social skills.
- The head circumference growth decelerates and produces microcephaly.
- Poor muscle coordination and gait disturbances.

5.Pervasive developmental disorder not otherwise specified.

Attention-Deficit Hyperactivity Disorder (ADHD)

Features: -

- Diminished attention and concentration.
- Overactivity in more than one situation; constant movement with inability to settle.
- Interfering and intruding on others.
- Impulsivity.
- Recklessness, prone to accidents.
- Disobedience and aggression.
- Learning difficulties.

Oppositional Defiant Disorder (ODD)

Features: -

- Negativistic, Hostile behavior; refusal to comply with adults, argument and annoyance of others, Loss of temper, anger outburst; spiteful / vindictive behavior.
- ODD may coexist with ADHD, conduct and many other disorders.

Conduct Disorder (CD)

Features: -

- Severe and prolonged antisocial behavior in older children and teenagers; aggressive or destructive behavior, rebellion against parents, lying, stealing, vandalism, fire setting, & truancy

Elimination Disorders

Functional Enuresis:

- Repeated involuntary voiding of urine after the age at which continence is usual (5 years) in the absence of any identified physical disorder.
- Nocturnal = bed wetting (at night).
- Diurnal = during waking hours.
- **Primary enuresis:** If there has been no preceding period of urinary continence for at least 12 months.
- **Secondary enuresis:** If there has been period of urinary continence for 12 months.
- It is likely to coexist with other psychological distress (e.g. sibling birth, parental discord…).

Functional Encopresis:

- Repeated passing of feces into inappropriate places after the age at which bowel control is usual (4 years).
- Physical causes should be ruled out: e.g. chronic constipation with overflow incontinence.
- Stressful events at home may precipitate the condition.

Separation Anxiety Disorder

Excessive anxiety concerning separation from home or from major attachment figure for at least 4 weeks.

Features: -

- Excessive distress when separation is anticipated.
- Excessive worry about possible harm befalling or losing attachment figures.
- Reluctance to go to school because of fear of separation.
- Excessive fear when left alone
- Reluctance to sleep away from attachment figure.
- The disorder may be initiated by a frightening experience or insecurity in the family, and is often maintained by overprotective attitude of the parents

Phobias in Children

- Phobias are common, and usually normal in children.
- Common feared objects and situations include: animals, strangers, darkness, loud noisy voices.
- Most childhood phobias improve without specific treatment measures.

School Phobia

- Irrational fear of going to school associated with unexplained physical complaints such as headache, diarrhea, abdominal pain or feeling sick.
- Complaints occur on school days not in weekends.
- It occurs most commonly at the commencement of schooling, change of school or beginning of intermediate or secondary school.

Depression in Children

- Depressive disorder in children is not uncommon.
- Child may not express his low mood verbally. Therefore, thorough assessment is required. Depression may be distinguished from normal lowered mood by associated **features: -**
    - Significant loss of pleasure (anhedonia) in all areas of interest.
    - Withdrawal from social activities.
    - Deterioration in school performance (poor concentration and motivation).
- Irritability Childhood depression is usually self-limiting, but may become chronic or recurrent.
- Masked depression may present as a behavior disorder.
- Depression in children may present mainly with somatic symptoms (depressive equivalents).

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