**MENTAL HEALTH NURSING**

**UNIT1.Chapter:-Mental health & mental illness Topic:-Mental Health**                                                                                                                                 According to WHO  state of well- being in which the individual realizes him or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”.

**Mental Health can be conceptualized as:**

　　a. Part of a general health.

　　b. A balance between individual and environment

　c. An ability to maintain an alert intelligence, even temper, socially considerate behaviour and happy disposition

　　d. Adaptive responses to the stressors

**Characteristic of mentally healthy person**

　　⎫ has an ability to make adjustments.

　　⎫ has a sense of personal worth, feels worthwhile and important.

　　⎫ Solves problem largely by own effort and makes own decision.

　　⎫ free from internal conflicts.

　　⎫ has a sense of responsibility.

　　⎫ can give and accept love.

　　⎫ searches for an identity.

　　⎫ shows emotional maturity in behavior

　　⎫ has a variety of interest and live a well-balanced life of work, rest and recreation

**Mental Illness:**                                                                                                                                                  Maladaptive responses to stressors from the internal and external environment, evidenced by thoughts, feelings and behaviors that are incongruent with the local and cultural norms and interfere with the individual’s social, occupational and/or physical functioning.”                                                                                                   (Townsend, 1996)

　　Maladjustment in living that produces a disharmony in the person’s ability to meet human

　　needs and perform effectively in society, and also the person’s behavior is causing distress and

　　suffering to self and others.

**Risk Factors of mental illness**

　　1. Predisposing causes

　　2. Precipitating causes

　　3. Maintaining causes(Perpetuating factor)

　　• **Predisposing factor:** determine an individual’s susceptibility to mental illness. Eg family

　　history of mental illness

　　• **Precipitating factor**: occurs first before the occurrence of illness, for eg loss of spouse

　　• **Perpetuating factor**: Prolong the disease already existing in an individual for eg not

　　taking drugs regularly etc

**Factors affecting mental health /Causes**

**Biological factors :**

　　• **Heredity:**.The principle of differential susceptibility suggests that individual differences in heredity exist that make people susceptible to the influence of certain environments.

　　The principle of differential exposure suggests that inherited characteristics cause differing reactions from people, which in turn affect or shape the personality of the individual.

**commonest cause of mental illness is : Biological factor ( heredity)**

**• Biochemical factors**: If neurotransmitters are out of balance, message may not make

　　through the brain correctly eg dopamine, serotonin etc

**• Brain damage:** Substance abuse, long term substance abuse can cause psychosis eg

　　steroid drugs cause psychosis

**• Psychological factors** : psychological stress, severe psychological trauma in childhood

　　• **Environmental** : dysfunctional family life, poverty, unemployment,toxic substances(murcury,Lead,carbon disulfide),Nutritional factor,minerals(iodine),Infections-Rubella n measles affect brain development,Trauma, Radiation

**• Physiological factors** :**“Healthy mind in a healthy body”.** certain critical period of life e.g. puberty, postpartum,pregnancy.                                                                                       **Prevalence of Mental disorder in Nepal**

　　• Prevalence of all types of psychosis - 1-2%(severe type of mental illness)

　　• Prevalence of Neurosis - 8-10%

　　Prevalence of  personality disorder 1%

　　• Prevalence of Depression 4-5%

　　• Prevalence of mental retardation 1-2%

　　• Prevalence alcohol dependence 3-5%

　　• Prevalence of drug abuse 0.5-1%

　　Prevalence of  Epilepsy  1%

**Mental Health Services in Nepal**

　　1961 AD : 1st mental outpatient clinic in Bir Hospital by first psychiatric Dr. Bishnu

　　Prasad Sharma

　　⎫ 1965 AD. : 5 bed for inpatient service ( Bir hospital)

　　⎫ 1971 AD : Extended to 12 beds ( Bir hospital)

　　⎫ 1972 AD : 10 bedded neuro psychiatric unit in Royal Army Hospital

　　⎫ 1984 AD : 12 bedded hospital was separated from Bir hospital

　　⎫ 1985 AD : shifted to the current site at Lanankhel, Patan.

　　⎫ 1986 AD : psychiatric OPD service was started in TUTH

　　⎫ 1987 : 12 beded psychiatric inpatient unit was started

　　⎫ 1997 AD: ten bedded drug detoxification unit started in TUTH.

　　⎫ 2000 AD : IOM started Bachelor in psychiatric nursing

　　⎫ 2007 AD: Lalitpur nursing Bachelor in psychiatric nursing

　　⎫ 2016 AD : Master degree in psychiatric nursing (TUIOM)

　　⎫ 1990 AD. : The Psychiatrists association of Nepal has been established

　　⎫ 1984 AD: 1st community mental health program by United Mission to Nepal in Lalitpur.

　　Mental health policy was formulated in 2053 BS

　　Nepal Mental Health legislation was drafted in 1999 AD.

**At present -only mental hospital in Nepal is Mental Hospital,Lagankhel Lalitpur and has got 50 beds**

**Classification of mental disorders**

　　At present there are two major classifications in psychiatry:                                                   **1.ICD (international classification of mental and behavioral disorder): by   world health organization (WHO)** 10th revision, 1992)

**2. DSM (diagnostic and statistical manual of mental disorders): by American psychiatric association (APA)** fifth edition

**1. ICD (international classification of mental and behavioral disorder): by world health organization (WHO)** 10th revision, 1992)

　　• The chapter ‘F’ classifies psychiatric disorder and codes them from F00 to F99.

　　Published dates:  1949, 1955, 1968, 1978, 1994, ICD-11 was accepted by WHO's World Health Assembly (WHA) on 25 May 2019 and officially came into effect from 1 January 2022. In US an expected implementation year of 2025 has been given, but if clinical modification is determined to be needed implementation might not begin until 2027

**ICD Classification**

　　F00-09: Organic, including symptomatic, mental disorders

　　F10-19: Mental and behavioral disorders due to use of psychoactive substances

　　F20-29: Schizophrenia, schizotypal and delusional disorders

　　F30-39: Mood [affective] disorders

　　F40-49: Neurotic, stress-related and somatoform disorders

　　F50-59: Behavioral syndromes associated with physiological disturbances and physical factors

　　F60-69: Disorders of personality and behavior in adult persons

　　F70-79: Mental retardation

　　F80-89: Disorders of psychological development

　　F90-98: Behavioral and emotional disorders with onset usually occurring in childhood and adolescence

　　F99:     In addition, a group of "unspecified mental disorders".

**2. DSM (diagnostic and statistical manual of mental disorders): by American psychiatric association (APA)** fifth edition

　　Published dates:  1952, 1968, 1980, 1994,  2013

　　Published by American Psychiatric Association on 18th May, 2013.

**Total three section :**

**A. Section I** : introduction

**B. Section II:**

　　⎫ Neurodevelopment disorder

　　⎫ 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 symptoms and related disorders

　　⎫ Disruptive, impulse control and conduct disorders

　　⎫ Substance related and addictive disorders

　　⎫ Neurocognitive disorders

　　⎫ Personality disorders

　　⎫ Paraphilic disorders

**C. Section III :** Emerging measures and models

**Multiaxial assessment  system** Multiaxial assessment is a system or method of evaluation, grounded in the biopsychosocial model of assessment that considers multiple factors in mental health diagnoses

　　Multiaxial diagnosis is characterized by five axes in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR; American Psychiatric Association, 2000).

**Types of Axes By Disorder  
Axis I** provided information about clinical disorders. Any mental health conditions

**Axis II** provided information about personality disorders and mental retardation.

**Axis III** provided information about any medical conditions

**Axis IV** was used to describe psychosocial and environmental factors affecting the person

**Axis V** was a rating scale called the Global Assessment of Functioning

**¬ Mental Health Assessment** :                                                                          Process of estimating psychological and behavioral function of patient    MENTAL STATUS EXAMINATION:

　　Mental status examination is used to identify the person's present mental status.

**Definitions:**

　　"Assessment of general motor behaviour, thought, emotional functioning along with evaluation of insight and judgement of the patient's present status."-Bimla kapoor, 2002

　　"Systematic evaluation of behaviour,emotion,cognitive functions of an individual. -K Lalitha, 2007

　　The MSE is the part of the clinical assessment that describes the sum total of the examiner's observation and impressions of the psychiatric patient at the time of the interview" (Kaplan & sadock, 1998)

**The MSE is of tremendous use to the psychiatric nurse. Some of these uses are:**

　　It is a diagnostic tool. It helps formulate the nursing diagnosis after identifying the clients problems

　　It is a teaching tool. It helps the nurse teacher to teach nursing students about the psychiatric client's symptoms of illness through demonstration of symptomatology.

　　It is a research tool. It can be used to test effectiveness of various nursing interventions on the psychiatric client.                                                                                                                                    It helps to assess changes in the psychiatric client during various stages interventions

**Purposes:**

　　- To assess the psychological functions of mentally ill people.

　　- To make the accurate diagnosis

　　- To plan the effective treatment

　　¬ **Components of Mental Status Examination**

　　1. General appearance and behavior

　　2.Talk & Speech

　　3. Mood and affect

　　4. Thought and process

　　5. Perception

　　6. Attention& concentration

　　7. Orientation

　　8. Memory

　　9. Grasp of general knowledge

　　10. Abstract thinking

　　11. Judgment

　　12. Insight

**i. General Appearance** ( person's age, race, sex, civil status,  or grooming)

　　• Level of grooming:personal hygiene ,nutritional status,

　　• Level of consciousness:

　　• Behavior : normal, over friendly, aggressive

　　• Gesture : normal , exaggerated,

　　• Rapport: spontaneous, difficult, not established

　　• Attitude towards examiner: positive, negative /Movement and behavior

　　person's gait (manner of walking), posture, psycho-motor coordination, eye contact, facial expressionn:-anxious, pleasant, sad and similar behavior                                                     **Clinical implication:**

　　Agitation suggests mania, schizophrenia, anxiety, stimulant use, alcohol or drug withdrawl.

　　Fine and coarse tremors can indicate anxiety, alcohol withdrawl.

　　Motor retardation suggests catatonia, depression  or parkinson’s disease.

　　Extrapyramidal symptoms, Akathisia, Akinesia, Dyskinesia etc all suggest antipsychotic side effect.

**ii. Speech:**patient's speech, including quality, quantity, rate, and volume of speech tone,Reaction time to answer and relevance during the interview

　　Some things to keep in mind during the interview are whether patients raise their voice when responding, whether the replies to questions are one-word answers or elaboratative, and how fast or slow they are speaking.

**Clinical implication:**

　　Mutism usually suggests schizophrenia, or depression.

　　Aphasia suggests dementia.

　　Unusual use of words (eg. Echolalia, perseveration, neologism, word salad etc)  suggests schizophrenia or organic mental disorder.

　　Ganser syndrome (nonsense answers to simple questions) may suggest dissociative  disorder

　　Slow reaction in depression and fast reaction in mania.

