

PREFACE

What is psychiatry?

Psychiatry is a medical specialty that is mainly concerned with disorders of mind i.e. brain dysfunction as a whole. (This is manifested in the domain of subjective experience and behavior.

Students frequently have many questions about illness and its treatment. Psychiatric disorders are widespread and are commonly encountered in medical settings. Estimates have shown that during any given year over 20% of the population suffers from at least one psychiatric disorder. Patients in general medical clinics, specialty clinics, and hospitals exhibit high rates of depression, anxiety, and substance use disorders, as well as other mental health problems. The costs of psychiatric disorders are enormous in terms of health care service, loss of productivity, and human suffering by boil, patients and their families. The social stigma associated with mental illness often prevents patients from seeking help. Many do not seek treatment because of a lack of knowledge or feelings of shame or hopelessness. However, “hen patients co as for help, they turn most often to their general physician or another non-psychiatric medical provider.

Psychiatric sheet

The psychiatric history is the record of the patient life; it allows the psychiatrist to understand who the patient is, where the patient has come from, and where the patient is likely to go in the future. A thorough psychiatric history is essential to making a correct diagnosis and formulating a specific and effective treatment plan.

The mental status examination (MSE) is a description of the patient's appearance, speech, actions, and thoughts during the interview. It is a systematic format for recording findings about thinking, feeling, and behavior.

I. Psychiatric History:

A. Identification

1. Name, age, marital status, sex, occupation, race, nationality, religion.
2. Previous admissions to a hospital for the same or a different condition.
3. Persons with whom the patient lives.
4. Source and cause of referral+ admission.

B. Chief complaint (CC)

1. Describe exactly why the patient came to the psychiatrist, preferably in the patient's own words.

2. If that information does not come from the patient, note who supplied it.

C. History of present illness (HPI)

1. Chronological background and development of the symptoms or behavioral changes that culminated in the patient seeking assistance.

2. Patient's life circumstances at the time of onset.

3. Personality when well; how illness has affected life activities and personal relations—changes in personality, interests, mood, attitudes toward others, dress, habits, level of tenseness, irritability, activity, attention, concentration, memory, speech.

4. Psycho physiological symptoms—nature and details of dysfunction; pain—location, intensity, fluctuation.

5. Level of anxiety—generalized and nonspecific (free floating) or specifically related to particular situations, activities, or objects.

6. How anxieties are handled—avoidance, repetition of feared situation.

7. Use of drugs or other activities for alleviation.

D. Past psychiatric and medical history

1. Emotional or mental disturbances—extent of incapacity, type of treatment, names of hospitals, length of illness, effect of treatment.

2. Psychosomatic disorders: hay fever, arthritis, colitis, chronic fatigue, recurrent colds, skin conditions.

3. Medical conditions—customary review of systems, sexually transmitted diseases, alcohol or other substance abuse, at risk for acquired immune deficiency syndrome (AIDS).

4. Neurological disorders—headache, craniocerebral trauma, loss of consciousness, seizures, or tumors

5. Prolonged periods of good health between episodes of illness; How was patient functioning during these period.

E. Drugs history and allergies

*Especially depots, clozapine, Li and other psychotropic drugs

*Past and present

•Prescribed; Name, dose and timing (frequency), indication

•Over the counter

•Responses and adverse effects

•Patient's views; Does it help?

•Discuss exact nature of allergy.

•Compliance

F. Lifestyle

*Thorough history of all substance use particularly current use but also previous use

•Quantity, timing, dependence? Harmful consequences of use?

Depression and suicide risk. Explore social factors.

G. Legal history

- Have you ever had any legal problems or contact with the police or courts?
- Note violent or sexual offences in particular. Including driving bans.
- Past, present, impending

H. Family history

1. Elicited from patient and from someone else, because quite different descriptions may be given of the same people and events.
2. Ethnic, national and religious traditions.
3. List other people in the home and descriptions of them—personality and intelligence—and their relationship to the patient.
4. Role of illness in the family and family history of mental illness.
5. Where the patient lives—neighborhood and particular residence of the patient; is the home crowded; privacy of family members from each other and from other families.
6. Sources of family income, public assistance (if any) and attitudes about it; will the patient lose his or her job or apartment by remaining in the hospital.
7. Child care arrangements.

I. Personal history (anamnesis)

1. Prenatal and prenatal:

- Full-term pregnancy or premature
- Vaginal delivery or caesarian
- Drugs taken by mother during pregnancy (prescription and recreational)
- Birth complications
- Defects at birth

2. Early childhood (through 3 years of age)

a. Prenatal history and mother's pregnancy and delivery: length of pregnancy, spontaneity and normality of delivery, birth trauma, whether the patient was planned and wanted, birth defects.

b. Feeding habits: breast-fed or bottle-fed, eating problems.

c. Early development: maternal deprivation, language development, motor development, signs of unmet needs, sleep pattern, object constancy, stranger anxiety, separation anxiety.

d. Toilet training: age, attitude of parents, feelings about it.

e. Symptoms of behavior problems: thumb sucking, temper tantrums, tics, head bumping, rocking, night terrors, fears, bed-wetting or bed soiling, nail biting, masturbation

f. Personality and temperament as a child: shy, restless, overactive, withdrawn, studious, outgoing, timid, athletic, friendly patterns of play, reactions to siblings.

g. Early or recurrent dreams or fantasies.

3. Middle childhood (3 to 11 years of age)

a. Early school history—feelings about going to school.

b. Early adjustment, gender identification.

c. Conscience development, punishment.

d. Social relationships.

e. Attitudes toward siblings and playmates.

4. Later childhood (pre puberty through adolescence)

a. Peer relationships: number and closeness of friends, leader or follower, social popularity, participation in group or gang activities, idealized figures, patterns of aggression, passivity, anxiety, antisocial behavior.

b. School history: how far the patient went in school, adjustment to school, relationships with teachers—teacher's pet or rebellious— favorite studies or interests, particular abilities or assets, extracurricular activities, sports, hobbies, relationships of problems or symptoms to any school period.

c. Cognitive and motor development: learning to read and other intellectual and motor skills, minimal cerebral dysfunction, learning disabilities—their management and effects on the child.

d. Particular adolescent emotional or physical problems: nightmares, phobias, bed-wetting, running away, delinquency,

smoking, drug or alcohol use, weight problems, feeling of inferiority.

e. Psychosexual history.

(1) Early curiosity, infantile masturbation, sex play.

(2) Acquiring of sexual knowledge. attitude of parents toward sex, sexual abuse.

(3) Onset of puberty, feelings about it, kind of preparation, feelings about menstruation, development of secondary sexual characteristics,

(4) Adolescent sexual activity: crushes, parties, dating, petting, masturbation, wet dreams (nocturnal emissions) and attitudes toward them need to impress, seductive, sexual conquests, promiscuity.

(5) Attitudes toward same and opposite sex: timid, shy, aggressive,

(6) Sexual practices: sexual problems, homosexual and heterosexual experiences, paraphilias, promiscuity.

f. Religious background: strict, liberal, mixed (possible conflicts), relationship of background to current religious practices.

5. Adulthood

a. Occupational history: choice of occupation, training, ambitions, and conflicts; relations with authority, peers, and subordinates;

number of jobs and duration; changes in job status; current job and feelings about

it.

b. Social activity: whether patient has friends; whether he or she is withdrawn or socializing well; social, intellectual, and physical interests; relationships with same sex and opposite sex; depth, duration, and quality of human relations.

c. Adult sexuality.

(1) Premarital sexual relationships, age of first coitus, sexual orientation.

(2) Marital history: common-law marriages; legal marriages; description of courtship and role played by each partner; age at marriage; family planning and contraception; names and ages of children; attitudes toward raising children; problems of any family members; housing difficulties, if important to the marriage; sexual adjustment; extramarital affairs; areas of agreement and disagreement; management of money; role of in-laws.

(3) Sexual symptoms: anorgasmia, impotence (erectile disorder), premature ejaculation, lack of desire.

(4) Attitudes toward pregnancy and having children; contraceptive practices and feelings about them.

(5) Sexual practices: paraphilias, such as sadism, fetishes, voyeurism; attitude toward fellatio, cunnilingus; coital techniques, frequency.

d. Military history: general adjustment, combat, injuries, referral to psychiatrists, type of discharge, veteran status.

Military data should include:

- Branch of service
- Rank on entry and at discharge, type of discharge, i.e., honorable, medical, etc.
- Duration and dates
- Experience
- Effect of military service on the patient's life
- Combat situation both at induction and at discharge
- Injury ·Problems arising after discharge
- Illness ·Hospitalizations

e. Value systems: whether children are seen as a burden or a joy; whether work is seen as a necessary evil, an avoidable chore, or an opportunity; current attitude about religion; belief in after life.

J. Pre morbid personality

a. Social relation:

- Number of intimate friends
- Introverted / extroverted
- Dependent /independent
- Leader or follower

b. Interest:

- Sports- type of sports, frequency
- Reading-type of books

-TV-type of movies, shows

c. Basic temperament:

-Stable/ fluctuating

-Cheerful/ sad

-Self confident/self doubt

-Anxious or not

-Optimistic/ pessimistic

d. Character:

- Relation to God

- Relation to self

Hygiene

Idealistic

Realistic

Selfish

Ego centric

Self confident/ self doubt

-Relation to others:

Selfish

Brave/shy

Generous/ misery

Suspicious

Sensitive

Kind/ aggressive

II. Mental Status examination

A. Appearance

I. Personal identification: may include a brief nontechnical description of the patient's appearance and behavior, as a novelist might write it. Attitude toward examiner can be described here: cooperative, attentive, interested, frank, seductive, defensive, hostile, playful, ingratiating, evasive, or guarded.

2. Behavior and psychomotor activity: gait, mannerisms, tics, gestures, twitches, stereotypes, picking, touching examiner, echopraxia, clumsy, agile, limp, rigid, retarded, hyperactive, agitated, combative, or waxy.

3. General description: posture, bearing, clothes, grooming, hair, nails; healthy, sickly, angry, frightened, apathetic, perplexed, contemptuous, ill at ease, poised, old looking, young looking, effeminate, masculine; signs of anxiety—moist hands, perspiring forehead, restlessness, tense posture, strained voice, wide eyes; shifts in level of anxiety during interview or with particular topic; eye contact (50% is normal).

B. Attitude - Possible descriptors:

Cooperative, hostile, open, secretive, evasive, suspicious, apathetic, easily distracted, focused, defensive.

C. Speech: rapid, slow, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, mumbled, stuttering, echolalia, intensity, pitch, ease, spontaneity, productivity, manner, reaction time, vocabulary, prosody.

We comment on:

A. Quantity: Talkative, spontaneous, expansive, paucity, poverty.

B. Rate: Fast, slow, normal, pressured.

C. Volume (Tone): Loud, soft, monotone, weak, strong.

D. Fluency and Rhythm: Slurred, clear, with appropriately placed inflections, hesitant, with good articulation, aphasic.

D. Mood and affect

I. Mood (a pervasive and sustained emotion that colors the person's perception of the world): how does patient say he or she feels; depth, intensity, duration, and fluctuations of mood—depressed, despairing, irritable, anxious, terrified, angry, expansive, euphoric, empty, guilty, awed, futile, self-contemptuous, anhedonic, alexithymic.

Possible questions for patient:

- “How are your spirits?”
- “How are you feeling?”
- “Have you been discouraged/depressed/low/blue lately?”

- “Have you been energized/elated/high/out of control lately?”

- “Have you been angry/irritable/edgy lately?”

2. Affect (the outward expression of the patient’s inner experiences).

Possible descriptors:

- Appropriateness to situation, consistency with mood, congruency with thought content.

- Fluctuations: Labile, even.

- Range: Broad, restricted.

- Intensity: Blunted, flat, normal intensity.

- Quality: Sad, angry, hostile, indifferent, euthymic, dysphoric, detached, elated, euphoric, anxious, animated, irritable.

E. Thinking and perception

1. Form of thinking

a. Productivity: overabundance of ideas, paucity of ideas, flight of ideas, rapid thinking, slow thinking, hesitant thinking; whether the patient speaks spontaneously or only when questions are asked; stream of thought, quotations from patient.

b. Continuity of thought: whether the patient’s replies really answer questions and are goal directed, relevant, or irrelevant; loose associations; lack of cause-and-effect relationships in the patient’s explanations; illogical, tangential, circumstantial,

rambling, evasive, persevering statements; blocking or distractibility.

c. Language impairments: impairments that reflect disordered mentation, such as incoherent or incomprehensible speech (word salad), clang associations, neologisms.

2. Content of thinking

a. Preoccupations about the illness, environmental problems.

b. Obsessions, compulsions, phobias.

c. Obsessions or plans about suicide and/or homicide.

d. Hypochondriacal symptoms, specific antisocial urges or impulses.

3. Thought disturbances

a. Delusions: content of any delusional system, its organization, the patient's convictions as to its validity, how it affects his or her life; persecutory delusions—isolated or associated with pervasive suspiciousness; mood-congruent or mood-incongruent.

b. Ideas of reference and ideas of influence: how ideas began, their content, and the meaning that the patient attributes to them.

c. Thought broadcasting—thoughts being heard by others.

d. Thought insertion—thoughts being inserted into a person's mind by others.

4. Perceptual disturbances

a. Hallucinations and illusions: whether the patient hears voices or sees visions; content, sensory system involvement, circumstances of the occurrence; hypnagogic or hypnopompic hallucinations; thought broadcasting.

b. Depersonalization and derealization: extreme feelings of detachment from self or from the environment.

5. Dreams and fantasies

a. Dreams: prominent ones, if the patient recalls them; nightmares.

b. Fantasies: recurrent, favorite, or unshakable daydreams.

F. Sensorium

1. Alertness: awareness of environment, attention span, clouding of consciousness, fluctuations in levels of awareness, somnolence, stupor, lethargy, fugue state, coma.

2. Orientation

a. Time: whether the patient identifies the day or the approximate date and the time of day correctly; if in a hospital, whether the patient

knows how long he or she has been there; whether the patient behaves as though oriented to the present.

b. Place: whether the patient knows where he or she is.

c. Person: whether the patient knows who the examiner is and

the roles or names of the persons with whom the patient is in contact.

3. Concentration and calculation:

whether the patient can subtract 7 from 100 and keep subtracting 7s; if the patient cannot subtract 7s, whether easier tasks can be accomplished— 4×9 and 5×4 ; whether the patient can calculate how many nickels are in \$1.35; whether anxiety or some disturbance of mood or concentration seems to be responsible for difficulty.

4. Memory: impairment, efforts made to cope with impairment—denial, confabulation, catastrophic reaction, circumstantiality used to conceal deficit; whether the process of registration, retention, or recollection of material is involved.

a. Remote memory: childhood data, important events known to have occurred when the patient was younger or free of illness, personal matters, neutral material.

b. Recent past memory: past few months.

c. Recent memory: past few days, what did the patient do yesterday and the day before, what did the patient have for breakfast, lunch, and dinner,

d. Immediate retention and recall: ability to repeat six figures after the examiner dictates them—first forward, then backward, then after a few

minutes' interruption; other test questions; whether the same

questions, if repeated, called forth different answers at different times.

e. Effect of defect on patient: mechanisms the patient has developed to cope with the defect.

5. Fund of knowledge

a. Estimate of the patient's intellectual capability and whether the patient

is capable of functioning at the level of his or her basic endowment.

b. General knowledge; questions should have relevance to the patient's educational and cultural background.

6. Abstract thinking: disturbances in concept formation; manner in which the patient conceptualizes or handles his or her ideas; similarities (e.g., between apples and pears), differences, absurdities; meanings of simple proverbs, such as "a rolling stone gathers no moss"; answers *may* be concrete (giving specific examples to illustrate the meaning) or overly abstract (giving generalized explanation); appropriateness of answers.

7. Insight: the recognition of having a mental disorder and degree of personal awareness and understanding of illness.

- a. Complete denial of illness.
- b. Slight awareness of being sick and needing help but denying it at the same time.
- c. Awareness of being sick but blaming it on others, external factors, or medical or unknown organic factors.
- d. Intellectual insight: admission of illness and recognition that symptoms or failures in social adjustment are due to irrational feelings or disturbances, without applying that knowledge to future experiences.
- e. True emotional insight: emotional awareness of the motives and feelings within and of the underlying meaning of symptoms, whether the awareness leads to changes in personality and future behavior, openness to new ideas and concepts about self and the important people in the patient's life.

CLINICAL HINT:

Test for insight by asking: "Do you think you have a problem?" "Do you need treatment?" "What are your plans for the future?" Insight is severely impaired in cognitive disorders, psychosis, and borderline IQ.

8. Judgment

- a. Social judgment: subtle manifestations of behavior that are harmful to the patient and contrary to acceptable behavior in the culture.

b. Test judgment: the patient's prediction of what he or she would do in imaginary situations; for instance, what the patient would do with a stamped, addressed letter found in the street or if medication was lost.

CLINICAL HINT:

Judgment is severely impaired in manic episodes of bipolar disorders and in cognitive disorders (e.g., delirium and dementia).

III. Further Diagnostic Studies:

- A. Physical examination
- B. Neurological examination
- C. Additional psychiatric diagnostic
- D. Interviews with family members, friends, or neighbors by a social worker
- E. Psychological, neurological, or laboratory tests as indicated: Electroencephalogram, computed tomography scan, magnetic resonance imaging, tests of other medical conditions, reading comprehension and writing tests, test for aphasia, projective or objective psychological tests, dexamethasone-suppression test, 24-hour urine test for heavy metal intoxication, urine screen for drugs of abuse

Summary of Findings

Summarize mental symptoms, medical and laboratory findings, and psychological and neurological test results, if available; include medications patient has been taking, dosage, duration. Clarity of thinking is reflected in clarity of writing.

