



Basic Psychiatry

Second Edition - 2011.

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Preface to the second edition

In this edition of Basic Psychiatry the entire text has been revised. I have tried throughout to maintain the style of the previous edition bearing in mind that this book is designed to undergraduate medical students. A new chapter on Evidence-Based Psychiatry has been added. Test 1 and Test 2 have been enriched with more case- oriented questions.

Acknowledgement

I should record my gratitude to all of my colleagues at the Psychiatry Department, College of Medicine, King Saud University for their encouragement, support and suggestions.

Special thanks are due to my teachers Professor Abdulrazzak Alhamad and Professor Abdullah Al-Subaie for their effort in reviewing the book.

Thoughtful suggestions and remarks have been provided by undergraduate students and deserve appreciation.

Foreword

It has been recognized worldwide that psychiatry is an integral part of medicine. This has made psychiatry an essential component of the undergraduate teaching curriculum of medical colleges. Therefore, teaching psychiatry to undergraduate students drew attention of academicians from many aspects such as the aims, scope and depth. Hence, appropriate references for medical students in psychiatry presented a difficulty and many teaching staff contributed their efforts in this field as this book written by Prof. M. Al-Sughayir.

Even though many books written for students fulfilled their purposes to a great extent, this book was formulated in a new shape where the display of knowledge, the organization of text and the teaching aids used achieved the intentions of many teachers of psychiatry towards their students.

This book covers comprehensively the whole continuum of basic sciences relevant to psychiatry and all subjects of clinical psychiatry. It also focuses on basic factual knowledge of the field in a clinically applied sense. The use of tables, lists and diagrams helps students efficiently. A complementary effort to the excellence of this book, is the addition of a series of clinical case vignettes with questions and answers and an Arabic glossary for psychiatric terminology. At last, all the above admirable features were expressed by a simple, clear and scientific language.

This book is unique for medical students and of a special interest to residents and primary care physicians, and its value will remain.

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INTRODUCTION

Knowledge of psychiatric disorders is essential to medical doctors in any branch of medicine.

This book is directed to make the undergraduate medical students understand the basic concepts of psychiatry. Efforts have been made to make the book brief, readable in a clear layout. It contains basic information in the form of focused format, key facts, definitions, figures and lists to fulfill the need for clarity.

“Basic Psychiatry” covers the main areas of knowledge required for undergraduate medical students. It also can be useful for trainees in psychiatry, other mental health professionals and allied disciplines.

Prof. Mohammed Alsughayir

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Chapter 1

Review of Basic Sciences

Relevant to Psychiatry

- **Neuroanatomy**
- **Neurophysiology**
- **Neurotransmitters**
- **Clinical Psychology**

A 70 year-old diabetic woman admitted to the medical ward because of a transient ischemic attack and dysarthria. She has disorientation, poor attention and memory impairment for several months.

The human brain contains approximately 10^{11} nerve cells (neurons) involved in information processing. The nervous system responds to changes in the external and internal environment. The anatomical organization and neurophysiology of the human brain are of particular relevance for psychiatric disorders. Because of their clinical relevance and importance, medical students in psychiatry clerkship should review basic neurosciences.

REVIEW OF NEUROANATOMY & NEUROPHYSIOLOGY

□ Frontal Lobe Functions

- Cognitive and intellectual functions:
Attention, concentration, registration, orientation (to time, place, and person) reasoning, understanding, analysis, comparison, critical thinking, problem-solving, planning and judgment.
- Control of behavior/ voluntary movements/ sphincters.
- Motor language: processing information to produce speech (dominant frontal).
- Control of emotion: right frontal lobe contains negative emotions (anger/fear...), whereas left frontal lobe controls such negative emotions and contains positive emotions. Brain lesions affecting left frontal lobe lead to exaggeration of fear and worries, whereas lesions affecting right hemisphere lead to unusual euphoria and inappropriate laughter.

□ Temporal Lobe Functions

- Retention and comprehension of auditory and visual information.
- Recall of recently registered information (dominant hippocampus).
- Emotions and sexual activity.

❑ **Parietal Lobe Functions**

- Interpretation of sensations: touch, pressure (stereognosis).
- Appreciation of body image (spatial orientation).
- Constructional skills: dressing, drawing ... (non-dominant lobe).

❑ **Occipital Lobe Functions**

- Perception and analysis of visual sensations (color, shape, dimensions...).

❑ **Cerebellum Functions**

- Coordination of muscle contractions and motor activity.
- Maintenance of posture and body balance.

❑ **Basal Ganglia Functions**

- Subconscious control of tone and movements of the skeletal muscles, such as swinging the arms while walking.

❑ **Midbrain Functions**

- Consciousness and arousal (function of the reticular formation which extends also through pons and medulla).
- Control of reflexive head and eye movements.
- Raphe nuclei function: serotonergic neurons in the brainstem projecting to a large number of brain structures.

❑ **Pons Functions**

- Connection of various parts of the brain with each other.
- Cranial nerve functions (5, 6, 7 and 8).
- **Locus Ceruleus** is the most important noradrenergic nucleus in the brain, which has very high density of noradrenaline neurons, and numerous projections to other brain regions; especially the cortex and hippocampus. It is essential for the behavioral and physiological expression of anxiety and fear.

□ **Medulla Functions**

- Medulla contains vital and non-vital centers.
 - Vital centers: cardiac, respiratory and vasomotor centers.
 - Non-vital centers: vomiting, swallowing, sneezing, coughing and hiccupping centers.
- Cranial nerves functions (9,10 & 11).
- Connection of the spinal cord with the brain.

□ **Functions of Reticular Formation System:**

- Consciousness and alertness.
- Control of skeletal muscles.
- Control of somatic and visceral sensations.

□ **Functions of the Thalamus:**

- Sensory relay station: processing tactile, proprioceptive, pain and temperature information, sending it to sensory cortical areas.
- Integrating a large variety of sensory and motor information, and the relation of this information to one's emotional feelings, subjective states and personality.
- Influencing the level of consciousness and alertness through connections with the reticular formation and cortical centers.

□ **Functions of the Hypothalamus**

Hypothalamus preserves body homeostasis through:

- **Regulation of food intake:**
Feeding / hunger center, located in the lateral side of hypothalamus, which is chronically active and its activity is transiently inhibited by activity in the satiety center, located in the ventro-medial side, after the ingestion of food.
- **Regulation of water intake** (superiolateral part of Hypothalamus).
- **Regulations of 24-hour sleep-wake cycle** (suprachiasmatic nucleus: light reduces melatonin in pineal gland whereas darkness enhances melatonin secretion).

- **Regulation of temperature:**
 - Antirising center in the anterior hypothalamus, mediates the parasympathetic system to increase body heat loss, thus reducing body temperature.
 - Antidrop center in the posterior hypothalamus mediates the sympathetic system to reduce body heat loss.
- **Higher control of hormones:**
Catecholamines-vasopressin-oxytocin-ACTH-TSH-FSH-LH-Prolactin and growth hormones .
- **Higher control of the autonomic nervous system**
 - Parasympathetic (by anterior hypothalamus)
 - Sympathetic (by posterior hypothalamus)

□ **The Autonomic Nervous System**

It is distributed throughout the central and peripheral nervous system, divided into two parts: the sympathetic and the parasympathetic.

- **The sympathetic nervous system.:**
 - Beta 1 stimulation*** : accelerates the heart rate and increases myocardial contractility.
 - Beta 2 stimulation:*** vasodilatation of coronary arteries, bronchodilatation relaxation of uterus, intestines and bladder, and skeletal muscle vasodilatation.
 - Alpha receptor stimulation*** : constriction of the arterioles of the skin and intestine .It dilates iris (mydriasis), closes the sphincters, decreases secretion of salivary glands , piloerection, sweating and ejaculation .
- **The parasympathetic nervous system**
It aims at conserving and restoring energy. It slows the heart rate; constricts the pupils; increases peristalsis of the intestine and glandular activities (increasing secretions); opens the sphincters and contracts the bladder wall. The parasympathetic neurons also facilitate erection.

□ **Limbic System**

- **Components:**

- Cingulate gyrus - Hippocampus(temporal lobe) - Amygdala
- Parahippocampal gyrus - Hypothalamus - Anterior nucleus of thalamus - Major tracts connecting the system

- **Functions:**

- Emotional and behavioral responses (fear, rage ...).
- Sexual feelings and pleasure: norepinephrine is involved in ejaculation (males) and orgasm (females).
- Recent memory.
- Neocortical activities modify emotional behavior and vice versa. However, one of the characteristics of emotion is that it cannot be turned on and off at will. Another characteristic of limbic circuits is their prolonged after-discharge following stimulation. This may explain in part the fact that emotional responses are generally prolonged rather than evanescent and outlast the stimuli that initiate them.

□ **The Gate Control Theory of Pain**

Cortical and subcortical centers process and filter afferent pain impulse through a gating mechanism in the dorsal horn of the spinal cord. Competing signals and neurotransmitters can open or close the gate on painful perceptions. Serotonin in descending pathways has an inhibitory effect, i.e., closing the gate. Endorphin deficiency seems to correlate with the augmentation of afferent stimuli. Substance P is involved in altering the pain threshold. Thus, neurobiological factors play a large role in the onset and perpetuation of pain experience.

REVIEW OF NEUROTRANSMITTERS

1 . SEROTONIN (5 Hydroxytryptamine = 5HT)

Serotonin is an indolamine synthesized from an essential amino acid L-tryptophan, found in the gastrointestinal tract, platelets, monocytes (5HT1A:enhance activity of natural killer cells

/psychoneuroimmunity), the brain and the spinal cord. The major site of serotonergic cell bodies in the brain is the raphe nuclei in the brainstem, from which fibers project to many brain structures, these include projections to:

- Frontal cortex: regulation of emotional reaction to stress and impulsive behavior (5HT1A).
- Limbic system: anxiety and panic feelings (5HT 2A-2C).
- Basal ganglia: movement control and compulsions (5HT2A).
- Hypothalamus: appetite and eating regulation (5HT3).
- Brainstem chemoreceptor trigger zone: vomiting (5HT3).
- Brainstem sleep centers: deep sleep (5HT2A).
- The ingestion of foods rich in tryptophan rapidly increases brain serotonin synthesis, which accounts for their mild sedating effects.
- Spinal cord: sexual spinal responses, orgasm (5HT2A).
- Peripheral serotonergic receptors (5HT3,4&7) in the intestine regulate intestinal secretions and motility.

Serotonin deficiency is found in depression, anxiety, panic disorder, phobias, obsessive compulsive disorder and bulimia nervosa.

Serotonin is metabolized to an inactive metabolite by MAO-A enzyme.

2. DOPAMINE

Dopamine is a catecholamine synthesized from tyrosine. There are 4 most important dopaminergic tracts:

1. *The mesolimbic dopamine pathway*: emotional behavior, reward reinforcement, pleasure feelings and sex drive. Pathological hyperactivity of this pathway accounts for active (positive) psychosis (hallucinations, delusions, aggression...)

Nucleus accumbens is a dopaminergic nucleus, located in the mesolimbic pathway, involved in the physiological reward system. Its reinforcing effects are stimulated by caffeine, nicotine, cocaine

and other CNS stimulants. Its stimulation increases sex desire and behavioral response, and suppresses appetite.

2. *The mesocortical dopamine pathway*: mental arousal and cognitive functions. Pathological underactivity of this pathway (mesocortical defect: due to glutamate excitotoxic overactivity, primary dopamine neuron defect or serotonergic overactivity) is responsible for most negative features and cognitive defects seen in some schizophrenic patients.
3. *The nigrostriatal tract*: low dopamine levels are associated with motor symptoms of Parkinson's disease. Antidopaminergic drugs lead to Parkinsonian extrapyramide side effects. Serotonin 2A receptors on dopamine neurons inhibit dopamine release.
4. *The tuberoinfundibular tract*: dopamine inhibits prolactin release from the anterior pituitary.

Dopamine Receptors:

- D₁ receptors may play a role in negative symptoms (D₁ antagonist treat negative symptoms).
- D₂ receptors blocked by anti-psychotic drugs for the treatment of positive psychotic symptoms. D₂ agonists are used for the treatment of Parkinson's disease.
- Other dopaminergic receptors (D₃, D₄ & D₅) : it is not clear to what extent these receptors contribute to the clinical properties of anti-psychotic drugs.

Serotonin-Dopamine Interactions:

Serotonin inhibits dopamine release in various dopamine pathways (understanding this is critical to understanding atypical antipsychotics).

3. NORADRENALINE (NOREPINEPHRINE)

Noradrenaline is a catecholamine synthesized through hydroxylation of dopamine. The major concentration of noradrenergic cell bodies in the brain is in the locus Cerulus from which neurons project to:

- *Frontal cortex*: regulation of mood (Beta 1 receptors) and regulation of cognitive functions (Alpha-2 receptors)

- *Limbic system*: energy, emotions and psychomotor activity control.
- *Cerebellum*: regulation of motor movements.
- *Cardiovascular centers in the brainstem*: -blood pressure regulation.

Noradrenergic innervation regulates the heart rate (via Beta 1 receptors in sympathetic neurons) and controls bladder emptying (via Alpha α -receptors). Alpha α -2 presynaptic noradrenergic autoreceptors (on adrenergic neurons) and heteroreceptors (on serotonergic neurons) have a negative feedback effect; inhibiting excessive release of noradrenaline and serotonin respectively.

Noradrenaline at low concentrations has stimulatory effects on immune function but it inhibits effects at high concentrations.

Noradrenaline is involved in ejaculation in men and orgasm in women.

Noradrenaline – Serotonin Interactions

There are two types of presynaptic noradrenergic receptors on serotonin neurons that regulate serotonin release:

- Alpha α -2 heteroreceptors (in the cortex): when stimulated they turn off serotonin release.
- Alpha α -1 receptors (in the brainstem; a pathway from locus Cerulus to raphe nuclei), when stimulated these receptors enhance serotonin release.

4. ACETYLCHOLINE (ACH)

Acetylcholine is synthesized from choline and acetyl coenzyme A. The major brain center for cholinergic neurons is *the nucleus basalis of Meynert*, which projects to cerebral cortex and the limbic system. These neurons have the principal role in mediating short-term memory. Additional cholinergic neurons are found in:

- The reticular formation: REM –sleep induction.
- Basal ganglia(extrapyrimal tract) and cerebellum : regulation of body posture, muscle tone and motor movements.

- The autonomic nervous system; parasympathetic (both pre and post synaptic pathways) some sympathetic pathways (presynaptic/sweat glands).
- Acetylcholine is involved in erection. N.B.: nitric oxide (NO), not nitrous oxide (N₂O), is also involved in erection .It is synthesized in the body from l-arginine.

5. GAMA AMINOBUTYRIC ACID (GABA)

GABA is an amino acid neurotransmitter with a very fast inhibitory action. It is found almost exclusively in the brain, and synthesized from glutamate.

GABA is thought to suppress seizure activity, anxiety and mania. There are three types of GABA receptors A,B&C. The GABA-A receptors have binding sites for benzodiazepines and barbiturates, which increase the affinity of the GABA-A receptors for GABA.

6. GLUTAMATE

Glutamate is an amino acid excitatory neurotransmitter. It is synthesized from deamination of glutamine. Many sensory organs – including the cochlea, the olfactory bulb, the retina and thalamocortical fibers – use glutamate as their principal neurotransmitter. Pyramidal neurons in the cortex are glutamatergic. Glutamate is involved in the highly organized information flow through the brain. In the hippocampus, glutamate may be specifically relevant to the pathophysiology of dementing illness(Alzheimer's disease). Glutamate excitotoxicity is suggested as a possible cause of neuronal degeneration in schizophrenic patients with negative features.

Sigma receptors(1&2) : these were thought of as opioid receptors but later on found to be related to glutamate receptors (NMDA) and involved in enhancement of memory and cognitive functions , when stimulated by flvoxamine they improved the negative symptoms in schizophrenic patients.

7. SUBSTANCE – P

It is an excitatory neurotransmitter associated with mediation of pain perception and thought to play an important role in the

pathogenesis of migraine, cluster headache and chronic pain. Abnormalities affecting substance P have also been hypothesized for mood disorders, Alzheimer's dementia and Huntington's disease.

8. HISTAMINE

Histamine is synthesized from histidine. In the brain it is located in the hypothalamus and fibers projecting to cerebral cortex, the limbic system, and the thalamus. There are three types of histamine receptors: H1 receptors regulate appetite and arousal and have a role in allergic symptoms. When antihistamines are used for allergic symptoms they exert marked sedative effects and weight gain; H2 receptors are involved in gastric acid output; when H2 – receptors antagonist are used they heal gastric and duodenal ulcers, H3 receptors; stimulation of these receptors thought to be expressed on histamine nerve terminals, suppresses histamine release.

9. MELATONIN

Hypnotic hormone produced by the pineal gland stimulated by darkness and inhibited by light (suprachiasmatic nucleus), involved in regulation of sleep-wake 24-hour cycle.

10. ENDOGENOUS OPIOIDS

Enkephalins, endorphins and dynorphins are involved through their receptors (mu, kappa and delta) in many mental functions : pain perception (analgesics), learning, memory, mood and dependence.

CLINICAL PSYCHOLOGY

1. LEARNING THEORIES

There are three basic learning theories:

I. Classical Conditioning II. Operant Conditioning III. Modeling

- Learning: a relatively permanent change in behavior brought about by prior experience.

I. Classical Conditioning

Stage 1: Unconditioned stimulus (e.g. food) > Unconditioned response (e.g. salivation)

Stage 2: Conditioned stimulus (e.g. sound of the bell) + Unconditioned stimulus (food) > Unconditioned response (salivation).

Stage 3: Condition stimulus (sound of the bell) > Conditioned response (salivation)

II. Operant Conditioning

Behavior, which is followed by advantageous consequences, is likely to be repeated, whereas behavior followed by noxious consequences will become less frequent.

- Reinforcement: the process of increasing the frequency of a particular piece of behavior by presenting a reinforcing stimulus.

Positive reinforcement : enhancement of behavior by a desired reward.

Negative reinforcement : enhancement of behavior by removal / avoidance of undesirable event.

III. Modeling occurs when the behavior of an individual(the observer) is affected by the opportunity to observe the behavior of another person (the model).

Clinical Uses of Learning Theories: (see Chapter 24)

- Treatment of phobias (systemic desensitization flooding).
- Treatment of obsessive rituals (modeling, response prevention).
- Relaxation training (for anxiety).
- Aversion therapy (for alcoholism and sexual deviation).

2. COGNITIVE THEORY

It emphasizes the impact of interpretation of events, expectations, and process of thinking about oneself, people, the environment, the past, and the future on the mood and behavior. Depression and anxiety result from, and complicated by, wrong automatic thoughts e.g. "I am bad person". Correction of erroneous thoughts with cognitive therapy usually relieves patients from negative emotions (see cognitive therapy Chapter 24 for clinical applications in psychiatry).

3. PSYCHOANALYSIS

A -Topographic model of the mind

This model divides the mind into three regions:

1. The conscious
2. The unconscious
3. The preconscious

Each of which has its own characteristics:

1. **The conscious:** The part of the mind in which perceptions coming from the mind, the body and from the outside world are brought into awareness. It's content can be communicated by means of language or behavior.
2. **The unconscious:** The part of the mind that contains the instinctual wishes and drives (self-preservative drives and sexual instincts) and represses them; keeping them out of conscious awareness through resistance to remembering.
3. **The preconscious:** The part of the mind that comprises those mental processes, contents and events that are capable of being brought into conscious awareness by deliberate focusing of attention on the memory.

B - Structural Theory Model (Ego Psychology)

This model divides the psychic apparatus into the id, the ego and the super ego.

1. **The “ id ”:** It includes the unconscious instinctual wishes and drives, and operates according to the pleasure principle (it lacks the capacity to delay or modify the instinctual drives).
2. **The “ ego ”:** It attempts to achieve and coordinate optimal gratification of instinctual wishes and drives while maintaining good relations with the demands of the outer world and external reality.
3. **The “ superego”:** It includes internalized moral values, prohibitions and standards; and offers approval or disapproval. The superego conducts an ongoing scrutiny of the person's feelings, thoughts, and behavior. It establishes and maintains the person's moral conscience.

- **Defense Mechanism:**

These are dynamic psychological strategies used by a person to deal with unpleasant situations or distressing internal conflicts, to manage instincts drives or affect (see Chapter 5).

4. INTELLIGENCE TESTING

Intelligence is the ability to solve environmental problems and to adapt to changes.

- Intelligence tests include:

A. Binet test:

$$\text{Intelligence Quotient (IQ)} = \frac{\text{Mental age} \times 100}{\text{Chronological age}}$$

B. Wechsler tests (for children and adults).

The tests include two sections verbal and performance.

IQ scores:

Average Normal	=	100 ± 10
Bright Normal	=	120
Superior	≥	130
Dull Normal	=	80 -90
Borderline	=	70 -79
Mild Mental Retardation	=	50 - 70
Moderate Mental Retardation	=	35 - 49
Severe Mental Retardation	=	20 - 34
Profound Mental Retardation	=	below 20

5. PERSONALITY TESTING:

Personality is the distinctive and characteristic patterns of thought, emotion, and behavior that define an individual's personal style and influence his or her interactions with the environment. The objective assessment of personality serves a number of practical needs in clinical psychiatry. Good personality test must have reliability and validity.

Reliability: the extent to which there is repeatability of consistent results.

Validity: the extent to which a test measures what it is designed to measure.

There are many personality tests. The two main tests widely used in clinical practice are:

- Eysenck Personality Inventory (EPI) : It measures the following personality dimensions: extroversion (vs. introversion), neuroticism (vs. stability), psychoticism (vs. stability).

- Minnesota Multiphasic Personality Inventory (MMPI). It consists of “yes” or “no” self-answered questions. The results are given as scores in 10 subscales.

Several intelligence and personality tests are available in Arabic language, and validated in some Arabic communities.

The clinical psychologist plays an important role within the psychiatric team for both patient’s assessment (Personality, IQ...) and treatment (behavior, cognitive, psychodynamic.....).

Chapter 2

Symptoms and Signs

(Psychopathology)

In

Psychiatry

A 75 year-old in-patient has the experience of misperceiving pictures on the wall as frightening figures.

Psychiatric symptoms and signs are common in patients of all kinds; therefore, medical students require sound knowledge of these symptoms and signs. In psychiatric clinical practice diagnosis is not made on a single symptom or sign, but on the pattern of several clinical features.

This chapter provides a concise description of the most common symptoms and signs of various psychiatric disorders. Following chapters, however, will clarify how to elicit these symptoms and signs through the psychiatric interview, and how to organize symptoms and signs into various diagnostic categories.

For simplification, symptoms and signs in psychiatry can be grouped into the following categories:

- Abnormalities of behavior and movements.
- Abnormalities of mood and emotion.
- Abnormalities of speech.
- Abnormalities of thinking.
- Abnormalities of perception.
- Abnormalities of awareness of self and others.
- Abnormalities of consciousness.
- Abnormalities of attention and concentration.
- Abnormalities of memory.
- Abnormality of judgment.
- Abnormality of insight.
- Abnormality of sleep, eating and sex.

ABNORMALITIES OF BEHAVIOR AND MOVEMENTS

*= very important to understand .

1. ***Psychomotor Retardation:** slowed mental and motor activities, the most common diagnosis is major depressive disorder.
2. ***Stupor:** a state in which a person , although is fully awake with open eyes ,does not react to the surroundings: mute, immobile and unresponsive. It can be due to organic or functional psychiatric disorders.
3. **Catatonic Stupor:** stupor with rigid muscles and posturing seen mainly in schizophrenia ;catatonic type.
4. ***Agitation:** restlessness with psychological tension. Patient is not fully aware of restlessness. It can be due to many psychiatric disorders: mania, depression, schizophrenia, substance abuse ,delirium ...e t c.
5. **Catatonic Excitement:** marked sudden unprovoked impulsive and aggressive behavior seen mainly in schizophrenia.
6. **Aggression:** hostile physical or verbal behavior, with rage and anger.
7. ***Akathisia:** inability to keep sitting still, due to a compelling subjective feeling of restlessness. Patient is fully aware of restlessness. It is due to antidopaminergic drugs.
8. **Dyskinesia:** restless movement of group of muscles , mainly in the orofacial and hands muscles.Tardive dyskinesia is a late onset type induced by several years use of antidopaminergics.
9. ***Dystonia:** painful severe muscle spasm mainly due to recent use of antidopaminergics.
10. **Torticollis:** contraction of neck muscles, tilting the head to one side. It is mainly due to recent use of antidopaminergics.
11. **Tics:** sudden repeated involuntary muscle twisting e.g. repeated blinking, grimacing , seen in normal people but when excessive and severe they indicate a psychiatric disorder e.g. Tic disorder.
12. ***Compulsions:** compulsive actions associated with obsessions e.g. compulsive hand washing, seen in obsessive compulsive disorder.

13. **Echopraxia:** imitative repetition of movement of somebody. It indicates an organic mental pathology.
14. ***Waxy Flexibility:** patient's limbs may be moved like wax, holding position for long period of time before returning to previous position, seen mainly in schizophrenia ;catatonic type.
15. **Stereotypies:** purposeless repetitive involuntary movements. e.g. foot tapping, thigh rocking, seen in normal people but when severe they indicate psychiatric disorder .
16. **Mannerism:** odd goal-directed movements. e.g. repeated hand movement resembling a military salute.

ABNORMALITIES OF MOOD / EMOTION

1. ***Anxiety:** feeling of apprehension accompanied by autonomic symptoms (such as muscles tension, perspiration and tachycardia), caused by anticipation of danger. Free-floating anxiety: diffuse, unfocused anxiety, not attached to a specific danger.
2. ***Fear:** anxiety caused by realistic consciously recognized danger.
3. ***Panic:** acute, self-limiting, episodic intense attack of anxiety associated with overwhelming dread and autonomic symptoms.
4. ***Phobia:** irrational exaggerated fear and avoidance of a specific object, situation or activity.
5. **Irritable mood:** easily annoyed and provoked to anger.
6. **Dysphoria:** mixture feelings of sadness and apprehension.
7. **Depressed mood:** feeling of sadness, pessimism and a sense of loneliness.
8. **Anhedonia:** lack of pleasure in acts which are normally pleasurable.
9. ***Grief:** sadness appropriate to a real loss (e.g. death of a relative)
10. ***Guilt:** unpleasant emotion secondary to doing what is

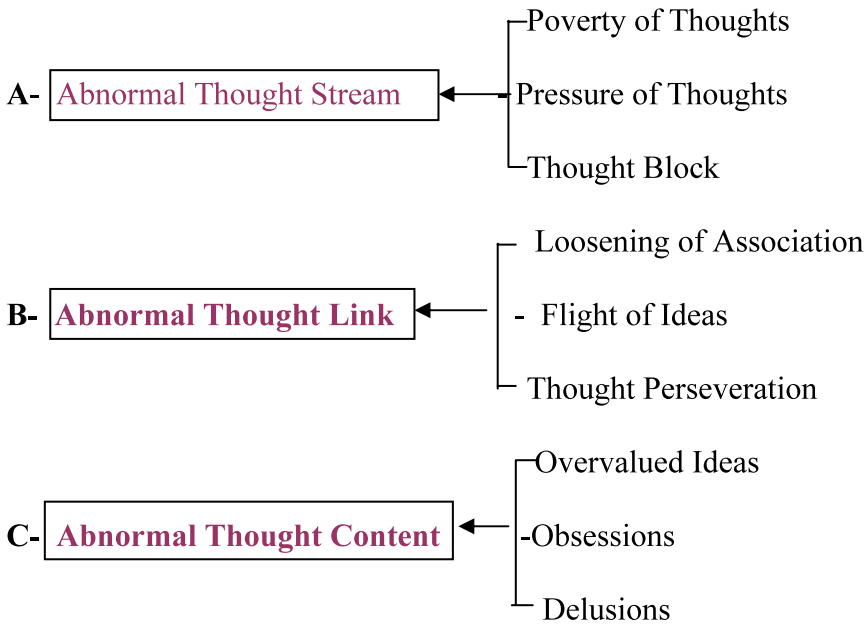
perceived as wrong.

11. **Shame:** unpleasant emotion secondary to failure to live up to self-expectations.
12. **Perplexity:** anxious mood with bewilderment.
13. **Ambivalent Mood:** coexistence of two opposing emotional tones towards the same object in the same person at the same time.
14. **Alexithymia:** inability to, or difficulty in, expressing one's own emotions.
15. **Elevated Mood:** a mood more cheerful than usual.
16. **Elation:** feeling of elevated mood with optimism and self-satisfaction.
17. **Euphoria:** intense elation with feeling of grandeur.
18. **Ecstasy:** very intense elation beyond reason and control.
19. **Expansive Mood:** expression of euphoria with an overestimation of self-importance.
20. **Grandiosity:** feeling and thinking of great importance (in identity or ability).
21. **Constricted Affect:** significant reduction in the normal emotional responses.
22. **Flat Affect:** absence of emotional expression.
23. **Apathy:** lack of emotion, interest or concern, associated with detachment.
24. **Labile Affect:** rapid, abrupt changes in emotions in the same setting, unrelated to external stimuli.
25. **La Belle Indifference:** inappropriate denial of expected affect and lack of concern about physical disability (seen in conversion disorders).
26. **Inappropriate Affect:** disharmony between emotions and the idea, thought, or speech, accompanying it.

ABNORMALITIES OF SPEECH

1. **Echolalia:** imitation of words or phrases made by others, seen in some schizophrenic patients , mentally retarded and some organic mental disorders.
2. **Pressure of Speech:** rapid, uninterrupted speech that is increased in amount seen in patients with mania or stimulant abuse.
3. **Circumstantialities:** over inclusion of details delaying reaching the desired goal , seen in people with obsessional personality.
4. **Elective Mutism:** refusal to speak in certain circumstances.
5. **Poverty of Speech:** restricted amount of speech seen in depression and schizophrenia.
6. **Stuttering (Stammering):** frequent repetition or prolongation of a sound or syllable, leading to markedly impaired speech fluency.
7. **Cluttering:** dysrhythmic rapid and jerky speech.
8. **Clang Associations (Rhyming):** association of word similar in sound but not in meaning (e.g. deep, keep, sleep) seen in patients with mania or substance abuse.
9. **Punning:** playing upon words, by using a word of more than one meaning (e.g. ant, aunt). seen in patients with mania or substance abuse.
10. **Word Salad:** incoherent mixture of words and phrases, seen in chronic schizophrenia.
11. **Dysarthria:** difficulty in articulation and speech production.
12. **Sensory Aphasia:** nonsensical fluent speech due to lesion affecting Wernick's (receptive) area.
13. **Motor Aphasia:** impairment in the ability to formulate fluent speech due to lesion affecting Broca's (motor) area.
14. **Dysphonia:** difficulty in voicing speech clearly, due to dysfunction of vocal cords or soft palate.

ABNORMALITIES IN THINKING



A. **Abnormal Thought Stream**

1. Poverty of Thoughts: few, slow, unvaried thoughts associated with poverty of speech, seen in schizophrenia and depression.

2.*Pressure of Thoughts: rapid abundant varying thoughts associated with pressure of speech and flight of ideas, seen in mania and stimulant abuse.

3. Thought Block: sudden cessation of thought flow with complete emptying of the mind, not caused by an external influence, seen in schizophrenia.

B. Abnormal Thought Link

Also called 'formal thought disorders'.

1. ***Loosening of Associations:** lack of logic connection between thoughts seen in chronic schizophrenia.
2. ***Flight of Ideas:** successive rapidly shifting incomplete ideas but with an understandable link, seen in mania and stimulant intoxication.
3. **Thought Perseveration:** repeating the same sequence of thoughts persistently and inappropriately, seen in organic brain pathology (e.g. dementia)

C. Abnormal Thought Content

1. Overvalued Ideas:

Strongly held false ideas but shakable (e.g. personal conviction that vitiligo is a contagious disease).

2. *Obsessions (mental ruminations):

Repetitive ideas, images, feelings or urges insistently entering person's mind despite resistance. They are unwanted, distressful and recognized as senseless and irrational. Obsessions are frequently, but not always, followed by compelling actions (which are called compulsions or rituals).

Common Obsessional Contents: dirt/contamination/cleaning /doubts about religious matters.

3. *Delusions:

Unshakable false beliefs out of keeping with the person's cultural background, not arrived at through logic thinking and not amenable to reasoning.

Common Delusional Contents:

1. Persecutory delusion:

Delusion of being persecuted (cheated, mistreated, harassed, followed for harm etc.). Persecutory delusion is sometimes called paranoid delusion, however, paranoid delusion means not only being persecuted but being persecuted because of having special importance.

2. Grandiose delusion:
Delusion of exaggerated self-importance, power or identity.
3. Delusion of jealousy: (infidelity delusion).
Delusion that a loved person (wife/husband) is unfaithful.
4. Erotomanic delusion:
Delusion that someone, (usually inaccessible, high social class person) is deeply in love with the patient.
5. Nihilistic delusion:
Delusion of nonexistence of part of the body, belongings, self, others or the world. Seen in some patients suffering from major depressive disorder with psychotic features.
6. Delusion of self - accusation:
Delusion that a patient has done something sinful, with excessive pathological feeling of remorse and guilt seen in severe depression.
7. Delusion of reference:
Delusion that some events and others' behavior refer to oneself in particular.
It can be seen in any type of psychosis. Note that : in some manic patients they feel happy with the content of the delusion, perceiving it as a sign of self importance.
8. Delusion of influence (delusion of control= passivity phenomena):
Delusion that person's thoughts, actions, or feelings are controlled by outside forces. Thought control (thought alienation) is a kind of delusion of control concerning patient's thoughts. Thought alienation can be:
 - Thought Insertion:
Delusion that some of person's thoughts being put into his mind against his will by an external forces (other people, a certain agency).
 - Thought Withdrawal / Broadcasting :
Delusion that some of person's thoughts being taken out of his mind against his will (withdrawal) and being broadcast over the air, radio, TV, newspapers or some other unusual way.

- Thought (mind) Reading :

Delusion that some body (or others) can read (i.e. know exactly) the person's hidden thoughts.

Delusion of influence is seen mainly in schizophrenia but might be present in other psychotic disorders.

*** Delusions can be either :**

Mood-Congruent Delusion	Mood-Incongruent Delusions
Delusional content has association to mood: . in depressed mood: delusion of self - accusation. . in elevated mood: grandiose delusion.	Delusional content has no association to mood, e.g. patient with elevated mood has delusion of thought insertion.

*** Delusions can be either:**

Systematized Delusion	Bizarre Delusion
Delusion united by a single event or theme e.g. delusion of jealousy.	Totally odd and strange delusional belief, e.g. delusion that person's acts are controlled by stars.

ABNORMALITIES OF PERCEPTION

- ***Illusions:**

Misperceptions of real external sensory stimuli:

e.g. Shadows may be misperceived as frightening figures.

It can occur in normal people (dim light/exhaustion). In patients illusions are non specific signs ,seen in many psychiatric cases : delirium, substance abuse and others.

- ***Hallucinations:**

Perception in the absence of real external stimuli; experienced as true perception coming from the external world (not within the mind) e.g. hearing a voice of someone when actually nobody is speaking within the hearing distance.

– Auditory hallucinations (voice, sound, noise).

Second-person hallucinations: voice(of one person or more) speaking to the person addressing him as “you”. These are seen

in many disorders: schizophrenia (usually derogatory voices calling bad names /giving orders), severe depression with psychotic features (usually self-depreciating associated with guilt feeling),mania (usually self-appreciating associated with acceptance).

Third-person hallucinations: voice talking about the person as “he” or “she”.

Thought echo: hearing one’s own thoughts spoken aloud (seen in schizophrenia)

- Visual hallucinations (images/sights): indicate organic mental disorder or schizophrenia.
- Olfactory hallucinations (smell/odor)
- Gustatory hallucinations (taste)
- Tactile hallucinations (touch/surface sensations)
- Somatic hallucinations (visceral and other internal sensations).

There are certain kinds of hallucinations that occur in normal people

- Hypnagogic hallucinations: hallucinations when falling asleep.
- Hypnopompic hallucinations: hallucinations when waking from sleep.

- **Pseudo-Hallucinations:**

Sensory deceptions perceived as emanating from within the mind.

E.g. when hearing a tape for long time the same heard material can be re-experienced even with no actual source (tape)

ABNORMALITIES OF AWARENESS OF SELF AND OTHERS

- **Depersonalization:**

The experience of altered self-awareness; being unreal, strange or detached.

It can occur in normal people (mental exhaustion/sleep deprivation). In patients depersonalization is a non specific sign, seen in many

psychiatric cases :severe anxiety, complex partial seizures, substance abuse, depersonalization syndrome ... e.t.c.

- **Derealization:**

The experience of changed reality; environment is unreal or changed. It can occur in normal people (mental exhaustion/sleep deprivation). In patients derealization is a non specific sign ,seen in many psychiatric cases :severe anxiety, complex partial seizures, substance abuse, depersonalization syndrome ... e.t.c.

- **Fugue:**

Assuming a new identity with amnesia for the old identity often involves travel or wandering to new environment seen in dissociative disorder.

ABNORMALITIES OF CONCIIOUSNESS

- **Drowsiness :**

Diminished awareness with inclination to sleep.

- **Somnolence:**

Severe abnormal drowsiness.

- **Disorientation:**

Disturbance of orientation in time, place, or person.

- **Confusion:**

Muddled thinking with disorientation and disturbance of consciousness.

- **Clouding of Consciousness:**

Drowsiness with impaired attention and reaction to stimuli.

- **Delirium:**

Disorientation with disturbed memory, perception, emotion, thinking and behavior.

- **Coma:**

Profound degree of unconsciousness

- **Trance State:**

A state of focused attention and altered consciousness with reduced control of thoughts, feelings and perception.

ABNORMALITIES OF ATTENTION AND CONCENTRATION

- **Distractibility:**
A state in which attention is easily drawn to irrelevant external stimuli.
- **Inattention:**
Inability to focus attention on a stimulus.
- **Selective Inattention:**
Choosing not to focus attention on unwanted stimuli: blocking out only stimuli that generate discomfort.
- **Hyper-vigilance:**
Excessive attention and concentration; continually watching or on guard.

ABNORMALITIES OF MEMORY

- **Amnesia:** Inability to recall past information and experiences.
 - Anterograde amnesia: amnesia for events occurring after a point in time.
 - Retrograde amnesia: amnesia for events occurring before a point of time.
 - Memory blackout: amnesia experienced by alcoholics for events during drinking bouts.
 - Dissociative (hysterical) amnesia: unconscious forgetting of painful memories.

- **Hypermnnesia:** exaggerated degree of retention and recall.
- **Paramensia:** distortions of recall.
 - confabulation: unintentional filling of memory gaps by imagined experiences, or miss-recalled information.
 - retrospective falsification: unintentional distortion of memory by being filtered through a person's emotional or cognitive state (to differentiated from delusional memory; undistorted recall but with new delusional memory interpretation).
 - Déjà vu: false feeling of familiarity; illusion of visual recognition in which a new situation is incorrectly regarded as a repetition of a previous memory.
 - Jamais vu: false feeling of unfamiliarity with a real situation that a person has experienced before.
 - Déjà entendu: Illusion of auditory recognition.
 - Déjà pense: illusion that a new thought is recognized as a thought previously felt.

ABNORMALITY OF JUDGEMENT

- Impaired judgment: diminished ability to assess and correctly understand a situation and to act appropriately.

ABNORMALITY OF INSIGHT

Insight is the degree of awareness of being mentally ill and being in need of psychiatric treatment.

Levels of Impaired Insight:

- Complete lack of insight (denial of illness)

- Diminished insight:
 - being aware of abnormal experiences but denying being mentally ill.
 - being aware of mental illness but attributing it to an imagined external force (e.g. persecutors).
 - being aware of mental illness but denying the need of psychiatric treatment.
 - being aware of mental illness and the need of psychiatric treatment but actually not motivated to be treated (intellectual but not actual insight).

ABNORMALITIES OF SLEEP

- **Insomnia:** diminished or lack of sleep.
 - Initial insomnia: difficulty in falling asleep.
 - Terminal insomnia: early morning awakening.
 - Middle insomnia: interrupted sleep with difficulty in going back to sleep.

- **Hypersomnia:** excessive prolonged sleep.

- **Parasomnia:** disturbed behavior during sleep.
 - Nightmare: an awakening from 'rapid eye movement' (REM) sleep to full consciousness with recall of unpleasant dream.

 - Night terrors: sudden awakening from Non-REM sleep with autonomic arousal (person may scream).

 - Somnambulism (sleepwalking): while still asleep a patient walks with open eyes but with poor concentration and appears unresponsive.

- Sleep talking: talking few words or sentences during sleep.
- Sleep paralysis: inability to perform voluntary movements during the transition between wakefulness and sleep; person is conscious but cannot move.
- Sleep related bruxism: tooth grinding occurring during sleep.

ABNORMALITIES OF EATING

- **Anorexia:** loss of, or decrease in, appetite.
- **Hyperphagia:** increase in appetite and intake of food.
- **Bulimia:** episodes of uncontrolled excessive eating with insatiable hunger (binge–eating).
- **Pica:** craving and eating of nonfood substances, such as clay and paint.
- **Psychogenic Vomiting:** repeated episodic vomiting without a medical cause; occurs commonly after meals and without nausea.

ABNORMALITIES OF SEX

- **Diminished Libido:** decreased sexual interest, drive and performance.
- **Impotence:** inability to attain or maintain erection enough for completion of satisfactory coitus.
- **Premature Ejaculation:** ejaculation before person's wish. It occurs with minimal stimulation, before, upon, or shortly after penetration.
- **Vaginismus:** involuntary painful contraction of vaginal introitus

(and thigh muscles) in response to attempts at penetration, that interferes with intercourse.

- **Dyspareunia:** persistent or recurrent genital pain during, before or after intercourse.
- **Anorgasmia (Frigidity):** persistent or recurrent absence or delay of orgasm in female after a normal sexual excitement.
- **Retarded Ejaculation:** persistent or recurrent absence, or delay of male orgasm (inhibited orgasm).

Chapter 3

Psychiatric Assessment

Relevant to Psychiatry

- **History**
- **Mental Status Examination**
- **Physical Examination**
- **Diagnostic Aids**

A 34 year-old female seen at the outpatient clinic appeared conscious and awake but unable to talk, unresponsive to stimuli, and immobile.

PSYCHIATRIC ASSESSMENT

A thorough assessment of a psychiatric patient consists of a psychiatric history, mental status examination, physical examination, and certain relevant laboratory and psychological tests. The psychiatric history and mental status examination are usually obtained during the initial interview. There are many goals for psychiatric interview:

1. To establish a relationship with the patient.
2. To obtain information.
3. To assess psychopathology (nature, severity ...) of the illness.
4. To provide feedback and formulate a treatment plan.

The clinical interview is very important in psychiatry; it requires practical skills, which cannot be learnt effectively without enough practical training under supervision of experienced interviewers. When interviewing a psychiatric patient, introduce yourself; greet the patient by name; arrange for a private comfortable setting; appropriately tell the purpose of the interview; put the patient at ease; and be supportive attentive nonjudgmental and encouraging. Avoid excessive note-taking, and observe the patient's nonverbal behavior.

THE PSYCHIATRIC HISTORY

The psychiatric history is the chronological story of the patient's life from birth to present. It includes information about who the patient is, his problem and its possible causes and available support. It should be emphasized that:

1. much more attention needs to be paid to psychological and social aspects.
2. patient's feelings, thoughts, perception and behavior during the interview are considered part of the mental status examination (not the psychiatric history).

The history should be compiled from information elicited both from the patient and from one or more informants (the informant's relationship to the patient should be noted together with the interviewer's impression of the informant's reliability). The following outline is a usual format for writing the psychiatric history.

The Main Items of the Psychiatric History

- Identification data
- Referral Source
- Chief Complaint
- History of present illness
- Family history
- Personal history
- Medical history
- Past Psychiatric history
- Personality traits

- **Identification of the Patient:**
Name, age, sex, marital status, occupation, education, nationality, residency and religion.
- **Referral Source:**
Brief statement of how the patient came to the clinic and the expectations of the consultation.
- **Chief Complaint:**
Exactly why the patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement). Note if the chief complaint differs significantly from the reports of those who accompany the patient (other informants).

- **History of Present Illness:**

Chronological background of the psychiatric problem: nature, onset, course, severity, duration, effects on the patient (social life, job, family...), review of the relevant problems, symptoms not mentioned by the patient (e.g. sleep, appetite, ...), and treatment taken so far (nature and effect).

- **Family History:**

Family history is important in psychiatry for several reasons:

1. Events happening currently to a family member may act as a stressor to the patient,
2. Family atmosphere has an effect on the patient's psychological condition.
3. Some psychiatric disorders are familial and have an important genetic contribution.

* Mother and father: current age (if died mention age and cause of death, and patient's age at that time), relationship with each other and with the patient.

* Siblings: list, in order of age, brothers and sisters, education, occupation, marital status, major illnesses and relationship with the patient. Ask about mental illnesses in second-degree relatives (grand parents, uncles, aunts, nephews, & nieces).

- ***Personal History:** (relatives may be a source of information). Personal history helps in constructing a brief biography of the patient that forms a background against which you understand the presenting complaints and predict future behavior.

- *Birth:* any known obstetric or prenatal difficulties?.

- *Early development:* developmental milestones (motor and language), early childhood attitudes and relationships with parents, siblings and others, any emotional or behavioral difficulties,

- *School:* age at starting and end of school life, approximate academic ability, specific difficulties, attitudes and relationships with teachers and pupils and highest grade attained.

- *Occupations:* age at starting work, jobs held, reasons for change, satisfaction in work, relationships with workmates and with supervisors.

- *Puberty*: age at onset, knowledge, attitude and practice of sex.
- *Adolescence*: attitude to growing up, to peers, to family and authority figures, and emotional or behavioral problems.
- *Marital history*: age at marriage, relationships within the marriage, number of children and attitude toward them.
- *Current social situation*: social environment and social relationships, financial circumstances and social difficulties.
- Tobacco and substance abuse, and legal (forensic) problems.

- **Medical History:**

All major illnesses should be listed (nature, extent, dates, treatment, outcome, and patient's reaction and attitude). Women should be asked about menstrual (and, if appropriate, about menopausal) difficulties.

- **Past Psychiatric History:**

Any previous psychiatric illness (nature, extent, dates, treatment, outcome and patient's reaction and attitude).

- ***Personality Traits:**

It is important to obtain adequate information (from a variety of sources) about the patient's characteristic traits that distinguish him as an individual. The patient's personality usually interacts with his illness and should be separated from episodes of illness. Elicit information about the following:

- Attitude to self (self-appraisal, performance, satisfaction, past achievements and failures, future..)
- Moral and religious attitudes and standards.
- Prevailing mood and emotions.
- Reaction to stress (ability to tolerate frustration and disappointments, pattern of coping strategies).
- Personal interests, habits, hobbies and leisure activities.
- Interpersonal relationships.

*MENTAL STATE EXAMINATION (MSE)

The mental status examination is a cross-sectional, systemic documentation of the quality of mental functioning at the time of interview. It serves as a baseline for future comparison and to follow the progress of the patient.

Items of Mental State Examination

1. Appearance
2. Behavior
3. Attitude
4. Speech
5. Affect
6. Perception
7. Awareness of self and others
8. Thoughts
9. Cognitive functions and consciousness
 - Consciousness level
 - attention
 - concentration
 - orientation(time, place, person)
 - memory
10. Abstract thinking
11. Visuospatial ability
12. Language and reading.
13. Judgment
14. Insight

1. Appearance:

Note and describe overall appearance, body build, self-care, grooming, facial expressions, and any unusual features (e.g. weight loss)

2. Behavior:

Note level of activity, posture, and unusual movements (tics, grimacing, tremor, disinhibited behavior...)

3. Attitude:

Note the patient's attitude during the interview (interested, bored, cooperative, uncooperative, sarcastic, aggressive).

The patient's attitude is reflected on his non-verbal behavior (eye contact, posture...)

4. Speech:

Listen to and describe how the patient speaks, noting:

- (1) amount of speech (2) flow (3) tone (4) coherence
(5) continuity (6) speech impairments (stuttering, dysarthria...)

5. Affect: (Current emotional state)

- Subjective affect: verbal expression of feelings by the patient.
- Objective affect: examiner's evaluation of the patient's outward observable expression of affect, through nonverbal signs; facial expression, posture & movements.

Note any abnormality in the nature of affect (e.g. anxiety, depression, elation...), the variability of affect (constricted affect, labile affect..), and whether the affect is appropriate to the thought content, the culture, and the setting of the examination.

6. Perception:

Ask the patient about perceptual disturbances (auditory, visual, olfactory, gustatory, tactile and somatic), and ascertain whether the disturbances are illusions (misperceptions of real external stimuli), hallucinations (perceptions without external stimuli) or pseudo- hallucinations (sensory deceptions perceived as emanating from within the mind). Determine the exact nature and complexity of perceptual distortions. Hallucinations of voices discussing the patient (third person hallucinations) should be distinguished from voices talking to the patient (second person

hallucinations). Ask the patient about his reaction to hallucinations.

7. Awareness of Self and Others:

When indicated ask about the extreme feelings of detachment from self (depersonalization) or from the environment (derealization).

8. Thought:

Thoughts are usually reflected in the person's speech. Ask about preoccupations (about the illness, environmental problems...) obsessions, abnormal beliefs (shakable or unshakable...), ideas of reference or influence, stream of thought, form of thought (does the person express his or her ideas in a coherent way?), and thought possession (do the thoughts of the person belong to him or her alone, or are interfered with in some way?).

9. Cognitive Functions and Consciousness

- **Consciousness:** note the patient's general state of awareness (alert, drowsy...)
- **Attention:** (The ability to focus on the matter in the hand). Attention is assessed by asking the patient to name five objects that start with a particular letter, to spell a word backward, or by the digit span test (see below).
- **Concentration:** (The ability to sustain attention) Concentration is tested by subtracting serial 7s from 100 (serial 7s test): the patient is asked to subtract 7 from 100 then to take 7 from the remainder repeatedly until it is less than seven. The examiner assesses whether the patient can concentrate on this task. Serial 3s test can be used if the patient lacks skill in arithmetic. Naming the months of the year in reverse order is another concentration test.
- **Orientation to Time, Place and Person.**
 - ***Time:** note whether patient identifies the day correctly; approximate date (day, month, year) and time of the day.
 - ***Place:** note whether patient knows where he or she is.

