Sindh Mental Health Authority

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SINDH MENTAL HEALTH AUTHORITY

MANUAL FOR MENTAL HEALTH TRAINING OF PRIMARY CARE PHYSICIANS

TRAINING NOTES

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CONTENTS FOR TRAINING OF PRIMARY CARE PHYSICIANS

INTRODUCTION TO PROGRAM

Psychiatric Problems commonly seen in General Practice

Psychiatric disorders are quite common in the community as well as in the attendees of all kind of health care settings including the General Practice. It has been found that about more than 50% patients can be managed efficiently by General Practitioners after appropriate training.

World Health Organization (WHO) Cross-Cultural study at 14 centers all over world found that 25% of the attendees at GP/PHC suffered from one or more diagnosable psychiatric disorders.

The commonest psychiatric disorders found in General Practice are Depression, Anxiety disorder, Drug dependence and Somatoform disorders.

About one third of the patients with psychiatric problems in GP have coexisting physical illnesses which, if persist, lead to delayed or incomplete recovery from the physical illness.

There is an inadequate exposure to psychiatry during undergraduate training in Pakistan. It has been observed that only 30-50% of the psychiatric patients are correctly diagnosed by the GPs. The rest remain undetected leading to delay in the treatment, unnecessary investigations for physical illness and the prolongation of overall disability in the patients. It has been demonstrated that the identification rate for psychiatric illnesses in General Practice / PHC can be significantly enhanced after adequate training of GPs in Mental Health. It will also address the poor scenario of mental health human resource in Pakistan.

It has been demonstrated in many countries that a short-term training of GPs can result in improvement in their skills to identify, manage and refer the psychiatric patients visiting them.

The main role of GPs include: Identification, Management, Referral & Rehabilitation and follow up care of psychiatric patients.

Scope and Need of Mental Health Service Delivery in Primary Care General Health Clinical Practice.

1. **Acute and short term care**: for severe & common mental disorders (SMD & CMD)

- Assessment
- Establishing need for the treatment
- Initiating pharmacological treatment
- Monitoring for improvement & side effects
- Counseling, if required
- Referral, if required

2. **Emergency Care**: for persons having suicidal attempts/ ideation, agitated and violent acts

a. For Suicidal Persons:

- Providing Reassurance &support
- Offer Hope &Optimism
- Assessment of Risk
- Referral to specialist

b. For persons with agitation and violent acts:

- Providing safety of all concerned
- Providing emergency sedation (Neuroleptization)
- Monitoring for side effects
- Referral to Specialist

3. **Referral**: for severe mental illnesses, severe and chronic forms of Common Mental Disorders and Substance Use Disorders, Personality disorders and Mental retardation by providing

- Initial Assessment
- Appropriate advice
- Referral
- Follow up care & Advice

4. **After care**: for Schizophrenia and Mood disorders on prophylaxis by

- Assessment & understanding the records
- Consulting specialist /Hospital
- Follow up Prescriptions, if required
- Ensuring compliance
- Monitoring for side effects &complications
- Helping in Problem Solving

5. **Advisory**: for Consultation, Family and Marital issues, Interpersonal issues by

- Providing awareness on various options &services
- Maintaining contact
- Avoiding getting 'involved'

Classification Systems of Psychiatric Disorders

Today, the two most widely established systems of psychiatric classification are the Diagnostic and Statistical Manuel of Mental Disorders (DSM) and the International Classification for Diseases (ICD). Despite each being as widely used as the other, the ICD and the DSM conceptualize and classify mental disorders in different ways.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The DSM is published by the American Psychiatric Association, America's main professional organisations of psychiatrists. It is the world's largest psychiatric organisations, with upwards of 38,500 members in over 100 countries. Given that the DSM only includes Mental

Disorders, it is used primarily by Psychiatrists but also by other mental health professionals. The current version of DSM being used is DSM V whose contents are:

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders

- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions That May Be a Focus of Clinical Attention

International Classification for Diseases (ICD)?

The other dominant diagnostic manual is the ICD. The ICD is created by the World Health Organization (WHO), an agency of the United Nations that is concerned with worldwide public health. Translated into 43 languages, the ICD is used in over 100 countries. Whilst the DSM is concerned only with psychiatric disorders, the ICD includes all health disorders so is

utilized by a variety of medical professionals. The current version of ICD being used is ICD 10 and its 6th chapter is related to mental & behavioral disorders, whose contents are:

- Organic, including Symptomatic, mental disorders
  - Dementia in Alzheimer's disease
  - Vascular dementia
  - Dementia in other diseases classified elsewhere
  - Unspecified dementia
  - Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
  - Delirium, not induced by alcohol and other psychoactive substances
  - Other mental disorders due to brain damage and dysfunction and to physical disease
  - Personality and behavioural disorders due to brain disease, damage and dysfunction
  - Unspecified organic or symptomatic mental disorder

- Mental and behavioural disorders due to psychoactive substance use of
  - Alcohol
  - Opioids
  - Cannabinoids
  - Sedatives or hypnotics
  - Cocaine
  - Other stimulants, including caffeine
  - Hallucinogens
  - Tobacco
  - Volatile solvents
  - Multiple drug use and use of other psychoactive substances

- Schizophrenia, Schizotypal and Delusional Disorders
  - Schizophrenia
  - Schizotypal disorder
  - Persistent delusional disorders
  - Acute and transient psychotic disorders
  - Induced delusional disorder

- Schizoaffective disorders

- Mood [affective] disorders
  - Manic episode
  - Bipolar affective disorder
  - Depressive episode
  - Recurrent depressive disorder
  - Persistent mood [affective] disorders
  - Other mood [affective] disorders
  - Other single mood [affective] disorders

- Neurotic, Stress-Related and Somatoform Disorders
  - Phobic anxiety disorders
  - Agoraphobia
  - Social phobias
  - Specific (isolated) phobias
  - Other phobic anxiety disorders
  - Phobic anxiety disorder, unspecified

- Other Anxiety Disorders
  - Panic disorder
  - Generalized anxiety disorder
  - Mixed anxiety and depressive disorder
  - Other mixed anxiety disorders
  - Other specified anxiety disorders
  - Anxiety disorder, unspecified

- Obsessive-Compulsive Disorder
- Reaction to Severe Stress, and Adjustment Disorders
- Post-traumatic stress disorder
- Dissociative [conversion] disorders
- Somatoform disorders
- Other neurotic disorders
- Behavioural syndromes associated with physiological disturbances and physical factors

- Eating disorders
- Nonorganic sleep disorders
- Sexual dysfunction, not caused by organic disorder or disease
- Mental and behavioural disorders associated with the puerperium, not elsewhere classified
- Psychological and behavioural factors associated with disorders or diseases classified elsewhere
- Abuse of non-dependence-producing substances
- Unspecified behavioural syndromes associated with physiological disturbances and physical factors

- Disorders of Adult Personality and Behaviour
  - Specific Personality Disorders
  - Paranoid Personality Disorder
  - Schizoid Personality Disorder
  - Dissocial Personality Disorder
  - Emotionally Unstable Personality Disorder
  - Histrionic Personality Disorder
  - Anankastic Personality Disorder
  - Anxious [Avoidant] Personality Disorder
  - Other Specific Personality Disorders

- Habit and impulse disorders
- Gender identity disorders
- Disorders of sexual preference
- Psychological and behavioural disorders associated with sexual development and orientation
- Other disorders of adult personality and behaviour

- Mental Retardation
  - Mild mental retardation
  - Moderate mental retardation
  - Severe mental retardation

- Profound mental retardation
- Other mental retardation
- Unspecified mental retardation

- Disorders of Psychological Development
  - Specific developmental disorders of speech and language
  - Specific developmental disorders of scholastic skills
  - Specific developmental disorder of motor function

- Pervasive Developmental Disorders
  - Childhood autism
  - Rett's syndrome
  - Other childhood disintegrative disorder
  - Overactive disorder associated with mental retardation and stereotyped movements
  - Asperger's syndrome
  - Other pervasive developmental disorders
  - Pervasive developmental disorder, unspecified
  - Other disorders of psychological development

- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
  - Hyperkinetic disorder
  - Conduct disorders
  - Mixed disorders of conduct and emotions

  - Depressive conduct disorder
  - Other mixed disorders of conduct and emotions

- Emotional Disorders with onset specific to childhood
  - Separation anxiety disorder of childhood
  - Phobic anxiety disorder of childhood
  - Social anxiety disorder of childhood
  - Sibling rivalry disorder

- Other childhood emotional disorders
- Childhood emotional disorder, unspecified

- Disorders of social functioning with onset specific to childhood and adolescence
  - Elective mutism
  - Reactive attachment disorder of childhood
  - Disinhibited attachment disorder of childhood

- Tic disorders
- Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
  - Nonorganic enuresis
  - Nocturnal enuresis only
  - Diurnal enuresis only
  - Nonorganic encopresis
  - Failure to acquire physiological bowel control
  - Feeding disorder of infancy and childhood
  - Pica of infancy and childhood
  - Stereotyped movement disorders
  - Stuttering [stammering]
  - Cluttering
  - Unspecified mental disorder

OVERVIEW OF ASSESSMENT OF MENTAL HEALTH PROBLEMS IN GENERAL PRACTICE

The principles of assessment, including indicators of "abnormal" behavior, as symptom or sign

Communication with people seeking care and their care providers:

- Ensure that communication is clear, empathic, and sensitive to age, gender, culture and language differences.
- Be friendly, respectful and non-judgmental at all times.
- Use simple and clear language.
- Respond to the disclosure of private and distressing information (e.g. regarding sexual assault or self-harm) with sensitivity.
- Provide information to the persons on their health status in terms that they can understand.
- Ask the person for their own understanding of the condition.

Symptomatic Presentation of Psychiatric Illnesses:

Thepatientsmaypresentwithpsychologicalsymptoms.Thepossiblediagnosesareasfollows:

Delirium, Dementia	Alterations in consciousness, orientation, concentration or memory difficulties etc.
Drug Abuse or Dependence	Craving for or abnormal behavior to acquire addictive substances like tobacco, alcohol, opioids, cannabis, etc.
Psychosis	Odd behavior like wandering aimlessly, aggression, violence, unexplained anger, muttering to self, smiling inappropriately, illogical speech, delusions or hallucinations.
Depression	Sadness of mood, hopelessness, helplessness, worthlessness, inability to derive pleasure, easy fatigability etc.
Mania, Bipolar Disorder	Elevated mood, hyperactivity, big talks or big spending etc.
Anxiety Disorders	Obsessions, compulsions, 'ghabrahat', fears, restlessness, agitation etc.
Sex Related Disorders	Sexual problems related to gender identity, sexual orientation, desire, erections, orgasms or perverse sexual behavior etc.
Others	Attention deficit/hyperactivity, impulsivity, difficulty in learning Maths and other subjects, academic decline, stuttering, bed- wetting, lying, stealing, running from school, problems with relationships, school refusal, Malingering, Compulsive behaviours like shopping, gambling, stealing or hair pulling, prolonged grief reactions, personality problems beginning in adolescence, stress, repeated attempts at self-harm, mood symptoms before periods, etc.

The patients with psychiatric illnesses may present with somatic symptoms. The possible diagnoses are as follows:

Depression or Anxiety Disorder	Weakness, low energy, vague aches and pains especially headaches, Panic, strange sensations, “ghabrahat”, irritability, tearfulness, etc
Conversion Disorders	Pseudo-seizures, motor or sensory deficits, patchy memory lapses, etc
Somatoform Disorders	Multiple pain symptoms, vomiting, diarrhea, genitor- urinary or menstrual disturbances, etc.
Eating Disorders	Eating too little, or excessively with induced vomiting, etc.
Sleep Disorders	Sleeping more, or less, sleepwalking, nightmares, etc

Psychiatric History Taking

- Take a detailed history, history of the presenting complaints (duration, onset, course, associated factors), past history, medical history, personal, forensic & drug history and family history, as relevant.
- Assess for psychosocial problems, noting the past and ongoing social and relationship issues, living and financial circumstances, and any other ongoing stressful life events.