IV. Diagnosis

Diagnostic classification is made according to DSM-IV-TR, which uses a multi axial classification scheme consisting of five axes, each of which should be covered in the diagnosis

Axis I: Clinical syndromes (e.g., mood disorders, schizophrenia, generalized anxiety disorder) and other conditions that may be a focus of clinical attention

Axis II: Personality disorders, mental retardation, and defense mechanisms

Axis III: Any general medical conditions (e.g., epilepsy, cardiovascular disease, endocrine disorders)

Axis IV: Psychosocial and environmental problems (e.g., divorce, injury, death of a loved one) relevant to the illness

Axis V: Global assessment of functioning exhibited by the patient during the interview (e.g., social, occupational, and psychological functioning); a rating scale with a continuum from 100 (superior functioning) to 1 (grossly impaired functioning) is used

V. Prognosis

Opinion about the probable future course, extent, and outcome of the disorder; good and bad prognostic factors; specific goals of therapy

VI. Psychodynamic Formulation

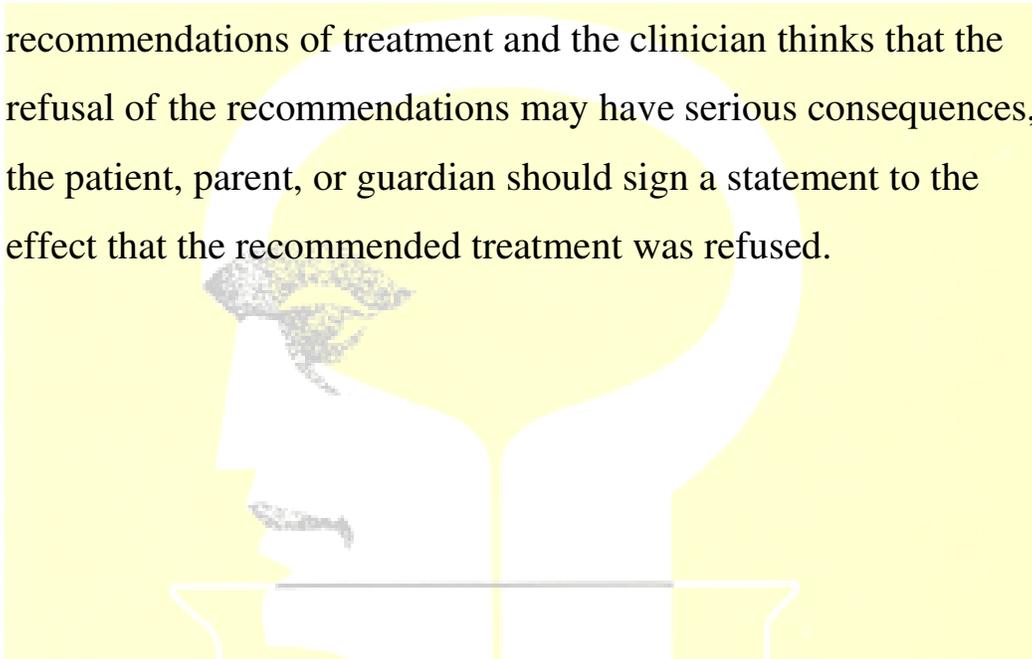
Causes of the patient's psychodynamic breakdown influences in the patient's life that contributed to present disorder; environmental, genetic, and personality factors relevant to determining patient's symptoms; primary and secondary gains; outline of the major defense mechanism used by the patient

VII. Comprehensive Treatment Plan

Modalities of treatment recommended, role of medication, inpatient or outpatient treatment, frequency of sessions, probable duration of therapy; type of psychotherapy; individual, group, or family therapy; symptoms or problems to be treated. Initially, treatment must be directed toward any life-threatening situations such as suicidal risk or risk of danger to others that require psychiatric hospitalization. Danger to self or others is an acceptable reason (both legally and medically) for involuntary hospitalization. In the absence of the need for confinement, a variety of outpatient treatment alternatives are available: day hospitals, supervised residences, outpatient psychotherapy or pharmacotherapy, among others. In some cases, treatment

planning must attend to vocational and psychosocial skills training and even legal or forensic issues.

Comprehensive treatment planning requires a therapeutic team approach using the skills of psychologists, social workers, nurses, activity and occupational therapists, and a variety of other mental health professionals, with referral to self-help groups (e.g., Alcoholics Anonymous [AA]) if needed. If either the patient or family members are unwilling to accept the recommendations of treatment and the clinician thinks that the refusal of the recommendations may have serious consequences, the patient, parent, or guardian should sign a statement to the effect that the recommended treatment was refused.



Summery

Topic	Questions	Questions in arabic
Identifying data	Be direct in obtaining identifying data. Request specific answers.	
Chief complaint	Why are you going to see a psychiatrist? What brought you to the hospital? what seems to be the problem?	جئت ليه لطبيب نفسى؟ ايه اللي جابك المستشفى؟ ايه المشكلة؟
HPI	When did you first notice something happening to you? Were you upset about any thing when symptoms began? Did they began suddenly or gradually?	امتى أول مرة لاحظت ان في شيء غريب بيحصلك؟ كنت مستاء من أي شيء عندما بدأت الأعراض؟

		هل الاعراض بدأت فجأة أو تدريجيا؟
Previous psychiatric and medical disorders	Did you ever lose consciousness? Have a seizure?	هل سبق و فقدت وعيك؟ او جاءت لك نوبة تشنجات؟
Personal history	Did you know any thing about your birth? If so, from whom? How old was your mother when you were born? your father?	تفكر شئ عن ولادتك؟ كم كان عمر والدتك ووالدك وقتها؟
childhood	Toilet training? bed wetting? Sex play with beers? What is your first childhood memory?	تفكر ايه عن طفولتك؟ كان البول او البراز ممكن يسبب منك غصب عنك بالليل؟ ؟

adolescence	Adolescents may refuse to answer questions, but they should be asked. They may distort memories of emotionally charged adolescent experiences. Sexual molestation?	اتعرضت لتحرش جنسي قبل كده؟
Adulthood	Open ended questions are preferable. Tell me about your marriage. Be non judgemental. What role does religion play in your life? If any? What is your sexual preference in a partner?	كلمنى عن زواجك؟ بتميل اكثر للنساء ام الرجال؟ ايه دور الدين في حياتك؟ هل بتصلي, تصوم, تروح الجامع بانتظام؟ تحب تطلب ايه من ربنا؟
Sexual history	Are there or have there	فى أي مشاكل أو

	<p>been any problems or concerns about your sex life? How did you learn about sex? Have there been changes in your sex drive?</p>	<p>مخاوف حول حياتك الجنسية؟ كيف تعلمت عن الجنس؟ هل هناك تغييرات في الدافع الجنسي لديك؟ هل التعب اثر على العلاقة الجنسية وازاي؟</p>
<p>Family history</p>	<p>Have any members in your family been depressed? Alcoholic? In a mental hospital? In jail? Describe your living conditions? Did you have your own room?</p>	<p>فى اى فرد بيتعالج من مرض نفسى فى العائلة؟ سبق وان تم حجز احد في مستشفى للأمراض العقلية؟ اوصفلي الظروف المعيشية الخاصة بك؟ لديك غرفتك الخاصة؟</p>
<p>General appearance</p>	<p>Introduce your self and direct patient to take a</p>	

	seat. In the hospital bring the chair to bed side; do not sit on the bed.	
Motoric bahavior	Have you been more active than usual? Less active? You may ask about obvious mannerism, e.g., I notice that your hand still shakes, can you tell me about that? Stay aware of smells,e.g., alcoholism/ketoacidosis.	<p>اخبار نشاطك اليومى ايه؟</p> <p>(نشيط - مايبطلش حركة وفرك - مايقعدش ساكت.</p> <p>كسلان - بطئ الحركة - مبيتحركش من مكانه).</p> <p>(عصبى - بيتترفز عليك - يضر ب ويشتم)؟</p> <p>هل بتحافظ على نظافتك الشخصية؟</p> <p>فى اى حركات غريبة فى جسمك؟ غصب عنك؟</p>
Attitude during interview	You may comment about attitude; you seen	يبدو انك متوتر؟ ده صحيح؟

	<p>irritated about something; is that an accurate observation.</p>	
<p>Mood</p>	<p>How do you feel? How are your spirits? Do you have thoughts that life is not worth living or that you want to harm your self? do you have plans to take your own life? Do you want to die? Has there been a change in your sleep habits?</p>	<p>اخبار مزاجك ايه؟ مزاجك الصبح احسن ولا بالليل؟ لو حد من قرابيك (تعب) حصلته حاجة وحشة) بتحس بايه؟ لو حد قالك خبر حلو/ نكته بتفرح؟ هل الميتين اريح ولا العايشين؟ هل فكرت فى الموت؟ هل حاولت الانتحار؟ كم مرة الوسيلة مين انقذك وازاى ايه شعورك بعد الانقاذ</p>

		هل عندك خطط لاتخاذ حياتك الخاصة؟ نومك اتغير بعد التعب ؟
Affect	Observe non verbal signs of emotion, body movements, facies, rhythm of voice. Laughing when talking about sad objects? E.g., death, is appropriate?	
Speech	Ask patient to say.....to test for dysarthria.	هل حاجة فى طريقة كلامك اتغيرت؟
Perceptual disorders	Do you ever see Things,or hear voices? Do you have strange experience as you fall a sleep or on awakening? Has the world changed	هل بتسمع حاجات او بنشوف (محدث غيرك بيسمعها او يشوفها؟ اوصف هذه الاشياء؟ هل ساعات بتحس انك

	<p>in any way? Do you have strange smells?</p>	<p>منفصل عن عقلك وجسمك ,مستغرب الناس والكون من حواليك؟ هل ساعات بتشم رائحة غريبة؟</p>
<p>Thought content</p>	<p>Do you feel people want to harm you? Do you have special powers? Is any one trying to influence you? Do you have strange body sensations? Are there thoughts that you can not get out of your mind? Do you think about the end of the world? Can people read your mind? Do you ever feel the TV is talking to you? Ask about fantasies and dreams.</p>	<p>هل بتفكر فى حاجات محدث غيرك بيفكر فيها؟ والناس مش مصدقينها؟ ساعات بتحس ان الناس عاوزين يؤذوك؟ بيتكلموا او بيشاوروا عليك؟ ساعات بتحس ان عندك قدرات خاصة مش عند حد؟ وانك احسن واحد فى الدنيا؟</p>

		<p>ان في حد بيجاول التأثير عليك؟</p> <p>هل لديك أحاسيس غريبة بجسمك؟</p> <p>هل هناك أفكار أنه لا يمكنك الخروج من عقلك؟</p> <p>بيجيك افكار عن نهاية العالم؟</p> <p>هل يمكن للناس قراءة عقلك؟</p> <p>بتحس التلفزيون بيكلمك؟</p> <p>هل بنتجى افكار فى دماغك بتكرر غصب عنك عارف انها غلط, بتحاول تمنعها ومش عارف؟</p>
<p>Thought process</p>	<p>Ask meaning of proverbs to test abstraction.e.g., people in glass houses should</p>	<p>قوللى ايه معنى المثل ده:</p>

	not throw stones. Concrete answer is glass breaks. Abstract answers deal with universal themes or moral issues. Ask similarity between bird and butterfly (both alive), bread and cake (both food).	ايه وجه التشابه بين) الطيور والفراشة)، والخبز والكعك.
Sensorium	What place is this? what is today's date? Do you know who I am? Do you know who you are?	احنا فين النهارده ايه عارف انا مين انت بتشتغل ايه
Remote memory	Where were you born? Where did you go to school? Date of marriage? Birthday of children? What were last week's newspaper headlines?	اين ولدت اين كانت مدرستك تاريخ زواجك/ ميلاد اطفالك عناوين الصحف الاسبوع الماضية؟
Recent memory	Where were you yesterday? What did	كنت فين امبارح؟

	you eat at your last meal?	اكلت ايه (الافطار/العشاء)؟ مين زارك امبارح؟ دخلت المستشفى امتى؟
Immediate memory	Ask patient to repeat six digits forward, then backward (normal response). ask patient to try to remember 3 non related items; test patient after 5 minutes.	كرر وراى 6 ارقام من الامام للخلف و الخلف للامام. (قلم, شباك, كرسي) كررهم وراى وحاول تفكرهم بعد 5 دقائق.
Concentration and calculation	Ask patient to count from 1 to 20 rapidly; do simple calculations (2*3); do serial 7 test,.i.e., subtract 7 from 100 and keep subtracting7.....	اخبر الذاكرة والتركيز؟ عد من (20-1) بسرعة؟ الربع جنيه فيه كم قرش؟ 7-100 كام-7-7
Information and intelligence	Distance from ... to ... Name some vegetables.	مين رئيس جمهورية مصر العربية؟

	What is the largest river in	مين اللي احتل فلسطين؟ كاس العالم هيتعمل فين؟
Judgment	What is the thing to do if you find an envelope in the street that is sealed, stamped, and addressed?	هتعمل ايه لو لاقيت جواب مرمى فى الشارع؟
Insight level	Do you think you have a problem? Do you need treatment? What are your plans for the future?	هل تعتقد ان عندك مشكلة؟ وانك محتاج للعلاج؟ ايه خططك للمستقبل؟

SYMPTOMS AND SIGNS IN PSYCHIATRY

Psychiatrist must learn the skill of precise observation & description and in turn learning of a new language.

Signs: are objective findings observed by the clinician.

Symptoms: are the subjective experiences described by the patients .

This chapter will discuss the mental phenomena and the signs and symptoms in psychiatric illnesses.

CONSCIOUSNESS

Definition: it is the awareness of self and environment.

Dream like state: it is an objective experience, in which a state of altered consciousness similar to sleep associated with elaborate dream content, so the patient looks detached.

Oneroid state: It is a subjective experience describing a real objective process. It should be associated with depersonalization derealization and perplexity.

Fugue: Patient go to unexpected, yet, organized journey in an automatic way to a new nonordinary place with different identity (but maintaining self care in dissociate type). There is partial or complete amnesia for the journey.

Trance: It is a temporary alteration of the state of consciousness show by any of the following:

I. Loss of usual sense of personality.

2. Narrowing of awareness to reach a selective, focusing on environmental stimuli.

3. Limitation of movement and speech to a limited repertoire.

Twilight state It is a disturbed state of consciousness with restriction of consciousness to a special sector of functioning (either **ideation** or perception).

Confusion: means inability to think clearly, so as to maintain a coherent stream of thought or action.

Drowsiness: a state of consciousness is characterized by ready arousal, sluggish response verbally & the presence of fending off movements induced by painful stimuli.

Stupor: is characterized by:

1. Inconsistent & vague response to verbal command or no verbal response occur.

2. Motor response to painful stimuli is still purposeful and of fending off type.

Light coma: is characterized by primitive and disorganized motor response to painful stimuli.

Deep coma: there is no response to attempts at arousal.

PSYCHOMOTOR

ACTIVITY

Definition: "Psychomotor activity refers to the part of psyche that includes impulses, motivation wishes, drives, instincts and

craving expressed in a person's behavior or motor activity”

Disturbances of psychomotor activity:

(a) quantitative changes

Psychomotor agitation: It is excessive motor & cognitive overactivity, usually non productive and **in** response to inner tension.

hyperactivity (hyperkinesis): It is restless, aggressive, and destructive activity.

Akathisia: It is subjective feeling of muscular tension secondary to antipsychotic or other medication, which can cause restlessness, pacing, repeated patting and repeated standing

polyphagia: pathological overeating

sleep walking (somnambulism): It is motor activity during sleep.

lypoactivity : It is decreased motor & cognitive activity as in psychomotor retardation there is visible slowing of thought, speech & movements.

Abulia: It is reduced impulse to act think associated with indifference about consequences of actions.

(b) qualitative-changes:

Echopraxia: It is pathological imitation of movements of one person by another.

Negativism: motiveless resistance to all attempts to be moved or

to all instructions.

Catatonia: It is motor abnormalities with many forms.

Preservation: persistent response to a prior stimulus after a new stimulus has been presented.

Stereotypy: It is a repetitive fixed pattern of physical action or speech which is not goal directed

Mannerism: It is a -deeply ingrained, habitual involuntary movement which appear as goal directed

movement that appear to have social significance but it is

Ambitendence: It is a special form of ambivalence in which a patients begins to make a movement but before We

should analyze it in the following steps: completing it, he starts to do the apposite movement (so

Spontaneity reaction time -amplitude- speed- putting hand back & forth without reaching the goal).

Mitgehen moving a limb in response to slight pressure on it despite being told to resist the pressure.

Automatic obedience: the patients obeys every command, though, he has first told not to do that.

Negativism, motiveless resistance to all attempts to be moved or to all instruction.

Compulsion: uncontrollable impulse to perform an act

Tremors, rhythmical movement at a joint produced by alternating interactions of agonists & antagonist muscle.

Chorea: sudden purposeless jerky involuntary fluency.

Hemiballismuss: continuous unilateral in voluntary movement more proximal than distal.

ATTENTION

Definition: Attention is the ability to focus on a certain portions of an experience (e.g the amount of effort exerted)

Concentration: is the ability to maintain that focus voluntarily for sufficient adequate time to reach the goal.

Types of attention:

1. *active attention* (voluntary attention): which is the active ability to focus e.g the intention to listen to important lecture.

2. *Passive attention:* (Involuntary attention) there is no active effort exerted to attend to a stimulus.

Disturbances of attention:

Hyper prosexia = Hyper vigilance: ‘excessive handicapping attention (as regards, intensity, range and increased details) to both external & internal stimuli.

Selective attention inattention: “a state of heightened attention directed towards specific target (selective attention), neglecting almost all others”(e.g punch drunkenness).

Double or multiple attention: “the ability to focus attention to more than one stimulus simultaneously or rather the ability to rapid shifts between two or more stimuli without losing the thread of attention. It is considered a type of hyperattention.

Distractibility: the inability to concentrate attention .

PERCEPTION

Definition: Perception is the process of becoming aware of what is presented through the sense organs. It is a imagery.

Hallucinations: “Definition: It is a percept experienced in the absence of an external stimulus to the

sensory organs”. It has the following criteria

- I. Experienced with a similar quality to true percept.
2. Experienced as originating in the outside world (or from within one’s own body) like a percept.

EMOTION

Definition “Emotions are complex responses produced by the human being as they react with the environment. Any emotional activity has its motivating and volitional aspect and associated overt or covert cognitive activity.

A healthy motivating emotion should be:

- I. Appropriate to the situation.
2. Adequate in amount in relation to the goal.
3. Enough and persisting till the goal is achieved.
4. Relatively observable in some optimal degree.
5. Partly awoken as a distinct subjective experience.
6. Inconcordance with other function.

Emotions has two component:

1. Emotional experience (Mood): It is the sustained internal emotional state of a person. In normal person, mood varies in parallel with the main theme discussed. i.e suited the context and in normal range.

2. Emotional expression (affect): It is the external expression of the present emotional content. In normal range of affect, there is a variation in facial expression, tone of voice, use of hands and body movements.

