Psychiatric Symptoms and signs

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Psychiatric symptoms and signs

- *Abnormalities of thinking*
- *Abnormalities of perception*
- *Abnormal behaviours*
  - *Psychotic symptoms*
- *Mood symptoms*
  - *Depressive symptoms*
  - *Manic symptoms*
- *Suicide / Homicide*
- *Vegetative symptoms:*
- *Catatonic features*
- *Anxiety symptoms*
- ADHD symptoms
- Eating disorders symptoms

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Abnormalities of thinking

1. Abnormalities of **content** of thinking
2. Abnormalities of **control** of thinking
3. Abnormalities of **flow** of thinking
4. Abnormalities of **form of** thinking

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Abnormalities of content of thinking

- **Delusions** (in psychosis)
- **Obsessions**
- **Phobias**
- **Overvalued ideas**
- Anxious **apprehension**
- Depressive **rumination**
- **Memory flashbacks** (in PTSD)
- **Preoccupations**

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Delusions

Definition

- It is a false fixed belief not corrected by reasoning, not shared by others.

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Delusions

Types of delusions

- **Delusion of persecution :** delusions that one is being attacked, cheated or persecuted.
  - ✓ **Robbed**
  - ✓ **Poisoning**
  - ✓ **Reference** *(the patient knows that people are talking about him, or slandering him)*
- **Grandiose delusion:** delusions of inflated worth, power, knowledge, identity, or special relationship to or famous person

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Delusions

Types of delusion

- **Erotomanic delusions** (delusions of love)**:** delusions that another person, usually of higher status, is in love with the individual.
- **Delusion of infidelity (jealous):** delusions that the individual's sexual partner is unfaithful

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Delusions

Types of delusion

- **Delusion of poverty :** The patient with delusions of poverty is convinced that they are impoverished and believe that destitution is facing them and their family.
- **Delusion of ill health (somatic delusions):** delusions that the person has some physical defect or general medical condition
- **Delusion of guilt :** In mild cases of depression the patient may be somewhat self-reproachful and self-critical. In severe depressive illness self-reproach may take the form of delusions of guilt, when the patient believes that they are a bad or evil person and have destructed their family.

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Delusions

Types of delusion

- **Nihilistic delusions:** Nihilistic delusions or delusions of negation occur when the patient denies the existence of their body, their mind, their loved ones and the world around them. They may assert that they have no mind, no intelligence, or that their body or parts of their body do not exist; they may deny their existence as a person, or believe that they are dead, the world has stopped, or everyone else is dead.
- **Bizarre delusions :** a delusion that involves a phenomenon that the person's culture would regard as totally implausible

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Obsessions and compulsions

In **obsessive compulsive disorder**

- **Obsessions** are defined by (1) and (2):
  - Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
  - The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

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Obsessions and compulsions

- **Compulsions** are defined by (1) and (2):
  - Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
  - The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

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Obsessions and compulsions

Obsession	Compulsion
1- Contamination	Obsession is followed by: Washing (patients may literally rub the skin off their hands by excessive hand washing) Compulsive avoidance of contaminated object.
2- **Pathological Doubt** : It often implies some danger of violence (e.g., forgetting to turn off the stove or not locking a door)	Obsession is followed by a compulsion of checking. The checking may involve multiple trips back into the house to check the stove, for example.

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Obsessions and compulsions

Obsession	Compulsion
3- **Intrusive Thoughts** : Such obsessions are usually repetitious thoughts of a sexual or aggressive act that is reprehensible to the patient.	No compulsions Patients obsessed with thoughts of aggressive or sexual acts may report themselves to police or confess to a priest.
4- Symmetry: It is the need for symmetry or precision.	Obsession leads to a compulsion of slowness. Patients can literally take hours to eat a meal or shave their faces.

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Obsessions and compulsions

Obsession	Compulsion
In **Body dysmorphic disorder** ▪ Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others. ▪ At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.	

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Obsessions and compulsions

Obsession	Compulsion

In **hoarding disorder**

- Persistent difficulty discarding or parting with possessions, regardless of their actual value.
- This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

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Obsessions and compulsions

Obsession	Compulsion

In **Trichotillomania (Hair-Pulling Disorder)**

- Recurrent pulling out of one's hair, resulting in hair loss.
- Repeated attempts to decrease or stop hair pulling.

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Overvalued ideas

Definition

- *This is a thought that, because of the associated feeling tone, takes precedence over all other ideas and maintains this precedence permanently or for a long period of time.*

DD form delusions

- Overvalued ideas tend to be less fixed than delusions and tend to have some degree of basis in reality.

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Overvalued ideas

Causes

- They can occur *in individuals both with and without mental illness*.

1. Personality disorders (paranoid PD with overvalued ideas of persecution; OCPD)
2. Eating disorders
3. Body dysmorphic disorder
4. Hypochondriasis (with overvalued ideas of ill health)
5. Depressive disorders (ex. overvalued ideas of ill health)
6. Gender identity disorder
7. Morbid jealousy

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Preoccupations

Definition

- Ideas that are present most of the time and dominating thinking with quantitative difference from normal ideas.

Causes

- Normal (pre exam)
- Somatoform disorders
- Anxiety
- Depression

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Flashbacks

Definition

- Flashbacks are sudden intrusive memories that are associated with the cognitive and emotional experiences of a traumatic event such as an accident.
- It may lead to acting and/or feeling that the event is recurring and attempts have been made to use this as a defence in some murder trials.

Causes

- It is regarded as one of the characteristic symptoms of **post-traumatic stress disorder** but is also associated with **substance misuse disorders and emotional events**

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Abnormalities of control of thought

- **Delusion of passivity or control**: a delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control.

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Abnormalities of control of thought

1. **Made affect** (someone controlling the mood/affect).
2. **Made volition** (someone controlling the action).
3. **Made impulse** (someone controlling the desire to act)
4. **Made thoughts:**
    A. **Thought withdrawal.**
    B. **Thought insertion.**

- **Thought broadcasting** "people act as if they know what I'm thinking".

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Abnormalities of form of thought

Formal thought disorders (FTD) or disorganized speech

- **How to assess the thought process (form)?**

✓ Goal directedness.
✓ Association between words, phrases, sentences & paragraphs.
✓ Rate, amount & rhythm of speech.
✓ Idiosyncrasy of word usage.

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Abnormalities of form of thought

- **Normal thought process?**

✓ Goal directed (direct).
✓ To the point.
✓ Good connection between elements of structure of the thought (words, sentences and paragraphs).
✓ No idiosyncratic use of words.

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Abnormalities of form of thought

- **FTD include:**
- **Abnormalities of Goal directedness**
- **Circumstantiality:**
  - ✓ overinclusion of details not directly relevant to the question
  - ✓ the sequential states are connected
  - ✓ the patient eventually returns to address the subject or address the question
- **Tangentiality:**
  - ✓ The patient never returns to the original point of question
  - ✓ The thought are irrelevant and related in a minor insignificant manner

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Abnormalities of form of thought

- **FTD include:**
- **Abnormalities of Association**
  - **Loosening of association:** (difficult or impossible to see connections between thoughts)
  - **Incoherence** (word salad, schizophasia): extreme loss of association
  - **Clang associations** (association based on alliteration rhyming or assonance) موسيقى
  - **Punning** (association by double meaning) سجع

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Abnormalities of form of thought

- **FTD include:**
- **Idiosyncratic use of language (private symbolism)**
  - **Neologism**

    Cryptolalia = the use of obscure (or private) language

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Abnormalities of form of thought

- **FTD include:**
- **Repetition**
  - **Stereotypy** (vocal and verbal) (repetitive or ritualistic utterance)
  - **Verbigeration** (repetition of stereotyped phrases)
  - **Perseveration** (repetition of word or phrase despite the absence or cessation of a stimulus)
  - **Echolalia** (repetition of words spoken by others)
  - **Palilalia** (auto-echolalia)
  - **Logoclonia** (repetition of the last syllable of a word)
  - **Coprolalia** (repetition of obscene language)

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Abnormalities of flow of thought

- **Flight of ideas**: rapid rated speech, frequent shifts in topics, in manic patient.
- **Slow stream** in depression
- **Thought block**: in schizophrenic patient.

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Abnormalities of perception

- Disorders of perception can be divided into
  1. **Sensory distortions**: there is a constant real perceptual object, which is perceived in a distorted way.
  2. **Sensory deceptions:** a new perception occurs that may or may not be in response to an external stimulus.

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Sensory distortions

- **Sensory distortions:** These are changes in perception that are the result of a change in the intensity and quality of the stimulus or the spatial form of the perception.

1. **Changes in intensity**
2. **Changes in quality**
3. **Changes in spatial form (dysmegalopsia)**

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Sensory distortions

- **Changes in intensity**
  - **Increased intensity of sensations**
    - Ex. migraine is associated with **increased sensitivity to noise (hyperacusis)**
  - **Decreased intensity of sensations**
    - **Ex.Hypoacusis** occurs in delirium

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Sensory distortions

- **Changes in quality**
  - ***Ex. Colouring*** *of yellow, green and red*. These are mainly the result of drugs (for example, digitalis)
- **Changes in spatial form**
  - **Micropsia** is a visual disorder in which the patient sees objects as smaller than they really are.
  - **Macropsia** is a visual disorder in which the patient sees objects as larger than they really are.

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Sensory deceptions

- **Sensory deceptions**
- These can be divided into
  1. **Illusions** = misinterpretations of stimuli arising from an external object.
  2. **Hallucinations** = perceptions without an adequate external stimulus.

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Hallucination

Definition:

- Perception without actual stimulus present
- They care from <within> although the subject reacts if they were true preceptors coming from < without>

DD from illusions

- Hallucination: no actual stimulus
- Illusions: with actual stimulus

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Hallucination

Types

- **Auditory hallucination:**
- Elementary: noises
- Partly organized: music
- Completely organized: hallucinatory voice
  - *Commanding , ordering, threatening, praising, abusive*
  - *Audible thought*
  - *Third person hallucinations*

- **Visual hallucination:**
- Elementary: flashes of light
- Partly organized
- Completely organized: vision of people, animals

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Hallucination

- **Olfactory hallucinations:** smell
- **Gustatory hallucinations:** taste
- **Tactile hallucinations**: sexual hallucinations
- **Hallucination of pain, deep sensation**

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Abnormal behaviours

- Manic and impulse control disorder → pleasure seeking behavior
- Histrionic → attention seeking behavior
- SUD → drug seeking behavior
- Psychotic → disorganized or bizarre behavior (collecting things from the floor)
- Catatonia → catatonic behavior
- Unexplained behavior
- Disinhibited behavior [socially, sexually]
- Autism → Ritualistic behaviour
- Autism → Stereotyped behaviour
- Stereotyped behavior (due to any cause)
- Impulsive behavior
- Manipulative behavior

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Abnormal behaviours

- Compulsive/ ritualistic behavior
- Aggressive/violent behavior
- Antisocial/conduct behavior
- Oppositional/defiant behavior
- Psychotic with hallucinations → hallucinatory behavior
- Maladaptive behavior
- Suicidal/homicidal behavior
- BPD → self mutilating behavior
- Sexually abused child → oversexualized/sexual promiscuity behavior
- GID → Cross gender identification behavior [cross dressing, play, games & activities]

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Abnormal behaviours

- **Catatonic behaviours**
- Excessive motor activity (excitement)
- Peculiarities of voluntary movement
  - ✓ *Posturing*
  - ✓ *Stereotyped movements*
  - ✓ *Prominent mannerisms*
  - ✓ *Prominent grimacing*
- Echopraxia
- Motoric immobility
  - ✓ *Stupor*
  - ✓ *Catalepsy (including waxy flexibility)*
- Extreme negativism

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Psychotic symptoms

- **Positive symptoms**
  - ✓ **Delusion**
  - ✓ **Hallucination**
  - ✓ Incomprehensible speech (disorganized speech)
  - ✓ Disorganized behaviors
  - ✓ Catatonic behaviours
- **Negative symptoms**

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Mood symptoms

Mood

- Mood is a pervasive and sustained emotion that colours the person's perception of the world.

Affect

- Affect, meaning short-lived emotion, is defined as the patient's present emotional responsiveness. It is what the doctor infers from the patient's *body language including facial expression* and it *may or may not be congruent with mood*.