**iii. Mood and Affect**Mood is defined in the following terms: expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation)

**a. Mood (subjective)**  Mood is the internal emotion that the patient is experiencing.

　　"sustained emotion that the patient is experiencing"                                                         Subjective: How are you feeling today?

**b. Affect (objective)**  Affect is the patient’s apparent emotion conveyed by the person's nonverbal behavior.

　　“person's outwardly observable emotional reactions”

　　Objective: Watch the consistency of mood.                                                                        **Clinical implication**: -                                                                                                          Whether the subjective and objective moods are congruent or not is noted.

**iv. Thought :**                                                                                                                     Thought should be goal directed, coherent and responsive to stimuli.

　　a. Thought formation

　　b. Thought process/ progression

　　c. Thought content (assesses what the patient is saying for indications of delusions, obsessions, phobia   thoughts of suicide etc)                                                                                                            **Clinical implications:**

　　Delusions

　　Delusion of persecution/ grandeur suggests schizophrenia, mania, stimulant intoxication etc.

　　Delusion of guilt suggests psychotic depression.

　　Delusion of partner’s infidelity suggests paranoid disorder.

　　Ideas of reference suggest schizophrenia or chronic stimulant abuse.

　　Capgras delusion (delusion of doubles) may suggest  organic psychosis  Obsessions suggest obsessive disorders.

　　Phobias are common in phobic  disorders.

　　Suicidal, as well as, homicidal  thoughts suggest depression, personality disorder, alcoholism or psychosis.

　　d. Abstract thought(ability to determine similarities & understand proverbs

**v. Perception**

　　Document information on all aspects of the patient's illusion (i.e. false perception), hallucination (i.e. perception without stimulation) and other perceptual abnormalities

　　perceptual disturbances like hallucination (auditory, visual, gustatory, olfactory, and tactile)

**Clinical implications:**

**Illusion**s suggest organic psychosis.

　　Hallucinations:-**Auditory** is more common in schizophrenia  and alcohol withdrawal.

**Visua**l suggests delirium, alcohol/ drug withdrawal or intoxication.

**Tactil**e suggests delirium or chronic stimulant abuse.

**Olfactory** and gustatory suggest **epilepsy.**

**vi. Attention and concentration**

　　Attention : ability to pay focus on particular things  (Selective perception)

　　concentration : ability to sustain attention for long time. (Sustained attention)

**Clinical implication:**

　　Defect in one or more suggest delirium, dementia or drug intoxication..

**vii. Orientation**

　　(ability to locate himself or herself) with regard to time, place, and personal identity.

　　• What time is it now? (time)

　　• Where are you now? (place)

　　• Who am I? (person)                                                                                                                      **Clinical implication:**

　　Defect in one or more suggest delirium, dementia or drug intoxication.

**viii. Memory**

　　ability to recall the past experiences and perception.                                                                Immediate  (memory within 5-10minutes)

　　Recent includes recall of the event that has happened within 24-72hours,

　　Remote (significant past)

**Clinical implication:**

　　Demented patients have trouble with recent memory.

　　Delirious patients have more global memory deficit.

**ix. Judgment**Estimate the patient's judgment based on the history or on an imaginary scenario. 

　　ability to assess a situation correctly and act appropriately within that situation.

　　• Personal Judgment: personal aim

　　• Test judgment

　　• Social judgment : response during hospital stay                                                                       **Clinical implication:**

　　Problem associated with frontal lobe.

**ix. Grasp of general knowledge**Higher number of correct answers is better interviewer always should take into consideration the patient's educational background and other training in evaluating answers and assigning scores

**x. Abstract thinking**

　　• ability to use concepts and give meaning to them.

　　• Ask the patient about similarities and dissimilarities between any substances,

**xii. Insight** :-                                                                                                                  Capacity to understand the reality.

**Insight Level**

　　It is graded in six scale :                                                                                                                    Grade1. Complete denial of illness :

　　Grade2. Slight awareness of being sick:

　　Grade3. Awareness of being sick but attributed it to external or physical factor :

　　Grade4. Awareness of being sick but due to something unknown in himself

　　Grade5. Intellectual insight:

　　Grade6. True emotional insight

**Clinical implication:**

　　Missing insight suggest psychosis.

**Difference between Psychosis and Neurosis**

**Neurosis**

　　Insight is present                                                                                                                     Contact with reality is present                                                                                                 Hallucination and delusion are absent                                                                              Personality is not affected                                                                                                    Disorganized speech absent                                                                                            Disorganized behaviour absent                                                                                           Treatment modality : Psychotherapy                                                                                               **Psychosis**

　　Insight is absent

　　Contact with reality s absent

　　Hallucination and delusion are present

　　Personality is greatly affected

　　Disorganized speech present

　　Disorganized behaviour present

　　Treatment modality : Drug Therapy

**PSYCHOTIC DISORDER**

**Psychosis** : Severe form of mental illness. Characterized by loss of contact with reality.

**Type of psychosis**

　　There are two types of psychosis. They are:

**1.Organic psychosis (organic brain disorder)**

　　Acute organic psychosis (delirium) Chronic organic psychosis (dementia)

**Delirium:** reversible condition with impairment of consciousness , disorientation.

**Dementia:** Irreversible condition (progressive) without impairment of consciousness.

　　Common Alzheimer’s disease.

**2.Functional Psychosis** (Having a psychological rather than an organic pathology)

　　A.Schizophrenia

　　B.Affective psychosis (manic depressive psychosis)

**Schizophrenia :**

　　• Previously called Dementia ( change in congition) Praecox( early onset)

　　• In 1908, Swiss psychiatrist **Eugen Bleuler** coined the word “Schizophrenia”

　　• Chronic and functional psychosis ( split of mind)                                                                  Major mental disorder n most common psychosis.

**Sign & Symptoms                                                                                                                 Positive symptoms** :**(DIDH)**

　　- **D**elusion                                                                                                                                     **I**nterference with thinking,                                                                                                   **D**isorganized speech &                                                                                                             **H**allucination                                                                                                                                 **Negative symptoms: 4A**

　　✓ **A**logia (poverty of speech/Blocking),

　　✓ **A**volition ( lack of motivation :-impaired grooming,lack of work n study),

　　✓ **A**nhedonia (inability to feel pleasure in relationship) and

　　✓ **A**ffective flattening or blunting(poor eye contact,unchanging facial expression

　　The previous version, the DSM-4, described the following five types of schizophrenia:

* Paranoid type
* Disorganized type/Hebephrnic
* Catatonic type
* Undifferentiated type
* Residual type

**paranoid schizophrenia as meeting the following criteria:**

* Delusions of persecution,grandiosity,infidelity jealousy  frequent [auditory hallucinations](https://www.medicalnewstoday.com/articles/auditory-hallucinations),hallucination of smell or test
* certain symptoms — disorganized speech, disorganized or catatonic behavior, and a lack of or inappropriate emotional response — are not prominent

**Delusions and hallucinations** are still elements of a schizophrenia diagnosis

**Disorganized schizophrenia//Hebephrenic:-** Disorganized speech thinking and behavior, as well as flat or inappropriate emotional expression.                               **Hebephrenic:-**Confused thinking and speech(Difficulty in communication) Unnessessary repetative movent are also commonD**isorganized speech and thought** are still elements of a schizophrenia diagnosis.

**Catatonic type**

**Cata:-Disturbed   Tonic:-Tone**    Characterized by marked disturbance of motor behaviour.                                                                                         Catatonia is a type of syndrome that causes a person to have abnormal physical movements, behaviors, and withdrawal.                                                                                                    Symptoms of catatonic schizophrenia may include:

* [Stupor](https://www.healthline.com/symptom/stupor) (a state close to unconsciousness)
* Catalepsy (trance seizure with rigid body)
* **Waxy flexibility** (limbs stay in the position another person puts them in)
* Mutism (lack of verbal response)
* Negativism (lack of response stimuli or instruction)
* Posturing (holding a posture that fights gravity)
* Mannerism (odd and exaggerated movements)
* Stereotypy (repetitive movements for no reason)
* [Agitation](https://www.healthline.com/symptom/agitation) (not influenced by eternal stimuli)
* Grimacing (contorted facial movements)
* [Echolalia](https://www.healthline.com/health/echolalia) (meaningless repetition of another person’s word)
* Echopraxia (meaningless repetition of another person’s movements)

**Undifferentiated type**

　　Undifferentiated schizophrenia involved symptoms that did not  fit into the paranoid, disorganized, or catatonic types of schizophrenia                                                                     (Have positive and Negative symptoms)

**Residual schizophrenia(Chronic schizophrenia)**

* Absence of prominent delusions, hallucinations,are reduced but not completely           Negative symptoms have been present  then it is called **Residual** schizophrenia

**Depending on the onset, course, and duration, we can divide psychosis into three level: They are:**

**1.Chronic psychosis**

　　Starts slowly

　　Continue for long time

　　Become chronic

　　Often has no obvious cause

**2.Acute psychosis**

　　Start suddenly

　　Usually of short duration (within a period of 2 weeks or less with psychotic features)                                                                                                                                             .May or may not have a precipitation factors.

　　Complete recover within two or three months, if proper treatment.

**3.Recurrent psychosis**:                                                                                                              occurs in episodes with the period of complete recovery in between. He/she recovered completely from the previous episodes and was perfectly normal during the period between episodes                                                                                                                                           .a. Organic Psychosis : Acute : Delirium, Chronic : Dementia

　　b. Functional/non organic Psychosis : Schizophrenia , Affective psychosis

**Treatment of Schizophrenia**

　　The acute psychotic schizophrenic patients will respond usually to antipsychotic medication.

　　According to current consensus we use in the first line therapy the newer atypical antipsychotics, because their use is not complicated by appearance of extrapyramidal side-effects, or these are much lower than with classical antipsychotics.

**Typical antipsychotics(classical neuroleptics)**

**1**.chlorpromazine, chlorprotixene, clopenthixole,   levopromazine, periciazine, thioridazine

**2**.droperidole, flupentixol, fluphenazine, fluspirilene, haloperidol, melperone, oxyprothepine, penfluridol, perphenazine, pimozide, prochlorperazine, trifluoperazine

**Atypical antipsychotics**

　　amisulpiride, clozapine, olanzapine, quetiapine, risperidone, sertindole, sulpiride

**ECT:**

　　ECT has special role in treating:

　　Schizophrenics with catatonic and affective symptoms.

　　Schizophrenics with suicidal and homicidal tendencies.

　　Refractory to drugs

　　Those requiring massive dose of neuroleptics

　　1. Pharmacological Management : 1st line of treatment

　　a.Antipsychotic drug eg haloperidole, olanzapine etc

　　b. Antianxiety drug : Lorazepam, Diazepam, Alprazolam

　　c. Antidepressant drugs :

　　2. ECT

　　3.Psychosocial treatment :

　　Individual, family and group counseling

　　Occupational and vocational therapy

　　Day care treatment programs in community setting that foster interpersonal relationships

　　• Group therapy : “social skill training

　　• Family therapy : help to decrease intra familial tensions.