***Person:** note whether patient knows other people in the same place (e.g. relatives, hospital staff).

Disorientation is an important feature which indicates impaired consciousness. It usually appears in this order: time - place - person, and clears in the reverse order: person - place - time.

- **Memory:**

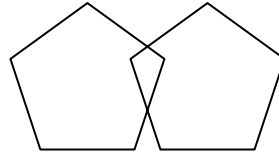
1. *Immediate registration, and recall:* it is tested by the digit span test; ability to repeat 7 digits (or figures) after an examiner dictates them slowly, first forward, then backward. A normal person can repeat 7 digits correctly, impaired immediate retention should be considered if less than 5 digits could be repeated. This test is also used to assess attention.
2. *Short term recall:* give the patient 3 things to remember (e.g. a banana, a clock and a shoe), and ask for recall after 5 minutes, during which time you distract the patient by doing something else.
3. *Recent memory:* ask questions regarding the last few days in the patient's life events that you can verify (e.g. what the patient did yesterday morning). *Recent past memory:* ability to recall events in the past few months.
4. *Remote memory* (long term memory): ask the patient to recall personal events (e.g. birth date, wedding date) or well known public events from some years before, provided that these events (personal or public) are known with certainty to you. Note also the sequence of events.

10. Abstract Thinking:

It is the ability to deal with concepts and to make appropriate inference. It can be tested by (1) similarities: ask the patient to tell you the similarity between 2 things (e.g. car and train), and the difference between 2 things (e.g. book and notebook), or (2) proverbs: ask the patient to interpret one or two proverbs (e.g. people in glass houses should not throw stones) the patient may give a concrete answer (e.g. stones will break the glass).

11. Visuospatial Ability: (When brain pathology is suspected)

Ask the patient to copy a figure such as interlocking pentagons:

**12. Language and Reading: (When brain pathology is suspected)**

- To test for nominal aphasia, ask the patient to name two objects (e.g. a pen and a watch).
- To test for expressive aphasia, ask the patient to repeat after you certain words.
- To test for receptive aphasia (auditory functions), ask the patient to carry out a verbal command.
- To test for reading comprehension, ask the patient to read a sentence with written command (e.g. close your eyes).

13. Judgment:

Test the patient's predicted response and behavior in imaginary situation (e.g. what would you do if you smelled smoke in a crowded place).

14. Insight:

Assess the degree of awareness and understanding the patient has that he or she is mentally ill. Ask about the patient's awareness of the nature of his symptoms, and find out whether the patient believes himself to be ill: if so, whether he thinks that the illness is physical or psychological; and whether he sees himself as in need of psychiatric treatment. The patient's compliance with psychiatric treatment largely depends on his insight.

The Mini-Mental State Examination (MMSE)

The MMSE is a brief instrument designed to assess cognitive functions. It is widely used as a screening test that can be applied during a patient's clinical examination, and as a test to track the changes in a patient's cognitive state. It assesses orientation, memory, calculations, writing and reading capacity, language, and visuospatial ability. The patient is measured quantitatively on these functions out of a perfect score of 30 points; a score of less than 24 points suggests impairment, and a score of less than 20 indicates definite impairment (delirium or dementia). It is advised to be done by more than one interviewer and repeated over a period of time.

Clock Drawing Test

It assesses an individual's ability to draw or copy the face of a clock, put in the correct numbers, and set the hands to indicate a specific time. Although originally conceived as relatively specific test of visuospatial and constructional ability, the test has recently gained favor as a quick and easily administered screening instrument for general cognitive dysfunction. However, subtle but clinically significant cognitive impairment in early Alzheimer's disease may not be detected by the test.

PHYSICAL EXAMINATION

Patient's medical status should be considered at the outset of a psychiatric evaluation, particularly when the patient has physical symptoms, such as palpitation, headache and numbness. The psychiatrist should be able to distinguish physical diseases that mimic psychiatric disorders and vice versa. He also should be able to recognize the symptoms of some physical diseases that have psychiatric manifestations. It should be determined what physical examination is relevant.

The psychiatrist is most likely to be concerned with the examination of the central nervous system and the endocrine system. If the patient's problem is clearly limited to social sphere there may be no special indication for physical examination.

DIAGNOSTIC AIDS IN PSYCHIATRY

Neurosciences have been accumulating evidences for subtle neurophysiological dysfunctions in many psychiatric disorders, and an effort is being made to quantify some of these abnormalities.

No psychiatric diagnosis can be based exclusively on a laboratory test.

The laboratory test has many functions:

1. To screen for medical illness in the psychiatric patient.
2. To help establish diagnosis.
3. To determine whether a treatment can be given.
4. To evaluate toxic and therapeutic effects of a treatment.

The screening tests used in psychiatric practice include:

1. Complete blood count (CBC) with ESR.
2. Liver function tests.
3. Renal function tests (urea, creatinine, electrolytes).
4. Thyroid function tests (TFT).
5. ECG.
6. Chest and skull X – ray.
7. Blood sugar level.
8. Vitamin B – 12 and folate levels.

Supplementary Tests

When the commonly used tests are negative and an organic cause is suspected, other tests can be use.

1. Computed Tomography (CT):
 - Suspected structural brain abnormality e.g.: tumor, stroke, abscess, subdural hematoma...
2. Magnetic Resonance Imaging (MRI):
 - Detection of demyelination diseases.

- Detection of lesions in brain stem, temporal areas and posterior fossa (better than C.T.).
 - Detection of suspected small structural abnormalities, that may not be detected by CT-Scan.
 - Functional MRI (f-MRI): helpful in investigating patients with cognitive disorders. It detects blood flow and tissue perfusion without radioactive substances, a great advantage over SPECT and PET.
3. Single photon Emission Computed Tomography (SPECT).
For a more accurate anatomical location of the functional abnormalities.
 4. Positron Emission Tomography (PET)
The most powerful currently available brain image technique for detecting functional abnormalities. It gives information specifically about neuronal metabolism.
 5. Electroencephalography (EEG)
Assists in diagnosis of epilepsy (especially complex partial seizure) and in detecting organic causes of psychiatric problems e.g. hydrocephalus, space occupying lesion.
 6. Cerebro Spinal Fluid (CSF) Examination.
 7. Anti-Nuclear Antibodies (ANA): autoimmune diseases e.g. SLE
 8. Skin Tests for Tuberculosis (T.B.)
 9. Serum Caeruloplasmin (low in Wilson's disease)
 10. Drug Levels
Mainly used for Lithium, Carbamazepine and Sodium Valproate (drugs commonly used in mood disorders & require therapeutic and toxicity ranges).

Chapter 4

Diagnosis
and Classification
in Psychiatry

A 78 year old lady seen at Emergency Department with 3 days history of dysarthria, pyrexia, and disturbed behavior.

- **Purposes of diagnosis and classification:**
 1. To identify groups of patients who are similar in their clinical features, response to treatment and outcome, and to distinguish one diagnosis from another.
 2. To bring order to the great diversity of phenomena met in clinical practice.
 3. To enable clinicians to communicate with one another about their patients' symptoms, treatment and prognosis. For many years it was not clear that psychiatrists were speaking to each other in the same language, as one doctor's mania was another doctor's Schizophrenia.
 4. To ensure that psychiatric research can be conducted with comparable groups of patients.

- **Diagnosis in Psychiatry**

Making a diagnosis in psychiatry can be difficult because of:

 1. most diagnoses are made at the level of symptoms and signs which are non-specific.
 2. the lack of biological markers.

Psychiatric diagnosis has long been criticized as vague. Classification attempts to avoid these pitfalls through the use of well-defined criteria.

There are two most important psychiatric classifications:

1. The International Classification of Diseases, (ICD), Chapter V: Classification of mental and behavioral disorders
 2. The Diagnostic and Statistical Manual of Mental Disorders.
- The two systems are closely similar because they are derived from a common base of knowledge and research, and their authors collaborated closely. They are basically descriptive classifications (based on symptoms and signs). However, etiology is included in some general categories, namely organic, substance-use-related, and stress-related.

- **The International Classification of Diseases (ICD)**

This system was developed by the World Health Organization (WHO). Mental disorders were first included in its 6th edition (ICD-6) in 1948.

The latest version is ICD - 10, introduced in 1992. The section on mental and behavioral disorders (chapter V of ICD -10) is used in most countries of the world for clinical purposes. It has been translated into all the widely spoken languages of the world. There are three forms of chapter V of ICD-10:

1. For clinical practice (see Table 4-1)
2. For use in primary care (see Table 4-2)
3. For research purposes.

Table 4-1. The Main Categories in ICD-10 – Clinical Version

- Organic, including symptomatic, mental disorders.
- Mental and behavior disorders due to psychoactive substance use.
- Schizophrenia, schizoaffective and delusional disorders.
- Mood (affective) disorders.
- Neurotic, stress-related, and somatoform disorders.
- Behavioral syndromes associated with physiological disturbances and physical factors.
- Disorders of adult personality and behavior.
- Mental retardation.
- Disorders of psychological development.
- Behavioral and emotional disorders with onset usually occurring in childhood or adolescence.

Table 4-2. ICD – 10 Primary Care Version*

. Dementia . Delirium . Alcohol use disorders . Drug use disorders . Tobacco use disorders
 . Phobic disorders . Panic disorders . Generalized anxiety disorder . Mixed anxiety and depression . Adjustment disorders . Dissociative conversion) disorder
 . Unexplained somatic complaint
 . Eating disorders . Sleep disorders . Sexual problems

* It is accompanied by concise advice about criteria for diagnosis and also about the management of the disorders in the primary care and the indications for seeking the help of a psychiatrist.

- **The Diagnostic and Statistical Manual (DSM)**

This system was developed by the American Psychiatric Association (APA). The first edition (DSM – 1) was published in 1952 as an alternative to ICD – 6 which had been widely criticized. It is now in its fourth edition DSM-IV which was introduced in 1994, and reviewed (DSM IV Text Revision) in 2000. Although designed for use in the United states, it is used in other countries, especially for research purposes. Categories are shown in Table 4-3.

Table 4-3. The Main Categories of Disorders in DSM – IV

- Disorders usually first diagnosed in infancy, childhood, or adolescence.
- Delirium, dementia and amnesic, and other cognitive disorders.
- Mental disorders due to a general medical condition.
- Substance – related disorders.
- Schizophrenia and other Psychotic disorders.
- Mood disorders.
- Anxiety disorders.
- Somatoform disorders.
- Factitious disorders.
- Dissociative disorders.
- Sexual and gender identity disorders.
- Eating disorders.
- Impulse – control disorders.
- Adjustment disorders.
- Other conditions that may be a focus of clinical attention.

DSM classification was developed for use in clinical – educational, and research settings.

* In this book “*Basic Psychiatry*”, the DSM categories have been used to a large extent, because they provide clear multi-axial approach to mental and personality disorders, and have considered the psychosocial aspects of patient’s condition which makes it more informative for educational purposes. However, there are some significant additions from ICD.

- **Multi-axial Classification:**

DSM is a multi-axial system that evaluates patients along several variables and contains five axes:

- **Axis I:** it consists of clinical disorders (e.g. schizophrenia) and other conditions that may be a focus of clinical attention.
- **Axis II:** it consists of personality disorders and / or mental retardation (none may be present)
- **Axis III:** it lists any physical disease relevant to mental disorder.
- **Axis IV:** it is used to code the psychosocial and environmental problems that significantly contribute to the development or exacerbation of the current disorder.
- **Axis V:** it is a global assessment of functioning scale.

Only the first three axes are used commonly in everyday clinical practice, and can be recorded without assigning them to separate axes

- **Categorical and Dimensional Classifications:**

Both DSM - IV and ICD - 10 are categorical classifications that divide mental disorders into categorical types based on criteria sets with defining features (this is schizophrenia, that is mania, and so forth). This classification works well when there is a clear dividing line between normality and disease, and between various diseases.

Dimensional classification rejects the use of separate categories, and argues that there is no evidence to support the traditional grouping of mental disorders into discrete entities. It does not impose boundaries between different diagnosis. Cases are described by their

positions on a dimension of continuum rather than categorized into separate categories. This approach has been used by psychologists to describe personality dimensions and rarely used in psychiatric clinical work.

• **Organic versus Functional Classifications**

Organic disorders are disorders with definite underlying neuropathology (e.g. delirium, dementia), whereas functional disorders are psychiatric disorders without structural brain disease (e.g. schizophrenia, mood disorders). This distinction between organic and functional has begun to appear less helpful now, because sophisticated modern techniques of investigation have revealed underlying neuropathology in some disorders previously considered functional (e.g. obsessive compulsive disorder, schizophrenia). However in everyday psychiatric practice the distinction between organic and functional disorders is still commonly used. See Table 4-4.

Table 4-4. Organic versus Functional Classification.

Psychiatric Disorders	
Organic	Functional
Structural brain pathology , detectable by clinical assessment or tests	No Structural brain pathology.
<ul style="list-style-type: none"> • Global <ul style="list-style-type: none"> - acute: delirium - chronic: dementia • Focal: <ul style="list-style-type: none"> - amnesic syndrome - complex partial seizures - frontal lobe syndrome - others • Others ... 	<ul style="list-style-type: none"> • Schizophrenia • Mood disorders • Schizoaffective disorders • Delusional disorders • Anxiety disorders • Adjustment disorders • Others ...

*** Features Suggestive of Organic Mental Disorders:**

- Physical illness (e.g. diabetes, hypertension)
- Vital signs disturbances.
- Neurological features (e.g. ataxia, dysarthria)
- Disturbed consciousness and / or other cognitive disturbance: in attention, concentration, orientation or memory.

• Neurosis versus Psychosis Classification

Although this classification is no longer used in the official current systems of classification, in everyday clinical practice these terms are still used widely; hence it is of practical value to know this distinction.

Psychoses (plural of psychosis)	Neuroses (plural of neurosis)
<p>Mental disorders in which the patient lacks insight and is unable to distinguish between subjective experience and external reality, as evidenced by disturbances in thinking (delusions), perception (hallucinations), and behavior (e.g. violence).</p> <p style="text-align: center;">* * * *</p> <p>Examples: schizophrenia, severe mood disorders, delusional disorders. It can be due to an organic cause e.g. delirium , dementia, substance abuse , head injury.</p> <p style="text-align: center;">* * * *</p> <p>Features are abnormal in quality (e.g. delusions ,hallucinations)</p>	<p>Generally less severe forms of psychiatry disorders in which the patient is able to distinguish between subjective experience and external reality. No lack of insight, delusions or hallucinations.</p> <p style="text-align: center;">* * * *</p> <p>Examples: dysthymic disorder, anxiety, panic & phobic disorders.</p> <p style="text-align: center;">* * * *</p> <p>Features are abnormal in quantity (e.g. excessive fear and avoidance)</p>

• Co- morbidity of more than one disorder

When a patient has more than one psychiatric disorder, clinicians can diagnose all disorders that meet diagnostic criteria (e.g. major depression and obsessive-compulsive disorder). This approach is used

in DSM-IV. However, in ICD-10 not all co-morbid conditions are recorded. Some diagnoses take precedence over others. For example, organic mental disorders take precedence over schizophrenia, and when symptoms of dementia and a schizophrenia occur together, only dementia would be diagnosed since dementia can present with schizophrenia-like symptoms.

Affective symptoms occur commonly with schizophrenia and they often improve when schizophrenia is treated; hence only schizophrenia should be diagnosed.

Anxiety symptoms occur commonly with depressive disorders. If the depressive disorder is treated, there may be improvement in anxiety as well as in the depressive symptoms. Similarly specific phobias occur so often in agoraphobia that they may be regarded as part of the clinical picture, therefore specific phobia would not be recorded as a diagnosis. This approach is described as an implicit hierarchy of categories with categorical classification system. Hierarchy is a system of organization in which the categories are arranged into higher and lower ranks (hierarchy):

Organic Mental Disorder

Schizophrenia

Affective disorders

Anxiety

Phobias

Chapter 5

Etiology
in
Psychiatry Disorders

A 53 year-old man has 7 year-history of hypertension, and diabetes mellitus developed major depression .

- **Etiology is important in Psychiatry:**

- 1 – For general understanding of psychiatric disorders.
- 2 – To allow primary prevention for those who are at risk.
- 3 – For better assessment and management of individual cases.

- **The Complexity of etiology in Psychiatry**

1. Time factor :causes are often remote in time from the effect they produce.
2. Single cause may lead to several psychological effects e.g. deprivation from parental affection may lead to depression or conduct disorder in children and adolescents.
3. Single effect may arise from several causes e.g. depression may be due to accumulation of several causes like endocrinopathies, psychosocial stresses and side effects of some drugs.

- **Classification of Causes**

A. Based on time factor:

1. Long term factors e.g. : childhood psychological distress
2. Med term factors e.g. : deviant personality traits
3. Immediate factors e.g. : recent head trauma.

B. Based on the nature of the cause:

1. Biological (Physiological): Hormonal – metabolic – autoimmune ...etc.
2. Psychological :
 - Behavioral (pathological conditioning)
 - Cognitive (distortions in thinking)
 - Dynamic (conflictual psychic forces)
3. Social :e.g. separation/divorce/financial stresses/cultural conflicts.

C. Based on the effect

1. Predisposing factors : e.g. disturbed family relationships, genetic factors
2. Precipitating factors : e.g. discovery of physical illness: diabetes, hypertension.
3. Aggravating factors : e.g. death of a close relative.
4. Maintaining factors : e.g. financial stresses.

Most psychiatric disorders are multifactorial.

The various causative factors in psychiatry include :

1. Genetic Factors :

There are various psychiatric and neuropsychiatric disorders, that have evidences supporting genetic transmission.

- . Huntington's Disease
- . Down Syndrome (Trisomy of chromosomes 21)
- . Turner's Syndrome (XO)
- . klinefelter's Syndrome (XXY)
- . Schizophrenia
- . Mood Disorders
- . Panic Disorder and Agoraphobia

2. Neuropathological Factors:

- . Dementias (e.g. Alzheimer's disease)
- . Complex Partial Seizure (Temporal lobe epilepsy)
- . Delirium (CNS infections, organ failure)
- . Brain Tumors
- . Stroke (vascular dementia)

3. Endocrinopathological Factors:

- . Hyperthyroidism / Hypothyroidism

- . Diabetes mellitus
- . Cushing's Syndrome

4. Pharmacological Factors:

Several psychiatric symptoms could be induced by some medications.

Examples include:

- . Rifampin > confusion
- . Vincristine > hallucinations
- . Bromocriptine > mania – paranoid psychosis
- . Steroids > mood changes

5. Social Factors:

There are several stressful social circumstances and life events that can predispose, precipitate or maintain psychiatric disorders. These include: marital discord /occupational problems/financial difficulties /migration (culture shock).

6. Psychological Factors:

- a. Behavioral problems e.g. the development of situational anxiety in phobic patients (avoidance enforces the problem)
- b. Cognitive problems: maladaptive modes of thinking predispose to, and maintain, some psychiatric problems e.g. depression, anxiety.
- c. Psychodynamic problems: dynamic psychopathology attempts to explain the phenomena of mental disorders in terms of psychodynamic theories. It discusses the psychodynamic, mental operations that unconsciously function outside of awareness to resolve intra- psychic struggles, and maintain a sense of safety.

***Etiological Factors can be classified as follows:**

	Predisposing	Precipitating	Aggravating	Maintaining
Bio	E.g. Genetic predisposition e.g. panic disorder	E.g. First dose of cannabis abuse	E.g. Further abuse	E.g. Continuation of cannabis abuse
Psycho	E.g. Abnormal personally traits with poor stress adaptation	E.g. Sudden or severe psychological stress	E.g. Further psychological stresses	E.g. Continuation of such stresses
Social	E.g. Parental separation	E.g. Marriage	E.g. Marital conflict	E.g. continuation of marital problems

PSYCHODYNAMIC FACTORS

When there is a conflict between instinctive needs, internalized prohibitions and external reality, it results in a state of unpleasant emotion characterized by the terms of worry, apprehension and fear that we all experience at times, and we become motivated to do something to alleviate it.

- Coping Strategy: is a direct healthy method of handling anxiety.
e.g. A student who is anxious about failing in examination copes by finding a way to improve his achievement.
- Defensive Strategies are indirect methods of handling anxiety. They do not deal with the anxiety – producing situation in anyway; they only defend the person against feeling of anxiety. They include:
 - i. Defensive strategies with maintained reality, e.g. to deaden anxiety by alcohol abuse.
 - ii. Defensive strategies with distorted reality (defense mechanisms).
- Defense mechanisms help a person, until he can learn more mature and realistic ways of coping with anxiety – producing situations and they contribute to a satisfactory adjustment. However, if the individual continues to rely upon defense mechanisms, so that he

is never forced to learn more mature and realistic ways of behaving, such mechanisms would constitute a barrier to satisfactory adjustment.

- People often use a combination of coping and defensive strategies in dealing with stressful situations.

□ DEFENSE MECHANISMS :

Unconscious or partly conscious processes that involve distortion of reality in order to deal with, and resolve, the intrapsychic anxiety (which results from conflict between instinctive needs, internalized prohibitions and external reality).

1. **ACTING OUT:** direct expression through action of an unconscious wish or conflict to avoid being conscious of either the idea or the affect that accompanies it. It occurs mainly in personality disorders.
e.g. Tantrums, child abuse, apparently motiveless assaults, pleasureless promiscuity.
2. **COMPENSATION:** covering up for a weakness by over – emphasizing or making up a desirable trait.
e.g. a) An academically weak high school student becomes a star in the school play.
b) In a psychiatric patient: a patient with social phobia who is unable to talk to others becomes known for his expressive poetry.
3. **CONVERSION:** symbolic unconscious expression of intrapsychic conflict through physical symptoms.
e.g. a) A student awakens with migraine the morning of a final examinations and feels too ill to take it.
b) In a psychiatric patient: a newly married lazy lady develops intermittent right arm paralysis whenever she gets exhausted due to home duties. By so doing two kinds of gains she achieves:
 1. Primary gain: her intrapsychic anxiety is resolved.
 2. Secondary gain: she presses on her husband to bring a housemaid to help her.
 - . This occurs in conversion disorder (hysteria).

4. **DENIAL OF REALITY:** an unconscious refusal to admit an unacceptable idea or behavior.
 - e.g. a) In a non-psychiatric patient: A smoker concludes that the evidence linking cigarette use to health problems is scientifically worthless.
 - b) In a psychiatric patient: A young wife who discovers her husband is having an affair with another woman deals with it as if not existing.
5. **DISPLACEMENT:** discharging bent-up feelings, often of hostility, on objects less dangerous than those arousing the feelings.
 - e.g. a) In a non-psychiatric patient : A man harassed by his boss at work, comes home and yells at his wife.
 - b) In a psychiatric patient: A patient screams at another patient after being told by a psychiatrist that she cannot have a weekend pass.
6. **DISSOCIATION:** an unconscious separation of painful feelings from conscious awareness, resulting in psychogenic amnesia, fugue, trance, somnambulism or dissociative personality disorders.
 - e.g. A patient who was sexually molested, cannot remember that circumstance.
7. **FANTASY:** gratifying frustrated desires by creating imaginary lives, occurring in eccentric, lonely frightened persons, especially the schizoid, who seem to be strikingly aloof.
 - e.g. A socially isolated and inhibited young man imagines himself living with a group of friends.
8. **IDENTIFICATION:** an unconscious attempt to behaviorally model oneself after a respected person that he admires.
 - e.g. a) When a little boy dresses up like his father, tries to talk and act like him.
 - b) A patient develops psychosomatic chest pain after death of a relative of heart attack.
9. **INTELLECTUALIZATION:** an unconscious removal of affective charge from an emotionally threatening situation by dealing with it in abstract intellectual terms.

e.g.: A man talks about his mother's death (due to cancer) concentrating only on the pathophysiology of cancer in medical terms (in order to avoid threatening emotions accompanying the circumstances).

- 10. INTROJECTION:** an unconscious incorporation of wishes, values attitudes of others as if they were his own. (The converse of projection).

e.g.: Without realizing it, a patient talks and acts like his therapist analyzing other patients.

- 11. ISOLATION:** a process by which the affect attached to an idea is rendered unconscious, leaving the conscious idea emotionally neutral. It is central to obsessive – compulsive disorder (together with UNDOING and REACTION FORMATION).

e.g. Fleeting thoughts about assaulting someone, shouting obscenities as part of obsessional thoughts.

- 12. PROJECTION:** attributing one's unacceptable motives or characteristics to others, or blaming someone else for one's difficulties.

. Using projection, a person protects himself from recognizing his own undesirable qualities by assigning them in an exaggerated amount to another person, thereby rendering the original feelings more acceptable.

e.g. Someone who dislikes a colleague may attribute to him feelings of anger, and in turn dislike. In this way, his own feelings of dislike may appear justified and become less distressing.

- 13. RATIONALIZATION:** substituting false acceptable reasons for the unacceptable real reasons.

e.g. A student states, "I was able to get grade "A", but I was afraid of evil eye, that is why I left some questions unanswered."

- 14. REACTION FORMATION:** unconscious adoptions of behavior or attitude opposite to that which would reflect true feelings and reactions.

e.g.: An excessively prudish attitude to the mention of sexual intercourse in conversation may occur in someone who has strong sexual drives that he cannot consciously accept.

- 15. REGRESSION:** a return to an earlier and more comfortable patterns of reaction or thinking involving less mature behavior and responsibility.

e.g. An adolescent boy whose self-esteem has been shattered reverts to child-like "show-off" behavior.

- 16. REPRESSSION:** an unconscious and involuntary forgetting of painful ideas, events and conflicts that would cause distress if allowed to enter consciousness.

e.g. Memory of an event in which a person was humiliated.

e.g. Incest may be kept out of patient's awareness. (Note that suppression is a similar but conscious process).

- 17. SPLITTING:** reaction to others & environment in an "all or none" manner rather than considering the full range of their qualities.

e.g. A conflicted manager does not recognize individual characteristics of his employees and views them all good or all bad.

- 18. SUBLIMATION:** diverting unacceptable drives (particularly sexual and aggressive) into personally and socially acceptable channels such as creative activities.

e.g. Turning angry feelings into vigorous sporting activities.

- 19. UNDOING:** doing something to counteract or dispel unacceptable desires or acts. e.g. A teenager who feels guilty about masturbation ritually cleans his hands excessively following each occurrence of the act.

Chapter 6

Cognitive Disorders

- **Delirium**
 - **Dementia**
 - **Amnestic Disorders**
-
- **Complex Partial Seizures**
 - **Neuropsychiatric Aspects of Head Injury**

A 45 yr-old man seen at psychiatry clinic because of disorientation, ataxia and poor memory. He asked for a referral to a specialist in eye diseases.

COGNITIVE DISORDERS

The disorders considered in this chapters were commonly called ‘Organic Mental Disorders: The term that is increasingly thought to be unsatisfactory because many so-called ‘functional’ disorders have a neurobiological basis; hence, the concept of functional disorders has been determined to be misleading, and both terms (organic and functional) are no longer used in that context in the DSM–IV. However, the term organic disorder is retained in ICD–10. In its section on delirium, dementia, amnesic and other cognitive disorders, the DSM–IV defines the predominant disturbance as a “clinically significant deficit in cognition or memory that represents a significant change from a previous level of functioning”. The origin of the disorders is a medical condition, although the precise condition may not be always identifiable.

This Chapter will focus on the following most common organic disorders:

1. delirium
2. dementia
3. amnesic syndrome

Two other relevant neuropsychiatric disorders are worth considering briefly:

1. Complex partial Seizure
2. Neuropsychiatric aspects of head injury

DELIRIUM

Definition: acute reversible global cognitive impairment with impaired or fluctuating consciousness.

Features: The clinical presentation differs considerably from patient to patient; however, there are several characteristic features that help make the diagnosis:

1. Impaired consciousness (the hallmark of delirium)
 2. Diminished ability to focus, maintain, or shift attention.
 3. Disorientation to time, place and lastly person.
 4. Memory impairment (typically a recent memory deficit).
 5. Perceptual disturbances: illusions & hallucinations (mostly visual).
 6. Disturbed thoughts and speech.
 7. Affective changes: mood lability, perplexity, irritability...etc.
 8. Behavior disturbances: shouting, hostility, agitation, restlessness. (Some patients may be excessively somnolent, and some may fluctuate from one state to the other, usually restless at night and sleepy during the day.)
- . The patient may be dangerous to himself or others.
 - . It is one of the serious medical & psychiatric emergencies.

Epidemiology:

- . Among hospitalized patients about 10 %.
- . Post burn patients 20%.
- . Intensive care unit 30%.
- More common among elderly and very young patients.

Etiology:

The presence of delirium indicates a serious physical problem affecting the brain and requires a search for causes. Common causes include:

- Infections: systemic(e.g. septicemia), specific(e.g. encephalitis).
- Medications (multiple drugs with multiple interactions, central anticholinergic effects).

- Metabolic disturbances/ electrolyte imbalance.
- Endocrinopathies (e.g. hypoglycemia).
- Organ failure: uremia, hypoxia.
- Substance abuse: alcohol withdrawal (delirium tremens) / intoxication.
- Neurological diseases: seizure / head trauma.

Differential Diagnosis (DDx):

1. Other organic psychiatric disorders:
 - dementia (however patients with dementia may develop delirium).
 - amnesic syndrome.
2. Acute functional psychosis (no disturbed consciousness).

Course and Prognosis:

The course is usually short (7-10 days). Delirium if not treated may progress rapidly into death or dementia, or spontaneously clear.

When treated, it usually resolves rapidly. However, some residual deficit may persist. Patients may have another episode later in their life.

Treatment: (It should be in a medical ward).

1. The referring physician should search for the cause and treat it properly.
2. Correct any metabolic abnormality: ensure nutrition, hydration, electrolyte balances.
3. Give low doses of a high potency antipsychotic for agitation (e.g. haloperidol 1mg oral or IM three times a day). Although benzodiazepines may be appropriate for promoting sleep at night, they should generally be avoided or given with caution in the daytime because their effects may increase disorientation, drowsiness and ataxia with possible falls, head trauma and fractures.
4. Keep the patient in a quiet, well lit-room; avoid over and under stimulation.
5. Frequently reorient, reassure and explain procedures clearly to the patient.

DEMENTIA

Definition: Chronic global impairment of cognitive functions without disturbed consciousness.

Features: The essential feature is a loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning or both.

- In early stages cognitive impairment may not be apparent, features include :
 - subtle changes in personality.
 - a decrease in the range of interest and enthusiasm.
 - shallow affect, lability of affect, and agitation.
 - emotional (depressive or anxiety).
 - multiple somatic complaints and vague psychiatric symptoms.
 - a gradual loss of social and intellectual skills (first noticed in work setting where high performance is required).

- In late stages cognitive disturbances emerge:
 - increasing memory impairment (recent memory first).
 - attention impairment (patient becomes less sharp).
 - impaired judgment.
 - Disorientation: particularly to time, and when severe to place and person.
 - significant change in mood and personality: often exaggeration of previous personality , catastrophic reaction (agitation under stressful circumstances secondary to the subjective awareness of intellectual deficits)
 - behaviour: shrinkage of social interaction.
 - language: vague and imprecise speech with inappropriate repetition of the same thoughts (perseveration).
 - psychotic features: hallucinations and delusions.

Epidemiology:

- It is primarily a syndrome of the elderly;(if > 65 years = senile dementia & if < 65 years = presenile dementia).

- Increasing age is the most important risk factor.

Causes of dementia :

1. Alzheimer's disease:
Continuous deterioration of intellectual functioning due to degenerative process affecting the whole cortex, especially cholinergic neurons.
2. Vascular (multi-infarct) dementia:
Stepwise deterioration of intellectual functioning due to multiple infarcts of varying sizes or arteriosclerosis in the main intracranial vessels. It usually occurs in patients with hypertension or diabetes.
3. General medical conditions: e.g. metabolic causes: vitamin deficiency (e.g. B12), hypothyroidism.
4. Substance- induced dementia: e.g. alcoholic dementia.
6. Chronic infections affecting the brain, e.g. T.B.
7. Others :
 - *Normal pressure hydrocephalus:*
Progressive memory impairment, slowness and marked unsteady gait (urine incontinence in late stages).
 - *Pick's disease* (dementia of frontal lobe type).
 - *Huntington's chorea:* global intellectual impairment with extra pyramidal features.
 - *AIDS dementia.*
 - *Creutz Feldt–Jakob's disease.*

DDx:

1. *Normal aging:* age-related cognitive decline (the course is not progressively deteriorating), no loss of social or occupational functioning.
2. *Depression in the elderly* (Pseudo-dementia): cognitive disturbance is relatively of rapid onset and preceded by depressive features. The differentiation is sometimes difficult as demented patients may also become depressed as they begin to comprehend their progressive cognitive impairment. EEG and CT scan are normal in pseudo-dementia.

3. *Delirium*: the onset is rapid and consciousness is impaired. Some demented patients may develop delirium. Diagnosis of dementia cannot be made before delirium clears.

Course and Prognosis:

The course depends on the cause.

- Alzheimer's dementias shows progressive slow deterioration. The patient may become incontinent of urine and / or stool.
- Vascular dementia shows stepwise deterioration.

Treatment:

1. Supportive measures:

- a. provide good physical care (meals, hygiene, ...).
- b. encourage the family's involvement.
- c. support the care giver.
- d. keep in familiar settings if possible to avoid accidents, wandering away,...etc.

2. Specific measures:

- a. Identify and correct any treatable or controllable condition e.g.: hypothyroidism, vitamin B12 deficiency, hypertension, diabetes.
- b. Symptomatic treatment:
 - agitation, aggression: small doses of major tranquilizers (e.g. Olanzapine 5mg).
 - insomnia: a sedative antidepressant(e.g. Citalopram 10 – 20 mg), small doses of major tranquilizers (e.g. Olanzapine 5mg) or benzodiazepine (e.g. lorazepam 1mg).
 - depression: small doses of antidepressant (e.g. Citalopram 10 – 20 mg).

Be aware of possible mental side effects of such medications e.g. confusion , over-sedation, risk of falling down.

- c. Cognitive-enhancing medications (mainly for Alzheimer's dementia)

* cholinesterase Inhibitors :

- Donepezil (Aricept): 5 mg at night & can be increased gradually to 10 mg. It is well tolerated (S/E: diarrhea , weight loss ,bradycardia ,and syncope).
 - Rivastigmine (Exelon):1.5 mg twice/day & can be increased gradually to maximum 6mg twice/day (S/E: anorexia , fatigue , somnolence, and dizziness)
 - Galantamine (Reminyl):4mg twice/day & can be increased gradually to 12mg twice/day (S/E: similar to rivastigmine)
 - Tacrine (Cognex):rarely used nowadays because of high risk of hepatotoxicity.
- * Memantine (Akatinol): an N-methyl-D-aspartate (NMDA) receptor antagonist , protects neurons from neurodegenerative process induced by glutamate excitotoxicity.

AMNESIC SYNDROME

Definition:

Impaired memory (recent memory mainly) due to a specific organic cause, in the absence of generalized intellectual impairment. It leads to social and occupational dysfunctioning. It is often known as Wernicke – Korsakoff’s syndrome, which starts as an acute syndrome (Wernicke’s encephalopathy) characterized by impairment of memory, ataxia, ophthalmoplegia and impaired consciousness. Then followed by Korsakoff’s psychosis (chronic memory defect, peripheral neuropathy and irritably). The immediate memory (frontal lobe function) is usually intact: i.e. digit span test is normal.

Etiology:

The condition usually results from lesions in the posterior hypothalamus and nearby midline structures, occasionally due to bilateral hippocampal lesions. The most common cause is thiamine (vitamin B₁), deficiency associated with alcohol abuse. Thiamin is essential for the enzyme transketolase which is essential for glucose metabolism. Other causes of thiamine deficiency include gastric carcinoma and persistent vomiting (e.g. typhoid fever).

Treatment:

- Identify and reverse the cause if possible.
- Thiamine supply (if due to thiamine deficiency).
- Supportive medical measures (no specific treatment).

Prognosis:

If it is due to thiamine deficiency and thiamine is provided promptly, prognosis is good. Otherwise, the course is usually chronic and may be progressive. Psychiatric symptoms occur with increased frequency in patients with seizures as a result of underlying brain tissue injury, side effects from anticonvulsant medications, or seizure-specific psychiatric disturbances.

COMPLEX PARTIAL SEIZURE

Definition: Episodic brief recurrent attacks stereotypic in nature associated with paroxysmal discharges of epileptic foci, usually located in limbic structure, particularly the temporal lobes (70 % arise from temporal lobe; therefore, it is commonly called temporal lobe epilepsy).

Features: (depend on the site of the focus)

- Pre-ictal: irritability, lethargy and dizziness.
- Aura: epigastric discomfort associated with distortion of sensations; visual, auditory, gustatory, olfactory or tactile.
- Ictus:
 - behavior disturbances: repetitive movements, e.g. chewing, grimacing, automatism.
 - confusion and disturbed consciousness.
 - fear, panic, derealization, memory disturbance.
 - thinking disturbances.
 - hallucinations .

Complex partial seizures, the most common focal seizures found in adults (30 % of all adult epileptics), may appear at any age; onset is usually in adolescence. Seizure may be triggered by bright lights, colors, noises, trauma, or intense emotions.

Possible Causes:

- Perinatal injuries.
- Prolonged febrile convulsions (lead to mesiotemporal sclerosis).
- Trauma to the base of the skull.
- Hamartomas of temporal lobe, fibrosis or gliosis.
- Hippocambal sclerosis.
- Vascular malformation

Diagnosis:

- This type of seizure disorder may mimic and be confused with any psychiatric disorder:
 - Psychosis: schizophrenia, mood disorder, brief psychosis, etc.
 - Neurosis: panic disorder, generalized anxiety disorder, depersonalization disorder, ...etc.
- Diagnosis is mainly clinical; EEG findings are not necessary for diagnosis. (EEG with sphenoidal or nasopharyngeal leads, shows temporal area spikes).

Treatment:

- Proper assessment of all aspects of the patient's life.
 - Anticonvulsants e.g. carbamazepine (Tegretol) 200 - 400 mg twice or three times per day.
 - Neurology consultation is helpful.
-

HEAD INJURY - Neuro-psychiatric Aspects.

Head injuries are common, with the majority being closed injuries (blunt trauma) occurring in motor accidents.

The neuropsychiatric effects of head trauma include:

A. Acute consequences:

- Impaired consciousness in varying duration (hours, days, weeks or months) long duration suggests poor prognosis.
- Delirium (after severe head trauma).
- Memory defects : on recovery of consciousness, defects of memory are usually present.

- a. *anterograde (post-traumatic) amnesia*:
amnesia for events in the time between the trauma and the resumption of normal continuous memory. It is a good prognostic factor: probably full recovery when anterograde amnesia was less than 12 hours.
- b. *retrograde amnesia*:
amnesia for events in the time between the trauma and the last clearly recalled memory before the injury. Final duration is frequently less than 1 minute. It is *not* a good predictor of outcome.

B. Chronic Consequences:

- Lasting cognitive impairment: there is more likelihood of cognitive impairment when the injury has caused a prolonged post traumatic amnesia (of more than 24 hours). Cognitive impairment was particularly associated with parietal and temporal damage, especially on the left side. Recovery of function may be very slow and may continue over the years.
- Emotional disturbances:
Depressive, anxiety and phobic features are common, and associated with somatic complaints such as headache, fatigue and, dizziness.
- Personality changes:
There may be irritability, reduced control of aggressive impulses, sexual disinhibition and some coarsening of behaviour and premorbid personality traits, particularly after frontal lobe injury.
- Psychotic features:
Depression with psychotic features (associated with non-dominant frontal damage). Paranoid Psychosis (associated with temporal lobe damage).
- Social consequences:
Many patients and their relatives experience severe distress of head injury, and have to make substantial changes in their way of life.

- Medico-legal aspects:
Compensation issue is more likely to contribute to disability if the patient feels someone else is at fault, financial compensation is possible, low social status and in industrial injury.

Treatment:

A plan for long-term treatment should be made as early as possible after head trauma.

The treatment of the cognitive and behavioral disorders is basically similar to the treatment approaches used in other patients. However, head trauma patients may be particularly susceptible to the side effects associated with antipsychotics; therefore, these drugs should be initiated in lower dosages than usual and should be titrated upward more slowly than usual.

Aggression and impulsivity can be treated with anticonvulsants or antipsychotics. Treatment should include physical and psychological rehabilitation to which the clinical psychologist can sometimes contribute behavioural and cognitive techniques. Problems of litigation and compensation should be settled as early as possible. Continuing psychosocial help should be provided to patient and carers, by a special team.

Factors affecting the outcome of head trauma:

- Loss of consciousness and post-traumatic amnesia.
- Amount and location of brain damage.
- Premorbid personality and past psychiatric history.
- Development of seizures.
- Medico-legal factors e.g. compensation.

Chapter 7

Substance-related Disorders

A 50 year-old man presented to Emergency Department with pulse of 120/min and BP 175/110. He has tremor and is unable to give clear history apart from insomnia for the last 3 days. He has been drinking alcohol since age 25 years but he has not had any alcohol drinks in last 3 days.

Substance abuse occurs in almost all countries and in all segments of all societies. Men are more at risk than women. Adolescents are most vulnerable age group for abusing psychoactive substance. Abuse of substances is commonly associated with low level of education, broken family, personality disorders, criminal records and financial difficulties.

Terminology in psychoactive substance abuse:

- **Abuse:** Self-administration of any substance in a culturally disapproved manner that causes adverse consequences.
- **Intoxication:** The transient effects (physical and psychological) due to recent substance ingestion, which disappear when the substance is eliminated.
- **Withdrawal:** A group of symptoms and signs occurring when a drug is withdrawn or reduced in amount.
- **Tolerance:** The state in which the same amount of a drug produces a decreased effect, so that increasingly larger doses must be administered to obtain the effects observed with the original use.
- **Dependence:** The physiological state of neuro-adaptation produced by repeated administration of a drug, necessitating continued administration to prevent the appearance of the withdrawal state.
- **Addiction:** A nonscientific term that implies dependence and associated deterioration of physical and mental health as well as a high tendency to relapse after discontinuation.

CLASSIFICATION OF SUBSTANCES

The two classification systems DSM and ICD use similar categories of substance use disorders but group them in different ways. This book adopts DSM classification with minor modifications see Table 7 –1.

Table 7-1. Classes of Substances

<ul style="list-style-type: none"> • Alcohol • Sedatives, hypnotics or anxiolytics • Inhalants (Volatile Solvents) • Amphetamines • Khat (Qat) * • Cocaine • Caffeine • Nicotine (Tobacco) • Cannabis • Opioids • Hallucinogens • Phencyclidine • Other (e.g. anabolic Steroids, anticholinergics). 	
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* Khat is considered here (though not included in DSM) because its relevance to stimulant substances and its wide use in some Arabic countries e.g. Yemen, Saudi Arabia.

Patient's Assessment:

Patients usually fear the consequences of acknowledging the problem, are manipulating, and prone to denial. They are often difficult to detect and evaluate and are unreliable. Therefore, it is necessary to obtain information from other sources, such as family members, because these patients are usually unreliable.

Urine and blood screening tests are useful in confirming suspected substance use. Most drugs are well detected in urine and are often positive for up to 2 days after taking most drugs. However, some drugs (e.g. alcohol, barbiturates) are best detected in blood. Screening urine and blood tests, though confirmatory and sensitive, are not specific;

many false positives can occur, e.g. in patients using antipsychotics. Substance abusers often abuse multiple substances (e.g. amphetamine, cannabis and alcohol). List all substances and determine the pattern of abuse (see Table 7- 2).

Table 7-2: Determining the Pattern of Abuse

For each psychoactive substance consider the following:

- **What?** (type, dose, route, effect: nature and duration).
- **How?** (frequency, duration, how long, source, and situation)
- **Why?** (? psychosocial problems).
- **Dependence :**
 - persistent abuse despite harmful effects
 - tolerance
 - withdrawal on abstinence
 - reinstatement after abstinence
 - feeling compelled to abuse substance

Substance abuse frequently coexists with personality disorders (e.g. borderline, antisocial), and with other psychiatric disorders such as depression, anxiety or psychotic conditions.

Complications of substance abuse should be carefully considered:

- **Psychosocial:** social isolation, depression, anxiety, psychosis...etc.
- **Physical:** concomitant medical conditions are often substance-related, e.g. thrombophlebitis, bacterial endocarditis, acquired immune deficiency syndrome (AIDS), infectious hepatitis, abscesses.

1. ALCOHOL

Alcohol abuse may mean any one of the following specific terms:

- **Excessive consumption:** harmful use.
- **Problem drinking:** drinking that has caused disability, but not dependence.
- **Alcohol dependence:** which usually denotes alcoholism.
- **Alcohol-related disability:** physical, mental and social.

Alcohol is the major substance of abuse all over the world. Mixed abused of alcohol and other substances is very common. Recreational alcohol drinking gradually grades into problem drinking and dependence. Most alcohol abusers go unrecognized by clinicians until their physical health and psychosocial life have been significantly harmed; therefore, early recognition is important. Many people go through prolonged periods (average 15 – 20 years) of gradual dependence on alcohol before clinical symptoms or signs are evident.

Alcohol depresses the central nervous system. Clinically, it may appear to be a stimulant because of early disinhibition due to suppression of inhibitory control mechanisms.

Alcohol drinking may occur in the late teens but dependence is most common in those aged 40 – 55 years.

- **Vulnerable personality:** impulsive, gregarious, less conforming, isolated or avoidant persons.
- **Vulnerable occupation:** senior businessmen, journalists, doctors.
- **Psychosocial stresses:** social isolation, financial, occupational or academic difficulties, and marital conflicts.
- **Emotional problems:** anxiety, chronic insomnia depression.

- **Detecting patients with alcohol problems :**

It is important to recognize alcohol problems as soon as possible, because treatment is more likely to be successful in early stages of alcohol abuse.

Clinician should have high index of suspicion of alcohol abuse in the following circumstances:

1. High-risk groups (see Table 7-3).
2. Psychiatric conditions associated with alcohol abuse:
 - Poor concentration and memory impairment.
 - Sexual dysfunction.
 - Morbid jealousy.
3. Medical conditions:
 - Nausea, vomiting, gastritis, peptic ulcer, liver disease.
 - Headache, sweating, flushing, blackouts.
 - Peripheral neuropathy, fits, repeated falls.
4. Social conditions:
 - Repeated absences from work.
 - Poor work records.
 - Interpersonal problems (with parents, spouse or children).
 - Financial stresses.
 - Isolated life style.
5. Legal conditions: e.g. reckless driving.

When you suspect alcohol abuse ask the patient clearly about alcohol ingestion and determine the pattern of abuse (see Table 7 –2). Carry out a physical examination for alcohol – related medical complications (see Table 7 – 5).

Laboratory test: abnormal high values of gamma glutamyl transpeptidase (GGT) and mean corpuscular volume (MCV) point to the possibility of alcohol abuse.

Identifying heavy drinkers: using CAGE questionnaire

C = Have you ever felt you must **C**ut down your drinking?

A = Have people **A**nnoyed you by criticizing your drinking?

G = Have you ever felt **G**uilty about your drinking?

E = Have you ever had a drink first thing in the morning as an “**E**ye opener”?

CLINICAL PRESENTATIONS

- **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, acute psychosis with delusions and / or hallucinations).

- **Alcohol withdrawal:**

Occurs in the dependent state, in those who have been drinking heavily for years and who have a high intake of alcohol for weeks at a time. The symptoms (see table 7 – 4) may begin after six hours of cessation or reduction of alcohol and peak by 48 hours. They follow a drop in blood concentration, characteristically appear on waking from sleep, after the fall in concentration during sleep. The symptoms subside over the course of 5 - 7 days. Epileptic generalized tonic clonic seizures may develop within 12 – 24 hours after cessation of alcohol intake. Delirium tremens may develop after about 48 hours.

Table 7-4. Symptoms of Alcohol Withdrawal

- Tremulousness (hands, legs and trunk).
- Nausea, retching and vomiting.
- Sweating, tachycardia and fever.
- Anxiety, insomnia and irritability.
- Cognitive dysfunctions.
- Thinking and perceptual disturbances.

Delirium Tremens:

It is a severe form of alcohol withdrawal starting 2 – 3 days after last alcohol intake; it may be precipitated by infections, and characterized by:

- gradual onset of delirium; fluctuating consciousness, disorientation, agitation, hallucinations, illusions, delusions.
- gross tremor (which gives the condition its name).
- autonomic disturbances (dysfunction of vital signs)
- dehydration and electrolyte disturbances.
- marked insomnia.

It usually peaks on third or fourth day, lasts for 3 – 5 days, worsens at night, and followed by a period of prolonged deep sleep, from which the person awakes with no symptoms and has amnesia for the period of delirium.

Complications include:

- chest infection/aspiration.
- violent behavior
- seizures/coma.
- death; mortality rate: 5-15%. Death can be due to:
volume depletion/cardiac arrhythmias/electrolyte imbalance/
infections/suicide.

Therefore, delirium tremens is a serious **medical emergency** that

requires early detection and prompt treatment in a **medical ward** (see treatment of alcohol withdrawal).

Alcohol Memory Blackouts:

- Loss of memory of events that occurred during a period of intoxication.
- Possible occurrence after a single episode of heavy drinking (in people who do not habitually abuse alcohol).
- When these episodes occur frequently they indicate heavy drinking.
- When they are prolonged, hours or days, they indicate excessive drinking.