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1- Depressive symptoms

- **Depressed mood**
- **Loss of interest** (markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- **Guilt feeling**
- **Feelings of worthlessness**
- **Lack of concentration**
- **Lack of energy**
- **Psychomotor agitation/retardation**

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2- Manic symptoms

- **Elevated mood**
- **Inflated esteem / Grandiosity**
- **More talkative than usual** or pressure to keep talking
- **Flight of ideas**
- **Distractibility** (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

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Suicide / Homicide

- Death thoughts
- Death wishes
- Suicidal ideation
- Suicidal intent
- Suicidal plan
- Suicidal attempt

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Vegetative symptoms:

- Appetite and Weight
- Sleep
- Sex
- Self hygiene

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Anxiety symptoms

- Generalized Anxiety Disorder
- Panic disorder: somatic symptoms, agoraphobia
- Social anxiety disorder: symptoms
- Simple phobias

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Eating disorders symptoms:

- Binge eating
- Purging
- Excessive fasting or exercise

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Major psychiatric disorders

- Psychotic Disorders (schizophrenia)
- Mood Disorders (depression, bipolar)
- Anxiety Disorders
- Dissociative Disorders
- Obsessive Compulsive Disorders
- Psychosomatic (Somatoform) Disorders
- Eating Disorders
- Sexual Disorders
- Substance use disorders
- Personality disorders
- Childhood psychiatry (Autism, ADHD)

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Psychiatric disorders

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I - Psychotic Disorders

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Psychotic Disorders

- **Psychotic** = Delusions + Hallucinations

1. Brief psychotic disorder (<1m)
2. Shizophreniform disorder (<6m)
3. Schizophrenia (>6m)

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Schizophrenia - Diagnostic Criteria

- **Characteristic symptoms**: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
  - delusions
  - hallucinations
  - disorganized speech (e.g., frequent derailment or incoherence)
  - grossly disorganized or catatonic behavior
  - negative symptoms, i.e., affective flattening, alogia, or avolition
- **Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

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Schizophrenia - Diagnostic Criteria

- ***Duration***: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms.

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Schizophrenia - Diagnostic Criteria

- *Schizoaffective and mood disorder exclusion.*
- *Substance/general medical condition exclusion.*
- *Social/occupational dysfunction*

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Schizophrenia - Types

- **Subtypes of schizophrenia**

1. Paranoid
2. Disorganized
3. Catatonic
4. Undifferentiated
5. Residual

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Schizophrenia - Types

Paranoid type

- Preoccupation with one or more delusions or frequent auditory hallucinations.
- None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

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Schizophrenia - Types

Disorganized type

- All of the following are prominent:
  - disorganized speech
  - disorganized behavior
  - flat or inappropriate affect
- The criteria are not met for catatonic type.

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Schizophrenia - Types

Catatonic type

- motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor
- excessive motor activity (that is apparently purposeless and not influenced by external stimuli)
- extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism
- peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing
- echolalia or echopraxia

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Schizophrenia - Types

Undifferentiated type

- A type of schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the paranoid, disorganized, or catatonic type.

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Schizophrenia - Types

Residual type

- Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.
- The presence of negative symptoms or two or more symptoms listed in Criterion A for schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

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Schizophrenia - Treatment

❖ **Biological therapies**

- **Pharmacotherapy (antipsychotics)**
  1. **First-generation antipsychotics** (Haloperidol, Chlorpromazine, Trifluoperazine, Fluphenazine)
  2. **Second-generation antipsychotics** (Aripiprazole, Clozapine, Olanzapine, Quetiapine, Risperidone, Sertindole , Ziprasidone)
- **Electroconvulsive therapy (ECT)**
- **Psychosurgery**

❖ **Psychosocial Therapies (psychotherapy)**

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II – Mood Disorders

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Mood Disorders

- **Mood** is a pervasive and sustained feeling tone that is experienced internally and that influences a person's behavior and perception of the world.
- **Affect** is the external expression of mood.
- Mood can be **normal, elevated, or depressed**.
- **Healthy persons** experience a wide range of moods and have an equally large repertoire of affective expressions; they feel in control of their moods and affects.
- **Mood disorders** are a group of clinical conditions characterized by a loss of that sense of control and a subjective experience of great distress.

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Classification of Mood Disorders

- **Major depressive disorder** (MDD) or unipolar depression is a disorder with only major depressive episodes, without a history of a manic, mixed, or hypomanic episode.

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- **Bipolar disorder**
- **Bipolar I disorder** is a disorder with one or more manic episodes, and sometimes major depressive episodes.
- **Bipolar II disorder** is a disorder with episodes of major depression and hypomania rather than mania.

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- **Dysthymia (dysthymic disorder)** is characterized by at least 2 years of depressed mood that is not sufficiently severe to fit the diagnosis of major depressive episode. *It represents less severe form of major depression.*
- **Cyclothymia (cyclothymic disorder)** is characterized by at least 2 years of frequently occurring hypomanic symptoms that cannot fit the diagnosis of manic episode and of depressive symptoms that cannot fit the diagnosis of major depressive episode. *It represents a less severe form of bipolar disorder.*

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- Minor depressive disorder
- Recurrent brief depressive disorder

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Major Depressive Episode – Diagnostic Criteria

- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
  Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
  - depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood
  - markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
  - significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
  - insomnia or hypersomnia nearly every day
  - psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - fatigue or loss of energy nearly every day
  - feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

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Major Depressive Episode – Diagnostic Criteria

- *Social/occupational dysfunction*.
- *Exclusion of mixed episode.*
- *Exclusion of substance/general medical condition.*
- *Exclusion of* bereavement (The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.)

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Criteria for Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
- During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
  - inflated self-esteem or grandiosity
  - decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - more talkative than usual or pressure to keep talking
  - flight of ideas or subjective experience that thoughts are racing
  - distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
  - increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

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Criteria for Manic Episode

- *Social/occupational dysfunction.*
- *Exclusion of mixed episode.*
- *Exclusion of substance/general medical condition.*

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.

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Criteria for Hypomanic Episode

- A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.
- During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
  - inflated self-esteem or grandiosity
  - decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - more talkative than usual or pressure to keep talking
  - flight of ideas or subjective experience that thoughts are racing
  - distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
  - increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

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Criteria for Hypomanic Episode

- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- The disturbance in mood and the change in functioning are observable by others.
- The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

- *Exclusion of substance/general medical condition.*

  Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar II disorder.

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Unipolar **Depression treatment**

- **Psychosocial Therapies (psychotherapy)**
  - Cognitive therapy
  - Behavior therapy
- **Biological therapies**
  - Pharmacotherapy
    - ✓ Antidepressant Medications
    - ✓ Augmentation drugs: lithium, antiepileptics, antipsychotics, thyroid
  - ECT
  - Vagal Nerve Stimulation
  - Sleep Deprivation
  - Phototherapy

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Antidepressant Medications

- ***MAO inhibitors*** (Tranylcypromine)
- ***Tricyclic antidepressnats*** (Clomipramine, Imipramine, Amitryptyline, Dothiepin,Tianeptine)
- ***Selective serotonin reuptake inhibitors*** (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Sertraline, Fluvoxamine)
- ***Serotonin–norepinephrine reuptake inhibitors*** (Venlafaxine, Duloxetine)
- ***Norepinephrine reuptake inhibitors*** (Reboxetine)
- ***Atypical antidepressants*** (Mirtazapine, Bubrobione, Trazodone)

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The pharmacological treatment of bipolar disorders

The pharmacological treatment of bipolar disorders is divided into both

- Treatment of acute episode
  - Treatment of acute mania or hypomania
  - Treatment of acute depression
- Maintenance treatment

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Treatment of Acute Mania

- **Lithium Carbonate**
- **Antieplieptic drugs** (Valproate, Carbamazepine, Oxcarba-zepine, Clonazepam & Lorazepam)
- **Anti-psychotics** (Atypical & Typical)
- **ECT**

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Treatment of Acute Bipolar Depression

- **Standard anti-depressants + mood stabilizer**
- **Mood stabilizers**
- **ECT**

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Maintenance Treatment of Bipolar Disorder

- **Lithium Carbonate**
- **Antieplieptic drugs** (Valproate, Carbamazepine, Lamotrigine)
- **Anti-psychotics** (Olanzapine)
- **Thyroid supplementation**

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III - Anxiety Disorders

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Anxiety Disorders

- Panic Disorder and Agoraphobia
- Specific Phobia
- Social Phobia
- Generalized Anxiety Disorder

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Generalized Anxiety Disorder

Diagnostic Criteria for Generalized Anxiety Disorder

- *Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).*
- The person finds it difficult to control the worry.
- The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).
  - restlessness or feeling keyed up or on edge
  - being easily fatigued
  - difficulty concentrating or mind going blank
  - irritability
  - muscle tension
  - sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

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- Exclusion of other psychiatric disorder.
- *Exclusion of substance/general medical condition.*
- *Social/occupational dysfunction*

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Panic Disorder and Agoraphobia

Criteria for Panic Attack

- *A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:*
- palpitations, pounding heart, or accelerated heart rate
- sweating
- trembling or shaking
- sensations of shortness of breath or smothering
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- feeling dizzy, unsteady, lightheaded, or faint
- derealization (feelings of unreality) or depersonalization (being detached from oneself)
- fear of losing control or going crazy
- fear of dying
- paresthesias (numbness or tingling sensations)
- chills or hot flushes

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Panic Disorder and Agoraphobia

Diagnostic Criteria for Panic Disorder without Agoraphobia

- Both (1) and (2):
  - recurrent unexpected panic attacks
  - at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
    - persistent concern about having additional attacks
    - worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
    - a significant change in behavior related to the attacks
- Absence of agoraphobia
- *Exclusion of other psychiatric disorders.*
- *Exclusion of substance/general medical condition.*

86

Panic Disorder and Agoraphobia

Diagnostic Criteria for Panic Disorder with Agoraphobia

- Both (1) and (2):
  - recurrent unexpected panic attacks
  - at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
    - persistent concern about having additional attacks
    - worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
    - a significant change in behavior related to the attacks
- The presence of agoraphobia
- *Exclusion of other psychiatric disorders.*
- *Exclusion of substance/general medical condition.*

87

Panic Disorder and Agoraphobia

Criteria for Agoraphobia

- Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.
- **Note**: Consider the diagnosis of specific phobia if the avoidance is limited to one or only a few specific situations, or social phobia if the avoidance is limited to social situations.
- The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.
- *Exclusion of other psychiatric disorders.*
- *Exclusion of substance/general medical condition.*

88

Specific Phobia

Diagnostic Criteria for Specific Phobia

- Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. **Note**: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
- The person recognizes that the fear is excessive or unreasonable. **Note**: In children, this feature may be absent.
- The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- *Social/occupational dysfunction*
- In individuals under age 18 years, the duration is at least 6 months.

89

- *Exclusion of other psychiatric disorders.*
- *Specify* type:
  Animal type
  Natural environment type (e.g., heights, storms, water)
  Blood-injection-injury type
  Situational type (e.g., airplanes, elevators, enclosed places)
  Other type (e.g., fear of choking, vomiting, or contracting an illness; in children, fear of loud sounds or costumed characters)

90

Social Phobia

- **Diagnostic Criteria for Social Phobia**
- A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.
  Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
- Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack.
- The person recognizes that the fear is excessive or unreasonable.
- The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- *Specify* if:
  Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder)

91

- *Social/occupational dysfunction*
- In individuals under age 18 years, the duration is at least 6 months.
- *Exclusion of other psychiatric disorders.*
- *Exclusion of substance/general medical condition.*

92

IV- Obsessive compulsive and related disorders

93

Obsessive-Compulsive Disorder

Diagnostic Criteria for Obsessive-Compulsive Disorder

- Either obsessions or compulsions:
  Obsessions as defined by (1), (2), (3), and (4):
  - recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
  - the thoughts, impulses, or images are not simply excessive worries about real-life problems
  - the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
  - the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)
- Compulsions as defined by (1) and (2):
  - repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
  - the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

94

Diagnostic Criteria for Obsessive-Compulsive Disorder

- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
- *Social/occupational dysfunction*
- *Exclusion of substance/general medical condition.*

95

	Thinking	Behaviour
Contamination (the most common)	Obsession of contamination.	Obsession is followed by: – Washing (patients may literally rub the skin off their hands by excessive hand washing) – Compulsive avoidance of contaminated object. The feared object is often hard to avoid (e.g., feces, urine, dust, or germs). Patient may be unable to leave their homes because of fear of germs.
Pathological Doubt (the second most common)	Obsession of doubt. It often implies some danger of violence (e.g., forgetting to turn off the stove or not locking a door).	Obsession is followed by a compulsion of checking. The checking may involve multiple trips back into the house to check the stove, for example.
Intrusive Thoughts (the third most common)	Intrusive obsessional thoughts without a compulsion. Such obsessions are usually repetitious thoughts of a sexual or aggressive act that is reprehensible to the patient.	Patients obsessed with thoughts of aggressive or sexual acts may report themselves to police or confess to a priest.
Symmetry (the fourth most common)	It is the need for symmetry or precision.	Obsession leads to a compulsion of slowness. Patients can literally take hours to eat a meal or shave their faces.