**Nursing Management of Psychotic condition**

　　• Assess the intensity, frequency and duration of delusion

　　• Misinterpretation are clarified and arguments are avoided

　　• Help client try to connect stress and anxiety

　　• Accept the fact that the voices are real to the client,

　　• Avoid touching the client without warning him/her

　　• monitor food and fluid intake

　　• Assess patient’s ability to meet self care activities

　　• Provide assistenance with self care needs as required

　　• Assess the nature and severity of hallucination by asking the pt to describe

　　• Approach him in a calm, unhurried manner.

　　• Create a safe environment for the pt

　　• clear or simple words, and keep directions simple as well

　　• Assess the family members’ current level of knowledge about the disease and

　　medications used to treat the disease.

**Neurotic Disorder:-Stress related                                cover minor psychiatric conditions**

**1. Anxiety Disorder:** Anxiety disorder are blanket terms covering several different forms of abnormal and pathological fear and anxiety which came under the aegies of psychiatry at the very end of 19th century.

**RISK FACTORS:** :

　　Gender                                                                                                                                                Age                                                                                                                               Environmental Factor                                                                                                        Personality traits                                                                                                                            Heredity         **CAUSES** Brain chemistry                                                                                                                       Trauma                                                                                                                                     Medication                                                                                                                              Medical conditions                                                                                                              Nutritional deficiencies                                                                                                             Stress                                                                                                                                    **a.Generalized anxiety disorder:(common neurotic disorder)**

* persistent anxiety of at least six months duration
* Generalized,Chronic, unrealistic and excessive anxiety
* Overly concerned about  money, death,health issues, family problems ,work difficulties.

**b. Panic anxiety disorder**

**Panic disorder** involves repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). You may have feelings of impending doom, shortness of breath, chest pain, or a rapid, fluttering or pounding heart (heart palpitations). .                                                                                                                          Females are more prone(2-3 times)                                                                                         Onset:-late 20s                                                                                                                         Prevalence:-1.5-2%

**b. Phobic Anxiety Disorder**

　　A phobia is **an uncontrollable, irrational, and lasting fear of a certain object, situation, or activity**. This fear can be so overwhelming that a person may go to great lengths to avoid the source of this fear. One response can be a panic attack.                                                             The word phobia comes from **the Greek:-  (phobos), meaning "aversion", "fear" or "morbid fear"**.                                                                                                                                                 - Fear is out of proportion to the dangerousness perceived.

　　- Insight present.

　　- Leads to persistent avoidance of the particular object

　　- Gradually phobic objects become a preoccupation with the patient causing distress

**Types of phobia:-**

　　✓ **Simple phobia/ specific phobia** : fear of specific situation or objects eg:-  fear of height,animals,water,close space( More common in Children)

　　✓ **Social phobia** : fear of social situation(fear of eating,speaking in public,writing in front of others)

　　 It's a common problem that usually starts during the teenage years. For some people it gets better as they get older. But for many people it does not go away on its own without treatment.                                                                                       **Aagarophobia** :- **An intense fear of being in open places or in situations where it may be hard to escape, or where help may not be available**. People with agoraphobia are usually very anxious about having a panic attack in a public place.(fear of being alone or away from familiar setting).

**Diagnosis of Agoraphobia**To meet the DSM-5 criteria for diagnosis, patients must have marked, persistent (≥ 6 months) fear of or anxiety about ≥ 2 of the following situations: Using public transportation. Being in open spaces (eg, parking lot, marketplace) Being in an enclosed place (eg, shop, theater)

　　Phobia: an irrational fear of an object, situation or activity.

　　– Agoraphobia : Fear of being alone in public places, open spaces.

　　– Agraphobia : fear of sexual abuse

　　– Social phobia : Fear of public speaking

　　– School phobia : Fear of attending school

　　– Claustrophobia : Fear of close space

　　– Acrophobia: fear of heights

　　– Bibliophobia: fear of books

**C. Conversion disorder**

　　is a mental health condition that causes physical symptoms. The symptoms happen because your brain “converts” the effects of a mental health issue into disruptions of your brain or nervous system. The symptoms are real but don’t match up with recognized brain-related conditions.                                           Neurotic condition in which emotional distress/unconscious conflicts are expressed through physical symptoms.

　　More common in women then men ,Family History **Characteristics:**

　　- No evidence of physical disorder that might explain the symptoms

　　- Evidence of psychological stress

　　- **Primary gain**: reduce anxiety

　　- **Secondary gain** : draw attention of significant person.

　　- **La belle difference** : shows less distress about symptoms.

　　- Symptoms **does no**t produce intentionally.

　　The term “la belle indifference” is a French term, which translates to “beautiful ignorance.” La belle indifference is defined as a **paradoxical absence of psychological distress despite having a serious medical illness or symptoms related to a health condition.**

**Difference between pseudo-seizure and epileptic seizure**

　　Features Pseudo seizure Epileptic seizure

　　Duration May be prolonged Brief

　　Diurnal variation Day time Day or night time

　　Injury rare Can occur with tonic-clonic seizure

　　Tongue biting rare Can occur with tonic clonic seizure

　　Urinary incontinence rare Frequent

　　Stress factor present Absent

　　onset Gradually Sudden

**D. Post traumatic stress disorder:PTSD**

　　- Following the experience of life threatening events. E.g disaster, serious accident, rape

　　etc

　　- Symptoms include re-experiencing the original trauma, flashback, difficulty in falling a

　　sleep etc

　　- Symptoms last for more than one month

* **Major types of symptoms experienced by people with PTSD include**:                                                                                                         **Re-experiencing symptoms**, including:
  + Flashbacks or intrusive thoughts about the traumatic event
  + Intense physical or emotional reactions to reminders of the event
  + Nightmares
* **Avoidance symptoms**, including:
* Avoiding thinking or talking about the trauma
* Avoiding people, places, activities or sensations that remind you of the trauma
* **Negative changes in your thinking and emotions**, including:
* Feeling more down, depressed, angry or anxious
* Finding it hard or impossible to feel happy
* Feeling shameful or guilty
* Feeling distant from other people
* Losing interest in things you used to enjoy
* Being unable to remember important parts of the trauma
* Having more negative thoughts about yourself, other people and the world
* **Hyper arousal or emotional/physical reactivity**, including:
* Being always on guard and/or easily startled
* Having trouble concentrating
* Being quick to anger and aggression
* Doing things that are risky (e.g., impulsive sex, binge drinking)
* Having trouble sleeping

**Obsessive Compulsive Disorder**

　　People with OCD experience severe anxiety and distress. To relieve this anxiety, they perform some repetitive acts known as **compulsions**.

　　• **Compulsion** can be defined as a repetitive behavior  or mental act that  the person feel driven to  performed in  response to an obsession or according to rules that must be applied rigidly.

**Obsessive** means unwanted, irrational and intrusive thoughts, ideas or images which occur in own mind again and again in a senseless form.

**OCD can be detected by observing the compulsive behavior of a person. The most common types of symptoms are:**

**Cleanliness**: People who have a constant fear of contamination; they repeatedly wash their hands and clean the house. Repetitive hand washing to deal with contamination,

**Order**: Some people are obsessed with symmetry and order. To relieve their anxiety they can be seen rearranging books,  aligning carpets, pillows and cushions, repeatedly.

**Hoarding**: People who find it impossible to dispose of anything. They collect old newspapers, clothes, mails, and other objects for no apparent reason.

**Counting**: Such people repeatedly count their belongings and other objects used in daily life, such as the number of steps on a staircase, or number of lights in a hallway. If they lose count, they go back and start again.

**Safety**: Some people have irrational fears about safety; they are constantly checking whether the doors and windows are secure, whether the stove has been turned off, and so on.

**Management of Neurotic disorder**

**a. Psychotherapy**

**b. Behavioural therapy**

　　✓ Exposure therapy : expose to phobic object

　　✓ Systematic desensitization : gradually exposing to phobic object

　　✓ Flooding : exposing the patient directly and suddenly to phobic object

　　✓ Relaxation technique: progressive muscle relaxation

　　✓ Drug therapy : very limited role eg benzodiazepine, antidepressants

**UNIT 1PERSONALITY DISORDERS**

**PERSONALITY** • Personality is the total quality of an individual’s behavior.

**Personality Disorder**

**-type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving**.                                                                                                               -has trouble perceiving and relating to situations and people.                                                     -abnormal and maladaptive behavior that causes significant social or occupational impairment or significant subjective distress.

　　is defined as the possession of **one or more personality traits so derived from the normal that they interfere** with his well-being or adjustment to society and require psychiatric attention.

　　• **Characteristics of Personality**

　　• Personality of each individual is unique

　　• Personality is dynamic and not static

　　• Personality is the product of both heredity and environment.

**Types of personality disorder :**

**Cluster A: Odd and Eccentric**

* Cluster A (odd, eccentric)
  + Paranoid personality disorder (distrust and suspiciousness )
  + Schizoid personality disorder ( aloofness and emotional apathy)
  + Schizotypal personality disorder (latent schizophrenics)

**Cluster B: Dramatic, emotional and erratic**

1. • Antisocial Personality Disorder(disregard for the rights  of others)
2. • Borderline Personality Disorder(instability of IPR, self  image, affect and impulsivity)
3. • Histrionic Personality Disorder(self dramatizing,  attention seeking)

　　d• Narcissistic Personality Disorder(grandiose)

**Cluster C: Anxious or Fearful**

* Avoidant personality disorder (Social inhbition)
* Dependent personality disorder (Submissive behaviour)
* Obsessive-compulsive personality disorder /Anankastic (Overtly disciplined, perfectionist)

**Cluster A**

**1. Paranoid personality disorder** : very suspicious, belief that other are lying, cheating,

　　exploiting and trying to harm him.

* Pervasive distrust and suspicion of others and their motives
* Unjustified belief that others are trying to harm or deceive you,
* Unjustified Hesitancy to confide in others due to unreasonable fear that others will use      the information against you
* Perception of innocent remarks or nonthreatening situations as personal insults or attacks
* Angry or hostile reaction to perceived slights or insults
* Tendency to hold grudges
* Unjustified, recurrent suspicion that spouse or sexual partner is unfaithful

**2. Schizoid personality disorder**

　　• very limited range of emotions and poor social relationship, lack close friends.