Start With	Patient's name, age, gender, education, marital status, occupation, religion, and circumstances of referral/ reasons for attending the clinic
History of the present illness	Patient's complaints: in the patient's own words Duration, nature and progression of symptoms Precipitating, predisposing and perpetuating factors Degree of functional impairment: effect on interpersonal relationships, work, family & other spheres of life Biological functions: Sleep & Appetite. Details of treatment to date
Past Psychiatric and Medical History	Nature and frequency of previous psychiatric contact Treatment & hospitalizations Past surgical &Medical history
Forensic & Drug History	Drug abuse (prescribed and recreational), tobacco consumption Past Forensic history
Family History	Parent's/ sibling's age, occupations, relationships with the patient Enquiry into family history of psychiatric illness, suicide, alcohol & drug abuse, and mental retardation
Personal history	Early life & development Details of present circumstances: Accommodation, occupation, financial status Occupational history: jobs, reasons for change, work satisfaction, relationships with colleagues Sexual practices, relationships, marriage In case of women: menstrual pattern, contraception, miscarriage/ termination of pregnancy
Pre Morbid Personality	How was the patient prior to the start of the illness? How sociable was he/She? What was his/her predominant mood? What were the leisure time hobbies? How much confident was he/she? How does the person reacts to the stressors? How often he/she follows religion? And rules and norms?

	What kind of character he/she posseses?

Mental Status Examination

The Examination methods mainly involve a mental state examination, which is quite time-consuming and difficult, because symptoms and signs are not easy to understand or interpret. However, Mental State Examination in Psychiatric assessment of a person is as important as Physical Examination in a general medical condition.

Appearance & Behavior	Careful observation of the patient's manner, rapport, eye contact, facial expressions, cleanliness, clothing, self-care, movements,
Mood	Changes in the mood states: depression, elation, euphoria, anxiety and anger
Speech	Rate, quantity (increased/ decreased) Pattern: spontaneity, coherence Abnormal words (neologisms)
Thought Content	Delusions, preoccupations, obsessions, phobias, suicidal intentions
Thought Flow	Abnormal form of thought may be deduced, for example where connections between statements are difficult to follow
Perception	Hallucinations (Auditory, Visual, Tactile, Gustatory & Olfactory), illusions
Sensorium & Cognition	Consciousness, orientation (time, place, person) Concentration & attention Memory General fund of knowledge & intelligence Educational background must be taken into account
Judgment & Insight	Social & Personal Judgement: patient's capability for social judgment, likely understanding of outcome of his/her behaviour Insight: awareness about being ill; degree of understanding of his/her illness, as well as willingness to accept treatment
Assessment of Functionality & Functionality Impairment	Premorbid Level of Functioning Impairment in Functionality (Social, Working & Interpersonal)

Rating Scales:

- GAD -7 & Patient Health Question v. 9 (Annex A)

PRINCIPLES OF GENERAL MANAGEMENT OF MENTAL HEALTH PROBLEMS IN GENERAL PRACTICE

Common Principles of Management

- Determine the importance of the treatment to the persons as well as their readiness to participate in their care.
- Determine the goals of treatment for the affected persons and create a management plan that respects their preferences for care (also those of their care provider, if appropriate).
- Devise a plan for treatment, continuation and follow-up, in consultation with the person.
- Inform the person of the expected duration of treatment, potential side-effects of the intervention, any alternative treatment options, the importance of adherence to the treatment plan, and of the likely prognosis.
- Address the person's questions and concerns about treatment, and communicate realistic hope for better functioning and recovery.
- Continually monitor for treatment effects and outcomes, drug interactions (including with alcohol& cannabis, over-the-counter medication and complementary/traditional medicines), and adverse effects from treatment, and adjust dosages accordingly
- Facilitate referral to specialists, where available and as required.
- Make efforts to link the person to community support.
- At follow-up, reassess the person's expectations of treatment, clinical status, understanding of treatment and adherence to the treatment and correct any misconceptions.

Pharmacotherapeutic Management

- Antipsychotics
- Antidepressants
- Mood Stabilizers
- Anxiolytics
- Anticholinergics
- Others

Selection of appropriate drugs in specific conditions eg Pregnancy, lactation, heart disease, diabetes, hypertension, etc.

LIMITATION: The General Practioners are NOT ALLOWED to administer:

a. Electroconvulsive Therapy

b. Psychosurgery
c. Long Acting Antipsychotic Injection
d. Clozapine

The treatment modalities can only be prescribed by the **QUALIFIED PSYCHIATRIST**

Non-Pharmacologic Management

Crisis intervention, counselling and structured problem solving are techniques used to help people who are under stress. Stress is a person's response to an event that requires him or her to change. A stressor may be either an adverse event, such as bereavement, or a desirable one, such as a promotion. Likewise, the outcome of facing a stressor can be positive or negative. A person under stress may or may not have an intercurrent mental illness. People with personality disorders are especially prone to stress. Their lives are frequently chaotic, and their maladaptive coping mechanisms mean that they often exacerbate or avoid their problems rather than find effective solutions to them. Some common stressors are:

- Losses
  - Bereavement
  - Separation/Divorce
  - Response To Major Surgery Or Medical Illness
  - Financial Loss

- Life Changes
  - New Job
  - Marriage
  - Retirement
  - Developmental Stage – E.G. Adolescence, Retirement

- Relationship Problems

- Others
  - Housing
  - Work Problems
  - Financial Problems
  - Problems With Neighbours

Elevated levels of arousal caused by a stressor initially lead to improved coping. However, when the levels of arousal rise above a certain point, coping deteriorates and can lead to decompensation.

Increased arousal initially improves coping, but excessive arousal can lead to decompensation. The ways of dealing with these two situations are quite different. The person who is under stress receives counselling and is taught structured problem solving, while the person who is decompensated first undergoes crisis intervention.

Crisis Intervention

The aim is to decrease the level of arousal until the person in crisis can return to his or her normal level of coping. As soon as this is achieved, responsibility for the problems is handed back to him or her, and counselling and problem solving can begin. Some of the steps used in crisis intervention are listed below.

- Crisis intervention aims to decrease the decompensated person's level of arousal so that he or she can begin to cope effectively with his or her problems.
- Temporarily take over responsibility for the problems.
- Remove the person from the stressful situation. In some cases, it may even be necessary to arrange a brief admission to hospital.
- Lower the person's level of arousal by listening, encouraging the person to ventilate his or her feelings and providing reassurance. A brief course of a benzodiazepine may sometimes be appropriate.
- Diagnose and treat any mental disorder.
- When the person's judgement has returned to normal, offer counselling and structured problem solving.

Counselling

The aim is for the person to cope as well as possible with the stressor.The problem is not treated as an illness. The person is not treated as being 'sick' but rather as a coping adult. The theory of counselling is that through facilitating the expression of feelings about the stressor in the context of a good therapeutic alliance, the person will be able to clarify and understand his or her problems better and solve them rationally to the best of his or her ability.

Counselling and structured problem solving aim to help people cope to the best of their ability with their problems.

Counselling begins by understanding and clarifying the problem. Some steps you might take in counselling (a woman) are listed below:

- Listen as she describes the stressful situation or event.
- Reflect back what she says and clarify her account of what has happened.

- Allow her to ventilate her feelings.
- Empathise with how she feels.
- Try to make sense of any precipitants. These may have special meaning in terms of her past history. For example, the loss of a loved one may rekindle grief over past losses.
- Take note of any dysfunctional ways of coping, for example alcohol or other substance abuse, aggression or violence.
- Ask how she has dealt with similar problems in the past.
- Ask how she has dealt with other stressful events.

Structured Problem Solving

The next step is to help via using structured problem solving to deal with the stressor.

Structured problem solving helps people find effective and rational solutions to their problems.

Use this to help solve problems that are causing you stress. If problems are not dealt with, they often worsen and cause more stress.

1. Make a list of the things that are worrying you.

2. Choose the problem that you want to deal with first and write it down as a need or a goal (e.g. 'I need to find a job', rather than, 'I don't know what to do with myself '. Or, 'I need to have more money in the bank', rather than, 'I haven't got enough money').

3. Write down all the possible solutions you can think of. List all solutions, including bad or silly ones. The aim at this stage is not to decide if a solution is good or bad.You might want to ask other people whom you trust to suggest some other possible solutions.

4. Beside a list of the possible solutions, draw two columns and write in them the advantages and disadvantages of each. Another person you trust may be able to help you with this.

5. Choose the best solution. It does not have to be the perfect solution. There rarely is such a thing.
But it is better to try some solution than to do nothing at all.

6. Write down the steps needed to carry it out. Include the things you need to do, the resources that you require (e.g. a car or a day off work), the hurdles you need to overcome and the time you anticipate that it will take. You may need to rehearse some of the steps (e.g. a difficult interview or phone call). Decide on your goals so that after you have put the plan into action, you can assess how well it worked. For example, the goal might be having more money in the bank, going out with friends once a week or having fewer arguments with your spouse.

7. Put the plan into action.

8. Review how effective the solution was. First of all, congratulate yourself on trying to solve the problem rather than doing nothing.What have you achieved? What problems remain? Should you continue with the current solution, modify it or try a different approach?

9. Repeat the process for the remaining problems.

Note:When you are under severe stress, your ability to solve problems is often impaired.Avoid making major life decisions in the midst of a crisis.

You will need to set aside two or three longer consultations (e.g. 25 minutes) in the counselling phase as you assess and define the problems.The other steps can usually be spread over about five15 minute sessions. However, new problems may then need to be addressed. Most of the work is done by the person (him or herself) at home.

Some steps that you might take in assisting a woman with structured problem solving are listed below:

- Explain the approach.
- Help to clarify the problem.The problem should be formulated as a specific goal or need.
- Suggest other possible solutions.

- Remind her of her strengths and weaknesses.
- Ensure that she is realistically appraising the different possible solutions.
- Make sure that she does not rush into action.
- Help her break down the plan into discrete steps.
- Help her to check the effectiveness of the action taken and identify any remaining problems.

Relaxation Therapies.

- Walk,
- Deep breathing exercises
- Yoga
- Sleep hygiene

Non-Specific Stress Reduction Techniques

In addition to the specific techniques discussed above, a number of non-specific techniques can be used to reduce stress. People should be advised to avoid major life changes in the midst of coping with major stressors. They should be reminded of the importance of dealing with problems in their lives rather than ignoring them (e.g. ongoing relationship problems). They may benefit from the controlled breathing, relaxation exercises and self-hypnosis. It may be useful for them to monitor their daily activities and to use a Daily Activity Schedule that includes enjoyable activities and a regular exercise program. Advice on avoiding self-medication with alcohol, cigarettes and benzodiazepines and improving sleep habit may also be indicated. It may be appropriate to refer people to other specialist agencies that can help with their problems (e.g. for financial counselling).

A Note on Advice

Rather than help people solve problems themselves, it is often tempting to tell them how to solve their problems. It may save time in the consultation and the 'solution' may seem obvious. However, you should resist this impulse. Telling a man what he should do will reinforce his sense of ineffectiveness and low self-esteem. Since it is the man himself who has to live with the consequences of his actions, he should take responsibility for these decisions himself. If the doctor tells him what to do, he will be less committed to the decision and may blame you if things do not work out well.

There are exceptions to this rule. As an expert in medicine, doctor will give advice on the diagnosis, treatment and prevention of illness. During the crisis intervention phase, when a person's judgment is severely impaired and his or her ability to cope is overwhelmed, it may be necessary to take control and advise him or her what to do. In particular, it is often wise to advise people who are in the midst of a crisis not to make major life decisions. PHC physicians should also advise people what to do in situations in which there is danger to themselves or others.