96

OCD Related Disorders

- Body dysmorphic disorder
- Trichotillomania
- Hoarding disorder

97

V- Trauma and stress related disorders

98

Posttraumatic Stress Disorder

Diagnostic Criteria for Posttraumatic Stress Disorder

- The person has been exposed to a traumatic event in which both of the following were present:
  - the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - the person's response involved intense fear, helplessness, or horror.
    Note: In children, this may be expressed instead by disorganized or agitated behavior.
- The traumatic event is persistently reexperienced in one (or more) of the following ways:
  - recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note**: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
  - recurrent distressing dreams of the event. **Note**: In children, there may be frightening dreams without recognizable content.
  - acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note**: In young children, trauma-specific reenactment may occur.
  - intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

99

- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
  - efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - efforts to avoid activities, places, or people that arouse recollections of the trauma
  - inability to recall an important aspect of the trauma
  - markedly diminished interest or participation in significant activities
  - feeling of detachment or estrangement from others
  - restricted range of affect (e.g., unable to have loving feelings)
  - sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
  - difficulty falling or staying asleep
  - irritability or outbursts of anger
  - difficulty concentrating
  - hypervigilance
  - exaggerated startle response

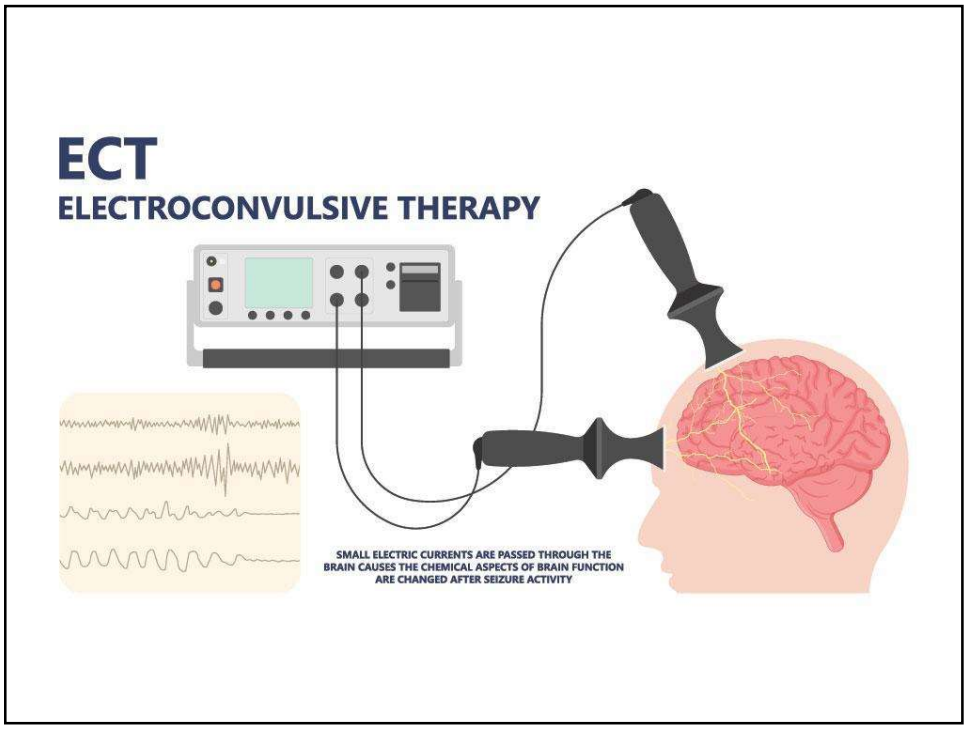
100

- Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- *Social/occupational dysfunction*
- *Specify* if:
  Acute: if duration of symptoms is less than 3 months
  Chronic: if duration of symptoms is 3 months or more
  Specify if:
  With delayed onset: if onset of symptoms is at least 6 months after the stressor

101

Case Study

102



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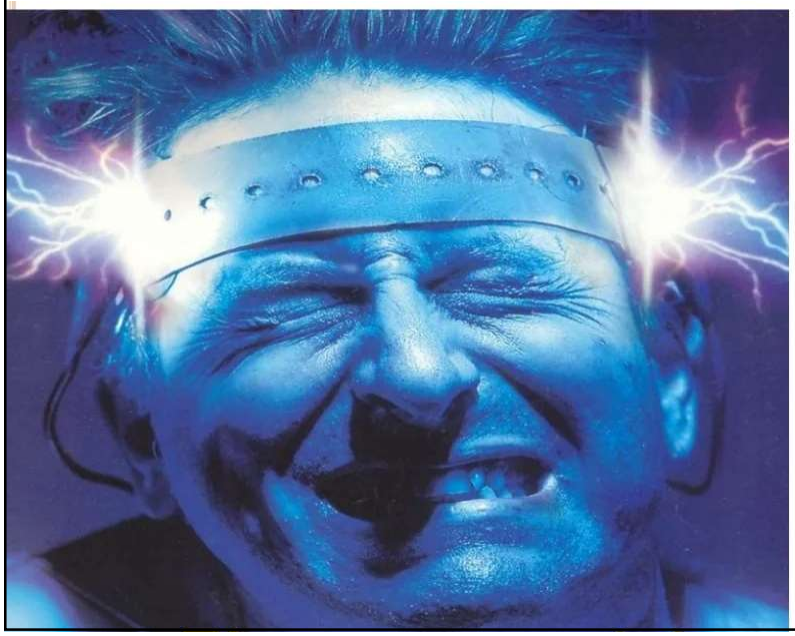


"For extreme diseases xtreme methods cure…ar most suitable.' -- Hippocra

104

WHAT DO YOU KNOW ABOUT ECT?

105

INTRODUTION

- Most of people (educated and non educated think that life inside mental illness hospitals is horror and scary.
- It is the effect of media that shows psychotic patients in disgusting appearance and doing unbelievable acts.

106

- It is also shows the role of electroconvulsive therapy in a scary scenario ,

-when two or more huge male nurses pull the patient

- then connect him to an electrical device , while he is fully awake
- –which make him scream with a loud voice
- - cry and then lose his consciousness because of the severe pain he got.

107

- Electroconvulsive therapy (ECT), also known as electroshock, is a well established, albeit controversial psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect.

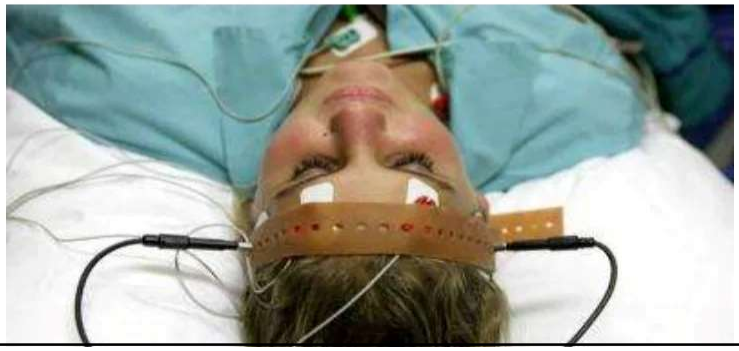
108

ECT: HISTORY

- ECT first appearance was by the scientist, Meduna in 1935 when he notice that most of schizophrenic symptoms are temporary disappear after a normal convulsion.
- He induced a seizure with an injection of campor-in-oil in a patient with catatonic schizophrenia

109

- **Cerletti and Bini introduced the use of "electric shock" to induce seizures in 1938,** and soon this method became the standard.



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DEFINITION

- "Artificial induction of a grandmal seizure (tonic phase 10-15sec, clonic phase:30-60 sec.)through the application of electrical current to the brain, the stimulus is applied through electrodes which are placed either bilaterally in the fronto-temporal region or unilaterally on the non dominant

111

PARAMETERS

- VOLTAGE- 70-120 Volts
- Duration - ***.7-1 .5 se***c

112

BENEFITS OF ECT:

- ECT relieve very severe depressive illnesses when other treatments have failed.
- ECT has saved patients' lives because 15% of people with severe depression will kill themselves.
- ECT works faster than all antidepressants drugs.

113

MECHANISM OF ACTION

- **Neuro-transmitter theory**
- **Neuro-endocrine theory**
- **Anti-convulsant theory.**
- **Brain damage theory.**
- **Psychological theory**.

114

- **Neurotransmitter theory.**

ECT works like anti-depressar medication, changing the way brai receptors receive important mood-relate chemicals.

- **Anti-convulsant theory.**

ECT-induced seizures teach the brain to resis seizures. This effort to inhibit seizure dampens abnormally active brai

115

- **Neuroendocrine theory.**

The seizure causes the hypothalamus to release chemicals that cause changes throughout the body. The seizure may release a neuropeptide that regulates mood

116

- **Brain damage theory.**

Shock damages the brain, causing memory loss and disorientation that creates an illusion that problems are gone, and euphoria, which is a frequently observed result of brain injury. Both are temporary.

117

- **Psychological theory.**

Depressed people often feel guilty, and ECT satisfies their need for punishment. Alternatively, the dramatic nature of ECT and the nursing care afterwards makes patients feel they are being taken seriously – the placebo effect

118

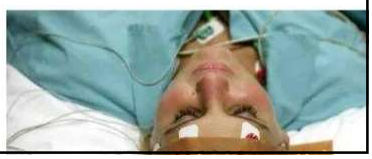
TYPAES OF ECT

- Direct ECT
- Modified ECT
- Unilateral ECT
- Bilateral ECT

119

ELECTRODE PLACEMENT

- Bilateral (BL) - most common, most effective, most cognitive dysfunction
- Right unilateral (RUL) - less cognitive effect, may be less clinically effective



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Modern ECT

❖ Electrode's are placed on the side of a patient's head just above the temples.

❖The patient is given anesthetic injections and a muscle relaxant to stop muscle contractions that can lead to broken bones.

❖A small electric current is passed through the brain

121

ELECTRODE PLACEMENT

- Each electrode is placed 2.5 -4 cm(1-1.5 inches) on the midpoint on a line joining the tragus of the ear and the lateral canthus of the eye

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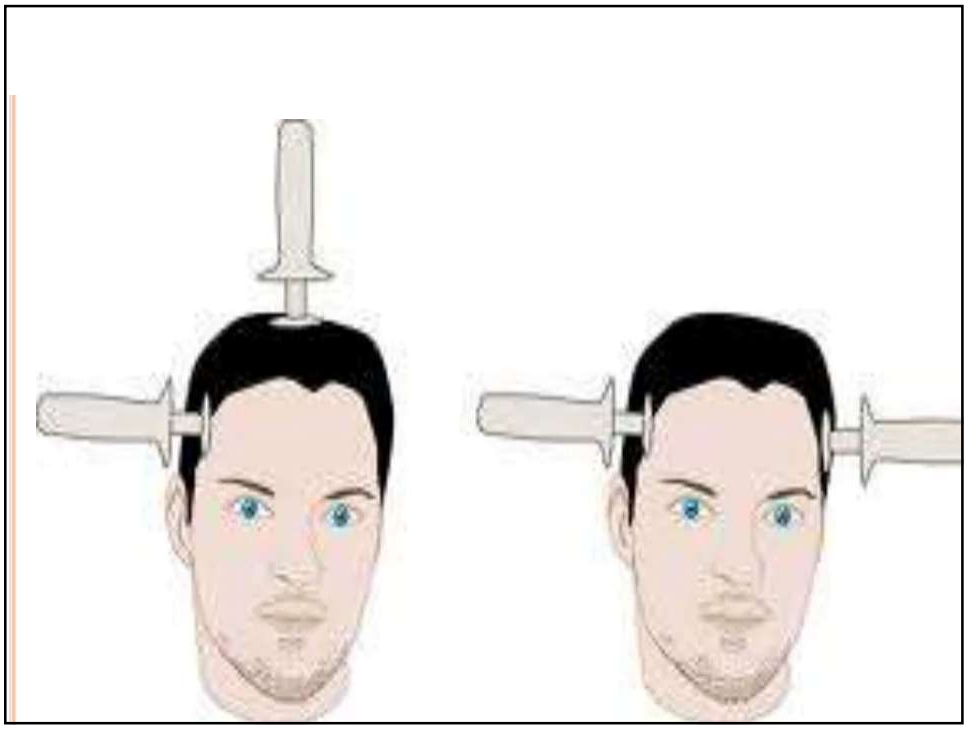