* Lack of interest in social or personal relationships, preferring to be alone
* Limited range of emotional expression
* Inability to take pleasure in most activities
* Inability to pick up normal social cues
* Appearance of being cold or indifferent to others
* Little or no interest in having sex with another person

**3.Schizotypal personality disorder**

　　• Persons has magical thinking, odd beliefs and strange appearance, behaviors

* Peculiar dress, thinking, beliefs, speech or behavior
* Odd perceptual experiences, such as hearing a voice whisper your name
* Flat emotions or inappropriate emotional responses
* Social anxiety and a lack of or discomfort with close relationships
* Indifferent, inappropriate or suspicious response to others
* "Magical thinking" — believing you can influence people and events with your thoughts
* Belief that certain casual incidents or events have hidden messages meant only for you

**Cluster B personality**

**1. Histrionic personality disorder**

* Constantly seeking attention
* Excessively emotional, dramatic or sexually provocative to gain attention
* Speaks dramatically with strong opinions, but few facts or details to back them up
* Easily influenced by others
* Shallow, rapidly changing emotions
* Excessive concern with physical appearance
* Thinks relationships with others are closer than they really are

　　Shows excessive self-dramatization and attention seeking behavior

**2. Antisocial personality disorder**

* Disregard for others' needs or feelings
* Persistent lying, stealing, using aliases, conning others
* Recurring problems with the law
* Repeated violation of the rights of others
* Aggressive, often violent behavior
* Disregard for the safety of self or others
* Impulsive behavior
* Consistently irresponsible
* Lack of remorse for behavior

　　• unable to follow social rules and engage in antisocial acts (lying, stealing, aggressive behavior).

**3. Narcissistic personality disorde**r

* Belief that you're special and more important than others
* Fantasies about power, success and attractiveness
* Failure to recognize others' needs and feelings
* Exaggeration of achievements or talents
* Expectation of constant praise and admiration
* Arrogance
* Unreasonable expectations of favors and advantages, often taking advantage of others
* Envy of others or belief that others envy you

　　• Person has a sense of grandiosity and need admiration, lack of empathy with others, and

　　also manipulate others to fulfill own desire.

**4. Borderline personality disorder**

* Impulsive and risky behavior, such as having unsafe sex, gambling or binge     eating
* Unstable or fragile self-image
* Unstable and intense relationships
* Up and down moods, often as a reaction to interpersonal stress
* Suicidal behavior or threats of self-injury
* Intense fear of being alone or abandoned
* Ongoing feelings of emptiness
* Frequent, intense displays of anger
* Stress-related paranoia that comes and goes

　　• Shows excessive instability of mood, self-image and interpersonal relationships. Person

　　has a feeling of being emptiness inside and fear of being alone.

**Cluster C personality**

**1. Avoidant Personality disorder** :Excessive hypersensitivity to negative events, feel

　　extreme shy in social situation

* Too sensitive to criticism or rejection
* Feeling inadequate, inferior or unattractive
* Avoidance of work activities that require interpersonal contact
* Socially inhibited, timid and isolated, avoiding new activities or meeting strangers
* Extreme shyness in social situations and personal relationships
* Fear of disapproval, embarrassment or ridicule

**2. Dependent Personality disorder**: Extreme need of others for any kind of decision

　　making, lack of self- confidence,

* Excessive dependence on others and feeling the need to be taken care of
* Submissive or clingy behavior toward others
* Fear of having to provide self-care or fend for yourself if left alone
* Lack of self-confidence, requiring excessive advice and reassurance from others to make even small decisions
* Difficulty starting or doing projects on your own due to lack of self-confidence
* Difficulty disagreeing with others, fearing disapproval
* Tolerance of poor or abusive treatment, even when other options are available
* Urgent need to start a new relationship when a close one has ended

**3/. Obsessive Compulsive Disorder :**

　　✓ Shows perfectionism, orderliness to rules and regulations.

　　✓ very devoted to work interfering own family relationship and recreation.

　　✓ inability to throw even broken, useless objects

* Preoccupation with details, orderliness and rules
* Extreme perfectionism, resulting in dysfunction and distress when perfection is not achieved, such as feeling unable to finish a project because you don't meet your own strict standards
* Desire to be in control of people, tasks and situations, and inability to delegate tasks
* Neglect of friends and enjoyable activities because of excessive commitment to work or a project
* Inability to discard broken or worthless objects
* Rigid and stubborn
* Inflexible about morality, ethics or values
* Tight, miserly control over budgeting and spending money

　　Predisposing Factors of Personality Disorder  
**Hereditary Factors:** chromosomal abnormality, such as XYY pattern, XXY pattern (Klinefelter syndrome).

**Relation of personality disorder to mental disorder** e.g. schizoid personalities is considered       to be partial expression of schizophrenia.

* **Others**
  + **Maternal deprivation, especially in *antisocial personality.***
  + **Physical and sexual abuse in childhood may cause *borderline personality*.**
  + **Fixation in oral of development causes *Dependent personality.***
  + ***Paranoid personality* is due to absence of trust, which results from lack of parental affection in childhood and persistent rejection by parents leading to low self-esteem**

**Related terminologies**

**Sexual identity:** is a person's biological sexual characteristics: chromosomes, external genitalia,   internal   genitalia,   hormonal   composition,   gonads   and   secondary   sex characteristics.

**Gender identity**: is a person's sense of maleness or femaleness.

**Sexual orientation:** describes the object of a person's sexual impulses: heterosexual (opposite sex), homosexual (same sex), or bisexual (both sexes).

　　3.Management of Personality Disorder

**1. Psychotherapy:**

　　⎫ Improve perceptions of and responses to social and environmental stressors.

**2. Behavior Therapy :**

　　⎫ Social Skills Training : learn to develop social relationship

　　⎫ Exposure Therapy : gradually exposed to group

　　⎫ Assertiveness training : learn to say no

**3.Occupational Therapy :**

　　⎫ Helps the patient to increase their level of functioning

**4. Recreation Therapy :-**

　　⎫ Can assist the patient to ventilate feelings and increase socialization.

**5. Pharmacotherapy**:

　　• Antidepressants and anxiolytics : to manage anxiety & depression

　　associated with disorder.

　　• Beta adrenergic receptor antagonists (Atenolol) to manage autonomic

　　nervous system hyperactivity.

**UNIT 1Mood disorder (affective disorder)**

　　⎫ when the mood swing is excessive in severity and duration and

　　⎫ when it interferes with a person’s day to day activities.

**1. Depression :** Persistent lowering of mood , loss of interest in usual activities and diminished ability to experience pleasure.

　　According to WHO,2017 : 322 million people

**Criteria of depression according to Daily activities and social activities**

　　Some difficulty in performance and usually distressed by symptoms **(Mild)**

　　Difficulty in performance **(Moderate)**

　　Unable to perform except to a very limited extent **(Severe)**

**Risk factors :**

　　a. Decreased level of neurotransmitter **( serotonin)**

**b. Genetic** : more common in 1st degree relatives, twins

**c. Cognitive theory** : Beck (1979) identifies three cognitive distortions that he believes serve as the basis for depression:

　　1. Negative expectations of the **environment,self and Future**

**d. Personality theory** :  low self-esteem, easily overwhelmed by stress

　　etc.

　　e. Environmental factors:  violence, neglect, abuse or poverty, seasonal, low light exposure etc.

**Sign and symptoms**

**Diagnosis : DLR**

　　• **D**epressed mood, **L**oss of interest and enjoyment, **R**educed energy

　　(increased fatigibility) are most typical symptoms of depression

　　• If the symptoms of depression are present for more than 2 weeks, then

　　diagnosis can be made.

**Other common symptoms are :**

　　• Reduced concentration and attention

　　• Reduced self esteem and self confidence

　　• Ideas of guilt and unworthiness

　　• Bleak and pessimistic views of the future

　　• Ideas or acts of self harm or suicide

　　• Disturbed sleep

　　• Diminished appetite

**Somatic symptoms :**

　　• Significant decrease in appetite                                                                                                       • Lack of interest and lack of reactivity to pleasurable stimuli.

　　• Early morning awakening, at least 2 hour or more before the usual time

　　• Diurnal variation, with depression being worst in the morning.

**Classification of Depression**

**Depression according ICD-10,                                                                                           Criteria 1**

　　Depressed mood

　　Loss of interest and enjoyment

　　Increased fatigability

**Note: At least 2 in Mild and Moderate Depression. & At least 3 in Major Depression.**

**Criteria 2**

　　Disturbed sleep  (S)

　　Ideas of guilt and unworthiness (G)

　　Reduced self-esteem and confidence (E)

　　Reduced concentration (C)

　　Loss of appetite (A)

　　Pessimistic thinking (P)

　　Ideas of self harm (S)

**Note: At least 2 in Mild, 3 in  Moderate Depression &  At least  4 in Major Depression.**

**Criteria 3**

　　Duration: At least of 2 weeks

* **Daily activities and social activities**
  + Some difficulty in performance and usually distressed by symptoms (Mild)
  + Difficulty in performance (Moderate)
  + Unable to perform except to a very limited extent (Severe)
* **DSM V criteria** Theindividual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either  depressed mood or loss of interest or pleasure

**“SIG E CAPS”,**

* Sleep, Interest/ depressed mood, Guilt
* Energy
* Concentration, Appetite, Psychomotor, and Suicidal ideation.

**Management**

　　• For severe depression with suicidal tendencies, hospitalization is required.

　　• Mild to moderate depression can be treated in OPD basis.

**Medication • Drug therapy:** antidepressant drug, it takes at least 2-4 weeks for the

　　clinical improvement of cases.

**Note:-SSRI is first line treatment**

　　Avoid Tyramine diet while taking MOAI

**• Electro- convulsive therapy(ECT)** effective physical method of treatment for major depression with suicidal tendencies

**•** Cognitive-behavioral therapy helps people change negative thinking and behavior patterns

**2. MANIA**

　　• Extremely elevated mood, energy and unusual thought patterns lasting at least 1 week.

　　abnormally elevated, extreme changes in your mood or emotions, unusual thoughts, energy level or activity level lasting atleast 1 week,.Lifetime risk : 0.5- 1 %

　　. **The word is derived from Ancient Greek “μανία” (manía) meaning frenzy (uncontrolled  excitement or wild behaviour)**                                                                                                          **The common mnemonic “DIG FAST”**                                                                               D = During the period of mood disturbance, three or more of the following symptoms have persisted.

* D = Distractibility
* I = Indiscretion (improper judgement)
* G = Grandiosity
* F = Flight of ideas
* A = Activity increased
* S = Sleep (decreased need for)
* T = Talkativeness (pressured speech)

**Predisposing factors**

**Biochemica**l: Mania is considered to be due to an excess of biogenic amines (nor epinephrine or serotonin) and electrolyte(alteration in normal electrolyte transfer across cell membrane in bipolar disorder resulting in elevated level of intracellular Calcium.) in the brain.

**Psychodynamic perspective factors**

　　-disturbed ego development give way to a strong Id (uncontrollable impulsive behavior).