Complications of Chronic Alcohol Abuse

Chronic alcohol abuse has numerous complications See Table 7-5

Table 7-5. Complications of Chronic Alcohol Abuse

Medical	Psychiatric	Social
<p>Neurological</p> <ul style="list-style-type: none"> • Cerebellar degeneration • Seizures • Peripheral neuropathy • Optic nerve atrophy • head trauma <p>Alimentary</p> <ul style="list-style-type: none"> • tumors (esophagus, liver..) • gastritis, peptic ulcer • pancreatitis • hepatitis, cirrhosis <p>Others:</p> <ul style="list-style-type: none"> • cardiomyopathy • anemia • obesity • impotence • gynecomastia 	<ul style="list-style-type: none"> • amnesic disorder • delirium • dementia • psychosis • depression • reduced sexual desire • insomnia • personality deterioration • increase risk of suicide • morbid jealousy 	<ul style="list-style-type: none"> • social isolation • job loss • marital conflicts • family problems • legal troubles • social stigma • others

Treating Alcohol Intoxicated Patient

- The conscious patient:
 - observation, with protective and supportive approach
 - In case of agitation, hyperactivity or risk of violence: restrain the patient and give antipsychotic drugs (e.g. haloperidol 5 – 10 mg im)
 - Sedatives are better avoided because they may potentiate depressant effects of alcohol on the central nervous system.
 - Wait for the alcohol to be metabolized.
- The unconscious patient:
 - hospitalization is required: protection of the airways, vital signs monitoring, prevention of further loss of body heat, correction of hypovolemia, and forced diuresis with maximal alkalinization of the urine. In extreme situation hemodialysis is necessary.

Treating Alcohol Withdrawal

Alcohol withdrawal (with or without delirium tremens) can be serious and can include coma, seizures and autonomic disturbances. Therefore, prompt in-patient treatment is required which should include:

- close observation and monitoring of vital signs.
- thiamine (B1 vitamin) supplement; it is essential for glucose metabolism, and prevention of Wernicke-Korsakoff's syndrome.
- rehydration and correction of electrolyte disturbances.
- sedation with benzodiazepines, e.g. chlordiazepoxide, to guard against fits and delirium tremens.
- treat any on going medical problems, e.g. infections.
- if seizures develop, use anticonvulsants, e.g. phenytoin.

Detoxification (Planned Alcohol Withdrawal)

People with alcohol-related disorders usually come to treatment because of fear that continued drinking will have a fatal outcome, or because of pressure from a spouse or an employer. A sudden

cessation of drinking may cause severe withdrawal state with serious complications including seizures, delirium tremens or coma. Therefore, detoxification should be carried out under close **medical** supervision.

- * Long-acting benzodiazepines (e.g. diazepam or chlordiazepoxide) are generally prescribed to reduce withdrawal symptoms because of:
 - their long half-life
 - the smooth reduction of the drug levels in the blood (a smooth course of withdrawal).
 - making the drug less likely to be abused.
 - Benzodiazepines then gradually discontinued over 2-3 weeks; otherwise, the patient may become dependent on them.
- * Chlormethiazole: Despite its long history of use in this field, it is not recommended due to possible respiratory depression and cross-dependence.
- * Vitamin supplements, especially vitamin B1.
- * Monitoring of vital signs, consciousness and orientation.
- * Good hydration and glucose intake.
- * Anticonvulsants may be used to control seizures.

Maintaining Abstinence:

Disulfiram (anta-abuse) helps those whose drinking pattern is impulsive and who are highly motivated to stop drinking. It blocks the oxidation of alcohol so that acetaldehyde accumulates with consequent unpleasant flushing of the face, choking sensations, headache, nausea, vomiting, tachycardia and anxiety. There is a risk of cardiovascular complications. Therefore, the drug should be used in specialist practice and should not be within 12 hours after the last ingestion of alcohol.

Citrated calcium carbimide is another drug used in maintaining abstinence; it induces a milder reaction with alcohol, and has fewer side effects.

Additional Treatments for Alcohol Abuse

- **Psychological treatment:**

- To explore the reasons for drinking, alternative ways are worked out. For instance, instead of using alcohol in social situations to reduced anxiety, learn anxiety management and assertiveness techniques.
- Provision of information about the hazards of alcohol
- Group therapy: about 7-12 patients and a staff member in a specialist unit attend regular meetings. It provides an opportunity for frank feedback from other members of the group concerning the problems that the patient faces and to work out better ways of coping with their problems.

Alcoholics Anonymous (AA) is a voluntary supportive self-help organization of persons with alcohol-related problems. Members attend group meetings (1-2 / week) and obtain support from one another. The meetings involve repeated emotional confession of each person's problems. The organization works on the firm belief that total abstinence is the aim.

2. Sedatives, Hypnotics, and Anxiolytics

This class of substances includes all controlled antianxiety and sleeping medications:

- Benzodiazepines (e.g. diazepam, Lorazepam)
- Benzodiazepine - like drugs (e.g. zolpidem, zopiclone)
- Barbiturates (e.g. secobarbital)
- Barbiturates - like hypnotics (e.g. methaqualone)
- Carbamates (e.g. meprobamate)

These substances are brain depressants. Like alcohol, they can produce very significant levels of physiological dependence, marked by both tolerance and withdrawal.

- **Intoxication:** Similar to alcohol intoxication, features include:
 - slurred speech
 - incoordination
 - unsteady gait

- nystagmus / ataxia
- impaired attention or memory
- stupor or coma

Abuse of sedative and hypnotic drugs causes clinically significant maladaptive psychological or behavioral changes, e.g. disinhibited behavior.

- **Withdrawal:** Similar to alcohol withdrawal, features include:
 - autonomic hyperactivity (e.g. sweating, tachycardia).
 - nausea, vomiting, anorexia
 - insomnia
 - anxiety / agitation
 - perceptual disturbances (e.g. illusions...)
 - seizures
 - delirium

The timing and severity of the withdrawal syndrome differ depending on the specific substances and its pharmacokinetics and pharmacodynamics. For example, withdrawal from substances with long-acting metabolites (e.g. diazepam) may not begin for 24 - 48 hours or longer; whereas withdrawal from substances with short-acting substances that are rapidly absorbed and have no active metabolites (e.g. triazolam) can begin within 4 - 6 hours after the substance is stopped. Withdrawal can be life-threatening which often requires hospitalization.

These substances are often taken with other brain depressants, like alcohol, which can produce additive serious effects (e.g. respiratory depression). Alcohol and all drugs of this class are cross-tolerant and cross-dependant, i.e., one drug is able to suppress the manifestations of physical dependence produced by another drug and to maintain the physical dependant state.

Treatment of intoxication and withdrawal states are similar to that of alcohol. Regardless of the particular sedative-hypnotic drugs of abuse, withdrawal can be accomplished safely using several different sedative hypnotics although the most commonly used are diazepam,

Phenobarbital, and pentobarbital. The patient should be supervised closely and the dose should be reduced gradually in steps (about 1/4 - 1/10 of daily benzodiazepine dose, every two weeks). Abrupt withdrawal may produce seizures, delirium, or psychosis.

In contrast to the barbiturates and the barbiturates-like substances, the benzodiazepines have a large margin of safety when taken in overdose because of the minimal degree of respiratory depression associated with the benzodiazepine. **Flumazenil** is a benzodiazepine receptor antagonists used to reverse the effects of benzodiazepine receptor agonists used for clinical indications (e.g. anesthesia, sedation) or in overdose. Its use is limited to emergency settings.

Despite the risk of dependence, benzodiazepines have

- less abuse potential than other drugs of this class.
- a higher therapeutic index.
- a wide range of therapeutic indications.

Therefore, a patient should not be deprived of a benzodiazepine drug when it is clinically indicated (e.g. anxiety, insomnia, akathisia).

3. Inhalants (Volatile Solvents)

Inhalants are volatile organic substances (most are aromatic hydrocarbons) that can be inhaled for psychotropic effects. The types of solvents, cleaners, and glues are numerous and include: gasoline/lighter fluids/spray paints/cleaning fluids/glues/typewriter correction fluids/fingernail polish removers.

The active compounds in these inhalants are usually acetone, benzene or toluene. These agents generally act as brain depressants (similar to alcohol and sedative hypnotics in their effects). Use of inhalants occurs mainly among adolescents in lower socioeconomic groups, usually as occasional experimentation. This is often a group activity. Inhalants are inexpensive, easily available and legal substances. These factors contribute to the high use of inhalants among people who are poor. People often use inhalants with a

partially closed container (e.g. a can), a plastic bag, a tube or an inhalant- soaked cloth from or through which a user can sniff the volatile substance through the nose, or huff and puff it through the mouth. Therefore, a recent abuse of inhalants can be identified by unusual breath or odor, rashes around the nose and the mouth or the residue on the face, hands or clothing. Other less specific identifying features include irritation of the patient's nose, mouth, eyes and throat. Inhalants are rapidly absorbed through the lungs and delivered, through the blood, to the brain. Their effects usually appear within 5 – 10 minutes and may last for several hours.

- **Intoxication :**

- Symptoms of mild intoxication are similar to intoxication with other brain suppressants (e.g. alcohol).
- In small doses, these agents produce:
 - Euphoria
 - excitement
 - disinhibition
 - pleasant floating sensations
- High doses can cause:
 - disturbed consciousness /sedation
 - nausea/vomiting
 - perceptual disturbances
 - impulsiveness / assaultiveness
 - impaired judgment
 - slurred speech/nystagmus/ataxia/incoordination.
- **Long-term use** can cause irreversible multi-organ damages (brain, lungs, liver, kidneys, muscles, peripheral nerves and bone marrow). Psychological dependence occurs but physical dependence is unusual. (Withdrawal syndrome does not occur frequently).
- * **Death** may occur during intoxication because of:
 - respiratory depression
 - asphyxiation
 - aspiration of vomitus

Attracting Features

- cardiac arrhythmia
 - or serious injury.
- **Treatment:**
Use of inhalants is relatively short-lived; for many users experimentation with inhalants is a temporary phase which does not appear to lead to chronic abuse. Support and advice may be sufficient for such patients.
Chronic inhalant abusers are more likely to have other problems:
 - Psychological: depressions, conduct or personality disorders...etc.
 - Social: broken or abusive family life.
 - Physical: e.g. cerebellar damage, renal failure.

A full range of biopsychosocial assessment and treatment is needed including physical and psychiatric rehabilitation. There is no specific drug treatment for inhalant abuse, but psychiatric complications (e.g. psychosis, depression) may require drug treatment.

Teenagers should receive education and counseling about the general topic of substance abuse.

4. STIMULANTS

These are group of psychostimulants that enhance the action of dopamine and noradrenalin and act as sympathomimetics peripherally. These drugs include:

- | | | |
|--|----------------------|-------------------|
| • amphetamine | • dextroamphetamine | • methamphetamine |
| • methylphenidate | • pemoline | |
| • ephedrine | • Khat (Qat) | |
| • caffeine | • pseudoephedrine | |
| • cocaine | • nicotine (tobacco) | |
| • amphetamine derivatives (also classified as hallucinogens) | | |

Amphetamine, pemoline, modafinil and methylphenidate have certain therapeutic **uses**:

1. Attention deficit hyperactivity disorder (ADHD)
2. Narcolepsy
3. Depression (occasional adjunct to antidepressants in certain patients).
4. Obesity (occasionally used to reduce appetite and increase energy expenditure).

Cocaine had been used for topical anesthesia.

These substances are **abused** to increase mental and physical performance and achievement, and to induce euphoria. They are commonly abused by people who desire attentiveness and wakefulness:

- * Students studying for examinations.
- * Long-distance truck drivers.
- * Athletes in competition.
- * Business people with important deadlines.

• **Clinical effects of stimulants:**

Psychological	Physical
Enhanced cognitive functions Elevated mood Over activity Over-talkativeness Increased confidence, self-esteem and sociability Insomnia. In high doses / prolonged use: Restlessness, irritability Paranoid psychosis Aggressiveness, hostility	Reduced sense of fatigue Reduced appetite (anorexia) Dilated pupils Tremor In high doses / prolonged use: Nausea, vomiting, cardiac arrhythmia. Severe hypertension, cerebrovascular accident, seizures, dizziness, hyperthermia, respiratory distress, cyanosis

Long - term cocaine snorting can lead to a rebound rhinitis, nose bleeds and eventually may lead to a perforated nasal septum.

- **Tolerance and dependence:**

Amphetamines do not readily induce tolerance. Crack (purified freebase cocaine) is smoked, has a rapid onset of action, and is highly addictive. A withdrawal syndrome of varying severity follows cessation of stimulants. In mild cases it consists mainly of low mood and decreased energy. In occasional severe cases severe depression, anxiety, lethargy, headache and sleep disturbances can occur. A prominent sign of withdrawal is craving (particularly with cocaine). Withdrawal symptoms usually peak in several days. However, depressed mood may last for several weeks.

- **Treatment**

- * *Intoxication:*

- Sedation
- Antiarrhythmic drugs
- Management of hyperpyrexia
- Antipsychotics (to control psychosis)
- Urine acidification (to increase drug clearance)

- * *Planned Withdrawal :*

- Psychosocial intervention (counseling ...)
- Sedatives to reduce distress associated with severe withdrawal.
- Antidepressants may be needed for a persistent depressive disorder.

Khat (Qat)

Khat is a bush (*catha edulis*) that grows in East Africa, Yemen, Saudi Arabia and Afghanistan. The fresh leaves are chewed for their stimulant effect. The active ingredients is cathinone (amphetamine-like substance). The psychological effects can last for up to 24 hours.

Chronic use of Khat can affect the oral cavity, induce inflammation of the mouth, and lead to secondary infections and loss of appetite.

In order to counteract the psychoactive effect of the khat and other stimulants the misuse of alcohol and hypnotosedatives is common.

Caffeine

Caffeine is a psychostimulant substance that readily crosses the blood – brain barrier. Caffeine is contained in coffee, tea, soft drinks (e.g. Cola), prescription medications (e.g. cafergot), over-the-counter preparations (e.g. some painkillers). Caffeine enhances dopamine and noradrenalin activity. Doses of 100 mg. induce mild euphoria.

- Intoxication >250 mg. :
 - * restlessness * excitement * agitation
 - * insomnia * diuresis * GI upset
 - * tachycardia * muscle twitching * flushed face
- Withdrawal (after prolonged use and abrupt cessation)
 - * headache * nausea * vomiting * anxiety
 - * dysphoria * fatigue * drowsiness

Nicotine

Nicotine has a stimulatory CNS effects by acting as an agonist at the nicotinic subtype of acetylcholine receptors and activating dopamine and noradrenalin. Nicotine also acts as a skeletal muscle relaxant.

The stimulatory effects of nicotine produce improved attention, learning, reaction time, and problem - solving ability. Tobacco is the most common form of nicotine. It is smoked in cigarettes, cigars, and pipes. Nicotine dependence develops rapidly and is strongly affected by environmental conditioning.

Features of nicotine withdrawal occur after abrupt cessation or reduction in the amount of nicotine used:

- * irritability * frustration * poor concentration
- * insomnia * dysphoric mood * increase appetite

These features generally peak in the first 24 - 48 hours and can continue for several weeks.

Smoking causes cancer of the lung, upper respiratory tract, bladder, pancreas, esophagus and probably kidney and stomach.

Cigarette smoking can induce liver microsomal enzymes and reduce plasma concentrations of antipsychotic agents.

5. OPIOIDS

This group includes several narcotic substances: • **opium**
• **heroin** • **morphine** • **codeine** • **pethidine** • **methadone**
• **pentazocine**

Some of these compounds are naturally occurring (e.g. opium, codeine) while the others are synthetic or semi-synthetic. Some of these substances have medical uses (e.g. Pethidine), while others are solely substances of abuse (e.g. heroin). The pharmacological effects of opiates are mediated through interaction with opiate receptors. The medical use of opioids is mainly for their powerful analgesic effects; they are abused for their powerful euphoriant effects (especially when taken intravenously).

These substances are used primarily by a young lower socioeconomic population.

• Clinical Effects of Opioid Abuse:

Psychological

- euphoria
- relaxation
- hyperactivity
- drowsiness
- analgesia
- reduced sexual desire

Physical

- small pupil
- bradycardia
- reduced appetite
- constipation
- respiratory depression

Tolerance develops rapidly (especially in intravenous usage) leading to increasing dosage. Tolerance diminishes rapidly and this can result in serious respiratory depression when a previously tolerated dose is resumed after a drug-free interval (e.g. after a stay in a prison or hospital).

• Opioid Withdrawal

The symptoms due to withdrawal from opioids are flulike, including:

- * lacrimation
- * muscle and joint pain

- * cold and hot flushes
- * nausea, vomiting and diarrhea
- * piloerection

Intense craving for the drug is a recognized feature.

These features usually begin about 6 hours after the last dose, reach a peak after 36 - 48 hours, and then wane. Untreated withdrawal results in no serious medical sequence and rarely threatens the life of someone in reasonable physical health, though they cause great distress.

Complications of Intravenous Usage:

- * AIDS * hepatitis * endocarditis * septicemia
- * Acute local infections (cellulitis, thrombophlebitis)

Treatment

- Opioids overdose can be dangerous (due to respiratory depression) and therefore, should be treated carefully in the intensive care unit:
 - Naloxone is a short acting antidote that is used to normalize respiration and to restore consciousness. Naloxone is usually given IV at a slow rate; 0.8/70 kg of body weight.
 - Open airway - oxygen - IV fluids .
 - Vital signs monitoring
- Opioids Withdrawal:

Assess the severity and give symptomatic treatment: pain killer and sedatives. Clonidine can be used to control the release phenomena (sympathetic over activity, nausea, vomiting and diarrhea).
- Other aspects of treatment include :
 - Nutritional treatment
 - Treat complications (e.g. thrombosis)
 - Antidepressants (if depressed)
 - Counseling, individual or group therapy.

6. CANNABIS

The main forms are marijuana and hashish which are either smoked or eaten, and the differences in the effects they produce depend primarily on their concentration of the active ingredient “tetrahydrocannabinol” (THC).

- **Clinical Effects:**

Psychological	Physical
<ul style="list-style-type: none"> - sense of well being - euphoria - relaxation - enhancement of aesthetic experiences through heightened perceptual awareness - impaired memory - impaired psychomotor performance. 	<ul style="list-style-type: none"> - tachycardia - reddening of the conjunctiva - dry mouth - respiratory tract irritation - increased appetite

A few persons find the use of cannabis dysphoric and develop anxiety, panic attacks, depression or paranoid psychosis.

- **Tolerance**

Tolerance can occur in people exposed to high doses for a prolonged period of time, but is much less evident in those who use small or intermittent dosing. Long-term use of high doses can give rise to dependence, though usually of the non – physiological type (psychological dependence).

- **Withdrawal**

Withdrawal from high doses gives rise to a syndrome of nausea, anorexia, irritability and insomnia.

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.

- **Treatment** (usually at out-patient clinic):

- Total abstinence and observation
- Symptomatic treatment (for anxiety, panic, depression, psychosis)

- Psychological measures : support, counseling
- Follow-up and monitoring.

7. HALLUCINOGENS

These are group of substances that induce hallucinations, and produce a loss of contact with reality and an experience of heightened and expanded consciousness.

Hallucinogens can be natural, e.g. Psilocybin (magic mushroom) or synthetic , e.g. Lysergic acid diethylamide (LSD): hallucinogenic prototype. Hallucinogens have no medical use and a high abuse potential. They act as partial agonists at postsynaptic serotonin receptors.

Though tolerance develops rapidly, neither physical dependence nor withdrawal symptoms occur with hallucinogens, (tolerance reverses quickly in few days) but a user can develop a psychological dependence

• Clinical Effects

Psychological	Physical
<ul style="list-style-type: none"> - marked perceptual distortion (changing shapes, colors...) - hallucinations (visual, tactile...) - false sense of achievement an strength - depersonalization, derealization - euphoria, anxiety, panic - paranoid ideation - homicide and suicide tendencies - flashbacks after abstinence - delirium 	<ul style="list-style-type: none"> - tachycardia - hypertension - cerebellar signs - wide pupils - hyperemic conjunctiva - blurred vision - hyperthermia - piloerection

• Treatment

- Supportive counseling (talking down): protection, and reassurance.
- Avoid provocation, agitation and dangerous behavior.
- Symptomatic treatment (anxiolytics, antipsychotics ...)
- Treat any persisting psychiatric disorder (e.g. depression)

8. PHENCYCLIDINE (PCP)

This is a dissociative anesthetic synthetic substance with hallucinogenic effects. It is no longer used as anesthetic in humans because it was associated with delirium, agitation and aggressive behavior. Phencyclidine is often added to other drugs of abuse to boost their effects. The effects of PCP are similar to those of hallucinogens with some differences in pharmacology and clinical effects. Thus DSM classifies PCP in a separate category.

Intoxication can be hazardous (hypertensive crisis, status epilepticus, malignant hyperthermia, etc.).

People abuse PCP for euphoria and peaceful floating sensations.

In treatment anxiolytics may be given. Antipsychotics can be used for calming the aggressive behavior and treating psychosis.

Common Routes of Substance Abuse

Oral	alcohol - hypnotics - sedatives - stimulants - hallucinogens .
Injections	opioids - stimulants
Smoking	cannabis - PCP
Sniffing	cocaine - volatile substances

Substances that can be tested in Urine

Substance	Length of time
Alcohol	8-12 hours
Cannabis	Varies depending on use ; 3 days – 4 weeks
Amphetamine	48 hours
Cocaine	8 hours (metabolites;2-4 days)
Heroin/Morphine	36 – 72 hours

Chapter 8

Schizophrenia

A 20-year old man was brought to psychiatry clinic by his father with one year history of disorganized behavior, marked deterioration in social and academic functioning, talking to self in an odd manner

SCHIZOPHRENIA

Schizophrenia is a term coined by the Swiss psychiatrist Eugen Bleuler in 1911 in his classic text “Dementia Praecox or the Group of Schizophrenia”, which means, “mind splitting”.

Bleuler distinguished certain symptoms of schizophrenia that he regarded as primary or essential (Four as):

1. Association loosening in the logical thoughts.
2. Affective blunting or incongruity.
3. Ambivalence: the co-existence of strongly conflicting feelings, attitudes and ideas leading to inconsistent behavior.
4. Autism (withdrawal in thinking and behavior).

Bleuler’s diagnostic approach has lost favor because of the poor reliability in identifying these symptoms and because none of these symptoms is specific to schizophrenia, e.g. ambivalence is frequent in other forms of psychiatric disorders: (obsessive-compulsive disorders, severe depression...)

- Schneider (1957) has defined diagnostic criteria for schizophrenia based on clustering and frequency of symptoms (phenomenological rather than etiological approach).

He designated a group of the most common (so-called first rank) symptoms, which in the absence of organic mental diseases signify schizophrenia, these include:

1. Thought alienation (insertion, withdrawal or broadcasting).
2. Hallucinations (third-person auditory hallucinations, discussing, or running commentary).
3. Thought echo (hearings one’s own thought spoken aloud).
4. Passivity phenomena: motor or sensory passivity, made feelings or impulses controlled by external forces.

5. Delusional perception (delusional misinterpretation of a normal perception).

Limitations of Schneider's approach:

1. These symptoms carry no prognostic value.
2. Their sensitivity is limited (around 20 % of schizophrenic patients never showed these symptoms).
3. Their specificity is also limited (around 30 % of patients with these symptoms have mood disorders; mania or depression).

Of all major psychiatric syndromes, schizophrenia is much the most difficult to define and describe. The main reason for this difficulty is that, over the past 100 years, many widely divergent concepts of schizophrenia have been held in different countries and by different psychiatrists.

Newcomers to psychiatry often have difficulty in learning about schizophrenia because the clinical presentations and outcome are so varied.

There are no specific limited pathognomonic features for schizophrenia. The best starting point is to study simplified descriptions of two variants; the acute syndrome and the chronic syndrome.

The Acute Syndrome	The Chronic Syndrome
Presence of active features which include : <ul style="list-style-type: none"> • Prominent Delusions • Prominent Hallucinations • Disorganized thinking and speech • Disturbed behavior • Mood incongruity 	Presence of negative features which include: <ul style="list-style-type: none"> • Poor self-care and hygiene. • Lack of initiative and ambition. • Social withdrawal. • Poverty of thought and speech. • Delusions and hallucinations become less prominent. • Restricted or apathetic affect. • Some cognitive impairment.

DIAGNOSTIC CRITERIA :

The most widely used and accepted criteria of schizophrenia are DSM criteria which are simplified here:

- Six months duration of disturbance (including the prodromal and residual phases).

- At least one month period of psychotic features, two out of five:
 1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g. incoherence).
 4. Catatonic features or disorganized behavior.
 5. Negative features (e.g. flat affect).
- Significant functional impairment (social, occupational, academic...etc.)
- Exclusion of other psychotic disorders (see the differential diagnosis).

VARIOUS SUBTYPES OF SCHIZOPHRENIA :

1. Paranoid Schizophrenia:

- Prominent paranoid delusion with frequent auditory hallucinations related to the delusion.
- Patient is usually potentially aggressive, angry or fearful, uncooperative and difficult to deal with. No prominent disorganized behavior or mood.
- The onset is usually late (compared to other subtypes of schizophrenia).
- The prognosis is better than the other subtypes and deterioration in functioning is usually much less.

2. Catatonic Schizophrenia:

- Presence of one or more of the catatonic features: stupor, mutism, rigidity, negativism, posturing, echopraxia, echolalia, waxy flexibility or purposeless excitement.

3. Disorganized Schizophrenia:

- Disorganized behavior.
- Marked incoherence and loosening of association.
- Inappropriate affect.
- Grimacing and bizarre mannerism are common.

4. Undifferentiated Schizophrenia :

- Prominent delusions and hallucinations.
- Prominent disorganization behavior.
- Incoherence.

6. Residual Schizophrenia :

- Schizophrenia in remission from active psychosis: absence of prominent delusions, hallucinations, disorganized speech or behavior.
- Presence of negative features or attenuated form of positive features (e.g. odd belief).

In ICD Hebephrenic Schizophrenia subtype is used (almost equivalent to disorganized type in DSM). It affects adolescents and young adults. Features include:

- Childish unpredictable behavior (e.g. silly smiles and giggle)
- Prominent affective changes (e.g. inappropriate, shallow affect)
- Delusions are common and not highly organized.
- Hallucinations also are common, and are not elaborate.

In the traditional sub-grouping of schizophrenia another subgroup is mentioned, Simple Schizophrenia, which is characterized by insidious onset of:

- Social withdrawal.
- Loss of drive and ambition.
- Deterioration of functioning.
- Odd behavior.

Simple schizophrenia is difficult to identify reliably because of absence of clear psychotic features (delusions, hallucinations...). It has the worst prognosis of all subtypes.

These subgroups, with the exception of paranoid subtype, are of uncertain validity in clinical practice. Some schizophrenic patients present symptoms of one group at one time, and then symptoms of another group later.

Recent studies on schizophrenia have provided several patterns of presentations and classification:

1. Type I vs. Type II

Type I	Type II
<ul style="list-style-type: none"> • Acute positive symptoms. • Good response to antipsychotics. • Brain structurally is normal. • Presumed dysfunction in dopamine system. 	<ul style="list-style-type: none"> • Chronic negative symptoms • Poor treatment response • Poor prognosis • Abnormal cerebral structures (ventriculomegaly, cortical atrophy).

2. Positive vs. Negative Symptoms

Positive Symptoms	Negative Symptoms
<ul style="list-style-type: none"> • Hallucinations • Delusions • Formal thought disorders (e.g. loose associations) • Bizarre behavior 	<ul style="list-style-type: none"> • Affective blunting • Alogia (poverty of thinking and speech) • Avolition & • Apathy • Anhedonia • Social isolation • Reduced attention

However, this dichotomy (positive - negative symptoms) is less influential now, since large symptoms overlap in many patients.

More recent studies advocate three patterns of symptoms.

Positive syndrome	Negative Syndrome	Disorganization Syndrome
<ul style="list-style-type: none"> • Also called ; “Reality Distortion syndrome” - Delusions - Hallucinations 	<ul style="list-style-type: none"> Also called ; “Psychomotor poverty syndrome” - Poverty of thoughts - Restricted affects - Lack of initiation 	<ul style="list-style-type: none"> - Formal thought disorders - Inappropriate affect - Disorganized behavior

□ EPIDEMIOLOGY:

Prevalence	- Worldwide life time prevalence is about 1 %.
Incidence	- Worldwide, 2 million new cases appear each year. Incidence is about 20 per 100,000 per year. The lifetime risk of developing schizophrenia is about 1%.
Age	- Most common between 15 - 35 years. Paranoid type: later onset than other types.
Sex	- Sex ratio is 1 : 1 Median age at onset: Males = 28 years, Females = 32 years.

□ ETIOLOGY:

No single etiological factor is considered causative. The model is most often used is that the person who develops schizophrenia has a specific biological vulnerability (or diathesis) that is triggered by stress and leads to emergence of schizophrenic symptoms.

1. Genetic:

- Single gene (serotonin receptor on chromosomes 5, D4 dopamine receptor gene on chromosome 11).
- Polygenic theory appears to be more consistent with heterogeneity of the presentation of schizophrenia.
- Consanguinity:
 - Incidence in families is higher than in general population.
 - Monozygotic twin concordance rate is greater than dizygotic concordance rate (50 % , 15 % respectively).
- Adoptive Studies:
 - Test for genetic versus environmental influence by examining rates of schizophrenia in adopted away offspring and of normal parents. (10 % from schizophrenic parents versus 0 % from normal parents).

Morbid Risk	Relationship to Schizophrenic
5 %	Parents
10 %	Sibling
14 %	Child of one schizophrenic parent
46 %	Child of two schizophrenic parents
Prevalence:	
10 - 12 %	First degree relative
5 - 6 %	Second degree relative

* From "Examination Notes in Psychiatry" (Buckley, Bird & Harrison)

2. Neurobiological:

A. Dopamine hypothesis : schizophrenic symptoms are in part a result of increased dopamine activity in mesolimbic & mesocortical pathways.

Evidences include:

1. Amphetamine increases central dopamine release and induces schizophrenia-like psychosis.
2. Antipsychotics block dopamine postsynaptic receptors to the extent that correlates with clinical potency.

B. Serotonin hypothesis:

Abnormal serotonin metabolism in some patients.

Evidence include:

1. LSD (serotonin agonist) induces psychosis.
2. Serotonin antagonist, such as clozapine, improves psychosis.

C. Disturbed balance between dopamine and serotonin as supported by the new generation of antipsychotics (dopamine-serotonin antagonists).

3. Neuropathology and Neuroimaging :

- CT scan studies:
 - Cortical atrophy in 10 - 35 %
 - Enlargement of the lateral and third ventricles in 10-50%.
 - Findings correlate more with negative features and with cognitive impairments.
- MRI and PET (Positron Emission Tomography):

- Abnormal frontal, parietal and temporal lobe structure and metabolism.

4. Slow Virus Infection:

- Increased frequency of perinatal complications and seasonality of birth data suggests an infectious hypothesis.

5. Psychosocial and Environmental:

A. Life Events:

Life stressors, particularly in the three months before onset, can induce schizophrenia in those who are vulnerable.

B. Family Psychodynamic (obsolete theories).

Precipitation of schizophrenia can be due to :

1. Schizophrenogenic mother.
2. Marital skew (submissive father and dominant mother).
3. Marital schism (contradicting parental messages).
4. Double-bind communication (a parent conveys two conflicting incompatible messages at the time, one is overt and the other is covert).

C. High Expressed Emotions (EE) of the family which include critical comments and emotional over-involvement.

Patients whose families have high expressed emotions have higher relapse rate than those whose families have low expressed emotions.

□ DIFFERENTIAL DIAGNOSIS OF SCHIZOPHRENIA :

1. Organic Mental Disorders:

- Complex partial seizure (e.g. temporal lobe epilepsy)
- CNS infections
- Substance intoxication (e.g. amphetamine, cocaine ...)
- Frontal lobe pathology (e.g. tumor, trauma ...)

2. Schizophreniform Disorder:

Similar features to those of schizophrenia but last for less than 6 months.

3. Brief Psychotic Disorder:

Similar features to those of schizophrenia but last for less than 1 month.

4. Mood Disorders:

- Manic episode or major depressive episode with psychosis. Note that: hallucination and delusions are mood – congruent and usually develop after the mood disturbance.
- The course of mood disorders is fluctuating: (repeated episodes of mood disturbance with normal periods in between).

5. Schizoaffective Disorder:

Concurrent presence of mood disturbance and schizophrenia features: (there must be delusions or hallucinations, for at least two weeks in the absence of prominent mood symptoms during some phase of the illness).

6. Delusional Disorders :

- Delusions are systematized and nonbizarre.
- No other features of schizophrenia
- Functioning is much less affected.

7. Personality Disorders :

- Schizotypal, paranoid, schizoid, and borderline personality disorders may confuse or co-occur with schizophrenia.

□ MANAGEMENT: Multidisciplinary/Bio-Psycho-Social approach.

□ Hospitalization is usually indicated in the acute phase in order to:

- Clarify diagnosis (rule out possible organic causes).
- Control the disturbed behavior.
- Protect the patient and / or others (risk of dangerousness or suicide)
- Give electroconvulsive therapy (ECT) for catatonic type, those with concomitant depression and in resistant cases.

□ Antipsychotic medications (see also Chapter 23)

Conventional antipsychotics are effective in alleviating the positive features (delusions, hallucinations, agitation...) they tend to be less effective in treating negative features.

- Choice of an antipsychotic depends on side-effect profile, previous response, and compliance.

- Minimum a six-week therapeutic trial warranted, before the drug is considered ineffective.
- If patient's compliance with oral treatment is poor, long-acting depot antipsychotic preparations are preferable.
- Resistant cases (around 25 %): augmentation with other drugs like lithium or carbamazepine may help some patients.
- Use anticholinergics (e.g. procyclidine 5 mg) if patient develops extrapyramidal side effects (e.g. acute dystonia).
- After 6 months in remission the drug can be withdrawn gradually for a trial period (if relapse occurs drugs are reinstated for at least 2 years).
- Some patients may require life long maintenance therapy to prevent relapse.

Atypical new antipsychotics (e.g., risperidone, olanzapine, quetiapine, clozapine) can help some resistant cases, and are effective in treating both negative and positive features.

□ **Psychosocial :**

- Family therapy, education, and explanation can significantly reduce relapse rate and high-EE family interaction can be diminished. Compliance may also be enhanced.
- Supportive therapy and counseling.
- Rehabilitation (Community - based process):
 - Social skill training (e.g. self-care).
 - Illness-management skills (e.g. when to take medication).
 - Vocational rehabilitation (for more stable cases).
- Token economy:
 - Useful for institutionalized chronic schizophrenics.
 - Positive and negative reinforcement are used to alter patient's unacceptable behavior.
 - It should be part of a behavioral program.

COURSE AND PROGNOSIS

- Patient may recover from the active psychotic phase but complete return to normal level of functioning is very unusual.
- The common course is one of acute exacerbations with increasing residual impairment between episodes.
- The longitudinal course is that of downhill nature (disintegration of personality and deterioration of mental abilities and psychosocial functioning).

□ Prognostic Factors:

Good Prognostic Factors	Bad Prognostic Factors
<ul style="list-style-type: none"> • Late onset • Acute onset • Obvious precipitating factors • Good premorbid personality • Presence of mood symptoms (especially depression) • Presence of positive symptoms • Good support (married, stable family) 	<ul style="list-style-type: none"> • Young age at onset • Insidious onset • No precipitating factors • Poor premorbid Personality • Low IQ • Many relapses • No remission in 3 years • Poor compliance • Negative symptoms • Poor support system • Family history of schizophrenia • High EE family

In general Third → Good prognosis
 Third → Poor prognosis
 Third → Intermediate prognosis

International Pilot Study on Schizophrenia (IPSS) undertaken by WHO in 1973, showed a more benign course in developing countries.

MISCONCEPTIONS:

- Schizophrenia means personality splitting.
- The cause is abnormal parenting.

Chapter 9

Mood Disorders

Mrs. A is 29 year-old housewife known case of psychiatric illness for 6 years. She was brought to Emergency Department with excessive activities, distractibility and decreased need for sleep for about 2 weeks..

MOOD (AFFECTIVE) DISORDERS

The mood disorders are so called because one of their essential features is abnormality of mood; abnormal feelings of depression or euphoria, with associated psychotic features in some severe cases. In mood disorders the sense of mood control is lost, and patient experiences considerable distress. Mood disorders are usually accompanied by disturbances in thinking, perception and / or behavior.

Although anxiety is a variant of normal mood, anxiety disorders are not considered as part of mood disorders in the modern classification.

Illnesses in which the prevailing mood is depression are much commoner than those presenting with elevation of mood, and people who suffer from episodes of mood elevation almost invariably suffer from depression as well at some stage of their illness.

Mood Disorders (DSM Classification)

- **Major depressive disorder:** characterized by one (single episode) or more (recurrent) major depressive episodes ; at least 2 weeks of low mood or loss of interest (lolo) accompanied by at least four additional symptoms from a list that includes death wishes, feelings of worthlessness, psychomotor retardation (or agitation), fatigue, insomnia (or hypersomnia) and significant weight loss. No features of schizophrenia, schizoaffective disorder, manic or mixed episode.
- **Dysthymic disorder:** At least two years history of chronic low mood with no remission periods more than two months and accompanied by additional depressive symptoms that do not meet criteria for major depressive episode.

- **Depressive disorder not otherwise specified.**
 - **Bipolar I disorder:** characterized by one or more manic or mixed episodes, usually accompanied by major depressive episodes.
 - **Bipolar II disorder:** characterized by one or more major depressive episodes accompanied by at least one hypomanic episode.
 - **Cyclothymic disorder:** characterized by at least 2 years of numerous periods of hypomanic symptoms that do not meet criteria for a manic episode, and numerous periods of depressive symptoms that do not meet criteria for a major depressive episode.
 - **Mood disorder due to general medical condition:** characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a general medical condition.
 - **Substance-induced mood disorder:** characterized by prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a drug of abuse, toxin exposure, or a medication.
-
- **Mood disorder not otherwise specified.**

MAJOR DEPRESSIVE DISORDERS

- Clinical features vary in nature and severity from patient to patient.
- The following list of features is not necessarily to be present in all patients.

A. Mood (Affective) Changes:

- Feeling low (more severe than ordinary sadness).
- Lack of enjoyment and inability to experience pleasure (anhedonia).
- Irritability.
- Frustration.
- Tension.

B. Appearance & Behavior:

- Neglected dress and grooming.
- Facial appearance of sadness:
 - turning downwards of corners of mouth.
 - down cast gaze.
 - tearful eyes.
 - reduced rate of blinking.
 - head is inclined forwards.
- Psychomotor retardation (in some patients agitation occurs):
 - lack of motivation and irritation.
 - slow movements.
 - slow interactions.
- Social isolation and withdrawal.
- Delay of tasks and decisions.

C. Biological Features (Neurovegetative Signs):

- Change in appetite (usually reduced but in some patients increased).
- Change in sleep (usually reduced but in some patients increased).
Early morning (terminal) insomnia; waking 2 - 3 hours before the usual time, this is usually associated with severe depression.
- Change in weight (usually reduce but may be increased).
- Fatigability, low energy level (simple task is an effort)
- Low libido and /or impotence.
- Change in bowel habit (usually constipation).
- Change in menstrual cycle (amenorrhea).
- Diurnal variation of mood (usually worse in the morning).
- Several immunological abnormalities(e.g. low lymphocytes) increasing the risk to infection.

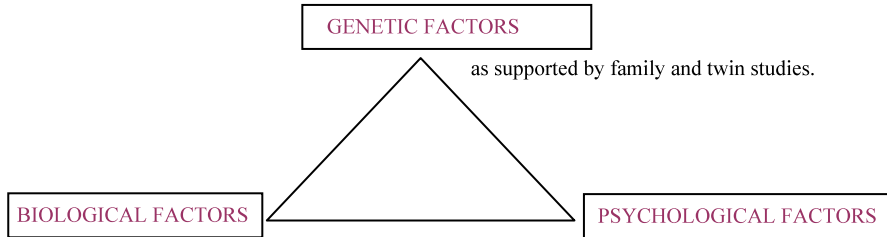
D. Cognitive Functions & Thinking:

- Subjective poor attention, concentration and memory. In elderly this may be mistaken as dementia (pseudo dementia)
- Pessimistic thoughts; depressive cognitions as suggested by Beck:
 - Present: patient sees the unhappy side of every event (discounts any success in life, no longer feels confident, sees himself as failure).
 - Past: unjustifiable guilt feeling and self-blame.
 - Future: gloomy preoccupations; hopelessness, helplessness, death wishes (may progress to suicidal ideation and attempt).
- **Psychotic Features Associated with Severe Depression**
 - A. Delusions (mood-congruent)
 1. Delusion of guilt (patient believes that he deserves severe punishment).
 2. Nihilistic delusion (patient believes that some part of his body ceased to exist or function, e.g. bowel, brain...).
 3. Delusion of poverty and impoverishment.
 4. Persecutory delusion (patient accepts the supposed persecution as something he deserves, in contrast to schizophrenic patient).
 - B. Hallucinations (mood-congruent)
 1. Usually second person auditory hallucinations (addressing derogatory repetitive phrases).
 2. Visual hallucinations (e.g. scenes of death and destruction) may be experienced by a few patients.
- Epidemiology of Major Depression**
 - It is more prevalent than bipolar mood disorder (more in women).
 - Lifetime risk is in the range of 10 - 15 %.
 - Lifetime prevalence is in the range of 15 - 25 %.
 - The mean age of onset is about 40 years (25 - 50 years).
 - It may occur in childhood or in the elderly.
 - In adolescents it may be precipitated by substance abuse.

- More common in those who lack confiding relationship (e.g. divorced, separated, single...).

□ **Etiology of Major Depression:**

The causative factors are multifactorial (interacting together)



Reduced levels of:

- Noradrenaline
- Serotonin
- Dopamine
- Stressful events
- Premorbid personality factors
- Cognitive distortions

□ **Differential Diagnosis of Major Depressive Disorder :**

- Depression secondary to medical diseases:
 - Thyroid dysfunction.
 - Diabetes mellitus.
 - Cushing's disease.
 - Parkinson's disease.
 - Stroke (anterior left hemisphere / posterior right hemisphere)
 - Carcinoma (especially of the pancreas and lung).
 - Multiple sclerosis.
- Depression secondary to medications:
 - Antihypertensives (e.g. beta-blockers, methyldopa, reserpine & Ca-channel blockers).
 - Steroids.
 - Bromocriptine & L - dopa.
 - Indomethacin.
 - Progestin-containing contraceptives (compared to estrogen-containing contraceptives which can reduce depression risk).

- Tamoxifen (estrogen-receptor antagonist used in breast cancer): it may induce depression that can be difficult to treat with antidepressants.
- Chemotherapy agents e.g. vincristine, Interferon (it may induce severe depression with suicidal ideas).
- Antipsychotics.
- Depression secondary to substance abuse.
- Psychiatric disorders:
 - Dysthymic disorder (chronic & less severe depression). However, both can occur together dysthymic disorder complicated by major depressive episodes (double depression).
 - Adjustment disorder with depressed mood.
 - Schizophrenia, schizoaffective disorder.
 - Somatization disorder
 - Anxiety disorder
- **Management of Major Depression:**
 - Hospitalization is indicated for:
 - Suicidal or homicidal patient.
 - Patient with severe psychomotor retardation who is not eating or drinking (for ECT).
 - Diagnostic purpose (observation, investigation...).
 - Drug resistant cases (possible ECT).
 - Severe depression with psychotic features (possible ECT).
 - Medications have proven to be very useful in the treatment of severe depression. They shorten the duration in most cases.
 - Antidepressants (see chapter 23)
 - . Tricyclics / Tetracyclics (**avoid in suicidal patient because of cardiotoxicity in overdose**)
 - . Selective Serotonin Reuptake Inhibitors (SSRIs) e.g. fluoxetine, paroxetine.
 - . Selective serotonin – Norepinephrine Reuptake Inhibitors (SNRIs) e.g. venlafaxine, duloxetine.
 - . Other new agents e.g. mirtazapine.

- Desirable therapeutic antidepressant effect requires a period of time, usually 3-5 weeks. Side effects may appear within the first few days.
 - After a first episode of a unipolar major depression, treatment should be continued for six months after clinical recovery, to reduce the rate of relapse.
 - If the patient has had two or more episodes, treatment should be prolonged for at least a year after clinical recovery to reduce the risk of relapse.
 - Lithium Carbonate can be used as prophylaxis in recurrent unipolar depression.
 - Electroconvulsive therapy (ECT):
 - The effect of ECT is best seen in severe depression especially with marked biological (neurovegetative), suicidal and psychotic features.
 - It is mainly the speed of action that distinguishes ECT from antidepressant drug treatment.
 - In pregnant depressed patient ECT is safer than antidepressants.
 - Psychosocial:
 - Supportive therapy.
 - Family therapy.
 - Cognitive-behavior therapy (for less severe cases or after improvement with medication). See chapter 24.
- **Prognosis of Unipolar Depressive Disorders**
- About 25 % of patients have a recurrence within a year.
 - Ten percent will eventually develop a manic episode.
 - A group of patients have chronic course with residual symptoms and significant social handicap.

DYSTHYMIC DISORDER

- Dysthymia (ill-humored) was introduced in 1980 and changed to dysthymic disorder in DSM-IV.
- It was also called “**depressive neurosis**” and “**neurotic depression**” compared to major depression (psychotic or endogenous depression)
- Dysthymic disorder is a chronic depressed mood that lasts most of the day and presents on most days.

□ Criteria:

- At least two years history of chronic low mood.
- No remission periods more than two months.
- During low mood there should be at least 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.

□ Differential Diagnosis:

This is essentially identical to that of major depression. However, two disorders require consideration:

1. Chronic Fatigue Syndrome / Neurasthenia
 - Disabling chronic fatigue of uncertain etiology associated with variable extent of somatic and / or psychological symptoms.
2. Recurrent Brief Depressive Disorder:

Brief (less than two weeks) periods during which depressive features are present with greater severity than that of dysthymic disorder. The course is episodic and recurrent.

□ **Treatment :**

The most effective treatment is the combination of pharmacotherapy and either cognitive or behavior therapy.

A. Pharmacological:

- Selective serotonin reuptake inhibitors (SSRI).
- Selective serotonin – Norepinephrine Reuptake Inhibitors(SNRIs) e.g. venlafaxine,duloxetine.
- **Or** Monoamine oxidase inhibitors (MAOI). Avoid combining with SSRI or tricyclic antidepressants.
- These groups may be more beneficial than tricyclic drugs in the treatment of dysthymic disorders.

B. Psychological:

- Supportive therapy.
- Cognitive therapy; to replace faulty negative self image, negative attitudes about the world and the future.
- Behavior therapy; to enable the patient to meet life challenges with a positive sense by altering personal behavior through implementing positive reinforcement.

□ **Course and Prognosis:**

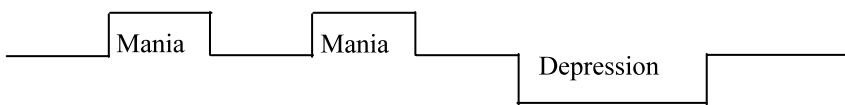
The onset is usually insidious before age 25; the course is chronic. Some patients may consider early onset dysthymic disorder as part of life. Patients often suffer for years before seeking psychiatric help.

About 25 percent never attain a complete recovery.

BIPOLAR MOOD DISORDERS

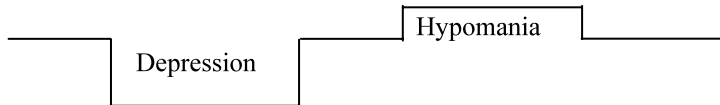
• **Bipolar I Disorders:**

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 Disorders :**

Patient has at least one major depressive episode and at least one hypomanic episode, but NO manic episode.



- **MANIA (manic episode)**

- **Features** (with varying degrees of severity)

- At least one week period of elevated (or irritable) mood.
 - elevated: cheerful, euphoric unduly optimistic.
 - irritable: tense, easily provoked into anger.
- Over- activity with excessive energy & incomplete tasks.
- Over- talkativeness with flight of ideas & pressure of thoughts.
- Expansive ideas (inflated self-esteem or grandiosity).
- Distractibility (reduced concentration).
- Excessive involvement in pleasurable acts (e.g. buying).
- Decreased need for sleep.
- Increased libido (may lead to sexual indiscretions).
- Delusions occur in severe cases (mood - congruent grandiose delusions).
- Poor judgment, aggression & disinhibition.

At times, delusions of persecutions, delusions of reference, passivity feeling and first rank symptoms may occur.

The delusions often change in content over days.

- * Hallucinations (mood-congruent) occur in severe cases. Voices talking to the patient about his special powers or, occasionally hallucinations of vision with religious content (e.g. seeing Angels).

- **Epidemiology:**

- Prevalence: 1 %.

- Incidence: 1.5 %.
- Lifetime expectancy: 1 %.
- Age: 30 years is the mean age (onset is most often in mid-20s).
- Sex: no gender differences.

□ Etiology:

1. Genetic:

One parent with bipolar I >25 % chance of mood disorder in child.

Two parents with bipolar I > more than 50 % chance of mood disorder in child.

Some studies found some defects in chromosomes 5,11 and X.

2. Neurochemical:

Increased biogenic amines (noradrenalin, dopamine and serotonin).

□ Differential Diagnosis :

1. Substance-induced mood disorder e.g. amphetamine intoxication.
2. Organic brain diseases involving the frontal lobes.
3. Schizophrenia (in acute phase, elevated mood and grandiosity may occur along with delusions and hallucinations but usually these are not mood-congruent).
4. Schizoaffective disorder (see later).

● HYPOMANIA:

- It is delineated from mania on grounds of severity which includes both symptomatic features and social incapacity.
- The episode is **not severe** enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization.
- There are no psychotic features.
- Otherwise the features are basically those of mania; elevated mood, grandiosity, overactivity ... etc.

- **MIXED & ALTERNATING AFFECTIVE STATES**
 - * In mixed affective state: manic and depressive symptoms occur simultaneously nearly every day for at least a one week period (e.g. overactive overtalkative patient may have at the same time profound depressive thoughts including suicidal ideas).
 - * In alternating affective states: 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).

- **RAPID-CYCLING BIPOLAR DISORDER**
 - * Alternating episodes (4 or more) of depression, mania or hypomania in the previous 12 months, separated by intervals of 48 - 72 hours.
 - * Usually more chronic than non-rapid cycling disorders.
 - * Around 80 % are lithium-treatment failures.
 - * Carbamazepine or sodium valproate are usual agents of choice.

- **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.
 - * Related to abnormal melatonin metabolism.
 - * Treated with exposure to light (artificial light for 2 – 6 hours a day).
 - * It may occur as part of bipolar I or II disorders.