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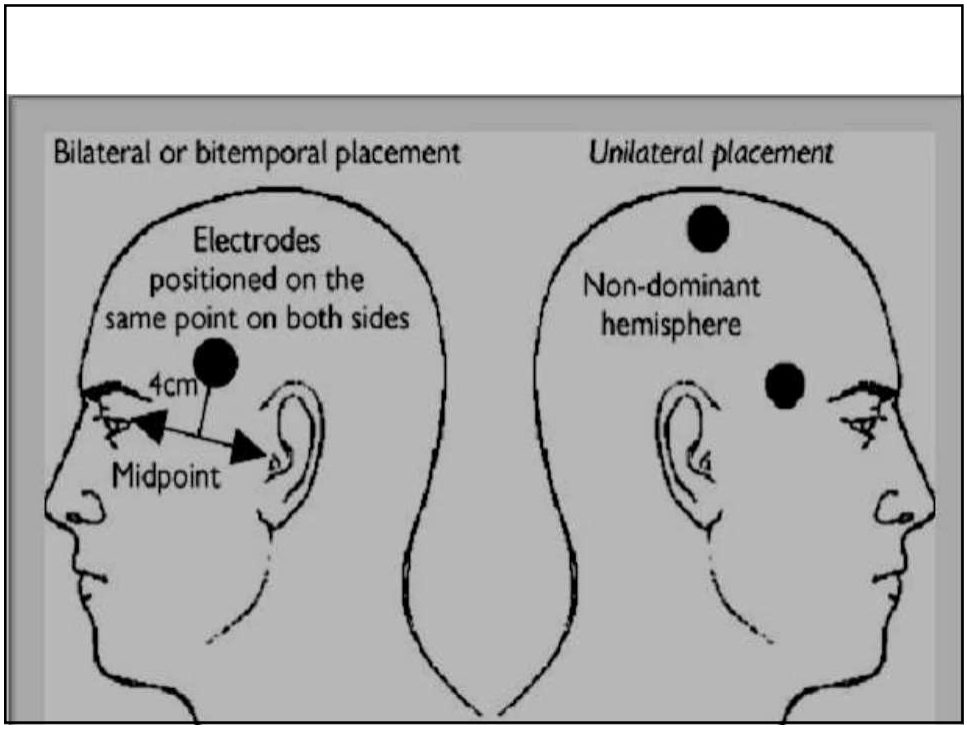
Bilateral or bitemporal placement
Unilateral placement
Electrodes positioned on the same point on both sides
4cm
Midpoint
Non-dominant hemisphere

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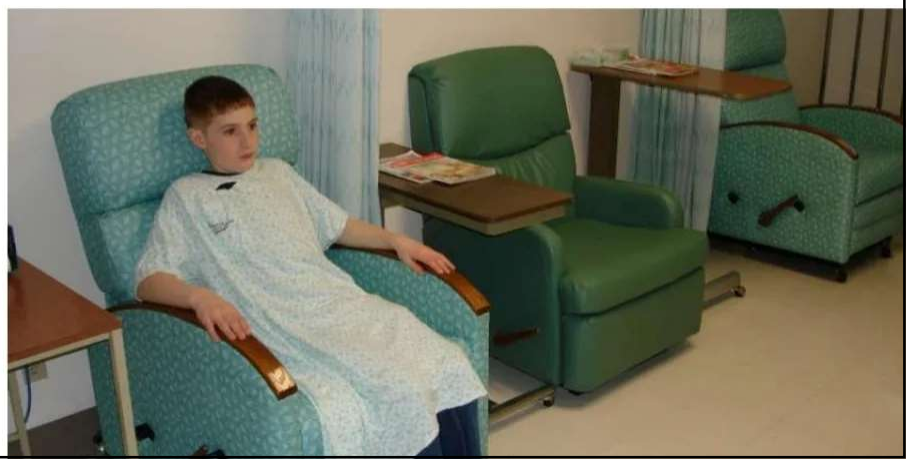

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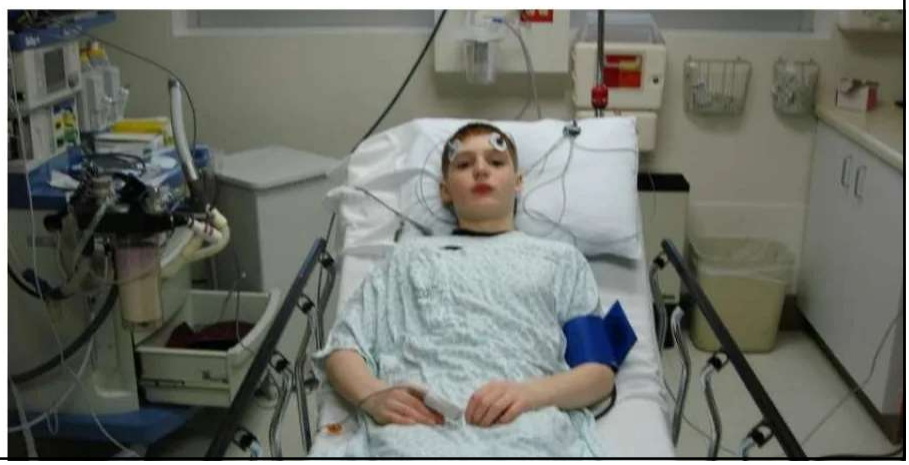

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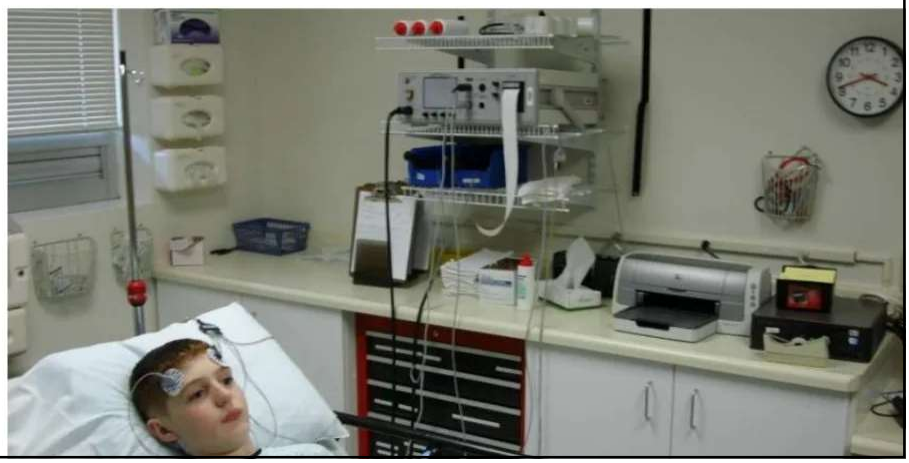

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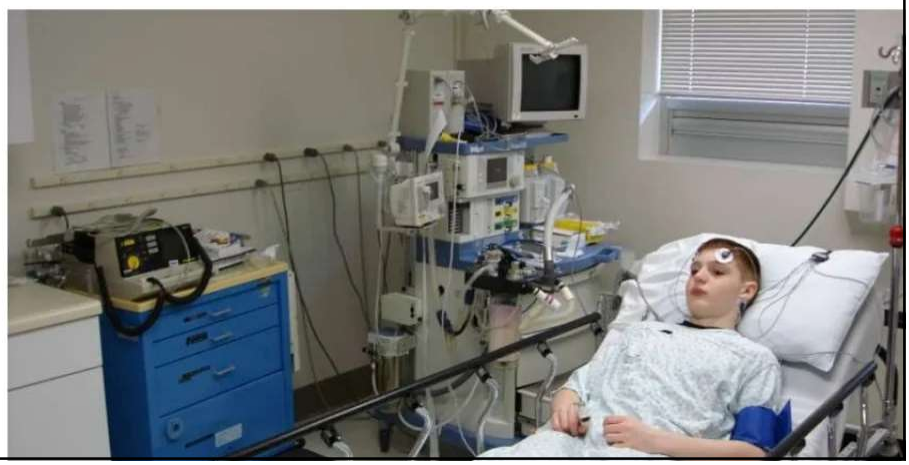

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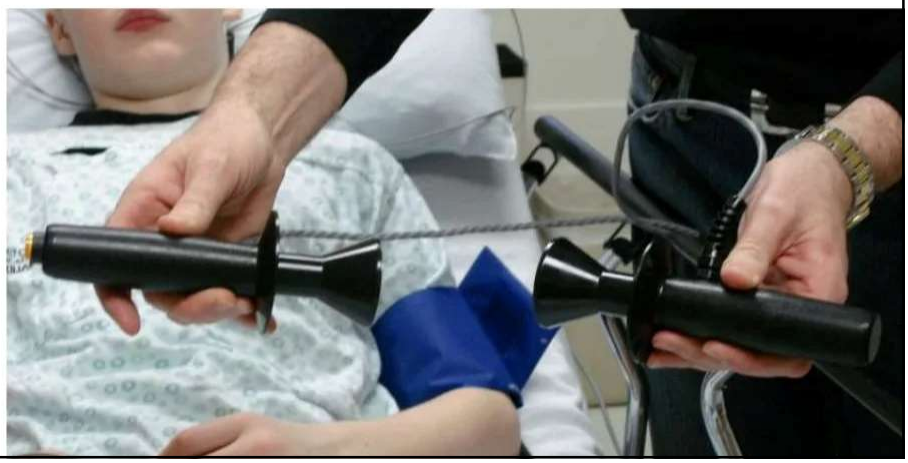

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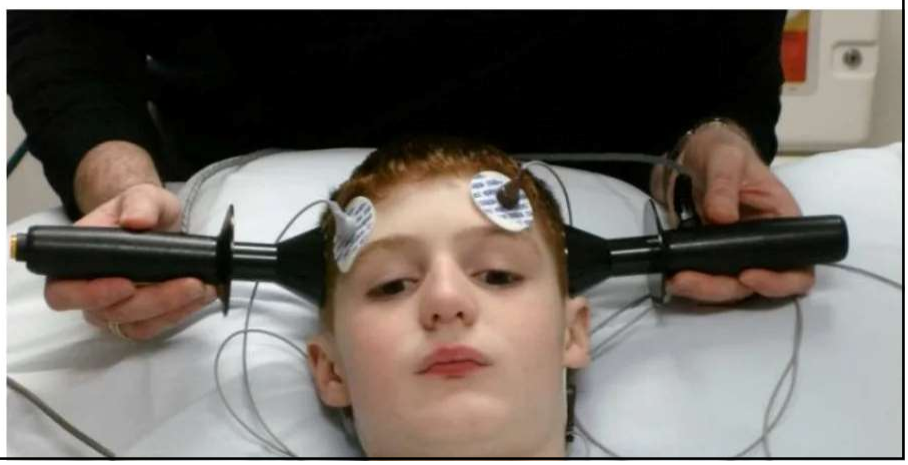

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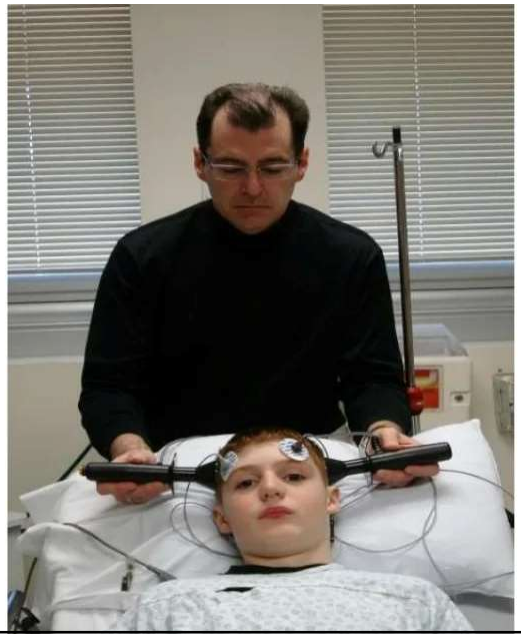

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INDICATIONS

Severe depression

a. Severe episodes.

b. Need for rapid antidepressant response (e.g
due to failure to eat or drink in depressive
stupor; high suicide risk).

c. Failure of drug treatments.

132

d Patients who are unable to tolerate side-effects of drug treatment

(e.g. puerperal depressive disorder).

e. Previous history of good response to ECT.

f. Patient preference.

g Suicidal ideas

133

- **Mania**

  That hasn't improved with medications

  - **Severe Catatonia**
  - **Schizophrenia Psychosis**

  When medications are insufficient or symptoms are severe

  - **All of the above disorders during pregnancy.**

134

CONTRAINDICATIONS

- **Absolute**
  - Increased ICP
- **Relative**
  - Cardiovascular (Coronary artery disease, HTN, aneurysms, arrhythmias)
  - Cerebrovascular effects (Recent strokes, space occupying lesions, aneurysms)
  - Severe pulmonary diseases

135

COURSE OF ECT

- ECT is usually given 3 times a week, reduced to twice a week or once a week once symptoms begin to respond. This limits cognitive problems.
- There is no evidence that a greater frequency enhance treatment response.

136

- Treatment of depression usually consists of 6-12 treatments.
- ·Treatment-resistant psychosis and mania up to (or sometimes more than)20 treatments.
- ·Catatonia usually resolves in 3-5 treatments.