Structured problem solving aims to help people find solutions to their problems themselves. It is not about telling people what they should do.

Patients often see doctors as authorities, not only on medicine, but on many other matters as well. This attitude may be a manifestation of a paternal or maternal transference. It is flattering to be regarded this way by our patients, but generally inadvisable to act out in the counter- transference by telling people how they should run their lives.

A note on 'Debriefing'

Note that 'debriefing' or crisis intervention alone is ineffective in preventing later psychological sequelae following a traumatic event. While those who are exposed to trauma have a high risk of later developing a psychiatric disorder, most who do so do not suffer an acute stress reaction at the time of the event. The key is in long-term observation and early intervention. General practitioners are well placed to do this.

ANXIETY DISORDERS

- Anxiety
    - It is a feeling characterized by a diffuse, unpleasant, vague, sense of apprehension, often accompanied by autonomic symptoms
- Characteristics of Anxiety
    - Unknown threat
    - Internal
    - Indefinite
    - Conflictual
- Adaptive Functions of Anxiety
    - It is an alerting signal, that warns of threats of
        - Body damage, pain, helplessness, possible punishment, or frustration of social or body needs
        - Separation from loved ones
        - Menace to one's success or status
        - Threats to one's unity or wholeness
    - It promotes the person to take the necessary steps to prevent the threat, or to lesson its consequences.

- Pathological Anxiety
    - Anxiety is said to be pathological when
        - It stops or hinders adaptive functioning
        - It hinders a person to perform it's functioning in
            - Home
            - Society
            - Occupation
        - Or it creates mental stress for a person, experiencing it

- Manifestations of Anxiety
    - Psychological
        - Attention and concentration
        - Appearance
        - Orientation
        - Memory
        - Mood
        - Thoughts
        - Perceptions
    - Vegetative
        - Sleep
        - Appetite
        - Sex
    - ANS
    - CNS
    - CVS

    - Respiratory
    - GIT
    - GUT
- Impact of Anxiety
    - Personal life
    - Family life
    - Social life
    - Occupational / Educational life

- Differential Diagnosis of Anxiety
    - Fear
        - Known threat
        - External
        - Definite
        - Non-Conflictual
    - Depression/ sadness
        - Symptoms
        - Thoughts
- Organic Differentials of Anxiety
    - General medical disorders
        - CNS
            - Neoplasm
            - CVA
            - Encephalitis
            - Wilsons disease, etc.
        - Hypoxia
        - Endocrine Disorders
            - Hyperthyroidism
            - Pheochromocytoma, etc.
        - Inflammatory diseases
            - SLE
            - RA, etc.
        - Metabolic disorders
            - Hypoglycemia
            - Porphyria
            - Uremia
        - CVS
            - Ischemic disorders
            - Mitral Valve Prolapse
    - Drugs
        - Amphetamine
        - Penicillin
        - Sulfonamides
        - Cannabis
    - Toxins
        - Mercury
        - Arsenic
        - Organophosphorus compounds

CLINICAL SYNDROMES OF ANXIETY

PANIC DISORDER

- Clinical Picture
- Diagnosis
    - ICD (3 attack in 3 weeks)
    - DSM (1 attack + 1 month)
- Etiology
    - Biological (NA, 5HT, GABA)
- Epidemiology
    - 1.5-3%; Life time prevalence
    - more common in females
    - More common in young adults
- Differential diagnosis
    - Medical Disorders
        - MI, Pheochromocytoma, MVP
        - Asthma, CVA, Hyperthyroidism
- Differential diagnosis
    - Psychiatric Disorders
        - Malingering
        - Factitious Disorders
        - Conversion Disorders
        - G A D, etc.
- Co-Morbidity: Agoraphobia
- Management:
    - Pharmaco therapy : BDZs, TCAs, MAO, Beta-Blockers, Azaspirones
    - Cognitive Behavior Therapy
    - Relaxation Techniques
    - Crisis Intervention

OBSESSIVE COMPULSIVE DISORDER

- Obsession: Recurrent and intrusive thought, image, idea, or impulse.
- Compulsion: Conscious, standardized, recurrent motor acts, based on obsessions
- Clinical Features
    - Obsession
    - Compulsion
        - Checking
        - Counting
        - Cleaning
        - Orderliness
        - Collecting
        - Touching & etc.
- Diagnostic Essentials
    - Excessive / irrational / un reasonable
    - Marked distress
    - No physical cause
    - Not better explained in another disorder
- Epidemiology
    - 2-3% life time prevalence
    - Unusually before the age 25
    - Single
- Etiology
    - Biological. Neurotransmitters : 5-HT, ACH, DA
- Psychological
    - Defense mechanisms
    - Anal phase
    - Learning
- Differential diagnosis
    - Touretter's syndrome
- Management
    - SRIs
    - SSRIs
    - Other drugs
    - Behavioral therapy

ACUTE STRESS DISORDERS

- Clinical Essentials
    - Severe anxiety
    - H/O acute stress
- Etiology
    - Event
    - Vulnerability
    - Temperament
    - Early life
- Epidemiology
    - Young adults
    - Single
    - Economically handicapped
    - Socially withdrawn
- Etiology
    - Benzodiazyme receptor
    - Hypthalamic – Pituitary – adrenal axis
- Management
    - Pharmacotherapy
    - Catharsis
    - Psycho-therapy

POST-TRAUMATIC STRESS DISORDER

- Clinical Features
    - Arousal on Cues
    - Flash Backs
    - Nightmares
- Epidemiology
    - 1-3% life time prevalence
    - Young adults
    - Single, divorced
- Etiology
    - Event
    - Learning Theory
    - Biological Factors
    - N.E., D.,A., Opiates
- Management
    - Support
    - Encouragement to expose & discuss
    - Education of coping strategies
    - Pharmacotherapy
        - TCAs
        - Imipramine
        - Amitriptyline
        - SSRI
        - SNRI
        - Antipsychotics
        - Anxiolytics
    - Psychotherapy

GENERALIZED ANXIETY DISORDER

- Clinical Picture
- Epidemiology
    - More in females
    - 20's
- Etiology
    - GABA & 5- HT
    - Learning
    - Existential
- Management
    - Pharmacotherapy
        - Benzodiazepines
        - TCAS
        - SSRIS
        - SNRIS
        - Other drugs (Buspirone, β-blocker)
    - Psychotherapy

PHOBIC ANXIETY DISORDER

- 'Phobia' is an irrational fear resulting in a consistent avoidance of feared object, activity, or situations.
- Types (based on clinical features)
    - Agora phobia : Fear of being in public places
    - Social phobia : Fear of social situation or performance, in front of un familiar people or possible scrutiny by others
    - Specific phobia
        - Executive & un reasonable
        - Cued
        - Any object
- Diagnostic points
    - Cues are avoided
    - Interference with normal life
    - Not due to any medical condition
    - Not due to drugs
    - Not better accounted for by another mental illness
- Epidemiology
    - Biological Factors
        - + NA, DA
        - + Genetic
    - Psychological factors
        - + Symbolization, Displacement
        - + Learning theory
- Management
    - Insight – oriented psychotherapy
    - Behavioral therapies
    - Pharmacotherapy

ANXIETY DISORDERS TREATMENT

- Reassurance
- Psychological Treatments
    - Relaxation Techniques
    - Anxiety Management Training
    - Biofeedback
    - Behavior Therapies
    - Cognitive Behavior Therapy (CBT)
- Drug Treatment
    - Benzodiazepines
    - Buspirone
    - SSRIs
    - Beta Blockers

DEPRESSION AND OTHER AFFECTIVE DISORDERS

- Types of Affective Disorders
  - Depression & Bipolar Affective Disorder
  - Dysthymia & Cyclothymic

DEPRESSION

- Symptoms of Depression
  - Psychological
  - Vegetative
  - Somatic
- Epidemiology
  - Male V/S Female
  - Catchment Area
  - Marital Status
- Diagnostic Criteria
  - Symptoms Check List
    - Sadness of Mood
    - Lack of joy or Interest in all activities
    - Weight loss or Weight gain
    - Sleep disturbances
    - Psycho-motor Agitation or Retardation
    - Fatigue / loss of energy
    - Feeling of worthlessness and guilt
    - Decreased ability to concentrate
    - Recurrent thoughts of death or suicide
    - Time duration - 2 Weeks Minimum
- Types
  - Mild
  - Moderate
  - Severe
- Etiology
  - Psycho-social
  - Biological
    - Biogenic Amines
    - Hormones
- Neurotransmitters
  - Depression is associated with low levels of serotonin in relation to norepinephrine and dopamine
  - Primary function of serotonin is to regulate our emotional reactions
  - When levels of serotonin are low, we are more impulsive and our moods swing more wildly

- Genetics
    - Family studies:Relatives of those with a mood disorder are two to three times more likely to have a mood disorder (usually major depression)
    - Twin studies: If one identical twin has a mood disorder the other twin is 3 times more likely than a fraternal twin to have a mood disorder

- Psychological Causes
    - Learned helplessness (Seligman)
    - Negative cognitive styles (Beck)
        - Automatic thoughts
        - Cognitive triad
        - Errors in thinking

- Social Causes
    - Stressful life events
    - Social support (marital relationship)
    - Gender

- Management
    - Psychological
        - Psychotherapies
    - Biological
        - TCAs
        - SSRIs
        - SNRIs
        - NASSA
    - ECT

- Need of Referral

BIPOLAR AFFECTIVE DISORDER

- Definition
- Types
    - Bipolar-1
    - Bipolar-2
- Symptoms
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep
    - More talkativeness
    - Flight of ideas
    - Distractibility

- Increase in goal directed activities
- Excessive involvement in pleasurable activities
- Time Duration - At least – One Week

- Epidemiology
  - Male V/S Female
  - Catchment Area
  - Marital Status
- Etiology
  - Biological
    - Genetic
    - Biogenic Amine
    - Others
  - Psychological

- Diagnosis
  - Symptoms Check List
  - Duration
  - Psychometric Test
- Management
  - Biological
    - Anti-Psychotics
    - Mood Stabilizers
    - ECT
    - Others
- Need of Referral

SOMATOFORM DISORDERS

- Physical symptoms that are:
    - Unexplained after medical/physical examination (i.e., medically unexplained symptom).
    - Without organic pathology
    - That are grossly in excess of what would be expected from the physical findings
    - Associated with significant concern, distress or impairment
    - As a manifestation of psychological distress.
- Somatizing patients:
    - Are unable to use emotional language to describe their distress
    - Express their psychological illness or social distress with somatic symptoms
    - Somatization is an entirely unconscious process
- Mechanisms of Somatization (Four Theoretical Perspectives)
    - Neurobiological: Somatization results from defective or deficient neurobiological processing of sensory and emotional information
    - Psychodynamic: Somatized physiological sensations occur as expressions of underlying emotional conflict. Somatization enables patients to meet latent needs for nurturing and support
    - Behavioral: Somatization is viewed as behavior that is brought about and reinforced by others in the patient's environment - "Illness-maintenance systems"
    - Sociocultural: Social norms concerning emotions
    - When a culture does not allow direct communication of emotional content, one means available to express emotions is through physical symptoms - Somatization serves to notify others of emotional or psychological distress in an acceptable or non-stigmatized manner
- Contributing Factors for Somatization
    - Childhood abuse
    - Acute stress
    - Societal roles
    - Learned behavior

- Secondary gain
- Cultural factors
- Histrionic, narcissistic, and borderline personality traits

- Symptoms
  - Vomiting
  - Nausea
  - Diarrhoea
  - Back pain
  - Dysuria
  - Shortness of breath
  - Chest pain
  - Amnesia
  - Visual changes
  - Sexual apathy
  - Impotence
  - Irregular menstruation
  - Deafness
  - Lump in the throat
  - Abdominal pain
  - Bloating
  - Pain in arms and legs
  - Joint pain
  - Headaches
  - Palpitations
  - Dizziness
  - Difficulty in swallowing
  - Paralysis/muscle weakness
  - Dyspareunia
  - Dysmenorrhoea
  - Menorrhagia
  - Seizures
  - Loss of voice