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.
- The treatment is similar to that of bipolar mood disorder.

□ Treatment of Bipolar Mood Disorder

- **Acute mania or mixed episode:**

Manic behavior can be damaging for the patient and others (e.g. loss of career, financial disaster, sexual insult). Hospitalization can provide a secure, protective environment. The initial task is to quieten the agitation that commonly occurs. This is usually accomplished with antipsychotic medication. Chlorpromazine and haloperidol are widely used to treat mania. They reduce psychotic symptoms and over-activity. Thus they bring the acute symptoms of mania under control. Haloperidol is a potent antipsychotic, less sedative and causes less postural hypotension compared with chlorpromazine which is sometimes the drug of choice in mania for its sedative property.

Recently, serotonin-dopamine antagonists (e.g. olanzapine, risperidone, clozapine,) have been found effective in mania.

When the manic patient settles (within weeks) he can be treated as an outpatient with close observation and frequent assessment. Antipsychotics can be then reduced gradually and carefully.

- **Long-Term Treatment :**

Mood disorders often recur and have relapsing course, thus preventive (prophylactic) treatment is required. **Lithium** has been found to be effective in preventing recurrence of manic depressive episodes.

Carbamazepine appears to be as effective as lithium in the prophylaxis of bipolar mood disorder, and can be considered in patients who are intolerant of lithium or who respond poorly to lithium (e.g. rapid-cycling mood disorders). **Sodium valproate** has been found effective in patients with refractory bipolar illness, even when there has been a poor response to lithium and carbamazepine. Combination of lithium with carbamazepine can be used, particularly in rapid-cycling disorders, and combination

of lithium with sodium valproate has been shown to be effective in the treatment of resistant patients.

- Electroconvulsive therapy (ECT):
ECT is used when antipsychotics are ineffective. It has a therapeutic effect in both mania and depression.
- Psychosocial treatment:
 - * Education of the patient and the family about:
 - the nature of the illness and its course.
 - how to recognize early features of recurrence.
 - * Increase support and reduce stresses.
 - * Counselling (for occupational, marital, financial or academic difficulties).

Course and Prognosis

If left untreated, most manic episodes will resolve within 8-12 weeks (rarely last longer than 24 weeks). The risk of recurrence is particularly high (50 %). About 80 % of manic patients eventually experience a full depressive episode. About 50 % will have multiple relapses with good interepisodic functioning. Chronic deterioration may occur in up to 30 % of bipolar patients. The prognosis is much better than schizophrenia, but there is a wide variation; some people having their lives repeatedly disturbed, whilst others experience only a single episode. Some individuals have years of normal functioning between episodes. Others have episodes in clusters. Some patients have rapidly cycling episodes. As the disorder progresses, the time between episodes often decreases. After about five episodes, however, the interepisodic interval often stabilizes at 6 - 9 months. Patients with bipolar I disorder have a poorer prognosis than do patients with major depressive disorder.

Chapter 10

Other Psychotic Disorders

1. **Schizophreniform Disorder**
2. **Schizoaffective Disorder**
3. **Brief Psychotic Disorder**
4. **Delusional Disorders**
5. **Shared Psychotic Disorder**
6. **Delusion of Double**
7. **Psychotic Disorders due to general medical condition**
8. **Substance-induced Psychotic Disorder**

A 23 year-old college male student was brought to outpatient psychiatry clinic with 3 months history of hearing voices commenting on his actions, and disorganized behavior without disturbed mood then he returned normal with no medications

1. SCHIZOPHRENIFORM DISORDER

- Similar features to those of schizophrenia except that an episode of the disorder (including prodromal active and residual phases) lasts at least one month and resolves within six months, then normal functioning returns.
- Patients have more mood symptoms and a better prognosis than schizophrenia.
- Good prognostic features ;at least 2 of the following : confusion, perplexity, good premorbid personality, good occupational functioning, and absence of blunted affect.
- Treated with antipsychotic medications which should not be continued for more than six months after symptoms control.

2. SCHIZOAFFECTIVE DISORDER

- A psychotic disorder with concurrent features of both schizophrenia and a mood disorder that cannot be diagnosed as either one separately.
- There should be delusions or hallucinations for at least two weeks in the absence of prominent mood symptoms. Schizoaffective disorder can be either depressive type or bipolar type.
- It occurs equally in males and females.
- Lifetime prevalence is about 1 %.
- Course and prognosis is between that of schizophrenia and of bipolar mood disorder.
- Treatment includes antipsychotics, mood stabilizers (lithium is a good choice) and antidepressants when needed.

3. BRIEF PSYCHOTIC DISORDER

- Psychotic features (delusions, hallucinations, disorganized speech...) last for less than one month (at least one day) with eventual full return to premorbid level of functioning.
- It must not be due to substance abuse or any medical or other mental diseases.
- Psychotic features are usually associated with an increase in mood lability, volatility, disorientation and affective symptoms.
- More highly associated with persons who have preexisting disturbed personality (borderline, paranoid, schizotypal, schizoid, ...).
- Brief psychotic disorder is classified into:
 - with marked stressor (brief reactive psychosis)
 - without marked stressor.
 - with postpartum onset(onset within 4 weeks postpartum).
- If symptoms occur shortly after, and apparently in response to, an obvious stress, it is called “ Brief Reactive Psychosis” which carries better prognosis.
- **Treatment:**
 - . Short-term antipsychotic and hospitalization.
 - . Psychological support and enhancement of coping mechanism for future stresses.

4. DELUSIONAL DISORDERS

- Psychotic disorders characterized by presence of one (or more) non-bizarre delusions that persist for at least one month.
- No other psychotic features prominent enough to diagnose schizophrenia, schizoaffective, mood or any other psychotic disorders.
- Auditory or visual hallucinations are uncommon and if present are not prominent. Tactile and olfactory hallucinations may be present in “Delusional Disorder” if they are related to the delusional theme.
- Functioning is usually not markedly affected.

- Behavior is not obviously odd (the patient may be judged to be without evidence of mental illness).
- The personality remains intact, but may deteriorate minimally.

TYPES:

1. **Grandiose type** : inflated self identity and / or ability.
 2. **Persecutory type**: the patient believes he is being conspired against, cheated, spied on, followed, maliciously maligned.
 3. **Jealous type** : delusion that the sexual partner is unfaithful, also called Othello Syndrome.
 4. **Erotomaniac type** :delusion that another person, usually of higher status is in love with individual, also called De Clerambault's Syndrome.
 5. **Somatic type** :delusion that the person has some physical defect or general medical condition. The most common somatic delusions are :
 - . *Monosymptomatic hypochondriacal delusion* e.g. skin infestation by insects, internal parasitosis, conviction of ugliness or emission of foul smell.
 - . *Nihilistic delusion (Cotard's Syndrome)*: delusion of nonexistence of part of the body, belongings, self, others or the world. It is usually seen in some patients suffering from major depressive disorder with psychotic features.
 6. **Mixed type** (more than one of the above-mentioned delusional disorders).
 7. **Unspecified type**.
- **Differential Diagnosis of Delusional Disorders:**
 1. Substance-induced psychosis with delusions e.g. sympathomimetics
 2. Organic mental disorders with delusions e.g. brain tumor.
 3. Schizophrenia-paranoid type.
 4. Paranoid personality disorder.
 5. Mood disorders.

- **Treatment :**
 - Antipsychotics: Choose a drug with less side effect e.g. sulpiride (the patient is more likely to react to adverse effect with delusional ideas). Increase the dose slowly. Long acting (depot) injections may be required because of poor compliance with oral treatment.
 - Hospitalization is required if the patient constitutes a danger to himself (suicidal) or others (homicidal...) and for a thorough organic work up.
 - Antidepressants may be required in cases associated with severe depression.
- **Course and Prognosis :**
 - Usually chronic and unremitting in about half of the cases.
 - Response to antipsychotics is less satisfactory than patients with delusional symptoms associated with schizophrenia or mood disorders.

5. SHARED PSYCHOTIC DISORDER

- Also called: “Induced Paranoid Disorder” / “Induced Psychosis” (folie a deux).
- It is a paranoid delusional system that develops in a healthy person who is in a close relationship with another person (usually a relative) who has an established similar delusional system.
- The person with the delusion is usually dominant in the relationship, while the other person (who develops the induced psychosis) is dependent and suggestible.
- Generally the two lived together for a long time in close intimacy, often cut-off from the outside world. More common in women and in persons with the physical disabilities that make them dependent on another person.
- **Treatment :**
 - Separation until the more submissive person develops other means of support to compensate for the loss of the relationship.
 - Antipsychotics are helpful.

6. DELUSION OF DOUBLES

- Also called: Capgra's Syndrome.
- Delusion that a person known to the patient has been replaced by an exact double (imitating the patient or impostors imitating someone else).
- Usually the person implicated is a closed relative particularly spouse.
- It is not part of disorientation of persons (feature of organic confusion) but a repeated misidentification of a specific person or people.
- May be part of functional psychotic disorders (schizophrenia, mood disorders...) or frontal lobe dysfunction.
- Possible etiology: ambivalent attitude to the person implicated.
- **Treatment :**
 - Treat underlying psychotic disorder with antipsychotics.
 - Support the involved relative.

7. PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION

Impaired reality testing and insight with prominent delusions or hallucinations due to a physical disease without disturbed consciousness (i.e. not due to delirium) e.g. psychosis due to SLE , brain tumor.

8. SUBSTANCE-INDUCED PSYCHOTIC DISORDER

Impaired reality testing and insight with prominent delusions or hallucinations due to substance abuse (intoxication or withdrawal)

TEST 1

Single Best Answers

1. While interviewing a 28 year-old lady, the psychiatrist asked a patient “*what would you do if you smelled smoke in the kitchen*”. The doctor is testing the patient’s:
 - a. Insight.
 - b. Judgment.
 - c. Tendency to worry.
 - d. Abstract thinking.
 - e. Thinking process.

2. A 22 year-old male said: “those people on the TV are able to make me do what they want”. The most likely thought psychopathology in this case is:
 - a. Nihilistic delusion.
 - b. Delusion of reference.
 - c. Delusion of thought withdrawal.
 - d. Delusion of influence.
 - e. Derealization.

3. While evaluating a 24 year-old lady she indicated that she feels as if detached from the environment:
 - a. She has pseudo hallucinations.
 - b. She has derealization.
 - c. She has illusions.
 - d. She is psychotic.
 - e. She has hallucinations.

4. A 45 year-old man seen at psychiatry clinic because of disorientation, ataxia and poor memory. He asked for a referral to a specialist in eye diseases.
 - a. The digital span test is normal in this condition.
 - b. He has acute dystonia.
 - c. Dementia is the most likely diagnosis.
 - d. He is suffering from Korsakoff’s psychosis.
 - e. Complex partial seizure is the most likely diagnosis.

5. A 33 year old single man was arrested by policemen and put in prison because he was driving his car recklessly in high speed at

- 3am in the highway. Next day he started to have excessive diarrhea, repeated vomiting, and multiple pains all over his body. However, his consciousness was intact.
- a. If not taken to hospital he may die soon.
 - b. Presence of craving will help in the diagnosis.
 - c. He is malingering.
 - d. The most likely substance he was abusing is cannabis.
 - e. This is a case of stimulants abuse.
6. A 23 year-old single female has nine-month history of self-neglect, flat affect, social isolation and inappropriate smiles. The following is the most appropriate statement:
- a. She has a neurotic illness.
 - b. An atypical antipsychotic drug is indicated.
 - c. The most likely diagnosis is brief reactive psychosis.
 - d. She is likely to be a case of schizophreniform disorder.
 - e. She has features suggestive of delusional disorder.
7. A 64 year-old man came complaining of 6 week- history of poor concentration, weight loss, poor sleep and loss of pleasure. There was no obvious stress in his life. His past history revealed similar features occurred three years ago then disappeared after two months:
- a. The most likely diagnosis is dementia.
 - b. Adjustment disorder is the most likely diagnosis.
 - c. He has dysthymic disorder.
 - d. He should be hospitalized.
 - e. Assess his suicidal risk.
8. A psychiatrist asked a patient about patient's reaction to usual life stresses. The psychiatrist was assessing the patient's :
- a. Cognitive functions
 - b. Personal history
 - c. Thinking process
 - d. Personality traits
 - e. History of present illness.

9. A 50 year-old diabetic and hypertensive male was referred to outpatient psychiatry clinic for evaluation of his poor sleep and reduced interest.
- He seems suffering from pseudo- dementia.
 - Give him imipramine 150mg twice/day.
 - Review his antihypertensive medications.
 - He should be admitted into a psychiatric ward.
 - Phenelzine is a suitable drug.
10. A 34 year-old female seen at the outpatient clinic appeared conscious and awake but unable to talk, unresponsive to stimuli, and immobile.
- She has stroke.
 - She has akathisia.
 - This condition is called dyskinesia.
 - She has stupor.
 - She has dystonia.
11. A 42 year-old mother of 8 children has bronchial asthma and hyperthyroidism. Her parents separated since her childhood. She has several week- history of non-specific psychological disturbances and she is worried about the cause of her problem as she was told by her aunt that most likely she is suffering from an evil eye .The following is true :
- Separation of her parents is the precipitating factor.
 - Give her risperidone.
 - Hyperthyroidism is less likely to precipitate panic disorder.
 - Review her medication and their side effects.
 - Convince her that *evil eye* is not the cause of her problem.
12. A 21 year- old man was involved in road traffic accident lost consciousness for 5 days, remained 3 weeks in the hospital. After discharge, his parents noticed that he became impulsive and aggressive at times.
- He has delirium.
 - The most likely diagnosis is amphetamine abuse.

- c. Anticonvulsants can be given to control his impulsive behavior.
 - d. He requires higher doses of benzodiazepines.
 - e. Retrograde amnesia is a good predictor of outcome.
13. A 48 year-old man has chronic insomnia, repeated nausea, sexual dysfunction, social isolation, episodic tremor and anemia:
- a. He has amnesic syndrome.
 - b. He has agoraphobia.
 - c. This presentation is suggestive of alcohol abuse.
 - d. Cocaine abuse is the most likely diagnosis.
 - e. He has social phobia.
14. A 23 year-old college male student was brought to outpatient psychiatry clinic with 3 months history of persecutory delusion , hearing voices commenting on his actions, and disorganized behavior without disturbed mood then he returned normal with no medications. The most likely diagnosis is:
- a. Schizophreniform disorder.
 - b. Schizoaffective disorder.
 - c. Brief psychotic disorder.
 - d. Schizophrenia.
 - e. Delusional disorder.
15. A 55 year-old man was admitted to the psychiatry inpatient service because of depression and suicidal ideation. The following Mental State Examination finding is unusual in such a patient:
- a. Somatic delusions
 - b. Crying.
 - c. Disorientation to time, place and person..
 - d. Agitation.
 - e. Obsessive thinking.
16. A 32 year-old married lady has 5-year continuous history of low mood, fatigue, low self-esteem and disturbed sleep. The most likely diagnosis is:
- a. Bipolar mood disorder.

- b. Adjustment disorder with depressed mood.
 - c. Hyperthyroidism.
 - d. Dysthymic disorder.
 - e. Major depressive episode.
17. A 24 year-old housewife noticed by her husband over the last two weeks to have excessive laughter, pressure of speech, tense mood, and decreased need for sleep. The following is true:
- a. She has rapid cycling disorder.
 - b. Antipsychotics are recommended.
 - c. Hospitalization is not indicated.
 - d. Give her lithium and outpatient appointment.
 - e. SSRIs are indicated.
18. A 30 year-old single male admitted into the medical ward to investigate him for painful legs and abdominal cramps of 2 days duration. He was crying loudly asking for pethidine.
- a. Give him heroin.
 - b. The presentation is suggestive of alcohol withdrawal.
 - c. He is in a state of heroin intoxication.
 - d. Test for HIV is worth doing.
 - e. Give him olanzapine.
19. A 77-year-old lady was referred to the outpatient psychiatry clinic with several month- history of poor sleep, poor judgment, becoming tough, rigid and verbally abusive.
- a. The most likely diagnosis is delirium.
 - b. Psuedodementia should be excluded.
 - c. She has schizophrenia.
 - d. Nitrazepam is a suitable drug.
 - e. Behavior therapy has a major role in the treatment.
20. A 29 year-old psychiatric patient has sudden cessation of thought flow with complete emptying of the mind not caused by external influence. This condition
- a. indicates a psychotic illness.
 - b. is called thought perseveration.
 - c. is called loosening of association.

- d. is due to obsessive thoughts.
- e. indicates abnormal thought content.

Answers

Question Number	Answer
1	B
2	D
3	B
4	A
5	B
6	B
7	E
8	D
9	C
10	D
11	D
12	C
13	C
14	A
15	C
16	D
17	B
18	D
19	B
20	A

Chapter 11

Anxiety and Phobias

A 32 year-old woman was referred to psychiatry outpatient clinic through cardiology clinic with several month history of recurrent episodic bouts of palpitation, sweating, nausea, dizziness and fear of death.

Anxiety is a normal human feeling of apprehension in certain threatening situations. Mild degree of anxiety is unavoidable and is not considered abnormal. Table 11–1 shows the main differences between normal and abnormal anxiety.

Table 11-1

NORMAL ANXIETY	ABNORMAL ANXIETY
<ul style="list-style-type: none"> • Proportional apprehension to the external stimulus. • Features of anxiety are few. • Anxiety is not severe and not prolonged. • Attention is focused on the external threat rather than on the person's feelings. 	<ul style="list-style-type: none"> • Apprehension is out of proportion to the external stimulus. • Features are multiple. • Anxiety is prolonged or severe or both. • Attention is focused also on the person's response to the threat (e.g. palpitation).

Anxiety can be:

- **Trait anxiety:** part of personality character in which a person has a habitual tendency to be anxious in a wide range of different circumstances (longitudinal view).
- **State anxiety:** in which anxiety is experienced as a response to external stimuli (cross – sectional view).

Anxiety disorders are abnormal states in which the most striking features are worry, dread and physical symptoms of anxiety (see table 11 – 2) that indicate a hyperactive autonomic nervous system and are not caused by an organic brain disease, medical illness nor psychiatric disorder.

Table 11-2. Features of Anxiety

Psychological	Physical
<ul style="list-style-type: none"> • excessive apprehension • fearful anticipation • feeling of dread • worrying thoughts • hypervigilance • feeling of restlessness/irritability • sensitivity to noise • difficulty concentrating • subjective report of memory deficit • sleep: insomnia / bad dreams 	<ul style="list-style-type: none"> • chest : <ul style="list-style-type: none"> - chest discomfort - difficulty in inhalation • cardiovascular : <ul style="list-style-type: none"> -palpitation - awareness of missed beats -cold extremities • neurological : <ul style="list-style-type: none"> -headache - dizziness -tinnitus - numbness -tremor - blurred vision • gastrointestinal : <ul style="list-style-type: none"> -disturbed appetite -dysphagia - epigastric discomfort -nausea - vomiting -disturbed bowel habits • genitourinary : <ul style="list-style-type: none"> - Increased urine frequency and urgency -Low libido / erectile dysfunction -Impotence -dysmenorrhea • musculoskeletal : <ul style="list-style-type: none"> - muscle tension / joint pain - easily fatigued • skin : <ul style="list-style-type: none"> - sweating - itching - hot /cold skin.

Anxiety disorders include:

1. Generalized Anxiety Disorder (GAD).
2. Panic Disorder.
3. Phobic Disorders (agoraphobia – social phobia – specific phobia).
4. Obsessive Compulsive Disorder (OCD) see chapter 12.
5. Acute and post traumatic stress disorders see chapter 13.

GENERALIZED ANXIETY DISORDER (GAD)

Diagnostic criteria :

- Excessive worry about number of events and circumstances for at least 6 months duration.
- The person finds it difficult to control the worry.
- Worry is accompanied by other features of anxiety: physical and psychological.
- Features cause clinically significant distress or functional impairment (social, occupational...).
- Sleep is often intermittent and accompanied by unpleasant dreams or night terrors. Patient may wake unrefreshed, or may have difficulty in falling asleep. If early morning waking is present, it should suggest the possibility of major depression which may be associated with anxiety symptoms.
- Not due to medical disease , substance abuse or axis I psychiatric disorder.

Mental State Examination (MSE):

- Strained face with furrowed brow and frequent blinking.
- Tense posture, tremulous and restless.
- Sweating (forehead, hands, feet).
- Difficulty in inhalation.

Symptoms that may be associated with generalized anxiety disorder:

- Panic attacks (see later).
- Mild depressive symptoms.
- Hypochondrical thoughts (see later).
- Depersonalization and derealization.

Epidemiology:

- One year prevalence rate: 3 %.
- Life time prevalence rate: 5 %.
- Women > men.

- Often begins in early adult life, but may occur for the first time in middle age.
- There is a considerable cultural variation in the expression of anxiety.
- Frequent in primary care and other medical specialties.

Etiology:

Generalized anxiety disorder appears to be caused by stressors acting on a personality predisposed by a combination of genetic and environmental influences in childhood. Maladaptive patterns of thinking may act as maintaining factors. Anxiety as a trait has a familial association.

Differential Diagnosis:

1. Anxiety disorder due to medical conditions /medications :
 - Hyperthyroidism / thyroxin supply in patients with hypothyroidism.
 - Anemia .
 - Beta agonists / steroids given to patients with bronchial asthma/hypoxemia.
 - Hypoglycemia.
 - Hypocalcaemia.
 - Pheochromocytoma.
 - Paroxysmal tachycardia.
2. Depressive Disorder:
 - When anxiety and depressive symptoms coexist, the diagnostic criteria may be met for both depressive disorder and generalized anxiety disorder. Anxiety is a common symptom in depressive disorder. It is conventional to make the diagnosis on the basis of the *severity* of symptoms and by the *order* in which they appeared. Ask any anxious patient routinely about symptoms of depression including depressive thinking, and when appropriate, suicidal ideation.

3. Substance-Induced Anxiety Disorder:
 - Intoxication with CNS stimulants (e.g. amphetamine).
 - Withdrawal from CNS depressants (e.g. alcohol).
4. Panic Disorder (see later).
5. Adjustment Disorders (see later).
6. Psychotic Disorders (e.g. mania).

Course and Prognosis:

- The course is often chronic, fluctuating and worsen during times of stress. Symptoms may diminish as patient gets older. Over time, patient may develop secondary depression (not uncommon if left untreated). When patient complains mainly of physical symptoms of anxiety and attributes these symptoms to physical causes, he generally seems more difficult to help. Poorer prognosis is associated with severe symptoms and with derealization, syncopal episodes, agitation and hysterical features.

Management:

- Ruling out possible organic causes e.g. anemia, hyperthyroidism.
- Reassurance that symptoms are not due to a serious physical disease.
- Explanation of the nature of the illness (overarousal of the autonomic nervous system accompanied by many physical and psychological features).
- Assisting the patient to deal with, or adjust to, any ongoing problem.
- Reduction of caffeine intake (coffee, tea, cola ...)
- Cognitive – behavior therapy:
 - Relaxation training.
 - Anxiety management training :
relaxation with cognitive therapy to control worrying thoughts, through identifying and changing the automatic faulty thoughts. (See chapter 24)

- **Drug Treatment:**

- *Benzodiazepines* (e.g. lorazepam 1mg twice / day) for rapid anxiolytic effect . They are usually given for a short period of time (2 -4 weeks to avoid the risk of dependence).Monitor and taper down the dose over 1-2 weeks. They can have a mild disinhibiting action.
- *Buspirone*: as effective as benzodiazepines and is much less likely to cause dependence. .It is more effective in reducing the cognitive symptoms of GAD than in reducing the somatic symptoms. Its effect takes about 3 weeks to become evident. No cross-tolerance with benzodiazepines thus, it is not an effective treatment for benzodiazepine withdrawal.
- *Antidepressants* (selective serotonin reuptake inhibitors , tricyclics or venlafaxine) can be used to treat anxiety. No risk of dependence. They act more slowly than benzodiazepines but with equivalent effect. It is reasonable to begin treatment with a benzodiazepine (e.g. alprazolam) and one of the SSRIs (e.g. paroxetine) and then to taper benzodiazepine use after 2 to 4 weeks.
- *Beta-adrenergic antagonists* can be used to treat some physical features of anxiety (palpitation, tremor ...) but not the underlying psychogenic condition.

MIXED ANXIETY AND DEPRESSIVE DISORDER

- Anxiety and depressive features are both present but neither set of features, considered separately, is severe enough to make a diagnosis of depressive disorder or anxiety disorder as a primary diagnosis.
- Seen commonly in clinical practice.

- Features of anxiety and depression may arise together because :
 - many stressful events combine elements of loss (associated with depression) and danger (associated with anxiety).
 - the antecedent causes may be similar.

Management: As in generalized anxiety disorder

PANIC DISORDER

Diagnostic criteria:

- Recurrent sudden unexpected panic attacks .
- At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - 1- persistent concern about having additional attacks.
 - 2- worry about the implications/consequences of the attacks(e.g. going mad or death)
 - 3- a significant change in behavior related to the attacks.
- Not due to medical disease , substance abuse or axis I psychiatric disorder.

Panic Attack:

A discrete period of sudden onset of intense fear or discomfort that builds up to a peak rapidly (usually in 5-15 minutes) and is often accompanied by a sense of imminent danger or impending doom and an urge to escape.

There are some somatic and cognitive symptoms that accompany fear. These include:

- Palpitation • Sensations of shortness of breath
- Feeling of choking • Chest pain
- Nausea/abdominal distress.
- Shaking • Tremor • Chills or hot flushes
 - Sweating
- Paraesthesia.
- Feeling dizzy, unsteady or faint.
- Fear of going mad, dying or losing control.
- Derealization (feelings of unreality) or depersonalization (being detached from one self)

Panic attacks (as attacks, not as a disorder) can occur in a variety of psychiatric disorders other than panic disorder:

- Generalized anxiety disorder
- Phobias
- Stress disorders (acute & post traumatic)
- Substance abuse
- Depressive disorders
- Obsessive Compulsive Disorder (OCD)

Mitral Valve Prolapse (MVP) is more common in patients with panic disorder (40-50 %) than in general population (6 – 20 %). Whether this association has a causal relationship, it is not clear.

In determining the *differential diagnostic significance* of a panic attack, it is important to consider the *context* in which the panic attack occurs. Panic attacks can be :

1. Unexpected panic attacks:

- Sudden spontaneous attacks not associated with a situational trigger .
- *Essential for the diagnosis of panic disorder.*

2. Situationally bound panic attacks:

- Occur on exposure to, or in anticipation of the situational trigger , seen in phobias.

3. Situationally predisposed panic attacks:

- More likely to occur on exposure to (but are not invariably associated with) the situational trigger e.g. attacks are more likely to occur while driving.

Epidemiology:

- Women > men
- Lifetime prevalence is 1 – 3 % (throughout the world).
- One-year prevalence rates 1 – 2 %.
- Age at onset: bimodal distribution, with one peak in late adolescence and a second smaller peak in the mid 30s.

Etiology:

- Genetic basis (panic disorder occurs more often among relatives).
- The biochemical hypothesis (panic attacks can be induced by chemical agents like sodium lactate, and can be reduced by drugs like imipramine).
- Panic disorder develops in a person with poorly regulated autonomic responses to stressors when he becomes afraid of the consequences of symptoms of autonomic arousal.
- The neurotransmitters involved are noradrenalin and serotonin.
- Locus Ceruleus is essential for anxiety expression (alarm system in the body). Pathological hyperactivity occurs in Locus Ceruleus.

Course and Prognosis:

- The usual course is chronic but waxing and waning.
- Some patients recover within weeks.
- Others have a prolonged course (those with symptoms persisting for 6 months or more).
- With therapy prognosis is excellent in most of the cases.

Treatment:

- Attention to any precipitating or aggravating personal or social problems.
- Explanation, support and reassurance.
- Cognitive therapy: eliciting and correcting the patient's wrong assumptions and beliefs about the origin, meaning, and consequence of symptoms.
- **Drugs:**

Choose one of selective serotonin reuptake inhibitors. All are effective for panic disorder although the most widely used is paroxetine. Clomipramine or imipramine (tricyclic antidepressants) can be a good alternative. For rapid onset of action add a benzodiazepine (usually alprazolam or lorazepam) for 2-4 weeks then

taper it down slowly. SSRI (or clomipramine/imipramine) is generally continued for 6-12 months. When treatment is discontinued relapse rate is high (30-90%) even when the condition has been successfully treated. This emphasizes the role of combining psychotherapy with medications.

HYPERVENTILATION SYNDROME (HVS)

Hyperventilation syndrome is included in this section because it may be mistaken for panic disorder. It can be considered as a psychosomatic complication of certain anxiety situations. It is a manifestation of anxiety with panic attacks characterized by recurrent episodes of hyperventilation (rapid, usually shallow breathing) associated with a variety of physical sensations:

- Pericardial pain / Palpitation.
- Headache /dizziness /vertigo /paraesthesia.
- Nausea / gastrointestinal discomfort.
- Carpopedal spasm and tetany may develop.

These symptoms increase the patient's fear and support the patient's conviction that he is in imminent danger. In some cases the respiratory rate is not increased but the patient has repeated habitual sighing which may induce hyperventilation syndrome.

Pathophysiology:

Under certain stressful settings autonomic arousal occurs as an immediate response to acute fear. Hyperventilation leads to hypocapnia and respiratory alkalosis due to loss of carbon dioxide, which brings into play a number of buffer reactions to maintain the PH in the blood. The reactions result in a fall in serum ionized calcium levels and reflex vasoconstriction that affects the CNS, skin, respiratory, gut and other systems.

Differential Diagnosis:

1. Bronchial asthma (difficulty in exhaling).
In hyperventilation syndrome, patient has a sensation of being unable to fill his lungs (difficulty in inhalation).
2. Cardiopulmonary disease (e.g. pulmonary embolism).

3. Metabolic disorder (e.g. diabetic ketosis).
4. Salicylate overdosed (metabolic acidosis).

Management:

- Rule out possible organic causes.
- Reassurance .
- Breathing bag (rebreath carbon dioxide) for few minutes. Avoid giving oxygen.
- Small doses of benzodiazepine (e.g. diazepam 5 – 10 mg IV) to reduce apprehension and fear.
- Treat any underlying psychological problems.

PHOBIC DISORDERS

Phobic disorders are characterized by:

- intense *irrational fear* of certain objects or situations.
- fear is *beyond voluntary control*.
- *avoidance of the feared object*(or endurance with distress).
- *impairment* of functioning.
- a disturbance is *not due to* a medical condition, substance abuse or a mental disorder.

AGORAPHOBIA

Literally it means fear of market place and open spaces(Greek).However, the term may be misleading. Fear in agoraphobic patients is about being in crowded places from which escape seems difficult or help may not be available in case of sudden incapacitation (places cannot be left suddenly without attracting attention e.g. a place in the middle of a row in mosque). Fear is usually revolving around *self safety issues* rather than *personal performance* in the presence of others (which is the case in social phobia).

Common feared and avoided situations:

- Overcrowding: a social situation (mass of people), shops

and markets.

- Distance from home: travelling away.
- Confinement: closed spaces, e.g. elevators (claustrophobia) bridges, tunnels ,public transport.

Features:

- Anxiety about fainting and / or loss of control when patient is away from home, in crowds, or in situations that he cannot leave easily.
- Anxiety symptoms identical to those of any other anxiety state (see physical and psychological features of anxiety Table 11-2).
- Anticipatory anxiety (it can be associated with panic attacks).
- Features of other disorders :
 - Panic disorder (in > 60 % of cases) .
 - Social phobia (in around 55% of cases)
 - Depressive symptoms (> 30 % of cases).
 - OCD / GAD.
- As the condition progresses, patients with agoraphobia may become increasingly dependent on some of their relatives or spouse for help with activities that provoke anxiety such as shopping.

Epidemiology:

- Women : men = 2 : 1
- Onset: most cases begin in the early or middle twenties, though there is a further period of high onset in the middle thirties.
 - Both of these ages are later than the average onset of specific phobia (childhood) and social phobias (late teenagers or early twenties).
- Prevalence :
 - one year prevalence:
 - Men : about 2 %.
 - Women : about 4 %.
 - Life time prevalence: 6 – 10 %.

Etiology:

- Personality: anxious, dependent (overprotected in childhood, separation anxiety...)
- Biological predisposition to respond with excessive anxiety (possibly because defective normal inhibitory mechanisms).
- Conditioning: avoidance learning.
- Often precipitated by major life events.
- Psychodynamic factors: repression, displacement and symbolization.

Treatment:

- Cognitive-Behavior Therapy:
 - detailed inquiry about the situations that provoke anxiety, associated thoughts, and how much these situations are avoided.
 - hierarchy is drawn up (from the least – to the most anxiety provoking).
 - the patient is then taught to relax (relaxation training).
 - exposure : the patient is persuaded to enter the feared situation (to confront situations that he generally avoids).
 - negative cognitive assumptions are challenged (see cognitive therapy later).
 - the patient should cope with anxiety experienced during exposure and try to stay in the situation until anxiety has declined.
 - when one stage is accomplished the patient moves to the next stage.
 - the patient is trained to overcome avoidance (as escape during exposure will reinforce the phobic behavior).
- **Drugs:** as for panic disorder.

Prognosis:

- If not treated early, agoraphobia can be chronic disabling disorder complicated by depressive symptoms.
- Younger age at onset is associated with *better* prognosis and vice versa.

- *House-bound housewife syndrome* may develop. It is a severe stage of agoraphobia when the patient cannot leave the house at all.

Agoraphobia and Panic Disorder

- In DSM panic disorder takes precedence and the following categories have been considered :
 - Panic Disorder with Agoraphobia.
 - Panic Disorder without Agoraphobia.
 - Agoraphobia without history of Panic attacks.
- In ICD categories include :
 - Agoraphobia with panic disorder.
 - Agoraphobia without panic disorder.
 - Panic disorders (moderate – severe).

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.

Examples: speaking in public(meetings, parties, lectures) - serving coffee or tea to guests- leading prayers.

The problem leads to significant interference with functioning (social, occupational, academic...). The person has anticipatory anxiety.

Social phobia can be either:

- a- specific to certain situations (e.g. speaking to authority) or
- b- generalized social anxiety.

Features:

- The symptoms are the same as those of generalized anxiety disorder.

- Common complaints: palpitation, trembling, sweating, and blushing.
- The response may take a form of panic attack (situationally bound or situationally predisposed).
- Negative thoughts about performance (others will judge them to be anxious, weak, stupid, inarticulate, embarrassed...).
- Avoidance of the situation or endurance with distress.

Associated Features:

- Hypersensitivity to criticism and negative evaluation or rejection (avoidant personality traits).
- Other phobias.

Complications:

- Secondary depression.
- Alcohol or stimulant abuse to relieve anxiety and enhance performance.
- Deterioration in functioning (underachievement in school, at work, and in social life e.g. delayed marriage).

Epidemiology:

- Age: late teenage or early twenties. It may occur in children.
- Lifetime prevalence : 3 – 13 %.
- In the general population, most individuals fear public speaking and less than half fear speaking to strangers or meeting new people.
- Only 8 – 10 % are seen by psychiatrists.
- Local studies in Saudi Arabia suggested that social phobia is a notably common disorder among Saudis, (composes 80 % of phobic disorders).
- Social and cultural differences have some effect on social phobia in terms of age at treatment, duration of illness and some social situations.

Etiology:

- Genetic factors: some twins studies found genetic basis for social phobia.
- Social factors: excessive demands for social conformity and concerns about impression a person is making on others, (high cultural superego increases shame feeling), some Arab cultures are judgmental and impressionistic.
- Behavioral factors: sudden episode of anxiety in a social situation followed by avoidance, reinforces phobic behavior.
- Cognitive factors: exaggerated fear of negative evaluation based on thinking that other people will be critical, and one should be ideal person.

Differential Diagnosis:

- Other phobias. However, multiple phobias can occur together.
- Generalized anxiety disorder.
- Panic disorder.
- Depressive disorder primary or secondary to social phobia.
- Patients with persecutory delusions avoid certain social situations.
- Avoidant personality disorder may coexist with social phobia.

Treatment:

A. Psychological:

1. Cognitive-Behavior Therapy:
 - Exposure to feared situations is combined with anxiety management (relaxation training with cognitive techniques designed to reduce the effects of anxiety-provoking thoughts).
 - It is the treatment of choice for social phobia.
2. Social Skill Training: e.g. how to initiate, maintain and end conversation.

3. Assertiveness Training: how to express feelings and thoughts directly and appropriately.

B. Medications:

1. Antidepressants (one of the following):
 - Selective serotonin reuptake inhibitors (e.g. fluoxetine)
 - Venlafaxine.
 or
 - Monoamine oxidase inhibitors (e.g. moclobemide).
2. Beta-blockers(e.g.propranolol),as they are non-sedative, they are useful in specific social phobia e.g. test anxiety to reduce palpitation and tremor. Beware of bronchial asthma.
3. Benzodiazepines (e.g. alprazolam): small divided doses for short time (to avoid the risk of dependence).

Prognosis:

If not treated, social phobia often lasts for several years and the episodes gradually become more severe with increasing avoidance. When treated properly the prognosis is usually good. Presence of avoidant personality disorder may delay the improvement.

SPECIFIC PHOBIA

Also called: **Simple Phobia.**

The central problem is irrational and persistent 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.

Common feared objects and Situations:

- Needles/ blood/ hospitals/clinics/dentists.
- Animals /spiders/ darkness.
- Storms and thunder.
- Heights (acrophobia), flying.
- Closed spaces (claustrophobia).

Epidemiology:

It is common in the general population though not necessarily among those seeking treatment (less than 20 % of patients are seen by psychiatrists).

- Animal phobia: common in children and women.
- Most specific phobias occur equally in both sexes.
- Most specific phobias of adult life are a continuation of childhood phobias. A minority begins in adult life, usually in relation to a highly stressful experience.

Etiology:

- It tends to run in families (? genetic or environmental).
- Modeling: observing the reaction in another person, usually a parent.
- Pairing of a specific object or situations with the emotions of fear and panic.

Differential Diagnosis:

- Obsessive compulsive disorder: some patients have fear and avoidance of specific objects e.g. dirt, knives. Both can be diagnosed if criteria are met (commonly called obsessional phobia).
- Depressive disorder: some patients with specific phobia seek help for long standing problem when a depressive disorder makes them less able to tolerate their phobic symptoms.
- Social phobia and agoraphobia.

Treatment:

- Behavior therapy ; exposure techniques either desensitization or flooding (see chapter 24).
- Drugs (e.g. benzodiazepines, beta adrenergic antagonists) before exposure sessions.

Prognosis:

- If started in adult life after stressful events the prognosis is usually good.

- If started in childhood, it usually disappears in adolescence but may continue for many years.
- Hospital /needle/dental/blood phobias may lead to bad consequences.

Chapter 12

Obsessive Compulsive Disorder
and
Habit and Impulse Control
Disorders

A 23 year-old women has recurrent persistent images in her mind about harming her husband by a knife. She knows that these images are senseless, silly and should be resisted, but she cannot make them go away.

OBSESSIVE COMPULSIVE DISORDER

OBSESSIONS: Recurrent, persistent *ideas, thoughts, images or urges* which enter the mind despite patient's resistance. The patient regards them a silly product of his own mind (coming within the self compared to delusions). Attempts to resist or dispel these obsessions lead to severe inner struggle, with intense anxiety.

COMPULSIONS: Repeated compelling *acts* done in response to obsessions.

Healthy people experience occasional intrusive but resistible obsessions. It is the persistence, intensity and frequency that make a disorder.

OBSESSIVE COMPULSIVE DISORDER (OCD):

A psychiatric disorder characterized by:

- 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.
- at least two weeks' duration (ICD criterion).

Anxiety is an important component of OCD; that is why these conditions are classified as anxiety disorders in DSM. However, some European researchers consider OCD as a separate category.

THE MAIN **FORMS** OF OCD: thoughts – images – urges .

THE MAIN **CONTENTS** (THEMES) OF OCD

- Contamination (accompanied by avoidance and followed by washing e.g. contaminated by one's own excreta, shaking hands with a contaminated person , etc.)
 - Self-doubt associated with guilt and followed by checking (e.g. locking a door, turning off the stove)
 - Accuracy concerning certain actions that may have not been done properly or completed adequately (e.g. ablutions, prayers, fasting, counting).
 - Religious wrong beliefs (blasphemous thoughts).
 - Obsessional ruminations: internal debates in which arguments for and against even the simplest everyday actions are reviewed endlessly.
 - Images or urges of aggressive behavior (e.g. as if harming self or others).When associated with fear and avoidance these are sometimes called *obsessional phobia*.
 - Sexual imagery (e.g.as if practicing sexual offences).
 - Insistence on symmetry: urges to have things in a particular precise order.
- **Associated features:**
- Avoidance of situations that involve the content of the obsessions, such as dirt or contamination.
 - Anxiety is an important component of OCD. Compulsions are done to reduce anxiety. Thus, reinforces obsessive compulsive behavior.
 - Depressive features either as precipitating factor (ie primary) , secondary to, or simultaneously arising with OCD.
 - Severe guilt due to a pathological sense of self-blaming and total responsibility to such absurd thoughts especially in blasphemous, aggressive and sexual obsessions.

Obsessive-compulsive spectrum:

Besides OCD, this includes many disorders characterized by repetitive thoughts and behaviors and share neurobiological origins. The

symptom dimension cuts across traditional diagnostic boundaries. Based on the clinical features and neurobiology of the obsessive-compulsive spectrum, the disorders can be classified into three subgroups:

1. Repetitive behaviors driven by impulsive pleasurable desires such as impulse control disorders ; trichotillomania(impulsive hair pulling), kleptomania(impulsive stealing) and others (see below).
2. Those involving excessive preoccupation with body appearance or functioning such as hypochondriasis, body dysmorphic disorder or anorexia nervosa (see later).
3. Neuropsychiatric disorders that present with repetitive behaviors, such as Tourette syndrome, and autism.

□ Epidemiology:

- Lifetime prevalence: 2 – 3 % of the population.
 - Sex distribution is equal.
 - Mean age at onset = 20 – 25 years.
 - Mean age of seeking psychiatric help = 27 years.
- In many Arabic countries, OCD may not be recognized as a mental disorder and religious leaders are usually consulted first for its diagnosis and treatment.

□ Etiology:

1. Genetic Factors:
 - OCD has been found in about 7 % of the parents of patients with these disorders.
 - Few twin studies, monozygotic 50 – 80 % for concordance rate compared to only 25 % in dizygotic twins.
2. Neurobiological hypothesis:
 - There is evidence that selective serotonin reuptake inhibitors (SSRIs) are effective treatment for OCD. However, there is no evidence of baseline pure serotonergic dysfunction in OCD patients. Multiple

neurotransmitter system is suggested; serotonin-dopamine interaction.

- MRI and PET have indicated abnormalities in the frontal lobes, cingulum and basal ganglia of OCD patients. More gray matter and less white matter, suggesting a developmental abnormality

3. Psychodynamic Theories:

There are unconscious urges of aggressive or sexual nature. These urges could potentially cause extreme intrapsychic conflict which is reduced by the action of the defense mechanisms of repression, isolation, undoing, and reaction formation (see chapter 5).

4. Behavioral Theory:

Excessive obsessions when followed by compulsions or avoidance are reinforced, maintained and perpetuated.

□ Differential Diagnosis:

OCD should be differentiated from other mental disorders in which some obsessional symptoms may occur, like:

- Depressive disorders.
- Anxiety, panic and phobia disorders.
- Hypochondriasis (see chapter 14)
- Schizophrenia: some schizophrenic patients have obsessional thoughts, these are usually odd with peculiar content (e.g. sexual or blasphemous). The degree of resistance is doubtful.
- Organic disorders: some organic mental disorders are associated with obsessions e.g. encephalitis, head injury, epilepsy, dementia.
- Obsessive Compulsive Personality Disorder (see chapter 18)

Although obsessive compulsive personality disorder (OCPD) and OCD have similar names, the clinical manifestations of these disorders are quite different. Obsessive compulsive personality disorder is not characterized by the presence of obsessions or

compulsions and instead involves pervasive pattern of preoccupation with orderliness, perfectionism, and control and must begin by early adulthood. If an individual manifests symptoms of both OCPD and OCD, both can be given. Comorbidity is common.

□ **Course and Prognosis:**

- In most cases onset is gradual but acute cases have been noted.
- The majority has a chronic waxing and waning course with exacerbations related to stressful events.
- Severe cases may become persistent and drug resistant.
- Depression is a recognized complication.
- Prognosis of OCD is *worse* when the patient has OCPD.
- Patient's age, sex, age of onset and duration of OCD showed no significant correlation with outcome.
- Good lasting outcome was found to be related to compliance with treatment, presence of mood component (depression/anxiety) and family support.

□ **Management:**

- Search for a depressive disorder and treat it, as effective treatment of a depressive disorder often leads to improvement in the obsessional symptoms.
- In case the patient is worried about that, these symptoms are signs of madness reassure him that they are not.
- Explain the nature of the illness and clarify to the patient the intrusive nature of the obsessions i.e. OCD is against his will. This helps the patient reduce the guilt that results from the sense of responsibility.
- Frequent supportive interviews providing continuing hope.
- Treatment should be biopsychosocial.
- Medications;
 1. Antiobsessional drugs
 - a. Clomipramine: required doses may reach 200 mg / day.
 - b. Selective serotonin-reuptake inhibitors (e.g.

- paroxetine)
2. Anxiolytics can give some short-term symptomatic relief.
- Behavior therapy (combined with medications):
 - It is more effective with prominent compulsions and less effective for obsessional thoughts.
 - About 60 % may improve greatly though not completely.
 - Behavioral Techniques used include (see Chapter 24):
 - Exposure and response prevention.
 - Thought distraction / thought stopping .

Behavior therapy may be done at out – patient clinics, day centers or as in – patient. It is important to interview relatives and encourage them to adopt an empathetic and firm attitude to the patient. A family co-therapist plays an important role.

In-patient behavior therapy can appreciably be helpful for resistant cases and can reduce patient's disability, family burden and major demands on health care resources that are incurred by severe chronic OCD patients.

Collaboration with religious leaders is helpful.

Psychosurgery: is limited to very severe and resistant incapacitating cases.

HABIT AND IMPULSE CONTROL DISORDERS

These are psychiatric disorders characterized by:

- Impulse drive to perform some action that is harmful to self (e.g. hair pulling) or to others (e.g. fire setting).
- An increasing sense of tension before committing the act.
- An experience of either pleasure gratification or release at the time of committing the act.

There are several categories:

1. Trichotillomania (impulsive hair pulling).

2. Kleptomania (impulsive stealing).
3. Pyromania (impulsive fire setting).
4. Intermittent explosive disorder (aggressive impulsive behavior resulting in harm to others).
5. Pathological gambling.
6. Other disorders including:
 - Repetitive self-mutilation.
 - Compulsive sexual behavior.
 - Addiction to video games, the Internet, etc.

TRICHOTILLOMANIA:

- recurrent pulling out of one's hair, resulting in a noticeable hair loss.
- more common in females.
- associated problems include:
 - Obsessive personality
 - OCD
 - Depression
 - The behavior increases if the patient is: alone, tired, unoccupied or distressed
- It generally begins in adolescence (sometimes in childhood).
- Patient may seek treatment from a dermatologist first.
- Treatment:
 - Psychological treatment for any underlying stress and personality problem (e.g. stress management programs).
 - Selective serotonin-reuptake inhibitors and anxiolytics have been found effective.
 - Lithium was found helpful for some cases.

Chapter 13

Stress-related Disorders

Normal Stress Reaction and Grief

Adjustment Disorders

Acute and Post-traumatic Stress Disorder

A 32 year-old lady lost her husband two days ago in a road traffic accident .She has lack of emotional response, anger and disbelief but no sadness or crying spells.

- **Stressor:** an internal or external physical or psychological stimulus that provokes a state of unpleasant arousal called “distress”
- **Stress Response:** physiological concomitants of distress together with the psychological responses (known as coping techniques).

Stress is part of our life; it is impossible to remove all stress from our everyday lives. Some stresses prepare us to meet certain challenges.

Thus, some stress is productive and therefore is essential, whereas some other stress is harmful. In this regards, the term *EUTRESS* is sometimes used to distinguish productive stress and the term *DISTRESS* is used to refer to harmful stress.

Each person has a personal threshold of vulnerability, and an innate ability to tolerate stress. The external events may not be sufficient to cause mental disorder. Rather a combination of genetic and external factors has to exist for illness to occur.

Types of reaction to stress

Normal reaction	Pathological reactions
<ul style="list-style-type: none"> • Normal physiological response. • Psychological responses are proportionate to the severity of the stress. • Both physiological and psychological responses diminish and then disappear after cessation of stress. • Normal grief reaction is a good example. 	<ul style="list-style-type: none"> • Pathological grief. • Adjustment disorders. • Acute stress disorder. • Posttraumatic stress disorder (PTSD). • Hysteria (conversion– dissociation). • Brief psychosis.

REACTION TO STRESS

Psychological Responses	
<p style="text-align: center;">Physiological Response</p> <p>Neural circuits between midbrain, limbic system and hypothalamus convey the effects of perceived stress to the endocrine and autonomic nervous systems which in turn affect cardiovascular, respiratory, GI--- -- systems.</p> <ul style="list-style-type: none"> • ↑ Blood pressure. • Rapid Pulse. • ↑ Sweat production • ↑ Muscle tension ----etc. 	<p style="text-align: center;">Emotional</p> <ul style="list-style-type: none"> - Apprehension (in case of threat). - Sadness (in case of loss). - Both sadness and apprehension may coexist.
<p style="text-align: center;">Cognitive</p> <ul style="list-style-type: none"> - Intensified cognitive functions (in mild stress). - Adversely affected in moderate and severe stresses. 	<p style="text-align: center;">Psychodynamic</p> <p>Certain psychological mechanisms are triggered to reduce the effect of stressful experiences, so that normal performance can continue.</p> <ol style="list-style-type: none"> 1. Coping strategies (direct and healthy). 2. Defense mechanism (indirect and may constitute a barrier to satisfactory adjustment). <p>See chapter 5.</p>

Factors playing a role in reactions to stress

1. The individual:
 - i. Personality: frustration tolerance, self-esteem, and coping mechanisms...
 - ii. Intelligence.
 - iii. Age and sex.
 - iv. Physical health
2. The stressor(s):
 - i. Severity and meaning to the person.
 - ii. Nature and number.
 - iii. Onset and duration.
3. Availability of support (emotional, financial...).