137

ECT TEAM

- Psychiatrist
- Anesthetist
- Trained Nurses
- Nursing aids
- ECT assistant

138

MEDICATIONS USED IN ECT

- Inj.Atropine 0.6mg
- Inj.Scoline 25-40 mg
- Sodium Pendothal 150-250 mg

139

- A pretreatment medication such as atropinsulfate , glycopyrolate is administered IM 30 minutes before treatment, (to decrease secretion and counteract the effect of vagal stimulation induced by ECT.
- a short acting anesthesia (the patient should be unconscious when the ECT is given)

140

- Muscle relaxant (to prevent muscle contraction during the seizure reduction of possibility of fracture or dislocated bone
- Pure oxygen before and after treatment .

141

TREATMENT FACILITIES

3 rooms

- Waiting room
- Ect room
- Recovery room

142

ARTICLES NEEDED FOR ECT

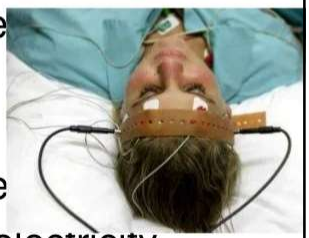
- Articles for anesthesia
- suction Apparatus
- Face mask
- O2 cylinder
- Tongue depressor
- Mouth gag
- Resuscitation apparatus
- Full set of emergency drugs, ECT drugs
- Defibrillator

143

PROCEDURE

- Time: 10-15
  - +time for prep & recovery

1. Intravenous (IV) catheter is inse
   or hand
2. Oxygen mask may be given
3. Electrodes are placed on the he
   - Unilateral: one side receives electricity
   - Bilateral: both sides
4. Anesthetic is injected into IV.



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1. Muscle relaxant is injected into IV.
   - Prevent violent convulsions
2. Blood pressure cuff placed around forearm or ankle
   - Prevents muscle relaxant from paralyzing, so doctor can confirm seizure with movement of hand/foot
3. Electric current is sent through electrodes to brain.
4. Seizure lasts 30-60 sec.

145

Risks & Side Effects

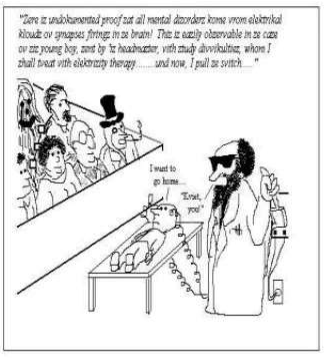
- Impairment of Cognition
  - Period of confusion immediately after ECT
    - May not know where you are or why you are there
    - Generally lasts few min. to several hrs.
- Memory Loss
  - May forget weeks/months before treatment, during treatment, or after treatment has stopped

146

- Medical Complications
  - Heart problems
  - Small risk of death
    - same as other procedures using anesthesia
- Physical Symptoms
  - Nausea
  - Vomiting
  - Headache
  - Muscle ache
  - Jaw pain

147

ECT is very controversial.



One reason is that ECT used to be dangerous and led to

Old ECT

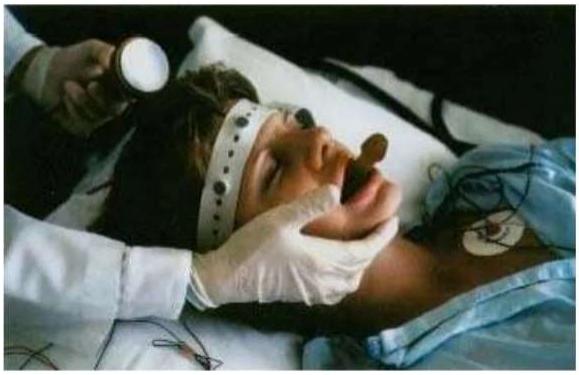
148

Another reason is how ECT has been portrayed in the media

One Flew Over The Cuckoo's Nest

149

Modern ECT is very different but there can still be serious side effects.



Modern ECT

150

CONSENT

- Description of the procedure
- Why recommended
- Alternative treatment
- Benefits may be transient
- Behavioral restrictions
- Voluntary treatment
- Available to answer questions
- Implies consent for emergency treatment
- Risks, major and minor

151

ROLE OF NURSE IN ECT

PRE ECT CARE

- Informed consent
- Fully explain the risks and benefits of procedure and answer questions from patients or their relatives.
- Information sheets
- Reduce patient's anxiety and help establish good patient-doctor relationship

152

- Administration of drugs
- Check patient record
- Explain procedure
- Keep patient on NPO 6-8 hrs before ECT
- Discourage smoking just before ECT
- Remove artificial dentures and articles

153

- Vital signs
- Ensure emergency articles are accessible
- Emotional support
- Transfer patient to ECT room with necessary records

154

CLIENT EDUCATION BEFORE ECT

1-An instruction sheet describing the procedure is given to client & their significant others.

3- The nurse emphasizes that the client will be asleep during the procedure.

4- Although low voltage current is passed to the brain, the client will not be harmed or feel any pain.

155

CLIENT EDUCATION BEFORE ECT

Instruction for preparation:

1- Nothing by mouth (NPO).

2- Outline the need to void before the procedure.

156

ECT ROOM

- Check patient's identity.
- Check patient is fasted (for 8hrs) and has emptied their bowels and bladder prior to coming to treatment room.
- Check patient is not wearing restrictive clothing and jewellery/ dentures have been removed.

157

ECT ROOM

- Consult ECT record of previous treatments (including anaesthetic problems).
- Ensure consent form is signed appropriately.
- Check no medication that might increase or reduce seizure threshold has been recently given.
- Check ECT machine is functioning correctly.

158

- DURING ECT
- Reassurance & support
- Place patient in supine position
- Necessary Drug administration
- Mouth gag
- Apply upward pressure to mandible
- Oxygen administration
- Clean the Scalp with normal saline

159

- Prevent fall, fracture,dislocation
- Remove the mouth gag after seizure occurred
- Suck the oral secretion & apply o2 mask
- POST ECT CARE
- Shift client to post-procedure room
- Check vital signs every 15 mts
- Administer drugs if patient is aggressive/violated/ confused

160

- If respiratory difficulty continue oxygen
- Provide side rails
- Be with the client
- Documentation
- Reorient the client after recovery

161

Ethics in ECT

People with a serious mental illness who are at risk of self harm or are thought to be a risk to othe people can be sectioned under the Mental Health Act.

162

This means they can be taken to a place of safety, usually a secure psychiatric unit, and given treatment against their will.

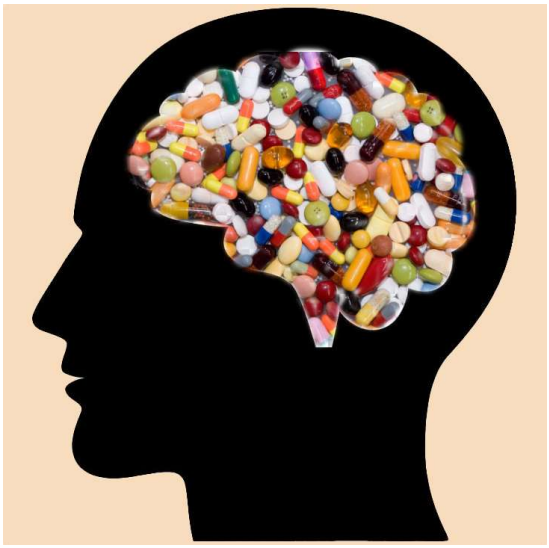
163

They may not consent to the treatment they are given and may be held against their will.

164

THANK YOU

165



166

PSYCHOTROPIC DRUG CATEGORIES

- Antipsychotics
- Antidepressants
- Mood Stabilizers
- Anti-anxiety Drugs
- Stimulants

167

ANTIPSYCHOTIC DRUGS

168

ANTIPSYCHOTIC DRUGS

- These are also known as NEUROLEPTICS
- These are used to treat symptoms of psychosis, such as delusions and hallucinations.
- They work by blocking the receptors of the neurotransmitter Dopamine.

169

ANTIPSYCHOTIC DRUGS

- Antipsychotic drugs are the primary medical treatment for Schizophrenia and are also used in psychotic episodes of acute mania, psychotic depression, and drug-induced psychosis.
- Persons with dementia who have psychotic symptoms sometimes respond to low doses of antipsychotics.
- Short-term therapy with antipsychotics may be useful for transient psychotic symptoms, such as those seen in some persons with borderline personality disorder.

170

TYPICAL ANTIPSYCHOTIC DRUGS

GENERIC (TRADE) NAME	FORMS	DAILY DOSAGE (mg)	EXTREME DOSAGE RANGE (mg/day)
Chlorpromazine (Thorazine)	T, L, INJ	200 – 1600	25 – 2000
Perphenazine (Trilafon)	T, L, INJ	16 – 32	4 – 64
Fluphenazine (Prolixin)	T, L, INJ	2.5 – 20	1 – 60
Thioridazine (Mellaril)	T, L	200 – 600	40 – 800

171

TYPICAL ANTIPSYCHOTIC DRUGS

GENERIC (TRADE) NAME	FORMS	DAILY DOSAGE (mg)	EXTREME DOSAGE RANGE (mg/day)
Trifluoperazine (Stelazine)	T, L, INJ	6 – 50	2 – 80
Thiothixene (Navane)	C, L, INJ	6 – 30	6 - 60
Haloperidol (Haldol)	T, L, INJ	2 – 20	1 - 100
Loxapine (Loxitane)	C, L, INJ	60 – 100	30 - 250

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ATYPICAL ANTIPSYCHOTIC DRUGS

GENERIC (TRADE) NAME	FORMS	DAILY DOSAGE (mg)	EXTREME DOSAGE RANGE (mg/day)
Clozapine (Clozaril)	T	150 – 500	75 - 700
Risperdone (Risperdol)	T	2 – 8	1 – 16
Olanzapine (Zyprexa)	T	5 – 15	5 - 20

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MECHANISM OF ACTION OF ANTIPSYCHOTIC DRUGS

- The major action of all antipsychotics in the nervous system is to block receptors for the neurotransmitter dopamine.
- The typical antipsychotic drugs are potent antagonists (blockers) of dopamine receptors D2, D3, and D4.
- This makes them effective in treating target symptoms but also produces many extrapyramidal side effects.

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MECHANISM OF ACTION OF ANTIPSYCHOTIC DRUGS

- Newer, atypical antipsychotic drugs, such as clozapine (Clozaril), are relatively weak blockers of D2, which may account for the lower incidence of extrapyramidal side effects.

- Atypical antipsychotics also inhibit the reuptake of serotonin, which makes them more effective in treating the depressive aspects of Schizophrenia

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SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS

- Extrapyramidal Symptoms (EPS) are serious neurologic symptoms that are the major side effects of antipsychotic drugs, which include:
  - **A**cute Dystonia
  - **P**seudoparkinsonism
  - **A**kathisia
  - **T**ardive Dyskinesia

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SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – EXTRAPYRAMIDAL SYMPTOMS (EPS)

- Blockade of D2 receptors in the midbrain region of the brain stem is responsible for the development of EPS
- Therapies for the neurologic side effects of acute dystonia, pseudoparkinsonism, and akathisia are similar and include:
  - 1) Lowering the dosage of the antipsychotic
  - 2) Changing to a different antipsychotic
  - 3) Administering anticholinergic medication

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DRUGS USED TO TREAT EXTRAPYRAMIDAL SIDE EFFECTS

GENERIC (TRADE) NAME	ORAL DOSAGES (mg)	IM / IV DOSES (mg)	DRUG CLASS
Amantadine (Symmetrel)	100 bid or tid	-	Dopaminergic Agonist
Benztropine (Cogentin)	1- 3 bid	1 – 2	Anticholinergic
Beperiden (Akineton)	2 tid – qid	2	Anticholinergic
Diazepam	5 tid	5 – 10	Benzodiazepin

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DRUGS USED TO TREAT EXTRAPYRAMIDAL SIDE EFFECTS

GENERIC (TRADE) NAME	ORAL DOSAGES (mg)	IM / IV DOSES (mg)	DRUG CLASS
Lorazepam (Ativan)	1 – 2 tid	-	Benzodiazepin
Procyclidine (Kemadrin)	2.5 – 5 tid	-	Anticholinergic
Propranolol (Inderal)	10 – 20 tid; up to 40 qid	-	Beta-blocker
Trihexaphenidyl	2 – 5 tid	-	Anticholinergic

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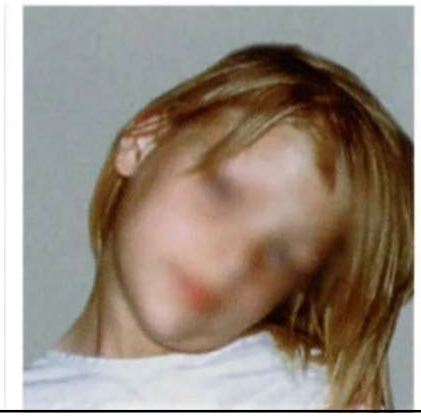
SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – (EPS)

ACUTE DYSTONIA

- This includes any of the following:
  - Acute muscular rigidity and cramping
  - A stiff or thick tongue with difficulty of swallowing
  - In severe cases, laryngospasm and respiratory difficulties.