　　-viewed as the mirror image of depression –a denial of depression

**Elevated mood can pass through following stage**

**1. Euphoria** ( mild elevation of Mood) : increased sense of psychological

　　wellbeing

**2. Elation** ( moderated elevation of Mood) : feeling of confident, enjoyment,

　　increased psychomotor activity

**3. Exaltation** (severe elevation of Mood): intense elation with delusion of grandeur.

**4. Ecstasy** (very severe elevation of mood): intense sense of blissfulness

**There are three stages of mania that may be experienced.  
  
Stages of Mania**

* Hypomania (Stage I)
* Acute Mania (Stage II)
* Delirious Mania (Stage III)
* **Hypomania (Stage I):** Hypomania is the mildest form of mania, a stage characterized by decreased sleep, irritability, and euphoria. It is popularly associated with increased productivity and creativity. However, if untreated, it can lead to severe mania and death.
* **Acute Mania (Stage II):** Acute mania is the second stage towards a manic episode, characterized by lack of sleep, rash actions, lack of judgment, and, in some cases, the onset of psychosis.
* **Delirious Mania (Stage III):** Delirious mania is the most severe of the three stages of mania and requires hospitalization. A person at this stage descends into a manic episode and experiences delirium and psychos

**TREATMENT**

**1. Pharmacotherapy**

　　⎫ Mood Stabilizer : Sodium Valproate , Lithium

　　⎫ Antipsychotic drugs, Antidepressants (fluoxetine)

**2. Individual psychotherapy**:

**3. Group therapy:**

**4. Family therapy** : Family functioning and marital relationships are often

　　disrupted in clients

**5. Cognitive Therapy**

**6. Electroconvulsive Therapy**: when the client does not tolerate or fails to respond

　　to Lithium or other drug treatment

**UNIT 1.DEVELOPMENT OF PERSONALITY             CHAPTER:-FRUSTRATION,CONFLICT AND  DEFENSE                          TOPIC:-Defense Mechanism**

　　¬ First time this term was used by Sigmund Freud in 1904 AD.

　　¬ It is a psychological processes that protect an individual from anxiety, stress

　　or unacceptable feeling

**i. Compensation**

　　¬ People overachieve in one area to compensate for failures in another.

　　Examples :

　　• A student who fails in his studies may compensate by becoming the college

　　champion in athletics.

　　ii. Substitution

　　¬ A mechanism by which tension or anxiety reduced by replacing the

　　unachievable goal with achievable goal.

　　Example :

　　• A student who has not been able to get admission to the MBBS course, may

　　try to substitute it with a course of Bsc nursing.

　　iii. Rationalization

　　¬ An individual justifies his failure by making excuses or formulate logical

　　reasons.

　　Examples :

　　• A person without a vehicle says that he does not want to risk his life by

　　driving.

　　iv. Denial

　　¬ An individual refuse to face the reality.

　　Examples :

　　• Difficulty in accepting that he has some incurable disease.

　　v. Sublimation

　　¬ A mechanism that causes channelization of socially unacceptable desires

　　into acceptable form

　　Example :

　　• A young man who has lost his lover may turn to write poetry about love.

　　vi. Repression ( selective forgetting)

　　¬ Process of unconscious forgetfulness or Involuntary blocking of

　　unpleasant experiences from one’s awareness.

　　Examples :

　　• A child who is abused by a parent later has no recollection of the events, but

　　has trouble forming relationships.

　　vii. Suppression ( selective forgetting)

　　¬ Voluntary blocking of unpleasant feeling and experiences from one’s

　　awareness.

　　¬ Only one defence mechanism that occur at conscious level.

　　Examples:

　　• Refuse to talk about child’s death by parents.

　　viii. Identification

　　¬ An individual attempts to increase self worth by acquiring certain

　　characteristics of an individual one admires.

　　Example :

　　• An illiterate father often takes his son’s higher education as his own

　　achievement.

　　ix. Projection

　　¬ Placing blame for own difficulties upon others

　　¬ Others are seen as responsible for own mistakes.

　　¬ Scapegoat mechanism

　　Examples :

　　• The student who fails in her examination may feel that the teacher was

　　unfair.

　　x. Displacement

　　¬ Discharging pent up feeling to a less threatening object than those who

　　initially aroused the emotion

　　Example :

　　• A person who is angry with his boss but can not show it for fear of losing the

　　job may fight with his wife or children on return from the office.

　　xi. Regression

　　¬ An immature way of responding to a stress or go backwards, flight to

　　childhood

　　Example :

　　• Crying after hearing bad news or doing mistake

　　• Nail biting to reduce the anxiety

　　xii. Conversion

　　¬ Strong emotional conflicts which are not expressed are converted into

　　physical symptoms.

　　Example:

　　• A student who is very anxious about her examination, may develop a

　　headache.

　　xiii. Reaction Formation

　　¬ Unacceptable real feelings are repressed and acceptable opposite feelings

　　are expressed.

　　Example:

　　• Women who actually dislike her mother in law hide her negative feeling by

　　being always nice to her.

**UNIT 1.CHILDHOOD MENTAL N BEHAVIOURAL DISORDERS                                                                                   Mental Retardation:(F70-F79)**

　　A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. **ICD-10** MR is a developmental disorder characterized by impairment in cognitive ability,intellectual capacity, delay developmental milestone and social & personal adaptation.

　　Onset during the development years **(0-18 years)**

　　Common in age group  2-3yrs, peak in 10-12 years of age                                                                                   Boys are more suffering than girls

　　• IQ= ( Intelligence Quotient )Mental age/ chronological age x 100

**Levels of intelligence based on IQ levels**

　　Level of Intelligence I.Q. range

　　Idiot                            0-25

　　Imbecile                     25-29

　　Moron                       50-69

　　Boderline                  70-79

　　Low normal               80-89

　　Normal                    90-109

　　Superior                  110-119

　　Very superior          120-139

　　Near Genius            140 and over

**Cause**

　　Etiology can be identified in **70% cases**

**A .Genetic condition** :- 5%,

**Chromosomal abnormalities:-** **Down;s syndrome** ( 47 chromosome ( Extra copy of 21 no.),

**Klinefelter's, syndrome XXY)** : boys and men are born with an extra X

　　Chromosome, **Turner syndrome,** affects only females, sex chromosomes is missing

　　⎫ **Phenylketonuria** (PKU): inherited disorder that causes a build-up of

　　phenylalanine (an amino acid) in the blood.

　　⎫ **b. Problem during pregnancy:** 30 % and at birth : 10% eg maternal infection

　　, nutritional deficiency

　　⎫ **c. Problem at the time of birth** : 10 % eg prolonged labour, instrumental

　　delivery

　　⎫ **d. Health problem after birth** : 5% eg head injury, malnutrition, brain

　　infection

　　⎫ **e. Socio, cultural and environmental factor : 20%**

**Degree I.Q. Level Deficit**

**Mild MR (85-90%)**                                                                                                                      I.Q. Level 50-69                                                                                                                    Deficit:- Educable, require very little support

**Moderate MR 10%**

　　I.Q. Level 35-49                                                                                                                       Deficit:Trainable , class up to 2

**Severe MR 1-2 %**

　　I.Q. Level  20-34                                                                                                                      Deficit :- Dependent, poor motor and speech development

**Profound MR 1-2 %**

　　I.Q. Level :-Below 20                                                                                                               Deficit:-Vegetative, require nursing care for life support

**Clinical features**

　　• Failure to achieve developmental milestone

　　• Deficiency in cognitive functioning

　　• Reduced ability to learn

　　• Acting out behaviour

　　• Inability to meet educational demand of school

　　• Difficulty in solving problem and thinking logically

**Management**

　　1**. Primary Prevention**

　　• **Genetic** counseling for at risk parents ,prenatal counseling

　　•**Social** Use universal iodination of salt, government nutrition program,

**• Infection** Rubella immunization ,limiting exposure from cat litter(prevent toxoplasmosis).

　　• Administration of folic acid

**•Toxic** Reduce exposure to lead, mercury and other toxin• Avoidance of teratogen

**Natal Care**

　　• Delivery should be conducted in • Avoid prolonged, obstructed labour.

　　• Prevent from head injuries during delivery.

　　• Never shake the baby that can cause shaken baby syndrome

**2. Secondary Prevention**

　　• Early detection and treatment of preventable disorder

　　• Providing loving and stimulating environment from early childhood

　　• Early detection and management of risk babies like low birth weight babies,

　　birth asphyxia, and seriously ill baby and so on.

**3. Tertiary Prevention**

　　⎫ Providing training on self-care, vocational skills, speech therapy,

　　⎫ Advice and counsel the family

　　⎫ Provide proper information to the parents

　　⎫ Repeat the same task everyday until the child learn it.

　　⎫ Provide special education in special school under supervision of specially

　　trained teachers.

**Autism**

　　The term autism first was used by psychiatrist **Eugen  Bleuler**. **The Greek word ''autos'' mean self and the word “autism” was used by Bleuler to mean morbid self-admiration and withdrawal within self**.

　　First described by Leo Kanner in 1943 as early infantile autism “Auto” – children are “locked within themselves                                                                                                                              Autism is characterized by impairment in  Verbal and nonverbal communication          Imaginative activity  Reciprocal social interactions                                                                  Much more common in males than females (3-4:1). The cause of autism is multifactorial .     limited joint attention or orienting to one's name, reliance on nonverbal communication and delay in use of words are early measurable diagnostic symptoms and signs                                                                                                                                                    • Type of brain development disorder ,

　　• Manifest before the age of **3 years** affects the brain's normal development of social and communication skills.

　　• Impairment in social interaction, communication and repetitive behaviour

**• Poor eye contact, enjoy little symbolic solitary play** are significant clinical features, limited joint attention or orienting to one's name, reliance on nonverbal communication and delay in use of words are early measurable diagnostic signs and symptoms.                                                                                                                                        **Autism spectrum disorder (ASD)** is a developmental disability caused by differences in the brain. Characterized by impaired with social communication and interaction, and restricted or repetitive behaviors or interests**•** Type of brain development disorder,

**pervasive developmental disorders (PDD**) refers to **a group of disorders characterized by delays in the development of socialization and communication skills**. Parents may note symptoms as early as infancy, although the typical age of onset is before 3 years of age                            . **There are 5 subtypes of PDD, each with related characteristics.**

　　While all the subtypes have PDD traits, they have some differences, too.

1. **Autism:** Here, children struggle with social interaction, have rigid routines and rituals, and might have intellectual disabilities.
2. **Asperger’s syndrome:**Effectively, a milder form of autism without the intellectual disabilities.
3. **PDD-NOS *(*pervasive developmental disorder, not otherwise specified*):*** Children with PDD-NOS have the traits of autism /Asperger’s, but are more sociable.
4. **Childhood disintegrative disorder:**These children start without PDD traits but then rapidly lose their language, motor, and social skills over just a few months.
5. **Rett’s syndrome:** Here, the emphasis is on motor skill issues — i.e., problems walking, picking things up, etc. It primarily affects girls since it’s caused by a difference in the X chromosome. (Note: It’s the only PDD subtype with a clear genetic cause.)