Grief

Grief: sadness appropriate to a real loss

Bereavement: being deprived of someone by death.

Mourning: the process of resolution from grief.

□ NORMAL GRIEF REACTION

It is a continuous psychological process of three stages:

	1. SHOCK	2. DISORGANIZATION	3. REORGANIZATION
Duration	Few hours-several days	A week - 6 months	Weeks to months
Features	<ul style="list-style-type: none"> • Numbness (lack of emotional response) • Denial (disbelief or incomplete acceptance and feeling of unreality) • Searching for the lost person • Anger • Yearning 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

□ PATHOLOGICAL GRIEF

There are four types of abnormal grief:

Abnormally intense grief	Prolonged grief	Delayed grief	Distorted grief
<p>Symptoms are severe enough to meet criteria for <i>major depression</i>:</p> <ul style="list-style-type: none"> • Severe low mood. • Global loss of self-esteem. • Self-blame is global. • Death wishes with suicidal ideation. • Does not respond to reassurance. • Psychomotor retardation. 	<p>It is often defined as grief lasting for more than 6 months.</p> <p>Symptoms of the first and second stages persist.</p> <p>May be associated with depression.</p> <p>* Duration of normal grief varies with culture (on average 6-12 months).</p>	<p>By convention it is said to occur when the first stage of grief does not appear until more than <i>2 weeks</i> after the death.</p> <p>It is said to be more frequent after sudden, traumatic or unexpected death.</p>	<p>Features that are unusual</p> <p>e.g. :</p> <ul style="list-style-type: none"> -marked overactivity. -marked hostility. -psychomotor features.

□ CAUSES OF ABNORMAL GRIEF

1. Sudden and unexpected death.
2. When the bereaved had a role in the death (e.g. RTA).
3. When the relationship with the deceased had been very intense, dependent or ambivalent.
4. When the bereaved person :
 - has to care for dependent children.
 - has suffered a previous psychiatric disorder.
 - cannot show grief easily and has difficulty in expressing feelings.

Social support although assists people who are bereaved, studies showed that it's lack does not cause abnormal grief.

□ REACTION TO IMPENDING DEATH

The following psychological stages (proposed by Elizabeth Kubler-Ross) are widely encountered .These stages begin when the patient is first aware of a terminal illness. Not everyone goes through each stage and the order may be different for each person.

1. Denial/Disbelief: "This can't be happening, not to me, I feel fine".

- It is a temporary shock defensive response to the psychological trauma of bad news. Some persons never pass beyond this stage and may keep going from doctor to doctor searching for one who supports their position.

2. Anger –"How can this happen to me?"; "*Who is to blame?*" "Why me? It's not fair!" "others are more deserving"

- Anger arises once the subconscious accepts the reality of the bad news and denial cannot continue. Patient becomes frustrated, irritable, and angry.
- Anger towards doctors, nurses, medical agencies, relatives, fate, self, and even God/Allah(Why me and now?!).
- Anger may be associated with envy of healthy people.

- Therefore, at this stage the person may become very difficult to care for due to misplaced feelings of rage and envy. It is essential for doctors not to take this anger personally. It represents patient's desire for controlling what he feels out of control.

3. Bargaining – "I will give/ do anything for a few more years."

- It is a negotiation for an extended life , made with a higher power in exchange for a reformed lifestyle.
- Bargaining arises when the subconscious recognizes that anger does not help.
- Psychologically, the subconscious is saying, " anger did not work maybe being good will work , I understand I will die, but if I could just have more time..."
- It involves the hope that the individual can somehow postpone or delay death.

4. Depression – "Nothing worked ,death is certain, I'm going to die, no way "

- Depression arises when the subconscious realizes that nothing has worked to prevent or delay the coming death so that despair and hopelessness prevail.
- Depressive features appear; low mood, low interest, lack of enjoyment, weeping, poor appetite, disturbed sleep and isolation, negative thoughts (dependence on others, loss of financial support ...) and other features of depression.
- It is not recommended to attempt to cheer up an individual who is in this stage. It is an important stage for grieving that must be processed.

5. Acceptance – " death is inevitable, I can't fight it, I better give up resisting and prepare for it."

- The subconscious begins to come to terms with mortality.
- This is not a "happy" stage; it is usually void of feelings.

- It takes a while to reach this stage and a person who fights until the end will not reach it.

These steps do not necessarily come in the order noted above, nor are all steps experienced by all patients. People may experience switching between two or more stages, returning to one or more several times before working through it.

Any patient could experience the stages in a different order, or could experience emotions not even mentioned in the stage theory.

A dying individual's approach to death has been linked to the amount of meaning and purpose a person has found throughout their lifetime. Research has found that those who felt they understood their purpose in life, or found special meaning, faced less fear and despair in the final weeks of their lives than those who had not. Spirituality helped dying individuals deal with the depression stage more adaptively than those who were not spiritual.

However, there are individuals who struggle with death until the end. Some researchers believe that the harder a person fights death, the more likely they are to stay in the denial stage. Others state that not confronting death until the end is adaptive for some people.

□ HELPING THE BEREAVED AND DYING PATIENTS

Normal process of grief should be explained and facilitated:

- help to overcome denial.
- encourage talking about the loss.
- allow expressing feelings.
- Continuous support through stages 1 and 2.
- Consider any practical problems :
 - Financial difficulties
 - Caring for dependent children
- Medications :
 - Anxiolytics for few days are helpful (when anxiety

is severe and sleep is markedly interrupted).

- Antidepressants do not relieve the distress of normal grief and therefore should be restricted to pathological grief which meets criteria for depressive disorder.

ADJUSTMENT REACTIONS

Commonly occurring stresses that provoke adjustment reactions include:

- Difficulties / failure at school.
- Transition from school to university.
- Financial stresses.
- Marriage /divorce / marital discord.
- Employment/promotion/retirement.
- Travelling abroad to live in a different country with different culture and moral values (culture shock).
- Birth of a defected child.
- Onset of a severe or chronic illness.

Bereavement is a special kind of normal adjustment which has already been discussed above.

NORMAL ADJUSTMENT

- Normal physiological response, proportionate to stressor in severity and timing.
- Brief period of anxious and /or depressed mood sometimes with irritability and poor concentration.
- There may be a brief period of denial but this is soon followed by acceptance.
- Normal healthy coping mechanisms are used :
e.g. problem-solving (working through problem).

ADJUSTMENT DISORDERS

Maladaptive psychological responses to usual life stressors resulting in impaired functioning (social, occupational or academic).

Presentation and Features:

- Symptoms develop within 3 *months* of the onset of the stressor (if more than 3 months it is less likely that the reaction is in 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 (low mood, tearfulness and hopelessness).
 - With anxiety (agitation, palpitation, jitters...).
 - 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:
1. *Acute*: if the disturbance lasts less than 6 months.
 2. *Chronic*: if the disturbance lasts for 6 months or

longer (when the stressors or consequences continue).

Epidemiology

- Sex : Female : Males 2:1
- Age: can occur at any age most frequent in adolescents.
- Common among hospitalized patients for medical and surgical problems.

Etiology: There are two main factors:

The Person's Vulnerability	The Stressor
<p>Common in those who have preexisting vulnerability :</p> <ul style="list-style-type: none"> • Abnormal personality traits. • Less mature defense mechanisms. • Low frustration tolerance. • High anxiety temperament. • Overprotection by family. • Lost a parent in infancy. • Loss of social support. 	<ul style="list-style-type: none"> • It's nature. • It's subconscious meaning. • It's severity. However, the severity of the stressor does not predict the severity of the adjustment disorders, because there are other factors involved. • The number of stressors, duration and reversibility.

Differential Diagnosis:

1. Acute stress and post traumatic stress disorder (life threatening stressor followed by extreme fear ,horror, avoidance and flashbacks).
2. Normal expected psychological reaction e.g. bereavement.
3. Major depression (severe depressive features with biological signs).
4. Anxiety disorders (generalized anxiety or panic disorders).
5. Personality disorders: coexisting (axis II diagnosis) personality disorders are common, e.g. histrionic, obsessive compulsive, avoidant, paranoid or borderline personality disorders.
6. Dissociative Disorders (see later)
7. Brief reactive psychosis.

Course and Prognosis:

- Generally favorable, particularly with early

intervention.

- Most symptoms diminish over time without treatment especially after stressor removal.
- Most patients return to their previous functioning capacity within few months.
- Adults recover earlier than adolescents.
- Some patients maintain chronic course with risk of anxiety, depression and substance abuse.
- Recurrence is common following other usual life stresses.

Treatment:

A. *Psychological (treatment of choice)*

- Empathy understanding and support.
 - Emotional ventilation.
 - Psychosocial Education: explanation & exploration (explore the meaning of the stressor to the patient).
- **Crisis Intervention:** (Several sessions over 4 – 8 weeks)
- The patient, during crisis, is passing through emotional turmoil that impairs problem-solving abilities.
 - Build good relationship with the patient.
 - Review the steps that have led to the crisis (stresses, defense mechanisms).
 - Identify and understand the maladaptive reactions.
 - Manipulate the environment to reduce distress (e.g. hospitalization).
 - Give small doses of drugs (e.g. anxiolytics) to reduce symptoms.
 - Encourage and support the patient until he goes through the problem.
 - Transform that into learning a more adaptive ways of coping strategies (for the future, to prevent such maladjustment reactions).
 - After successful therapy the patient usually emerges stronger.

- ❑ **Group therapy:** for patients with similar problems, e.g. newly discovered diabetes mellitus.
- ❑ **Family therapy:** for patients whose problems are related to family dynamics.

B. Medication :

- Short course of benzodiazepines in case of adjustment disorder with anxious mood.
- Small doses of antidepressants might be beneficial for adjustment disorder with depressed mood.

Misconceptions:

In many Arab countries, great number of patients with adjustment disorders are seen first and treated by faith and folk healers who consider various non-medical conclusions and therapeutic trials, which coincide with the natural course of the illness and resolve with time. Thus most of these cases are attributed to Evil Eye, Witchcraft or Jinni possessions despite the presence of obvious psychosocial stresses severe enough to precipitate psychological disturbances.

ACUTE STRESS DISORDER

- Abnormal psychological reactions to a severe sudden traumatic stressor (usually life threatening or a threat to the physical integrity of self or others). The person experienced, witnessed or was confronted with the stressor.
- Examples of stressors: fire, physical attack, sexual assault, mugging, robbery, major road accident, war, flooding, earthquake.
- Onset: it occurs within *1 month* after exposure to a stressor.
If symptoms appeared after one month consider post-traumatic stress disorder(PTSD).
- Duration: a minimum of 2 days and a maximum of 4 weeks.
If symptoms continued more than one month consider PTSD.

Features include:

- Intense fear, horror, autonomic hyperarousal.
- Dissociative symptoms; derealization, depersonalization, detachment, reduction in awareness of the surroundings(e.g. "being in a daze").
- Marked avoidance of stimuli that arouse recollections of the trauma(places, activities, people, conversation) with marked distress on exposure to reminders
- the traumatic event is persistently re-experienced (recurrent dreams, images, thoughts or mental flashbacks).
- The illness causes marked functional impairment (social, occupational or academic).

Etiology:

- Recent research work places great emphasis on a person's subjective response to trauma than the severity of the stressor itself, which was considered the prime causative factor.
- The traumatic event provokes a massive amount of information and emotions which is not processed easily by the brain (There are alternating periods of acknowledging the event and blocking it, creating distress).

Differential diagnosis, treatment, and prognosis:

(See post-traumatic stress disorder.)

POST-TRAUMATIC STRESS DISORDER (PTSD)**Features:**

See those of acute stress disorder. However, PTSD differs from acute stress disorder in the following:

1. *Onset* is usually after a latency period (minimum is 1 month).
2. *Duration* of symptoms (last more than one month).

Etiology: See acute stress disorder.

Differential Diagnosis (for both acute and PTSD).

1. Adjustment disorders (usual life stresses not life-threatening, no dissociative features, mental flash backs or horror).
2. Anxiety disorders.
3. Head injury sequence (if the traumatic event has included injury to the head, e.g. road accident). Neurological examination should be carried out to exclude a subdural hematoma or other forms of cerebral injury.
4. Substance abuse (intoxication or withdrawal).

Treatment:**Psychological** (the major approach):

- Support – reassurance – explanation – education.
- Encourage discussing stressful events and overcome patient's denial.
- In vivo (imaginary) exposure with relaxation and cognitive techniques.
- Eye movement desensitization and reprocessing (EMDR) :while maintaining a mental image of the trauma the patient focuses on, and follow the rapid lateral movement of the therapist's finger so that the traumatic mental experience is distorted and the associated intense emotions are eliminated.
- Group therapy (for group of people who were involved in a disaster).

Pharmacological:

Symptomatic treatment ; anxiolytics(e.g. alprazolam) and serotonin-selective reuptake inhibitors(e.g. sertraline) or tricyclics (e.g. imipramine).

Prognosis: good if

- (1) the person is cooperative with treatment and has healthy premorbid function.
- (2) the trauma was not severe or prolonged.
- (3) early intervention and social support exist.

Chapter 14

Somatoform Disorders

- ❑ **Somatization Disorder**
- ❑ **Hypochondriasis**
- ❑ **Psychogenic Pain Disorder**
- ❑ **Body-dysmorphic Disorder**
- ❑ **Conversion Disorder**

A 29 year-old woman referred to outpatient psychiatry clinic by a cardiologist with several months' history of intense worries about arrhythmia and sudden death. She kept asking her cardiologist to repeated echocardiogram.

There are five main recognized somatoform disorders:

1. Somatization Disorder.
2. Hypochondriasis.
3. Psychogenic Pain Disorder.
4. Body Dysmorphic Disorder.
5. Conversion Disorder

These are a group of disorders in which physical symptoms are the main complaints and cannot be explained fully by a general medical condition, a direct effect of a substance or a mental disorder.

Psychological factors are judged to be behind the somatic symptoms and complaints. The complaints are not faked(in contrast to factitious disorders and malingering). They usually lead to distress and / or functional impairment in social, occupational or academic aspects.

However, because the current terminology for somatoform disorders is confusing and because somatoform disorders, psychological factors affecting medical condition, and factitious disorders all involve presentation of physical symptoms and/or concern about medical illness, the DSM-5 work group suggests combining somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled ***“Complex Somatic Symptom Disorder” (CSSD)*** which emphasizes the symptoms plus the patients' abnormal cognitions. The term “complex” is intended to denote that in order for this diagnosis to be made, the symptoms must be persistent and must include both somatic symptoms as well as cognitive distortions.

1. SOMATIZATION DISORDER (previously called Briquet's Syndrome)

- Multiple somatic symptoms (affecting multiple organ system) that cannot be explained adequately on the basis of physical examination and laboratory investigations.
- The symptoms are not intentionally produced.
- The disorder is chronic beginning before age 30 (DMS-IV criterion, not in ICD - 10)
- It is associated with excessive medical help-seeking behavior.
- It leads to significant distress and functional impairment (social, occupational...).
- DSM requires at least 4 pain symptoms – 2 GI symptoms – one neurological symptom and one reproductive or sexual symptom.

Epidemiology:

- Women > men 5 – 10 : 1.
- The lifetime prevalence in the general population is about 2%.
- More common in patients who bottle up their emotions and are less assertive.

Etiology:

- Genetic factors:
 - About 15 % of the first-degree female relatives have the disorder.
 - Monozygotic twins concordance rate 29 % (compared with dizygotic 10 %). However, as yet there is not enough evidence of true genetic transmission.
- Neuroscience: Faulty perception and assessment of somatosensory inputs due to characteristic attention impairment.
- Psychological:
 - Displacement of unpleasant emotions into a physical symptom.
 - Alleviation of guilt through suffering.
 - To obtain attention or sympathy.

Differential Diagnosis:

1. Medical diseases (e.g. SLE, endocrinopathies, chronic infections). Vigilance is required to ensure that such diseases are not overlooked. It is important to keep in mind that patients with somatization have the same chance of developing genuine physical diseases as any other individual at that age; they may also suffer from iatrogenic diseases due to excessive medical help-seeking behavior.
2. Depression (multiple somatic complaints are associated with low mood and / or loss of interest).
3. Anxiety (many physical manifestations of anxiety e.g. headache, low back pain are accompanied with excessive worries and apprehension).
4. Hypochondriasis (the emphasis is on overconcern with a serious disease).
5. Psychogenic pain disorder (limited to one or two pain symptoms).

Course and Prognosis:

- Chronic disorder.
- Fluctuating course (exacerbation of symptoms is associated with stressful events).
- Risk of multiple unnecessary operations and possible complications.

Treatment:

- The number of medical staff involved is better limited (a single identified physician as the primary care taker) because opportunity of the patient to express somatic complaints increases when more than one physician is involved.
- Arrange brief regularly scheduled appointments, e.g. every month.
 - Repeat physical examination.
 - Avoid additional diagnostic procedures.
- Shift the patient's awareness to psychological factors, and support her/him.

- Minimize the use of psychotropic drugs (patients tend to use drugs unreliably and erratically).
- Encourage graded return to normal activities.
- Antidepressants are useful when secondary depression develops.

2. HYPOCHONDRIASIS

- Intense prolonged (> 6 months) overconcern 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.

Associated Features:

- Doctor – shopping and deterioration in doctor-patient relationships, with frustration and anger on both sides.
- The patient often believes that he is not getting a proper medical care and may resist referral to psychiatry.
- Physical complications may result from repeated diagnostic procedures.
- Family and social relationships may become disturbed because the patient expects special consideration.

Associated Psychiatric Disorders:

Hypochondriasis can be part of another disorder such as major depression, dysthymic disorder, generalized anxiety disorder or adjustment disorders.

Most of such patients have obsessional and anxiety personality traits.

Epidemiology:

- Age: it can begin at any age. However, onset is thought to be most common between 25 – 45 years.
- It is thought to be more common in men, and those closely

associated with the disease (e.g. relatives of a patient with cancer).

- The true prevalence is uncertain, but it is common amongst patients attending general medical clinics.

Etiology: No specific cause has been detected; however, there are some etiological theories:

1. 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.
2. Psychodynamic defense mechanisms:
Hypochondriasis is a defense against guilt, as a result of low self-esteem, or a sign of excessive self-concern.
Anger and hostile wishes towards others are transferred into physical complaints through either displacement or repression.
Identification with a close person, e.g. a relative who died of heart attack.
3. Learning the sick role which is reinforced through family and doctor's attention.

Differential Diagnosis:

1. Physical diseases (e.g. endocrinopathy).
2. Somatization disorder (the focus is on the symptoms and not on the overconcern with a disease).
3. Underlying other psychiatric disorders (depression – anxiety).
4. Monosymptomatic hypochondrical delusion
 - It is a psychotic disorder in which a patient firmly believes that he has a physical disease and gathers evidence for this, e.g. delusion of internal parasitosis or disturbance of body image.
This delusion can be part of any psychotic disorder, e.g. schizophrenia.

Course and Prognosis:

- Usually chronic course with waxing and waning symptoms.
- Complete recovery occurs in some cases specially if there is

underlying depressed or anxious mood.

- Presence of secondary gain (e.g. sick role) and personality problems are unfavorable prognostic factors.

Management:

1. Exclude a possible organic pathology.
2. Search for and treat any underlying depression or anxiety. (Hypochondriasis often improves when these conditions are treated).
3. A cognitive-educational approach:
 - provide a more realistic interpretation of complaints(e.g. hyperarousal of the autonomic nervous system associated with exaggeration and misinterpretation of the consequences)
 - explain the role of psychological factors in symptoms origin and fluctuation.
4. From their clinical experience some psychiatrists suggest trial of tricyclic antidepressant in all patients even if no underlying depressive features.

3. PSYCHOGENIC PAIN DISORDER

The central feature is pain whether acute or chronic which is severe enough to warrant clinical attention and causes significant distress or functional impairment (social, occupational...). No adequate physical findings.

The pain is not intentionally produced and not due to another psychiatric disorder (e.g. anxiety). The pain is inconsistent with anatomical distribution of the nervous system. Psychological factors are judged to have a significant role in the onset, exacerbation or maintenance of the pain, even though the patient may not accept this explanation.

Common sites: head (psychogenic headache), neck, lower back and abdomen. Pain may lead to inactivity and social isolation which in turn can lead to additional psychological suffering.

- Acute pain (less than 6 months) appears to be most

frequently associated with anxiety disorder.

- Chronic pain (6 months or longer) appears to be more frequently associated with depressive disorders.
 - It may occur at any age.
 - Women experience certain chronic pain conditions most notably musculoskeletal pain and headache.

Etiology: no specific cause has been found. However, there are several explanations:

1. Deficiency of endogenous endorphins and serotonin in the CNS.
2. Unconscious release of emotional pain displacing it to the body, and physical pain may function as a method of obtaining love.
3. Pain may help in avoidance of unwanted responsibilities.

Treatment:

- Treat any underlying physical problem.
- Treat any associated psychiatric problem (depression, anxiety).
- Reduce current psychosocial stresses.
- Patients respond better to psychotropics (e.g. tricyclics) than analgesics. In psychogenic headache SSRIs may exacerbate headache.
- Supportive psychotherapy.
- Relaxation training.
- These patients are prone to pethidine and benzodiazepine abuse.

4. BODY DYSMORPHIC DISORDER

It is a persistent inappropriate preoccupation with an imagined bodily defect, ugliness, or an exaggerated distortion of a minimal existing defect that the patient feels noticeable to others.

The most concerns are about the nose, ears, mouth, hair, buttocks, skin, breasts (female) and penis (males). It seems to the patients that other people notice and talk about his/her supposed deformity.

The condition was recognized more than 100 years ago and

named “**dysmorpho phobia**”. However, this term inaccurately implied the presence of a behavioral pattern of phobic avoidance.

Patients may have either excessive mirror checking or avoidance of reflective surfaces and attempts to hide the presumed deformity. It causes significant distress to the patient or functional impairment (e.g. avoiding social and occupational exposure). The severe conditions are infrequent, but less severe forms are more common, especially in dermatology and plastic surgery clinics. Comorbid diagnosis of depressive disorders and anxiety disorders are common. These patients may also have traits of personality disorders (obsessive compulsive, narcissistic...).

If the belief is delusional the condition is considered as delusional disorder - somatic type (mono symptomatic hypochondriacal delusion). Cultural emphasis on concepts of beauty plays a role in the etiology. If not treated the course is chronic with waxing and waning of symptoms over time.

Treatment:

- Search for and treat any underlying anxiety or depression.
- Treatment of primary cases is usually difficult.
- It should be explained tactfully that there is no real defect.
- Reassurance and support.
- Selective serotonin-reuptake inhibitors found to be effective treatment.
- Tricyclic antidepressants, MAOI and pimozide (an antipsychotic) have been reported to be useful in individual cases.
- Counseling for social, occupational or sexual difficulties that accompany the condition.

Plastic (Cosmetic) Surgery

- may help some patients who have clear reasons for requesting an operation (mild defects).
- those who do not have realistic expectations have a poor prognosis.

5. CONVERSION DISORDER

It involves a subconscious conversion of a psychological conflict into an acute loss of physical functioning, which suggests a neurologic disease; motor or sensory deficit.

The symptom is temporarily related to a psychological stressor. The pattern of symptoms reflects the medical knowledge of the patient and may be inconsistent with known pathophysiology, (e.g. a stocking – glove anesthesia).

Symptoms are related to the neurological system:

- * **Motor:** paralysis, paresis, aphonia, gait disturbances (astasia – abasia), tremor, rigidity.
- * **Sensory:-** general: paraesthesia, anesthesia, or hyperalgesia.
 - special: visual disturbances (e.g. partial blindness), deafness, loss of taste, loss of smell.
- * **Others:-** vomiting (psychogenic vomiting is not associated with nausea).
- 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” (literally: “Beautiful 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.

Conversion disorder occurs mainly in young females. It is more common among little educated persons, those with low intelligence and in low socioeconomic groups. Common associated disorders include anxiety and depressive disorders.

- **Psychodynamic explanation:**
The unconscious intrapsychic conflict between an instinctual impulse, (e.g. aggression) and the prohibitions against its expression is repressed and disguised through physical expression which also help the patient to manipulate and control others indirectly.
- **Neurobiological explanation:**
The symptoms may be caused by an excessive cortical arousal that sets off negative feedback loops between cerebral cortex & the brain stem reticular formation.

Differential Diagnosis:

- Neurological diseases e.g. multiple sclerosis, stroke, optic neuritis, etc. (about 30 % of patients followed up later were discovered to have neurologic diseases).
- Acute dystonic reaction (a side effect of antipsychotics).
- Factitious disorders: intentionally produced symptoms and sign to assume the sick role without external incentives. (See chapter 15).
- Malingering: faked symptoms motivated by an external incentive e.g. to evade the police. Patient stops the symptoms when they are no longer useful. (See chapter 15).

Course and Prognosis:

- Conversion symptoms usually remit in a short time (hours, days).
- Recurrence is common.
- Good prognosis is associated with:
 - acute onset.
 - an obvious stressful precipitant.
 - good premorbid personality.
 - above average intelligence.
 - a short interval between onset and treatment.
 - absence of other forms of psychopathology.
 - blindness, aphonia and paralysis.
- Minority have a chronic course.

Treatment:

- Sympathetic approach with reassurance that the condition is a reaction to stress and will resolve overtime. This helps the patient let go of symptoms without confrontation.
- Avoid confrontation.
- Abreaction (drug-aided interview): using amytal or diazepam with suggestion can result in a dramatic resolution.
- Stressful events in the patient's life should be evaluated and appropriate intervention made: individual, marital or family therapy.
- Underlying psychiatric illness, such as depression, should be recognized and properly treated.

There are two other categories included in somatoform disorders:

1. Undifferentiated Somatoform disorder: one or more physical complaints (e.g. fatigue, loss of appetite...) that persist for 6 months or longer.
2. Somatoform disorder not otherwise specified:
This residual category is used for a wide range of somatoform symptoms that do not meet criteria for the specific categories mentioned before.

Chapter 15

Psychosomatic Medicine
and
Consultation-liaison
Psychiatry

A 35 year- old single man was admitted in the medical ward for assessment of non-specific abdominal pain, headache, drowsiness and inability to walk. Physical assessment has revealed no abnormality .The patient was not cooperative with investigation procedures.

- **Psychosomatic Medicine:**

Psychosomatic medicine is based upon observation that psychological and sociocultural factors play a role in the predisposition, onset, course and response to treatment of some physiological changes and biomedical disorders.

The term “*psychosomatic*” was not in common use because it implies a causal association between psychological factors and certain physical conditions, the notion that has not been supported by recent research. Other terms: “*psychological factors affecting the physical illness*” or “psychophysiological disorders” were used.

However, in 2005 the American Board of Medical Specialties and the American Board of Psychiatry and Neurology approved a separate Board to be called the American Board of Psychosomatic Medicine . That decision brought the term psychosomatic back into common use.

The concepts of psychosomatic medicine are subsumed in the diagnostic entity called *Psychological Factors Affecting Medical Conditions (PFAMC)*. This category covers physical disorders caused by emotional or psychological factors. It also applies to psychiatric disorders induced or aggravated by physical disease.

- **Liaison Psychiatry:**

The work of a psychiatrist in a general hospital which covers the area between psychiatry and other branches of medicine where he attends medical ward rounds and other clinical meetings. It was developed in the USA.

- **Consultation Psychiatry:**

Each patient on whom an opinion is sought is referred to the psychiatrist who may visit the ward at any time.

- **Consultation-Liaison Psychiatry:**

Consultation-liaison(C-L) psychiatry is the study, practice, and teaching of the relation between medical and psychiatric disorders. It is associated with all the diagnostic, therapeutic, research and teaching services that psychiatrists perform in the general hospital and serves as a bridge between psychiatry and other specialties.

The psychiatrist and physician meet regularly to discuss individual patients and general aspects of patient care. It is not confined solely to psychiatric disorders.

Advantages of consultation-Liaison psychiatric services:

1. Improve the quality of life and the quality of care provided to patients in non-psychiatric wards, e.g. reduce the number of unnecessary investigations performed for physical symptoms that actually reflect underlying psychological distress.
2. Reduce the length of patient's stay in the hospital and the readmission rate .Thus, reducing the cost and increasing the vacancy capacity and bed turnover.

Psychological disorders occur frequently in the general hospital. As many as 30 – 60 % of hospital patients may have diagnosable psychiatric disorders. Although common, psychological disorders may not be recognized and adequately dealt with in the general hospitals. Reasons for that include:

1. Many staff have not received adequate training or encouragement to pay sufficient attention to the psychological aspects of patients care.
2. Many interviews fail to elicit psychological problems.
3. Modern medicine is oriented towards technological investigations, which may divert attention away from psychological problems.

The training of physicians should be improved so that their interviews with patients allow discussion of psychological problems and they have full understanding of the importance of detection and management of psychological disorders throughout the general hospital. Such training should start at the undergraduate level.

Consultation-liaison psychiatry involves the practical application of all psychiatric knowledge, ideas, skills, and techniques where they may be helpful to non-psychiatrists in the care and understanding of their patients.

- **Physical and psychiatric morbidity**

There are different types of association between physical and psychiatric morbidity

1. Psychiatric *reactions to* physical disease (e.g. anxiety provoked by heart disease).
2. Psychiatric disorder *presenting with* physical symptoms (e.g. dizziness as a feature of anxiety).
3. Psychological factors *affect* the physical illness through:
 - prolonging the course (e.g. anxiety may prolong the course of essential hypertension).
 - maintaining unhealthy habits (e.g. psychoactive substance abuse).
 - determining whether a person seeks helps from a doctor for a physical complaint (e.g. a person may seek medical help for backache when he feels depressed, but not when his mood is normal).
 - affecting compliance with treatment (e.g. neglecting the oral hypoglycemic agents when depressed).
4. Psychiatric and physical illness *occurring together independently* (e.g. gallstone and depression).The physical illness may exacerbate psychiatric symptoms.
5. Physical disease presenting with psychiatric features (e.g. psychosis as early presentation of SLE).

Most people are remarkably resilient when physically ill. During the acute stages of serious illness it is usual to experience the distress of an acute reaction to stress. If the physical illness is chronic, the psychological consequences are those of an adjustment disorder.

The risk of psychiatric consequences in physically ill people may be increased by the following:

1. low frustration tolerance and lifelong inability to deal with adversity.
 2. previous psychiatric illness.
 3. concurrent psychosocial problems.
 4. serious illness.
 5. illness that requires lengthy treatment (e.g. T.B.).
- **The major reasons for referral to psychiatry:**
 1. The patient has a psychiatric disorder, on psychotropic medications, or has a past history of such.
 2. The staff are under strain over the patient because of his behavior is disturbing, demanding, manipulative, or suicidal.
 3. Diagnostic uncertainty with suspicion of a psychiatric problem behind the physical symptoms.
 4. The patient has asked to see a psychiatrist. However, patients are usually reluctant to see psychiatrist, and families may reinforce this attitude.

Some clinicians believe that psychiatric illness does not affect medical outcome and may therefore not refer their patients who have psychiatric illness.

- **Characteristics of an effective psychiatric consultation :**
 1. Reviewing the patient's chart.
 2. Obtaining a good psychiatric history (paying attention to psychological and social factors).
 3. Mental State Examination (and Mini – Mental State Examination if cognitive impairment is suspected).
 4. Making a logic differential diagnosis among medical, neurological and psychiatric disorders.
 5. Arriving at a diagnosis based on clinical features, laboratory investigations, and psychiatric knowledge.
 6. Making a reasonable treatment recommendations (medications, psychological treatment, etc.).
 7. Following the patient during the entire hospitalization and after discharge.

On receiving the request for a consultation the psychiatrist should make sure that the referring doctor has discussed the psychiatric referral with the patient.

Before interviewing the patient, the psychiatrist should read the relevant medical notes and ask the nursing staff about the patient's mental state and behavior.

The psychiatrist should know about treatment the patient is receiving. It may be necessary to ask further questions of the ward staff or social worker, to interview relatives and inquire about the patient's social background and any previous psychiatric history. It is often appropriate to discuss the proposed plan of management with the referring team. Nursing staff can help in the management of most brief psychiatric problems that arise in a general hospital.

- **Psychosomatic Theories:**

- A. **Specific Theory (Alexander's Theory):**

- Specific unconscious conflicts and / or psychological factors cause specific illnesses in organs innervated by the autonomic nervous system. Alexander also believed that there are certain constitutional predisposing factors involved. Alexander's theory led to the concept of classic psychosomatic diseases including: bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, thyrotoxicosis, peptic ulcer, neurodermatitis.

- B. **Nonspecific Theory:**

- Whatever event perceived by the patient as stressful can produce stress. Psychological reaction to stress can lead to a failure of adapted physiologic responses which then may lead to a nonspecific cause of disease (e.g. high levels of cortisol in response to stress act on different organs to produce variety of changes).

- C. **Biopsychosocial Model:**

- All factors (biological, psychological and social) are important and should be objectively studied by multiple investigators (see chapter 5)

Psychosomatic disorders and patient's reaction:

Patient's reaction to a physical disease depends on his beliefs about the disease and its effects on his body and life .For normal and abnormal adjustments reactions see Chapter 13.

It is helpful to know and differentiate between the following terms:

Disease : pathophysiological process recognized by physicians. It is objective based on biological changes in the body.

Illness: individual's understanding of disease. It is very subjective and varies from person to person.

Illness behavior: patient's behavior to adjust to his disease. This can be adaptive (e.g. consulting doctors, accepting to be referred to psychiatrist, taking medications) or non-adaptive (e.g. exaggerating symptoms ,refusing medication)

Some patients develop illness behavior without physical disease e.g. hypochondriasis. Some patients follow illness-denying behavior (e.g. rejecting the obvious *abnormal* results of investigations and looking for further investigations), and some follow illness-affirming behavior (e.g. rejecting the obvious *normal* results of investigations and looking for further investigations to confirm the disease or its complications).

Sick Role : socially expected/required role of ill person e.g. exemptions from some responsibilities, the right to seek care and help from others. If sick role continues after the disease is over the sick role is maladaptive.

Somatic responses to psychosocial stress

- **Neuroendocrine responses:**

Stress > autonomic hyperarousal > secretion of CRF from the hypothalamus > release of ACTH >stimulation of adrenal cortex to release glucocorticoids > "flight or fight" response; increasing cardiovascular activity and promoting energy use.

- **Neuroimmune responses:**

a- Stress > glucocorticoids>inhibition of immunity, reproduction, and growth.

b- Stress > norepinephrine release> immune activation>release of cytokines(humoral immune factors)>further release of CRF> glucocorticoids.

- **Common medical diseases associated with psychiatric consultations**

System	Disorders
G.I.	Functional G.I. disorders e.g. irritable bowel syndrome(see below)
	Peptic ulcer disease.
	Ulcerative colitis / Crohn's disease.
	Drug overdose (parasuicide).
C.V.	Coronary artery diseases
	Cardiac arrhythmias
	Hypertension
Respiratory	COPD
	Asthma
Endocrine	Hypothyroidism / Hyperthyroidism
	Diabetes mellitus
	Hyperprolactinemia
Musculoskeletal	SLE (depression/psychosis due to lupus or its treatment)
	Rheumatoid arthritis.
CNS (see Chapter 6)	Delirium / Dementia
	Stroke (commonly followed by depression)
	Head trauma
	Headache/Migraine
	Complex partial seizure
Skin	Psoriasis/Pruritis/Excoriation/Urticaria
Renal	Renal failure/Uremia

Other reasons for psychiatric consultation

- Depression in medically ill patient (see Chapter 9).
- Terminally ill/dying patients (see Chapter 13).
- Substance abuse (see Chapter 7).
- Factitious disorders (see Chapter 16).
- Suicide and parasuicide (see Chapter 19)

Irritable Bowel Syndrome (IBS)

- It is very common in G. I. Clinics.
- Features include:
 - Nonspecific abdominal pain and discomfort.
 - Abdominal distention with alteration of bowel habits; constipation or diarrhea (with mucous in the stool but no blood).

- Absence of demonstrable medical causes.
- Exacerbation of symptoms with stresses.
 - Anxiety and depression are common.
 - Psychosocial dysfunction is common (? cause or effect).
 - Psychological treatment, antispasmodics, and antidepressants are effective in some patients.

- **Common psychiatric consultations in surgical ward:**

There is a linear relationship between anxiety before and after surgery.

Those who show more general ability to cope with stress suffer fewer post-operative psychiatric problems. Psychological preparations for surgery can reduce post-operative distress and problems.

Postoperatively, psychiatrists are sometimes asked to advise on the management of patients with pain.

Delirium is common after major surgery especially in the elderly.

Adjustment disorders are common following mastectomy and after surgery that has not lead to the expected benefit.

Phantom limb sensations follow limb amputation.

Organ transplantation is associated with certain psychosocial stresses that may cause anxiety or depression. Problems of transplant rejection are frequently associated with anger and low mood. Psychological symptoms may also occur as side effects of immunosuppressive drugs, steroids in high doses and antihypertensive drugs.

Chapter 16

Dissociative Disorders

Factitious Disorders

Malingering

A 40 year-old single female nurse was admitted into medical ward because of bleeding per rectum, vomiting and fever. The patient gave a dramatic history of 3 years duration, attended a series of hospitals, underwent many medical procedures and two abdominal surgeries. In the hospital she was noticed by other nurses inducing vomiting with her finger just before the consultant round. Her past history revealed childhood deprivation.

DISSOCIATIVE DISORDERS

A normal person has a unitary sense of self as a single human being with integrative functions of identity, consciousness, memory and motor behavior.

In dissociative disorders that unitary state is partially lost through mental cleavages which arise as defense mechanisms against certain psychological stresses.

There are four Dissociative Disorders

1. Dissociative amnesia.
2. Dissociative fugue.
3. Dissociative identity disorder (previously called multiple personality disorder).
4. Depersonalization disorder.

DISSOCIATIVE AMNESIA

A sudden inability to recall important information already stored in the patient's memory. The forgotten information is usually about a stressful or traumatic event in the person's life (painful memory). It cannot be explained by ordinary forgetfulness and there is no evidence of an underlying brain disorder. The capacity to learn new information is retained. Termination of amnesia is typically abrupt with complete recovery.

- It is the most common of the dissociative disorders.
- Women > men.
- Young adults > old.
- It is more common during natural disasters and in wartime.
- Stressful events include: rape, abandonment by a spouse, discovery of extramarital affair by a spouse, threat of physical injury or death.
- There are two different proposed explanations for dissociative amnesia:
 1. **Psychoanalytic:**
Amnesia is due to repression (unconscious blocking of disturbing painful memory from reaching consciousness) and denial (ignorance of some aspects of external reality by the conscious mind). By doing so, defense mechanisms find a way of dealing with an emotional conflict of external stressors.
 2. **Behavioral:**
Learning is often state-dependent (on the context in which the learning occurs). The memory of a traumatic event is laid down during the event and the emotional state may be so out of the ordinary for the affected person that it is hard for the person to remember information learned during that state.

Management:

- Support with compassionate approach.
- Establish a sense of safety.
- Promote appreciation of the person encouraging positive expectancy.
- Abreaction (sodium amytal or diazepam aided interview).

Most of the cases recover spontaneously.

DISSOCIATIVE FUGUE

Sudden unexpected purposeful wandering away from the usual surrounding (unexpected travel from home or work) associated with confusion about one's identity.

- It is rare (occur in wartime, after natural disaster or as result of intense personal crisis).

Etiology:

- Primitive denial: a desire to withdraw from emotionally painful experiences (“not me” defense).
- Predisposing factors include certain personality disorders (e.g. borderline, historic) and mood disorders.

The fugue is usually brief (days) followed by spontaneous rapid recovery. If fugue continued for several weeks, with assumption of new identity, malingering should be suspected.

Treatment: similar to that of dissociative amnesia.

DISSOCIATIVE IDENTITY DISORDER

Sudden alternations between the patient's normal state and another complex pattern of behavior (a second personality). Each is forgotten by the patient when the other is present.

It is extremely rare chronic, and the most serious of the dissociative disorders. It occurs in females more than males.

Etiology:

- It is still ambiguous.
- The following factors have been mentioned to have some role in the development of dissociative identity disorder:
 - biological tendency and capacity to dissociate.
 - shattered security, self-esteem and future orientation.

- subjective dyscontrol and passively endured assaults.
 - buried psychological trauma (e.g. sexual abuse) and sequestered affect.
 - broken psychological boundaries.
 - a traumatic life event mobilizing the dissociative defences.
 - the absence of support from significant others (parents, relatives, teachers...).
- In so many cultures most of these cases are claimed to be possessed by devils (jinn), usually resistant to faith healing sessions. Patients may continue suffering for years in spite of repeated exorcisms.

Differential Diagnosis:

1. Dissociative fugue and dissociative amnesia.
2. Schizophrenia (delusion of separate identities).
3. Rapid – cycling bipolar mood disorder.
4. Personality disorders may coexist (borderline or masochistic).
5. Malingering.
6. Complex partial seizure.

Treatment:

- The treatment is prolonged and its goal is to optimize the patient's functional level and adaptation.
- The most efficacious approach involves insight-oriented psychotherapy in association with abreaction (drug-assisted interview).
- Psychotropic drugs have a limited role.
- Family interventions can be helpful.

DEPERSONALIZATION DISORDER

Depersonalization as a **symptom** is the feeling that one's body or one's personal self is unreal and strange. Patient may feel detached from his body, in a dream, or feel as if he were mechanical.

Depersonalization disorder is the occurrence of one or more episodes of depersonalization that cause social or occupational impairment. The individual maintains grossly intact reality and does not accept these unpleasant feelings (ego dystonic).

Epidemiology:

Transient depersonalization symptoms may occur in as much as 70 % of a given population with no significant difference between men and women.

Depersonalization disorder: two-thirds of patients are women.

Age: adolescence or early adult life (rarely after 40).

Etiology:

- The causes of primary depersonalization disorder are not yet known.
- Psychological, neurological and systemic diseases have been considered.
- Anxiety and depressed mood are known precipitating factors.
- Possible association with schizoid personality disorder.

Differential Diagnosis:

1. Neurological diseases: temporal lobe epilepsy, brain tumour, head trauma, etc.
2. Substance abuse.
3. Endocrine diseases.
4. Schizophrenia.
5. Other dissociative disorders.

Treatment:

- Search for a primary cause and treat it.
- Anxiolytic drugs may give relief (short-term treatment).
- Antidepressants and anticonvulsants may be helpful in some patients.
- Supportive therapy.
- Counselling: enable the patient to live as normal life as possible.

Prognosis: Primary cases tend to be long lasting conditions.

FACTITIOUS DISORDERS

Factitious: not genuine, not real, faked.

FACTITIOUS DISORDERS:

Intentionally produced physical pathology or faking (feigning of) psychological or physical symptoms with the apparent objective of being diagnosed as ill to assume the role of a patient or to challenge doctors.

No secondary gain or obvious external incentives for the behavior, such as avoiding legal responsibility, duties, or financial compensation.

- **TYPES:**

1. **Factitious disorder with physical features** (symptoms, signs or abnormal laboratory results).

- Features are fabricated in a subtle and undisclosed manner.
- Features include:
 - Skin lesions (dermatitis artefacta).
 - Pyrexia of unknown origin.
 - Hypoglycemia.
 - Dramatic symptoms suggesting an acute surgical emergency.
 - Worsening of an existing physical disease (e.g. preventing ulcer healing).
- Patients tend to have pathological lying (Pseudologia Fantastica) and a pattern of extensive wandering from city to city or from one hospital to another with a similar presentation each time.

Munchausen's Syndrome (Hospital Addiction):

It is a severe form of factitious disorder in which a patient gives dramatic plausible stories of severe illness. Attending a series of hospitals giving different names to each, undergoing unnecessary medical procedures or surgeries.

Munchausen's Syndrome by proxy:

It refers to a form of child abuse in which a parent fabricates an evidence to suggest, falsely, that the child is ill. A parent gives false accounts of symptoms, and may fake or inflict signs in the child. The parent is the ill person who should be evaluated and treated.

2. Factitious disorder with psychological features.

The feigned features include:

- memory loss
- depression
- simulated psychotic features (e.g. hallucinations)
- odd behavior

Patients with factitious disorder usually obstruct efforts to obtain additional information about them and may interfere with the diagnostic process.

3. Factitious disorder with both physical and psychological features.**• Etiology:**

No known causes but the following factors have been reported to play a role:

- abnormal personality (e.g. borderline personality disorder).
- childhood deprivation or abuse.
- escape from a traumatic home situation to a loving and caring environment (doctors, nurses...).
- unresolved conflicts involving hostility, dependency...
- employment in careers allied to medicine (e.g. nursing).

- **Management:** (No specific treatment has been effective.)
 - early recognition and intervention.
 - carefully planned confrontation in a nonpunitive manner.
 - close collaboration between psychiatrist and medical treating physician or surgical staff.
 - comprehensive evaluation of personality and psychosocial stresses.
 - the patient is helped to face reality.

The majority of patients simply leave treatment when their methods of gaining attention are identified.

MALINGERING

Intentional production of features (physical or mental) motivated by external incentives.

Malingers have an obvious, recognizable environmental secondary goal. They usually seek hospitalization to evade the police, avoid work, or secure financial compensation. They always have some apparent end of their behavior.

When to suspect malingering:

- Lack of cooperation with the diagnostic steps.
- Presence of antisocial personality traits.
- Marked discrepancy between the person's claimed distress or disability and the objective findings.

The physician's primary responsibility is to evaluate objectively the presence of clinical findings, and their congruence (or incongruence) with the patterns of the disease.

Comparison between malingering, factitious and conversion disorders.

Diagnosis Distinction	Dissociative and Conversion Disorders	Factitious Disorders	Malingering
Intentions	No	Yes	Yes
Goal & motivation	Subconscious. Secondary gain	Not fully conscious. To assume the sick role	Fully conscious motivated by external incentives
Suggestibility	Yes	No	No
Course	Short & Recurrent	Intermittent or chronic	Varies depending on the goal.

Chapter 17

Sleep, Eating
and Sexual Disorders

SLEEP DISORDERS

Normal Sleep:

Sleep is a state of loss of consciousness from which a subject can be aroused by appropriate stimuli. As a person falls asleep, different stages can be identified from an EEG recording:

1. Alert wakefulness, characterized by high-frequency beta waves.
2. Quiet wakefulness, in which the person is relaxed and quiet with the eyes closed and which is associated with alpha waves.
3. Light sleep (stage 1), which is characterized by low voltage waves, broken by sleep spindles i.e. spindle shaped burst of alpha waves (12-14Hz).
4. Slow-wave sleep (stage 2,3,&4) which is characterized by very low frequency waves.

Sleep is regulated through the reticular activating system (RAS) which is a multisynaptic pathway located within the reticular formation of the brain stem. The RAS is activated to an equal degree by impulses from all the classical sensory pathways. Descending impulses from the temporal lobe and certain areas of the frontal lobe of the cortex have a strong excitatory effect on RAS. Such impulses may be responsible for the alerting responses due to emotions and related psychic phenomena. Motor cortex activates RAS so that voluntary movements help in keeping a person awake.

It takes the average person about 20 minutes to fall asleep then descends, over the next 45 minutes to deep sleep (stages 3 & 4). After another 45 minutes (90 minutes from the onset of sleep) one reaches the first rapid eye movement (REM) period (period of vivid dreams). Alternating periods of deep sleep and REM sleep occur during the night and as the night progresses, each REM period gets longer and deep sleep (stages 3 & 4) disappears. Children sleep longer than adults (an average adult sleeps 6 – 8 hours / day). With age sleep duration gets less, with frequent waking periods.

Sleep Disorders are frequent in the general population. They include:

- A. Insomnia
- B. Hypersomnia
- C. Sleep-wake schedule disorder
- D. Parasomnia (nightmare, night terrors, sleep walking).

□ **INSOMNIA:**

- Difficulty in falling or maintaining sleep which continues for at least a month.
- Primary insomnia (no cause can be found) 15 % of cases.
- Secondary insomnia can be due to:
 - anxiety
 - depression
 - dementia
 - excessive caffeine, tobacco or other stimulants
 - painful physical condition
- **Treatment:**
 - Identify and treat underlying causes.
 - Non-specific measures:
 - Regular pattern of going to bed and waking up (to set the biological clock).
 - Regular exercise.
 - Avoid large meals near bedtime.
 - Avoid night caffeine.
 - Relaxation techniques at night.
 - Reserve sedative drugs for severe cases, and give them for a short period to avoid the risk of dependence.

□ **HYPERSOMNIA**

- Excessive somnolence occurring for at least a month.
- Usually secondary to psychiatric problems (major depression, seasonal affective disorder...)
- Antihistamine psychotropic drugs (tricyclics, anti-psychotics...) are associated with sedation.

- **Narcolepsy:**

- A rare sleep disorder in which a person, usually under the age of 20, has recurrent sudden episodes of irresistible sleep attacks of short duration 10 – 15 minutes (directly enters into REM sleep). Most patients have sudden loss of muscle tone with paralysis (cataplexy).

Sleep paralysis (paralysis on waking from sleep) and hypnagogic hallucinations may occur. The condition may be complicated by depression.

- **Treatment:**

- Safety considerations (caution in driving...).
- Regular bedtime.
- Daytime naps.
- Stimulants (e.g. methylphenidate) for daytime stimulation.

. Modafinil(Provigil), an $\alpha 1$ -adrenergic receptor agonist, has been approved to reduce the number of sleep attacks and to improve psychomotor performance in narcolepsy.

- **SLEEP - WAKE SCHEDULE DISORDER:**

- This is a circadian rhythm sleep disorder, which includes a wide range of conditions involving a mismatch between desired and actual sleep periods, such as:
 - Work shifts changes (security, police, airport employee...).
 - Traveling across time zones (jet lag).
 - During and after “Ramadan” (fasting month).
- It is usually self-limited gradually vanishing as body readjusts to new sleep-wake schedule. The patient can adjust through gradual delay of sleep time until new schedule is achieved.