180

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS (EPS) – ACUTE DYSTONIA



- Spasms or stiffness in muscle groups can produce torticollis (twisted head and neck)

181

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS (EPS) – ACUTE DYSTONIA

- Spasms or stiffness in muscle groups can produce opisthotonus (tightness in the entire body with the head back and an arched neck)

182

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS (EPS) – ACUTE DYSTONIA

- Spasms or stiffness in muscle groups can produce an oculogyric crisis (eyes rolled back in a locked position)

183

TREATMENT FOR (EPS)
ACUTE DYSTONIA

- Rapid relief is brought about by immediate treatment with anticholinergic drugs such as:
  - Intramuscular benztropine mesylate (Cogentin)
  - Intramuscular or intravenous diphenhydramine (Benadryl)

184

TREATMENT FOR (EPS)
ACUTE DYSTONIA

- Recurrent dystonic reactions would necessitate a lower dosage or a change in the antipsychotic drug.

185

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – (EPS)
PSEUDOPARKINSONISM

- Drug-induced Parkinsonism or pseudoparkinsonism have the following symptoms:
  - A stiff, stooped posture
  - Masklike facies
  - Decreased arm swing
  - A shuffling, festinating gait (with small steps)
  - Cogwheel rigidity (ratchet-like movements of joints)
  - Drooling
  - Tremor
  - Bradycardia
  - Coarse pill-rolling movements of the thumb and fingers while at rest

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TREATMENT FOR (EPS)
PSEUDOPARKINSONISM

- Pseudoparkinsonism is treated by changing to an antipsychotic medication that has a lower incidence of EPS or by adding an oral anticholinergic agent or amantadine .

187

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – (EPS)
AKATHISIA

- Akathisia is reported by the client as an intense need to move about
- The client appears restless or anxious and agitated, often with a rigid posture or gait and a lack of spontaneous gestures.
- This feeling of internal restlessness and the inability to sit still or rest often leads clients to discontinue their antipsychotic medication.

188

TREATMENT FOR (EPS)
AKATHISIA

- Akathisia can be treated by a change in antipsychotic medication or the addition of an oral agent such as a beta-blocker, anticholinergic, or benzodiazepine.

189

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – (EPS)
TARDIVE DYSKINESIA (TD)

- TD is a syndrome of permanent, involuntary movements, is most commonly caused by the long-term use of typical antipsychotics.
- Once it has developed, TD is irreversible.
- Symptoms of TD include:
  - Involuntary movements of the tongue, facial and neck muscles, upper and lower extremities, and truncal musculature
  - Tongue-thrusting and protrusion, lip-smacking, blinking, grimacing and other excessive, unnecessary facial movements

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TREATMENT FOR (EPS)
TARDIVE DYSKINESIA

- Although TD is irreversible, its progression can be arrested by decreasing or discontinuing the antipsychotic medication.
- Preventing the occurrence of TD is done by keeping maintenance dosages as low as possible, changing medications, and monitoring the client periodically for the initial signs of TD.
- Persons who have already developed signs of TD but who still need to take antipshychotic medication are often given clozapine, which has not yet been found to cause, or therefore worsen, TD.

191

OTHER SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS

- **N**euroleptic Malignant Syndrome
- **A**nticholinergic Side Effects

192

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – NEUROLEPTIC MALIGNANT SYNDROME (NMS)

- NMS is a potentially fatal, idiosyncratic reaction to ar antipsychotic drug with the following symptoms:
  - Rigidity
  - High fever
  - Autonomic instability such as unstable bloo pressure, diaphoresis, pallor, delirium an elevated levels of enzymes (particularly CPK).
  - Confusion
  - Being mute

193

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – NEUROLEPTIC MALIGNANT SYNDROME (NMS)

- Dehydration, poor nutrition, and concurrent medical illness all increase the risk for NMS.

194

TREATMENT FOR NEUROLEPTIC MALIGNANT SYNDROME (NMS)

- This includes the following:
  - Immediate discontinuance of all antipsychotic medications
  - Institution of supportive medical care such as rehydration and hypothermia, until the client's physical condition is stabilized

195

SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS – ANTICHOLINERGIC SIDE EFFECTS

- Symptoms usually decrease after 3 – 4 weeks but do not entirely remit and include the following:
  - Orthostatic hypotension
  - Dry mouth
  - Constipation
  - Urinary hesitance or retention
  - Blurred near vision
  - Dry eyes
  - Photophobia
  - Nasal congestion
  - Decreased memory

196

TREATMENT FOR ANTICHOLINERGIC SIDE EFFECTS

- The client who is taking anticholinergic agents for EPS may have increased problems with anticholinergic side effects, but some nutritional or over-the-counter remedies can ease these symptoms

197

CLIENT TEACHING AND MEDICATION MANAGEMENT ANTIPSYCHOTIC DRUGS

- Drink sugar-free fluids and eat sugar-free hard candy to ease the anticholinergic effects of dry mouth.
- Avoid calorie-laden beverages and candy because they promote dental caries, contribute to weight gain, and do little to relieve dry mouth
- Constipation can be prevented or relieved by increasing intake of water and bulk-forming foods in the diet and by exercising.

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CLIENT TEACHING AND MEDICATION MANAGEMEN
ANTIPSYCHOTIC DRUGS

- Stool softeners are permissible, but laxatives should be avoided.
- Use sunscreen to prevent burning and avoid long periods of time in the sun. Wear protective clothing as photosensitivity can cause a patient to burn easily.
- Rising slowly from a sitting or lying position will prevent falls from orthostatic hypotension or dizziness due to a drop in blood pressure. Wait to walk until any dizziness

199

CLIENT TEACHING AND MEDICATION MANAGEMEN
ANTIPSYCHOTIC DRUGS

- Monitor the amount of sleepiness or drowsiness you experience. Avoid driving a car or performing other potentially dangerous activities until your response time and reflexes seem normal.
- If you forget a dose of antipsychotic medication, take it if the dose is only 3 to 4 hours late. If the missed dose is more than 4 hours late or the next dose is due, omit the forgotten dose.

200

CLIENT TEACHING AND MEDICATION MANAGEMEN
ANTIPSYCHOTIC DRUGS

- If you have difficulty remembering your medication, use a chart to record doses when taken, or use a pill box labeled with dosage times and/or days of the week to help you remember when to take medication.

201

SIDE EFFECTS OF ATYPICAL ANTIPSYCHOTIC DRUGS – CLOZAPINE (Clozaril)

- This drug produces fewer traditional side effects than most typical antipsychotic drugs, but it has the potentially fatal side effect of agranulocytosis.
- This develops suddenly and is characterized by fever, malaise, ulcerative sore throat, and leukopenia.

202

TREATMENT OF AGRANULOCYTOSIS DUE TO CLOZAPINE (Clozaril)

- Blood samples should be taken weekly to monitor the WBC count of patients with agranulocytosis.
- The drug must be discontinued immediately if the white blood cell count drops by 50% or to less than 3,000.

203

Personality disorders

Dr. Mohamed Moslem Al-Hefny

204

PERSONALITY

The totality of emotional and behavioral characteristics that are particular to a specific person and that remain somewhat stable and predictable over time

PERSONALITY TRAITS…« enduring patterns of perceiving, relating and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. »
(APA, 2000)

205

PERSONALITY DISORDERS

Personality disorders are diagnosed when personality traits become inflexible and maladaptive and significantly interfere with how a person functions in society or cause the person emotional distress.

206

CATEGORIES OF PERSONALITY DISORDERS

Cluster A : People whose behavior appears odd or eccentric
- Paranoid personality disorder.
- Schizoid personality disorder.
- Schizotypal personality disorder.

Cluster B :People who appear dramatic, emotional, or erratic
- Antisocial personality disorder.
- Borderline personality disorder.
- Histrionic personality disorder.
- Narcissistic personality disorder.

Cluster C : People who appear anxious or fearful
- Avoidant personality disorder.
- Dependent personality disorder.

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CLUSTER A PERSONALITY DISORDERS

208

PARANOID PERSONALITY

209

A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent beginning by early adulthood and present in variety of contexts

210

INCIDENCE

- More common in men than in women

211

PREDISPOSING FACTORS

- Hereditary
- Parental antagonism & harassment

  They learn to perceive the world as harsh and unkind

212

CLINICAL PICTURE

- Constantly on guard, hypervigilent and ready for any real or imagined threat.
- Appear tense and irritable
- Insensitive to the felings of others
- Avoid interactions with others
- Always feel that others are taking advantage of them
- Extremely oversensitive
- Do not accept responsibility for their own

213

DIAGNOSTIC CRITERIA

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of conterxts as indicated by 4 or more of thr following

- Suspects without sufficient basis that others are exploiting harming or deceiving him or her
- Is preoccupied with unjustified doubts

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- Is reluctant to confide in others bacause of unwarranted fear that the information will be used maliciously against him or her
- Reads hidden demeaning or threatening meanings into bedign remarks or events
- Persistently bears grudges
- Preceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
- Has recurrent suspicions without justification regarding fidelity of spouse or sexual partner

215

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general medical condition.

216

TREATMENT

- Psychotherapy – Interpersonal psychotherapy
  Psychoanalytical psychotherapy
- Group therapy
- Behavioral therapy
- Psychopharmacology
- Antipsychotics for psychotic symptoms

217

SCHIZOID PERSONALITY

218

Characterized by primarily by a profound defect in the ability to form personal relationships or to respond to others in any meaningful, emotional

PREVALENCE

3 – 7.5%

Gender ratio:-Not known but diagnosed frequently in men.

219

PREDISPOSING FACTORS

- Hereditary:-

  Unclear, the feature of introversion appear to be a highly inheritable characteristic.
- Psychosocially:-
  - The development of schizoid personality is influenced by early interactional patterns that the person found to be cold & unsatisfying
  - The childhood of these individuals have often been characterized as bleak, cold, unempathic &

220

- Schizoid personality disorder occurs in adults who experienced cold, neglectful & ungratifying relationships in early childhood

221

CLINICAL PICTURE

- Appear cold, aloof & indifferent to others
- They prefer to work in isolation & are unsociable with little need or desire for emotional ties.
- In the presence of others they appear shy, anxious or uneasy.
- They are inappropriately serious about everything and have difficulty acting in a lighthearted manner.
- They are unable to experience pleasure and their

222

DIAGNOSTIC CRITERIA

- A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by 4 or more of the following:
  - Neither desires nor enjoys close relationships including being part of a family.
  - Almost always chooses solitary activities.
  - Has little, if any, interest in having sexual

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- Takes pleasure in few, if any activities
- Lacks close friends, or confidants other than first-degree relatives.
- Appears indifferent to the praise or criticism of others
- Shows emotional coldness, detachment or flattened affectivity
- Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiological effects of a general

224

TREATMENT

- Psychotherapy – Interpersonal psychotherapy
  Psychoanalytical psychotherapy
- Group therapy
- Behavioral therapy
- Psychopharmacology
- Antipsychotics for psychotic symptoms

225

SCHIZOTYPAL PERSONALITY

226

- Described as latent schizophrenics
- Behavior is odd and eccentric, but does not decompensate to the level of schizophrenia

PREVALENCE

- Less than 3%

227

PREDISPOSING FACTOR

- Hereditary:-More common among first degree relatives of people with schizophrenia
- Anatomical deficits or neurochemical dysfunctions resulting in diminished activation, diminished pleasure-pain sensibilities and impaired cognitive functions.
- Family dynamics:- characterized by indifference, impassivity or formality, leading to a pattern of discomfort with personal affection and closeness

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CLINICAL PICTURE

- Aloof & isolated & behave in a bland and apathetic manner
- Magical thinking
- Ideas of reference
- Illusions
- Depersonalization
- Bizzare speech pattern
- They cannot orient their thoughts logically and

229

- Under stress they may decompensate and demonstrate psychotic symptoms
- Affect is bland or inappropriate

230

DIAGNOSTIC CRITERIA

- A pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts as indicated by 5 or more of the following
- Ideas of reference
- Odd beliefs or magical thinking that influences

231

- Unusual perceptual experiences including bodily illusions
- Odd thinking and speech (eg:- vague, circumstantial, metaphorical, over elaborate and stereotyped)
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Behavior or appearance that is odd, eccentric or peculiar
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

232

- Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder or a pervasive developmental disorder.