Disorders of emotion

A. Disorders of affect: Affect varies in amount and range of the expressive behavior. Abnormalities include:

1. Incongruity with mood.

2. Decrease in the amount and range.

B. Disorders of mood; They can be divided into the following:

1. Pleasant emotions: e.g - Elation-(elevated mood): means exaggerated and cheerful than usual.

2. Dysphoric emotions e.g Dysphoric mood: not well defined, not directed toward a source of provocation.

Irritable: Means easily annoyed and provoked to anger.

3. Depression related dysphoria. e.g Depression; which is an exaggerated sadness especially pathological if it is handicapping or dangerous. It is associated with gloomy look Lu self, life and future.

4. Fear related disorders, e.g. anxiety: refers to a sense of fear which is pervasive, ill focused, (or with a rapid shift) not attached to any idea or situation.

Apprehension: An intense fear of any non fearful stimulus, looks as if in an overwhelming threatening situation.

Phobia: irrational exaggerated pathological dread of some specific idea, stimulus or situation.

5. Insufficient Emotions, e.g. Apathy; a shallow emotion, in which patient looks motionless and not experience emotion.

Indifference: there is shallowness of the apparent emotion however, patient experience emotion. **Sense of empty affect:**

A sense of loss of feeling and denial of affect.

6. Primitive Emotions: e.g. rage: is an explosive overwhelming anger which is the least connected to cognition or volition.

THINKING.

Definition: “Thinking is a mental activity for concept formation and problem solving, not depending directly on the present motor and sensory contact’.

Disorders of content of thought:

1. Preoccupation or trend of thought. The thought contents are centered on a particular idea (exaggerated concern) which is associated with a strong affective tone e.g suicidal preoccupation, hypochondriasis and egomania.

Hypochondriasis: means exaggerated concern about one's health that is not based on a real organic pathology but on unrealistic interpretation of physical signs or sensation as abnormal egomania:

Pathological self-preoccupation. Monomania: preoccupation with a single object preoccupation may reach to obsessive rumination e.g. depression.

2. Overvalued ideas: it is an isolated preoccupying belief neither delusional nor obsessional in nature which dominates a person's life for many years & may affect his actions & it can be understandable when the patient's background is known.

3. Delusion: "It is a conviction or a belief which is characterized by being:

- i. Firmly held on inadequate ground and not corrected by reasoning (means that it is not arrived through a normal process of thinking, so it is based on incorrect inference IN.
2. Not a conventional belief that the person might be expected to hold especially in knowing his educational & cultural background. & intelligence"

Delusion may be described as:

1. bizarre delusion totally implausible or
2. systematized delusion united by a single theme, or
3. Mood congruent delusion,
4. Mood incongruent delusion

Types of delusions: include: nihilistic delusion., delusion of poverty, paranoid delusions (including delusion of persecution of grandeur. delusion of reference) delusion of selfaccusation, delusion of control, thought withdrawal, thought insertion, thought broadcasting, thought control, delusion of infidelity. erotomania.

4- Obsession “It is a persistent, recurrent thoughts, impulses. or Images enter the mind despite the person’s effort to exclude it nevertheless, it enter his awareness. It is recognized by the person as his own & not implanted from elsewhere . it is characterized by the presence of resistance .

5-Compulsions-’Uncon impulse to do an act repetitively & in a seemingly purposeful behavior accompanied by a sense that it must be carried out and by an urge to resist & recognized as senseless’

Coprolalia compulsive utterance of obscene words.

6-Phobia: “persistent irrational, exaggerated & invariably pathological dread of some specific type of stimulus or situation . It results in compelling desire to avoid the feared stimulus”,

Types of phobia

1-specific phobia it is a circumscribed dread of a discrete object or situation (e.g of spiders)

Agoraphobia. dread of open places,

Allophobia: dread of pain. **Allurophobia.** dread of cats,

Erythrophobia: dread of red. **Pauphobia** dread of every thing. **Claustrophobia** dread of closed places.

Xenophobia: dread of dangers.

2- **Social phobia:** it is a of public speaking, **Acrophobia:** dread of dread of public humiliation as in tear performing or eating in public.

Disorders of the stream of thought

1. Pressure of thought: It is characterized by the unusual variety & abundance of ideas which pass through the mind rapidly and in gushes. Patients complain of the sudden running of overcrowded thoughts and his failure to stop them or to select needed ideas from *them*". It occurs in manic & schizophrenic patients.

2- **Poverty of thought:** It is characterized by a few ideas in a unit of time and they seem to pass through the mind slowly (ideas may be scanty and repetitive). It result in looseness of connections which lead to negative incoherence, if there is increased repetition, it lead to stereotyped thinking.

3- **Thought blocking thought deprivation**

"It is characterized by sudden abrupt interruption of the stream of thought before the thought is finish, after a brief pause, the person indicate no recall of what was being said & may continue in another subject". It may occur due to distraction by another thought or anxiety or fatigue or overwhelming preoccupation or in "schizophrenia. In schizophrenic, it is

characterized by being:

- Sudden & strikingly repeated.

Described by patients as an abrupt complete emptying of his mind

- **Strengthened if the Pt interprets the experience in an unusual way.**

Disturbances in the process of thinking:

Impaired reality testing: It is impaired objective evaluation & judgment of the world outside self.

Illogical thinking: thinking contains erroneous conclusions or internal contradictions. It is pathological when it is marked, or when not caused by cultural values .

Irrelevant answer: answer is not in harmony with the question. Patient appear not attending to question and ignoring it.

Formal thought disorder: means a disturbance in the form of thinking which is characterized by loosened association and illogical construct

A. Construct error: include the following: primary process thinking (which may by concrete thinking, psychotic insight, active concretization), overinclusion, interpenetrating of themes (widening of concepts), desymbolization & desocialization, Asyndesis, Metanornic & personal idioms, verbalism too much abstraction hyperintellectualization, and condensation:

B) Looseness of association: it include, the following: Loosening of association, tangentially, derailment Incoherence,

word salad, neologisms,
C) Special type of associations: they include the following:
hyperactive association, circumstantiality, flight of idea,
repetitive association (perseveration, verbigeration,
glossolalia, echolalia).

MEMORY

Definition “It is a function by which information stored in the brain, is later recalled to consciousness

Levels of memory:

a) Short-term memory: (immediate memory): It means reproduction or recall of perceived material within seconds to minutes (examined by digit span)

b) Long-term” memory: It include:-
Recent memory: It means recall of events over past few days. It is examined by asking about events in the patients last days. Events should may be widely reported within the media & within the patients interests.

Recent past memory: It means recall of events over the past few months. It is examined by asking about past personal or general events within this period).

Remote memory: It means recall of events in distant past (examined by asking about remote past personal or general events).

Disorders of Memory: It include the following:

Amnesia: It means partial or complete recall of past experiences due to failure in encoding or recalling or recognition.

It may be due to organic or emotional disorder. for events occurring after a to failure to analyze the total

JUDGMENT

Definition is the ability to assess a situation” correctly appropriately within this situation. It is the ability to grasp the current information & to assess the realistic situations & having a logic attitude & performance which is compatible with the situation as a whole”.

Disturbance of judgment

Critical judgment. It is the ability to choose among various options in a situation.

Automatic Judgment It is a reflex performance of an action

impaired Judgment It is diminished ability understand a situation correctly and to act appropriately.

INSIGHT

Definition; awareness of ones own mental condition and so to understand the objective circumstances of his illness.

True insight : It is the ability to understand the objective reality of a situation coupled with the emotional power and motivation to master the situation.

impaired insight:

(admitting that he is ill but not convinced, the patients may rationalize or may not cooperate therapy or may not persist.

MCQ

A 36-year-old man comes to a physician's office with a chief complaint that "people are out to hurt me." Despite being reassured by his wife that this is untrue, the patient is convinced that men are observing his behavior and actions at home and at work, using telescopic lenses and taping devices. He has torn apart his office on more than one occasion looking for "bugs." The patient's wife says that this behavior is relatively new, appearing somewhat suddenly after the patient was robbed on the way to his car approximately 6 months previously.

Which of the following symptoms best describes what the patient is experiencing?

- A. Ideas of reference
- B. Hallucinations
- C. Paranoid delusions
- D. Paranoid ideations
- E. Thought disorder

COGNITIVE DISORDERS

Cognitive disorders include three group of disorders; delirium, dementia, and amnesic disorders, in which the cardinal symptom is cognitive impairment.

DELERIUM

Definitions:

Delirium is a reversible state of global cortical dysfunction characterized by alterations in attention and cognition and produced by a definable precipitant. Delirium is categorized by its etiology as due to general medical conditions, substance related, or multifactorial in origin table (1).

Common Causes of Delirium

General Medical	Substance-Related
Infectious	Intoxication
Urinary tract infections	Alcohol
Meningitis	Hallucinogens
Pneumonia	Opioids
Sepsis	Marijuana
Metabolic	Stimulants
Hyponatremia	Sedatives
Hepatic encephalopathy	Withdrawal
Hypoxia	Alcohol
Hypercarbia	Benzodiazepines
Hypoglycemia	Barbiturates
Fluid imbalance	Medication-induced
Uremia	Anesthetics
Hypercalcemia	Anticholinergics
Postsurgical	Meperidine
Hyper/hypothyroidism	Antibiotics
Ictal/postictal	Toxins
Head trauma	Carbon monoxide
Miscellaneous	Organophosphates
Fat emboli syndrome	
Thiamine deficiency	
Anemia	

Table (1): Aetiology of delerium.



Clinical Manifestations:

Key features of delirium are:

1. Disturbance of consciousness, especially attention and level of arousal;
2. Alterations in cognition, especially memory, orientation, language, and perception;
3. Development over a period of hours to days; and
4. Presence of medical or substance-related precipitants.

Delirium describes a relatively brief, but global, cognitive impairment. Delirious individuals often are not oriented to place or time, believing themselves to be at home rather than in the hospital, or confusing day and night. They are easily distracted, and their rapidly shifting attention may make conversation difficult or impossible.

There is frequently disruption of the sleep-wake cycle, ranging from hypersomnia to insomnia; and sometimes a reduced wakefulness or “clouded consciousness” dominates. Motor activity can vacillate, shifting between hyperactivity and lethargy. Shifting emotional disturbances are typical, including extremes such as euphoria, anger, and depression. Fear is commonly present and sometimes leads to attempts to escape or to attack others perceived to be threatening. Visual hallucinations, especially of animals or people, were common,

and together with delusions were the most significant sources of fear and anxiety.

Speech disruptions in delirium can include articulation difficulties, inability to name objects, incoherent speech, repetition, or difficulty understanding words. Writing ability may be impaired as well. These emotional, perceptual, and speech disturbances can resemble other psychotic conditions, *except for their fragmented and fluctuating presentation.*

Delirium is often difficult to separate from dementia, in part because dementia is a risk factor for delirium (and thus they frequently co-occur) and in part because there is a great deal of symptom overlap. Key differentiating factors are the time course of development of the mental status change (especially if the patient did not have a prior dementia) and the presence of a likely precipitant for the mental status change. Individuals with delirium may also display periods of complete lucidity interspersed with periods of confusion, whereas in dementia, the deficits are generally more stable. In both conditions, there may be nocturnal worsening of symptoms with increased agitation and confusion (“sundowning”).

Differential Diagnosis

Delirium should be differentiated from dementia (although both can be present at the same time), psychotic or manic disorganization, and status complex partial epilepsy

Treatment:

As long as the underlying condition is treated, most people recover from delirium fully. Treatment of the florid and often psychotic symptoms of the disturbance often involves sedation, usually via low-dose antipsychotic medication.



DEMENTIA

Like delirium, the cognitive disturbance associated with dementia is global, involving both memory and speech. In contrast to delirium, dementia may have a gradual, slow onset and, more frequently, has a chronic course. The person with dementia is usually alert and does not show disturbance of consciousness.

Dementia always involves a memory deficit, which is most apparent in recent memory and the retention of new learning. For example, a person may lose recently handled items, forget activities that are in progress, or be unable to recall a list of words given moments before. The demented person may become easily lost when walking in unfamiliar settings.

When dementia is advanced, memory impairment extends beyond recent events, and people may forget important personal information (such as occupation or even name).

In addition to memory impairment, the diagnosis of dementia requires that one of the following cognitive disturbances must be present:

-**Aphasia:** is a language disturbance that involves impairment in understanding or expressing ideas through language. Sentences may appear to be devoid of meaning or empty, and they may be long and disconnected. People may be unable to label common items in the room. Understanding of spoken

words is also affected; individuals may have trouble following instructions or comprehending normal conversation.

-**Apraxia:** is manifested by impaired ability to execute motor activities although motor function is intact. For example, individuals may not be able to demonstrate how to comb their hair or brush their teeth, or how to wave good-bye, although they are physically capable to making those movements. As a result, normal self-care abilities such as dressing and grooming are often disrupted.

-**Agnosia:** is failure to recognize objects or people that were formerly familiar to the person. Common items such as car keys or pencils might not be identified, or labeled verbally. In severe cases of dementia, individuals may not recognize close friends, family members, or even themselves in a mirror.

-**Disturbances in executive functions:** involve impairments in the ability to plan and execute actions. Abstract thinking is deficient, and serial tasks are impaired, such as counting or reciting familiar sequences (e.g., the alphabet).

To diagnose dementia, the deficits in memory and cognitive functioning must also cause impairment in important areas of life and represent a significant decline from a previous level of functioning. As dementia progresses, these impairments become more obvious. Individuals may show early symptoms of difficulty with financial issues or with shopping, progressing to

problems in daily activities such as dressing, bathing, and eating; they may lose the ability to use common tools such as telephones. They almost always have impaired judgment and poor insight and may underestimate the dangers of certain activities, such as driving.

Delusions (often persecutory) and hallucinations (often visual) can occur; and depending on the causal factor, additional delirium may also be present. However, the dementia must be separable from the effects of any pre-existing delirium before the diagnosis can be applied.

Etiology

Generally, the etiology of dementia is brain neuronal loss that may be due to neuronal degeneration or to cell death secondary to trauma, infarction, hypoxia, infection, or hydrocephalus. Table (2) lists the major discrete illnesses known to produce dementia. In addition, there are a large number of general medical, substance-related, and multifactorial causes of dementia.

Specific Diseases Associated with Dementia	
Disease	Description
Alzheimer's	Most common cause of dementia, accounts for greater than 50% of all cases. Risk factors are familial, Down syndrome, prior head trauma, increasing age. Clinically, it is a diagnosis of exclusion. Post-mortem pathology reveals cortical atrophy, neurofibrillary tangles, amyloid plaques, granulovacuolar degeneration, loss of basal forebrain cholinergic nuclei. Course is progressive, death occurs 8–10 years after onset.
Vascular	Second most common cause of dementia. Risk factors are cardiovascular and cerebrovascular disease. Neuroimaging reveals multiple areas of neuronal damage. Neurological exam reveals focal findings. Course can be rapid onset or more slowly progressive. Deficits are not reversible, but progress can be halted with appropriate treatment of vascular disease.
HIV	Limited to those cases caused by direct action of HIV on the brain; associated illnesses, such as meningitis, lymphoma, toxoplasmosis producing dementia are categorized under dementia due to general medical conditions. Primarily affects white matter and cortex.
Head trauma	Most common among young males. Extent of dementia is determined by degree of brain damage. Deficits are stable unless there is repeated head trauma.
Parkinson's	Occurs in 20–60% of individuals with Parkinson's disease. The most likely pathological finding on autopsy is Lewy body disease. Bradyphrenia (slowed thinking) is common. Some individuals also have pathology at autopsy consistent with Alzheimer's dementia.
Huntington's	Risk factors are familial, autosomal dominant on chromosome 4. Onset commonly in mid 30s. Emotional lability is prominent. Caudate atrophy is present on autopsy.
Pick's	Onset at age 50–60. Frontal and temporal atrophy are prominent on neuroimaging. The dementia responds poorly to psychotropic medicine.
Creutzfeldt-Jakob	Ten percent of cases are familial. Onset age 40–60. Prion is thought to be agent of transmission. Clinical triad of dementia, myoclonus, and abnormal EEG. Rapidly progressive. Spongiform encephalopathy is present at autopsy.

Table (2): causes of dementia.

Differential Diagnosis

Dementia should be differentiated from delirium. Individuals with major depression and psychosis can appear demented; they warrant a diagnosis of dementia only if their cognitive deficits cannot be fully attributed to the primary psychiatric illness. A critical component of differential diagnosis in dementia is to distinguish pseudodementia associated with depression. In pseudodementia, mood symptoms are prominent, and patients characteristically give “I don’t know” answers to mental status examination queries but may answer correctly if pressed. Memory is intact with rehearsal in pseudodementia, but not in dementia.

Management

Dementia from reversible, or treatable, causes should be managed first by treating the underlying cause of the dementia; rehabilitation may be required for residual deficits. Reversible (or partially reversible) causes of dementia include normal pressure hydrocephalus; neurosyphilis; HIV infection; and thiamine, folate, vitamin B12, and niacin deficiencies. Vascular dementias may not be reversible, but their progress can be halted in some cases. Nonreversible dementias are usually managed by placing the patient in a safe environment and by medications targeted at associated symptoms.

Dementia of the Alzheimer's Type

Dementia of the Alzheimer's Type is the most common form of dementia; its prevalence is increasing as the population ages. Alzheimer's disease accounts for up to 60 percent of all cases of dementia. Alzheimer's disease causes a progressive and irreversible dementia that gradually worsens as brain deterioration proceeds, with death typically occurring within 10 years of diagnosis.

Alzheimer's disease is caused by a gradual and chronic deterioration of cholinergic neurons (those neurons that use acetylcholine, or ACh, as their neurotransmitter). The microtubules within the axons of these neurons begin disintegrating, and tau proteins (which normally stabilize the

structure of the neuron) form remnant clumps of material called neurofibrillary tangles. In addition, a sticky plaque, consisting of beta amyloid protein fragments and degenerated axon terminals, accumulates in deposits called senile plaques, which also damage neurons. As the condition progresses, more and more brain areas are impacted; the brain ventricles become enlarged, and the cortex shows clear signs of atrophy

Treatment:

It is not yet possible to stop or reverse the course of Alzheimer's disease or its accompanying dementia. At present, treatment is focused on techniques to slow the advancement of the deterioration, and to improve the quality of life of patients. It is known that destruction of cholinergic neurons reduces levels of acetylcholine in the brain and interferes with the functioning of the hippocampus and other areas important to memory. The ACh depletion might be addressed by use of cholinesterase inhibitors, which slow the breakdown of ACh in the synapse, causing levels of the neurotransmitter to decline less steeply.