- Somatization Disorder (Briquet's Syndrome)
  - Multiple recurrent physical complaints over many years
  - No organic etiology for these complaints
  - Begins by age 30
  - Pain, GI, sexual, pseudoneurologic symptoms: impaired coordination or balance, paralysis or localized weakness, difficulty swallowing, aphonia, urinary retention, hallucinations, loss of touch or pain sensation,double vision, amnesia, sensory losses, loss of consciousness
  - Frequently consult with many different doctors seeking treatment, often with vague, inconsistent and disorganized medical histories.
  - Has impaired social/work/personal functioning
  - Symptoms may be exacerbated by stress
  - No element of feigning symptoms to occupy sick role (Factitious Disorder) or for material gain (Malingerer)

SOMATOFORM PAIN DISORDER

- Somatoform pain disorder is pain that is severe enough to disrupt a person's everyday life.
- The pain is like that of a physical disorder, but no physical cause is found. The pain is thought to be due to psychological problems.
- The pain that people with this disorder feel is real. It is not created or faked on purpose (malingering).
- Diagnostic Criteria
    - Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
    - The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
    - Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
    - The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
    - The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder.
- Management
    - Explain to the patient and family relationship between psych and somatic
    - Empathic attitude
    - Avoid unnecessary investigation
    - Treat underlying depression and anxiety
    - Symptom variation provides teaching moments.
    - "Goal of treatment is to figure out how you can control symptoms."
    - Describe the potential for stress to affect symptoms.
    - Normal stress reaction in terms of sympathetic arousal—the body's "emergency mode."
    - For example, digestive functions are "turned off" when stressed. If prolonged, results in digestive distress (e.g., pain, constipation, diarrhea).

- Behavioral Techniques
  - Increased Activity Involvement
    - Combats stress (minimize functioning in emergency mode)
    - Improves overall mood (as we see in dep treatment)
    - Provides Distraction from somatic symptoms
    - Pain perception has a subjective component—improved mood and distraction reduce the experience of pain
    - Exercise has physiological effects that combat somatization and stress
  - Do they get their daily dose of meaningful activity, productivity, and exercise?
- Relaxation Techniques
  - Directly acts on physical symptoms, given its effects on breathing, heart rate, muscle tension, etc.
  - Patients report benefit soon upon learning the technique
  - Helps with stress management
  - Includes Diaphragmatic Breathing, Progressive Muscle Relaxation, Biofeedback
    - Practiced in session with patient, consecutively for a period of weeks (combined with practice at home).
- Sleep Strategies
  - Establish consistent sleep patterns (same bedtime and waketime everyday)
  - Go to bed only when sleepy (stimulus control)
  - If not asleep within 20-30 minutes leave bed and return when sleep again (stimulus control)
  - Bed is only for sleep and sex. No TV, reading, etc. (stimulus control)
  - Comfortable sleep environment
  - Avoid alcohol/caffeine during 6 hours before bedtime
  - Exercise regularly, but not within 4 hours of bedtime
- Cognitive Strategies
  - Much like CBT for depression

        - Looking for adaptability of thoughts
        - Eliminating distortions
    - Use somatic symptoms as anchors for examining thoughts
    - Look for variations in adaptability of thoughts and discuss their effect
    - Patients are likely to have difficulty identifying thoughts/emotions.
    - Likely to have schemas that include health concern

CONVERSION DISORDER

- Conversion disorder is a mental health condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation.

- Symptoms of a conversion disorder include the loss of one or more bodily functions, such as:
    - Blindness
    - Inability to speak
    - Numbness
    - Paralysis
    - Common signs of conversion disorder include:
    - A debilitating symptom that begins suddenly
    - History of a psychological problem that gets better after the symptom appears
    - Lack of concern that usually occurs with a severe symptom
    - 1 or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition
    - Psychosocial factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors
    - The symptom or deficit is not intentionally produced or feigned.
    - The symptom or deficit cannot, after appropriate investigation, be fully explained by a known general medical condition or the direct effects of a substance, or as a culturally sanctioned behavior or experience.
    - The symptom or deficit causes clinically significant distress or impairment in functioning, or warrants medical evaluation

- The symptom or deficit is not limited to pain or sexual dysfunction, does not occur during the course of Somatization Disorder, and is not better accounted for by another medical disorder.

HYPOCHONDRIASIS

- It is an overwhelming fear that you have a serious disease, even though health care providers can find no evidence of illness. People with hypochondriasis misinterpret normal body sensations as signs of serious illness. This fear is severe and persistent, and interferes with work, as well as relationship.
- Criteria
  - Persistent belief in the presence of one or more serious illness underlying a presenting symptoms
  - Unable to accept reassurance from multiple doctors that there is no physical illness
  - Persistent for more than 6 months
  - Causing significant impairment/distress
  - Not delusional in intensity
- Epidemiology
  - Prevalence of 4.2-13.8% in general medical clinics
  - Equal prevalence amongst men and women
  - No increasing prevalence with age
- Aetiology
  - No geographical factors
  - No evidence of genetic factors
  - Maladaptive behaviour can contribute
  - May be associated with childhood experiences (chronic/serious illness in pt or family members/missing school/traumatic experiences)
  - May be associated with parental characteristics i.e. overprotectiveness
  - Chronic stable condition
- Despite being a stable chronic condition, there is an increased morbidity associated with it:
  - risks of complications from investigations (3 times more likely to be referred for further investigation)
  - Side-effects from inappropriate treatments

PSYCHIATRIC EMERGENCIES

SUICIDE

- Intentional self-inflicted death
- Common Risk Factors
    - **Major psychiatric illness** - in particular, mood disorders (e.g., depression, bipolar disorder, schizophrenia)
    - **Substance abuse** (primarily alcohol abuse)
    - **Family history of suicide**
    - **Long term difficulties with relationships** with friends and family
    - **Losing hope** or the will to live
    - **Significant losses** in a person's life, such as the death of a loved one, loss of an important relationship, loss of employment or self-esteem
    - **Unbearable emotional or physical pain**
        - A person who is at risk of committing suicide usually shows signs
        - Whether consciously or unconsciously - that something is wrong.
- Keep an eye out for:
    - Signs of clinical depression
    - Withdrawal from friends and family
    - Sadness and hopelessness
    - Lack of interest in previous activities, or in what is going on around them
    - Physical changes, such as lack of energy, different sleep patterns, change in weight or appetite
    - Loss of self-esteem, negative comments about self-worth
    - Bringing up death or suicide in discussions or in writing
    - Previous suicide attempts
    - Getting personal affairs in order, such as giving away possessions, or having a pressing interest in personal wills or life insurance
    - Though many people considering suicide seem sad, some mask their feelings with excessive energy. Agitation, hyperactivity, and

restlessness may indicate an underlying depression that is being concealed.

- Epidemiology
  - Male : Female
  - Age
  - Marital Status
  - Occupation
  - Catchment
- Etiology
  - Psychological Causes
    - Freud
    - Behavioral
    - Newer
  - Biological. Low 5HT (impulsivity),
    - Low NA (Hopelessness and Passivity),
    - Over-activity of HPA, Genes,
  - Social.
    - Poor parenting
- Methods
  - Firearms are still the most common method for suicide (51.6%),
  - Hanging or suffocation is used in about one out of five suicides
  - Poisoning accounts for slightly less than one out of five suicides.
- Management
  - Report
  - Assess
    - The person retrospectively
    - The family
    - The community
  - Facilitate mourning
- Attempted Suicide
  - Physical management
  - Psychological interviewing
  - Underlying psycho-pathology
  - Further risk
- Need of Referral

SUBSTANCE USE DISORDERS

- Types of Psychoactive Substances
    - Alcohol
    - Sedatives, Hypnotics & Anxiolytics
    - Opiates (Morphine, Heroin)
    - Hallucinogens (LSD, Mescaline)
    - Stimulants (Amphetamine, Cocaine)
    - Methamphetamine (Ice, Crystal)
    - Cannabis (Marijuana, Hashish)
    - Nicotine
    - Caffeine
    - Inhalants (Glue, Paint, Thinner)
    - Phencyclidine (PCP, Angel Dust)
- Types of Substance Use Disorder
    - Acute Intoxication
    - Withdrawal State
    - Dependence Syndrome
    - Harmful Use
- Harmful Use/ Substance Abuse: A maladaptive pattern of substance leading to clinically significant impairment or distress as manifested by one or more of the following:
    - Failure to fulfill major role obligations at home, school, or work.
    - Recurrent substance use in situations in which it is physically hazardous.
    - Recurrent substance related legal problems.
    - Recurrent substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- Substance dependence is defined as adaptive pattern of substance use leading to clinically significant impairment, as manifested by three or more of the following occurring at any time in a 12 months period.
    - Tolerance
    - Withdrawal

- Repeated unintended , excessive use
- Persistent failed efforts to cut down.
- Excessive time spent trying to obtain the substance
- Reduction in important social, occupational or recreational activities.
- Continued use despite awareness that substance is the cause of psychological or physical difficulties.

- Etiology
  - Psychological: associated with conduct disorder, ADHD, depression
  - Cultural
  - Genetic
  - Neurochemical
    - Reward circuits in brain involving 5HT
    - Dopamine in Prefrontal cortex, Nucleus Accumbens, and VTA
- Risk Factors
  - Individual Factors. Psychological profile, Personality, Psychiatric illness, short attention spans etc
  - Family Factors. Parenting style, parents' beliefs about drugs, parental drug abuse.
  - Peers.
  - Community
    - Low Socioeconomic Status
    - High population density
    - High crime rate
- Prevention
  - Parental counseling and trainings
  - Community reforms
  - Early detection and treatment of psychiatric illnesses
  - Awareness campaigns
- Management
  - Motivational interviewing
  - Detox. Substitution Therapy, Symptomatic, Supportive therapy
  - Rehabilitations
  - Management of underlying psychiatric disorder
- Follow Up Care
- Need of Referral

SCHIZOPHRENIA & OTHER PSYCHOTIC ILLNESS

a. Psychosis v/s Neurosis
b. Thought Disorder
c. Manifestations
    - Speech
    - Mood
    - Thoughts
    - Perceptions
    - Cognitive Functions
    - Behavior
    - Movements
d. What will be the effects
    - On sleep
    - On appetite
    - On sex
    - On self care
    - On motor functions
    - On daily activities
    - On relations
    - On functionality
e. Epidemiology
    - Male v/s Female ratio 1:1
    - Life time prevalence 1%
    - Each year, one in 10,000 people age 12 to 60 develops schizophrenia. It is diagnosed 1.4 times more frequently in males than females and typically appears earlier in men
    - males have a bimodal age of onset, with peaks at 21.4 years and 39.2 years old, while females have a trimodal age of onset with peaks at at 22.4, 36.6, and 61.5 years old
f. Types
    - Disorganized/ Hebephrenic
    - Paranoid