233

TREATMENT

- Psychotherapy – Interpersonal psychotherapy
  Psychoanalytical psychotherapy
- Group therapy
- Behavioral therapy
- Psychopharmacology
- Antipsychotics for psychotic symptoms

234

CLUSTER B PERSONALITY DISORDERS

235

ANTISOCIAL PERSONALITY

236

Antisocial personality disorder is a pattern of socially irresponsible, exploitative and guiltless behavior that reflects a disregard for the rights of others

-Phillips, Yen & Gunderson, 2003

237

EPIDEMIOLOGY

- Usually diagnosed by age 18 yrs
- H/o conduct disorder
- Common among males
- Common in substance abuse treatment setting and prisons (50%)
- Common in lower socioeconomic classes
- Impulsive behavior is common

238

RISK FACTORS

- Child abuse
- Deprived environment
- Neglect
- Antisocial environment in home
- Antisocial parents
- Alcoholic parents
- ADHD
- Reading disorder

239

PREDISPOSING FACTORS

Biological influences:

- Common among first degree biological relatives
- Children of antisocial personality- even when they are separated from biological parents
- Temperament in newborn
- Serotonergic dysregulation in septohippocampal system

240

Family dynamics

- Chaotic home environment
- Separation due to parental delinquency
- Physical abused in childhood
- Absence of parental discipline
- Extreme poverty
- Removal from the home
- Growing up without parental figures of both sexes
- Erratic and inconsistent methods of discipline
- Being rescued each time they are in trouble
- Maternal deprivation

241

CAUSES

- Idiopathic
- Heredity
- Environmental influence
- Difficulty in developing emotional bonds
- Few healthy role models for behavior
- No rewards for socially acceptable behavior

242

CLINICAL FEATURES

- Indifferent to the needs of others
- Manipulation
- Fails to pay debts
- Usually loners
- Aggressive, violent involves in fights
- Frequent encounters with the law
- Persistent lying or stealing
- Inability in keeping jobs

243

- Tendency to violate the rights of others
- A persistent agitated or depressed feeling
- Inability to tolerate boredom
- Disregard for hurting others
- Impulsiveness
- Inability to make or keep friends
- No acceptable behavior
- Provoking arguments

244

- Violation of the rights of others
- Lack of remorse for behavior
- Shallow emotions
- Lying
- Rationalization of own behavior
- Poor judgment

245

- Impulsivity
- Irritability and aggressiveness
- Lack of insight
- Thrill-seeking behaviors
- Exploitation of people in relationships
- Poor work history
- Consistent irresponsibility

246

TREATMENT

- Psychotherapy
- Pharmacotherapy
  - ADHD- psycho stimulants such as methylphenidate (Rilantin)
  - Impulsive behavior- antiepileptic (carbamazepine, valporate)
  - Aggression- adrenergic receptor antagonist

Symptom wise- antidepressant, antipsychotics

247

OTHER TREATMENT MODALITIES

- Occupational therapy
- Art therapy
- Music therapy
- Recreational therapy
- Individual therapy

248

BORDERLINE PERSONALITY DISORDER...

249

- Border between neurosis and psychosis
- Characterized by extraordinarily unstable affect, mood, behavior, object relations and self image

250

- Also called ambulatory schizophrenia (Helene Deutsch)
- Pseudoneurotic schizophrenia (Paul Hoch 7 Philip Politan)
- ICD 10…emotionally unstable personality disorder

251

EPIDEMIOLOGY…

- 1-2% of the population
- Twice as common in women as in men
- Increased prevalence of major depressive disorder
- Alcohol use disoders & substance abuse in first degree relatives of patients

252

PREDISPOSING FACTORS

- Biological influences
- Biochemical :- Defect in serotonergic activity
  (Decreased serotonin)
- Genetic :- Relatives with mood disorder
- Psychosocial influences
- Childhood trauma
- Neglect
- Separation
- Exposure to physical or sexual abuse
- Serious parental psychopathology such as substance

253

- Developmental factors(Mahler's Theory of Object Relations)
- Phase 1 Autistic phase
- Phase 2 Symbiotic phase
- Phase 3 Differentiation phase
- Phase 4 Practicing phase
- Phase 5 Rapprochement phase
- Phase 6 On the way to object Constance phase

254

CLINICAL FEATURES…

- Always in a state of crisis
- Mood swings
- Short lived psychotic episodes (macro psychotic episodes) almost always
- Fleeting or doubtful
- Highly unpredictable behavior

255

- They show deviant processes on projective tests such as Rorschach test
- Consider persons- all good or all bad
- As nurturing or hateful (splitting)

256

PATTERNS OF INTERACTION

- Clinging and Distancing
- Splitting
- Manipulation
- Self destructive behavior
- Impulsivity

257

DIAGNOSTIC CRITERIA

A pervasive pattern of instability of ins, interpersonal relationships, self image and effects and marked impulsivity beginning by early childhood and present in a variety of contexts as indicated by 5 or more of the following

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

258

- Identity disturbance: markedly and persistently unstable self image or sense of self
- Impulsivity in at least two areas that are potentially self damaging
- Recurrent suicidal behavior, gestures or threats or self mutilating behavior
- Affective instability due to marked reactivity of mood
- Chronic feeling of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Transient, stress related paranoid ideation or severe

259

TREATMENT

- Psychotherapy
- Pharmacotherapy
  - Antidepressants
  - Antipsychotics

260

HISTRIONIC PERSONALITY DISORDER

261

- Persons with histrionic personality disorder are excitable and emotional and behave in a colourful, dramatic, extroverted fashion.
- Characterized by a pervasive pattern of excessive emotionality and attention-seeking.

262

EPIDEMIOLOGY

- 2 to 3 percent of general population.
- 10 to 15 % of clinical population.
- More in women than in men.
- Studies have found an association with somatization disorder and alcohol use disorders.

263

CLINICAL FEATURES

- Fluctuation in emotions
- Attention seeking, self-centered attitude
- Attentiveness to own physical appearance
- Dramatic, impressionistic speech style
- Vague logic – lack of conviction in arguments

264

- Shallow emotional expressions
- Craving for immediate satisfaction
- Complaints of physical illness, somatization
- Use of suicidal gestures and threats to get attention

265

TREATMENT

- Psychotherapy
- Pharmacotherapy

  Symptomatic
  - Antidepressants for depression and somatic complaints
  - Antianxiety agents for anxiety
  - Antipsychotics for psychotic symptoms.

266

NARCISSISTIC PERSONALITY DISORDER

267

- Enduring patterns of inner experience and behavior that are sufficiently rigid and deep seated to bring a person into repeated conflicts with his/ her social and occupational environment
- A pattern of grandiosity in the patient's private fantasies or outward behavior, a need for constant admiration from others and lack of empathy for others.

268

EPIDEMIOLOGY

- Common in late adolescence and early adulthood
- It occurs in 1% to 2% of the general population and 2% to 16% of the clinical population
- 50% to 75% of people with this diagnosis are men

269

CAUSES

- Arrested psychological development
- Young child's defense against psychological pain
- Problems or unsatisfactory relationship in parent- child relationship or interaction
- Harsh and punishing super ego

270

PREDISPOSING FACTORS

- Child need not met- sense of emptiness
- (Mark 2002)-Narcissistic parents
- Physical or emotional abuse or neglect
- Environment- parents forcing the child to achieve which they were not able to
- Not setting limits

271

MANIFESTATIONS

- Significant emotional pain or difficulties in relationship and occupational performance
- Grandiose sense of self importance
- Lives in a dream world of exceptional success, power, beauty, genius, perfect love
- Thinks themselves as ‘ special’ ‘privileged’ only can understand by higher status people

272

- Demands excessive amount of praise or admiration from others
- Exploitative towards other and takes advantage of them
- Lacks empathy and does not identify with others feeling
- History of intense but short term relationship with others

273

- Inability to make or sustain genuine intimate relationship
- Tendency to be attracted to leadership or high profile positions or occupations
- Assessment of others in terms of usefulness
- Centre of attraction or admiration in a working group or social situation

274

- Hypersensitivity to criticism
- Preoccupation with outward appearance, image or public opinion
- Painful emotions based on shame
- impairment

275

TREATMENT

- Antidepressant- to relieve narcissistic grandiosity
- Psychotherapy
- Hospitalization- if low functioning

276

AVOIDANT PERSONALITY DISORDER...

277

- Extreme sensitivity to rejection and may lead a socially withdrawn life
- Although shy, not asocial
- Show a great desire for companionship, unsually strong guarantees of uncritical acceptance
- Described as having inferiority complex
- ICD 10…anxious personality disorder

278

EPIDEMIOLOGY…

- 1-10% of the general population
- No information on sex ratio or familial pattern

279

CLINICAL FEATURES

- Hypersensitivity to rejection
- Main personality trait is timidity
- Desires warmth and security of human companionship
- When talking with someone, they express uncertainty,

280

Lack of self confidence

Afraid to speak up in public

Misinterpret others comments

Refusal of requests makes them withdraw

281

- Vocational sphere…jobs on the sidelines
- Rarely attain much personal advancement or exercise much authority
- Shy & eager to please
- Have no close friends or condidants

282

TREATMENT…

- Psychotherapy:
- Group therapy
- Assertiveness therapy
- Pharmacotherapy….

  Used to manage anxiety and depression

  Serotonergic agents may help rejection

283

DEPENDENT PERSONALITY DISORDER...

284

- Subordinate their needs to those of others
- Get others to assume responsibility for major areas of their lives
- Lack self confidence
- Intense discomfort when alone for longer periods
- Also called passive dependent personality

285

- Freud described personality dimension characterized
- by dependence, pessimism, fear of sexuality, self doubt, passivity suggestibilty and lack of perseverance

286

EPIDEMILOGY…

- More common in women
- 2.5% of personality disorders as falling in this category
- More common in younger children than older ones
- Persons with chronic physical illness in childhood may be more susceptible

287

CLINICAL FEATURES…

- Pervasive pattern of dependent and submissive behavior
- Cannot make decisions without and excessive amount
- of advice & reassurance
- Avoid positions of responsibility

288

- Become anxious if asked to assume a leadership role
- When on their own, difficult to persevere at tasks
- Seek out others on whom they can depend
- Relationships are distorted by their need to be attached to another person

289

- Pessimism
- Self doubt
- Passivity and fears of expressing sexual or aggressive feelings
- An abusive, unfaithful or alcoholic spouse may be tolerated for long periods to avoid

290

TREATMENT…

- Behavioral therapy
- Assertiveness training
- Family therapy
- Group therapy

291

Pharmacotherapy…

- To deal with specific symptoms such as anxiety and depression
- Panic attacks or separation anxiety…imipramine
- Benzodiazepines and sereotonergic agents
- psychostimulants

292

OBSESSIVE COMPULSIVE PERSONALITY DISORDER

293

Obsessive-compulsive personality disorder is characterized by a pervasive pattern of preoccupation with perfectionism, mental and interpersonal control, and orderliness at the expense of flexibility, openness, and efficiency.

- ICD -10 : Anancastic personality disorder

294

EPIDEMIOLOGY

- 1 to 2 % of general population
- 3 to 10% in the clinical population
- Twice in men than in women
- Most often in oldest children.
- Occurs more frequently in first-degree biological relatives of persons with the disorder
- Patients often have backgrounds characterized by harsh discipline.

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CLINICAL FEATURES

- Preoccupation with perfection, organization, structure and control.
- Excessive devotion to work
- Difficulty relaxing
- Rule-conscious behavior
- Self criticism and inability to forgive own errors
- Reluctance to delegate

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- Inability to discard anything
- Insistence on others' conforming to own methods
- Rejection of praise
- Reluctance to spend money
- Background of stiff and formal relationship
- Preoccupation with logic and intellect

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TREATMENT

- Psychotherapy
- Pharmacotherapy
  - Clonazepam ,Clomipramine and serotonergic agents such as fluoxetine ---- useful if obsessive-compulsive signs and symptoms.

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PSYCHIATRIC EMERGENCIES

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EMERGENCY

- An emergency is defined as an unforeseen combination of circumstances which calls for an immediate action.
- A medical emergency is defined as a medical condition which endangers life and/or causes great suffering to the individual.

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PSYCIATRIC EMERGENCY

- Psychiatric emergency is a condition wherein the patient has disturbances of thought, affect and psychomotor activity leading to a threat to his existence (suicide), or threat to the people in the environment.
- Conditions in which there is alteration in behaviors, emotion or thought, presenting in an acute form, in need of immediate attention

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CHARACTERISTICS

- Any condition/ situation making the patient & relatives to seek immediate treatment.
- Disharmony between subject and environment.
- Sudden disorganization in personality which affects the socio-occupational functioning.

302

OBJECTIVES FOR EMERGENCY INTERVENTION

- To safeguard the life of patient.
- To bring down the anxiety of family members.
- To enhance emotional security of others in the environment.

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TYPES OF PSYCHIATRIC EMERGENCIES

i. Suicide or deliberate self harm
ii. Violence or excitement
iii. Stupor
iv. Panic
v. Withdrawal symptoms of drug dependence.
vi. Alcohol or drug overdose
vii. Delirium
viii. Epilepsy or status epileptics
ix. Severe depression (suicidal or homicidal

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Contd.....

x. Iatrogenic emergencies

a. Side effects of psychotropic drugs
b. Psychiatric complications of drugs used in medicine (eg: INH, steroids, etc.)

xi. Abnormal responses to stressful situations.