AMNESTIC DISORDERS

Amnestic disorders are isolated disturbances of memory without impairment of other cognitive functions. They may be due to a general medical condition or substance related.

Etiology:

Amnestic disorders are caused by general medical conditions or substance use. Common general medical conditions include head trauma, hypoxia, herpes simplex encephalitis, and posterior cerebral artery infarction.

Amnestic disorders due to substance-related causes may be due to substance abuse, prescribed or over-the counter medications, or accidental exposure to toxins. Alcohol abuse is a leading cause of substance related amnestic disorder. Persistent alcohol use may lead to thiamine deficiency and induce Wernicke-Korsakoff's syndrome. If the syndrome properly treated, the acute symptoms of ataxia, abnormal eye movements, and confusion may resolve, leaving a residual amnestic disorder.

Clinical Manifestations

Amnestic disorders present as deficits in memory, either in the inability to recall previously learned information or the inability to retain new information.

The cognitive defect must be limited to memory alone; if additional cognitive defects are present, a diagnosis of dementia or delirium should be considered. In addition to defect in memory, there must be an identifiable cause for the amnesic disorder (i.e., the presence of a general medical condition or substance use).

Differential Diagnosis: Delirium and dementia are the major differential diagnostic considerations. Amnesic disorders are distinguished from dissociative disorders on the basis of etiology. By definition, amnesic disorders are due to a general medical condition or substance.

Management

The general medical condition is treated whenever possible to prevent further neurologic damage; in the case of a substance-related amnesic disorder, avoiding reexposure to the substance responsible for the

amnesic disorder is critical. Pharmacotherapy may be directed at treating associated anxiety or mood difficulties. Patients should be placed in a safe, structured environment with frequent memory cues.

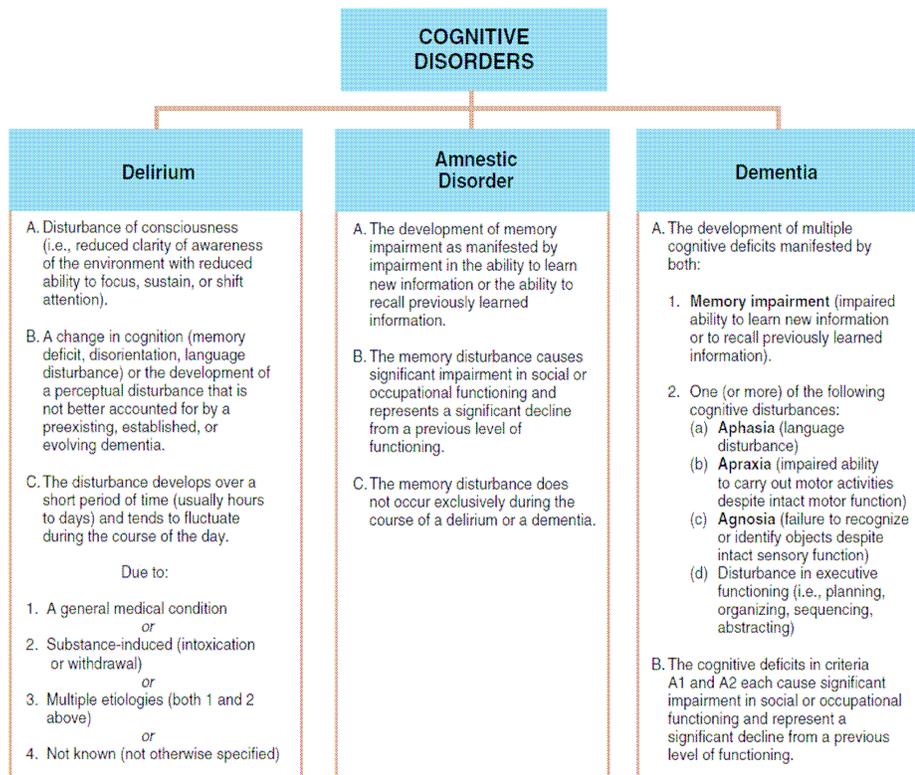
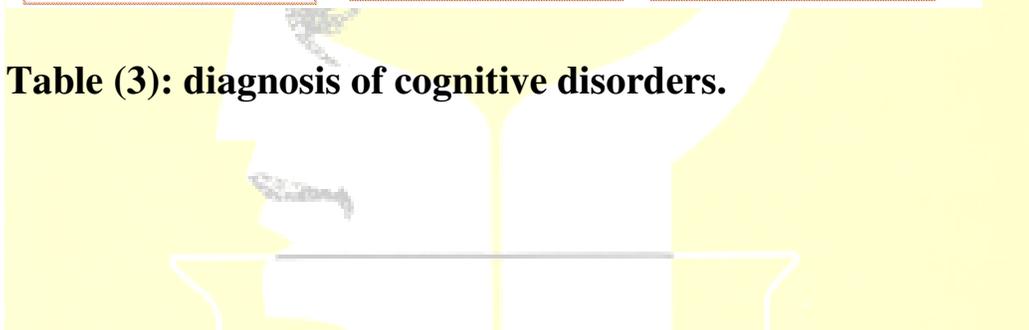


Table (3): diagnosis of cognitive disorders.



Mood disorders

Definition

Healthy persons experience a wide range of moods and have an equally large repertoire of affective expressions they feel in control of their moods and affects.

Mood disorders encompass a large spectrum of disorders in which pathological mood disturbances dominate the clinical picture. **they include the following 7 disorders;**

- major depressive disorders
- Bipolar disorders
- Dythymic disorders
- cyclothymic disorder
- Mood disorders due to a general medical condition
- substance-induced mood disorder

-the general category of depressive and bipolar disorders not otherwise specified

!!- Epidemiology

a-Incidence and prevalence mood disorders are common . the most recent survey major depressive disorder has the highest lifetime prevalence (almost 17%).

Mood Disorder	Lifetime Prevalence
Depressive disorders	
Major depressive disorder (MDD)	10%–25% for women; 5%–12% for men
Recurrent, with full interepisode recovery, superimposed on dysthymic disorder	Approximately 3% of persons with MDD
Recurrent, without full interepisode recovery, superimposed on dysthymic disorder (double depression)	Approximately 25% of persons with MDD
Dysthymic disorder	Approximately 6%
Bipolar disorders	
Bipolar I disorder	0.4%–1.6%
Bipolar II disorder	Approximately 0.5%
Bipolar I disorder or bipolar II disorder, with rapid cycling	5%–15% of persons with bipolar disorder
Cyclothymic disorder	0.4%–1.0%

b-sex;

major depression is more common in women bipolar 1 disorder is equal in men and women.

c-age

the age of onset for bipolar disorder 1 is usually about age 30. However, the disorder also occurs in young children as well as old adults.

d-Socioeconomic and Cultural Factors

Depression is more common in single and divorced persons compared to married persons, rural areas than in urban areas. The prevalence of mood disorder does not differ among races and religion.

!!!-aetiology;

A-neurotransmitters

1-serotonin. the most commonly associated with depression, Depletion of serotonin may precipitate depression, and some patients with suicidal impulses have low cerebrospinal fluid (CSF) concentrations of serotonin metabolites and low concentrations of serotonin uptake sites on platelets.

2-Norepinephrine

The correlation suggested by basic science studies between the downregulation or decreased sensitivity of β -adrenergic receptors and clinical antidepressant responses is probably the most compelling piece of evidence indicating a direct role for the noradrenergic system in depression. Other evidence has also implicated the presynaptic β_2 receptors in depression because activation of these receptors results in a decrease of the amount of norepinephrine released. Presynaptic β_2 receptors are also located on serotonergic neurons and regulate the amount of serotonin released. The clinical effectiveness of antidepressant drugs with noradrenergic effects—for example, venlafaxine (Effexor)—further supports a role for norepinephrine in the pathophysiology of at least some of the symptoms of depression.

3-dopamine; The data suggest that dopamine activity may be reduced in depression and increased in mania. Drugs that reduce

dopamine concentrations (e.g., reserpine [Serpasil]) and diseases that reduce dopamine concentrations (e.g., Parkinson's disease) are associated with depressive symptoms. In contrast, drugs that increase dopamine concentrations, such as tyrosine, amphetamine, and bupropion (Wellbutrin), reduce the symptoms of depression.

B-psychosocial

1-psychoanalytic

Freud described internalized ambivalence toward a love person which produce a pathological form mourning if the person is lost.

2-cognitive; Aaron Beck postulated a cognitive triad of depression that consists of views about (1) the self—a negative self-precept; (2) the environment—a tendency to experience the world as hostile and demanding; and (3) the future—the expectation of suffering and failure.

3-learned helplessness

A theory that attributes depression to a person ability to control events

4-stressful life events

Often precede first episodes of mood disorders

!v. laboratory , brain imaging, and psychological tests

a-dexamethasone suppression test. Nonsuppression (positive result) represents hypersecretion of cortisol secondary to hyperactivity of hypothalamic-pituitary –adrenal axis. abnormal in 50% of patients with major depression.

Diminished release of TH in response to TRH reported in both depression and mania

Prolactin release decreased in response to tryptophan

B-brain imaging; No gross changes

c-Psychological tests;

1-Rating scales. The beck depression inventory (Bdi), Hamilton rating scale for depression (Ham-d)

v-Bipolar disorder

Bipolar disorder I characterized by appearance of manic episodes with or without a major depressive episode and bipolar II characterized by at least of one depressive episode with or without a hypomanic episode.

A. Depression (major depressive episode). See Table 14–2.

1. Information obtained from history

- a. Depressed mood: subjective sense of sadness, feeling “blue” or “down in the dumps” for a prolonged period of time.
- b. Anhedonia: inability to experience pleasure.
- c. Social withdrawal.
- d. Lack of motivation, little tolerance of frustration.
- e. Vegetative signs.
 - (1) Loss of libido.
 - (2) Weight loss and anorexia.
 - (3) Weight gain and hyperphagia.
 - (4) Low energy level; fatigability.
 - (5) Abnormal menses.
 - (6) Early morning awakening (terminal insomnia); approximately 75% of depressed patients have sleep difficulties, either insomnia or hypersomnia.
 - (7) Diurnal variation (symptoms worse in morning).
- f. Constipation.
- g. Dry mouth.
- h. Headache.

2. Information obtained from mental status examination

- a. **General appearance and behavior:** psychomotor retardation or agitation, poor eye contact, tearful, downcast, inattentive to personal appearance.
- b. **Affect:** constricted or labile.
- c. **Mood:** depressed, irritable, frustrated, or sad.
- d. **Speech:** little or no spontaneity; monosyllabic; long pauses; soft, low monotone.
- e. **Thought content:** suicidal ideation affects 60% of depressed patients, and 15% commit suicide; obsessive rumination; pervasive feelings of hopelessness, worthlessness, and guilt; somatic preoccupation; indecisiveness; poverty of thought content and paucity of speech; mood-congruent hallucinations and delusions.
- f. **Cognition:** distractible, difficulty concentrating, complaints of poor memory, apparent disorientation; abstract thought may be impaired.
- g. **Insight and judgment:** impaired because of cognitive distortions of personal worthlessness.

B. Mania (manic episode). Persistent elevated expansive mood.
14–3.

1. Information obtained from history

- a. Erratic and disinhibited behavior.
(1) Excessive spending or gambling.

(2) Impulsive travel.

(3) Hypersexuality, promiscuity.

- b. Overextended in activities and responsibilities.

- c. Low frustration tolerance with irritability and outbursts of anger.

- d. Vegetative signs.

(1) Increased libido.

(2) Weight loss, anorexia.

(3) Insomnia (expressed as no need to sleep).

(4) Excessive energy.

2. Information obtained from mental status examination

- a. **General appearance and behavior:** psychomotor agitation; seductive, colorful clothing; excessive makeup; inattention to personal appearance or bizarre combinations of clothes; intrusive; entertaining; threatening; and hyperexcited.

- b. **Affect:** labile, intense (may have rapid depressive shifts).

- c. **Mood:** euphoric, expansive, irritable, demanding, and flirtatious.

- d. **Speech:** pressured, loud, dramatic, exaggerated; may become incoherent.

- e. **Thought content:** highly elevated self-esteem, grandiose, extremely egocentric; delusions and less frequently hallucinations (mood-congruent themes of inflated self-worth and power, most often grandiose and paranoid).

- f. **Thought process:** flight of ideas (if severe, can lead to incoherence); racing thoughts, neologisms, clang associations, circumstantiality, tangentially.

- g. **Sensorium:** highly distractible, difficulty concentrating; memory, if not too distracted, generally intact; abstract thinking generally intact.

- h. **Insight and judgment:** extremely impaired; often total denial of illness and inability to make any organized or rational decisions.

C. Other types of bipolar disorders

1. **Rapid-cycling bipolar disorder.** Four or more depressive, manic, or mixed episodes within 12 months. Bipolar disorder with mixed or rapid-cycling episodes appears to be more chronic than bipolar disorder without alternating episodes.
2. **Hypomania.** Elevated mood associated with decreased need for sleep, hypoactivity, and hedonic pursuits. Less severe than mania with no psychotic features (see Table 14–4).

D. Depressive disorders

1. **Major depressive disorder.** Can occur alone or as part of bipolar disorder. When it occurs alone, it is also known as *unipolar depression*. Symptoms must be present for at least 2 weeks and represent a change from previous functioning. More common in women than in men by 2:1. Precipitating event occurs in at least 25% of patients. Diurnal variation, with symptoms worse early in the morning. Psychomotor retardation or agitation is present. Associated with vegetative signs. Mood-congruent delusions and hallucinations may be present. Median age of onset is 40 years, but can occur at any time. Genetic factor is present. Major depressive disorder may occur as a single episode in a person's life or may be recurrent.

2. Other types of major depressive disorder

- a. **Melancholic:** severe and responsive to biological intervention.
- b. **Chronic:** present for at least 2 years; more common in elderly men, especially alcohol and substance abusers, and responds poorly to medications. Accounts for the condition of 10% to 15% of those with major depressive disorder. Can also occur as part of depression in bipolar I and II disorders.
- c. **Seasonal pattern:** depression that develops with shortened daylight in winter and fall and disappears during spring and summer; also known as *seasonal affective disorder*. Characterized by hypersomnia, hyperphagia, and psychomotor slowing. Related to abnormal melatonin metabolism. Treated with exposure to bright, artificial light for 2 to 6 hours each day. May also occur as part of bipolar I and II disorders.

- d. **Postpartum onset:** severe depression beginning within 4 weeks of giving birth. Most often occurs in women with underlying or pre-existing mood or other psychiatric disorder. Symptoms range from marked insomnia, lability, and fatigue to suicide. Homicidal and delusional beliefs about the baby may be present. Can be psychiatric emergency, with both mother and baby at risk. Also applies to manic or mixed episodes or to brief psychotic disorder (Chapter 13).
- e. **Atypical features:** sometimes called *hysterical dysphoria*. Major depressive episode characterized by weight gain and hypersomnia, rather than weight loss and insomnia. More common in women than in men by 2:1 to 3:1. Common in major depressive disorder with seasonal pattern. May also occur as part of depression in bipolar I or II disorder and dysthymic disorder. (See Table 14–6.)
- f. **Catatonic:** stuporous, blunted affect, extreme withdrawal, negativism, and psychomotor retardation with posturing and waxy flexibility. Responds to electroconvulsive therapy (ECT).
- g. **Pseudodementia:** major depressive disorder presenting as cognitive dysfunction resembling dementia. Occurs in elderly persons, and more often in patients with previous history of mood disorder. Depression is primary and preeminent, antedating cognitive deficits. Responsive to electroconvulsive therapy (ECT) or antidepressant medication.
- h. **Depression in children:** not uncommon. Signs and symptoms similar to those in adults. Masked depression seen in somatic symptoms, running away from home, school phobia, and substance abuse. Suicide may occur.
- i. **Double depression:** development of superimposed major depressive disorder in dysthymic patients (about 10%–15%).
- j. **Depressive disorder not otherwise specified:** depressive features that do not meet the criteria for a specific mood disorder (e.g., minor depressive disorder, recurrent brief depressive disorder, and premenstrual dysphoric disorder).
- k. **Psychotic features:** hallucinations or delusions associated with depression.

3. **Dysthymic disorder** (previously known as *depressive neurosis*). Less severe than major depressive disorder. More common and chronic in women than in men. Insidious onset. Occurs more often in persons with history of long-term stress or sudden losses; often coexists with other psychiatric disorders (e.g., substance abuse, personality disorders, obsessive–compulsive disorder). Symptoms tend to be worse later in the day. Onset generally between ages of 20 and 35, although an early-onset type begins before age 21. More common among first-degree relatives with major depressive disorder. Symptoms should include at least two of the following: poor appetite, overeating, sleep problems,
4. **Cyclothymic disorder**. Less severe disorder, with alternating periods of hypomania and moderate depression. The condition is chronic and nonpsychotic. Symptoms must be present for at least 2 years. Equally common in men and women. Onset usually is insidious and occurs in late adolescence or early adulthood. Substance abuse is common. Major depressive disorder and bipolar disorder are more common among first-degree relatives than among the general population. Recurrent mood

VI. Differential diagnosis

Table 14–9 lists the clinical differences between depression and mania.

- A. **Mood disorder resulting from general medical condition**. Depressive, manic, or mixed features or major depressivelike episode secondary to medical illness (e.g., brain tumor, metabolic illness, HIV disease, Parkinson’s disease, Cushing’s syndrome) (Table 14–10). Cognitive deficits are common.
 1. **Hypothyroidism**. Hypothyroidism associated with fatigability, depression, and suicidal impulses. May mimic schizophrenia, with thought disorder, delusions, hallucinations, paranoia, and agitation. More common in women. Was called myxedema madness.
 2. **Mercury**. Chronic mercury intoxication (poisoning) produces manic (and sometimes depressive) symptoms. Was called mad hatter’s syndrome.