- Catatonic
- Simple
- Undifferentiated
- Residual

g. How to confirm the diagnosis of Schizophrenia?
    - At least 6 months duration, with at least one month active symptoms

h. Etiology
    - Dopamine
    - Serotonin
    - Other neurotransmitters, suggested.
    - Heredity
    - Psycho-social, Parenting
        - Schizophrenogenic Mother
        - Double Bind
        - Skew
        - Schism

i. But what if
    i. Duration is less
        1. Few days.. . . . .
            - Acute Psychotic Disorder
        2. About a month. . . .
            - Scizophreniform Disorder
    ii. Only one delusion and nothing else
        1. Delusional Disorder

j. Treatment Modalities
    i. Pharmacological agents
        - Conventional anti-psychotics
        - Atypical Anti-psychotics
        - Others
    ii. Psychotherapy
        - Supportive
        - CBT
    iii. Electroconvulsive Therapy

k. First episode
    - Brought aggressive. Hospitalize. Neuroleptize. Start with Atypical/ conventional antipsychotic. Calculate dose. If stabilize. continue,. If not, see next slide
    - Chronic/ non-aggressive. Start with Atypical
    - Catatonic symptoms. ECT
    - Post-partum onset. ECT
    - Treatment intolerant. ECT

l. First line treatment fails
    - Add a conventional antipsychotic. If improved, maintain the dose.
    - Add CBT
    - Add rehabilitation process
    - Label it TREATMENT RESISTANT,
    - If still not working,
    - If symptoms better but inadequately treated,
    - If side effects too much,

m. In cases of treatment resistance and treatment intolerance
    - CLOZAPINE is the treatment of choice.
    - Risk of Agranulocytosis
    - Weekly CBC for first 18 weeks, later on every month
    - Better under the guidance and supervision of specialist.

n. Need of referral

EMOTIONAL, BEHAVIOURAL AND DEVELOPMENTAL DISORDERS IN CHILDREN AND ADOLESCENTS

MENTAL RETARDATION / INTELLECTUAL DISABILITY

- Mental Retardation is defined statistically as tested cognitive performance that is two standard deviation below the mean of the general population (roughly below the 3rd percentile)
    - Sub-Average intellectual function
    - That result from an injury, disease or abnormality before the age of 18 years
    - Resulting in impaired ability to adapt to the environment
- Intelligence is defined as general cognitive problem-solving skills. A mental ability involved in reasoning, perceiving relationships and analogies, calculating, learning quickly… etc
- Intelligence v/s IQ
- I.Q.(intelligence quotient) is 100; normal ranges from 90 to 110

Border line MR	IQ 70-80
Mild MR	IQ 55-70
Moderate MR	IQ 40-55
Severe MR	IQ 25-40
Profound MR	IQ below 25

Mild retardation	Moderate retardation	Severe retardation	Profound retardation
75% to 90% of all cases of retardation	~10% to 25% of all cases of retardation	~10% to 25% of all cases of retardation	~10% to 25% of all cases of retardation
Function at one half to two thirds of CA (IQ: 50 to 70)	Function at one third to one half of CA (IQ: 35 to 49)	Function at one fifth to one third of CA (IQ: 20 to 34)	Function at < one fifth of CA (IQ: < 20)
Slow in all areas	Noticeable delays, especially in speech	Marked and obvious delays; may walk late	Marked delays in all areas
May have no unusual physical signs	May have some unusual physical signs	Little or no communication skills but may have some understanding of speech and show some response	Congenital abnormalities often present
Can acquire practical skills	Can learn simple communication	May be taught daily routinesand repetitive activities	Need close supervision
Useful reading and math skills up to grades 3 to 6 level	Can learn elementary health and safety habits	May be trained in simple self-care	Often need attendant care
Can conform socially	Can participate in simple activities and self-care	Need direction and supervision	May respond to regular physical activity and social stimulation

- Etiology
  - Prenatal
    - Genetic Disorders :
      - Fragile X syndrome FXS:Most common cause
      - Klinefelter syndrome :male with extra x chromosome 47,XXY
      - Down syndrome
    - Metabolic disorders: PKU, Tay-sachs, Galactosemia
      - Skin disorders: neurofibromatosis and Tubererous sclerosis .
      - Prader-Willi Syndrome :
      - Endocrine : hypothyroidism
  - Perinatal
    - Low Birth Weight: premature, teen pregnancy, poor nutrition
    - 21 % with MR
    - Birth Anoxia: breech presentation, knotted umbilical cord.
  - Postnatal
    - Child abuse and neglect

        - Traumatic brain injury
        - Infection: meningitis and encephalitis
        - Nutritional deficiencies
        - Cultural and familial
- Clinical Presentation
    - Academic slowness
    - Inability to learn fast
    - Comorbids such as depression, behavioral disorder, epilepsy, etc
- Diagnosis
    - Careful and thorough history
    - Developmental History
    - Physical (neurological) examination
    - Psychometry, and IQ testing
    - Metabolic assessment
    - EEG and imaging
    - Chromosomal studies
- Management
    - There is no cure for intellectual disability, but services and supports play an important role and can enable the person to thrive throughout their lifetime.
    - Services for people with intellectual disabilities and their families are primarily there to provide adequate support to allow for full inclusion in their communities. These services touch their daily lives (education, justice, housing, recreational, employment, health care, etc.) and may include
        - Parental Counseling
        - IQ testing
        - Managing Comorbids
        - Identifying and maximizing the strengths
        - Special educator , Language , behavioral and occupational therapists
        - Special school programs
        - Community services

AUTISM SPECTRUM DISORDER

- Signs & Symptoms
    - Difficulties in Communication
    - Difficulties in Social Interaction
    - Repetitive/Stereotypic Behavior

- Types
    - Autism
    - Pervasive Developmental Disorder, Not Otherwise Specific
    - Asperger's Syndrome

ATTENTION DEFICIT HYPERACTIVITY DISORDER

- Presentation
    - Marked Academic problems, fail to complete home works/assignments
    - Restless, hyperactive, leaves his seat in situations when remaining seated is expected
    - Difficulty waiting in turn, talks excessively, Often blurts out answers before a question has been completed
    - Problems with concentration, activity level and organization
    - Make careless mistakes, inability to copy down from board.
    - Does not seem to listen when spoken to directly
    - Difficulty sustaining attention in tasks or activities
    - Is easily distracted by extraneous stimuli

CONDUCT DISORDER

- Presentation
    - Aggressive and Destructive behavior
    - Deceitful behavior and Violation of rules
    - Cruelty to animals often an early symptom
    - Irritable, have low self-esteem, and tend to throw frequent temper tantrums.
    - More prone to abuse drugs and alcohol.
    - Have little guilt or remorse about hurting others.

OPPOSITIONAL DEFIANT DISORDER

- Presentation
    - Excessively arguing with adults, especially those with authority
    - Actively refusing to comply with requests and rules
    - Deliberately trying to annoy or upset others, or being easily annoyed by others
    - Blaming others for your mistakes
    - Having frequent outbursts of anger and resentment
    - Being spiteful and seeking revenge
    - Swearing or using obscene language
    - Saying mean and hateful things when upset
    - Moody, have low self-esteem. Prone to abuse drugs and alcohol.

PSYCHIATRIC PROBLEMS IN ELDERLY

DEMENTIA

- Interplay between Psychiatry and Dementia
    - Psychiatric Disorders as cause of Dementia
    - Treatment of Psychiatric Disorders causing Dementia
    - Treatment of Dementia leading to Psychiatric symptoms
    - Psychiatric Symptoms observed in Dementia
- Behavioural and Psychological Symptoms of Dementia (BPSD): "A heterogeneous range of psychological reactions, psychiatric symptoms, and behaviors occurring in people with dementia of any etiology"
    - Clinically significant BPSD are found in approximately one-third of community-dwelling persons with dementia.
    - nearly 80% in persons with dementia residing in skilled nursing facilities
    - The development of BPSD is a major risk factor for caregiver burden and depression.
    - BPSD is a major risk factor for Institutionalization of patients,
    - BPSD is a major risk factor for worse quality of life,
    - BPSD is a major risk factor for greater impairment in activities of daily living,
    - BPSD is a major risk factor for more rapid cognitive decline
- Symptoms
    - Depressive symptoms are seen in about one-third to one-half of patients.
    - But patient rarely is able to express the typical pathological feelings of sadness, unhappiness, and preoccupation with depressing topics, hopeless and loss of self-esteem
    - Anhedonia (Lost of interest in previously pleasurable stimuli),
    - Expression of somatic concerns and anxiety,
    - A subjective unpleasant experience of fear manifested as apprehension, tension, panic,
    - Worry associated with autonomic activation and

- Observable physical and motor manifestations of tension
- Anxiety has been reported to occur in about 24% to 65% of persons with dementia and is often associated with dysphoria and agitation
- Apathy, a disorder of motivation with additional loss or diminished goal-directed behaviors, cognitive activities and emotions/ Occurs in 48% to 92% of patients
- Sometimes delusions are also present in dementia. The delusions are typically less complex and organized than those observed in non-demented psychotic patients and the usual content of delusional thoughts involves suspiciousness, abandonment, and misidentification theft and infidelity, as well as Phantom Boarder Syndrome (belief that an unseen person is living in the home).
- Dementiaalso presents with hallucinations at some time during the course of the illness. Visual hallucinations remain the most prominent.
- Particularly common in subjects with dementia with Lewy bodies, and typically consist of well-formed images of animals or persons that the patient describes in detail.
- Irritability and mood lability occur in about 35% to 54% of patients with dementia and these behaviors become more frequent as the disease progresses. Affective lability is characterized by rapid emotional shifts, within seconds or minutes
- Pacing, wandering, rummaging, picking, and other stereotyped, purposeless behaviors, which are more common in moderate-to-severe stages of disease, are seen in 12% to 84% of patients with dementia.
- Euphoria is less common in these patients, with a prevalence rate of approximately 3.5% to 8%
- Sleep disturbance is found in approximately 25% of patients with dementia. Includes hypersomnia, insomnia, sleep-wake cycle reversal, fragmented sleep, and rapid eye movement sleep behavior disorder
- Appetite changes can be quantitative (anorexia or hyperphagia) or qualitative (preference for particular foods associated or not to changes in taste). The preference for sweets is particularly frequent in fronto-temporal dementia.

- Disinhibition characterized by tactlessness and impulsivity occurs in 36%

- Predispositions
  - Gender
    - Aggressiveness or aberrant motor behavior has been more frequently reported in men with dementia whereas female gender has been associated with depressive/anxious symptoms and verbally agitated help-seeking behavior.
    - In one study, female elderly with VaD had more neuropsychiatric symptoms than male elderly.
    - In other studies, age and gender did not influence the likelihood of BPSD manifestation in AD or VaD.
  - Those with a family history of depression are at increased risk for developing major depressive episodes.
  - Psychological factors such as premorbid neuroticism and low frustration tolerance.
  - Early onset AD patients showed fewer BPSD than their late onset counterparts, particularly delusions, hallucinations, agitation, disinhibition, and aberrant motor behavior although this was not confirmed by a recent study
- Pathophysiology
  - Both Anatomical and Biochemical changes within the brain.
    - Pathological changes in the cholinergic system cause BPSD via the denervation of the frontal and temporal cortices.
    - Higher levels of norepinephrine in the substantia nigra and
    - Lower levels of serotonin in the pre-subiculum are seen in patients with BPSD.
    - Neuritic plaques and tangles in the frontal and temporal lobes
    - Persons with DMS showed increased electroencephalogram delta power over the right hemisphere, and their computed tomography scans demonstrated more severe right frontal lobe atrophy.

    - In addition the number of pyramidal cells in area ca1 in patients with DMS was lower than in patients without DMS.
    - Chronic elevation of inflammatory mediators
    - Altered serotonin metabolism
    - Reduced neurotrophic activity
    - Changes of Gabaergic plasma levels observed in final stages of AD have also been associated with depression, apathy, and aggressive behaviors
    - Post-mortem and in vivo studies suggest that AD is associated with a dysfunctional dopaminergic system, since reduced levels of dopamine (DA) and homovanilic acid, as well as altered DA receptor density, have been described in discrete brain regions coinciding with the mesocorticolimbic pathway
    - Neuroimaging studies in AD have been consistently showing a significant association between apathy and changes in the brain reward system including atrophy, hypoperfusion and hypometabolism in the anterior cingulated gyrus and orbitofrontal areas.
- Genetics
    - Apolipoprotein E (ApoE) 3/4 genotype had higher rates of depression and psychosis
    - While anxiety and sleep disorders appeared more frequently in patients who had ApoE epsilon 3 allele
    - A study by Holmes et al 54 of subjects with late-onset AD found an association between serotonin receptor polymorphism and BPSD.
    - The presence of the C102 allele was associated with visual and auditory hallucinations, and the presence of the Ser23 allele was associated with visual hallucinations

- Measure the extent of behavioral and psychiatric disturbance
    - Evaluate the degree of social support by means of
        - Interview with the patient
        - Caregiver interview

- Standardized clinical assessment
  - BEHAVE-AD , evaluating the presence and severity of 25 behavioral symptoms in 7 symptomatic categories
  - Currently, one of the most extensively used instruments to assess BPSD is the Neuropsychiatric Inventory (NPI) whose validity and reliability has been well established in several languages.