**Attention Deficit Hyperactive Disorder(ADHD)**

　　ADHD is the most common neurobehavioral disorder   affecting school-aged children                                                                                                                                                                        is characterized by inattention, including increased distractibility and difficulty sustaining attention; poor impulse control and decreased self- inhibitory capacity; and motor over activity and motor restlessness                                                                                                                      .• Poor ability to attend to a task, motor activity and impulsivity

　　• Diagnosed after 7 years of age                                                                                                  **School phobia (Fear of School)**

　　School phobia is describing children who are avoiding/refusing to attend  school.                                                                        It  is  a symptom of other anxiety disorders.                                                                              School refusal is more likely to affect children during times of transition.

　　School phobia  is often associated with other other anxiety disorders                                                                                                                                           Another name for school phobia is didaskaleinophobia.School phobia affects about **2% to 5%** of children —  up to 1 in every 20 childrenIt's most common in young children ages **5 to 6** or middle school-age children ages **10 to 11                                                                            separation anxiety disorder**Separation anxiety is a normal part of childhood development. It commonly occurs in babies between 8 and 12 months old, and usually disappears around age 2Separation anxiety disorder (SAD) is a type of mental health problem. A child with SAD worries a lot about being apart from family members or other close people. The child has a fear of being lost from their family or of something bad occurring to a family member if he or she is not with the person. **causes separation anxiety disorder**

　　SAD is caused by both biological and environmental factors. A child may inherit a tendency to be anxious. An imbalance of 2 chemicals in the brain (norepinephrine and serotonin) most likely plays a part.

　　A child can also learn anxiety and fear from family members and others.                                                               A traumatic event may also cause SAD.

**Risk for separation anxiety disorder**

　　SAD happens equally in males and females.                                                                                                         But children who have parents with an anxiety disorder are more likely to have SAD.

**symptoms of separation anxiety disorder**

　　most common signs of SAD are:

* Refusing to sleep alone, Repeated nightmares with a theme of separation
* Too much worry about getting lost from family
* Refusing to go to school
* Fearful and reluctant to be alone ,being kidnapped or getting lost
* Frequent stomachaches, headaches, or other physical complaints Muscle aches or tension
* Being very clingy, even when at home, Crying, Panic or temper tantrums

**Treatment for SAD often involves a mix of the following:**

* **Cognitive behavioral therapy.** This treatment helps a child learn how to better handle his or her anxiety. The goal is also to help a child master the situations that may lead to the anxiety.
* **Medicines.** Antidepressant or antianxiety medicine may help some children feel calmer.
* **Family therapy.** Parents play a vital role in any treatment.
* **School input.** A child’s school may also be involved in care.

**CHILDREN BEHAVIOURAL PROBLEM                                                                                         Bedwetting (Enuresis)**

　　Enuresis is the medical term for bedwetting.                                                                        Repeated or frequent involuntary emptying of bladder or bed wetting( accidental or intentional )results after bladder control occurs.                                                                         Girls usually obtain bladder control before boys do.                                                           Diagnosed in girls older than age 5 and in boys **6**                                                                                                                            **Types of bedwetting:**

* Diurnal enuresis (wetting during the day)
* Nocturnal enuresis (wetting during the night)
* Primary enuresis (Will never attain bladder)
* Secondary enuresis (once attain bladder control then subjected to enuresis)

**key facts about urinary incontinence enuresis**

* According to the American Academy of Pediatrics (AAP), nocturnal enuresis affects 5 million children older than age 6 in the U.S.
* Nocturnal enuresis occurs more frequently in boys than in girls.
* Of the children with bedwetting, most have wetting at night.
* Primary enuresis is the most common form of urinary incontinence among

**causes urinary**

* Poor toilet training
* Delay of the ability to hold urine (this may be a factor up to about age 5)
* Small bladders
* Poor sleep habits or the presence of a sleep disorder
* A problem with the proper functioning of hormones that help to regulate urination
* Familial tendency.
* Medication that affects sleep                                                                                                                                          Enuresis is basically a symptom and not a disease state Intervention is justified for psychological benefit of child and family Problem of enuresis                                                 **should be solved with 5 “P” regimen** • Praise • Patience • Perseverance • Passion • Positive attitude

1. **General Tratement** 1. Avoid excessive fluids 2. Empty bladder at bed time 3. Told to wake up at night and use toilet to remain dry 4. Improve access to toilet 5. Include the child in morning cleaning up of urine-soiled cloths Behavioural Intervention Active participation & commitment of • parents • the child & • the pediatrician
2. **Motivation Therapy (for > 7 yrs. Old).**
3. Alarm Therapy 1. Alarm triggered when the diaper gets wet to awaken the child from sleep and stop micturition.
4. **Wet Alarm Therapy**
5. **Bladder Stretching**
6. **Pharmacotherapy 1**. DDAVP (1-deamino-8 Arginine Vasopressin) for > 4 yrs old. • Reduces nocturnal urine output to a volume lower than functional bladder capacity • Useful in those who do not manifest diurnal rhythm of vasopressin • Dose: 20 micrograms (one spray) in each nostril • Max. up to 80 micrograms Adverse Effects Hyponatremia, disorientationm seizures, coma
7. **Pharmacotherapy 2**. Anticholinergics • Oxybutenin chloride Acts by increasing bladder capacity and reducing frequency of detrusor contractions. Adverse Effects: Dryness of mouth, blurred vision, facial flushing. Dose: For > 7 yrs : 5 mg 2-3 times a day
8. **Pharmacotherapy 3**. Tricyclic antidepressants • Imipramine Alteration of sleep mechanisms and rousal pattern Cholinergic properties

* **Encopresis**                                                                                                                             Encopresis (en-ko-PREE-sis), sometimes called fecal incontinence or soiling, is **the repeated passing of stool (usually involuntarily) into clothing**.                                                          Refers to the passage of feces into inappropriate places after a chronologic age of 4 yr (or equivalent developmental level)                                                                                                            Encopresis is when a child accidentally leaks stool into his or her underwear. It is also called **stool soiling.**
* It happens to **children ages 4** and older who have already been toilet trained.
* It is most often because of long-term (chronic) constipation.
* Encopresis can cause both physical and emotional problems.
* It can be very embarrassing for your child.
* It can be helped with diet and lifestyle changes, and medicines.

**Subtypes include                                                                                                                            1. Retentive encopresis**:-Encopresis with constipation and overflow  **2. Nonretentive encopresis** Encopresis without constipation and overflow incontinence                   **Encopresis may be**                                      1.**Primary:-**persist from infancy onward                                                                             **2.secondary:-**may appear after successful toilet training                                                                     *About 2/3rd sof encopresis cases are of the retentive  and associated with chronic constipation;* In children younger than 4 yr of age, the male: female ratio for chronic **constipation is 1:1**  In the school-aged child however, **encopresis is more common in Boys**                                                       **unit 1.PSYCHIATRIC EMERGENCY**

**Suicide,Hysteria,panic attack,Anger,hostality,aggressive behaviour,Lithium Toxicity**

**SUICIDE**                                                                                                                                  willful act of ending one’s life.

**Risk factors ;**

**• Gender**: Men commit suicide more than **4 times** women attempt suicide or

　　have suicidal thoughts 3 times as often as men.

**• Age:** Among men, suicides peak after **age 45**; among women, the greatest

　　number of completed suicides occurs **after age 55.**

**• Marital Status**: the suicide rate for single, never-married persons is twice

　　that for married

**Others potential factors :**

　　Unemployed or recent financial difficulties

　　• Divorced, separated, widowed

　　• Social isolation prior traumatic events or abuse

　　• Previous suicide behaviour

　　• Chronic mental illness

　　• Chronic illness

**Five level of suicidal behavior;**

**• Suicidal ideation** : thinking about and inclination toward self injury

**• Suicidal gesture :** non lethal self injury act, including cutting or burning of

　　skin, ingesting small amount of drugs etc, attention seeking measures

**• Suicidal threats :** verbal statement that may declare person’s intent to

　　commit suicide

　　• **Suicidal attempt :** actual implementation of self injury act but not success.

**• Suicide :** ends with the fatal outcome

**Epidemiology**

**According to WHO, 2019 data :**

**• 800, 000** people die due to suicide every year.

　　• For every suicide **20 people** make a suicide attempt.

　　• Suicide accounts for **1.4%** of total death worldwide.

　　• Suicide is the **18th leading** cause of death in 2016. the

　　• Every **40 seconds** someone dies of suicide.

　　• Suicide is the 2nd  leading cause of death among 15–29-year-olds after road injury.

　　• Suicide is currently the leading cause of death for **Nepalese women aged 15–49**.

　　• **According to Nepal police data 16.5 person/day)** across the country have ended their lives.

**Warning signs of Suicide:**

　　• Loss of interest and initiative

　　• Sudden appearance of peacefulness in an agitated, depressed mood

　　• Making a will

　　• Isolates self from others

　　• Give away prized possession

　　• Talking about going away.

**Management**

　　• Talk to the patient with supportive and understanding attitude

　　• Keep patient under supervision

　　• Patient should not be left alone

　　• Treatment with medication

　　• ECT is the treatment of choice in patient with severe depression

　　• Counseling

**Suicide prevention**

　　• World suicide prevention day : **September 10**

**• Prevention for vulnerable group**

**Gatekeeper Training:** can include anyone who is strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends,neighbors, teachers, police officers etc)

**Crisis helpline:**

　　• Prevention of individual risk factor

**• Responsible media reporting** : Provide accurate information about where to seek help.

　　• Prevention of suicide at work place

　　• Restriction of access to lethal means.

**SUICIDE HOTLINES**

　　• TUTH – 9840021600, 9849630430

　　• TU, Teaching Hospital Maharajgunj, Psychiatrict Helpline 9841630430

　　• Patan hospital – 9813476123

　　• TPO Nepal – 16600102005

　　• Mental Health Helpline Nepal – 16600133666

　　• Kanti Children Hospital , Child Psychiatric Helpline: 9808522410

**What is lithium toxicity?**

　　Lithium toxicity is condition of excess ingestion of lithium either accidently or intentionally. Lithium is  a soft metal that is used to treat [bipolar disorder](https://www.healthline.com/health/bipolar-disorder) and [major depressive disorder](https://www.healthline.com/health/clinical-depression).                                                                                                                                            [Lithium](https://www.healthline.com/health/bipolar-disorder/lithium-use-bipolar) helps reduce episodes of [mania](https://www.healthline.com/health/bipolar-disorder/mania) and lowers the risk of suicide in people with these conditions.

**The reference range for therapeutic levels of lithium is 0.8-1.2 mEq/L**.                                         A safe blood level of lithium is 0.6 and 1.2 milliequivalents per liter (mEq/L).                         **Lithium toxicity** can happen when this level reaches **1.5 mEq/L or higher**.                                **Severe lithium toxicity** happens at a level of  **2.0 mEq/L and above**, which can be life-threatening in rare cases.                                                                                                                 Levels of 3.0 mEq/L and higher are considered a medical emergency.