□ PARASOMNIAS:

A. Nightmares:

An awakening from REM sleep (hence good recall of an unpleasant dream) associated with fear. Common in preschool children, provoked by frightening experiences during the day. No specific treatment (reassurance, reduce stressful circumstances). It is a self-limiting condition.

B. Night Terrors:

Sudden awakening from deep non-REM sleep (hence no recall of dreams), accompanied by intense anxiety, screaming and autonomic arousal. It is especially common in children, but less common than nightmares. After a few minutes, the child settles slowly and returns to normal sleep. No specific treatment but it is sometimes helpful to wake child repeatedly prior to regular night terror.

C. Breathing-related sleep disorders:

Obstructive Sleep Apnea Syndrome (OSA) : sleep disruption due to functional obstruction of the upper airway during sleep (it tends to occur in obese patients who snores), resulting in hypoventilation.

Treatment: nasal continuous positive airway pressure and weight reduction.

D. Sleep Walking (Somnambulism):

- While still asleep a patient, usually child walks around in a mechanical way with open eyes but poor concentration (during non-REM sleep). The patient does not remember the episode. It can be potentially dangerous.
- No specific treatment; protection is essential (windows, stairs, doors...).

EATING DISORDERS

- Obesity
- Anorexia nervosa
- Bulimia nervosa
- Pica

OBESITY

Psychiatrists are sometimes asked to participate in the assessment and management of some obese people whose excessive eating seems to be determined by some psychological factors (behavioral, emotional...).

Obesity, by convention, is diagnosed when the body weight exceeds 120 % of average for age, sex and height. A precise measurement of obesity is the body mass index (BMI)

$$\text{BMI} = \frac{\text{body weight (kg)}}{\text{Height (M}^2\text{)}}$$

A normal BMI is in the range of 20 – 25. The food-regulating mechanism is susceptible to psychological factors which can contribute to the development of obesity. Hyperphagia may be used as a coping mechanism to reduce emotional stress. This behavior may be a learned behavior during childhood when food was given by parents at times of stress. Juvenile-onset obesity tends to be associated with more emotional disturbance than adult obesity. Some people are unable to distinguish between hunger and other kinds of dysphoria. In some obese people eating behavior is more related to external stimuli (e.g. time of day, smell or sight of food). Many obese people have low self-esteem and lack of social confidence. Many psychiatric patients develop obesity following their regular use of psychotropic drugs.

Some obese people develop psychological symptoms when dieting e.g. anxiety, low mood, lack of interest, irritability. A few may abuse some appetite suppressant drugs for their stimulant effects (e.g. dextroamphetamine).

Psychological treatment of obesity include:

- Behavioral modification:
 - Recognizing external cues that are associated with eating.
 - Keeping diaries of food intake.
 - Eating slowly and chewing food well.
 - Not reading or watching television while eating
 - Not eating between meals.
 - Self and group monitoring and reinforcement.
- Cognitive therapy:
 - Correcting faulty thoughts, and resulting emotions (e.g. guilt, shame...)
- Insight – oriented psychodynamic therapy

ANOREXIA NERVOSA

A potentially serious eating disorder characterized by a profound weight loss, refusal to maintain body weight (body weight is less than 85 % of that expected), intense fear of becoming fat and gaining weight (even though underweight), disturbed body image and self-imposed severe dietary limitation, usually resulting in serious malnutrition.

Another significant feature in females is amenorrhea (at least 3 consecutive menstrual periods are absent).

Patient goes on weight – losing diet and sometimes self – induced vomiting. Severe cases may have underlying psychiatric disorders (e.g. depression, psychosis...). See Table 17-1: DSM-IV diagnostic criteria of anorexia nervosa.

The onset is usually between 15 – 20 years, often associated with psychosocial stresses or dieting behavior.

Anorexia nervosa occurs mainly in females (90 %) mostly in developed countries and westernized families in developing countries.

Differential diagnosis includes:

- Medical conditions:
 - brain tumor
 - gastrointestinal diseases e.g. superior mesenteric artery syndrome
 - neoplasia
 - endocrinopathies
 - autoimmune diseases
- Psychiatric: schizophrenia, depression, OCD...

Treatment:

Multifaceted approach in medical or psychiatric unit, in-patient or out-patient depending on degree of weight loss and physical health.

Hospitalization is indicated for:

1. assuring weight gain, especially if patient has metabolic complications of starvation.
2. monitoring suicidal patient.

Nurse supervision during and after meals to avoid induced vomiting and compensatory behavior.

Regular diet to attain 1.5 kg / week. Chlorpromazine may stimulate appetite and help in weight gain. Antidepressants, anxiolytics and cyprohepatadine may be useful. However, patients often resist medications.

Education, counseling, cognitive-behavior therapy and family therapy may be helpful.

Prognosis:

Mortality is high (40 % if not treated). When treated 30 % improve, 30 % become chronic and 40 % recover.

BULIMIA NERVOSA

Uncontrolled episodes of excessive compulsive eating of large amounts of food over a short period of time (binge eating), followed by guilt feelings inappropriate behavior; self-induced vomiting, excessive exercise, fasting, or use of laxatives in order to reduce

weight leading to ↓ k (hypokalemia) and its complications (cardiac, renal...). Patient's self-evaluation is influenced by body shape and weight; patient tends to respond to societal pressures to be slim. Bulimia nervosa is much more common than anorexia nervosa. Female-male ratio is 9 : 1.

Most patients have emotional lability, anxiety or depressive features, tend to be impulsive and angry. See table 17-1: DSM-IV diagnostic criteria of bulimia nervosa.

Treatment:

Most patients are treated as outpatients and are more motivated than anorexia nervosa patients. Cognitive-behavioral therapy have been found to be effective for attitudes to body shape and weight, and self-control. Antidepressants help in reducing binge eating and depressive feelings.

Prognosis:

Severe cases tend to run a chronic course, particularly when associated with personality disorder (impulsivity, labile mood...). However, overall prognosis is better than anorexia nervosa.

PICA

Pica is defined as persistent eating of non-edible non-nutritive substance for at least 1 month, usually after 18 months of age. Pica must not be culturally sanctioned. It appears much more frequently in young children than in adults. Both sexes are equally affected. Mentally retarded people particularly institutionalized children and adolescents are at special risk. Pregnant women may develop certain forms of pica like clay eating (geophagia), and starch eating (amylophagia).

Causes may include nutritional deficiencies (iron, zinc...) and psychosocial deprivation. Complications include intestinal parasites, lead poisoning & intestinal obstruction. The prognosis varies: in pregnant women pica is usually limited to the pregnancy itself; in children pica often resolves with increasing age. In mentally retarded,

pica may run a chronic course. Treatment should include proper assessment of possible underlying causes (e.g. neglect, emotional abuse...), and medical complications. Correction of iron or zinc deficiency can eliminate pica. Family guidance, environmental and psychosocial approaches are required.

Table 17-1: DSM Diagnostic Criteria

Anorexia Nervosa	Bulimia Nervosa
<p>A. Refusal to maintain body weight at or above minimally normal weight for age and height.</p> <p>B. Intense fear of gaining weight even though underweight.</p> <p>C. Disturbance in the way in which one's body weight or shape is experienced.</p> <p>D. Amenorrhea (at least 3 consecutive periods)</p>	<p>A. Recurrent episodes of binge eating.</p> <p>B. Recurrent inappropriate compensatory behavior in order to prevent weight gain (e.g. self-induced vomiting)</p> <p>C. Both A&B occur, on average, at least twice a week for 3 months.</p> <p>D. Self-evaluation is unduly influenced by body shape and weight.</p> <p>E. The disturbance does not occur exclusively during episodes of anorexia nervosa.</p>

PSYCHOSEXUAL DISORDERS

- ★ Sex is part of normal human life and involves all aspects of the psychosexual, biological and sociocultural framework. Normal sexual responses are shown in Table (17-2).

Table 17-2: Normal Sexual Responses:

Phase	Male	Female
<i>Desire</i>	Fantasy & drive to sex	Fantasy & drive to sex
<i>Excitement and arousal</i>	Erection with sexual pleasure	Vaginal lubrication
<i>Orgasm</i>	Peak of sexual pleasure, release of sexual tension with emission of seminal fluid	Peak of sexual pleasure with contractions of outer third of vagina
<i>Resolution</i>	Sense of relaxation, penile detumescence, refractory period	Sense of relaxation vagina returns to normal pre- excitement position, no refractory period

- Psychosexual disorder can be:
 - a - in performance: sexual dysfunction.
 - b - in preference: sexual deviations (Paraphilias) e.g. homosexuality, pedophilia.
- Sexual dysfunction can be:
 - Desire disorders.
 - Arousal disorders (e.g. erectile disorder, i.e. impotence).
 - Orgasmic disorders (e.g. premature ejaculation).
 - Sexual pain disorders (e.g. vaginismus, dyspareunia).

The most common sexual problems are:

1. erectile dysfunction (males).
2. premature ejaculation (males).
3. vaginismus (females).
4. low sexual desire (females, males).
5. inhibited female orgasm.

Assessment of a psychosexual problem:

- Define the problem:
 - nature
 - onset
 - severity
 - complications
- Assess sexual history:
 - puberty
 - fantasy
 - orientation
 - practice
 - drive
 - education / attitude to sex
 - expectations
 - sexual traumas (e.g. rape)
- Sex atmosphere (privacy, foreplay...)
- Psychiatric disorders:
 - Depression.
 - Anxiety

- Physical diseases e.g. diabetes mellitus, hypertension...
- Marital relationships

In many Arabic cultures, psychosexual problems like many other psychiatric disorders are commonly attributed to supernatural causes (witchcraft, jinn or evil eye).

□ **ERECTILE DISORDER (IMPOTENCE)**

- Inability to attain or maintain enough erection until completion of satisfactory coitus.
- Causes include:
 - Physical diseases e.g. diabetes mellitus, arteriosclerosis, drugs, alcohol.
 - Psychological: anxiety, depression.
 - Presence of morning erection suggests a psychological cause particularly in an anxious person who is sensitive to issues related to sex.
 - Complications: depression, anxiety, unconsummated marriage and divorce.
- **Management includes:**
 - Identifying and treating any possible underlying physical or psychiatric problems.
 - Psychological treatment
 - Education about normal sexual phases and the importance of privacy and foreplay.
 - Improving the couple communication (increasing understanding of the wishes and feelings of the other partner).
 - Behavior techniques: gradually reducing performance anxiety and increasing sensual sexual feelings.
 - Physical treatment include intracavernosal injection of prostaglandin E1 (smooth muscle relaxant), sildenafil (viagra) and vacuum devices.

□ **PREMATURE EJACULATION:**

Ejaculation with minimal sexual stimulation (before, upon, or shortly after penetration) and before the person wishes it, so that woman gains no pleasure.

It is common among young newly married men. It may improve with increasing sexual experience.

Treatment includes:

- Sex education.
- Anxiety reduction (relaxation training, anxiolytics).
- Squeeze or stop-start technique (the woman interrupts foreplay whenever the man feels highly aroused, in order to prolong the period of arousal before reaching orgasm).
- Some psychotropic drugs delay ejaculation (e.g. clomipramine, paroxetine) can be given few hours before sex.

□ **VAGINISMUS:**

An involuntary painful muscle spasm of the vaginal muscles (outer third) that interferes with penile insertion. Thigh muscles may also contract. The condition may be made worse by an inexperienced harsh partner. Some cases had past history of sexual abuse. Anxious sensitive women are at higher risk.

Complications include:

- Anxiety
- Depression
- Marital discord, unconsummated marriage and divorce.

Treatment:

- Education and explanation
- Graded behavioral approach (woman is encouraged to gradually insert her finger into vagina) wait until anxiety disappears doing this repeatedly (with increasingly larger probes) facilitates the process of muscle relaxation and vaginal lubrication.

- Additional lubrication may be required to facilitate penile penetration.
- Anxiety reduction (relaxation training, anxiolytics).
- Hypnotherapy.

Chapter 18

Personality Disorders

- **Personality:**
The distinctive set of characteristics that defines the emotions, thoughts, perception and behavior or an individual's personal style and influence his interactions with the environment. These characteristics comprise ingrained and habitual ways of individual's entire developmental history. Temporal stability and cross-situational consistency are fundamentals to the concept of personality.
- **Characters:**
Personal qualities that represent the individual's adherence to the value and customs of society, a moral standard is applied here.
- **Temperament:**
The biological constitutions and dispositions that underlie the tendency to respond to stimulation in particular ways, and color the moods of the individual. The term "temperament" is used when talking about children and adolescents characteristics (before the age at which the personality is well formed).
- **Traits:**
Prominent enduring aspects and qualities of a person.
- **Personality disorders:**
Enduring, inflexible, pervasive patterns of behavior or inner experience that deviate markedly from the expectations of the individual's culture and lead to clinically significant distress, or impairment in social or occupational functioning.

These patterns are manifested in various ways:

- Ways of perceiving and interpreting self, other people, and events (i.e., cognition).
- The range, intensity, lability and appropriateness of emotional response (i.e., affect).
- Interpersonal functioning
- Impulse control

A personality is disordered when it causes suffering to the person or to other people. Personality pathology comprises those consistent and chronic traits that persist inflexibly, are exhibited inappropriately and intensify already present difficulties.

Judgment about personality functioning must take into account the individual's ethnic, cultural, and social background.

□ **COURSE:**

The features of a personality disorder usually become recognizable during adolescence or early adult life. Some types of personality disorders (e.g. antisocial and borderline personality disorders) tend to become less evident or to remit with age, whereas some other types (e.g. obsessive compulsive personality disorder) persist for long time.

The traits of a personality disorder that appear in childhood will often not persist unchanged into adult life. The development of a change in personality in middle adulthood or later life warrants a thorough evaluation to determine the possible presence of a personality change due to a general medical condition or an unrecognized substance – related disorder.

□ **Epidemiology:**

Overall, males and females are affected equally. However, certain personality disorders (e.g. histrionic personality disorder) are diagnosed more frequently in females. Others (e.g. antisocial personality disorder) are diagnosed more frequently in males. The overall prevalence of personality disorders in certain community surveys is about 6 – 10 %.

● **Determinants of personality and its disorders**

The development of personality involves a complex interaction of several factors (see table 18 – 1) which come together in late adolescence and early adulthood.

Table 18–1. Determinants of Personality and its Disorders

- | |
|---|
| <ul style="list-style-type: none">– Biological factors (genetics, perinatal injury...)– Family environment (abuse, deprivation...)– Psychological factors (cognitive distortions...)– Social factors (poverty, migration...) |
|---|

Personality Assessment:

It is important to know how to assess the personality because:

1. Personality traits need to be differentiated from episodes of mental illness. However, coexistence of the two is common in clinical practice.
2. Pathology of personality can increase the vulnerability to maladjustment to psychological and physical stresses.
3. Presence of personality disorder can alter the presentation of mental disorder, which may complicate the clinical picture and make the final diagnosis difficult.
4. The treatment of a mental disorder is more difficult when the patient has personality pathology. These patients are far more likely to refuse psychiatric help and deny their problems than are people with anxiety or dysthymic disorders. Moreover, personality abnormal traits are often acceptable to the person's ego (ego-syntonic) and not considered by him as abnormal.

* Aspects to assess:

- Emotional reactivity and stability.
- Social relationships, extent and intensity.
- Intellectual abilities.
- Motives and self-control.
- Frustration tolerance and ability to deal with stress.
- Judgment, decision-making, and problem solving.
- Beliefs, attitudes and moral standards.
- Habits and hobbies.

★ **How to assess?**

The following sources of information can be considered:

1. observing the patient in various circumstances.
2. patient's own description of his own personality. However, caution should be exercised because personal evaluation is at a high risk of bias.
3. the reports and views of other informants who are acquainted with the patient (e.g. a spouse, a parent, a close friend...).
4. patient's account of his behavior in a variety of past circumstances.
5. certain psychological tests of personality which are usually applied by a clinical psychologist.

The most commonly used tests are:

- Minnesota Multiphasic Personality Inventory (MMPI).
 - Eysenk Personality Inventory (EPI).
 - Five-factor model of personality.
- **Classification of personality disorders**
DSM classifies the personality disorders into three clusters based on similarities in symptoms, traits, and defense mechanisms involved.

Table 18-2. Classes of Personality Disorders

Cluster	DSM	ICD Equivalent
<i>A: odd and eccentric</i>	Schizoid Paranoid Schizotypal	Schizoid Paranoid -----
<i>B: dramatic and Emotional</i>	Histrionic Antisocial Borderline Narcissistic	Histrionic Dissocial Emotionally unstable (• Borderline • impulsive) -----
<i>C: anxious and fearful</i>	Avoidant Dependent Obsessive compulsive	Anxious Dependent Anankastic

[1.] Schizoid Personality Disorder

- **Main Features:**

- Social isolation and detachment from social relationship (few close friends)
- Self-sufficiency with emotional coldness and restricted range of emotional expression.
- Indifference to praise, criticism and feelings of others.
- Choosing solitary activities and jobs
- Excessive daydreams and fantasies.
- Lack of social skills.

Schizoid person is attracted by non-emotional interests (e.g. computer, mathematics, philosophy...) and is able to invest enormous intellectual and affective energy in such interest giving creative ideas and actions.

- **DDx:**

1. Avoidant personality disorder: socially isolated due to fear of criticism and rejection; patient strongly wishes to participate in activities.
2. Paranoid personality disorder.
3. Schizotypal personality disorder.
4. Obsessive compulsive personality disorder.
5. Schizophrenia.

- **Treatment:**

Psychological treatment (identification of emotions, and focus on relatedness). Pharmacological treatment (small doses of antipsychotics, antidepressants, or psychostimulants may be effective in some patients).

[2.] Paranoid Personality Disorder

- **Main Features:**

- Suspiciousness of others without sufficient basis and excessive mistrust of others' motives and loyalty of friends or associates.
- Sensitivity to offenses.
- Exaggerated perception of imagined threatening meanings or hidden demeaning of benign events and remarks, with ideas of reference.
- Exaggerated counter attacking and reacting angrily with abusive behavior.
- Exaggerated bearing of grudges persistently (e.g. insults, slights, injuries).
- Excessive jealousy and competition.
- Excessive secrecy.
- Projection of faults and malevolent motives on others and avoidance of accepting blame when it is deserved.
- Stubbornness and tendency to argumentations.

DDx:

1. Other personality disorders (e.g. antisocial, narcissistic, schizotypal) however, coexistence may occur.
2. Paranoid psychosis (e.g. stimulant intoxication, delusional disorder, schizophrenia).

Treatment:

Psychological treatment (individual therapy, supportive, reassuring, straightforward approach to reduce suspiciousness and improve reality perception). Pharmacological treatment (small doses of antipsychotics can be used for short periods to deal with agitation and anxiety, explain the possible side effects).

[3.] Schizotypal Personality Disorder

- **Main Features:**

- Odd patterns of thinking, speech, belief, behavior or appearance compared to the social norms.

- Unusual perceptual experiences (e.g. bodily illusions)
 - Constricted affect with excessive social anxiety associated with suspiciousness and ideas of reference.
- **DDx:**
 1. Psychotic disorders especially schizophrenia (in ICD Schizotypal disorder is considered as a variant of Schizophrenia).
 2. Paranoid personality disorder.
 3. Schizoid personality disorder.
 - **Treatment:**
The principles of treatment are similar to those of schizoid and paranoid personality disorders.

[4.] Antisocial Personality Disorder

- **Main Features:**
 - Violation of the rights of others and conflicts with the law.
 - Lack of remorse and guilt.
 - Lack of loyalty (lying, exploiting others...)
 - Failure to learn from experience.
 - Impulsive behavior & failure to plan ahead.
 - Tendency to violence.
 - Consistent irresponsibility.
- * Diagnosis is not made before the age of 18.
- **DDx:**
 1. Substance abuse: it may be a comorbidity primary or secondary to antisocial behavior.
 2. Mental subnormality.
 3. Borderline personality disorder (coexistence is common).
 4. Psychotic disorders (e.g. mania, schizophrenia...).
- **Treatment:**
Psychological treatment (group therapy is more helpful than individual therapy particularly if patients are immobilized, e.g. placed in hospitals), firm limits are essential. Therapeutic

community or long-term hospitalization is sometimes effective. Treatment of substance abuse often effectively reduces antisocial attitude and tendency.

[5.] Borderline Personality Disorder

- **Main Features:**
 - Unstable mood, behavior and relationships.
 - Identity disturbance (uncertainty about self-image and goals...).
 - Persistent feelings of emptiness and boredom.
 - Insistence on immediate gratification of needs.
 - Impulsive behavior with poor planning.
 - Self – mutilating behavior with anger outburst.
 - Dichotomous pattern of thinking (all bad or all good).

- **DDx:**
 - Mood disorders (cyclothymic or bipolar II disorders).
 - Schizophrenia
 - Substance-related disorders (may co-exist).
 - Other personality disorders (antisocial, histrionic).

- **Treatment:**

Psychological treatment: exploratory, supportive and behavior therapy). Pharmacological treatment: mood stabilizers help in minimizing mood fluctuations. Antidepressants and antipsychotics can be used as symptomatic treatment.

[6.] Histrionic Personality Disorders

- **Main Features:**
 - Attention seeking behavior (verbal and nonverbal).
 - Excessive superficial emotions (shallow and shifting).
 - Self – dramatization and exaggeration.
 - Provocative and seductive behavior.
 - Suggestibility with superficial thinking.

- **DDx:**
 1. Narcissistic personality disorder.
 2. Borderline personality disorder.
 3. Somatoform disorders (may co-exist).
- **Treatment:**
 Psychological treatment: supportive and directive approaches to increase awareness of the real feelings underneath the histrionic behavior. Pharmacological treatment: antianxiety or antidepressant drugs may transiently be used.

[7.] Narcissistic Personality Disorder

- **Main Features:**
 - Exaggerated self-importance and superiority.
 - Preoccupation with entitlement, success and power.
 - Excessive and unrealistic fantasies.
 - Constant seeking of admiration.
 - Excessive concern about appearance more than substance.
 - Relationships with others are characterized by lack of empathy, exploitation and hypersensitivity to criticism.
 - Over preoccupation with feelings of envy.
 - Fragile self-esteem.
- **DDx:**
 1. Histrionic personality disorder.
 2. Paranoid personality disorder.
 3. Delusional disorders, mainly grandiose type.
- **Treatment:**
 They rarely seek or accept treatment as their traits are highly desired and accepted by ego (ego-syntonic) and drive to success. Episodes of anxiety or depression can be treated symptomatically.

[8.] Avoidant Personality disorder

- **Main Features:**
 - Sensitivity to criticism and rejection.
 - Fearfulness of disapproval.

- Timidity and shyness.
 - Feelings of inadequacy in new situation.
 - Reluctance to take personal risks.
 - Very restricted number of friends.
- **DDx:**
 1. Social phobia (may coexist)
 2. Dependent personality disorder.
 3. Schizoid personality disorder.
 - **Treatment:**

Psychological treatment: posting self-confidence and self-acceptance, assertiveness training social skills, and group therapy. Pharmacological treatment to manage anxiety or depression when present.

[9.] Dependent Personality Disorder

- **Main Features:**
 - Submissive and clinging behavior.
 - Fear of separation.
 - Excessive compliance with others.
 - Lack of self-reliance and self-confidence.
 - Excessive demands for reassurance and advice.
 - Excessive worries about abandonment.
 - Difficulty in initiating tasks.
- **DDx:**
 1. Avoidant personality disorder.
 2. Agoraphobia (may co-exist).
- **Treatment:**

Psychological treatment: behavior therapy and insight oriented therapy. Pharmacological treatment: for specific symptoms e.g. anxiety agoraphobia....

[10.] Obsessive Compulsive Personality Disorder

- **Main Features:**
 - Excessive perfectionism interfering with achievement very idealistic views.
 - Preoccupation with minor unnecessary details.
 - Inflexibility and rigidity.
 - Indecisiveness and hesitation
 - Excessive self-blame and guilt feeling.
 - Scrupulousness about issues of morality.
 - Excessive devotion of time and energy to work, at the expense of social life.
 - Reluctance in delegating tasks to others.

- **DDx:**
 - Obsessive-compulsive disorder (OCD): presence of obsessions / compulsions (coexistence may occur).
 - Narcissistic personality disorder patient seeks perfectionism and more likely to believe that he has achieved it.

- **Treatment:**

Psychological: supportive and directive individual or group therapy
Pharmacological: fluoxetine and clomipramine have been found useful.

- **Other less agreeable personality disorders:**
 1. *Passive-aggressive personality disorder:*

Negativistic attitude and passive resistance to demands for adequate performance with excessive complaints of being unappreciated and misunderstood by others.

 2. *Self-defeating personality disorder:*

defeating self repeatedly through choosing people or situations that inevitably lead to mistreatment or disappointment, and rejection of attempts to help.

3. *Depressive personality disorder:*
pervasive pattern of anhedonic mood with pessimistic views and low self-esteem.
4. *Sadistic personality disorder:*
aggressive, cruel and demeaning behavior with lack of empathy and respect for others.

Chapter 19

Emergency Psychiatry

A 17 year-old girl known case of schizophrenia was brought to Emergency Department because of severe neck spasm , tongue protrusion ,rigid limbs and sustained upward gaze of her eyes.

PSYCHIATRIC EMERGENCIES

- Psychiatric symptoms and signs can be the presenting features of a mental, a neurological or a medical disease; thus the clinician should be alert, open-minded and thorough in evaluating patients with possible psychiatric emergencies.

Psychiatric Emergency:

A disturbance in mental functions that potentially threatens the patient or other's health, and requires immediate intervention.

Psychiatric emergencies may occur

A. In hospitals:

- Emergency Departments /Medical or Surgical Units/ Psychiatric Wards or Clinics / Others.

B. Outside hospitals:

- Homes / Streets / Markets / Others.

Common Types of Psychiatric Emergencies:

- Suicide and parasuicide / Violence / Stupor/ Complications of drugs

General Assessment and Interventions:

• Immediate Measures:

- Know as much as possible about the patient before coming in contact with him (her).
- Assess the dangerousness of the patient's behavior (threatening, agitated, angry...).
- Psychiatric interview if possible.
- Protect self and prevent harm.

• Further Steps:

- Hospitalization.
- Treatment of physical problems.

- Pharmacotherapy.
- Psychotherapy.

SUICIDE

Sui: self, Cide: murder

- Suicide means the intentional self-killing. In western countries suicide rate is high and accounts for about 1 % of total deaths.
- In Saudi Arabia transient suicidal ideas are found in many depressed patients. However, no figures of suicide rate are available, although a few cases have been reported by doctors and the police.
- **Common Underlying Factors:**
 1. Depressive disorder
 2. Substance abuse
 3. Schizophrenia
 4. Personality disorder
 5. Serious chronic physical disease
 6. Social isolation and lack of support
 7. Financial problems
- **Suicide Methods:**
 - Hanging
 - Shooting
 - Rushing in front of running vehicles
 - Jumping from high places
 - Burning
 - Poisoning
- **Risk Factors for Suicide:**

These risk factors should be recognized, assessed and utilized in conjunction with careful clinical assessment in deciding the suicidality of a patient.

 1. Age > 45 years old.

2. Male > Female.
3. Separated, divorced, widow > single > married.
4. Previous suicide attempts or behavior.
5. Family history of suicide behavior.
6. Current psychopathologic conditions:
 - Severe depression
 - Substance abuse
 - Psychosis
 - Personality disorder
7. Concurrent serious or chronic medical condition.
8. Lack of social support.
9. Suicide note.
10. Planning with precautions against discovery.
11. Strong intent to die.

Who requires suicide evaluation?

Any patient who

- has recently attempted suicide.
 - presents with suicidal ideation.
 - reveals suicidal ideas only when asked.
 - has behavior indicating possible suicidality.
- **The Assessment of Suicide Risk:**
1. **Evaluation of intentions:**
 - Asking about suicidal intentions is very important. It will not make suicide more likely.
 - Sympathetic approach, which also helps the patient feel better understood and hence may reduce the risk of suicide.
 - Systemic enquires about :
 - Thoughts whether life is worth living.
 - Wishes to die.
 - Suicidal ideation.
 - Suicidal intent.
 - Suicidal specific preparatory acts (e.g. planning with precautions against discovery).
 - Actual suicidal trial.

2. History of intentional self-harm.

- Serious deliberate self harm.
- Repeated dangerous attempts.
- Continuing wish to kill or harm self.
- Writing a farewell suicidal note.

3. Presence of mental disorders:

- Severe depression with guilt feelings hopelessness and helplessness. Depressed patient may not be able to plan and commit suicide while
- severely depressed. However, it was found that suicide may occur during recovery from sever depression.
- Schizophrenia: on recovery from acute phase or in chronic schizophrenic illness.
- Substance abuse with psychiatric and physical complications.
- Personality disorders (e.g. borderline personality disorder; these patients have poor impulse control and chronic emotional instability).

4. Presence of adverse social and medical conditions:

- Social factors (e.g. home, work, finances...) need to be assessed.
- Medical problems (especially if they are painful disabling or rapidly deteriorating in spite of medical interventions).

5. Presence of homicidal ideation:

e.g. to kill a spouse, children or parents, in order to spare them intolerable suffering after committing suicide (some severely depressed suicidal patients have homicidal ideas).

• Management:

- Proper assessment of suicidal risk.
- Every suicidal ideation, impulse, gesture or attempt should be taken seriously.
- Hospitalization: for patients with serious suicidal risk.

- Prevent access to all means of harm (sharp objects, ropes, drugs...). Search the patient thoroughly.
- Appropriate close observation: vigilant nursing staff with good communication.
- Treat any psychiatric disorder.
- **If the risk does not seem to require hospitalization:**
 - Ensure good support.
 - Relatives: responsible, reliable and understanding.
 - Encouraging positive view of the future.
 - Counseling.
 - Problem solving.
 - Treat underlying psychiatric condition.
 - Keep regular follow up visits.

Suicidal persons remain suicidal for only limited periods thus the value of early detection and restraint.

Some patient die by suicide whatever carefully the correct procedures have been followed.

PARASUICIDE

Also called: “Non-fatal deliberate self-harm” or “attempted suicide”.

□ Definition:

Any act of self-damage carried out with the apparent intention of self- destruction; yet ineffective, half-hearted and vague.

□ Etiology:

- Impulsive behavior: seen commonly in borderline personality disorder.
- Unconscious motives: to influence others, a signal of distress or a cry for help seen commonly in histrionic personality disorder.
- Failed suicide: 25 % of cases.

□ **Risks Factors:**

- Young (15 – 35 years)
- Commoner in females
- Personality problems (e.g. borderline personality disorder).
- Situational stress (e.g. arguments with parents, spouse...).

□ **Methods:**

- Drugs overdose (e.g. paracetamol) is the most common method.
- Self-injury e.g. laceration of wrist.
- Jumping from heights.

□ **Management: each case should be assessed thoroughly.**

- intentions
- plans
- psychosocial stresses
- personality
- available support
- possibility of repetition
- Treat any psychiatric disorder
 - Inpatient or outpatient depending on the case.
- Problem solving and counseling
 - To resolve current difficulties.
 - To deal better with future stresses.
- Prolonged follow up is required for some cases who are at risk of repetition of self-harm and suicide those with personality disorders and long-term adverse psychosocial situations.

VIOLENCE

Potentially assaultive and aggressive patients are frequently seen in emergency departments and in the medical and psychiatric wards.

• **Causes:**

1. Acute schizophrenia or schizophreniform disorder.

2. Brief psychosis.
 3. Mania.
 4. Agitated depression.
 5. Substance abuse (e.g. intoxication with stimulants, alcohol withdrawal).
 6. Acute organic brain syndrome (delirium).
 7. Personality disorders (e.g. antisocial and borderline personality disorders).
- **Approach:**
 - Arrange for adequate enough help.
 - Appear calm and helpful.
 - Avoid confrontation.
 - Take precautions:
 - other persons should be present (security guards or policemen).
 - keep the door open for an unavoidable exit.
 - restraints if needed by an adequate number of people using the minimum of force.
 - carefully search for any kind of offensive weapon.
 - Aim to save the patient and others.
 - Anticipate possible violence:
 - from hostile, threatening behavior.
 - from restless, agitated abusive patient.
 - Do not bargain with a violent person about the need for restraints, medication or psychiatric admission.
 - Never attempt to evaluate an armed patient.
 - Reassure the patient and encourage self-control and cooperation.
 - **Medications: major tranquilizers**
 - e.g. Olanzapine 5-10mg Im , Haloperidol 5 - 10 mg IM or Chlorpromazine 50 - 100 mg IM
 - Hospitalization for further assessment and treatment.

□ **Restraint Technique:**

- Enough staff should be available.
- If restraint becomes necessary, assign one team member each to the patient's head and to each extremity.
- Be human but firm, and do not bargain, start together to hold the patient and accomplish restraint quickly.

STUPOR

Lack of reaction to, and awareness of the environment without loss of consciousness.

□ **Differential Diagnosis:**

1. Catatonic Schizophrenia (Catatonic Stupor)

- Affect is blunted
- Facial expression = "Dead Pan" type
- Posturing and rigidity are common.
- Incontinence is common.

2. Major Depression (Depressive Stupor)

- Facial expression : bewilderment and anxiety.
- Depressed affect
- No posturing
- Incontinence is uncommon

3. Organic Stupor:

- Several neurological disorders can present with stupor including:
 - Viral encephalitis
 - Brain tumor
 - Vascular lesions (frontal or temporal lobes).
 - Heat stroke.
- Differentiation is based on findings in the history, physical examination and investigations.

4. Neuroleptic malignant syndrome

5. Central anticholinergic syndrome

6. Serotonergic syndrome

□ **Management:**

- Full assessment: proper history, mental state examination, physical examination and relevant laboratory investigations.
- Hospitalization:
 - If organic causes are suspected admission is better in a medical ward.
 - If catatonic or depressive stupor is highly suspected (after enough assessment) admission is better in a psychiatric ward.
 - ECT is helpful in such cases.
 - Psychotropic drugs, e.g.:
Antipsychotics if schizophrenia.
Antidepressant in case of depressive stupor.

DRUG COMPLICATIONS

- A. Neuroleptic malignant syndrome
- B. Acute dystonia
- C. Lithium toxicity
- D. Anticholinergic toxicity
- E. Serotonergic syndrome
- F. Hypertensive crisis due to MAOIs

A. Neuroleptic Malignant Syndrome (NMS):

- **Etiology is not well known**
(? Idiosyncratic response to acute hypodopaminergic states)
- **Features:**
 - Muscle rigidity (trunk, limbs, neck, and throat).
 - Sweating and hyperthermia (check temperature).
 - Autonomic instability: fluctuating pulse, BP and respiration.
 - Akinesia.
 - Clouding consciousness.
- **Onset** after 2 – 28 days , lasts 5 – 10 days after oral antipsychotics.
- **Incidence** is higher in males > 40 years.

- **Laboratory Abnormalities (Secondary Features)**
 1. Raised CPK (creatinine-phosphokinase)
 2. Raised potassium
 3. Neutrophilia
- **Treatment:** (should be in Medical Intensive Care Unit “ MICU”)
 - Stop antipsychotics.
 - Monitor vital signs.
 - Support respiratory functions.
 - Reduce body temperature (cooling).
 - Treat secondary infection (if any).
 - Rehydrate.
 - Bromocriptine (30 – 60 mg / day) to enhance dopaminergic activity.
 - Dantrolene (5 – 10 mg / day) to reduce muscle rigidity.
 - Supportive treatment: dialysis may be required, to reduce the risk of acute renal failure that may result from excessive amounts of myoglobin in the blood following muscle tissue destruction due to excessive prolonged very severe muscle rigidity.

- Differential diagnosis:

1- Malignant hyperpyrexia : similar condition not induced by antidopaminergic medications. It occurs mainly in patients with muscle disorders after rhabdomyolysis.

2- Lethal catatonia (Stauders) : similar to NMS features but associated with excitement , violence, and hallucinations.

3- Heat stroke.

B. Acute Dystonia

- Antidopaminergic effect of antipsychotics especially potent ones (e.g. haloperidol).
- **Features:**
 - Painful sustained muscle contractions e.g.:
 - Torticollis spasm of neck muscles tilting the head to one side.
 - Spasm of ocular muscles (oculogyric crisis).
 - Tongue protrusion.

- Opisthotonos: spasm of back muscles arching the vertebral column.
- It is worrying to the patient and the family and may interfere with compliance with antipsychotics, but not a serious condition.
- **Treatment:**
 - Immediate anticholinergic drug e. g. procyclidine 5 – 10 mg IM
 - Prophylactic oral anticholinergics e. g. procyclidine 5 mg p.o. three times / day.

C. Lithium Toxicity

This is a serious emergency; condition that requires immediate intervention.

It is likely to occur if the lithium serum level exceeds 1.5 m.mol/L. It increases in case of severe diarrhea , hot weathers and with concomitant use of thiazide diuretics due to sodium loss in the sweat and urine respectively as the body compensates by retaining more lithium.

Features:

- Coarse tremor.
- Ataxia.
- Dysarthria.
- Confusion.
- Muscle twitching.
- Hyperreflexia.
- Nausea, vomiting.
- Profuse diarrhea.
- Abdominal pain.

It may progress to fits, coma, cardiovascular collapse and death.

If the patient recovers, he may develop:

- Permanent neurological damage.
- Renal failure.

Treatment:

- Stop lithium.
- High fluid intake with extra sodium chloride to facilitate lithium loss.
- Osmotic diuretics e.g. dextran.
- Renal dialysis may be required especially if serum level is very high.

D. Anticholinergic Toxicity

This is a common syndrome due to the widespread simultaneous use of several highly anticholinergic psychotropic drugs:

- Tricyclic antidepressants
- Antipsychotics
- Antiparkinsonian drugs
- Antihistamines

Features vary in severity according to the degree to which the drugs block both muscarinic and nicotinic receptors.

- Dry skin (dry as a bone)
- Flushing (red as a beef)
- Hyperthermia (hot as hades)
- Tachycardia
- Urinary retention
- Paralytic ileus
- Ataxia / confusion (anticholinergic delirium)
- Hallucinations

Serious complications may occur:

- seizures
- cardio-respiratory collapse
- coma

Treatment:– **First Step:**

- Supportive care and basic life support:
- IV line (fluids...)

- Cardiac monitoring
 - Anticonvulsants & antiarrhythmics
 - Close observation.
- **Second Step:** (if no response to the first step)
- Physostigmine (used cautiously and need to be given repeatedly due to short half-life) to reverse both central and peripheral anticholinergic effects.

E. Serotonergic Syndrome

The Main Features:

Neurological Symptoms	Mental State Changes	Other Features
<ul style="list-style-type: none"> - Headache - Nystagmus - Tremor - Myoclonus - Seizures - Rigidity 	<ul style="list-style-type: none"> - Confusion - Irritability - Agitation 	<ul style="list-style-type: none"> - Hyperpyrexia - Cardiac arrhythmia

Complications: coma, death.

It is due to a combination of a number of drugs that potentiate brain serotonin function. The most common combination is MOAIs (which inhibit the catabolism of serotonin) with SSRIs, clomipramine and fenfluramine.

Treatment:

- Stop all medications
- Supportive measures and monitoring of vital signs.

F. Hypertensive Crisis due to MAOIs

Tyramine ingestion or concomitant use of sympathomimetics with MAOIs.

Features:

- Throbbing severe headache
- Dangerously elevated BP
- Agitation, irritability
- Flushing

Treatment:

- Blocking alpha-adrenoreceptors by parenteral phentolamine or IM chlorpromazine.
- Nifedipine can also be helpful
- Follow blood pressure

See also alcohol withdrawal , delirium tremens , intoxication with substances of abuse (chapter 7).

Self assessment :

1. A 45 year-old diabetic man on insulin known to his friends as kind, calm and cooperative person suddenly became potentially assaultive , disoriented and aggressive without an obvious provoking event. He was then taken to hospital and after receiving only dextrose he became calm, kind and oriented . The most appropriate statement is:
 - a. He had brief psychosis.
 - b. He had agitated depression.
 - c. *His violence was due to delirium.(T)*
 - d. His violence was due to manic episode.
 - e. He should be given regular doses of antipsychotics.

2. A 55 year-old housewife has resistant depression seen at out-patient clinic and given maximum dose of paroxetine with no improvement then she went to a private psychiatric clinic and given moclobemide 300 mg twice per day (along with paroxetine). Three days later she showed tremor, nystagmus , myoclonus, confusion and then coma. The most appropriate statement is:
 - a. Give her procyclidine IM injection.
 - b. She has neuroleptic malignant syndrome.
 - c. She has hypertensive crisis.
 - d. *She has serotonergic syndrome.(T)*
 - e. She has anticholinergic delirium.

Chapter 20

Women Related Psychiatry

Geriatric Psychiatry

A 43 year-old woman delivered two weeks ago, she then gradually became paranoid, agitated aggressive restless and insomniac.

Women-Related Psychiatry

□ Premenstrual Syndrome (PMS):

A group of physical and psychological features beginning a few days before and ending shortly after the onset of menstrual period.

- Psychological features: tension, anxiety, irritability, nervousness and low mood.
- Physical features: abdominal distension and pain as well as breast tenderness.
 - The condition may lead to social, academic or marital dysfunctioning.
 - No specific cause has been found.
 - Treatment:
 - Support
 - Identify and treat familial and social stresses.
 - Cognitive-behavior therapy.
 - Many drugs have been tried (hormones, psychotropic drugs..) with varying degrees of response.

□ Pregnancy:

- Minor psychological symptoms are common during pregnancy, especially in the first and third trimesters (anxiety, irritability and minor lability of mood). Risk increases in case of unwanted pregnancy, marital conflicts, and previous history of abortion or depression and in adolescent mothers.
- Management consists of:
 - Counseling, increased support by medical services as well as family and marital therapies.

- Medications are rarely used and should be avoided in the first trimester.

Lithium may cause congenital cardiac anomalies.

Tricyclics may be indicated in second and third trimester.

Abortion:

Depressive mood is an expected reaction especially if there is a previous history of abortion, a past psychiatric history or poor marital adjustment.

Counselling, reassurance and supportive therapy are indicated.

□ Maternity Blues:

- Brief emotional disturbance: tearfulness, irritability, crying, lability of mood, insomnia and poor concentration.
- It starts 2-3 days after delivery, remains for few days. Very common (about 50 %), more common in primiparous and those who complain of premenstrual tension.
- May be related to hormonal changes.
- No specific treatment. General measures are enough; reassurance, support ... etc.

□ Post-Partum Depression:

- About 10 - 15 % recently delivered women develop disabling depression within 6 weeks of childbirth (10–14 days after delivery) which if not treated may continue for six months or more and cause considerable family disruption.
- It is associated with increasing age, mixed feelings about the baby, physical problems in the pregnancy and prenatal period, family distress and past psychiatric history.
- Depressed mood may be associated with irritability, self-blame and doubt of being a good mother, excessive anxiety about the baby's health and death wishes.
- Counselling, additional help with child-care may be needed. Antidepressants or ECT are indicated if there are biological features of depression.

□ Post-Partum Psychosis:

- It is uncommon (about 1 in 500 birth).
- The most common form is affective psychosis (70 %).
- It begins 2-4 days after delivery.
- More frequent among primiparous women, those with family history of psychiatric illness and those with previous major psychiatric disorders.
- The clinical features include disturbed mood, perplexity, excitement, restlessness (or withdrawal), excessive guilt, disturbed thinking and suicidal and infanticidal threats.
- Schizophrenia-like psychosis occurs in about 25 % of cases who usually remain chronically ill.
- About 5 % of patients develop delirium.
- Treatment: hospitalization
 - ECT (Its rapid effect enables the mother to care for her baby).
 - Drugs: antipsychotics.

□ The Menopause

Menopausal women often complain of multiple physical symptoms including sweating, dizziness, flushing, headache. No strong evidence that depressive symptoms are more common in menopausal women than in non-menopausal. Psychiatric symptoms at menopause could have several causes:

- Altered perception of the self.
- Altered relationship with husband.
- Children leave home (empty nest syndrome).
- Parents become ill or die.

Oestrogen deficiency has been suggested but the results of oestrogen replacement were much debated. Depression and anxiety in a menopausal women can best be treated with the usual methods that have been shown to be effective for these disorders at any other time of life.

Geriatric Psychiatry

This is a branch of psychiatry concerned with the prevention, diagnosis and treatment of psychiatric disorders in the elderly. Psychiatric morbidity is common among old people. The elderly may suffer from any psychiatric disorders but the most common disorders are :

- Dementia (see Chapter 6).
- Delirium (see Chapter 6).
- Depression (see Chapter 9).
- Anxiety (see Chapter 11).
- Insomnia (see Chapter 17).

□ Assessment:

Assessment in the elderly generally follows the same way as in young people with special emphasis on:

- * Physical health diseases, medications....
- * Social circumstances and support.
- * Financial aspects.
- * Self-care and independence.

□ Treatment:

Treatment in psychogeriatrics resembles that of the same conditions in young adults. However, the following considerations should be emphasized:

- * Treat with the lowest effective dose.
- * Introduce drug slowly and carefully.
- * Explain treatment to patient and relatives.
- * Involve family members in the treatment.
- * Encourage maintaining self-esteem despite physical and psychosocial changes.

□ Depressive Disorders in the Elderly:

Frequency of depressive episodes in those with past history of depression tends to increase with age. Somatic, hypochondrical and anxiety symptoms are frequent. Agitation is much more common than retardation, often accompanied by delusions of

poverty, guilt, nihilism or persecution in severe cases.

Pseudodementia is common with a subjective report of difficulty in concentrating and remembering but no corresponding defect, patient tends to answer “don’t know” rather than confabulate. Pseudodementia often begins with mood symptoms with a course of weeks or months, and normal orientation compared to actual dementia.

Suicide is a particular danger in socially isolated elderly depressed men. The incidence of suicide increases steadily with age and is usually associated with depressive disorder.

TEST 2

Single Best Answers

1. A 38 year-old lady mother of 6 children, divorced two months ago, came to the outpatient psychiatry clinic with 10 days history of low mood, irritability, tearfulness and poor sleep.
 - a. The prognosis of such a case is usually good.
 - b. The most likely diagnosis is dysthymic disorder.
 - c. Generalized anxiety disorder is the most likely diagnosis.
 - d. Lithium is an appropriate treatment.
 - e. Give her diazepam.

2. A 32 year-old man presented with intense worries when he becomes in the middle of a row in the mosque as escape seems difficult.
 - a. He has avoidant personality disorder.
 - b. He has specific phobia..
 - c. His social phobia is better treated with response prevention.
 - d. This is the most common type of phobias in Saudi Arabia.
 - e. Negative cognitive assumptions should be challenged.

3. A 26 year-old medical student doing medicine rotation came to his tutor asking to be exempted from presenting his assigned presentation because he cannot withstand talking in front of his classmates. He feels marked distress, palpitation, sweating and shortness of breath. The following is false:
 - a. Avoidance reduces symptoms temporarily.
 - b. Propranolol will reduce his shortness of breath
 - c. Exempting him reinforces the problem.
 - d. Search for avoidant personality disorder and treat it.
 - e. He is prone to benzodiazepine abuse.

4. A 37 year-old mother of 6 children has one year history of disturbed appetite, epigastric discomfort, sweating, dysmenorrhea, feeling of restlessness, sensitivity to noise, tinnitus and dizziness, seen at primary care clinic by general practitioner. The following is the *least* appropriate statement:

- a. This can be a case of physical disease.
 - b. Alprazolam for 2 weeks is helpful.
 - c. She could have generalized anxiety disorder.
 - d. She should be referred to gastroenterology clinic.
 - e. The general practitioner is expected to assess and manage such a case.
5. A 30 year-old lady came to primary care clinic asking for investigations because she has shoulder pain, headache, abdominal distention, numbness in her left arm, nausea and discomfort in her pelvis for 2 years:
- a. Minimize the use of psychotropic medications.
 - b. She is very prone to have parasuicide.
 - c. Minority of such patients have a chronic course.
 - d. Abreaction is indicated.
 - e. She has body dysmorphic disorder.
6. A 24 year-old newly married woman, has marital conflict, presented to Emergency Department with 2 hours history of inability to talk or walk and excessive vomiting.
- a. She has adjustment disorder.
 - b. She has hypochondriasis.
 - c. Abreaction is helpful.
 - d. She has factitious disorder.
 - e. She is malingering.
7. A 28 year-old man has repeated chest pain and is extremely worried about his coronary arteries and afraid of sustaining myocardial infarction. His treating physician told him "nothing wrong in your heart"
- a. Give him an antipsychotic medication.
 - b. Exclude anxiety and depressive disorders.
 - c. He is doing the right approach.
 - d. He has somatization disorder.
 - e. He has an acute adjustment disorder.

8. A 55 year-old woman has resistant depression, seen at out-patient clinic and given paroxetine with no improvement then she went to a private psychiatric clinic and given moclobemide 300 mg twice per day (along with paroxetine 40 mg). Three days later she showed tremor, nystagmus, myoclonus, confusion and then coma.
- Give her procyclidine IM injection.
 - She has neuroleptic malignant syndrome.
 - She has hypertensive crisis.
 - She has serotonergic syndrome.
 - She has anticholinergic delirium.
9. A 17 year-old known schizophrenic girl was brought to Emergency Department because of tongue protrusion, rigid limbs and sustained upward gaze of her eyes. The best initial therapeutic step would be:
- I.M. haloperidol.
 - Immediate admission.
 - I.M. anticholinergic medication.
 - Diazepam.
 - Fluoxetine .
10. A 32 year-old married lady has 5-year continuous history of low mood, fatigue, low self-esteem and disturbed sleep. The most likely diagnosis is:
- Bipolar mood disorder.
 - Adjustment disorder with depressed mood.
 - Hyperthyroidism.
 - Dysthymic disorder.
 - Major depressive episode.
11. A 46 year-old male has long history of mental disorder, recently became violent and aggressive then he was taken to a private hospital where he was given many intramuscular injections. Three days later he developed clouding of consciousness, sweating, hyperthermia, disturbed vital signs

and raised potassium:

- a. He has hypertensive crisis.
 - b. He has anticholinergic toxicity.
 - c. Bromocriptine is indicated.
 - d. Give IM procyclidine.
 - e. He should be admitted into a psychiatric ward.
12. A 27 year-old man witnessed death of a person in a road traffic accident. Two weeks later he started to have horror, and distress on exposure to reminders.
- a. Encourage him discussing the stressful event
 - b. Admit him into psychiatry ward.
 - c. Give olanzapine 5 mg.
 - d. He has an adjustment disorder.
 - e. Give propranolol 80 mg twice/day.
13. A 35 year-old mother of 4 children delivered a baby defected with cleft palate. Three weeks later she developed excessive crying, hopelessness, agitation, social withdrawal, and insomnia, . Her husband reported that she has low frustration tolerance when she faces moderate stresses.
- a. She has posttraumatic stress disorder.
 - b. Her condition has poor prognosis.
 - c. This is a brief reactive psychosis.
 - d. Crisis intervention is contraindicated.
 - e. The most likely diagnosis is adjustment disorder.
14. A 32 year-old lady lost her husband 2 weeks ago in a road traffic accident. She has lack of emotional response, anger and disbelief but no sadness or crying spells.
- a. She has acute stress disorder.
 - b. She has adjustment disorder.
 - c. She is in the reorganization stage of normal grief.
 - d. She has an abnormal grief.
 - e. She has conversion disorder.