- B. Substance-induced mood disorder.** See Table 14–11. Mood disorders caused by a drug or toxin (e.g., cocaine, amphetamine, propranolol [Inderal], steroids). Must always be ruled out when patient presents with depressive or manic symptoms. Mood disorders often occur simultaneously with substance abuse and dependence.
- C. Schizophrenia.** Schizophrenia can look like a manic, major depressive, or mixed episode with psychotic features. To differentiate, rely on such factors as family history, course, premorbid history, and response to medication. Depressivelike or maniclike episode with presence of mood-incongruent psychotic features suggests schizophrenia. Thought insertion and broadcasting, loose associations, poor reality testing, or bizarre behavior may also suggest schizophrenia. Bipolar disorder with depression or mania more often is associated with mood-congruent hallucinations or delusions.
- D. Grief.** Though recent research disputes if it is different in course and severity from major depression. Known as *bereavement* in *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*). Profound sadness secondary to major loss. Presentation may be similar to that of major depressive disorder, with anhedonia, withdrawal, and vegetative signs. Remits with time. Differentiated from major depressive disorder by absence of suicidal ideation or profound feelings of hopelessness and worthlessness. Usually resolves within a year. May develop into major depressive episode in predisposed persons.
- E. Personality disorders.** Lifelong behavioral pattern associated with rigid defensive style; depression may occur more readily after stressful life event because of inflexibility of coping mechanisms. Manic episode may also occur more readily in predisposed people with pre-existing personality disorder. A mood disorder may be diagnosed on Axis I simultaneously with a personality disorder on Axis II.
- F. Schizoaffective disorder.** Signs and symptoms of schizophrenia accompany prominent mood symptoms. Course and prognosis are between those of schizophrenia and mood disorders.
- G. Adjustment disorder with depressed mood.** Moderate depression in response to clearly identifiable stress, which resolves as stress diminishes. Considered a maladaptive response resulting from either impairment in functioning or excessive and disproportionate intensity of symptoms. Persons with personality disorders or cognitive deficits may be more vulnerable.
- H. Primary sleep disorders.** Can cause anergy, dyssomnia, and irritability. Distinguish from major depression by assessing for typical signs and symptoms of depression and occurrence of sleep abnormalities only in the context of depressive episodes. Consider obtaining a sleep laboratory evaluation in cases of refractory depression.
- I. Other mental disorders.** Eating disorders, somatoform disorders, and anxiety disorders are all commonly associated with depressive symptoms

VIII. Treatment

A. Depressive disorders. Major depressive episodes are treatable in 70% to 80% of patients. The most effective approach is to integrate pharmacotherapy with psychotherapeutic interventions.

1. Psychopharmacological.

- a. Most clinicians begin treatment with a selective serotonin reuptake inhibitor (SSRI). Early transient side effects include anxiety, gastrointestinal upset, and headache. Educating patients about the self-limited nature of these effects can enhance compliance. Sexual dysfunction is often a persistent, common side effect that may respond to a change in drug or dosage, or adjunctive therapy with an agent such as bupropion (Wellbutrin) or buspirone (BuSpar). The early anxiogenic effects of SSRIs may aggravate suicidal ideation and can be managed by either reducing the dose or adding an anxiolytic (e.g., 0.5 mg of clonazepam [Klonopin] in the morning and at night). Insomnia can be managed with a benzodiazepine, zolpidem (Ambien), trazodone (Desyrel), or mirtazapine (Remeron). Patients who do not respond to or who cannot tolerate one SSRI may respond to another. Some clinicians switch to an agent with a different mechanism of action, such as bupropion, venlafaxine (Effexor), duloxetine (Cymbalta), mirtazapine (Remeron), a tricyclic, or a monoamine oxidase

b-augmentation strategies in treatment –resistant or partially responsive patients include liothyronine, lithium, amphetamines, buspirone or antidepressant combinations such as buprion added to ssri

c-Major depressive episodes that have atypical features or psychotic features or that are related to bipolar I may respond to MAOIS. MAOIS must not be administered for 2 to 5 weeks after discontinuation of SSRI

D- ECT;

E-lithium can be first drug in treating depression of bipolar

F-Repetitive transcranial magnetic stimulation (Rtms) shows promise as a treatment for depression

G-Vagus nerve stimulation

2-psychological

Cognitive therapy; correcting negative cognitions and unconscious assumptions that underlie them



b. bipolar disorders

1. Biological

- a. Mood stabilizers such as lithium and divalproex (Depakote) are the first choice of drugs used for bipolar disorder but second generation antipsychotics such as olanzapine (Zyprexa) are also used. Carbamazepine (Tegretol) is also a well-established treatment. Lamotrigine (Lamictal) is used in the maintenance phase of bipolar disorder. Topiramate (Topamax) is another anticonvulsant used in bipolar patients. ECT is highly effective in all phases of bipolar disorder. Carbamazepine, divalproex, and valproic acid (Depakene) may be more effective than lithium in the treatment of mixed or dysphoric mania, rapid cycling, and psychotic mania, and in the treatment of patients with a history of multiple manic episodes or comorbid substance abuse.
- b. Treatment of acute manic episodes often requires adjunctive use of potent sedative drugs. Drugs commonly used at the start of treatment include clonazepam (1 mg every 4 to 6 hours) and lorazepam (Ativan) (2 mg every 4 to 6 hours). Physicians should attempt to taper these adjunctive agents when the patient stabilizes. Bipolar patients may be particularly sensitive to the side effects of typical
- c. Lithium remains a mainstay of treatment in bipolar disorders. A blood level of 0.8 to 1.2 mEq/L is usually needed to control acute symptoms. A complete trial should last at least 4 weeks, with 2 weeks at therapeutic levels. Prelithium workup includes a complete blood cell count, electrocardiogram (ECG), thyroid function tests, measurement of blood urea nitrogen and serum creatinine, and a pregnancy test. Lithium has a narrow therapeutic index, and levels can become toxic quickly when a patient is dehydrated. A level of 2.0 mEq or higher is toxic. Lithium treatment can be initiated at 300 mg three times per day. A level should be checked after 5 days and the dose titrated accordingly. The clinical response may take 4 days after a therapeutic level has been achieved. Typical side effects include thirst, polyuria, tremor, metallic taste, cognitive dulling, and gastrointestinal upset. Lithium can induce hypothyroidism and, in rare cases, renal toxicity. Lithium achieves an antidepressant response in

- d. Valproic acid and divalproex have a broad therapeutic index and appear effective at levels of 50 to 125 mcg/mL. Pretreatment workup includes a complete blood cell count and liver function tests. A pregnancy test is needed because this drug can cause neural tube defects in developing fetuses. It can cause thrombocytopenia and increased transaminase levels, both of which are usually benign and self-limited but require increased blood monitoring. Fatal hepatic toxicity has been reported only in children under age 10 who received multiple anticonvulsants.
- f. Lamotrigine is an anticonvulsant that may have antidepressant, anti-manic, and mood-stabilizing properties and does not require blood monitoring. Lamotrigine requires gradual titration to decrease the risk for rash, which occurs in 10% of patients. Stevens–Johnson syndrome occurs in 0.1% of patients treated with lamotrigine. Other side effects include nausea, sedation, ataxia, and insomnia. Dosage can
- g. Maintenance treatment is required in patients with recurrent illness. During long-term treatment, laboratory monitoring is required for lithium, valproic acid, and carbamazepine.
- h. Patients who do not respond adequately to one mood stabilizer may do well with combination treatment. Lithium and valproic acid are commonly used together. Increased neurotoxicity is a risk, but the combination is safe. Other combinations include lithium plus carbamazepine, carbamazepine plus valproic acid (requires increased laboratory monitoring for drug interactions and hepatic toxicity), and combinations with the newer anticonvulsants.
- i. Other agents used in bipolar disorder include verapamil (Isoptin, Calan), nimodipine (Nimotop), clonidine (Catapres), clonazepam, and levothyroxine (Levoxyl, Levothroid, Synthroid). Clozapine (Clozaril) has been shown to have antimanic and mood-stabilizing properties and is used if and when patients do not respond to con-

MCQS AND CASES

1-A 70-year-old woman presents to her primary care provider complaining of fatigue for the past 7 weeks. She admits to difficulty falling asleep, a poor appetite with a 10-lb weight loss, and thoughts of wanting to die. She admits to having had symptoms similar to these on several occasions in the past, but “never this bad.” Her medical problems include asthma and high cholesterol. She uses an albuterol inhaler only as needed. Which of the following symptoms is necessary in order to make a diagnosis of major depressive disorder?

- A. Depressed mood
- B. Decreased appetite
- C. Excessive guilt
- D. Fatigue
- E. Suicidal ideation

2-For the following clinical vignettes (questions 4.1 through 4.5), choose the one most likely diagnosis (A through D):

- A. Bipolar disorder, manic
- B. Major depression
- C. Mood disorder due to a general medical condition
- D. Substance-induced mood disorder
- E. Adjustment disorder with depressed mood

1 An 18-year-old man presents with 3 days of an irritable mood, decreased sleeping, talkativeness, increased energy, and distractibility.

He has no personal or family psychiatric history and no current medical problems. His mental status examination is remarkable for psychomotor agitation and an irritable affect. He is paranoid but denies delusions or hallucinations. His physical examination is notable for a slightly elevated pulse rate and blood pressure as well as markedly dilated pupils bilaterally. The result of his urine toxicology screening is positive for cocaine.

2 A 39-year-old woman presents with 1 month of a gradually worsening depressed mood, with increased sleeping, low energy, and difficulty concentrating, but no appetite or weight changes. Her medical history is significant for multiple sclerosis, but she is currently not taking any medication. Her mental status examination is notable for psychomotor slowing and a depressed affect. Her physical examination demonstrates several different sensory and motor deficits.

3 A 52-year-old male executive presents with an onset of depression, early-morning awakening, decreased energy, distractibility, anhedonia, poor appetite, and weight loss for the past 3 months. His symptoms

began shortly after he suffered a myocardial infarction.

Although he did not experience significant sequelae, he has felt less motivated and fulfilled in his life and work, believing that he is now “vulnerable.” As a result, he does not push himself as he used to, and his output is beginning to decline.

4 An 80-year-old woman without a psychiatric history is examined after a left-sided cerebral vascular accident has left her paralyzed on her right side. Since her stroke, she complains of an absence of pleasure in anything that she formerly enjoyed. She describes frequent crying spells, increased sleeping, a decreased appetite with weight loss, and feelings of hopelessness and helplessness

5 A 36-year-old man with a past history of a major depressive episode is brought into the emergency room by the police after stopping traffic on the highway proclaiming that he is “the Messiah.” His wife is contacted who states that he has been walking throughout the house all night for the last 4 nights, talking “nonstop,” and starting many home repair projects that remain unfinished. She believes that he is taking sertraline for his depression and propranolol for high blood pressure. His blood alcohol level is less than 10, and his urine toxicology screen is negative.

3-A 27-year-old woman is brought to the local A&E department by her family. She appears restless, pacing around the waiting room, and her parents say that she has recently been asked to

leave her job. She has not slept for several nights, and her speech is rapid and quickly wanders off the point. She had recently purchased an expensive car, and makes references to being offered a new job as chief executive of a major company. She is very reluctant to remain in the A&E department because she has far too much to do and considers it a waste of everyone's time. She believes that she is far too important to be messed around in such a way

Q1. What is the likely differential diagnosis?

Q2. What information in the history supports the diagnosis, and what other information would help to confirm it?

Q3. What might the important aetiological factors be?

Q4. What treatment options are available?

Q5. What is the prognosis in this case?

4-A 45-year-old man presents to his GP with feelings of hopelessness, sadness and helplessness. He says that he cries for no reason, and has difficulty sleeping. He noticed that the problems began about 6 weeks before, and he didn't feel able to shrug them off. He has been drinking more alcohol than usual, and has stopped going to work. When on his own he admitted that he had thought of driving his car into the local lake

Q1. What is the likely differential diagnosis?

Q2. What information in the history supports the diagnosis, and what other information would help to confirm it?

Q3. What might the important aetiological factors be?

Q4. What treatment options are available?

Q5. What is the prognosis in this case?

1-A 55-year-old woman comes to a psychiatrist complaining of experiencing a depressed mood over the past 3 months. She notes that her mood has been consistently low, and she describes her condition as “just not me.” She has also noticed a decrease in energy and a weight gain of 6 to 7 lb. occurring over the same period of time, although her appetite has not increased. She has never visited a psychiatrist before and does not remember ever feeling this depressed for this long before. She states that she has no medical problems that she is aware of and takes no medications.

Her family history is positive for schizophrenia in one maternal aunt.

On a mental status examination the patient appears depressed and tired, although she has a normal range of affect. Her thought processes are linear and logical. She is not suicidal or homicidal and does not report hallucinations or delusions.

Her physical examination reveals a blood pressure of 110/70 mm Hg and a temperature of 98°F (36.7°C). Her thyroid gland is diffusely enlarged but not painful. Her heart has a regular rate and rhythm. She has coarse, brittle hair but no rashes.

➤ What is the most likely diagnosis?

Neurotic stress related disorders

“Anxiety disorders”

Anxiety : feeling of apprehension caused by anticipation of danger, which maybe internal or external

Fear : anxiety “feeling of apprehension” caused by consciously recognized and realistic danger

Anxiety disorders are the most prevalent mental disorders in the general population. Approximately one in four adults in the U.S. population has an anxiety disorder at some point in his or her life. Similar to adults, anxiety disorders are the most common mental disorder in children and adolescents.

Several psychological factors have been associated with **increased risk for anxiety** disorders. Among the most intensively researched has been the concept of anxiety sensitivity.

Anxiety sensitivity has been defined as the individual response to physiological alterations associated with anxiety and fear.

Patients with anxiety disorders have exaggerated psychological reactions that are reflective of misinterpretation of bodily cues, such that the patient misperceives these sensations inappropriately as being harmful and dangerous, leading in a circular fashion to increased anxiety and fear. Anxiety

sensitivity is associated with a selective cognitive bias toward threat. There is evidence that parental concern about anxiety increases anxiety sensitivity in their children.

It has become clear also that some children have an **inherited neurobiological predisposition** to increased physiological reactivity and anxious symptoms in the context of unfamiliar environments and consequently are more vulnerable to one or more of the anxiety disorders.

In a recent study, **behavioral inhibition** was associated with social anxiety disorder in children whose parents had panic disorder. These data suggest that parental panic disorder and childhood behavioral inhibition could be used to identify children at high risk for social anxiety disorder.

Parental overprotection, excessive criticism, and lack of warmth are risk factors for the appearance of anxiety disorders in childhood. Another parental behavior that may enhance the risk of anxiety in offspring is parental sensitization of anxiety through enhancing cognitive awareness of the child to specific events and situations, such as bodily functions, social disapproval, the importance of routines, and the necessity for personal safety. In addition, another feature of the parental relationship that has received widespread attention in recent research has been the exposure to severe childhood trauma through separation or abuse.

Environmental risk factors for the development of anxiety disorders (as well as depression) include poverty, exposure to violence, social isolation, and repeated losses of interpersonal significance

The epidemiology of anxiety disorders:

* The most common is the generalized anxiety disorder affects 3-8% of population. Male to female ratio is 1:2. 25% of patient's relatives are affected.

* Next is the phobia which affects 3-5% of population. Male to female ratio is 1:2. May run in families especially the blood, injury, injection type.

The etiology of anxiety disorders:

- **Biological:** increased release of catecholamine, decreased GABA, increase serotonin, and dopaminergic activity. The center of noradrenergic neurons is the locus cerulus is found hyperactive in anxiety.
- **Learning theory:** conditioned response to frustration or stress, learning through identification and imitation of parents, or association with a naturally frightening stimulus.
- **Psychoanalytic :** unconscious impulses that threaten to burst into consciousness and produce anxiety
- Life events have often been designated a causal role in the onset of phobias, which are linked inherently to particular

events or objects. More broadly, life experiences that, to some extent, threaten one's notion of safety and security in the world are often perceived at least retrospectively to trigger or to precipitate the onset of anxiety disorders.

Psychological signs	Physical signs
Feeling of dread	Trembling, twitching, feeling shaky
Difficulty of concentrating	Backache, headache
Hyper vigilance	Muscle tension
	Shortness of breath, hyperventilation
	Fatigability
	Startle response
	Autonomic hyperactivity: <ul style="list-style-type: none"> - flushing and pallor - tachycardia and palpitation - sweating - cold hands - diarrhea - dry mouth - urinary frequency
	Paresthesia
	Insomnia
	Decreased libido

	Upset stomach 'butterflies'
	Difficulty of swallowing

**** The anxiety disorders “stress related disorders” include:**

a. Generalized anxiety disorder:

A. Excessive anxiety and worry (apprehensive expectation) about a number of events or activities (such as work or school performance) occurring more days than not for at least 6 months.

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:**

Only one item is required in children.

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating
4. Irritability
5. Muscle tension

6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder—e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety or worry does not occur exclusively during posttraumatic stress disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

Case example:

Ms. X. was a successful, married, 30-year-old attorney who presented for a psychiatric evaluation to treat mounting symptoms of worry and anxiety. For the preceding 8 months, Ms. X. noted that she had become increasingly worried about

her job performance. For example, although she had always been a superb litigator, she found herself worrying more and more about her ability to win cases. Similarly, although she had always been in outstanding physical condition, she increasingly worried that her health had begun to deteriorate. Ms. X. noted frequent somatic symptoms that accompanied her worries. For example, she often felt restless while she worked and while she commuted to her office, at which time she tended to think about the upcoming challenges of the day. She reported feeling increasingly fatigued, irritable, and tense. She noted that she had increasing difficulty falling asleep at night as she worried about her job performance and impending trials.

b. Panic disorder and agoraphobia:

Criteria for panic disorder without agoraphobia (300.01)

A. Both (1) and (2)

1. Recurrent unexpected panic attacks
2. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - a. Persistent concern about having additional attacks
 - b. Worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
 - c. A significant change in behavior related to the attacks

B. Absence of agoraphobia.

C. The panic attacks are not due to the direct physiological effects of a substance (drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., occurring on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., occurring on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., occurring on exposure to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., occurring on response to being away from home or close relatives).

Criteria for panic disorder with agoraphobia (300.21)

A. Both (1) and (2)

1. Recurrent unexpected panic attacks

2. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:

a. Persistent concern about having additional attacks

b. Worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)

c. A significant change in behavior related to the attacks

B. Presence of agoraphobia. "fear of leaving the house alone "

C. The panic attacks are not due to the direct physiological effects of a substance (drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., occurring on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., occurring on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., occurring on exposure to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., occurring on response to being away from home or close relatives).