**Early Signs of Lithium Toxicity**

　　If you have one or more of the following symptoms, you may be experiencing early lithium toxicity:

* Loss of appetite, or vomiting
* [Blurred vision](https://www.webmd.com/eye-health/why-is-my-vision-blurry)
* Excessive thirstiness
* Needing to pee frequently
* Uncontrollable urination and bowel movements
* A [lightheaded](https://www.webmd.com/brain/ss/slideshow-reasons-dizziness-lightheadedness) or drowsy feeling
* Confusion and blackouts
* Shaking, muscle weakness, twitches, jerks, or spasms affecting your face, tongue, eyes, or neck
* Slurred speech
* **Acute lithium toxicity:-** Dizziness, tremor, [feeling unbalanced or uncoordinated](https://www.webmd.com/brain/ataxia-types-brain-and-nervous-system), poor concentration, diarrhea,ataxia,muscle twitches,slurred speech,nystagmus
* **Acute-on-chronic lithium toxicity.**With this level of poisoning, you could experience gastrointestinal (GI) problems. You may also experience [neurological](https://www.webmd.com/brain/nerve-pain-and-nerve-damage-symptoms-and-causes) problems.

　　UNIT:-1MENTAL HEALTH PROBLEM IN OLD AGE                CHAPTER                                                                           TOPIC                                                                                  4.Some key points

**• Dyslexia** (reading disability): inability to translate written language received

　　from the eyes

**• Dysgraphia** (writing disability) : difficulty in expressing thoughts in writing

　　and graphing

　　• Dyscalculia ( math disability) : difficulty in learning math concepts

**• Waxy flexibility:** Parts of body can be placed in positions that will be

　　maintained for long periods of time, even if very uncomfortable;

**ATPD : Acute and Transient Psychotic Disorder:**

　　• Acute onset (within 2 weeks) of hallucination and delusion

　　• Presence of typical syndromes : rapidly changing

　　• Presence of associated acute stress

　　• If symptoms persist for more than 1 month , diagnosed as schizophrenia

　　¬ Unipolar depression (major depression) :absence of mania or hypomania,

　　¬ Dysthymic depression: chronic depression for at least 2 years.

　　¬ Bipolar Affective Disorder: manic-depressive disorder in the same patient at

　　different times.

　　¬ Cyclothymic depression : frequent period of mild depression and hypomania

　　for at least 2 years

**Attention Deficit Hyperactive Disorder(ADHD)**

　　• Poor ability to attend to a task, motor activity and impulsivity

　　• Diagnosed after 7 years of age

**Terminology related to Psychosexual disorder**.

**Paraphilia:-** persistent and recurrent sexual interests, urges, fantasies, or behaviors of marked intensity involving objects, activities, or even situations that are atypical in nature.

　　.

**Classification :**

**• Fetishism**: Sexual fantasies or behavior involving the use of non-human

　　objects to produce sexual arousal.

**• Paedophilia:** Sexual preference for children

**• Zoophilia:** Sexual activity with animals

**• Necrophilia :** sexual gratification obtained from sexual relations with a dead

　　body

**• Sexual sadism:** Sexual pleasure derived from inflicting or physical

　　suffering on another.

**• Sexual Masochism:** Sexual pleasure derived from being humiliated or

　　beaten

**• Exhibitionism:** Persistent tendency to expose the genitalia

**• Transvestitism:** Sexual excitement from wearing the clothes of opposite

　　sex

**• Frotteurism:** touching one’s genitalia against the body of another person.

**• Voyeurism:** look at people engaging in sexual activity eg video watching

**Sexual Orientation Disorder**

**Homosexuality :** sexual relationship maintained with same person eg. lesbian, gay, bisexual, transgender, intersex, and questioning **(LGBTIQ)**

**Lesbian** : Female sexually attracted to female

**Gay :** male to male

**Bisexual :** sexual orientation to both sex

**Transgender:** gender different from biological sex

**Intersex:** discrepancy between external and internal genitalia ( testes and ovaries)

**UNIT 1 SUBSTANCE AND ALCOHOL RELATED DISORDER                                   SUBSTANCE ABUSE**

　　pattern of abnormal substance use that leads to impairment of occupational,

　　physical and social functioning and

　　Minimal duration of disturbances of at least a month.

**Some terminology related to substance abuse**

**• Intoxication:** transient condition following the administration of substance resulting in       disturbances in level of consciousness.

**• Withdrawal:** development of symptoms resulting from cessation or reduction in substance use

**• Tolerance**: increasing dose is required to produce the same effects.

**• Dependence:** one cannot perform the daily activities without the use of substance.

**Criteria for diagnosis of Dependence (ICD-10)**

　　1. A strong desire to take the substance

　　2. Difficulty in controlling substance taking behavior.

　　3. A physiological withdrawal state

　　4. Development of tolerance

　　5. Progressive neglect of alternative pleasures or interest

　　6. Persisting with substance use despite clear evidence of harmful consequence

**Causes of Substance Abuse**

　　• Easy availability

　　• Biochemical factors (deficiency of brain neurotransmitter endorphins

　　predispose an individual to alcoholism)

　　• Learned behavior

　　• Social and cultural factors

　　• Psychiatric disorders

　　• Genetic

　　• Curiosity

　　• Peer pressure, Poor impulse control

　　• Poor stress management skills

　　• Lack of strict law in country

**Classification of commonly used substance:**

**a. Depressants** : Alcohol, Sedatives ,barbiturates

**Withdrawal symptoms;** Restlessness, hypertension, tremor, seizure, anxiety,

　　irritability, insomnia, vomiting, weakness, postural hypotension

**b. Stimulants :** excite the CNS; Amphetamine, Cocaine, nicotine, inhalant or

　　volatile solvent, caffeine

**Withdrawal symptoms:** Craving, fatigue, Lethargy, guilt, anxiety, feeling of

　　helplessness, depression

**c. Hallucinogens :** ketamine, Dhaturo, magic mushroom

**Withdrawal symptoms**: flashbacks

**d. Opioids :** derived from opium poppy : Codeine, Heroin, Opium, Methadone,Morphine

**Withdrawal symptoms** : peak in 24 hours Craving, yawning, lacrimation,

　　dilated pupil, rhinorrhea, excessive sweating, diarrhea, stomach pain, loss of

　　appetite, increased blood pressure, temperature and pulse.

　　Note : Morphine and coddeine ( natural opioid), Methadone and Tramadol (

　　fully synthetic)

**e. Cannabis :** Bhang, Ganja, Chares, Marijuana

　　Ingridents : Delta 9 tetrahydrocannabinal

　　Most commonly found in the first 72-96 hours

　　Paranoid psychosis is most common.

**Withdrawal symptoms**: inappropriate laughter, red eyes, others same as that of

　　opoids,

**Sign and symptoms of substance abuse**

　　• Denial of problems

　　• Unreasonably asking for money

　　• Blaming others for problems

　　• Repeatedly absent from workplace

　　• Marks and injury on body

　　• Substance may found on pocket

　　• Difficulty in performing the expected role

　　• Physical and psychological problems

**Tests**

　　• Toxicology screening : urine test

　　• Opiates and narcotics : present in urine 12 – 36 hours

　　• CNS stimulants : eg. Cocaine; 1-12 days

　　• CNS depressants: eg Valium : upto 7 days

　　• Hallucinogen : up to 7 days after last dose

　　• Cannabis : up to 28 days in regular user

**Alcoholism**

　　⎫ Alcohol (ethanol): primarily metabolised in liver

　　⎫ Alcohol dehydrogenise converts the alcohol into acetaldehyde

　　⎫ Blood alcohol concentration : less than 80: euphoric feeling, more then 350 :

　　death occurs

**CAGE Questionnaire :**

　　C : Cut down on alcohol

　　A: Annoyed by peoples criticism

　　G : Felt guilty about drinking

　　E: Need an eye opener drink ( early morning)

　　Note : A score of 2 or more identifies problem drinkers

**Process of development of alcoholism**

　　¬ Experimental

　　¬ Recreational

　　¬ Relaxational

　　¬ Compulsive

**Alcohol withdrawal** : insomnia, autonomic hyperactivity, increased hand

　　tremor, psychomotor agitation, generalized tonic clonic seizures etc

**Alcohol intoxication** : slurred speech, incoordination, unsteady gait,

　　impairement in attention, stupor or coma

**Consequences of alcoholism**

**1. Medical complication**

　　⎫ Liver related problem and gastritis

　　⎫ Wernicke- Korsakoff syndrome : due to low thiamine level ( due to

　　mal-absorption from the stomach) ; triad symptoms

　　⎫ Confusion b. ataxia( loss of muscle coordination) and c. Nystagmus

　　⎫ Cardiovascular problem

**2. Psychiatric complication**

**A. Withdrawal Phenomena:** tremor, nausea, vomiting, tachycardia, fits,

　　elevated BP, irritability etc

**B. Delirium tremens (DT)** : occurs within 2-4 days of complete

　　abstinence from alcohol, last 3-7 days

　　• Triad symptoms : clouding of consciousness and confusion,

　　vivid hallucination +illusion and marked tremor

**3. Legal problem** : Crime, RTA

**Management:**

**1. Detoxification :** to remove the toxic substances from body,

**Minor tranquilizers** like chlordiazepoxides, loree to reduce the withdrawal symptoms in case of alcoholism

　　Naloxone : opioid antagonist

**2. Methadone replacement therapy :** oral administration once a day Anti craving agent eg. Flouxetine , naltrexone 4 ‘D’will be helpful i.e.

**D**rink water, **D**eep breathing, **D**elay and **D**ebriefing                                                                **Symptomatic treatment**

**• Vitamin B1** (Thiamin) replacement in case of alcoholism

**• Antabuse therapy**: **Disulfiram therapy** (deterrent agent that sensitize alcohol)               
Disulfiram produces a sensitivity to alcohol which results in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol. Disulfiram works by **blocking the breakdown of alcohol in the body**. This leads to buildup of a toxic alcohol-related compound that can cause people who drink alcohol while taking this medication to become very sick. This reaction helps encourage people to avoid alcohol while taking the medication.

　　⎫ Dose : starting does 500mg OD for 1-2 weeks followed by maintenance dose 250 mg

　　⎫ Require 12 hours abstinence before starting dose

　　⎫ Reaction may occur up tp 1-2 weeks after last intake

　　⎫ Reaction : nausea, vomiting, throbbing headache, flushing, dizziness

　　5.Epilepsy

　　• Abnormal excessive electrical discharge from brain cells

　　• resulting in brief, sterotyped episodes with or without loss of consciousness.