15. A 31 year-old male admitted to surgery ward for assessment of his bleeding per rectum, weight loss, vomiting, and fatigue. His medical workup revealed no physical problems. The patient was noticed inducing vomiting intentionally but he denied that.
- It is appropriate to interview a relative.
 - The patient is better discharged home.
 - The patient is better confronted with his manipulative behavior.
 - He is malingering.
 - Give him lorazepam.
16. A 20 year old girl was admitted in the medical ward because she intentionally ingested 30 tablets of aspirin . Her mother described her as unstable person with persistent feelings of emptiness. The following is false:
- She should be referred for psychiatry consultation .
 - The mother's description suggests a psychotic mental illness.
 - Assess her past history of suicidal attempts.
 - Carbamazepine can be a suitable medication for this patient.
 - Most likely she has personality disorder.
17. A 48 year-old woman was admitted for hysterectomy. After 2 days of admission , before surgery she became excessively worried, anxious and sleeps poorly. The least appropriate statement is:
- Psychological preparation for surgery can reduce her anxiety.
 - There is linear relationship between anxiety before and after surgery.
 - Imipramine 150 mg at bedtime is indicated.
 - Give her Alprazolam 1 mg twice daily.
 - Simple explanation of the surgery can reduce her anxiety significantly.

18. A 29 year-old woman known case of psychiatric illness for 6 years. Her illness started with excessive activities, distractibility and decreased need for sleep for about 5 weeks. Then followed by a period of lethargy, lack of motivation and slow interactions. The following is true:
- Psychotherapy is the treatment of choice.
 - Carbamazepine can induce manic episodes.
 - Sodium valproate is good choice in this case.
 - She has mixed affective state.
 - Olanzapine is contraindicated.
19. A 23 year old female got married 2 weeks ago was noticed by her husband to be tense, worried, sad, isolated, and has poor sleep and appetite. She said she has these features started 10 days before marriage and she has been trying her best to adapt with her new life but cannot, therefore she kept asking her husband to divorce her although she had accepted this marriage.
- She is malingering.
 - This is a deliberate histrionic behavior.
 - Divorce is advisable before she gets pregnant.
 - Crisis intervention is indicated.
 - She is entering a phase of psychosis.
20. A 34 year-old lady was admitted in the rheumatology ward because of SLE exacerbation . She was noticed by the nurse talking nonsense , smiling inappropriately, and asking for discharge.
- She has functional psychosis.
 - She should be transferred to the psychiatry ward.
 - Her mental disturbance can be due to cerebral lupus.
 - She has adjustment disorder.
 - Give her fluoxetine.

Answers

Question Number	Answer
1	A
2	E
3	B
4	D
5	A
6	C
7	B
8	D
9	C
10	D
11	C
12	A
13	E
14	D
15	A
16	B
17	C
18	C
19	D
20	C

Chapter 21

Child Psychiatry

A 9 year-old boy student in the third grade brought by his parents because of impulsive behavior, learning difficulties, disobedience, excessive movement in the class and inability to settle in one place. How would you assess this case?

Child psychiatry is concerned with the assessment and treatment of children's emotional, behavioral and relationship problems.

Children are not small adults, but immature and developing individuals. Childhood is a period of life characterized by change and the necessity for adaptation. During childhood the child undergoes a remarkable transformation from a helpless dependent infant to an independent self-sufficient individual with his own views and outlook capable of living separately from his family. In order to judge whether any observed emotional, social or intellectual functioning is abnormal, it has to be compared with the corresponding normal range for the age group.

The practice of child psychiatry differs from that of adult psychiatry in several important aspects:

1. Children are generally less able to express themselves in words. Therefore, evidence of disturbance is based more on observations of behavior made by parents, teachers and others.
2. Greater attention must be paid to the stage of development of the patient and the duration of the disorder in order to decide what is normal and what is abnormal.
3. The treatment of children makes less use of medication or other methods of individual treatment. Instead the main emphasis is on changing the attitudes of parents, reassuring and retraining children, working with the family and coordinating the efforts of others who can help children, especially at school. The family is a most powerful force for the promotion of health as well as for the production of disturbance in the child's life. Assessment of parenting qualities, the marital relationship and the quality of the family interaction are essential components of child psychiatric practice. It is a frequent observation that it is the parents who are disturbed and not the child.

Children development has many aspects:

- intellectual
- emotional
- social
- psychodynamic

Development results from continuous interaction of:

- Heredity (biological predisposition).
- Maturation of the body systems.
- Environmental influences.

Assessment:

Child assessment follows the usual steps in the adult assessment with the following important considerations:

- Flexibility is essential.
- Both parents should be asked to attend the assessment interview, and it is often helpful to have other siblings present.
- The interview room should be large enough to seat the family comfortably and also allow the children to use play material in a relaxed manner.
- Detailed personal history is required.
- Obtaining detailed family interaction is essential:
 - Quality of parenting.
 - Parent - child relationship.
 - Pattern of family relationships.
 - Separation from caretaker for more than a week.
- General health: eating, elimination, sleeping and physical complaints.
- School: attendance, achievement, and relationship with schoolmates and teachers.
- Attention span, concentration and activity.
- **Observation of the child should include:**
 - Degree of attachment to parents and ease of separation.

- Abnormal movements e.g. tics.
- Nutritional status.
- Evidence of neglect or physical abuse.

Childhood Psychiatric Disorders:

Many childhood psychiatric disorders cannot be classified in a satisfactory way by allocating them to a single category.

Table 21-1 shows the DSM and ICD classification for the main child psychiatric disorders.

Table 21-1. The Main Categories of Childhood Disorders

DSM	ICD
<ul style="list-style-type: none"> • Learning disorders • Motor disorders • Communication disorder • Pervasive developmental disorders • Attention – deficit and disruptive behavior disorders • Tic disorders • Feeding and eating disorders of infancy and childhood • Elimination disorders • Other disorders 	<ul style="list-style-type: none"> • Specific disorders of scholastic skills • Specific disorders of motor function • Specific disorders of speech and language. • Pervasive developmental disorders • Hyperkinetic disorders • Conduct disorders • Mixed disorders of conduct and emotions • Tic disorders • Emotional disorders with onset specific to childhood • Other disorders

Children are also susceptible to most of previously mentioned adult psychiatric disorders: phobia, anxiety disorders , depression ...etc.

Intellectual Disability (Mental Retardation)

Intellectual impairment starting early in life, associated with educational and social disabilities.

Types:

- Mild (IQ: 50 – 70) about 75 % of cases; educable.
- Moderate (IQ: 35 – 49) about 15 % of cases; trainable.
- Severe (IQ: 20 - 34) about 8 % of cases.
- Profound (IQ: below 20) about 2 % of cases.

Causes:

- Congenital, chromosome or gene defects.
- Intrauterine infections.
- Perinatal: anoxia, intraventricular hemorrhage ...
- Postnatal: encephalitis, meningitis, trauma ...
- Psychosocial causes; chronic lack of intellectual stimulation.

Psychiatric disorders are common in intellectually disabled individuals due to:

- possible common genetic etiology.
- organic brain disease.
- reaction to the stigma of subnormality.
- family reactions e.g. overprotection, punishment.
- consequences of abnormalities associated with handicap e.g. lack of social skills.

Diagnosis of psychiatric disorders is sometimes difficult because symptoms may be modified by low intelligence and poor verbal fluency.

- Depression is common but less likely to be expressed verbally.
- Adjustment disorders are frequently encountered in mildly retarded people.
- Personality problems may accompany low intelligence and sometimes lead to greater problems in management.
- Hyperactivity occurs commonly.

- Schizophrenia may occur. The main features include further deterioration of mental functions with disturbed behavior and social adjustment. Delusions and hallucinations are less likely to be expressed clearly.

Assessment and Management:

- Detailed history including:
 - family history of inherited diseases.
 - prenatal, perinatal and neonatal history.
 - development and milestones.
- Physical examination.
- Behavioral assessment.
- IQ test.
- Special education and training.
- Family support and education.
- Residential care for severe cases.
- Regular reassessment and follow up.
- Physical and psychological treatment.

AUTISTIC DISORDER (Infantile Autism)

It is a severe pervasive disorder of emotions, speech and behavior starting in early childhood after a brief period of normal development. **Onset:** before 30 months of age. It occurs at a rate of 4 – 8 / 10,000 , affecting boys more than girls.

Features:

1. Inability to relate:
 - No emotional interaction with people.
 - Emotional responses to parents, strangers and inanimate objects are the same.
 - Gaze avoidance is a characteristics feature.
2. Language impairment:
 - Interpersonal verbal communication is markedly affected.
3. Preoccupation with certain objects and rituals with resistance to change (e.g. the same food).

4. Other features:

- Labile mood and non-specific anger and fear.
- Overactivity and distractibility.
- Disturbed sleep.
- Varying degrees of mental retardation are present in 75 % of cases.
- Epilepsy may develop in adolescence in 20 – 25 % of severe cases.
- Enuresis and encopresis may occur.

Causes: unknown organic brain insult is suggested.

Treatment:

- No specific treatment
- Special school:
 - Programs to promote behavioral skills and to reduce undesirable behavior.
 - Family education and support.

Prognosis:

- Varies depending on several factors such as IQ, language development, and early treatment.
- About 15 % can lead independent life.
- About 50 % can acquire some useful speech but continue to have disturbed behavior and cold emotions.

Attention-Deficit Hyperactivity Disorder (ADHD)

The male : female ratio is 4 : 1. The prevalence is about 4 %.

Features:

- Overactivity in more than one situation; constant movement with inability to settle.
- Diminished attention and concentration.
- Impulsivity.
- Excitability.
- Excessive talking.

- Interfering and intruding on others.
- Recklessness, prone to accidents.
- Disobedience and aggression.
- Learning difficulties.

Etiology: The causes are unknown. Most children with ADHD do not show evidence of gross structural damage in the CNS.

- Several factors have been suggested to play some role :
 - Prenatal toxic exposures & prematurity.
 - Perinatal trauma and early malnutrition.
 - Non specific subtle CNS disease.
 - Specific learning disabilities.
 - Hidden depression.
 - Intolerant parents and teachers.

Treatment:

- Stimulant medications have been found to reduce hyperactivity and improve attention span in 75 % of cases, the exact mechanism of action is not yet known, however, stimulation of cortical inhibition is suggested.
- Dextroamphetamine (in children > 3 years) and methylphenidate (> 6 years) in the morning and afternoon, doses are adjusted according to the response. Possible side effects include restlessness, tremor, sleep disturbances, growth inhibition (growth chart is needed) and dependence.
- Psychological treatment: individual and family therapy.
- Special education.

Prognosis:

Hyperactivity improves with age in most cases. Some cases may continue in adult life; mainly those with low intelligence and major learning problems.

Conduct Disorder

Severe and prolonged antisocial behavior in older children and teenagers.

Features:

- Aggressive behavior to other children.
- Destructive behavior
- Rebellion against parents
- Lying
- Stealing
- Vandalism
- Fire setting
- Truancy

Etiology:

- Adverse psychosocial situations play major roles e.g. broken family, unstable relationships, and poverty.

Treatment:

- Explore the environmental settings, social & family situations.
- Family and individual therapies.
- Haloperidol, lithium and carbamazepine have been found effective in controlling aggression and impulsivity.

Prognosis:

Some teenagers continue to have antisocial behavior after the age of 18 years (antisocial personality disorder).

Oppositional Defiant Disorder

Defiant hostile and negativistic behavior, manifested by frequent:

- Loss of temper and anger outburst.
- Argument and refusal to comply with adults.
- Annoyance of others.
- Spiteful / vindictive behavior.

This disorder may coexist with ADHD, conduct and many other disorders. It's occurrence increases in families with rigid parents, and intense moody children.

Treatment:

- Psychological (individual / family).
- Behavior modification.
- Carbamazepine or lithium.

Elimination Disorders

A. Functional Enuresis

B. Functional Encopresis

A. 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...).
- **No specific etiology:**
 - ? delay in maturation of some brain centers.
- **Psychological sequel of enuresis:**
 - * Conflicts with parents
 - * Low self-esteem
 - * Social ostracism

Treatment:

- Search for and treat any possible physical disease e.g.

repeated urinary tract infections (UTIs), diabetes, epilepsy.....

- Treat any associated emotional problem.
- Advice to parents (to avoid criticism...).
- Fluid restrictions before bedtime.
- Going to toilet before sleep.
- **Behavior therapy:**
 - Record dry nights on a calendar and reward dry nights with a star and 7 consecutive dry nights with a gift (star chart technique).
 - A bell and pad apparatus is helpful.
 - Bladder training.
- **Drugs:**
 - imipramine (a tricyclic antidepressant) 10 – 50 mg at night can reduce bed wetting significantly, but relapse rate after discontinuing treatment is high.
 - desmopressin (an analogue of vasopressin) can be helpful but there is a risk of fluid overload.
 -

I. 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.
- Assessment should include parental attitudes, emotional factors in the child, and the child's concern about the problem.
- Behavior therapy (rewarding success and ignoring failure) often is helpful.
- Parental guidance and family therapy is required.

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). Treatment may include a variety of measures discussed earlier in chapter 9. Antidepressants may be started with low doses. Psychosocial treatment approaches are important.

Separation Anxiety Disorders

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.

Treatment:

- Psychological (individual / family) therapy.
- Behavior therapy.
- Tricyclic antidepressants.

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. However, parents should adopt a reasonable reassuring approach. Behavior treatment is required if phobia persists.

School Phobia

- Irrational fear of going to school associated with unexplained physical complaints such as headache, diarrhea, abdominal pain or feeling sick. Boys and girls are equally affected.
- 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.
- Academic achievement is good or superior.
- Possible precipitating factors:
 - * Separation anxiety (mainly in younger children) child wants to stay with a major attachment figure. Mothers are frequently overprotective.
 - * Minor physical illness.
 - * Upsetting event either at home (e.g. parental discord), or at school (e.g. criticism).
 - * General psychiatric problems e.g. low self - esteem and depression (in older children).

Treatment:

- Identify and treat possible causes.
- Early graded return to school (most helpful).
- Both parents should participate.

- School and teachers should be involved.
- Drugs have some role in reducing anxiety / or depressive features.

School Refusal: a pattern of behavior that can have many psychosocial causes and may not be a disorder (e.g. a form of rebellion).

Specific Developmental Disorders

These circumscribed developmental delays do not affect intellectual function. There are four kinds:

- 1- reading disorder 2- arithmetic disorder
3- motor disorder 4- communication disorders.

The causal factors and mechanisms are still unknown.

- Specific reading disorder is characterized by below level of reading abilities expected from age and IQ and this is not due to inadequate education.
- Specific arithmetic disorder is characterized by below level of arithmetic abilities expected from age and IQ.
- Specific motor disorder is characterized by delayed motor development and poor coordination without general intellectual impairment or a specific neurological cause.
- Specific communication disorder is characterized by delayed speech development in the absence of mental retardation, autism, deafness or other causes.

Early detection of these specific developmental disorders is important. Management include special education perceptual-motor training, speech therapy and treatment of comorbid conditions.

Self assessment:

1. A 5 year-old boy was brought by his mother because she has noticed that he does not interact well with his relatives, does not speak properly and does not laugh as other children. The *least* appropriate statement is:
 - a. Gaze avoidance can be another feature of this child.
 - b. Mental retardation is common in such a case.
 - c. Enuresis may occur in this case.
 - d. Start methylphenidate for his attention deficit hyperactivity disorder.
 - e. Medications have a limited role in this case.

2. A 10 year-old boy brought by his parents because of impulsive behavior, learning difficulties, disobedience, inability to settle in one place:
 - a. He has elimination disorder.
 - b. Methylphenidate should be avoided in this disorder.
 - c. There is no effective medication for this condition.
 - d. Abnormal parenting is the likely cause.
 - e. Growth chart is required before starting medications.

3. A 7 year old girl was brought by her mother with 3 months history of reluctance to sleep away from her mother and excessive fear when her mother becomes away from her even at home.
 - a. This oppositional defiant behavior requires behavior modification.
 - b. This disorder can be treated with carbamazepine.
 - c. She has autistic disorder.
 - d. This condition is often maintained by mother's overprotective attitude.
 - e. She has at least mild mental retardation.

4. A 6 year-old girl was seen at child psychiatry clinic because of bed wetting. Her mother always takes her to toilet before sleep. Her father kept asking her to clean her bed in the morning. The *least* appropriate statement is:

- a. Imipramine can reduce bed wetting significantly.
 - b. Five years is the age at which urine continence is usual.
 - c. Going to toilet before sleep is an advised step in the treatment.
 - d. Fluoxetine gives good results in such a case.
 - e. Search for diabetes .
5. An 11 year-old girl was referred from pediatric clinic because she has repeated unexplained abdominal pain, vomiting, diarrhea, and headache. These symptoms occur on school days but not at other times.
- a. She has somatization disorder.
 - b. She is expected to have nocturnal enuresis.
 - c. Separation anxiety can be a precipitating factor.
 - d. She should not be referred to psychiatry.
 - e. Her symptoms are suggestive of autistic disorder.

Answers

Question	Answer
1	D
2	E
3	D
4	D
5	C

Chapter 22

Community and Rehabilitation

Psychiatry

COMMUNITY PSYCHIATRY

Community psychiatry concerns with provision and organization of preventive, treatment and rehabilitative services for psychiatric patients outside hospitals. It assumes that people with psychiatric disorders can be most effectively helped when links with family, friends, workmates and society in general, are maintained.

Community psychiatry varies from country to country based on the local prevalence of psychiatric disorders and how patients with these disorders come into contact with the health services.

About 20 % of patients attending the general health services do not suffer from physical disorders but they are actually anxious or depressed (WHO studies 1995).

According to several studies in Saudi Arabia (National Manual of Mental Health Care 1997), there is increasing number of people attending mental health services. The most common psychiatric disorders are depression and anxiety.

□ Principles of the provision of mental health services:

Services should be:

- Relevant to the need of the community.
- Socially acceptable.
- Accessible to all users.
- Efficient.
- Economical.

□ Factors influencing person's decision to seek mental advice:

- Knowledge about possible help.
- Attitude to mental disorder.
- The nature, duration, and severity of the disorder.

In many societies, people with mental problems do not seek professional help. The social stigma of mental illness is an important deterrent against seeking help. Negative attitudes toward the mentally ill is still a big problem facing mental health services.

□ **Levels of prevention in community psychiatry:**

1. **Primary prevention:** preventing the onset, and reducing the incidence of mental illness.
 - Improving the social environment.
 - Parental education about childhood and adolescence problems.
 - Control of substance abuse.
2. **Secondary prevention:** reducing the complications and prevalence of the illness, through early recognition and proper treatment.
 - Screening programs e.g. detecting social and school phobias early in adolescents and children.
 - Family - based health services to identify emotional problems e.g. marital discord ...
 - Counseling
 - Early treatment of depression and anxiety.
 - Crisis intervention teams.
3. **Tertiary prevention: reducing patient's disability.**
 - Preventing further relapses of chronic psychosis.
 - Rehabilitation services.

□ **Community psychiatric services:**

1. **Family practitioners.**
They can help greatly in prevention, early detection, assessment and early management of mental problems.
2. **Community psychiatry nurses (CPN).**
They can take an active role in the assessment and the long term care of some patients e.g. giving depot injections to chronic schizophrenic patients at their homes.
3. **Social Workers.**
They can assess the need for social services required and facilitate links with other services.
4. **Day care centers and day hospitals.**
 - These are intermediate places between in - patient and

out - patient services.

- They can provide assessment and treatment for patients who require long term help such as chronic schizophrenic patients.

5. In - patient facilities.

- For acute cases, and relapses of chronic cases who require intensive psychiatric care.

6. Out - patient clinics

These can be attached to hospitals or in general practice.

PSYCHIATRIC REHABILITATION

Definition:

The process through which a person is helped to readjust to the limitations of his disability so that he attains an acceptable degree of independence (psychologically, socially and physically) in his community.

Aim: empowering the patient to attain his full potential (maximum functioning) within the limitations of his disability.

Components:

1. **Enabling:** enabling the person to use his assets and talents to acquire confidence and self - esteem, to minimize psychiatric impairment, social disadvantage and adverse personal reactions and finally to lead as normal life as possible in spite of his limitations.
2. **Caring:** creating a supportive environment adapted to patient's limitations.

Scope: rehabilitation can be either:

- a. Relatively short – term for few months (e.g. work restoring individual full functions).
- b. Long – term for years (e.g. support to prevent relapse and to maintain the possible optimal level of functioning).

Difficulties:

1. Progress is slow (it takes years) and may be interrupted by frequent relapses. Thus no quick results should be expected.
2. Great efforts have to be done by multiple agencies (medical, social vocational, educational...) with effective organization and collaboration.
3. The work may be tedious and frustrating at times.

Who requires Psychiatric Rehabilitation

- Chronic psychotic patients (e.g. schizophrenia, relapsing mood disorder).
- Severe and chronic non – psychotic patients.
- Some patients with personality disorders (e.g. dependent persons).

Nature of disablement (WHO 1980)

- **Impairment** : Loss of function at the organ level.
- **Disability** : disturbance at the level of the person due to impairment.
- **Handicap** : disadvantages suffered by an individual as a result of impairments and disabilities; it reflects interaction with, and adaptation to the environment.

□ PRINCIPLES OF REHABILITATION PROGRAMME :

There are three basic principles :

1. Thorough Assessment
2. Program Formulation
3. Continuity of Care

1. Thorough Assessment :

The program should be based on a thorough initial assessment of the individual, taking into consideration strengths as well as disabilities, including :

- Self – care.
- Social skills.
- Use of leisure time.

- Personal goals.
- Abilities and talents.
- Motivation.
- Symptoms
- Medications and side effects.
- Education and work history.

2. **Program formulation :**

The program should be well designed and tailored to meet the individual's condition, guided by the thorough initial assessment. A comprehensive approach is required involving bio – psycho – social services. Multidisciplinary teamwork and interagency cooperation are essential. Aims and intermediate goals are decided upon involving the patient and carers. Roles should be clarified and specified. The program involves a series of steps, the early ones being small and designed so that success is readily achieved to give a sense of success.

3. **Continuing of care :**

Periodic reassessment is undertaken and the aims and goals may require readjustment in the light of progress or altered circumstances.

□ **AREAS OF REHABILITATION:**

1. Illness-management skills 2.Psychosocial 3. Occupational

1. Illness – management skills: Skills concerned with educating patients and carers about :

- The illness nature, course and treatment.
- Improvement monitoring
- Detecting side effects of drugs.
- Early detecting relapse and exacerbation.

2. Psychosocial:

Psychosocial rehabilitation includes abilities required for normal

social interaction. Social skill training pays attention to such factors as :

- Reduction of socially embarrassing behavior.
- Making conversation.
- Expressing feelings.
- Interview behavior
- Appropriate self -assertion.
- Money management.

3. Occupational:

Work is important to mental health in general. The primary role of work in rehabilitation was never re-entry into employment. Work has intrinsic value both as means in rehabilitation and as an end in itself. Work imposes a time structure on the working day, it enlarges the scope of social relations beyond the often emotionally highly charged family relations, it assigns social status and clarifies personal identity.

Chapter 23

Physical Treatments

A: Psychopharmacology

B: Electroconvulsive Therapy

Medications used in psychiatry are called psychotropic drugs, which have effects mainly on mental symptoms. According to their principal actions, they are classified into several groups:

1. Antipsychotics (Formerly Major Tranquilizers /Neuroleptics)

Typical / Conventional	Atypical / Non-conventional
They block dopamine receptors improving positive psychotic features, but they are associated with significant extrapyramidal side effects (EPSE), e.g. chlorpromazine , haloperidol.	They act on dopamine and serotonin receptors to improve both positive and negative symptoms of psychosis. They produce an antipsychotic effect without causing extrapyramidal side-effects. e.g. olanzapine, risperidone

2. Mood Stabilizing Drugs

Indications : mania (acute phase and prophylaxis), schizoaffective disorder, unipolar recurrent major depressive episodes (as an adjunct treatment), impulsive and aggressive behavior. E.g. lithium, carbamazepine, sodium valproate .

3. Antidepressants

Besides their common use as antidepressants, they have several other uses. Some antidepressants are used in anxiety, panic disorder phobias, obsessive-compulsive disorder, premature ejaculation, insomnia, eating disorders, and others.

Antidepressants include many groups:

- Monoamine Oxidase inhibitors:
 - Irreversible (phenelzine, tranylcypramine, isocarboxazid)
 - Reversible (moclobemide).
- Tricyclics: E.g. amitriptyline, imipramine, clomipramine, doxepin.
- Tetracyclics: e.g. maprotiline.
- Selective-Serotonin Reuptake Inhibitors (SSRIs):
E.g. fluoxetine, fluvoxamine, paroxetine, citalopram, escitalopram sertraline.
- Selective-Serotonin-Norepinephrine Reuptake Inhibitors(SNRIs):
E.g. venlafaxine, duloxetine.
- Others: mirtazapine, trazodone, nefazodone, bupropion.

4. Antianxiety (Anxiolytic) Drugs

Benzodiazepines : e.g. lorazepam, alprazolam, diazepam.

Buspirone.

Beta - adrenergic antagonists e.g. propranolol.

5. Sedative - Hypnotics (for insomnia)

Benzodiazepines e.g. Nitrazepam.

Chlormethiazole.

Zolpidem , zopiclone.

Ramelteon(It is a new drug. It targets melatonin receptors)

Antihistamines e.g. hydroxyzine .

6. Antiparkinsonian/Anticholinergic drugs (used in case of EPSE)

E.g. procyclidine .

7. Others:

- Medications used in dementia: cholinesterase Inhibitors (donepezil, rivastigmine, galantamine), and memantine.
- Psychostimulants e.g. methylphenidate, modafinil.
- Disulfiram.

Common misconceptions about psychotic drugs

1. Dangerous drugs.
2. Mere tranquilizers.
3. Full of side effects that outweigh any benefit.
4. Hinder the effect of psychological treatment.
5. Always lead to addiction.

ANTIPSYCHOTICS• **Indications:**

- Functional psychosis: schizophrenia, mania, schizoaffective disorders, schizophreniform disorder, brief psychosis, and delusional disorders.
- Organic psychosis: delirium intoxication with substances, dementia, others.
- Violence, agitation and excitement
- Medical uses: e.g. nausea, vomiting, poor appetite
- Others e.g. tic disorders, ADHD.

- **Mechanism of action:**

- A-Antipsychotic effects:*

1. In mesolimbic tract; pathological hyperactivity of this pathway accounts for active psychotic features: hallucinations, delusions, aggression, and disorganized behavior. Postsynaptic blockade of CNS dopamine receptors type 2 (D2) in this pathway reduces active psychotic features.
2. In mesocortical tract; primary dopamine neuron defect or serotonergic overactivity is responsible for most negative features and cognitive defects seen in some schizophrenic patients. Atypical antipsychotics act on dopamine and serotonin receptors to improve negative symptoms of psychosis: lack of motivation, restricted affect, poor self-care, and others.

- B – Side effects:*

1. In Nigrostriatal tract; they induce extrapyramidal effects due to antidopaminergic effect (these side effects are better treated with anticholinergic medications rather than dopaminergic drugs (compared to Parkinson's disease).
2. In Tuberoinfundibular tract; dopamine inhibits prolactin release from the anterior pituitary. Antidopaminergics induce excessive prolactin secretion.

- **Adverse Effects:**

- (1.) Extra-Pyramidal Side Effects (EPSE)**

- **Acute dystonia:**

- Appears within days after antipsychotics.
 - Severe painful spasm of neck muscles (toricollis), ocular muscles (oculogyric crisis) muscles of the back (opisthotonus) and tongue protrusion. Treated with anticholinergic drugs (e.g. procyclidine 5 – 10 mg IM or P.O.).

- **Parkinsonism:**

- Appears within weeks after treatment, its features: stooped posture, akinesia, muscle rigidity, masked face, and coarse tremor. Treated with anticholinergic drugs

(e.g. procyclidine)

- **Akathisia** (inability to keep still, associated with unpleasant feelings of inner tension)
 - Appears within days – weeks.
 - Generally disappears if the dose is reduced.
 - Benzodiazepine or beta-blockers may help in the treatment, whereas anticholinergics have no therapeutic effect.
- **Rabbit Syndrome** (perioral tremor)
- **Tardive Dyskinesia**
 - occurs in about 10 – 20 % of patients on long-term antipsychotics for several years.
 - chewing, sucking or choreo-athetoid movements of the facial and neck muscles.
 - may be due to super-sensitivity of dopamine receptors resulting from prolonged dopamine blockade.
 - no specific treatment, the only agreed treatment is to discontinue the antipsychotic drug when the patient's state allows this.

(2.) Antiadrenergic:

- postural hypotension
- inhibition of ejaculation

(3.) Anticholinergic:

- dry mouth.
- blurred vision.
- constipation.
- urinary retention.
- precipitation of closed – angle glaucoma.
- Poor erection.

(4.) Others: weight gain, galactorrhea, amenorrhea, sedation (antihistamine effect)

Toxic Effect: Neuroleptic Malignant Syndrome (NMS) see psychiatric Emergencies (chapter 19).

The therapeutic effect of antipsychotics may take up to 6 weeks to appear.

Antipsychotics can be classified according to their potency into:

High potency drugs:

- More antidopaminergic effect.
- Less anticholinergic effect.
- EPSE are prominent. e.g. haloperidol, trifluoperazine.

Low potency drugs:

- More anticholinergic effect.
- Less antidopaminergic effect.
- EPSE are less prominent.
- Postural hypotension and sedation are marked, e.g. chlorpromazine.

• **NEW ATYPICAL ANTIPSYCHOTICS:**

Compared to the typical antipsychotics (which bind strongly to postsynaptic D2 receptors) these new agents bind in varying degrees to dopamine D2, D4, 5HT2, alpha adrenergic and muscarinic receptors.

- They are less likely to cause extrapyramidal side effects.
- These include:

1 .Olanzapine 2. Risperidone 3. Paliperidone. 4. Quetiapine 5. Aripiprazole 6. Ziprasidone 7. Sertindone 8. Clozapine

Clozapine was the first atypical antipsychotic drug. It is indicated for resistant psychosis not responding to traditional antipsychotics, schizophrenia with negative features or in patients who cannot tolerate the adverse effects associated with those drugs. Its side effects include: Neutropenia and agranulocytosis. Therefore, regular blood tests are required. These are *not* dose dependent. Risk is about 2%. Others: seizure , sedation, weight gain, sialorrhoea, hypotension, constipation and tachycardia (all are dose dependent).

DEPOT (SLOW RELEASE) ANTIPSYCHOTICS:

These are long-acting antipsychotic drugs, , given as deep intramuscular injections to patients who improve with drugs but cannot be relied on to take them regularly by mouth (i.e. poor

compliance). Such patients usually suffer from either; chronic schizophrenia, delusional disorders, or schizoaffective disorder.

Depot Antipsychotics:

- Fluphenazine decanoate (Anatensol – Modecate): e.g. 25 – 75 mg / month.
- Haloperidol decanoate (haldol) : 200 – 400 mg. / month.
- Flupenthixol decanoate (Depixol – Fluanxol): e.g. 20 – 100 mg / month.
- Zuclopenthixol decanoate (Clopixol) : 200 – 600 mg. /month.
- Risperdal consta:25-50 mg./2weeks.

A test dose is usually given ($\frac{1}{4}$ - $\frac{1}{2}$ the dose) to check patient's tolerability. Depot injections are released slowly in 1 – 8 weeks.

ANTICHOLINERGIC ANTIPARKINSONIAN DRUGS

- They are used in psychiatry to control the extra-pyramidal side effects of antipsychotic drugs.
- The commonly used compounds are :
 - procyclidine (kemadrin) 5 mg. P.O. / IM injections are available and commonly used in the treatment of acute dystonia.
 - benztropine (cogentin).
 - trihexyphenidyl / benzhexol (artane).
 - biperiden (akinetone).
- Their side effects include:
 - dry mouth
 - blurred vision
 - constipation
 - urinary retention
 - precipitation of glaucoma (closed – angle)
 - anticholinergic intoxication (delirium, dry skin, hyperthermia...)

MOOD STABILIZERS

LITHIUM

- **Mechanism of action:**

The exact mechanism is unknown, however it is thought that it stabilizes neuronal activities (decreases sensitivity of postsynaptic receptors and inhibits release of neurotransmitters).

- Before starting lithium, a note should be made of any other medications taken by the patient and a physical examination should be carried out.
- Prerequisite laboratory test:
 - Renal functions and electrolytes.
 - Thyroid functions.
 - ECG if cardiac disease is suspected.
 - Pregnancy test (if indicated).
- **Contraindications:**
 - Renal or cardiac failure.
 - Recent myocardial infarction.
 - Chronic diarrhea sufficient to alter electrolytes.
 - First trimester of pregnancy

Lithium is not recommended in children.

- **Side effects:**

- Fine tremor.
- Gastric discomfort and diarrhea.
- Dry mouth, metallic taste.
- Fatigue
- Weight gain
- Reversible hypothyroidism.
- Reversible nephrogenic diabetes insipidus (polyuria – polydipsia) due to blockade of ADH – sensitive adenylcyclase in distal tubules.
- Toxicity (course tremor, ataxia, confusion, diarrhea, vomiting...).

- **Drug interactions:**
- There are several drugs that increase lithium concentration and may lead to Lithium toxicity:
 - Thiazide diuretics.
 - Non - steroidal anti – inflammatory drugs (NSAID)
 - Angiotension - converting enzyme inhibitors e.g. lisinopril.
 - Haloperidol high doses (e.g. 40 mg/day)
- Lithium may potentiate the effect of muscle relaxants. This is important when a patient undergoes an operation or ECT.
- It may potentiate extrapyramidal side effects of antipsychotics.
- It may precipitate 5 - HT syndrome if given with SSRIs.
- The recommended plasma concentrations are:
 - 0.9 - 1.2 mmol / liter (during acute phase)
 - 0.4 - 0.8 mmol / liter (for prophylaxis)
- Dose is 300 - 450 mg twice or three times a day.
- Plasma concentration requires continuous measurement because the narrow therapeutic index of lithium (therapeutic and toxic levels are close). Toxic levels ≥ 1.5 mmol / liter.
- Plasma level should be measured 12 hours after the last dose.

CARBAMAZEPINE (Anticonvulsant)

- **Doses:**
- Starting dose is usually 200 mg two times a day. (in children 100 mg / day).
- It can be increased gradually to 600 – 1000 mg.
- Therapeutic concentration for psychiatric indications is 8 – 12 ug per mil.

- **Side effects:**
- Nausea
- Drowsiness
- Dizziness
- Double vision
- Skin rash

- Agranulocytosis (rare 1 in 20,000 patients but serious)
- Jaundice.

SODIUM VALPROATE (Anticonvulsant)

- **Doses:**
 - Starting dose is usually 250 mg twice/day. It can be increased gradually to 2500 mg./day
- **Common side effects include:**
 - Gastrointestinal disturbances (nausea, vomiting ...)
 - Sedation
 - Weight gain
 - Tiredness
 - Neurological: tremor, ataxia, and dysarthria.
- **Rare side effects:**
 - Fatal hepatitis.
 - Platelets dysfunction

ANTIDEPRESSANTS

Antidepressants have therapeutic effects in depressive disorders but do not elevate mood in healthy people. They are usually commenced in small doses, which are then increased gradually (to reduce the risk of side effects). Sudden withdrawal may lead to restlessness, insomnia, anxiety and nausea. Antidepressant action may take 2-4 weeks to appear. They have to be continued for several months (six months is a usual period) after symptoms have been controlled, to avoid relapse.

TRICYCLIC ANTIDEPRESSANT:

They are of proven effectiveness and commonly used though they have many side effects. They are generally less expensive than other antidepressants.

Uses:

- Depressive disorders.
- Anxiety, phobic disorders and panic disorders.
- Obsessive compulsive disorders (especially clomipramine because it regulates serotonin in the CNS).
- Nocturnal enuresis.
- Pruritis (H₁ blockade e.g. doxepin).
- Gastric ulcer (H₂ blockade e.g. amitriptyline)

Side Effects:

- Anticholinergic: constipation, urinary retention, dry mouth , impaired visual accommodation, worsening of glaucoma central anticholinergic toxicity(delirium)
 - Antiadrenergic (alpha-receptors):Postural hypotension, delayed ejaculation and drowsiness
 - **Others:** sweating, weight gain, arrhythmia, tremor precipitation of mania in susceptible patients.
- If a patient has insomnia a sedative tricyclic antidepressant (e.g. amitriptyline, or doxepin) is preferred.
 - Tricyclics are dangerous in overdose and should be avoided in suicidal patients.

II. SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)

- Selectively inhibit serotonin reuptake into presynaptic neurons.
- No significant interactions with muscarinic, or histaminergic receptors.
- Relatively safe in overdose.
- **Uses :**
 - depressive disorders.
 - anxiety, phobia & panic disorders.
 - obsessive compulsive disorder.
 - trichotillomania.
 - tic disorders.
 - premature ejaculation.
 - Others.

- **Side Effects:**
 - gastrointestinal upset, nausea, reduced appetite, diarrhea / constipation.
 - headache.
 - irritability.
 - sexual dysfunction (delayed orgasm).
 - insomnia (mainly with Fluoxetine).
 - sedation (mainly with Fluvoxamine).
 - sweating.
 - tremor.
 - serotonin syndrome (see psychiatric emergency chapter 19).

II. MONOAMINE OXIDASE INHIBITORS (MAOIs)

- Because of their serious interactions with tyramine – containing food stuffs and other drugs, they are seldom used as first choice drugs.
- They have been found effective in patients who have not responded to other antidepressants, those with atypical depression and in patients with phobic and panic disorders. Narcolepsy is another indication.
- They should not be given to patients who cannot understand or comply with dietary prescriptions.

Side effects:

- Constipation.
- Dry mouth.
- Urinary retention.
- Postural hypotension.
- Sexual dysfunction.
- Headache.
- Sleep disturbances.
- Weight gain
- Dizziness.

- Tremor.
- Ankle edema.
- Hepatotoxicity.
- Hypertensive crisis (see chapter 19).

Patients already on MAOIs should not be started on another type of antidepressant (except in resistant cases, under supervision of a psychiatrist). At least a two- week interval should separate the last dose of any MAOI and initiation of tricyclic or SSRI therapy.

Precautions and Contraindications :

Liver failure. cardiac disease, acute confusional states, Pheochromocytoma, and conditions that require the patient to take any of the drugs which interact with MAOIs.

Moclobemide (Reversible Inhibitors of Monoamine Oxidase – A " RIMA"

- It has clear advantages over conventional MAOIs due to its freedom from tyramine reactions and its quick offset of activity.
- It is better tolerated than conventional MAOIs or tricyclics.
- Side effects include nausea and insomnia.
- It should not be combined with SSRI or clomipramine.

BENZODIAZEPINES

- They act on specific receptor sites (benzodiazepine receptors) linked with gamma aminobutyric acid (GABA) receptors in the C.N.S. They enhance GABA action which has an inhibitory effect.
- They have several actions:
 - Sedative & hypnotic action.
 - Anxiolytic action.
 - Anticonvulsant action.
 - Muscle relaxant action.

- They differ in potency and half-life.
 - Long acting (more than 24 hours) e.g. diazepam, nitrazepam.
 - Relatively short acting e.g. alprazolam, lorazepam.

- **Side effects:**
 - Dizziness and drowsiness (patient should be warned about these side effects which may impair functions e.g. operation of dangerous machinery, driving).
 - Release of aggression due to reducing inhibition.
 - Dependence and withdrawal:
 - If given for several weeks.
 - Short acting drugs have more risk of dependence.

- **Withdrawal Syndrome:**
 - It generally begins 2 – 3 days after cessation of short acting, and 7 days after cessation of long acting benzodiazepines and then diminishes in another 3 – 10 days.
 - Features:
 - Anxiety, irritability, apprehension
 - Nausea
 - Tremor and muscle twitching
 - Heightened sensitivity to stimuli
 - Headache
 - Sweating
 - palpitation
 - Muscle pain
 - Withdrawal fit may occur when the dose of benzodiazepine taken has been high.

- Withdrawal is treated with a long acting benzodiazepine (e.g. diazepam) in equivalent doses before withdrawal then the dose is reduced gradually by about 10 – 20 % every 10 days.

BUSPIRONE

- It has anxiolytic activity comparable to that of benzodiazepines. However, it is pharmacologically unrelated to benzodiazepines.
- It stimulates 5HT – 1A receptors and reduces 5 HT (serotonin) transmission.
- It's onset of action is gradual (several days – weeks) therefore, it is not effective on PRN basis.
- It does not cause functional impairment, sedation nor interaction with CNS depressants.
- It does not appear to lead to dependence.
- **Adverse effects:**
 - Headache.
 - Irritability.
 - Nervousness.
 - Light-headedness.
 - Nausea.

MEDICATIONS USED IN DEMENTIA

See Chapter 6 (dementia).

ELECTROCONVULSIVE THERAPY (ECT)

History and Concept:

Patients with concomitant schizophrenia and epilepsy were found to improve in psychosis following repeated fits. It was therefore, thought that there is an antagonism between schizophrenia and epilepsy.

In 1938 Cerletti administered an electrically – induced fit to a catatonic vagrant schizophrenic patient who then showed reasonable improvement.

Later, anesthesia was introduced and convulsions were modified using muscle relaxing agents.

Indications for ECT

1. Depression:
 - depressive disorder with suicidal risk.
 - depressive stupor or marked retardation.
 - depressive disorder with delusions
 - inability to take drugs :
 - first trimester of pregnancy.
 - in the elderly.
 - in physical diseases e.g. renal failure.
2. Schizophrenia (catatonic, resistant to drugs).
3. Post partum psychosis.
4. Schizoaffective disorder.
5. Mania and mixed affective states.

Precautions and Contraindications:

Recent research showed no absolute contraindications to ECT. At one time raised intracranial pressure was considered as the only absolute contraindication to ECT. Remember that not all space occupying lesions produce raised intracranial pressure.

Relative Contraindications:

- To ECT itself:
 - Cardiac infarct in the preceding 3 months (some references extend it to 2 years).
 - Other cardiac diseases including arrhythmias.
 - History of cerebral infarction.
 - Brain tumor.
- To anesthesia and muscle relaxants.

Psychiatric disorders that may show deterioration or no response to ECT:

- Phobic disorders
- Conversion disorder
- Primary hypochondriasis (not due to depression)
- Depersonalization disorder.

Mode of Action of ECT:

The exact mode of action is unknown.

The current hypothesis: the beneficial effect which depends on the

cerebral seizures (not on the motor component) is thought to result from neurotransmitter changes probably involving serotonin and noradrenaline transmission.

ECT Preparations:

Explanation to the patient (or his caretakers).

ECT consent by the patient or his caretaker.

Hospital admission for full physical assessment (fitness for anesthesia and ECT).

Fasting (midnight).

Oxygenation to overcome succinylcholine-induced apnea, to facilitate seizure activity and to reduce memory impairment.

Muscle relaxant to reduce the consequent motor effects (severe muscle contraction may lead to bone fracture).

Placing a mouth gag in patient's mouth to prevent tongue or lip bites.

Machine and electrodes preparations.

Decreasing scalp's resistance with jelly or normal saline.

ECT Procedure:

- Bilateral (most commonly used procedure)
 - One electrode on each side of the head (fronto-temporal position).
 - It gives a rapid response.
 - Bi-frontal position can be used; it produces less memory impairment but may be therapeutically ineffective.
- Unilateral:
 - Both electrodes are placed on the non – dominant side.
 - It produces less memory impairment but less effective than bilateral.
- ECT is usually given 2 – 3 times a week with a total of 6 – 12 sessions, according to response and progress. Response begins usually after 2 – 4 sessions. If there is no response after 8 sessions, it is unlikely that more sessions will produce a useful change.

In depressed patients antidepressants should be started towards the end of the course of ECT to reduce the risk of relapse.

Side Effects of ECT: (ECT in general is a safe procedure)

- Headache (due to temporary increase in intracranial pressure).
- Body aches and myalgias (due to muscle contraction)
- Memory impairment (both retrograde and anterograde amnesia).
 - Duration varies (days – several months).
 - May be due to neuronal hypoxia during seizure.
- Bone fracture and tongue or lip injury.
- Very rarely death (in patients with cardiovascular disease).

Misconceptions about ECT

- Dangerous procedure.
- Causes serious brain damages.
- Involves a high voltage (110 – 220 V) current.

Some traditional healers tried 110 V current with some patients assuming that it is the same procedure used by psychiatrist (ECT).

Chapter 24

Psychological Treatment

A 20 year-old female student came to outpatient clinic complaining that when talking to important people she feels embarrassed , dizzy, and tremulous . She came asking for cognitive behavior therapy.

PSYCHOLOGICAL TREATMENTS

- **Definition:**

A group of non-pharmacological psychotherapeutic techniques employed by a therapist to ameliorate distress, abnormal patterns of relations or symptoms.

- **Classification:**

A – According to concept:

- Behavior therapy.
- Cognitive therapy.
- Psychodynamic therapy.
- Person - Centered therapy.
- Eclectic model of therapy.

B - According to aim:

- Maintenance of function, e.g. supportive therapy.
- Readjustment to distress, e.g. problem - solving.
- Restoration of function, e.g. cognitive-behavior therapy.
- Reconstruction of personality, e.g. analytic therapy.

C - According to participants:

- Individual therapy.
- Group therapy.
- Marital therapy.
- Family therapy.

General Indications for Psychological Treatments:

A - Based on diagnosis:

- Neurotic illness (acute - chronic).
- Personality disorders.
- Psychoactive substance abuse.

- Childhood disorders.
- Chronic psychosis.

B - Based on presenting features:

- Subjective symptoms e.g. anxiety, phobia.
 - Interpersonal difficulties e.g. overdependence, marital discord.
- Predictions of good outcome :
 - Willingness and motivation.
 - Reasonable intelligence.
 - Capacity to :
 - Verbalize feelings.
 - Tolerate frustration.
 - Efficient and committed therapist.
 - Early intervention.
 - Psychotherapy is sometimes used to mean all forms of psychological treatments.
 - Counseling is used to refer to a wide range of the psychological treatments ranging from the giving of advice, to structural ways of encouraging problems solving.

BEHAVIORAL THERAPY

- **Concept :**

Intrapersonal and interpersonal problems are seen as resulting from learning maladaptive inappropriate behavior. There is no place in this approach for the unconscious repressed conflicts. It is assumed that the main aim of any person is to adapt effectively to his environment. A person can achieve this goal on the basis of the application of the principles of learning. The aim for the client (patient) is to increase desirable behaviors and decrease undesirable ones. Behavioral assessment seeks to observe and measure maladaptive behaviors focusing on how the behavior varies in particular settings and under specific conditions. Problems will be

decreased or extinguished through client's learning more adaptive behaviors or unlearning maladaptive ones.

- **Behavioral techniques:**
 1. Exposure.
 2. Relaxation training.
 3. Assertiveness training
 4. Response prevention and thought stopping
 5. Token economy.
- **Exposure** (mainly for phobic disorders)
 - Exposing the patient to enter, repeatedly, situations that he has avoided previously or, if this is not practicable, to imagine doing so.
 - Gradual re-entry is called desensitization.
 - Rapid re-entry is called flooding.
 - Hierarchy of avoided situations is drawn (situations are arranged in a descending order).
 - Anxiety is reduced by relaxation training. (see down).
 - Asking the patient to enter a situation that provokes the least anxiety (at the bottom of the hierarchy) and stay until anxiety subsides.
 - The procedure is then repeated with the next situation on the hierarchy and so on.
 - Repeated adequately prolonged exposure (for about an hour everyday) is required until patient's anxiety subsides.
 - A family co-therapist is sometimes required to sustain motivation, praise success and encourage practice.
- **Relaxation Training**
 - There are various techniques which include the following common procedures :
 - Slow deep and regular breathing.
 - Clearing the mind of worrying thoughts; by concentrating on an imagined tranquil scene (meditation).

- Progressive repeated tension and relaxation of group of muscles (face, neck shoulders, back, abdomen, arms and legs) until generalized relaxation is achieved.
 - About 20 sessions are required until a person becomes able to achieve rapid relaxation. Time required for each session gets less with repeated sessions.
 - Tape recording of the instructions for relaxation is useful.
 - Relaxation is helpful in anxiety and phobic disorders.
- **Assertiveness Training**
- Unassertive persons are usually deficient in expressing their honest feelings and thought directly to others.
 - Assertiveness training helps unassertive persons to practice appropriate social behavior in everyday life, expressing their honest feelings and thoughts in terms of:
 - Verbal (tone of voice, volume and content)
 - Non - verbal (posture, eye contact, facial expression)
 - Role play (therapist and patient exchange roles) helps the patient understand the view point of the other person in the situation.

Response Prevention:

It helps patients with compulsions (obsessive rituals). Patient is asked to exert efforts to suppress (prevent) compulsions for enough time (about an hour) until the associated anxiety wanes.

Repeated efforts are helpful in diminishing the frequency and intensity of compulsions and associated obsessional thoughts. Patient should be encouraged to overcome the initial rising in anxiety.