- Management
  - Antipsychotics for Psychosis
    - Despite serious side effects, including extrapyramidal symptoms, sedation, tardive dyskinesia, gait disturbances, falls, anticholinergic side effects, cerebrovascular events, and increased mortality, antipsychotic are still widely used off-label.
    - Risperidone, olanzapine, and haloperidol appear to be more effective for managing BPSD
    - But a recent study on dementia patients reported a 1.5-fold increase in mortality associated with the use of haloperidol, compared to risperidone, olanzapine or Quetiapine
  - Antidepressants for Depression
    - Antidepressants can be effective and well-tolerated.
    - Some authors found that citalopram and sertraline could improve symptoms of agitation and psychosis in subjects with dementia with similar efficacy, but better tolerability and safety, than haloperidol and risperidone
    - Donepezil, galantamine, or rivastigmine have all shown a modest effect on the broad spectrum of neuropsychiatric symptoms in dementia
  - Anxiolytics for Anxiety symptoms
    - Benzodiazepines may be used at short-term for acute agitation or agitation associated with anxiety

  - Non Pharmacological
    - Reminiscence Therapy

        - Reminiscence involves exchanging memories with the old and young, friends and relatives, with caregivers and professionals, passing on information, wisdom and skills. It is about giving the person with Alzheimer's a sense of value, importance, belonging, power and peace.
    - Different Mediums used for Reminiscence Therapy and Activities
        - Visually: photographs, slides. Painting pictures, looking at objects of autobiographical meaning.
        - Music: using familiar tunes from the radio, C.Ds, or making music using various instruments.
        - Smell or taste: using smell kits, different foods
        - Tactile: touching objects, feeling textures, painting and pottery.
    - Family Psycho-education
    - Dealing with caregivers burden
- Need of Referral

EPILEPSY

- Epilepsy is a disorder of the brain characterized by an enduring predisposition to generate epileptic seizures and by the neurobiologic, cognitive, psychological, and social consequences of this condition. The definition of epilepsy requires the occurrence of at least one epileptic seizure.
- Seizure:
    - An epileptic seizure is a transient occurrence of signs and/or symptoms due to abnormal excessive or synchronous neuronal activity in the brain.
    - It is 2nd most common neurological disorder after stroke (0.8%)
    - Associated with comorbid psycho-pathologies
    - Stigma
    - Cognitive impairment
    - Accidents
    - Chronicity
    - Low Quality of life
    - Side effects of Anti-epileptics
- Operational/Practical/Clinical Definition of Epilepsy
    - At least two unprovoked seizures occurring more than 24 hours apart.
    - One unprovoked seizure and a probability of further seizures similar to the general recurrence risk after two unprovoked seizures (approximately 75% or more).
    - At least two seizures in a setting of reflex epilepsy.
- Aetiology
    - Epileptogenesis: Multiple researches on epileptic patients have come out with the following.
    - Neurodegeneration
    - Neurogenesis
    - Gliosis
    - Dendritic plasticity
    - BBB damage and Angiogenesis
    - Axonal Injury
    - Channelopathy

- Changes in extracellular Matrix

- Classification of Epilepsy
  - Partial/ Focal
    - In partial seizures the electrical disturbance is limited to a specific area of one cerebral hemisphere (side of the brain).
    - Partial seizures are the most common type of seizure experienced by people with epilepsy. Virtually any movement, sensory or emotional symptom can occur as part of a partial seizure

1. Simple Partial

    - Are a very subjective experience
    - Usually start suddenly and are very brief, typically lasting 60 to 120 seconds
    - Preserved consciousness
    - Sudden and inexplicable feelings of fear, anger, sadness, happiness or nausea
    - Sensations of falling or movement
    - Experiencing of unusual feelings or sensations
    - Sensory illusions or hallucinations, derealization depersonalization
    - A sense of spatial distortion—things close by may appear to be at a distance.
    - Déjà vu or jamais vu, laboured speech or inability to speak at all

2. Complex Partial
    - Often preceded by a seizure aura (simple partial seizure)
    - Once consciousness is impaired, the person may display automatisms such as lip smacking, chewing or swallowing. There may also be amnesia surrounding the seizural event
    - The person may still be able to perform routine tasks such as walking, although such movements are not purposeful or planned. Witnesses may not recognize that anything is wrong.

- Key Things to Remember about Partial Seizures
    - Although partial seizures affect different physical, emotional, or sensory functions of the brain, they have some things in common:
    - They don't last long. Most last only a minute or two, although people may be confused and need a lot more time (2 to 30 minutes) afterwards to recover fully.
    - They end naturally. Except in rare cases, the brain has its own way of bringing the seizure safely to an end after a minute or two.
    - You can't stop them. In an emergency, doctors may use drugs to bring a lengthy, non-stop seizure to an end. However, the average person should wait for the seizure to run its course and try to protect the person from harm while consciousness is clouded. People who have been shown how to use a Vagus Nerve Stimulator (VNS) magnet may try to stop a seizure in that way.
    - They are not dangerous to others. The movements produced by a seizure are almost always too vague, too unorganized and too confused to threaten the safety of anyone else.
    - They may become generalized
- Generalized Seizures
    - Also called, Idiopathic
    - According to the types of discharges

      A. Absence seizures (formerly called petit mal)

      B. Myoclonic seizures

      C. Clonic seizures

      D. Tonic seizures

      E. Tonic clonic seizures (formerly called grand mal)

      F. Atonic seizures (drop attacks)
    - There are a number of different PGE syndromes. Each syndrome has its own characteristic seizure type(s), typical age of onset, and specific EEG patterns. Some of these syndromes are:

        - Childhood absence epilepsy
        - Juvenile myoclonic epilepsy
        - Juvenile absence epilepsy
        - Epilepsy with generalized tonic-clonic seizures on awakening
        - Generalized epilepsies with febrile seizures
- Confirmation of Diagnosis
    - Witness
    - Fundus
    - EEG
    - Imaging
    - Metabolic
    - Comorbidities
- Management
    - Aims of management
        - The aim of therapy in epilepsies is total seizure freedom without clinically significant adverse effects.
        - The seizure type(s) and epilepsy syndrome, etiology and co-morbidity should be determined.
        - Help person with epilepsy, full and productive life
        - Tailor the treatment to the needs of patient.
    - Areas to be covered
        - Confirmation of Diagnosis
        - Informational care
        - Symptom control
            - Pharmacotherapy
            - Psychological Interventions
        - Comorbidities
        - Preventing complications
        - Taking care of the factors that affect treatment options
- Informational Care
    - Breaking the news
    - Educating about the illness
    - Stating the role of pharmacotherapy

- Life style changes
- Follow ups briefing

- Symptom Control - **Anti-epileptics**
  - Mainstay of management of epilepsies
  - Goal of AED treatment in epilepsies is to abolish seizures completely (freedom of seizures) with minimal if any drug-related adverse reactions
  - Polytherapy should be avoided if possible
  - Remember that special groups of patients with epileptic disorders require particular attention and management, Children, the elderly, women (particularly of childbearing age), and people with mental and physical disabilities.
- Medication Treatment Strategies
  - Establish an epilepsy syndrome diagnosis
  - Select medications appropriate for that epilepsy syndrome
  - From the appropriate medications, choose the agent best suited for the patient based on patient and medication characteristics
  - Initiate and titrate the medication at appropriate dosages, increments and rates to enhance tolerability
  - Increase the medication, regardless of serum levels, until complete seizure control is achieved or until persistent, unacceptable side effects occur
  - If satisfactory seizure control is not achieved, change to another; the goal should be antiepileptic drug monotherapy in each patient, when possible
- Need of Referral

MISCELLANEOUS

Overview of Personality Disorders

Personality disorders include 10 diagnosable psychiatric conditions that are recognized and described in the fifth and most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Each is a distinct mental illness and not, as the name suggests, a flaw or quirk in someone's personality but rather are defined by personality styles that can be troubling enough to create problems with relating to other people in healthy, normal ways.

Note, though, that there are many comorbidities between personality disorders, meaning that a person who meets the criteria for one personality disorder will often also meet criteria for one or more additional personality disorders.[1]

One recent study, funded by the National Institute of Mental Health, found that about 85% of people with borderline personality disorder also meet diagnostic criteria for at least one other personality or mood disorder.

Personality disorders tend to appear in adolescence or early adulthood, continue over many years, and cause a great deal of distress. During that time they can cause enormous conflict with other people, cause relationships to fail or prevent them from developing in the first place, interfere with someone's ability to function appropriately in social situations and get in the way of reaching life goals.

Clusters

The DSM-5 organizes the ten personality disorders into three groups, or clusters, based on shared key features.

Cluster A

These personality disorders are characterized by odd or eccentric behavior. People with Cluster A personality disorders tend to experience major disruptions in relationships because their behavior may be perceived as peculiar, suspicious, or detached.

Cluster A personality disorders include:

- Schizotypal Personality Disorder features odd speech, behavior, and appearance, as well as strange beliefs and difficulty forming relationships.
- Paranoid Personality Disorder affects between 1 percent and 2 percent of adults in the U.S. Symptoms include chronic, pervasive distrust of other people; suspicion of being deceived or exploited by others, including friends, family, and partners; angry outbursts in response to deception; and cold, secretive, or jealous behavior.
- Schizoid Personality Disorder is characterized by social isolation and indifference toward other people. It affects more men than women. People with this relatively rare disorder often are described as cold or withdrawn, rarely have close relationships with other people and may be preoccupied with introspection and fantasy.

Cluster B

The "Cluster B" personality disorders are characterized by dramatic or erratic behavior. People who have a personality disorder from this cluster tend to either experience very intense emotions or engage in extremely impulsive, theatrical, promiscuous, or law-breaking behaviors.

Cluster B personality disorders include:

- Borderline Personality Disorder is characterized by emotional instability, intense interpersonal relationships, and impulsive behaviors.
- Histrionic Personality Disorder features a need to always be the center of attention that often leads to socially inappropriate behavior in order to get attention. People with this disorder may have frequent mood swings as well.
- Antisocial Personality Disorder tends to show up in childhood, unlike most other personality disorders that don't appear until adolescence or young adulthood. Symptoms include a disregard for rules and social norms and a lack of empathy for other people.
- Narcissistic Personality Disorder is associated with self-centeredness, exaggerated self-image, and lack of empathy for others.

Cluster C

Cluster C personality disorders are characterized by anxiety. Individuals with personality disorders in this cluster tend to experience pervasive anxiety and/or fearfulness.

Cluster C personality disorders include:

- Dependent Personality Disorder involves fear of being alone and often causes those to have the disorder to do things to try to get other people to take care of them.
- Obsessive-Compulsive Personality Disorder is characterized by a preoccupation with orderliness, perfection, and control of relationships. It's not the same as obsessive-compulsive disorder (OCD).
- Avoidant Personality Disorder can show up during childhood. It's characterized by a disregard for rules and lack of empathy and remorse.