　　• Seizure : abnormal electrical activity which cause involuntary changes in body function

　　Types

**a. Partial seizure** : focal/jacksonian seizure

　　✓ Abnormal electrical discharge originates from some specific area of brain

　　Types:

　　✓ **Simple partial seizure** : no loss of consciousness or awareness

　　✓ **Complex partial seizure** : some alternation of awarness, mostly originates from

　　temporal lobe

　　✓ Partial seizure involving to secondary generalized seizure

**B.Generalized seizure:** Tonic clonic seizures; eye rolling, frothy secretion, urine/ stool

　　incontinence

**1. Aura** : - pre-ictal phase before onset of seizure : e.g. palpitation,flash of light, test in mouth,

　　✓ person may cry out before losing consciousness completely

**2. Tonic stage**: Ictal Phase (10-60 sec) Muscle become stiff, breathing stops, lip become blue,

　　hand clenched

**3. Clonic stage**: 3-4 mins,

　　- rhythmic jerky contraction and relaxation of all body muscle, frothy secretion, urine and

　　stool incontinence, tongue bite

**4. Recovery or coma stage**: recovers consciousness but may be confused for several minutes.

**5. Status epilectus:** single seizure lasting 30 mins or longer or next episode of seizure without

　　regaining consciousness.

**CAUSES**

　　✓ Neurocysticercosis is one of the leading cause of epilepsy in Nepal.

　　✓ Caused by pork tapeworm Taenia solium

　　✓ 50 % of patients will develop epilepsy before the age of 18 years

**Treatment**

**• Anticonvulsant drugs or antiepileptics** : monotherapy in 70 % of cases and 30 % may

　　require polytherapy

**Phenobarbiton, phenytoin** ( minimum period of 5 years from the date of last fits.

**Treatment Modalities used in Mental Illness**

**✓ Psychotropic drugs** : drugs that have main effects on brain and psychological function

　　• Anxiolytics drugs (anti-anxiety drugs)- hyposedatives

　　• Anti-psychotic drugs

　　• Anti depressant drugs

　　• Lithium and other mood stabilizing drugs/Anti-manic drugs

　　• Anti parkinsonian drugs

　　• Antabuse drugs

　　• Anticonvulsant drugs

**1. Antianxiety agents** :

　　that calm and relax people,

　　✓ also called anxiolytics and minor tranquilizer,

　　✓ bind to the specific sites on the GABA receptors

　　✓ increase GABA level.

　　• Benzodiazepines : e.g. short acting (Midazolam), Intemediate (loree, alprazolam), Long

　　acting (diazepam, clonazepam, chlorodiazepoxide). Chlordiazepoxide is the first

　　benzodiazepines introduced in 1959.

　　• Non benzodiazepine

　　• Barbiturates : e.g. phenobarbitol, thiopentone etc

　　• Beta blocker : propranolol

**2. Antipsychotics:**

　　✓ also called Neuroleptics, major tranquilizer, schizophrenic drugs,

　　✓ block dopamine receptors ( D2receptor) in the brain,

**Classification:**

　　• **Dopamine receptor antagonist, 1st generation antipsychotic** : classical/ conventional

　　- Chlorpromazine (1952) and Reserpine were the first drugs

　　- e.g. haloperidol , prolixin, chlorpromazine and thioridazine, Fluphenazine etc

**• Serotonin dopamine antagonist 2nd generation antipsychotic :** atypical antipsychotic,

　　- e.g. Risperidone, Aripiprazole clozapine, Quetiapine olanzapine etc.

　　- Effective for both positive and negative symptoms

**Common side effects of Antipsychotic drugs :**

　　✓ Dry mouth, dehydration

　　✓ Constipation, gastritis

　　✓ Photosensitivity

　　✓ Sleepiness, drowsiness

　　✓ Postural hypotension

　　✓ Hyperprolactinemia, weight gain, high sugar level

　　✓ Jaundice: due to elevated liver enzyme

　　✓ Extrapyramidal side effects :

　　Blockade of D2 receptors in the midbrain region is responsible for the development of EPS.

**1. Pseudo – Parkinsonism** (TRAP)Tremor,Rigidity,Akinesia,Postural hypotension

**2. Akinesia(muscular weakness)**: 1 to 5 days following initiation of antipsychotic medication.

**3. Akathiasia :** muscular discomfort, Restless ( walking in place) (  1st 2 weeks )

**4. Acute Dystonia** ( most life threatening), - Rapidly developing contraction of the muscle of the tongue, jaw, neck and extra ocular muscle, abnormal posture, stiffness (immediately after treatment within 3 days)

**5. Tardive dyskinesia:-** long term use of drugs (after 6 months,

　　- Grimacing, Protrusion of the tongue, lip smacking etc

　　- Involuntary and rapid movement of extremities and trunk

**C. Antidepressant drugs:**

　　✓ also called mood elevators, increased serotonin level in blood.

　　Imipramine is the 1st drug

　　a. Selective serotonin reuptake inhibitor e.g Fluoxetine, paroxetine, fluvoxamine, sertaline, etc

　　b. Tricyclic antidepressant : amitriptyline, imipramine, clomipramine etc

　　c. Monamine Oxidase inhibitor : Isocarboxazide

　　Note : it takes 2-4 weeks for the antidepressant drugs to work

　　- Monoamine oxidase inhibitor : avoid food containing high level of tyramine , an amino acid

　　that regulates blood pressure eg cheese

　　D. Antimanic:

　　✓ also called mood stabilizing agents,

　　• Lithium carbonate is the drug of choice for mania.

　　Plasma Level of Lithium

　　• Therapeutic levels = 0.6-1.2 mEq/L (For the treatment of **acute mania)**

　　• Prophylactic levels = 0.6-1.0 mEq/L (For relapse prevention in bipolar disorder)

　　• Toxic lithium levels > 2.0 mEq/L

**E.Antiparkinsonian drugs**

　　• Used for the treatment of parkinsonism syndrome caused by antipsychotic drugs

　　• For eg. Trihexyphenidyl, Benztropine and  Biperiden etc

**• Anticonvulsants**- Carbamazepine, Sodium Valproate, Lamotrigine, Gabapentin etc.

**Nursing management of patient receiving psychotrophic drugs**

　　• Be cautious while driving and operating dangerous machinery.

　　• Don’t stop medication after long time use.

　　• use sunscreens and wear protective clothing

　　• Rise slowly from sitting position

　　• Take frequent sips of water , chew sugarless gum

　　• If the clients forget a dose , take it if the dose is only 3-4

　　• Carry card or other Identification at all times

**PHYSICAL THERAPY**

**Electroconvulsive Therapy:**

　　• Discovered by Bini and Cereletti at 1938AD

　　• Treatment done by artificial induction of seizure

　　• Voltage : 70- 120 volts and

　　• Duration : 0.7 – 1.5 sec

　　Direct ECT; is given without muscle relaxants

　　Modified ECT: given with drugs

　　• Bilateral ECT : places electrode 2.5 to 4 cm above the mid point , on both side of the

　　temporal region,

　　• Unilateral ECT : place electrode only on one side of the head, non dominant side

　　Types of seizure produced

　　• -Grandmal seizure tonic phase lasting for 10 to 15 sec.

　　• -Clonic phase, lasting for 30-60 sec.

**Indication :**

　　⎫ Best treatment modality in severe depression ,

　　⎫ severe catatonia,

　　⎫ danger for suicide and homicide,

　　⎫ failure to drug regimes and post partum depression psychosis

　　Absolute contraindication : Raised intracranial pressure

　　Relative contraindication : cerebral aneurysm, cerebral haemorrhage, brain tumour MI etc

**Side effects of ECT**

　　⎫ Memory impairment ( short term memory loss)

　　⎫ Confusion and restlessness

　　⎫ Headache, poor concentration

　　⎫ Back pain and muscle ache

**Nursing Management**

**Before ECT**

　　• Obtain detail history

　　• informed consent, nil per oral

　　• Remove any metallic hair clips, glasses,

　　• Empty bladder

　　• Hair wash.

　　• Administer Inj. Atropine 0.6mg IM half an hour before ECT to decrease the oral

　　secretions

　　• Monitor vital signs.

**During ECT**

　　• Transfer the patient

　　• administering anesthetic agent

　　• Provide oxygen.

　　• Clean the temporal region

　　• Observe duration and types of seizure

　　• Take patient in recovery room.

**After ECT**

　　• Keep the patient in side lying position without pillow

　　• record vital signs, conscious level,

　　• Check for tongue bite and bleeding from gum and tongue.

　　• Provide oral fluids after 1-2 hours,

　　• Record the procedure

**Other modality of treatment**

　　1. Psychotherapy

　　• Talk therapy

　　• Treat mental health problem by talking with psychiatrist

　　Psychoanalysis : developed by Sigmund Freud, focus on

　　- Comfortable physical environment

　　- Free association

　　- Slips of tongue

　　- Dream interpretation

　　- Catheresis

　　- Insight

**2. Behavioural Therapy**

　　- Focus on application of certain principle of learning to create change in behaviour

　　Technique of behavioural therapy :

　　For the treatment of phobia:

　　- Systematic desensitization

　　- Flooding

　　For the treatment of compulsive act:

　　- Modelling

　　- Response prevention

　　• For the treatment of alcoholism and sexual deviation

　　Aversion therapy

　　For the treatment of schizophrenia and mental retardation

　　- Social skill training

　　a. Behavioral therapy : Exposure

　　• Create fear hierarchy

　　– List of fearful events, rated on 0-100 scale from least to most anxiety-provoking

　　– Example: Fear of snakes

　　• Talk about snakes 3

　　• See pictures of snakes 5

　　• Watch movies of snakes 6

　　• Touch a rubber snake 8

　　• Go to pet store and hold snake 10

　　– Gradual exposure: Child confronts fear

　　b. Exposure with Response Prevention

　　• Obsessive-compulsive behaviour

　　– In addition to exposures, the child is asked to refrain from engaging in compulsive

　　rituals

　　c. Systematic Desensitization

　　• based on the principle of classical conditioning, developed by Wolpe

　　• remove the fear response of a phobia,

　　• and substitute a relaxation response

　　d. Aversion therpay

　　• type of behavioral therapy

　　• Based on principle of classical conditioning

　　• that involves repeat pairing an unwanted behavior with discomfort

　　Eg. Alcohol is paired with an emetic drug.......alcoholic may associates alcohol with being sick

　　...do not want to eat more

　　e. Relaxation

　　• Deep breathing

　　• Imagery

　　• Progressive Muscle Relaxation

　　• In addition to behavioral strategies...

　　• Teaches to understand how thoughts contribute to anxiety

　　• And how to modify distorted thoughts to decrease symptoms

　　• Family therapy

　　• Marital therapy

　　• Group therapy

　　• Milieu therapy : use of therapeutic communities, stay for 8 to 18 months

**Diversional therapy**

　　• Provide in non threating and non demanding environment

　　• Provide activities that are relaxing and without rigid guideline

　　• Provide activities that are enjoyable and self satisfying

　　Counselling

　　• Contact with individuals which aims to offer him/her assistance in changing his/her attitude and behaviour

　　• Developed by Carl Rogers

　　Basic elements in counselling

　　- Trust

　　- Confidentiality

　　- Self determination

　　- Positive approach

　　- Focus on feeling

　　- Giving empathy

　　-