□ Thought Stopping:

- It is used to treat obsessional thoughts.
- Obsessional thoughts are interrupted by a noxious stimulus e.g. an elastic band worn around the wrist (mildly painful).
- Gradual reduction in the intensity of the thoughts is achieved by repeated interruptions.

□ Token Economy:

- Repeated rewards of a desired behavior encourage persons to repeat the behavior.
- It is used with chronic schizophrenic patients to improve their social skills e.g. self-hygiene.
- Also used with children and mentally subnormal people.

COGNITIVE THERAPY

Concept:

- Persons' behavior is associated with their own particular cognitive processes (ways of thinking, expectations, attitudes and beliefs).
- Maladaptive cognitive processes are associated with behavioral and emotional problems.
- Correcting maladaptive cognitive processes reduces patient's problems.

Process:

- Maladaptive thinking is **identified**; the common cognitive errors include :
 1. Magnification and minimization of events out of proportion to their actual significance, e.g. depressed patient magnifies his faults and minimizes his achievements.
 2. Overgeneralization:
 - Forming a general rule from few instances and applying this rule to all situations no matter

how inappropriate.

3. Arbitrary inferences:
 - Making an inference without backing it up with evidence, or alternatively ignoring conflicting evidences.
4. Selective abstraction:
 - Taking a fact out of context while ignoring other significant features and then proceeding to base entire experience on that isolated fact.
5. Dichotomous thinking:
 - Thinking about events or persons in terms of opposite extremes (all or none).
6. Personalization:
 - Relating events and incidents to self where such incidents have no personal bearing or significance.

- The maladaptive thinking is then **challenged** by correcting misunderstandings with accurate information and pointing out illogical ways of reasoning.
- Then alternative ways of thinking are sought out and tested.

Cognitive behavioral therapy is mainly indicated in:

- Depressive disorders (mild – moderate)
- Anxiety disorders (GAD, phobias, panic disorders).

SUPPORTIVE THERAPY

Uses:

- To relieve distress during a short period of personal misfortune, a short episode of illness or in the early stages of treatment before specific measures have had time to act.

- To sustain a patient who has stressful life problems that cannot be resolved completely or a medical disease that cannot be treated.
- It is a systematic professional approach that involves the following procedures:
 - Building a reasonable patient - doctor therapeutic relationship.
This should not be too intense.
 - Careful listening to the patient's problems and concerns facilitating emotional ventilation and sharing emotions with the patient.
 - Giving reasonable explanations and advice.
 - Instillation of hope and improving self-esteem.
 - Encouraging self-help.

Counseling

- It helps persons to solve stressful problems through decision making.
- The counselor's role is not to provide solutions to the client's problems, instead he assists the client to choose a decision among alternative courses of actions.
- Pros and cons of each alternative are considered before selecting one
- Counseling process requires:
 - Empathy: understanding the client's feelings.
 - Unconditional positive regard of the client.

PSYCHODYNAMIC PSYCHOTHERAPY

- **Concept:**
 - Person's behavior is determined by unconscious process.
 - Current problems arise from unresolved unconscious conflicts originating in early childhood.
 - Problems will be reduced or resolved through the client attaining insight (greater understanding of aspects of the

disorder) as a mean to gaining more control over abnormal behavior).

- It helps some chronically depressed or anxious patients and those with personality problems.

Marital Therapy

- **Indications:**
 - Marital discord
 - When marital problems act as a maintaining factor of a psychiatric disorder in one or both partners.
- The couple and the therapist identify marital problems, such as:
 - Failure to listen to the other partner.
 - Failure to express wishes, emotions and thought directly.
 - Mind reading.
- The couple then are helped to understand each other.
- The therapist should remain neutral.
- Techniques used include:
 - Behavioral: reinforcement of positive behavior
 - Dynamic: eliciting and correcting unconscious aspects of interaction.
 - Problem solving.

Family Therapy

- Family members are all involved in the treatment to reduced suffering of one or more of the members.
- Concept and techniques are similar to marital therapy.

Group Therapy

- Group of patients (6 – 10) with similar psychiatric problems (e. g. social phobia) are guided by a trained therapist through using a variety of psychological techniques (behavioral, cognitive...) to help them overcome their psychological problems.

- Therapeutic factors:
 - Group cohesion and support.
 - Acceptance and ventilation.
 - Identification and universalization.

Chapter 25

Evidence-based Psychiatry

Evidence-Based Psychiatry, keeping up-to-date.

A career in medicine is synonymous with life-long learning. Clinical decision-making is based on combination of information received during medical training and the experiences gained through clinical practice. Many clinical decisions in psychiatric practice are likely to be based on inadequate evidences and outdated textbooks. Textbooks do provide a background knowledge foundation concerning relatively well-established facts. Background information is the type of information that medical students and beginning residents most frequently require.

As knowledge rapidly increases, textbooks become out-of-date whatever effort is made to ensure that they are up-to-date. There is a significant gap between knowledge obtained from clinical trials regarding effective treatments for mental disorders and the actual treatments in the clinical practice. Practice often lags years behind research findings.

Studies demonstrated that up to 40% of clinical decisions are unsupported by evidence from the research. Reasons include: information overload, uncritical acceptance of available information, over-reliance on one's own clinical experience and the excessive influence of pharmaceutical companies through advertising and sponsorship of speakers .

It can be difficult for a psychiatrist to find unbiased information about treatments of mental illnesses. The psychiatrist, without knowing how to find the best available evidence, may become out of date. The doctor needs a way of quickly accessing the best available information. Advances in clinical epidemiology and medical informatics have introduced an approach to close the gap between research and practice, thus improving the quality of patients care. This approach is called Evidence-Based Medicine (EBM).

EBM is a relatively new discipline whose positive impact is just beginning to be validated.

Mental health professionals need to know whether advice in practice guidelines is sound and whether the conclusions from systematic reviews are valid.

Psychiatrists practicing EBM are expected to identify and apply the most efficacious interventions to help their patients. They are faced with daunting tasks of keeping track of a tremendous amount of new and potentially important information. EBM emphasizes the examination of evidence from clinical research and de-emphasizes unsystematic clinical experience and subjective rationale. It requires new skills for decision-making including efficient literature search and the application of formal evidence in evaluating the clinical literature. These unique skills are not part of traditional medical education. EBM is a systematic approach to utilizing the best available scientific information to make clinical decisions regarding diagnosis and treatment for individual patients. The term Evidence-Based Medicine (EBM) originated at McMaster University in Canada, and first appeared in the medical literature in 1992. The first article on “evidence-based psychiatry” appeared in 1995 .

EBM is a valuable teaching tool with its emphasis on reviewing medical literature, interpreting results and implementing new scientific information into practice. The practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research. It has a positive influence on the provision of patients care. Excellence in patient care correlates with use of the best current available evidence .

EBM empowers clinicians to make their own decisions about patient care, guided by the best available evidence to support those decisions.

Evidence-based practice is gaining global recognition and acceptance as a novel approach in the practice of medicine. Numerous international workshops and conferences are well established to aid the acquisition of skills in practicing and teaching EBM. Health care organizations in the USA and the UK have already established an

EBM programs and centers. There has been a proliferation of literature and web sites about EBM.

The Five-step Evidence-Based Approach

To apply evidence from the medical literature to patient care, evidence-based process involves the application of 5 steps:

1. Formulate a precise structured clinical question, which involves issues related to the patient care (the diagnosis, treatment, prognosis or etiology).
2. Search for the best kind of evidence to answer the question. See “Hierarchy of Evidence”.
3. Critically appraise the evidence validity and importance before applying the results to your patient.
4. Apply the evidence to the care of your patient.
5. Assess the outcome.

Hierarchy of Evidence

Evidence-based practice assumes that some kinds of evidence are more valid and of greater clinical applicability than others. There are generally agreed-upon hierarchies of evidence that indicate certain types of research result should be given more weight than other types. The specific hierarchy of evidence depends on the type of clinical question being asked. The clinician moves down a hierarchy of evidence, when the best sort of evidence is not available, and searches for the best available evidence. Types of evidence higher in the hierarchy are more apt to give valid and unbiased evidence. The hierarchy of evidence is best worked out for treatment studies.

Hierarchy of evidence for treatment studies:

- 1a. Systematic review of randomized controlled trials (RCTs).
- 1b. At least one randomized controlled trial (with narrow confidence interval).
- 2a. At least one controlled study without randomization/systematic review of cohort studies.
- 2b. Individual cohort study/at least one other type of quasi-experimental study.
- 3a. Systematic review of case-control studies/non-experimental descriptive studies.

- 3b. Individual case-control study.
4. Case series
5. Clinical experience of respected authorities.

Advantages

1. EBM encourages life-long self-directed learning. It encourages open-minded attitude toward seeking out and integrating new knowledge into practice. Thus, making advances in one's own professional behavior.
2. EBM encourages advance in clinical research quality.
3. Evidence-based practice will lead to the use of proven diagnostic measures and therapeutic interventions only where data exists to support their use and also will lead to withdrawal of unproven therapies and diagnostic tests.
4. Evidence-based approach will improve source utilization resulting in more efficient patients care and reduced cost per patient. This approach can economize resources and aid health care policymakers. EBM helps institutions and policymakers to examine the long-term financial impact in relation to other health care priorities.

Critique

Adversaries of EBM argue about the validity of EBM by focusing on its limitations.

1. Most of the EBM data place more emphasis on therapeutic decisions and less on diagnosis or prognosis.
2. The evidence from meta-analysis and systematic review articles may be inconclusive or conflicting.
3. EBM can only provide numbers that may or may not be applicable for an individual patient.
4. There is no evidence that improved delivery of medical information as taught by the EBM centers will lead to better patient outcome. It has been demonstrated in a randomized clinical trial that conventional continuous medical education (CME) had little impact upon the quality of patient care although knowledge in the experimental group rose substantially.

5. Evidence is often based on data from Western populations, and may not be applicable to the developing countries where exposures and risk factors, such as genetics, lifestyle, and sociocultural factors, may be significantly different.
6. EBM diminishes the role of clinical acumen and experience so that the “art” of decision-making will be lost, only replaced by Cookbook.

Nevertheless, EBM when properly applied it provides viable and sound tool for our daily clinical practice. Psychiatry residency programs should adopt and adapt evidence-based psychiatry practice. This begins with medical education and participation of academic staff as teachers of evidence-based practice and as role models of its practical use. Evidence-based practice requires the commitment of hospital administrators to provide their professional staff with essential resources and technology, adequate and accessible library and internet facilities. Individual psychiatrists who are outside of academic medical centers (who constitute the vast bulk of psychiatrists) may face difficulties in learning and applying EBM and should be helped. In many cases they will require initial workshops.

There are a number of routes that can be used to increase psychiatrist’s knowledge of EBM. These include books and journals, online resources and courses.

Further Reading

A – Papers

1. Sackett D. Cochrane collaboration. *BMJ* 1994; 309: 1514-1515.
2. Sackett D., Rosenberg W., Gray M. et al. Evidence-based medicine: what it is and what it isn’t. *BMJ* 1996; 312: 71-72.
3. Geddes J., Harrison P. closing the gap between research and practice. *Br. J Psychiatry.* 1997; 171: 220-225.
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5. Hope T. Evidence-based patient choice and psychiatry. *Evidence Based Mental Health*: 2002; 5: 101-102.
6. Rushton J. The burden of evidence. *BMJ* 2001; 323: 349.
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9. Geddes J., Carney S. Recent advances in evidence-based psychiatry. *Can J Psychiatry*, 2001; 46: 403-406.

B – Books

1. Evidence-Based Medicine: How to practice and teach EBM. Sackett D., Strauss S., Richardson W. et al. 2nd Edition. New York, Churchill Livingstone 2000.
2. Evidence-Based Practice: a critical appraisal. Trinder Z, Reynolds S. Oxford, UK Blackwell Scientific, 2000.
3. Evidence-Based Practice in mental Health Care. American Psychiatric Association. American psychiatric publishing Inc. Washington DC, 2003.
4. Concise guide to evidence-based psychiatry. Gray G. American Psychiatric Publishing Inc. Washington, DC 2004.

C – Web Sites

<http://www.cebm.net/index.asp>
<http://www.cebm.utoronto.ca>
<http://www.cebmh.com>
<http://www.cche.net/che/home.asp>
<http://www.mclibrary.duke.edu/respub/guides/ebm/index.html>
<http://www.hsl.unc.edu/ahec/ebmcoe/pages>
<http://www.ebmny.org>
<http://www.phru.org.uk/-casp/casp.htm>
<http://www.shef.ac.uk/-scharr/ir/netting>
<http://www.medicine.ox.ac.uk/cairns/ebm>
<http://www.shef.ac.uk/-scharr/ir/mschi/>
<http://ugi.usersguides.org>

D – Online Databases

<http://www.update-software.com/abstracts/mainindex.htm>

<http://nhscrd.york.ac.uk/darehp.htm>

<http://nhscrd.york.ac.uk/htaph.htm>

<http://www.ahcpr.gov/clinic/epc/>

http://www.ccohta.ca/entry_e.html

<http://www.med.monash.edu.au/healthservices/cce/evidence>

<http://www.york.ac.uk/inst/crd/ehcb.htm>.

TEST 3

Case 1:

A 22-year-old male college student failed six weeks ago in two subjects. This is his first semester in the College of Education. He was in the College of Sciences last year. He has been complaining for the past four weeks, of excessive worries about his future, poor sleep and crying bouts.

Q – 1 What is your differential diagnosis?

Q – 2 What is the most likely diagnosis?

Q – 3 What would be the most effective treatment for this patient?

Case 2:

A 30-year-old married man presented with five years history of low self-esteem, diminished interest and low spirit.

Q – 1 What is the most likely diagnosis and why?

Q – 2 What is the other psychiatric disorder that you should exclude?

Q – 3 Would you admit this patient into a psychiatric unit?

Case 3:

A 48-year old man known to have psychiatric illness for more than 15 years with relapses and remissions, brought to Emergency Department at 2 a.m. by his concerned son who found him awake, weeping and asking his wife to forgive him and to take care of the children.

Q – 1 What is the most likely diagnosis?

Q – 2 Can this patient be psychotic?

Q – 3 Would you recommend giving him amitriptyline and seeing him after two weeks at the out-patient psychiatric clinic?

Case 4:

A 50-year-old man referred to out-patient psychiatry clinic by a gastroenterologist consultant who has investigated him thoroughly and found no organic pathology behind his non - specific abdominal pain and distention. The patient was not convinced about the referral and was over- concerned with a hidden physical disease that has not been discovered yet.

Q – 1 What is the psychiatric diagnosis?

Q – 2 What are the possible concomitant psychiatric disorders this patient may have?

Q – 3 How would you manage this patient?

Case 5:

A 29-year-old housewife referred to psychiatry from primary care clinic with one-year history of medically unexplained continuous multiple symptoms including headache, chest pain, abdominal discomfort, dizziness and paraesthesia over the upper limbs, dysphagia and heartburn. Her baseline investigations were normal. She was not preoccupied with a serious disease.

Q – 1 What is the most likely psychiatric diagnosis and why?

Q – 2 what is the next likely diagnosis and why?

Q – 3 Would you recommend pain killers in her case?

Case 6:

A 40-year-old female teacher mother of 8 children referred to out-patient psychiatric clinic with one year history of excessive worries about her children and home duties, dizziness, tinnitus, disturbed sleep, facial numbness, headache, poor concentration, reduced appetite, excessive sweating. Symptoms fluctuate in severity but never disappeared.

- Q – 1 What is the most likely diagnosis, and why?
- Q – 2 Mention 3 medical diseases that can present with such a presentation.
- Q – 3 What are the possible psychological etiological factors?

Case 7:

A 27-year-old man referred to the psychiatry clinic from a cardiology clinic with 7 months' history of increasing episodes of sudden palpitation, tremor, headache, shortness of breath and extreme fear. His investigations showed no abnormality.

- Q – 1 What is the diagnosis?
- Q – 2 What physical conditions that can result in such symptoms?.
- Q – 3 How can cognitive therapy help this patient?

Case 8:

A 21-year-old male college student presented with feeling tense in the presence of others. His academic achievement has been adversely affected by his condition, his attendance was poor so as his participation in seminars.

- Q – 1 What is the most likely diagnosis
- Q – 2 What is the most common personality disorder associated with this psychiatric problem?
- Q – 3 Would you consider the possibility of substance abuse in this case?

Case 9:

A 32-year-old housewife brought to the psychiatry clinic by her husband with two years history of being anxious when she is away from home, unable to go shopping alone.

- Q – 1 What is the most likely diagnosis?

Q – 2 What is the other psychiatric problem commonly found in such a patient?

Q – 3 How would you treat her?

Case 10 :

A 68-year-old lady admitted in the medical ward because of complications of her uncontrolled hypertension and diabetes mellitus. She was noticed by the nursing staff to be uncooperative, irritable, aggressive, shouting and drowsy at times.

Q – 1 What is the most likely diagnosis?

Q – 2 What are the possible causes?

Q – 3 Would you consider dementia in this case?

Case 11:

A 75-year-old man brought to psychiatric clinic by his grandson who thinks his grandfather developed schizophrenia as he started to be agitated, verbally aggressive, suspicious and uncooperative with relatives.

He has poor sleep and appetite.

He talks a lot about his childhood.

Q – 1 Was schizophrenia the correct diagnosis?

Q – 2 What is the most likely diagnosis?

Q – 3 What is the functional (non organic) psychiatric disorder that can present with such a picture?

Case 12:

A 45-year-old businessman admitted into the surgical ward for hernia operation. Two days later, before the operation he developed disorientation, illusions, hallucinations, sweating, tremor and unstable blood pressure but no fever. His liver functions were grossly impaired.

Q – 1 What is the most likely diagnosis?

Q – 2 Is this patient psychotic?

Q – 3 What is the treatment?

Case 13:

A 19-year-old male brought to Emergency Department by policemen who found him quarrelling with others, physically and verbally abusive and irritable. When his mother was contacted at home she reported that he left home two days ago, his sleep has been recently interrupted.

Q – 1 What is your differential diagnosis?

Q – 2 How would you manage him?

Q – 3 If there is no available bed in the psychiatric ward, how would you manage him?

Case 14:

A 21-year-old male brought to out-patient psychiatric clinic by his parents with seven months history of poor self-care, isolation and deteriorating academic performance.

Q – 1 What is your differential diagnosis?

Q – 2 In mental state examination, what should you be concerned about to clarify the diagnosis?

Q – 3 How would you treat him?

Case 15:

A 19-year-old girl brought to Emergency Department with tilted neck, rigid limbs and protruding tongue.

Q – 1 What are the most common two psychiatric problems that can present with such a picture?

Q – 2 How can you differentiate between the two?

Q – 3 How would you manage her?

Case 16:

An 18-year-old girl was found semi-conscious at home after a hot debate with her brother who found her talking over the telephone to a non-relative man about her love affair. The mother found an empty bottle of medicine in her daughter's room.

Q – 1 What is your diagnosis?

Q – 2 What are the possible etiological factors.

Q – 3 What is the expected outcome?

Case 17:

A 30-year-old jobless male admitted two days ago in the hematology unit with swollen tender left leg. Gradually he started to complain of severe muscular and joint pain, vomiting and diarrhea. He kept asking for pethidine. Hematologist consultant referred him for psychiatric assessment.

Q – 1 What is the most likely psychiatric diagnosis?

Q – 2 What are the complications of this condition?

Q – 3 How would you manage such a case?

Case 18:

A 7-year-old boy brought by his parents with history of repeated bed-wetting for the past four months. He achieved urine continence by the age of five years for more than a year.

Q – 1 What is the diagnosis?

Q – 2 Is this an organic or functional psychiatric problem?

Q – 3 What is the management?

Case 19:

A 9-year-old boy student in the first class referred by his teacher for assessment of his intelligence. Teachers reported excessive movement, inability to settle in one place, learning difficulties and disobedience.

Q – 1 What is your diagnosis?

Q – 2 Is he mentally retarded?

Q – 3 How would you treat him?

Case 20:

A 7-year-old girl student in the first class brought by her parents who reported vague abdominal pain associated with crying. Pain usually comes in the morning and disappears when she is taken to the Pediatrician.

In Pediatric clinic she was assessed thoroughly by a consultant who advised the parents to take her to a psychiatrist.

Q – 1 What is the most likely diagnosis?

Q – 2 What is the most common important cause of this disorder?

Q – 3 What is the prognosis?

Case 21:

A 6-year-old boy referred to psychiatric clinic by a speech therapist. The mother complained that her son is delayed in his speech (utters only few words), prefers to stay alone, insists to engage in the same repetitive games.

Q – 1 What is the diagnosis?

Q – 2 The mother is concerned with an abnormal parenting as a cause of the problem. Would you agree with her?

Q – 3 What is the treatment?

Answers

TEST 3

Case 1

- A – 1 Differential diagnosis includes:
1. Adjustment disorder
 2. Major depressive disorder
 3. Normal adjustment reaction
- A – 2 The most likely diagnosis is Adjustment disorder with mixed anxious and depressed mood.
- A – 3 Though drugs can help in reducing his symptoms, this patient requires psychological treatment (especially crisis intervention and counseling) which is the most effective on the long - term.

Case 2

- A – 1 Dysthymic disorder
Because:
- The nature of symptoms
 - Chronic course
 - Mild degree of depressive features
- A – 2 Major depressive disorder which is characterized by:
- More severe depression.
 - Presence of death wishes and suicidal ideation.
 - Biological features:
 - Early morning waking
 - Poor appetite and weight loss
 - Constipation
- However, major depression can complicate dysthymic disorder leading to double depression.
- A – 3 Admission is not required unless he is resistant to antidepressant or a hidden physical disease is suspected requiring an in – patient investigation.

Case 3

- A – 1 Major depressive disorder (recurrent type).
- A – 2 Yes, he may have a delusion of guilt.

- A – 3 No, because the suicidal risk is very high he should be admitted into a secure psychiatric ward and treated with ECT.

Tricyclic antidepressants are lethal in overdose and should not be given to a patient with high suicidal risk. Selective serotonin reuptake inhibitors are preferred in this case after treating him with ECT as in - patient.

Case 4

A – 1 Hypochondriasis

A – 2 Depressive disorder

Anxiety disorder

Irritable bowel syndrome

A – 3

- Reassurance and explanation.
- Searching for and treating any associated psychiatric disorder (e.g. depression).
- Avoiding unnecessary investigations.
- Cognitive-behavior therapy.
- Regular visits with predetermined appointments.

Case 5

A – 1 Somatization disorder, because:

- Age
- Chronic continuous multiple physical symptoms not explained medically.
- No obvious depressive or anxiety psychopathological features.

A – 2 Generalized anxiety disorder

- She has several physical features of anxiety, which are non-episodic.

A – 3 No. Pains and aches in somatization disorder are less likely to respond to painkillers.

Psychotropic drugs (e.g. moderate dose of a tricyclic antidepressant such as amitriptyline) can help her.

Case 6

A – 1

- Generalized anxiety disorder.
- She has psychological and physical features of anxiety which are not episodic and not related to a specific situation.

A – 2

1. Hyperthyroidism
2. Diabetes mellitus
3. Hypoparathyroidism

A – 3

- anxiety traits (worried, anxiety – prone person).
- being a teacher and having 8 children.
- possible conflicts at work.
- possible marital discord.
- ill parents.

Case 7

A – 1 Panic disorder

- A – 2
1. Stimulant intoxication (e.g. amphetamine, cocaine)
 2. Pheochromocytoma
 3. hyperthyroidism

A – 3 Patients with panic disorder have distorted beliefs that physical symptoms of anxiety (e.g. palpitation) are evidences of a serious physical disease. These beliefs increase the anxiety (vicious circle).

The patient is informed about the nature of symptoms (normal response to stress) and the cognitive distortions and their role in increasing the anxiety. Positive thinking is encouraged.

Anticipatory anxiety is also reduced.

Case 8

- A – 1 Social phobia
- A – 2 Avoidant personality disorder
- A – 3 Yes, because some persons with social phobia tend to resort to abusing stimulants or alcohol to overcome their social anxiety.

Case 9

- A – 1 Agoraphobia
- A – 2 Panic attacks
- A – 3
 - Look for associated depression and treat it.
 - Behavior therapy
 - Exposure
 - Relaxation training
 - Drugs:
 - E.g. Imipramine
 - Anxiolytic (short course)

Case 10

- A – 1 Delirium (acute organic brain syndrome)
- A – 2
 - Uncontrolled diabetes mellitus
 - Medications
 - Infections
 - hypoxia
- A – 3 Dementia might be present in this case but can't be diagnosed before delirium clears out, unless a clear - cut dementia features are reported by relatives who are acquainted with her before she develops delirium.

Case 11

- A – 1 No, in fact, there is little in the presentation to suggest schizophrenia.
- A – 2 Organic brain syndrome
- Dementia (chronic)
 - Delirium (acute)
- Absence of disturbed consciousness makes delirium less likely.
- A – 3 Pseudodementia (major depression in the elderly affecting the higher mental functions).

Case 12

- A – 1 Delirium tremens is the most likely diagnosis.
- A – 2 Yes, this is a case of organic psychosis.
- A – 3
- Close supportive medical supervision.
 - Benzodiazepines (e.g. diazepam 10 mg) in divided doses to guard against withdrawal fit.
 - Repeated reassurance and reorientation to reduce anxiety and disorientation.
 - Vitamin B-1 (thiamin) and dextrose.
 - Monitor vital signs.

Case 13

- A – 1
1. Intoxication with stimulants.
 2. Manic episode
 3. Brief psychosis
 4. Schizophreniform disorder
- A – 2
- Non – provocative approach.
 - IM major tranquilizers (e.g. haloperidol, olanzapine or chlorpromazine).
 - Hospitalization in a locked psychiatric ward for further assessment and management.

A – 3

- Contact another hospital where a psychiatric secure ward is available.
- If there is no chance for admission in another hospital, medium acting major tranquilizer can be given (clopixol acuphase 50 – 100 mg. IM), repeated after 2 – 3 days with frequent assessment until a bed is available.

Case 14

- A – 1
1. Schizophrenia
 2. Depressive disorder
 3. Substance abuse

A – 2

- Psychotic features: delusions, hallucinations, bizarre behavior, incoherent speech and lack of insight (these features indicate schizophrenia).
- Depressed mood, guilt feeling, hopelessness, helplessness, pessimistic thinking, loss of pleasure, death wishes and suicidal ideation (these features indicate a depressive disorder).

A – 3

- He can be treated as an out-patient.
- Treatment depends on the diagnosis
 - Schizophrenia – antipsychotics
 - Depressive disorder – antidepressant.
- Admission is indicated if he requires ECT (e.g. suicidal), or he does not respond to enough doses of psychotropic drugs or an organic pathology is suspected that requires extensive investigations.

Case 15

- A – 1
1. Acute dystonic reaction (a side effect of antipsychotic drugs).
 2. Conversion disorder

A – 2 History:

- If she is known psychotic, and recently received antipsychotic drugs then acute dystonia is the most likely diagnosis.
- If no history of antipsychotic drugs and the features were preceded by a psychological problem then the most likely diagnosis is conversion disorder.

A – 3 According to the diagnosis:

- If acute dystonia, give anticholinergic drugs e. g. procyclidine (kemadrin) IM 5 mg to counteract severe hypodopaminergic state; symptoms usually disappear within half an hour.
- If conversion disorder, abreaction with 10 mg IV slowly infused diazepam helps in resolving symptoms.

Case 16

A – 1 Deliberate self – harm

Most likely she took a drug overdose to influence her family and as a temporary escape from her problem.

A – 2

- Unstable personality (borderline / histrionic):
 - Unstable relationships
 - Impulsive behavior
- Psychiatric disorder (depression – anxiety ...)
- Stressful life problems

A – 3 There is a high risk of:

- Long-term psychological problems.
- Repetition of deliberate self-harm and suicidal attempts.
- Interpersonal problems with family, relatives and spouse (if she gets married).

Case 17

A – 1 Opioid withdrawal (most commonly heroin).

A – 2

- Accidental overdose, often related to loss of tolerance after a period of enforced abstinence. It commonly leads to death because of respiratory suppression.
- Complications of intravenous drug usage:
 - HIV.
 - Hepatitis B and C.
 - Endocarditis.
 - Necrosis at the injection site.
 - Deep vein thrombosis and pulmonary embolism.

A – 3 Although withdrawal symptoms are very unpleasant, they are not usually dangerous to an otherwise healthy person. Therefore, it is best not to offer pethidine.

Severe pain can be controlled by non-steroidal painkillers (e.g. voltaren). Methadone (longer acting drug) may be used in planned withdrawal of opioids. Benzodiazepine can be used to control symptoms.

Psychological management is important.

Case 18

A – 1 Nocturnal enuresis – secondary type.

A – 2 Secondary nocturnal incontinence is usually psychological.

Possible precipitating factors:

- Entering school
- Birth of a sibling
- Anxiety, depression.

A – 3

- Proper assessment.
- Identify and treat any psychiatric problem.
- Fluid restriction before bedtime.
- Advice to parents.
 - Praise success.

- Avoid disapproval
- Tricyclic antidepressant (e.g. imipramine 25 mg at bedtime).
- Behavior therapy.
 - Star charts
 - Pad and bell

Case 19

- A – 1 Attention-Deficit Hyperactivity Disorder (Hyperkinetic Syndrome).
- A – 2 Many children with mental retardation are distractible, overactive and impulsive. Hyperkinetic disorder occurs more commonly among children with mental retardation than among those of normal intelligence. However, diagnosis of mental retardation in this boy is better deferred until his hyperkinetic disorder is treated, then IQ test can be done.
- A – 3
- Stimulant drugs (e.g. methylphenidate) can reduce overactivity and improve the attention span.
 - Explain the nature of the condition to the parents and teachers who should be supported in their efforts to contain and live with the condition.
 - Remedial teaching is required if no improvement with the above measures.

Case 20

- A – 1 School phobia.
- A – 2 Separation anxiety.
- A – 3 Prognosis depends on presence or absence of good and bad prognostic factors. Most younger children eventually return to school unless the case is severe, and perpetuating factors keep maintaining the disorder (e.g. marital problems, failure in class, bullying by other children).

Case 21

- A - 1 Autistic disorder (childhood autism).
- A – 2 No, abnormal parenting has not been shown to be a cause of autistic disorder. The cause is still unknown, though some studies suggest an organic pathology.
- A – 3 There is no specific treatment.
Management should include:
- Special schooling (may be residential) to help the child to achieve his remaining potential development
 - Control or modification of abnormal behavior.
 - Support for the family.
 - Sulpiride (dogmatil) an antipsychotic drug was found useful in autism.

Glossary

Index

ثبت المصطلحات GLOSSARY

A

Ablution	الوضوء
Abreaction	تنفيس (تفريغ) الانفعال والمشاعر المكبوتة
Abstinence	امتناع (إقلاع عن التعاطي)
Abstract thinking	تفكير تجريدي (استخلاص المفاهيم المعنوية من الألفاظ)
Abulia	فقد الإرادة (العجز)
Abuse	سوء استعمال
Acting Out	تهور (آلية نفسية تدفع الشخص للتصرف التلقائي دون التفكير بالعواقب)
Adaptive	تكيفي
Addict	مدمن
Addiction	إدمان
Adolescence	مراهقة
Adolescent	مراهق
Adjustment Disorders	اضطرابات التكيف النفسي
Affect	شعور - عاطفة
Aggression	عدوان
Agitated	ثائر - هائج
Agitation	إثارة - هياج
Agoraphobia	رهاب الأسواق (الخوف الناتج عن التواجد في الأماكن المفتوحة)
Akathisia	تململ حركي (زلز)
Akinesia	لا حركية (فقد الحركة)
Alexithymia	العجز النفسي - عدم القدرة على التعبير شفويًا عن المشاعر الشخصية

Altruism	إيثار وتفانٍ في خدمة الآخرين
Ambiguous	غامض، ملتبس
Ambivalence	تناقض وجداني (ازدواجية وجدانية - حب ويغض أو سخط ورضا في الوقت نفسه)
Amnesia	نسيان (فجوة في الذاكرة)
Anterograde amnesia	نسيان المعلومات اللاحقة
Retrograde amnesia	نسيان المعلومات السابقة
Anniversary	ذكرى سنوية (كالعيد مثلاً)
Anorexia Nervosa	قهم (فقدان شهية الأكل) عصابي (بسبب حالة نفسية)
Anxiety	قلق
Anxiolytic	مزيل القلق
Anxious	قلق
Apathic	فاتر المشاعر
Apathy	فتور المشاعر
Aphonia	فقد الصوت
Apprehension	توجس
Arbitrary inferences	استنتاجات اعتباطية
Assertiveness training	تدريب توكيد الذات
Association of ideas	ترابط الأفكار
Asthenia	وهن
Ataxia	رنح
Attitude	موقف (اتجاه)
Autism	توحد (انطواء على الذات)
Automatism	سلوك تلقائي

Avoidant Personality disorder

اضطراب الشخصية التجنبية

B

Behavior

سلوك / تصرف

Behaviorism

المدرسة السلوكية

Behavior therapy

علاج سلوكي

Bereavement

الحرمان، الفقدان

Blushing

احمرار الوجه

Borderline Personality Disorder

اضطراب الشخصية الحدية (متقلبة المزاج)

Bulimia Nervosa

تُهام عصابي (شره في الأكل)

C

Cannabis

الحشيش

Catalepsy

الجُمدة (تصلب عضلات الأطراف في أوضاع مختلفة)

Cataplexy

هُوار (ارتخاء مفاجئ في العضلات يؤدي إلى سقوط الواقف)

Catastrophic Reaction

ارتكاس النكبة (انفعال بعد استشارة نفسية)

Catatonia

تحشب (تيبس عام في عضلات الجسم)

Chorea

رقص مرضي

Choreiform

رقصي الشكل

Classification

تصنيف

Claustrophobia

رهاب الانغلاق (رهاب الأماكن المغلقة كالمصاعد)

Clouding

تغييم - تشوش

Cocaine

مادة كوكائين

Codeine

مادة كودين

Cognitive	معرفي، إدراكي
Cognitive Functions	الوظائف الإدراكية (الانتباه والتركيز والذاكرة ومعرفة المكان والزمن والأشخاص)
Coma	سُبات/ إغماء
Comatose	مسبوت/ مغمى عليه
Compatibility	توافق
Compensation	تعويض
Complex partial seizure	صرع جزئي مركب
Compulsions	تصرفات قهرية (جبرية)
Concentration	تركيز
Concept	مفهوم
Concussion	ارتجاج
Conditional learning	تعلم شرطي (تكيفي)
Conditioning	تكيف
Conduct disorders	اضطرابات السلوك والتواصل
Confabulation	تلفيق (سد فراغ في الذاكرة بمعلومات مغلوطة)
Conflict	صراع
Confusion	تخليط (اختلاط) تشوش ذهني
Conscious	واع
Consciousness	وعي
Constitution	بنية
Conversion Disorder	اضطراب الهستيريا التحويلية
Crisis	نوبة/ أزمة
Cyclothymia	المزاج الدوري (متأرجح بين المرح اليسير والكآبة اليسيرة)

D

Deceased	المتوفى
Decompensation	فقد القدرة على التحمل
Deconditioning	إزالة التكيف الشرطي
Defect	عيب
Defense	دفاع
Defense Mechanisms	آليات الدفاع (الحيل النفسية)
Deja Entendu	سبق سماعه
Déjà vu	سبق رؤيته
Delirium	هذيان
Delirium tremens	هذيان ارتعاشي
Delinquency	جنوح
Delirious	هاذىء (مصاب بالهذيان)
Delusion	توهم / ضلالة في التفكير
Dementia	خرف
Denial	إنكار
Dependence	اعتماد - اتكال
Dependant personality Disorder	اضطراب الشخصية الاعتمادية
Depersonalization	تبدد الشخصية (تُحِيل للشخص بالغرابة عن الذات)
Depot	مدّخر (طويل المفعول)
Depressed	مكتئب
Depression	اكتئاب
Derangement	اختلال

Derealization	تبدد المحيط والواقع (يُحيل للشخص بأن البيئة المحيطة قد تغيرت)
Desensitization	إزالة التحسس
Despair	يأس
Despondent	قناط
Destructive	مخرب
Detachment	انفصال
Deterioration	تردٍ
Detoxification	إزالة السّمية
Deviation	انحراف
Diagnosis	تشخيص
Dichotomous thinking	تفكير منقسم (يرى الأمور على طرفي نقيض ولا وسط بينهما)
Didactic	تعليمي (تلقيني)
Differential	تفريقي
Disintegration	تلاشٍ - تفكك
Disorientation	توهان
Disoriented	تبهان - تائه
Displacement	إزاحة
Disposition	استعداد / ميل / أهبة
Dissociation	افتراق / تفكك / انشقاق
Dissociative	افتراقي / انشقاقي
Distraction	شروذ ذهني، ذهول، تحول انتباه
Distress	كرب، ضيق، محنة
Dizziness	دُوار

Drive	باعث
Drowsiness	نعاس
Drunk	سكران
Dyskinesia	عسر الحركة
Dysmenorrhea	عسر الطمث (ألم الدورة الشهرية)
Dysmorphophobia	رهاب التشوه البدني
Dyspareunia	عسر الجماع (ألم الجماع)
Dysphoria	حزن مع قلق
Dysthymia	سوء المزاج (كآبة مزمنة غير شديدة)
Dystonia	خلل التوتر (توتر العضلات)

E

Eclectic	انتقائي
Echolalia	صدى لفظي (ترديد الألفاظ)
Ecstasy	نشوة (ابتهاج غامر)
Ego	الأنا / الذات
Egocentric	مركزي الذات
Egoism	الأنانية / التمرکز حول الذات
Ejaculation	دفق
Elation	ابتهاج
Electro-convulsive therapy (ECT)	العلاجة بالجلسات الكهربائية
Electroencephalogram (EEG)	مخطط كهربائية الدماغ
Elimination Disorders	اضطرابات الإخراج (التبول - التبرز)

Emaciation	هُزَال
Emotion	انفعال (عاطفة)
Emotional incontinence	سلس الانفعال (خروج المشاعر دون تحكم و يوجد في حالات الحرف)
Empathy	التفهم الوجداني (فهم مشاعر الطرف الآخر)
Encopresis	اضطراب التحكم في عملية التبرز
Enuresis	اضطراب التحكم في عملية التبول
Epidemic	وبائي
Epidemiology	الوبائيات (مدى انتشار المرض في فئات المجتمع)
Episode	نوبة عارضة
Erection	نعوظ (انتصاب)
Erotic	مُشْبِق
Erotomania	هوس العشق / هوس الجنس
Erratic	تائه - خاطئ
Ethical	أخلاقي
Euphoria	مرح
Eustress	الكرب السوي
Evil Eye	العين الحاسدة
Excitation	استثارة
Excitement	ثوران
Exhaustion	إنهاك
Exhibitionism	استعراء
Exogenous	خارجي
Exorcism	تعويذة (رقية....)

Expansive Mood	مزاج متمسم بوهم العظمة
Exposure	مواجهة - تعرض
Extrapyramidal	خارج الحزمة العصبية الهرمية
Extraversion	الانبساط (عكس انطواء الشخصية)

F

Factitious	مفتعل / مكذوب / مصطنع
Fainting	غشي / إغماء
Fantasy	خيال
Fascination	الافتتان
Fear	خوف
Fit	نوبة
Flight of ideas	تطاير الأفكار (كل فكرة تجرّ غيرها قبل اكتمالها هي)
Flooding	غمر (مواجهة كاملة)
Frigidity	برود جنسي (عند المرأة)
Frustrating	خيبة
Fugue	شُرَاد (ذهول)

G

Gaze	حلقة
Gender	الجنس (المذكر / المؤنث)
Generalization	تعميم
Giddiness	دُوَام (دوار)
Gustatory	ذوقي (متعلق بحاسة الذوق)

Grandiosity	العظمة
Grief	الأسى على فقد عزيز محبوب
Guilt	شعور بالإنثم والذنب
Gynecomastia	تثدي الرجل (زيادة حجم ثدي الذكر)

H

Habit	عادة
Habituation	تعود
Hallucinations	هلاوس
Hallucinogens	مهلوسات
Hashish	الحشيش
Hebephrenia	فصام المراهقة (فند البلوغ)
Heroin	مادة الهروين
Homicide	قتل الإنسان غيره
Homosexuality	جنسية مثيلة
Hostile	عدائي
Hyperactivity	فرط النشاط
Hyperkinesia	فرط الحراك
Hypermnnesia	فرط التذكر
Hypnagogic hallucinations	هلاوس نعاسية
Hypnopomic hallucinations	هلاوس استيقاظية
Hypnotic	منوم
Hypochondriasis	توهم المرض (المراق)
Hypomania	هوس طفيف (مرح)

Hypothalamus	الوطاء (ما تحت المهاد)
Hysteria	هراع (هستيريا)
I	
Identification	تمثل، تعرف، تماهي، تقمص
Idiopathic	غامض، غير معروف السبب
Identity	هوية
Illusion	انخداع (خداع الحواس)
Impotence	عنانة
Impression	انطباع
Impulsive	اندفاعي
Inattention	قلة انتباه، غفلة
Incentive	حافز
Incipient	وشيك
Incoherence	لا ترابط (كلام غير مفهوم)
Incontinence	سلس - تدفق غير منضبط
Indifference	لا مبالاة
Infanticide	قتل الوليد (المولود)
Insight	البصيرة (بصيرة المريض بمرضه)
Insomnia	أرق
Instinct	غريزة (رغبة غريزية)
Insufficiency	قصور - نقص
Intelligence	ذكاء
Intention	قصد - نية

Intellectualization	العقلنة (المبالغة في الجوانب العقلية الفكرية هرباً من المعاناة الوجدانية)
Intolerance	لا تحمّل / عدم القدرة على التحمّل
Intoxication	انسام
Introspection	تفكير ذاتي
Introjection	الاستدماج
Introversion	الانطواء (الميل إلى العزلة)
Involuntary	لا إرادي
Irritability	تهيج
Irritable Bowel Syndrome	متلازمة القولون المتهيج (القولون العصبي)

J

Jealousy	غيرة
Jitters	نرفزة شديدة

K

Kleptomania	هوس السرقة (ولع بالسرقة دون حاجة في المسروق)
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L

Labeling	وسم (وصم)
Labile	مقلقل (متقلب)
Lassitude	إنهاك
Libido	رغبة جنسية
Lucid	صافي

M

Malaise	فتور - وعك
Malingering	تمارض - إدعاء المرض كذباً عن عمد
Mania	هوس
Mannerisms	حركات نمطية شبه هادفة
Marijuana	المروانا (قنب هندي)
Marital	زواجي
Medicolegal	طبي شرعي
Medulla oblongata	النخاع المستطيل
Melancholia	السوداوية (اكتئاب شديد)
Mile stones	معالم النمو خلال الطفولة (بداية المشي - الكلام....)
Milieu therapy	معالجة بيئية
Mind	العقل
Mood	المزاج
Motive (Motivation)	دافع
Mourning	الحداد (المدة التي يمر بها المحزون بعد فقد عزيز إلى أن يسلمو)
Mute	أبكم
Mutism	بكم (خرس)

N

Narcissistic	نرجسي (أناني محب لذاته معجب بها جداً)
Narcolepsy	نوم انتبايي، سبخ
Narcotic	مخدر

Nausea	غثيان
Negativism	السلبية
Nervousness	عصبية
Neurasthenia	وهن عصبي
Neuroleptic	مضاد الذهان
Neuroleptic Malignant Syndrome	متلازمة المنعش العصبي الخبيثة
Neurosis	عُصاب
Neurotic	عُصابي
Neuroticism	عُصابية
Nightmare	كابوس ليلي
Night Terror	فزع ليلي
Nihilistic delusion	توهم العدم
Nocturnal	ليلي
Nosology	علم تصنيف الأمراض
Nystagmus	رأفة (تهزز حدقة العين)
○	
Obsession	وسواس ، وسوسة
Obsessive	وسواسي
Obsessive Compulsive Disorder	اضطراب الوسواس القهري
Oculogyric Crisis	تدور المقلة (شخص البصر بسبب انقباض عضلات العين)
Opiate (opium)	أفيوني
Opisthotonos	التشنج الظهري (تشنج عضلات الظهر مع تقوس)

Orgasm	هزة الجماع (الإيغاف)
Orientation	الاهتداء (معرفة المكان والزمان والأشخاص)
Overcompensation	المعاوضة المفرطة
Overgeneralization	التعميم المفرط

P

Palilalia	لجلجة (إعادة المقطع الأخير من كلمة بتكرار لا داعي له)
Palpitation	خفقان
Panic	هلع / ذعر
Paranoid	هذائي، زوراني، شكّي
Paraphrenia	فصام هذائي متأخر
Paraphilia	شدوذ جنسي
Parasomnia	شدوذ النوم
Parietal	جداري
Paroxysm	اشتداد / موجة عارمة
Path gnomonic	واصم / دال دلالة قوية
Pattern	طراز
Perception	إدراك
Perplexity	حيرة وارتباك
Persecution	اضطهاد، ظلم
Perseveration	مواظبة (مداومة، معاودة)
Personality	شخصية
Persuasion	إقناع

Pessimism	تشاؤم
Phobia	رهاب
Pica	الوحم (الرغبة في أكل ما ليس بطعام كالطين ونحوه)
Pons	القنطرة
Postnatal (post-partum)	بعد الولادة
Posttraumatic Stress Disorder	اضطراب الكرب بعد المرض
Premorbid	قبل المرض
Presenile	ما قبل الشيخوخة
Precipitating factors	عوامل محرضة
Predisposing factors	عوامل مؤهبة
Priapism	انتصاب القضيب بآلم (قُسوح)
Primary gain	مكسب أولى
Prodromal	بادري
Prodromata	بوادر
Profile	سبب
Prognosis	مآل (سير المرض)
Projection	إسقاط
Promiscuity	تعدد العلاقات الجنسية
Prophylaxis	وقاية
Provisional	مؤقت (مبدئي غير نهائي)
Psyche	نفسي
Psychiatrist	طبيب نفسي
Psychiatry	الطب النفسي

Psychoanalysis	التحليل النفسي
Psychogenic	نفسى المنشأ
Psychology	علم النفس
Psychologist	مختص نفسي (غير طبيب)
Psychomotor	نفسى حركي
Psychopath	معتل النفس (علة شخصية تتسم بضعف الضمير)
Psychosis	دُهان.
Psychosomatic	نفسى - بدني
Psychotherapy	المعالجة النفسية غير الدوائية
Psychotic	دُهاني
Psychotropic drugs	الأدوية النفسية
Puerperal	نفاسي

Q

Quotient	حاصل القسمة
(IQ=Intelligence Quotient)	حاصل الذكاء

R

Rape	اغتصاب جنسي
Raphe	منقطة التحام
Rapport	الوثام / علاقة توافق
Rational	منطقي
Rationale	أساس منطقي
Rationalization	تسويغ (تبرير)

Reactive	تفاعلي
Reaction formation	تكوين عكسي
Reassurance	تطمين
Regression	تراجع (نكوص)
Rehabilitation	إعادة تأهيل
Reinforcement	تعزيز
Rejection	رفض
Relapse	نكس - انتكاسة
Relaxation	إرخاء (استرخاء)
Reliability	المصدقية
Remission	هدأة
Remorse	ندامة
Replacement	استبدال
Repression	كظم
Restlessness	تململ
Retardation	عوق - تعويق
Retrograde	رجوعي
Rigidity	صلابة (صمل)
Ritual	شعائري
Rumination	اجترار الأفكار والصور الذهنية
S	
Sadism	القسوة المفرطة
Satiety	شبع

Schizoid	فُصاماني - شبيهة بالفُصام
Schizophrenia	فُصام
Schizotypal	فصامي الشكل
Secondary gain	مكسب ثانوي
Sedation	تركين - تسكين
Sedative	مسكِّن
Seizure	نوبة
Self-esteem	تقدير الذات / المعنويات النفسية
Senile	شيخوخي
Sensation	إحساس
Sequel	عقاييل - عواقب
Simulation	المحاكاة - التقليد
Sociable	اجتماعي
Social Withdrawal	انسحاب اجتماعي
Social worker	مختص اجتماعي
Somatization	تجسيد (تأثير المعاناة النفسية على الجسد)
Somnambulism	السير النومي (المشي أثناء النوم)
Somnolence	الوسن
Spasm	تشنج
Spirit	روح
Splitting	الشطط / الفصل
Stammering (Stuttering)	تأتأة - فأفأة
Stereotypes	حركات نمطية غير هادفة

Stiffness	تيبس
Stress	ضغط - وطأة - شدة
Stress reaction	تأثير الضغط والإجهاد
Stupor	خدر / سُبات
Sublimation	تسامي (تصعيد)
Suggestibility	قابلية الإيحاء
Suggestible	قابل للإيحاء
Suicide	انتحار
Superego	الأنا العليا / الضمير
Supernatural	خارق للطبيعة (غيبى فوق إدراك البشر....)
Suppression	كبت (كبح)
Sympathy	التواؤ (الموافقة الوجدانية)

T

Tardive	آجل
Tradive Dyskinesia	عسر الحركة الآجل
Temperament	المزاج
Temporal	صدغي / وقتي
Thumb-Sucking	مص الإبهام
Tics	عرات (تقلصات عابرة مفاجئة في العضلات)
Torticollis	صعر (تقلص عضلات الرقبة وميل الوجه جانباً)
Trait	سمة طبع
Trance state	حالة ذهول نفسي تشبه الغيبوبة لكن مع بقاء الوعي
Transference	انقال - تحويل

Trauma	رضخ (رض)
Tremor	رعاش
Tremulous	رعاشي
Trichotillomania	هوس التفت (إزالة الشعر)

U

Unconscious	اللاشعور / مغمى عليه
Undoing	الإبطال

V

Validity	الدقة والصواب
Verbigeration	ثرثرة نمطية
Vigilance	تيقظ
Volition	إرادة
Vulnerability	تعرض (كون الشخص أو الشئ عرضة لـ...)
Vulnerable	عُرْضة لـ... ..

W

Wandering	متجول
Waxy flexibility	الإثنائية الشمعية
Witchcraft (black magic)	سحر
Withdrawal	عزل (انسحاب)
Working through	الاختراق (المعالجة بالوصول إلى الاستبصار بالعلة)

Y

Yawning

تثاؤب

Yearning

الشفقة على، الرثاء لحال

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