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GENERAL GUIDELINES TO MANAGE PSYCHIATRIC EMERGENCIES

1. Handle with the utmost of tact and speech so that well being of other patients is not affected
2. Act in a calm and coordinate manner to prevent other clients from getting anxious.
3. Shift the client as early as possible to a room where they can be safe guarded against injury.
4. Ensure that all other clients are reassured and the routine activities proceed normally.
5. Psych. emergencies overlap medical

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SUICIDE
(Deliberate Self Harm)

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SUICIDE
(Deliberate Self Harm)

- One of the commonest psychiatric emergency
- Commonest cause of death among psychiatri patients.
- *Suicide is defined as the intentional taking of one's life in a culturally non-endorsed manner.*
- Attempted suicide is an unsuccessful suicidal

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EPIDEMIOLOGY

- One among the top 10 causes of death.
- Suicide rate in India – 10.8 per 1 lakh population
- Male to female ratio – 64 : 36
- Highest in the age group 15-29 yrs
- Methods used
  - Ingestion of poison (34.8%)
  - Hanging (32.2%)
  - Burning (8.8%)
  - Drowning (6.7%)

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AETIOLOGY

1. Psychiatric disorders
   - Major depression
   - Schizophrenia
   - Drug or alcohol abuse
   - Dementia
   - Delirium
   - Personality disorder
2. Physical disorders
   - Chronic or incurable physical disorders like

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Contd....

3. Psychosocial factors
   - Failure in examination
   - Dowry harassment
   - Marital problems
   - Loss of loved object
   - Isolation and alienation from social groups
   - Financial and occupational difficulties

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RISK FACTORS

1. Age > 40 years
2. Male gender
3. Staying single
4. Previous suicidal attempts
5. Depression
   - Presence of guilt, nihilistic ideation, worthlessness..
   - Higher risk after response to treatment
   - Higher risk in the week after discharge

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Contd…

6. Alcohol or drug dependence
7. Chronic illness
8. Recent serious loss or major stressful life event
9. Social isolation
10. Higher degree of impulsivity

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WARNING SIGNS FOR SUICIDE

- Appearing depressed or sad most of the time
- Feeling hopeless, expressing hopelessness
- Withdrawing from family and friends,
- Sleeping too much or too little
- Making overt statements like "I can't take it anymor "I wish I were dead";
- Making covert statements like "it's okay now, everything will be fine"; "I wont be a problem f much longer"
- Loosing interest in most activities
- Giving away prized possessions

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COMMON MISCONCEPTIONS ABOUT SUICIDE

- People who talk about suicide do not complete suicide
- People who attempt suicide really want to die.
- Suicide happens without any warning
- Once people decide to die by suicide, there is nothing you can do to stop them.
- All suicidal individuals are mentally ill.
- Once a person is suicidal, he is suicidal forever.

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MANAGEMENT

- Be aware of the warning signs
- Monitor the patient's safety needs
  - Take all suicidal threats or attempts seriously.
  - Search for toxic agents such as drugs/ alcohol.
  - Do not leave the drug tray within reach of the patien
  - Make sure that daily medication is swallowed.
  - Remove sharp instruments from the environment.
  - Remove straps and clothing such as belts.
  - Do not allow the patient to bolt the door from inside

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Contd…

- Spent time with patient; allow ventilation of emotions.
- Encourage to talk about his suicidal plans/ methods
- In case of severe suicidal tendency – sedation
- A ' no suicide' agreement may be signed
- Enhance self esteem by focusing on his strengths.

- Acute psychiatric emergency interview
- Counseling and guidance
  - To deal with the desire to attempt suicide

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VIOLENCE / EXCITEMENT / AGGRESSIVE BEHAVIO

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VIOLENCE

- Physical aggression by one person on another.
- During this stage, patient will be irrational, unco-operative, delusional and assaultive.

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ETIOLOGY

- Organic psychiatric disorders
  - Delirium
  - Dementia
  - Wernicke-Korsakoff's psychosis
- Other psychiatric disorders
  - Schizophrenia
  - Mania
  - Agitated depression
  - Withdrawal from alcohol and drugs
  - Epilepsy

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DO'S

- Protect yourself
- Unarm the patient
- Keep the doors open
- Keep others near you
- Do restrain if necessary
- Assert authority
- Show concern, establish rapport and assure the patient

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DONT'S

- Do not keep potential weapon near the patient
- Do not sit with back to patient
- Do not wear neck tie or jewellery
- Do not keep any provocative family member in the room
- Do not confront
- Do not sit close to the patient

322

MANAGEMENT

- Untie the patient, if tied up
- Reassurance
  - Talk to the patient softly
  - Firm and kind approach is essential
  - Ask direct and concise questions
  - Avoid yes or no questions
  - Assist the patient in defining the problem
- Sedation
  - Diazepam 5-10 mg slow IV

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Contd.....

- Collect detailed history and explore the cause
- Carry out complete physical examination
- Check hydration status; if severe dehydration– IV fluids
- Have less furniture in the room, remove all sharp instruments
- Keep environmental stimuli to the minimum
- Stay with the patient to reduce anxiety
- Redirect violent behavior with physical outlets such as exercise, outdoor activities

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Contd….

- Physical Restraints
  - Used as a last resort
  - Should be done in a humane way
  - Take written consent from care givers (preferable)
  - Get a second opinion if possible

GUIDELINES

- Approach patient from front
- Never see a potentially violent patient alone
- Have a 4 member team to hold each extremity
- Keep talking while restraining
- Do not leave the unattended after restraining

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GUIDELINES FOR SELF PROTECTION WHILE HANDLING AN AGGRESSIVE PATIENT

- Never see the patient alone
- Keep a comfortable distance away from patient
- Be prepared to move
- Maintain a clear exit route
- Be sure that the patient has no weapons with him
- If patient is having a weapon, ask him to keep it down rather than fighting with him.
- Keep something (pillow, mattress, blanket) between you and weapon.
- Distract the patient to remove the weapon (eg:

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STUPOR & CATATONIC SYNDROME

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STUPOR & CATATONIC SYNDROMI

- *Stupor* is a clinical syndrome of akinesis and mutisr but with relative preservation of conscious awareness.
- Often associated with catatonic signs and symptoms
- *Catatonic syndrome* -- any disorder which presents with atleast two catatonic signs.
- Catatonia– either excited or withdrawn
- Catatonic signs--
  negativism, mutism, stupor, ambitendency, echola

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MANAGEMENT

- STUPOROUS PATIENT
  - Ensure patent airway
  - Maintain hydration (Ryle's tube feeding or IV fluids)
  - Check vital signs
  - History and physical examination
  - Draw blood for investigation before starting any treatmer
  - Identify the specific cause and treat
  - Provide care for an unconscious patient

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PANIC ATTACKS

- Episodes of acute anxiety and panic – occur as a part of psychotic or neurotic illness
- MANIFESTATIONS
  - Palpitations
  - Sweating
  - Tremors
  - Feelings of choking
  - Chest pain
  - Nausea
  - Abdominal distress
  - Fear of dying

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MANAGEMENT

- Give reassurance
- Search for causes
- Inj. Diazepam 10 mg or Lorazepam 2 mg
- Counsel the patient and relatives
- Use behavior modification techniques

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VICTIMS OF DISASTER

- People who have survived a sudden, unexpected, overwhelming stress
- Features
  - Anger
  - Frustration
  - Guilt
  - Numbness
  - Confusion
  - Flashbacks

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MANAGEMENT

- Treatment of the life threatening physical problem
- Intervention
  - Listen attentively
  - Do not interrupt
  - Acknowledge understanding of the pain & distress
  - Look into their eyes
  - Console them – patting on the shoulders / touching / holding their hands
  - Use silence
  - Do not ask them to stop crying

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Contd…

- Referral to mental health service, if required.
- Educate about the available resources
- Teach them that these reactions are normal to these type of situations.
- Teach coping strategies to avoid the development of crisis.

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Important questions commonly asked:

- Do they exist (childhood psychiatric disorders)?

338

How are they presented?

339

Could they be mistaken for other diseases and conditions?

340

Nature or Nurture?

341

How to deal with?

342

Common difficulties

1- The effect of the parents' view
2- Difficulty of making a relation
3- Atypicality of symptoms
4- The restrictions of the age
5- The view of the public (stigma)

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Common presentations

1- Regression
2- Learning difficulties
3- Deterioration of schoolastic achievement
4- Behavioral manefestations
5- Psychogenic symptoms
5- Bodily (somatic symptoms)

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Bodily (somatic) symptoms

Including:

- disturbance of Sleep
- disturbance of Appetite
- Headache
- Somatization

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Headache as a symptom in children:

Do not forget:

- Visual acuity and ENT
- Migraine
- Increased ICT
- Psychogenic headache

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Smoatization in children:

- Commonly seen
- Usually with headache, GIT disturbances and joint pains
- In many times denotes attention seeking
- Look for a family member with somatization

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Etiology of Psychiatric Disturbance in Childhood:

and Nurtur

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Nature

Genes
Pregnancy issues
Labor
Infection, Trauma, Nutrition
Epilepsy

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Intersections with Epilepsy

1- Learning difficulties and decreased concentration
2- Impulsivity
3- Smoatic presentations as chronic repeated vomiting
4- Psychiatric syndromes secondary to epilepsy

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Nurture

Social issues
Family factor
Parents and sibs
School and learning

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Some important childhood Psychiatric conditions

1- Mental retardation
2- Attention deficit disorders
3- Tic disorders
4- Elimination disorders
5- Mood disorders including depression

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Mental retardation

- 1-1.5 of the population
- Rated in 4 degrees: mild, moderate, severe, and profound
- In Egypt: the most common etiology is HIE
- Acquired type: infection, trauma and asphyxia
- Common problems: aggression and self injurious behavior, explosive rage, ADHD

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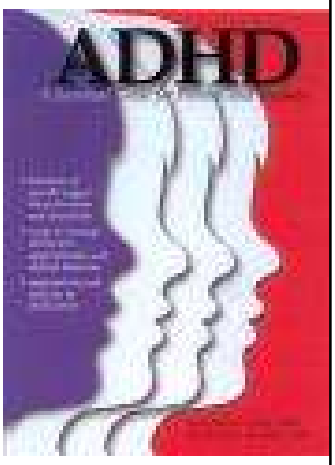
Attention deficit disorders

- More common in boys (4:1)
- More common in first born children
- Symptoms of: hyperactivity, short attention span and easy distractibility
- Risk of scholastic deterioration
- Increased risk of trauma
- Should be differentiated from anxiety of childhood



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Tic Disorders

- These are involuntary, sudden, rapid, recurrent, non rhythmic stereotyped motor movements or vocalizations.
- Examples: eye blinking, neck jerking, shoulder shrugging, and facial grimacing
- Simple vocal tics like: coughing, throat clearing, grunting, and sniffing.
- Stressful situations and anxiety may exacerbate the case
- If multiple and complex, they may lead to secondary major depression

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Elimination Disorders:

- Example: **Enuresis**
- In > 25% of children by the age of 4 years
- More common jn boys (2:1)
- If day and night, MR should be excluded
- Factors of etiology include: familial, functionally small bladder, Decreased night time ADH, and psychosocial stressors

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Depression in Childhood:

- About .,3% in preschool children, and abou 2% in school children
- More in boys than in girls
- **Social factors implicated include**: parent marital status, marital functioning, socioeconomic status, number of siblings, familial structure, death of father before the age of 13

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interest and pleasure are seen
* In addition: failure to thrive, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, decreased concentration and thinking, recurrent thoughts of death.
* Prepubertal children commonly have somatic compla and psychomotor agitation
* Childhood onset may be the most severe of a mood disorder
* Sometimes complicated with anti-social behavior.

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Investigations

1- Full history taking (including FH)
2- Neurological exam.
3- EEG
4- IQ
5- CT brain

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Important observations

1- The structure of the family
2- Personality and behavior of parents
3- The relation between Parents
4- The attitude of the parents towards the child and his illness
5- The degree and type of care given to the child
6- The attitude of the child towards his family members
7- Family history of psychiatric illness

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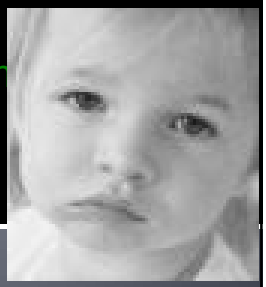
On examination note:

1- facies and look,
2- Tone of voice,
3- Cooperation and interaction
4- Psychomotor status,
5- Level of intelligence



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Management of childhood psychiatric disorders:

1- Recognition of the cases

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2- Seeing in whole

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3- Family therapy

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4- Making a relation

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5- Treat or refer

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