Culture Bound Syndromes:

It appears that a mentally normal person in one society or culture may not be considered normal in other setups due to existence of a great deal of trans-cultural variations across the globe.1 If a person speaks and laughs too much, if one is violent or unduly undermined in behaviour, resorts to deliberate self-harm, disinhibited and odd in expression and behaviour and/or very unstable in emotional discharge, he can perhaps be labeled as "psychic or mentally disturbed" in one socio-cultural sect while not in other.2 Human beings are very complex in nature and for them it is not possible to maintain a particular mood and expression throughout twenty-four hours of the day. This is a very important point especially for evaluation of mental health.

Possession States

- These occur widely across a number of traditional societies and usually affect women who assert that they are possessed by a spirit, which may be a god or a demon. There is a dramatic change in behaviour and in voice, and unusual desires are expressed. Possession states usually occur in the context of a ritual designed to encourage their induction and are transient. They are usually not

maladaptive but rather to help people cope with everyday life and its attendant misfortunes

Koro

- This occurs in South-East Asia and affects Chinese people. Patients are usually males, who believe that the penis is withdrawing inside the abdomen. This results in a panic as the person also believes that once the penis has completely retracted he will die. Remedial action is taken by tying the penis with strings and getting help from relatives and friends. It can affect females as well and may occur individually or in epidemics. Koro responds to reassurance and education. In psychiatric terms, koro is an anxiety state and is not delusional.
- Koro epidemics have been described in other cultures including Thailand (*rok joo*) and Assam in India (*jinjina bemar*).
- Koro-like states characterized by fear of the penis shrinking have been described in individuals from outside South-East Asia, but these patients do not show the other features of koro and have a history of psychiatric conditions including anxiety, depression and schizophrenia

Other Culture-Bound Conditions

- Apart from the well-known entities described earlier there are a number of other conditions:
- **Dhat**: it is seen in Pakistan where a number of ailments are attributed to semen loss. Similar beliefs prevail in other Asian countries. Dhat has been variably defined as discharge of semen only or any whitish discharge, the loss of which the patient perceives to be debilitating. In a study, about 25% of the patients diagnosed as having Dhat disorder did not report passage of Dhat through urine

Psycho-Sexual Disorder:

- Disorders of Sexual Preference
- Decrease Libido
- Increase Libido
- Erectile Dysfunction
- Premature Ejaculation
- Issues of Homosexuality

LEGAL AND ETHICAL ISSUES IN PSYCHIATRY

Medical Ethics:

- Medical ethics is the study of the moral aspects of a doctor's professional life.
- Two branches of ethics relevant to a medical professional are:-
    1. Normative Ethics: Established norms of conduct, that provide theoretical framework & principles to guide a doctor dealing with a practical problem. e.g. Taking informed consent from an illiterate man
    2. Descriptive Ethics: Study & compilation of the data on the actual moral behavior and beliefs expected by the society as regards behavior of the doctors, medical issues and dilemmas. e.g. Use of public money on addicts treatment etc

Codes of Medical Ethics:

- Physician should uphold the dignity and honor of his profession with prime objective of rendering service to humanity.
- Physician should try continuously to improve medical knowledge and skills
- Should maintain the medical records of the patients
- Should display the registration number in clinic, on prescription, certificate etc.

Ethics in Psychiatry:

The word ethics is derived from the word Ethikos meaning rules of conduct that govern natural disposition in human beings. According to Britannica Encyclopedia it is systematic study of the ultimate problems of human conduct. Dorland's dictionary defines it as the values and guidelines that should govern decisions in medicine. Aim of the ethics is to deal with relations between people in different groups and often entail balancing rights. A sound ethical mindset is required in psychiatry, particularly important due to the facts that:

- Line of demarcation between normal and abnormal is hazy, validity of diagnosis and treatment can be questioned
- Psychiatric treatment can be used for vested interests

- Close relationship between therapist & the patient can lead to intense transference which could be maliciously utilized
- Poor insight may affect patient's decision making
- Confidence reposed in therapist may be exploited

Ethical Principles:

- **Autonomy**: Sufficient time and information is given to understand the benefits, risks and cost of all reasonable options.
    - Honoring individual's right not to hear every detail, even choosing someone else to decide the best course of the treatment
    - Influence limited to persuasion, not coercion.

- **Beneficence**: It is an ethical principle that addresses the idea that a physician's actions should promote good.
    - Doing good is thought of as doing what is best for the patient.

- **Non-Maleficence:** It is an ethical principle that states that do no harm to your patient.
    - Careful in decision making and action and should be adequately trained in what is being done.
    - Open to seeking second opinions
    - Avoid creating risk by action or inaction.
    - Helpful effects should overweigh the harmful ones.

- **Justice**: Aristotle wrote, "Justice involves treating equals equally and those not equal differently."
    - Concerns issues of reward and punishment and equitable distribution of social benefits.

Professionalism:

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. A physician should avoid professional misconducts which are:

- Advertisement and touting
- Association with drug companies – favours
- Employer-fee splitting
- Alcoholic behaviour
- Adultery

- Human rights violation
- Prescribing or dispensing secret medicines
- Breach of confidentiality without an appropriate reason.
- Not taking appropriate consent
- Violation of guidelines while conducting the research
- Conducting procedures without sufficient training.

Basic Human Rights & Protection of Human Rights

Legal Issues:

Criminal Responsibility: Law considers everyone to be sane unless proved otherwise. For defense contrary has to be proved.

Criminal responsibility is based on McNaughten Rule(s). It says, "Nothing is an offence, which is done by a person, who at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law."

If a person who has committed a crime is incapable of understanding the consequences of their acts and was unaware of the fact that the act was wrong under law, then such a person would not be punished. The plea of insanity is generally raised in murder cases.

Fitness to Plead: Fitness to plead is the capacity of a defendant in criminal proceedings to comprehend the course of those proceedings.

If a person with unsound mind, cannot understand the proceedings of the court nor he is able to defend himself in proper way. His lawyer can opt for the fitness to plead/fitness for stand trial. If the person is found not fit for standing a trial, the trial will remain halted till his fitness is regained.

Sindh Mental Health Act, 2013

How to get a mentally ill person hospitalized & Role of Medical Officer:

Process of Admission

- For all involuntary admission (Form-III) need to be filled by attendant of patient & addressed to:
  - In-charge of facility in case of admission by family
  - Magistrate in legal case for issuance of admission order (Form-IV)
- Form III should be accompanied medical certificate from two Medical Officers or psychiatrist on Form-V.

Urgent Admission

- For urgent admission under section-12 patient can be admitted on recommendation of one MO on Form-XI
- It cease to work after 72hours unless recommendation of second Medical Officer /Psychiatrist is received who can be in-charge of psychiatric facility.
- Meanwhile application admission for assessment can be move to magistrate.
- No application is required for emergency holding for 24 hours under Section-13
- Beside these formal admissions Section-8 allows psychiatrists to have informal voluntary admissions.

Miscellaneous

Attempted Suicide & Issues of Blasphemy: A person who attempts suicide or found to be involved in any act of Blasphemy shall be assessed by an approved psychiatrist and if found to be suffering from a mental disorder shall be treated appropriately under the provisions (Section 49)

MASTER TRAINING WORKSHOP

LEARNING OUTCOMES:

By the end of this training workshop, the master trainers will be able to:

1. Understand the areas of Master Training
2. Teach Primary Care Physicians regarding Common Psychiatric Illnesses
3. Develop the psychiatric assessment, communication and therapeutic skills in Primary Care Physicians
4. Induce Advocacy for Mental Health among Primary Care Physicians
5. Convey the Legal and Ethical issues in Mental Health to Primary Care Physicians

FORMAT OF TRAINING SESSIONS FOR PRIMARY CARE PHYSICIANS

Format of Training Sessions should include:

- Introduction of Participants
- Advocacy of Mental Health
- Experience Sharing of Every Day Clinical Practice in Mental Health by both facilitator & participants.
- Participants Interaction
- Peer Discussion
- Case Vignettes
- Scenario Based Learning
- Role Play Activities
- Assessment of Participants(skills and knowledge to teach and train)
  - Assessment should be formative in nature where:
    - Knowledge should be assessed through MCQs
    - Skills should be assessed through practical sessions (peer- and facilitator-assessed role plays)
    - Attitude change should be assessed byrole plays and observations from supervision

CONTENTS FOR TRAINING OF PRIMARY CARE PHYSICIANS

1. **INTRODUCTION TO PROGRAM**
    a. Psychiatric Problems commonly seen in General Practice
    b. Scope and Need of Mental Health Service Delivery in Primary Care General Health Clinical Practice.
    c. Classification Systems of Psychiatric Disorders

2. **OVERVIEW OF ASSESSMENT OF MENTAL HEALTH PROBLEMS IN GENERAL PRACTICE**
    a. The principles of assessment, including indicators of "abnormal" behavior, as symptom or sign
    b. Psychiatric History Taking
    c. Mental Status Examination
        i. Assessment of Mood
        ii. Assessment of Speech
        iii. Assessment of Psychotic Features (Hallucinations & Delusions)
        iv. Assessment of Abstract & Judgement
        v. Assessment of Insight
    d. Risk Assessment (Homicidal & Suicidal)
    e. Assessment of Functionality & Functionality Impairment
    f. Rating Scales – GAD -7 & PHQ 9
    g. Role Playing, Group Activities

3. **PRINCIPLES OF GENERAL MANAGEMENT OF MENTAL HEALTH PROBLEMS IN GENERAL PRACTICE**
    a. Common Principles of Management
    b. Pharmacotherapeutic Management
    c. Non-pharmacologic Management
        i. Counselling
        ii. Crisis Intervention
        iii. Structured Problem Solving
        iv. Relaxation therapy.
        v. Psychotherapy

4. ANXIETY DISORDERS

a. Introduction and Epidemiology
b. Types of Anxiety Disorders
c. Phobic Anxiety Disorder
d. Panic Disorder
e. Generalized Anxiety Disorder
f. Obsessive Compulsive Disorder
g. Acute Stress Disorder
h. Post-Traumatic Stress Disorder

For Individual Anxiety Disorder

i. Diagnostic Criteria
    i. Clinical Features
    ii. Mental Status Examination
j. Differential Diagnosis (General Medical Conditions and Substances inducing Anxiety)
k. Management
    i. Pharmacological
    ii. Non pharmacological
l. Need of Referral

5. DEPRESSION AND OTHER AFFECTIVE DISORDERS

a. Types of Affective Disorders
b. Introduction and Epidemiology

DEPRESSION

c. Diagnostic Criteria
    i. Clinical Features
    ii. Mental Status Examination
d. Differential Diagnosis (General Medical Conditions overlapping with Depression)
e. Management
    i. Pharmacological
    ii. Non pharmacological
    iii. Special population
f. Need of Referral

BIPOLAR AFFECTIVE DISORDER

g. Diagnostic Criteria
    i. Clinical Features
    ii. Mental Status Examination
h. Management
    i. Pharmacological
i. Need of Referral

6. SOMATOFORM DISORDERS

a. Introduction and Epidemiology
b. Clinical Features
c. Types of Somatoform Disorders
d. Assessment & Diagnosis
e. Differentials
f. Management
    i. Pharmacological
    ii. Non pharmacological
g. Need of Referral

7. PSYCHIATRIC EMERGENCIES

SUICIDE

VIOLENT BEHAVIOR

Others (Substance Withdrawal, Panic Attack & Drug Induced Dystonia)

a. Identification of Psychiatric Emergencies
b. Evaluation of the Cause of the Emergent Psychiatric Presentation
c. Risk Assessment
d. Management
    i. Seclusion / Restrain
    ii. Coordination
    iii. Pharmacological
    iv. Non-Pharmacological
e. Extrapyramidal Symptoms & Neuroleptic Malignant Syndrome
f. Need of Referral