Criteria for panic attack:

A discrete period of intense fear or discomfort, in which 4 or more of the following symptoms developed abruptly and reached a peak within 10 minutes:

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, lightened or faint

9. Derealization 'feelings of unreality' or depersonalization
'being detached from oneself'
10. Fear of losing control or going crazy
11. Fear of dying
12. Paresthesias 'numbness or tingling sensations'
13. Chills or hot flushes

Case example:

Ms. S. was a 25-year-old student who was referred for a psychiatric evaluation from the medical emergency department at a large university-based medical center. Ms. S. had been evaluated in this emergency department three times over the preceding 3 weeks. Her first visit was prompted by a paroxysm of extreme dyspnea and terror that occurred while she was trying out for the volleyball team. The dyspnea was accompanied by palpitations, choking sensations, sweating, shakiness, and a strong urge to flee. Ms. S. thought that she was having a heart attack, and she immediately went to the emergency room. She received a full medical evaluation, including an electrocardiogram (ECG) and routine blood work, which revealed no sign of cardiovascular, pulmonary, or other illness. Ms. S. was given the number of a local psychiatrist, but she did not make a follow-up appointment, because she did not

think that her episode would recur. She developed two other episodes of a similar nature—one while she was on her way to visit a friend and a second that woke her up from sleep. She immediately went to the emergency department after experiencing each paroxysm and received full medical workups that showed no sign of illness.

c. Specific phobia:

A. Marked and persistent fear that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The phobic situation(s) is avoided or is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the

feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under the age of 18 years, the duration is at least 6 months.

G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as obsessive-compulsive disorder (e.g., fear of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), separation anxiety disorder (e.g., avoidance of school), social phobia (e.g., avoidance of social situations because of fear of embarrassment), panic disorder with agoraphobia, or agoraphobia without history of panic disorder.

Specify type:

Animal type

Natural environment type (e.g. heights, storms, water)

Blood–injury type

Situational type (e.g., airplanes, elevators, enclosed places)

Other type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

Case example:

Mr. A. was a successful businessman who presented for treatment after a change in his business schedule. Although he had formerly worked largely from an office near his home, a promotion led to a schedule of frequent out-of-town meetings requiring weekly flights. Mr. A. reported being “deathly afraid” of flying. Even the thought of getting on an airplane led to thoughts of impending doom in which he envisioned his airplane crashing to the ground. These thoughts were associated with intense fear, palpitations, sweating, clamminess, and stomach upset. Although the thought of flying was terrifying enough, Mr. A. became nearly incapacitated when he went to the airport. Immediately before boarding, Mr. A. would often have to turn back from the plane, running to the bathroom to vomit

d. Social phobia:

A. A marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people, and the anxiety must occur in peer settings, not just in interactions with

adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The feared social or performance situations are avoided or are endured with intense anxiety or duress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid

personality disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it (e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa).

Specify if:

Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder).

Case example:

Ms. S. was a successful secretary working in a law firm. Although she reported a long history of feeling uncomfortable in social situations, Ms. S. only came for treatment when she began to feel that her uneasiness was interfering with her social life and job performance. Ms. S. reported that she noticed herself feeling increasingly nervous whenever she met a new person. For example, upon meeting a new member of the law firm, she described feeling suddenly tense and sweaty and noticing that her heart was beating very fast. She had the sudden thought that she would say something very foolish in these situations or commit a terrible social gaffe that would cause people to laugh at her. At social gatherings, she described

similar feelings that led her to either leave the gathering very early or even decline invitations to attend

e. Obsessive compulsive disorder:

A. Either obsessions or compulsions:

Obsessions are defined by (1), (2), (3), and (4):

1. Recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance as intrusive and inappropriate and that cause marked anxiety or distress

2. The thoughts, impulses, or images are not simply excessive worries about real-life problems

3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions are defined by (1) and (2)

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

2. The behaviors or mental acts are aimed at preventing or

reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder, hair pulling in the presence of trichotillomania, concern with appearance in the presence of body dysmorphic disorder, preoccupation with drugs in the presence of a substance use disorder, preoccupation with having a serious illness in the presence of hypochondriasis, preoccupation with sexual urges or fantasies in the presence of a paraphilia, or guilty ruminations in the presence of major depressive disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With poor insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Case example:

Ms. B. presented for psychiatric admission after being transferred from a medical floor where she had been treated for malnutrition. Ms. B. had been found unconscious in her apartment by a neighbor. When brought to the emergency department by an ambulance, she was found to be hypotensive and hypokalemic. At psychiatric admission, Ms. B. described a long history of recurrent obsessions about cleanliness, particularly related to food items. She reported that because she often had the thought that a food item was dirty, it was difficult for her to eat any food unless she had washed it three or four times. She reported that washing her food decreased the anxiety she felt about its dirtiness. Although Ms. B. reported that she had occasionally tried to eat food that she had not washed (e.g., in a restaurant), she found that she became so worried about becoming ill from eating such food that she could no longer dine in restaurants. Ms. B. reported that her obsessions about the cleanliness of food had become so extreme over the past 3 months that she could eat very few foods, even if she washed

them excessively. She recognized the irrational nature of these obsessive concerns, but either could not bring herself to eat or became extremely nervous and nauseated after eating.

f. Post traumatic stress disorder:

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2. The person's response involved intense fear, helplessness, or horror. **Note:** In children this may be expressed, instead, by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including

those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others

6. Restricted range of affect (e.g., unable to have loving feelings)

7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before

the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

With delayed onset: if onset of symptoms is at least 6 months after the stressor

Case example:

Mr. F. sought treatment for symptoms that he developed in the wake of an automobile accident that had occurred approximately 6 weeks before his psychiatric evaluation. While driving to work on a mid-January morning, Mr. F. lost control of his car on an icy road. His car swerved out of control into oncoming traffic, collided with another car, and then hit a nearby pedestrian. Mr.

F. was trapped in his car for 3 hours while rescue workers cut through the car door. After referral, Mr. F. reported frequent intrusive thoughts about the accident, including nightmares of the event and recurrent intrusive visions of his car slamming into the pedestrian. He reported that he had altered his driving route to work to avoid the scene of the accident and that he found himself switching the TV channel whenever a commercial for snow tires appeared. Mr. F. described frequent difficulty falling asleep, poor concentration, and an increased focus on his environment, particularly when he was driving.

Differential diagnosis of anxiety disorders:

**** Psychiatric disorders:** e.g. depression, adjustment disorders with anxiety manifestations....etc.

**** Medical & neurological disorders:**

- Neurological disorders: migraine, cerebral trauma and postconcussion syndrome.
- Systemic conditions: anemia
- Endocrine disturbances: thyroid dysfunction
- Inflammatory disorders: rheumatoid arthritis
- Deficiency states: pellagra, vitamin b₁₂ deficiency

- Miscellaneous conditions: hypoglycemia, premenstrual syndrome.
- Toxic conditions: alcohol toxicity, cannabis, penicillin, drug withdrawal, amphetamines.

Treatment of anxiety disorders:

- **Pharmacotherapy:**

benzodiazepines (xanax, valium), tricyclic antidepressants (tofranil), selective serotonin reuptake inhibitors “citalopram”, monoamine oxidase inhibitors (paroxetine), imipramine, buspar.

- **Psychological:** insight oriented psychotherapy, behavior therapy, cognitive behavioral therapy, group therapy.

Somatoform disorders

Somatoform means taking the form of (or in) soma, which implies that these illnesses are nonsomatic. Somatoform is thus a misnomer and reflects the historical and current lack of knowledge about the physiology of these disorders. With respect to the epistemological problems of mind–body dualism, the general category of somatoform disorders is better thought of as unexplained symptoms.

Etiology:

- a. Psychosocial: suppression of anger toward others and turning anger towards one self can account for symptoms. Sick role model as identification with parents (learned behavior).
- b. Genetic: positive family history; present in 10-20% of mothers and sisters of affected patients; twins-concordance rate is higher in monozygotic twins than dizygotic ones.
- c. Behavioral: Sick role model as identification with parents (learned behavior). Pain is usually rewarded also by attentive behavior which reinforces its existence.

Somatization disorders:

Definition

Somatization disorder is an illness of multiple somatic complaints in multiple organ systems that occurs over a period of several years and results in significant impairment or treatment seeking, or both.

Epidemiology:

Studies report widely variable lifetime prevalence rates of somatization disorder, ranging from 0.2 to 2.0 percent among women and less than 0.2 percent in men

Clinical presentation:

- a. There must be a history of at least 2 years complaints of multiple and various physical symptoms that cannot be explained by any detectable physical disorder.
- b. Preoccupation with the symptoms causes persistent distress and leads the patient to seek repeated consultations or sets of investigations with either primary care or specialist doctors. In the absence of medical services within either the financial or physical reach of the patient, there must be persistent self-medication or multiple consultations with local healers.
- c. There is persistent refusal to accept medical reassurance that there is no adequate physical cause for the physical symptoms.
- d. There must be a total six or more symptoms from the following list, with symptoms occurring in at least 2 separate groups:
 - Gastrointestinal symptoms: abdominal pain, nausea, feeling bloated or full of gas, vomiting or regurgitation of food, bad taste in the mouth, complains of frequent and loose bowel motions or discharge of fluids from the anus.
 - Cardiovascular symptoms: chest pains, breathlessness without exertion.
 - Genitourinary symptoms: dysuria or complains of frequency of micturition, unpleasant sensations in or

around the genitals, complains of unusual or copious vaginal discharge.

- Skin and pain symptoms: blotchiness or discoloration of the skin, pain in the limbs, joints, or extremities, unpleasant numbness or tingling sensations.

e. The exclusion of mood disorders and schizophrenia.

Case example for somatization disorder:

A 34-year-old female temporary clerk presented with chronic and intermittent dizziness, paresthesias, pain in multiple areas of her body, and intermittent nausea and diarrhea. On further history, the patient said that the symptoms had been present most of the time, although they had been undulating since she was approximately 24 years of age. In addition to the symptoms previously mentioned, she had mild depression, was disinterested in many things in life, including sexual activity, and had been to many doctors to try to find out what was wrong with her. Even though she had seen many doctors and had many tests, she stated that “no one can find out what's wrong” with her. She wanted another opinion. She commented that she had been “sick a lot” since childhood and had been on various medications on and off. Physical examination revealed a normotensive, slightly overweight female in no acute distress. She had diffuse and mild abdominal tenderness, without true guarding or rebound tenderness. Her neurological examination

was normal. She winced when physical examination was conducted on various parts of her body, although this wincing went away when the physician was speaking with her while conducting the examination

Hypochondriachal disorder:

Definition :

Hypochondriasis is characterized by 6 months or more of a general and non delusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. This preoccupation causes significant distress and impairment in one's life, it is not accounted for by another psychiatric or medical disorder, and a subset of individuals with hypochondriasis has poor insight about the presence of this disorder.

Epidemiology:

Best current estimates are that there is a 1.1 to 4.5 percent prevalence of hypochondriasis in the community and an additional 10 percent of people who have hypochondriacal fears and beliefs.

Clinical presentation:

- a. Either of the following must be present;
 - A persistent belief for at least 6 months duration, of the presence of a maximum of 2 serious physical

diseases (one of which is specifically named by the patient)

- A persistent preoccupation with a presumed deformity or disfigurement (body dysmorphic disorder)

b. Preoccupation with the belief and the symptoms causes persistent distress or interference with personal functioning in daily living, and leads the patient to seek medical treatment or investigations

c. There is persistent refusal to accept medical reassurance that there is no adequate physical cause for the physical symptoms.

d. The exclusion of mood disorders and schizophrenia

Case example of hypochondriasis:

A 54 year old woman visited her doctor more than 20 times over the last year. She complains all the time that she is not feeling right, she has vague stomach rumblings, aches and pains in her ankles and wrists and occasional headaches. Most of her time she is preoccupied by searching the internet for articles about serious, life threatening diseases and then goes to her physician convinced that she has a variety of the diseases listed. She becomes reassured feeling safe and relieved after every visit when the doctor tells her that she is healthy and she doesn't have the illness she thought she had , yet after a short time she becomes again irritable worried preoccupied by her physical

complaints .being put under observation by her physician other than her over concern by having a serious illness , her mental illness didn't reveal depression or anxiety or any other mental illnesses.

Body dismorphic disorder:

Definition :

Patients with body dismorphic disorders have a pervasive subjective feeling of ugliness of some aspect of their appearance despite a nearly normal appearance. The core of the disorder is the person's strong belief that he or she is unattractive or even repulsive

Epidemiology :

This disorder is poorly studied because most patients go either to dermatologists or plastic surgeons yet in one study in a group of college students more than 50% of the students had at least some preoccupations with some particular aspects with their appearance and 25% of them these preoccupations had a significant effect on their feelings and functioning.

Etiology :

The cause is unknown . the high co-morbidity with mood disorders and obsessive compulsive disorders and the good response to serotonin specific drugs indicate that the

pathophysiology of the disease may involve serotonin and may be related to other mental disorders.

Clinical presentation:

- a. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
- b. The preoccupation causes clinically significant distress or impairment in the social, occupational, or other important areas of functioning
- c. The preoccupation is not better accounted for by another mental disorder" e.g. dissatisfaction with body shape like in anorexia nervosa"

Treatment :

Serotonin-specific disorders gave best reported results with these disorders

Going to surgeons or dermatologists were unsuccessful

Treating underlying or co morbid mental disorders also improved the results of treatment

Combined psychotherapy and pharmacotherapy is the best choice in these disorders.

Case example of body dysmorphic disorder:

Ms. J., a 30-year-old single unemployed woman, presents to a psychiatrist with this chief complaint: “My biggest wish is to be invisible so that no one can see how ugly I am. My biggest fear is that people are laughing at me thinking I'm ugly.” In reality, Ms. J. is an attractive woman who has been preoccupied with her supposed ugliness since 12 years of age. At that time, she became “obsessed” with her nose, which she thought was too “big and shiny.” Before the onset of this concern, Ms. J. had been confident, a good student, and socially active. However, as a result of her fixation on her nose, she became socially withdrawn and was unable to concentrate in school; her grades plummeted from As to Ds and Fs. “deterioration of her educational level”. At age 18 years, Ms. J. dropped out of school because of her concern about her nose. Shortly after this, she took a job she disliked and, at that time, also became excessively focused on her minimal acne. She frequently picked at her few “blemishes”—sometimes all night long—with tweezers and needles, a behavior she found difficult to resist. Over the following years, Ms. J. developed additional excessive preoccupations with the appearance of her hair, which “wasn't smooth and neat enough”; her breasts, which she thought were too small; her supposedly thin lips; and her supposedly large buttocks. Ms. J. thinks about her “defects” nearly all day long and states that “I always have two tapes playing—one saying not to worry and the other saying I'm ugly.”

Ms. J. frequently checks her supposed defects in mirrors and other reflecting surfaces, such as windows, car bumpers, and spoons. Before she can leave her house, she asks her family members “at least 30 times” whether she looks OK, but she cannot be reassured by their responses. She also combs her hair excessively and attempts to camouflage her supposed defects with clothing, posture, and elaborate makeup that takes several hours a day to apply. Despite her efforts to hide her “ugliness,” Ms. J. thinks that others are probably taking special notice of her, staring at her or laughing at her behind her back. She sometimes drives through red lights, because she is “unable to tolerate people looking at me.” On one occasion, when she was stuck in a traffic jam, Ms. J. became so anxious over her belief that other drivers were staring at her nose, skin, and hair that she fled her car and left it in the middle of the highway.

Ms. J. thinks that her view of her appearance and her belief that others are ridiculing her are probably accurate. However, she is able to acknowledge that she has “a small amount of doubt” about her beliefs, noting that it is possible—although unlikely—that she has a distorted view of her defects. Nonetheless, Ms. J. occasionally briefly feels “100 percent” convinced that she is hideously ugly and is “completely certain” that others are taking special notice of her, as happened when she abandoned her car. At these times, she firmly believes that the neighbors are staring

at her through binoculars, and she hides where she thinks they cannot see her.

As a result of her preoccupation with her appearance, Ms. J. has been able to work only briefly and intermittently. She became increasingly socially isolated and avoided dating and other social interactions. As her concern intensified, Ms. J. began to go out only at night when she could not be seen. Finally, after more than a decade of symptoms, Ms. J. stopped working altogether and went on disability. She also became completely housebound, even hiding when relatives came to visit. As she explains, "I didn't leave my house because I didn't want people to see how ugly I was." Although Ms. J. relies on her family members to buy her clothes, food, and other necessities, she is unable to tell them about her concerns about her appearance, because she is too embarrassed. She has become increasingly depressed, with poor sleep, appetite, and energy, and has suicidal ideation. As a result of her social isolation and her feelings of hopelessness about her appearance, Ms. J. has made two suicide attempts and has been hospitalized on several occasions.

Before she became housebound, Ms. J. received antibiotics from several dermatologists, but this did not alleviate her concerns about her appearance. She was refused a rhinoplasty by a plastic surgeon she consulted. Ms. J. also sought outpatient psychiatric

treatment but was never able to discuss her preoccupations with her therapist, because she was too embarrassed to do so.

Persistent somatoform pain disorder:

Definition :

Patients with pain somatoform disorders complain of the pain as the main focus of clinical attention .Psychological factors may play a role in this disorder.

Etiology :

***psychodynamic factors:** physical pains express the intrapsychic conflicts through the body where pain is used as a way of obtaining love and a way of expiating guilt and self punishment of wrong doing through first suppression then substitution and displacement as defense mechanisms.

***behavioral explanation:** pain as a learned behavior because pain behaviors are reinforced when rewarded and inhibited when ignored or punished .

***interpersonal factors:** where pain is used as a way to manipulate others

***biological explanation:** where endorphin deficiency seems to correlate with augmentation of incoming sensory stimuli.

Clinical presentation:

- a. Persistent severe and distressing pain (for at least 6 months, and continuously on most days), in any part of the

body, which can not be explained adequately by evidence of a physiological process or a physical disorder, and which is constantly the main focus of the patient's attention

- b. The exclusion of mood disorders and schizophrenia and other somatoform disorders especially somatization disorder.

Treatment:

- a. Pharmacological: antidepressants and anti-anxiety drugs can help when anxiety or secondary depression are present.
- b. Psychological: insight-oriented psychotherapy, cognitive-behavioral, teaching patients new coping styles are very efficient as the response to medications is usually very temporary.