8. SUBSTANCE USE DISORDERS

a. Types of Psychoactive Substances
b. Types of Substance Use Disorder
    i. Acute Intoxication
    ii. Withdrawal State
    iii. Dependence Syndrome
    iv. Harmful Use
c. Assessment of Behavioral Problems/ Psychosis
d. Assessment of Complications
e. Management
    i. Pharmacological Management of:
        1. Symptoms
        2. Withdrawal State
    ii. Non-pharmacological
f. Follow Up Care
g. Need of Referral

9. SCHIZOPHRENIA& OTHER PSYCHOTIC DISORDERS

a. Identify Cases of Psychosis
b. Preliminary Assessment of Psychosis
c. Pharmacological Management of Psychosis
d. To understand dosages, duration and side effects of commonly used antipsychotics
e. Effective follow-up care of patients with psychosis
f. Need of Referral

10. EMOTIONAL, BEHAVIOURAL AND DEVELOPMENTAL DISORDERS IN CHILDREN AND ADOLESCENTS

a. Introduction and Epidemiology
    i. Etiology of Childhood Psychological Problems/Disorders
    ii. Types of Psychological Problems observed in Children /Adolescent
        1. Learning Disorders (Specific Learning Disorders)
        2. Pervasive Developmental Disorders (Autism)
        3. Mental Retardation / Intellectual Disability

4. Attention Deficit Hyperactivity Disorder
5. Conduct Disorder
6. Childhood & Adolescent Depression

b. Clinical Presentations
   i. Emotional problems in Children and Adolescents
   ii. Behavioural problems in Children and Adolescents
c. Assessment of Problems:
d. Management
   i. Pharmacological
   ii. Non Pharmacological
   iii. Preventive Approaches
e. Need of Referral

11. PSYCHIATRIC PROBLEMS IN ELDERLY

a. Introduction and Epidemiology
b. Types of Psychiatric Problems in Elderly
   i. Dementia
   ii. Delirium
   iii. Depression
   iv. Psychosis

DEMENTIA

c. Clinical Presentation
d. Assessment (ADL, BPSD & Memory Impairment)
e. Management
   i. Pharmacological
   ii. Non Pharmacological
   iii. Preventive Approaches
f. Need of Referral

12. EPILEPSY

a. Introduction and Epidemiology
b. Etiology & Classification of Epilepsy
c. Clinical Picture

d. Diagnosis &Differential Diagnosis
e. Assessment
f. Management
    i. Pharmacological
    ii. Non pharmacological
    iii. Special population
g. Need of Referral

13. MISCELLANEOUS

a. Overview of Personality Disorders
b. Culture Bound Syndromes in relation to Pakistan
c. Psychosexual Disorder
    i. Issues of Homosexuality

14. LEGAL AND ETHICAL ISSUES IN PSYCHIATRY

a. Protection of Human Rights
b. Care of Mentally Ill in Community Settings & in Hospital
c. Ethics in Psychiatry
    i. Ethical Principles
    ii. Ethical Requirements
    iii. Misconducts
    iv. Ethical Issues pertaining to Mental Health in community
d. Legal Issues
    i. Criminal Responsibility
    ii. Civil Responsibility
        1. Marriage
        2. Adoption
        3. Transfer of Property
        4. Right to Vote
e. Orientation to Sindh Mental Health Act, 2013
f. Miscellaneous
    i. Attempted Suicide
    ii. Issues of Blasphemy

Office Use Only		PHQ-9		GAD-7		Global	

نام

تاریخ

گزشتہ 2 ہفتوں کے دوران، آپ کو درجِ ذیل مسائل کی وجہ سے کتنی مرتبہ مشکل پیش آئی ہے؟

PHQ-9	خانے میں اپنے جواب کی نشاندہی کرنے کے لئے " ✓ " استعمال کیجئے	بالکل نہیں	کئی دن	آدھے دن سے زیادہ	تقریباً روزانہ
1	کچھ بھی کرنے میں بہت کم دلچسپی یا خوشی ہوتی ہے۔	0	1	2	3
2	پژمردہ، افسردہ یا ناامید ہونا۔	0	1	2	3
3	سونے یا سوئے رہنے میں مشکل ہونا، یا بہت زیادہ سونا۔	0	1	2	3
4	تھکان محسوس کرنا یا بہت کم توانائی محسوس کرنا۔	0	1	2	3
5	بھوک میں کمی یا بہت زیادہ کھانا۔	0	1	2	3
6	اپنے متعلق برا محسوس کرنا ۔ یا یہ کہ آپ ناکارہ ہیں یا آپ نے خود کو یا اپنے خاندان کو مایوس کیا ہے۔	0	1	2	3
7	کسی کام میں توجہ مرکوز کرنے میں مشکل ہونا، جیسے کہ اخبار پڑھنا یا ٹی وی دیکھنا۔	0	1	2	3
8	اتنا آستہ حرکت یا بات کرنا جسے دوسرے لوگ محسوس کر سکتے تھے؟ یا اس کا الٹ ۔ اتنی بے چینی محسوس کرنا کہ آپ معمول سے زیادہ حرکت کریں۔	0	1	2	3
9	اس قسم کے خیالات آنا کہ آپ کا مر جانا ہی بہتر ہے یا خود کو کسی طریقے سے تکلیف پہنچانے کے بارے میں سوچنا۔	0	1	2	3

GAD-7	خانے میں اپنے جواب کی نشاندہی کرنے کے لئے " ✓ " استعمال کیجئے	بالکل نہیں	کئی دن	آدھے دن سے زیادہ	تقریباً روزانہ
1	حواس باختہ، مضطرب یا بے بس محسوس کرنا	0	1	2	3
2	فکر کرنا بند نہ کرنا یا اس پر قابو نہ پانا۔	0	1	2	3
3	مختلف چیزوں کے بارے میں بہت زیادہ فکر کرنا۔	0	1	2	3
4	سستانے میں مشکل محسوس کرنا۔	0	1	2	3
5	اتنا بے چین محسوس کرنا کہ ایک جگہ بیٹھنا مشکل ہو۔	0	1	2	3
6	بہت آسانی سے ناراض یا غصہ ہو جانا۔	0	1	2	3
7	یہ ڈر محسوس کرنا کہ کچھ برا ہونے والا ہے	0	1	2	3

اگر آپ نے مذکورہ بالا مسائل پر نشان لگائے ہیں تو ان مسائل نے آپ کے کام کرنے، گھر میں صورتِ حال سے نمٹنے، یا دوسرے لوگوں کے ساتھ تعلقات رکھنے کو کتنا مشکل بنایا ہے؟

☐ بالکل مشکل نہیں بنایا ہے ☐ کچھ حد تک مشکل بنایا ہے ☐ بہت مشکل بنایا ہے ☐ حد سے زیادہ مشکل بنا ہے

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Suicide: a global problem that requires local solutions

Suicide is one of the most personal yet one of the most complex acts anyone can perform. It continues to be a major global public health problem. According to the World Health Organisation worldwide, approximately 800,000 people died by suicide in 2018. This is despite the fact that there have been significant advancements in the fields of science and technology, of material wealth and living conditions as well as in the early diagnosis and effective treatment of many mental disorders, including mood disorders.

Almost 80% of suicides take place in developing countries. Currently the highest suicide rates (per 100,000 population) are recorded in Lithuania, Russia, Lesotho, Zimbabwe and Suriname, though the actual number of people who kill themselves is highest in China and India- the two countries contributing almost 40% of global suicides.

For every suicide, there are at least 10 to 20 acts of self-harm and 100 people getting suicidal ideation.

Suicide is a complex phenomenon in which biological, psychological, social and personal factors come together at a certain point in time to make a person vulnerable to suicidal behaviour. Suicide does not happen in a vacuum. Before making an attempt on one's own life, a person passes through a 'suicidal pathway' during which he/she crosses many 'thresholds of protection'. These thresholds may include religious and social factors, family obligations, responsibility of children, legal prohibitions, etc.

However, as a person progresses along the pathway and passes along these protective barriers he/she reaches a critical 'tipping

point' or 'point of no return'. At that point, nothing matters to the subject — neither religion or legal prohibitions, nor family obligations or children, nor the effect of act on others. The suicidal person's anguish is so great that death is seen as the only way out of their predicament.

In recent years, the public health perspective of suicide has gained a lot of importance as majority of people dying by suicide are young. Their productive years of life lost (YLL) is much more as compared to those who are older. This is a huge loss to society.

Studies conducted in different countries show conclusively that mental illness is associated with the vast majority of suicides. Of these, clinical depression is the most common mental disorder. Hence early recognition and treatment of depression has the potential to prevent many suicides.

Broadly, the causative factors of suicide can be divided into distal (or upstream) and proximal (or downstream) factors. Distal factors include socio-economic conditions, poverty, unemployment, recourse to justice, while proximal factors include adverse life events such as failure in exams, relationship breakdown, trauma, loss of job etc.

Both distal and proximal factors are necessary for suicide to take place. Distal factors provide the groundwork on which proximal factors act. Many newspapers highlight only the more proximal factors. People don't kill themselves just because someone scolded them or they failed an exam. In most cases, the suicide victim was already on the suicidal pathway and the incident proved to be the final tipping point.

While more women attempt suicide, more men than women die by suicide. Traditionally, suicide rates are low in Islamic countries compared to non-Islamic ones. However, in recent years suicide rates in some Islamic countries such as Turkey, Iran, Bangladesh

and Indonesia have been increasing.

In Pakistan both suicide and attempted suicide are criminalized acts (section 329 of Pakistan Penal Code). Attempted suicide is punishable with a jail term and heavy financial penalty. In practice, though prosecution for a suicide attempt is rare, harassment of the victim and his/her family is not uncommon. Because of this and also social stigma, most people try their best to conceal the act. There is, therefore, gross underreporting of cases of suicide and attempted suicide in Pakistan.

While there are no official figures for suicides, WHO estimated that in 2012 there were 13,377 suicides and a rate of 7.5/100,000 for Pakistan. Going by this figure, it is possible there are between 150,000-300,000 acts of self-harm every year in Pakistan. Most of these cases are given medical treatment and sent home, while the psychological factors that may have precipitated the act in the first place are not addressed.

Despite the strict prohibition in Islam, incidents of suicides have been increasing in Pakistan over the last few years. The most plausible explanation is that the fine balance between the protective influence of religion and socio-economic factors appears to have been disturbed in Pakistan.

Behind every suicide there are shattered families who go through a range of emotions ranging from grief and shame to guilt, anger and despair as they try to come to grips with their loss. Many blame themselves for treating the victim harshly or not being sensitive enough to have picked up the signs earlier. Many family members become clinically depressed themselves. Postvention is the term used for the management of psychological reactions of those bereaved by suicide. It is a neglected area but one of utmost importance.

The daily reports of suicides in Pakistan show a serious public health problem that needs to be addressed on an urgent basis. There is need for national suicide prevention strategy that encompasses the elements WHO proposes for a prevention strategy: means restriction; surveillance systems, early identification and treatment of depression; responsible media reporting; crisis intervention; stigma reduction; access to services and postvention. Most of these are doable but it requires political will and commitment on the part of government and institutions. There is also urgent need for decriminalization of both suicide and attempted suicide in Pakistan

The government needs to introduce social policies that are just, fair and equitable that will address the needs of the people. Issues of poverty, unemployment, lack of health and education facilities and recourse to justice need to be addressed urgently. In Pakistan, these macro level factors contribute to the high levels of stress and despair being experienced by our population.

There is also an urgent need to establish low-cost mental health facilities, which are accessible to the poorer sections of society. All professional educational institutions must have psychological counsellors to deal with the psychological stress of their students. It is a sad indictment of our society that while we can pay lakhs of rupees to a singer to entertain wedding guests or spend the amount on lavish weddings, we cannot find the money to address some of the basic mental health issues of our population.

Most suicides are preventable. As a society we bear collective responsibility for these tragic deaths, as well as a commitment to prevent them.

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