Case example for pain somatoform disorders:

A 72 year old man who was admitted to the orthopedic service of a general hospital complaining of unbearable pain in the arches of the feet. Trying to solve his problem through examination and investigations the physicians discovered that he has no medical or other organic disorder that would explain the pain. He also gave a history of being exposed to several attacks of excruciating bodily pains across the past years in the form of blinding headache, severe back spasm, facial pain, abdominal pain, or pelvic pain. These unusual pains used to be associated

with specific emotional stressors and receded usually after the stress ends. He had mood changes from glum to gloomy from now and then, remained his complaints of pain non specific, and fluctuating.

Conversion disorder:

Definition:

Conversion disorder is an illness of symptoms or deficits that affect voluntary motor or sensory functions, which suggest another medical condition, but that is judged to be due to psychological factors because the illness is preceded by conflicts or other stressors. The symptoms or deficits of conversion disorder are not intentionally produced, are not due to substances, are not limited to pain or sexual symptoms, and the gain is primarily psychological and not social, monetary, or legal.

Epidemiology:

Reported rates of conversion disorder vary from 11 out of 100,000 to 300 out of 100,000 in general population samples. Five to 16 percent of all psychiatry consultation patients in a general hospital setting have symptoms that are consistent with conversion disorder. Conversion disorder is the focus of treatment in 1 to 3 percent of outpatient referrals to mental health clinics. Some studies suggest a lifetime risk of approximately 33 percent for transient or longer-term conversion symptoms

Etiology:

- a. Biological: increased susceptibility in patients with frontal lobe trauma or other neurological signs
- b. Psychological: expression of unconscious psychological conflict, which is repressed. Premorbid personality disorder, as hysterionic. Identification with family member with same symptoms from real disease. Secondary gain is a main issue for these patients as attention-seeking is part of there psychodynamics.

Clinical criteria:

Characterized by one or more neurological symptoms associated with psychological conflict or need, not physical or neurological or substance-related disorder.

Signs & symptoms:

- a. Motor abnormalities- paralysis, ataxia, vomiting, aphonia
- b. Disturbances of consciousness-pseudoseizures, unconsciousness
- c. Sensory disturbances or alterations-blindness, deafness, anosmia, analgesia, anesthesia.
- d. Close relationship to stress or intense emotions
- e. The person is not conscious of intentionally producing the symptom
- f. The symptom is not a culturally sanctioned response pattern and after appropriate investigation cannot be explained by a known physical disorder.

Differential diagnosis:

- ataxia
- paralysis
- blindness
- other neurological symptoms
- malingering or factitious disorder
- other psychiatric disorders as schizophrenia, mood disorders

Treatment:

- a. Pharmacological: drug-assisted interviews (amytal interview or abreaction), may help resolving the symptom as a start ; then anxiolytics and antidepressants for any anxiety or depression symptoms or signs.
- b. Psychological: insight-oriented psychotherapy, behavioral therapy in form of relaxation techniques to reduce symptoms and tension.

Case example for conversion disorder:

Mr. J. is a 28-year-old single man who is employed in a factory. He was brought to an emergency department by his father, complaining that he had lost his vision while sitting in the back seat on the way home from a family gathering. He had been

playing volleyball at the gathering but had sustained no significant injury except for the volleyball hitting him in the head a few times. As was usual for this man, he had been reluctant to play volleyball because of the lack of his athletic skills, and was placed on a team at the last moment. He recalls having some problems with seeing during the game, but his vision did not become ablated until he was in the car on the way home. By the time he got to the emergency department, his vision was improving, although he still complained of blurriness and mild diplopia. The double vision could be attenuated by having him focus on items at different distances.

On examination, Mr. J. was fully cooperative, somewhat uncertain about why this would have occurred, and rather nonchalant. Pupillary, oculomotor, and general sensorimotor examinations were normal. After being cleared medically, the patient was sent to a mental health center for further evaluation. At the mental health center, the patient recounts the same story as he did in the emergency department, and he was still accompanied by his father. He began to recount how his vision started to return to normal when his father pulled over on the side of the road and began to talk to him about the events of the day. He spoke with his father about how he had felt embarrassed and somewhat conflicted about playing volleyball and how he had felt that he really should play because of external pressures. Further history from the patient and his father revealed that this

young man had been shy as an adolescent, particularly around athletic participation. He had never had another episode of visual loss. He did recount feeling anxious and sometimes not feeling well in his body during athletic activities.



Substance related and addictive Disorders

Definition of drug dependence:

The term includes the concepts of both behavioral dependence and physical dependence. Behavioral dependence has emphasized the substance seeking activities and related evidence of pathological use patterns. Physical dependence has emphasized the physical (physiological) effects of multiple episodes of substance use (tolerance or withdrawal).

Epidemiology:

Trends in substance use vary from country to country and fluctuations occur in the prevalence rates across time periods. A 2007 report stated that 8.5 percent of Egyptians - or six million people - are addicted to drugs. The majority of them are between 15 and 25 years of age. Drug abuse in Egypt is mainly a male problem although female abusers are increasing. The age of drug abusers is reported to be decreasing starting according to some reports from the age of 12 years.

The main drugs of abuse in Egypt are tramadol, and hashish followed by heroin and bango. Other substances like alcohol, pure opium, and cocaine are present but to a less degree.

In a recent report drug addiction in Cairo recorded high levels, with five to seven percent of the population believed to be addicted to some form of drugs. That figure translates to between 1-1.4 million people. This report didn't include occasional users, who were reported to be 25-30 percent of the population.

Etiology:-

psychodynamic approach:

- Drug abuse is a maladaptive psychological coping strategy.
- Drug abuse is a form of disturbed self medication with substances.
- Drug abuse is a symptom of underlying psychological problems

Psychosocial approach:

- Drug use is a learned behavior, and people use drugs because drug use is modeled by others.
- Peer pressure.
- Environmental effects lead to drug use (e.g. availability, etc.).

Behavioral approach:

- Most substances of abuse are associated with a positive experience after taking them the first time, thus, the substance acts as a positive reinforce.

Biological approach:

Genetic: Studies of twins, adopted and siblings indicate that alcohol abuse has a genetic component in its cause.

Neurochemical: Researchers have identified particular neurotransmitters or neurotransmitter receptors on which the

substances have their effects i.e. opiates acts on opiate receptor& Thus a person who has too little endogenous opiate activity or who has too much activity of an endogenous opiate antagonist may be at risk for development of opiate dependence. Even in a person with completely normal endogenous receptor function and neurotransmitter concentration, the long term use of a particular substance may eventually modulate those receptor systems in the brain.

The major mediator of the sensation of reward are the dopaminergic neurons in the ventral tegmental area that project to the cortical and limbic regions especially the nucleus accumbens.

Diagnostic criteria for substance dependence:

A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by 3 or more of the following occurring at any time in the same 12-month period:

1. Tolerance as defined by either of the following:-

-A need for markedly increased amounts of the substance achieve intoxication or desired effect.

-Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal as manifested by either of the following: -The characteristic withdrawal syndrome for the substance.

-The same substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. a great deal of time is spent activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance, or recovery from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine — induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Treatment:

The Egyptian Fund for Drug Control and Addiction Treatment reported that 19,700 addicts had been treated at its medical centers between 1st January and 30 June 2012, whilst in the whole of 2011 the number was 18,000. The increased number could be down to increased awareness of the treatment available as well as an actual increase in the number of addicts.

Egyptians who have a drug problem can call the fund's hotline on 16023 for free and confidential support.

Treatment approaches for substance abuse and dependence vary according to the type of substance pattern abuse, the availability of psychosocial support systems, and the individual features of the patient. The first goal of treatment is the abstinence from the substance. The second goal is the physical, psychiatric and psychosocial wellbeing.

Inpatient treatment is indicated in:

1. Severe medical or psychiatric symptoms.
2. History of failed out patient treatment.
3. Lack of psychosocial support.

Severe or long-term history of substance use treatment strategy include initial period of detoxification with rehabilitation

together with individual, family, and group psychotherapies and education about Substances

Summary of the effects and use patterns of the most frequently used illicit drugs:

Heroin; is derived from morphine, a naturally occurring substance extracted from the seed pod of the Asian poppy. Mainly taken by injection, it is a fast acting drug, resulting in an initial feeling of elation followed by a longer period of drowsiness. In addition to the physical and psychological effects of the drug itself, injecting may result in injury and infection, and brings high risks of HIV and hepatitis infection where injecting equipment is shared. Heroin overdose, often resulting in death, is a particular risk for users.

Heroin is highly addictive, and chronic users can experience intense cravings for the drug even years after last use. Because the initial effects of the drug are short lived, addicts typically inject up to four times a day. Addiction to heroin usually has a destructive effect on the life of the user, with severe adverse impacts in many areas, including health, finances, employment and interpersonal relationships. It frequently results in chronic users being marginalized within society.

Tramadol; is a centrally-acting synthetic opioid used to treat moderate to moderately severe pain. Tramadol comes in tablet

form and is available by prescription only. Unfortunately it's widely available in the black market. Manual workers usually take it to help them work for extra time. Others use it as a self medication for premature ejaculation. The small doses they start with; half or one tablet a day; will increase to higher doses due to tolerance and users then have to take the drug to prevent withdrawal manifestations which are severe and close to those of heroin.

Cannabis; Hashish and Bango; generally smoked, induces a relaxed feeling and mild hallucinations. It can influence mood and concentration, cause panic attacks and aggravate depression and schizophrenia. Misuse of the drug is most prevalent in the 15-24 age groups. A big myth among Egyptian is that cannabis is not addictive. Actually many of those who become dependent on heroin or tramadol start with Hashish and Bango.

Cocaine; gives users a sense of confidence and can cause heightened aggression. Routes of administering the drug include sniffing, smoking and injecting. Cocaine can lead to raised blood pressure, respiratory failure, seizures and heart attacks. It was traditionally regarded as a drug used mainly by the wealthy, increased supply and falling prices has resulted in its more widespread use.

Stimulants; such as ecstasy and amphetamines, even in small doses, affect the body in much the same way as natural

adrenaline. These drugs can cause panic attacks and hallucinations as well as heart difficulties.

Hypnotics and sedatives; such as benzodiazepines are drugs which depress or slow down the body's functions with their effects ranging from reducing anxiety to inducing sleep. They can cause both physical and psychological dependence, and may be a problem for users of any age, including older people.

Other Addictive disorders:

The last classification of psychiatric disorders included gambling disorder as the sole condition in a new category on *behavioral addictions*. This reflects that gambling disorder is similar to substance-related disorders in clinical expression, brain origin, co-morbidity, physiology, and treatment.

Internet gaming disorder is now under further research before its consideration as a formal disorder. This condition is included to reflect the scientific literature on persistent and recurrent use of Internet games, and a preoccupation with them, can result in clinically significant impairment or distress.

Personality Disorders

I. General Characteristics of Personality Disorders:

A. A personality disorder is diagnosed when personality traits become inflexible, pervasive and maladaptive to the point where they cause significant social or occupational dysfunction or subjective distress.

B. Personality traits consist of enduring patterns of perceiving, relating to, and thinking about the environment, other people and oneself.

C. Personality patterns must be stable and date back to adolescence or early adulthood. Therefore, personality disorders are not generally diagnosed in children.

- A personality disorders can be classified into *three clusters*:-

- **Cluster A Personality Disorders**

- *Paranoid, schizoid and schizotypal* personality disorders are referred to as cluster A personality disorders characterized by *odd and eccentric behaviors*.

- They are considered part of the schizophrenia-spectrum disorders.

Paranoid Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive distrust and suspiciousness of others is present without justification, beginning by early adulthood, and is manifested by *at least four* of the following:

1. The patient suspects others are exploiting, harming, or deceiving him.
2. The patient doubts the loyalty or trustworthiness of others.
3. The patient fears that information given to others will be used maliciously against him.
4. Benign remarks by others or benign events are interpreted as having demeaning or threatening meanings.
5. The patient persistently bears grudges.
6. The patient perceives attacks that are not apparent to others, and is quick to react angrily or to counterattack.
7. The patient repeatedly questions the fidelity of his spouse or sexual partner.

II. Clinical Features of Paranoid Personality Disorders:

A. The patient is often hypervigilant and constantly looking for proof to support his paranoia. Patients are often argumentative and hostile.

B. Patients have a high need for control and autonomy in relationships to avoid betrayal and the need to trust others. Pathological jealousy is common.

C. Patients are quick to counterattack and are frequently involved in legal disputes. These patients rarely seek treatment.

D. Paranoid personality disorder patients have lifelong problems working and living with others. Occupational and marital problems are common.

III. Epidemiology of Paranoid Personality Disorder:

A. The disorder is more common in first-degree relatives of schizophrenics compared to the general population,

B. More common among minorities, immigrants and deaf.

C. The prevalence is 0.5% to 2.5% in general population.

D. The disorder is more common in men than women.

IV. Differential Diagnosis:

A. Delusional Disorder: Fixed delusions are not seen in personality disorders.

B. Paranoid Schizophrenia: Hallucinations and formal thought disorder are not seen in personality disorder.

C. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to a medication, drugs or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

V. Treatment of Paranoid Personality Disorder:

A. Psychotherapy is the treatment of choice for PPD, but establishing and maintaining the trust of patients may be difficult because these patients have great difficulty tolerating intimacy.

B. Symptoms of anxiety and agitation may be severe enough to warrant treatment with antianxiety agents.

C. Low doses of antipsychotics are useful for delusional accusations and agitation.

Schizoid Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive pattern of social detachment with restricted affect, beginning by early adulthood and indicated by *at least four* of the following:

1. The patient neither desires nor enjoys close relationships, including family relationships.

2. The patient chooses solitary activities.
3. The patient has little interest in having sexual experiences.
4. The patient takes pleasure in few activities.
5. The patient has no close friends or confidants except first-degree relatives.
6. The patient is indifferent to the praise or criticism of others.
7. The patient displays emotional detachment or diminished affective responsiveness.

II. Clinical Features of Schizoid Personality Disorder:

- A. The patient often appears cold and aloof, and is uninvolved in the everyday concerns of others.
- B. Patients with SPD are often emotionally blunted, and these patients generally do not marry unless pursued aggressively by another person.
- C. These patients are able to work if the job allows for social isolation.
- D. Schizoid personality disorder is long lasting, but not necessarily lifelong. The proportion of patients who incur schizophrenia is unknown.

III. Epidemiology of Schizoid Personality Disorder:

- A. Schizoid Personality Disorder is more common in first-degree relatives of schizophrenics compared to the general public.
- B. May affect 7.5% of general population.
- C. Patients with Schizoid Personality Disorder may develop schizophrenia.
- D. Schizoid Personality Disorder is a rare disorder, which is thought to be more common in men than women.

IV. Differential Diagnosis:

- A. Schizophrenia: Hallucinations and formal thought disorder are not seen in personality disorders. Patients with schizoid personality disorder may have good work histories, whereas schizophrenic patients usually have poor work histories.
- B. Schizotypal Personality Disorder: Eccentricities and oddities of perception, behavior and speech are not seen in schizoid personality disorder.
- C. Avoidant Personality Disorder: Social isolation is subjectively unpleasant for avoidant patients. Unlike schizoid patients, avoidant patients are hypersensitive to the thoughts and feelings of others.

D. Paranoid Personality Disorder: Paranoid patients are able to express strong emotion when they feel persecuted. Schizoid patients are not able to express strong emotion.

E. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to a medication, drugs or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

V. Treatment of Schizoid Personality Disorder:

A. Individual psychotherapy is the treatment of choice. Group therapy is not recommended because other patients will find the patient's silence difficult to tolerate.

B. The use of antidepressants, antipsychotics and psychostimulants has been described without consistent results.

Schizotypal Personality Disorder

I. DSM-IV Diagnostic Criteria

A. A pervasive pattern of discomfort with and reduced capacity for close relationships as well as perceptual distortions and eccentricities of behavior, beginning by early adulthood. *At least five* of the following should be present:

1. Ideas of reference: interpreting unrelated events as having direct reference to the patient (eg, belief that a television program is really about him).
2. Odd beliefs or magical thinking inconsistent with cultural norms (eg, superstitiousness, belief in clairvoyance, telepathy or a “sixth sense”).
3. Unusual perceptual experiences, including bodily illusions.
4. Odd thinking and speech (eg, circumstantial, metaphorical, or stereotyped thinking).
5. Suspiciousness or paranoid ideation.
6. Inappropriate or constricted affect.
7. Behavior or appearance that is odd, eccentric or peculiar.
8. Lack of close friends other than first-degree relatives.
9. Excessive social anxiety that does not diminish with familiarity.

II. Clinical Features of Schizotypal Personality Disorder:

- A. These patients often display peculiarities in thinking, behavior and communication.
- B. Discomfort in social situations, and inappropriate behavior may occur.

C. Magical thinking, belief in “extra sensory perception,” illusions and derealization are common.

D. Repeated exposure will not decrease social anxiety since it is based on paranoid concerns and not on self-consciousness.

E. The patient may have a vivid fantasy life with imaginary relationships.

F. Speech may be idiosyncratic, such as the use of unusual terminology.

G. 10% of schizotypal personality disorder patients eventually committed suicide.

III. Epidemiology of Schizotypal Personality Disorder:

A. This disorder is more common in relatives of schizophrenics compared to the general population.

B. Patients with schizotypal personality disorder may develop schizophrenia.

C. The prevalence is approximately 3% in the general population.

IV. Differential Diagnosis of Schizotypal Personality Disorder:

A. Schizoid and Avoidant Personality Disorder: Schizoid and avoidant patients will not display the oddities of behavior, perception, and communication of schizotypal patients.

B. Schizophrenia: No formal thought disorder is present in personality disorders. When psychosis is present in schizotypal patients, it is of brief duration.

C. Paranoid Personality Disorder: Patients with paranoid personality disorder will not display the oddities of behavior, perception and communication of schizotypal patients. Unlike schizotypals, paranoid patients can be very verbally aggressive and do not avoid conflict.

D. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to a medication, drugs or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

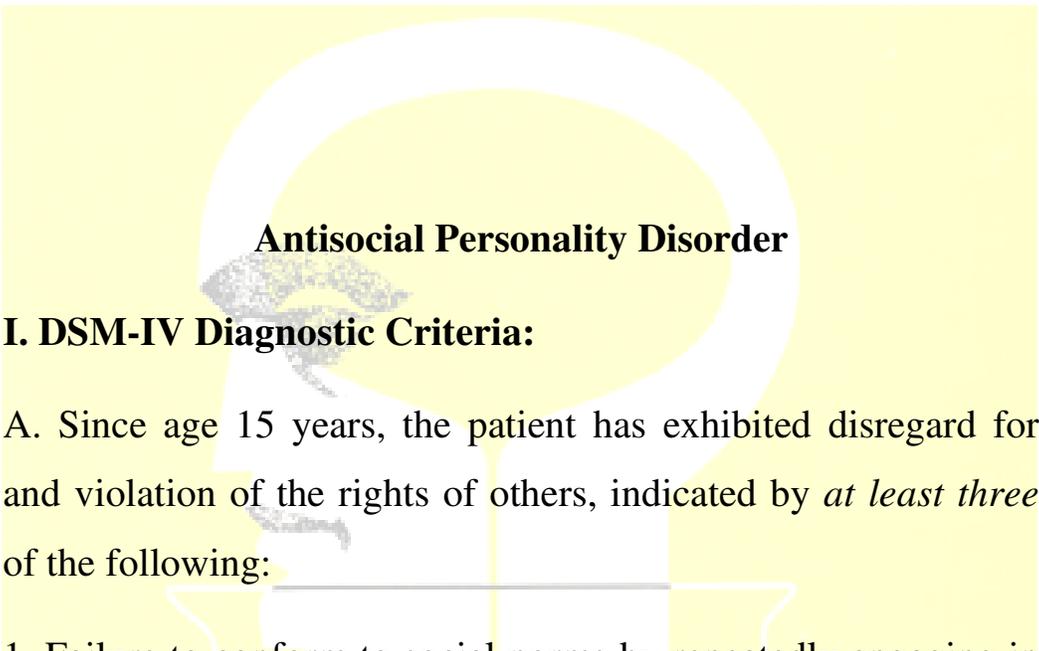
V. Treatment of Schizotypal Personality Disorder:

A. Psychotherapy is the treatment of choice for schizotypal personality disorder. Antipsychotics may be helpful in dealing with low-grade psychotic symptoms or paranoid delusions.

B. Antidepressants is useful if the patient also have a mood disorder.

- **Cluster B Personality Disorders**

- *Antisocial, borderline, histrionic and narcissistic* personality disorders are referred to as cluster B personality disorders.
- These disorders are characterized by *dramatic or irrational behavior*. These patients tend to be very disruptive in clinical settings.



Antisocial Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. Since age 15 years, the patient has exhibited disregard for and violation of the rights of others, indicated by *at least three* of the following:

1. Failure to conform to social norms by repeatedly engaging in unlawful activity.
2. Deceitfulness: repeated lying or “conning” others for profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, such as repeated physical fighting or assaults.

5. Reckless disregard for the safety of self or others.
 6. Consistent irresponsibility: repeated failure to sustain consistent work or honor financial obligations.
 7. Lack of remorse for any of the above behavior.
- B. A history of some symptoms of conduct disorder before age 15 years as indicated by:

1. Aggression to people and animals.
2. Destruction of property.
3. Deceitfulness or theft.
4. Serious violation of rules

II. Clinical Features of Antisocial Personality Disorder:

- A. Interactions with others are typically exploitative or abusive.
- B. Lying, stealing, fighting, fraud, physical abuse, substance abuse, and drunk driving are common.
- C. Patients may be arrogant, but they are also capable of great superficial charm.
- D. These patients do not have a capacity for empathy.
- E. Once an antisocial personality disorder develops, it runs an unremitting course. The prognosis varies indicate symptoms decrease as persons grow older.

F. Somatization disorder, depressive disorders, alcohol use disorders, and other substance abuse are common.

III. Epidemiology of Antisocial Personality Disorder:

A. The male-to-female ratio is 3:1. In prisons, may reach 75%.

B. APD is more common in first-degree relatives of those with the APD disorder.

C. Predisposing conditions include ADHD and conduct disorders.

IV. Differential Diagnosis:

A. Adult Antisocial Behavior: Patients with adult antisocial behavior do not show the pervasive, long-term patterns required for a personality disorder.

B. Substance-Related Disorder: Substance abuse is common in antisocial personality disorder, and crimes may be committed to obtain drugs or to obtain money for drugs. Many patients will meet criteria for both diagnoses.

C. Narcissistic Personality Disorder: Narcissistic patients also lack empathy and are exploitative, but they are not as aggressive or deceitful as antisocial patients.

D. Borderline Personality Disorder: These patients are also impulsive and manipulative, but they are more emotionally unstable and they are less aggressive. The manipulateness of borderline patients is aimed at getting emotional gratification rather than aimed at financial motivations.

V. Treatment of Antisocial Personality Disorder:

A. These patients will try to destroy or avoid the therapeutic relationship. *Inpatient self-help groups* are the most useful treatment because the patient is not allowed to leave.

B. Psychotropic medication: Anticonvulsants, lithium, and beta-blockers have been used for impulse control problems, including rage reactions. Antidepressants can be helpful if depression or an anxiety disorder is present.

Borderline Personality Disorder

I. DSM-IV Diagnostic Criteria:

A pervasive pattern of unstable interpersonal relationships, unstable self-image, unstable affects, and poor impulse control, beginning by early adulthood, and indicated by at least *five* of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. Unstable and intense interpersonal relationships, alternating between extremes of idealization and devaluation.

3. Identity disturbance: unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (eg, spending, promiscuity, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures or threats; or self-mutilating behavior.
6. Affective instability (eg, sudden intense dysphoria, irritability or anxiety of short duration).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger.
9. Transient, stress-related paranoid ideation, or severe dissociative symptoms.

II. Clinical Features of Borderline Personality Disorder:

- A. The clinical presentation of BPD is highly variable. Chronic dysphoria is common, and desperate dependence on others is caused by inability to tolerate being alone.
- B. Chaotic interpersonal relationships are characteristic, and self-destructive or self-mutilatory behavior is common.
- C. A childhood history of abuse or parental neglect is common.
- D. Splitting and projective identification are the main defense mechanisms.

E. Borderline personality disorder is fairly stable; patients change little over time. No progression toward schizophrenia, but patients have a high incidence of major depressive disorder.

III. Epidemiology of Borderline Personality Disorder:

A. The female-to-male ratio is 2:1. The disorder is *five* times more common in first-degree relatives.

B. The prevalence is 1-2%, but the disorder occurs in 30-60% of psychiatric patients.

IV. Differential Diagnosis:

A. Adolescence: Normal adolescence with identity disturbance and emotional lability shares many of the same characteristics of BPD; however, the longstanding pervasive pattern of behavior required for a personality disorder is not present.

B. Histrionic Personality Disorder: These patients are also manipulative and attention seeking, but they do not display self-destructiveness and rage. Psychosis and dissociation are not typically seen in histrionic patients.

C. Dependent Personality Disorder: When faced with abandonment, dependent patients will increase their submissive behavior rather than display rage as do borderline patients.

D. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to medications, drugs, or a medical condition.

V. Treatment of Borderline Personality Disorder:

A. Psychotherapy is the treatment of choice. Patients frequently try to recreate their personal chaos in treatment by displaying acting-out behavior, resistance to treatment, lability of mood and affect, and regression.

B. Suicide threats and attempts are common.

C. Pharmacotherapy is frequently used for coexisting mood disorders, eating disorders, and anxiety disorders. Valproate (Depakote) or SSRIs may be helpful for impulsive-aggressive behavior.

Histrionic Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood, as indicated by *five or more* of the following:

1. The patient is not comfortable unless he is the center of attention.
2. The patient is often inappropriately sexually seductive or provocative with others.

3. Rapidly shifting and shallow expression of emotions are present.
4. The patient consistently uses physical appearance to attract attention.
5. Speech is excessively impressionistic and lacking in detail.
6. Dramatic, theatrical, and exaggerated expression of emotion is used.
7. The patient is easily influenced by others or by circumstances.
8. Relationships are considered to be more intimate than they are in reality.

II. Clinical Features of Histrionic Personality Disorder:

- A. The patient is bored with routine and dislikes delays in gratification.
- B. The patient begins projects, but does not finish them (including relationships).
- C. Dramatic emotional “performances” of the patient appear to lack sincerity.
- D. These patients often attempt to control relationships with seduction, manipulation, or dependency.
- E. The patient may resort to suicidal gestures and threats to get attention.

III. Epidemiology of Histrionic Personality Disorder:

- A. The prevalence of HPD is 2-3%.
- B. Histrionic personality disorder is much more common in women than men.
- C. These patients have higher rates of depression, somatization and conversion disorder compared to the general population.

IV. Differential Diagnosis:

A. Borderline Personality Disorder: 1. While patients with Borderline Personality can also be sensation-seeking, impulsive, superficially charming, and manipulative, they also have identity disturbance, transient psychosis, and dissociation which are not seen in histrionic patients. 2. Some patients meet criteria for both BPD and HPD.

B. Antisocial Personality Disorder: 1. Antisocial patients are also sensation-seeking, impulsive, superficially charming, and manipulative. 2. Histrionic patients are dramatic and theatrical but typically lack histories of antisocial behavior.

C. Narcissistic Personality Disorder: 1. Narcissists also seek constant attention, but it must be positive in order to confirm

grandiosity and superiority. 2. Histrionics are less selective and will readily appear weak and dependent in order to get attention.

D. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to medication, drugs, or a medical condition.

V. Treatment of Histrionic Personality Disorder:

A. Insight-oriented psychotherapy is the treatment of choice. Keeping patients in therapy can be challenging since these patients dislike routine.

B. Antidepressants are used if depression is also present.

Narcissistic Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy. The disorder begins by early adulthood and is indicated by *at least five* of the following:

1. An exaggerated sense of self-importance.
2. Preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

3. Believes he is “special” and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement.
6. Takes advantage of others to achieve his own ends.
7. Lacks empathy.
8. The patient is often envious of others or believes that others are envious of him.
9. Arrogant, haughty behavior or attitudes.

II. Clinical Features of Narcissistic Personality Disorder:

- A. Patients with narcissistic personality disorder exaggerate their achievements and talents, and they are surprised when they do not receive the recognition they expect.
- B. Their inflated sense of self results in a devaluation of others and their accomplishments.
- C. These patients feel very entitled, expecting others to meet their needs immediately, and they can become quite indignant if this does not happen. These patients are self-absorbed and unable to respond to the needs of others. Any perception of criticism is poorly tolerated.

D. Much of narcissistic behavior serves as a defense against very poor self-esteem.

III. Epidemiology of Narcissistic Personality Disorder:

A. The prevalence of NPD is less than 1% in the general population and up to 16% in clinical populations.

B. The disorder is more common in men than women. Studies have shown a steady increase in the incidence of narcissistic personality disorder.

IV. Differential Diagnosis:

A. Histrionic Personality Disorder: Histrionic patients are also attention seeking, but the attention they seek does not need to be admiring. They are more highly emotional and seductive compared to patients with NPD.

B. Borderline Personality Disorder: These patients also tend to idealize and devalue others, but narcissistic patients lack the unstable identity, self-destructive behavior, and abandonment fears that characterize borderline patients.

C. Antisocial Personality Disorder: Interpersonal exploitation, superficial charm, and lack of empathy can be seen in both antisocial personality disorder and narcissistic personality disorder. However, antisocial patients do not require constant admiration nor do they display the envy seen in narcissistic patients.

D. Personality Change Due to a General Medical Condition and Substance-Related Disorder: All symptoms are temporally related to medication, drugs or a medical condition.

V. Treatment of Narcissistic Personality Disorder:

A. Psychotherapy is the treatment of choice, but the therapeutic relationship can be difficult since envy often becomes an issue.

B. Coexisting substance abuse may complicate treatment. Depression frequently coexists with NPD; therefore, antidepressants are useful for adjunctive therapy.

- **Cluster C Personality Disorders**

- *Avoidant, dependent and obsessive-compulsive* personality disorders are referred to as cluster C personality disorders.
- These patients tend to be *anxious or fearful* and their personality pathology is a maladaptive attempt to control anxiety.

Avoidant Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity, beginning by early adulthood, and indicated by *at least four* of the following:

1. The patient avoids occupational activities with significant interpersonal contact due to fear of criticism, disapproval or rejection.

2. Unwilling to get involved with people unless certain of being liked.

3. Restrained in intimate relationships due to fear of being shamed or ridiculed.

4. Preoccupied with being criticized or rejected in social situations.

5. Inhibited in new interpersonal situations due to feelings of inadequacy.

6. The patient views himself as socially inept, unappealing or inferior to others.

7. Reluctance to take personal risks or to engage in new activities because they may be embarrassing.

II. Clinical Features of Avoidant Personality Disorder:

A. The patient is usually shy and quiet and prefers to be alone. The patient usually anticipates unwarranted rejection before it happens.

B. Opportunities to supervise others at work are usually avoided by the patient. These patients are often devastated by minor comments they perceive to be critical.

C. Despite self-imposed restrictions, avoidant personality disorder patients usually long to be accepted and be more social.

III. Epidemiology of Avoidant Personality Disorder:

A. The male-to-female ratio is 1:1.

B. Although adults with avoidant personality disorder were frequently shy as children, childhood shyness is not a predisposing factor.

IV. Differential Diagnosis:

A. Social Phobia, Generalized Type: shares many features of avoidant personality disorder. Patients may meet criteria for both disorders. The two disorders may only be differentiated by a life-long pattern of avoidance seen in patients with avoidant personality disorder.

B. Dependent Personality Disorder: These patients are also hypersensitive to criticism and crave acceptance, but they will risk humiliation and rejection in order to get their dependent needs met. Patients may meet the criteria for both disorders.

C. Schizoid Personality Disorder: These patients also avoid interactions with others and are anxious in social settings;

however, schizoid patients do not fear criticism and rejection. Avoidant patients recognize that social isolation is abnormal.

D. Panic Disorder with Agoraphobia: In patients with panic disorder with agoraphobia, avoidance occurs after the panic attack has begun, and the avoidance is aimed at preventing another panic attack from occurring.

V. Treatment of Avoidant Personality Disorder:

A. Individual psychotherapy, group psychotherapy and behavioral techniques may all be useful. Group therapy may assist in dealing with social anxiety. Behavioral techniques, such as assertiveness training and systematic desensitization, may help the patient to overcome anxiety and shyness.

B. Beta-blockers can be useful for situational anxiety.

C. Since many of these patients will meet criteria for Social Phobia (generalized), a trial of SSRI medication may prove beneficial. Patients are prone to other mood and anxiety disorders, and these disorders should be treated with antidepressants or anxiolytics.

Dependent Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive and excessive need to be cared for. This need leads to submissive, clinging behavior, and fears of separation

beginning by early adulthood and indicated by at least *five* of the following:

1. Difficulty making everyday decisions without excessive advice and reassurance.
2. Needs others to assume responsibility for major areas of his life.
3. Difficulty expressing disagreement with others and unrealistically fears loss of support or approval if he disagrees.
4. Difficulty initiating projects or doing things on his or her own because of a lack of self-confidence in judgment or abilities.
5. Goes to excessive lengths to obtain nurturance and support, to the point of volunteering to do things that are unpleasant.
6. Uncomfortable or helpless when alone due to exaggerated fears of being unable to care for himself.
7. Urgently seeks another source of care and support when a close relationship ends.
8. Unrealistically preoccupied with fears of being left to take care of himself.

II. Clinical Features of Dependent Personality Disorders:

A. Patients will endure great discomfort in order to perpetuate the caretaking relationship. Social interaction is usually limited to the caretaker network.

B. These patients may function at work if no initiative is required.

III. Epidemiology of Dependent Personality Disorders:

A. Women are affected slightly more than men.

B. Childhood illness or separation anxiety disorder of childhood predispose patients to dependent personality disorder.

IV. Differential Diagnosis:

A. Avoidant Personality Disorder: Avoidant patients are more focused on avoiding shame and rejection rather than getting needs met. Some patients may meet criteria for both disorders.

B. Borderline Personality Disorder: Borderline patients react with rage and emptiness when feeling abandoned. Dependent patients react with more submissive behavior when feeling abandoned.

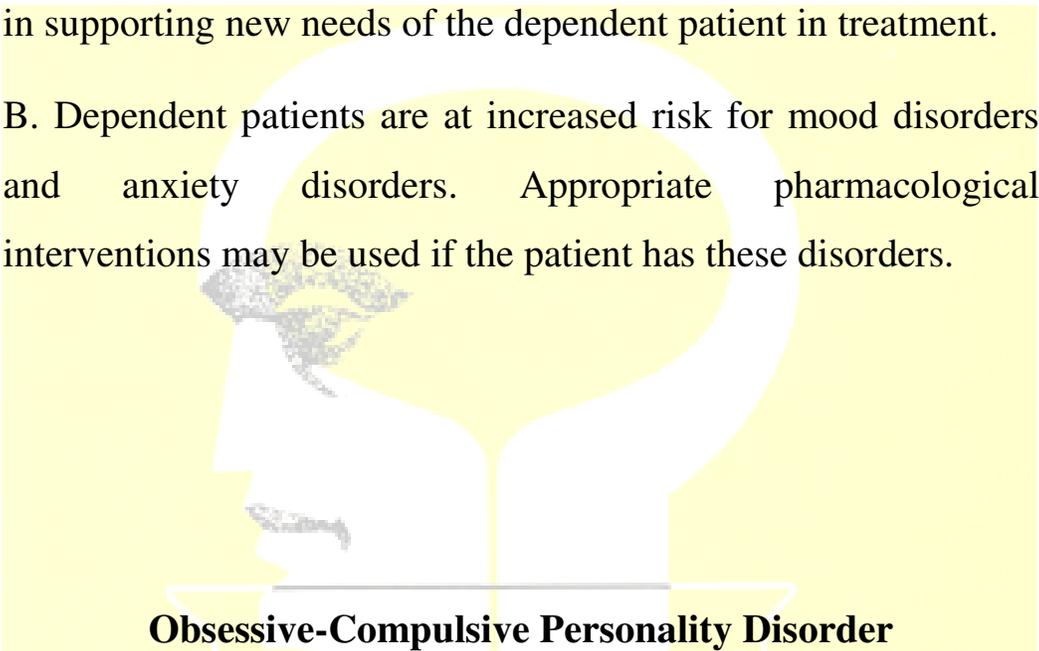
C. Histrionic Personality Disorder. These patients are also needy and clinging, and they have a strong desire for approval, but these patients actively pursue almost any kind of attention. They tend to be very flamboyant, unlike dependent patients.

D. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to a medication, drugs or a medical condition.

V. Treatment of Dependent Personality Disorders:

A. Insight-oriented psychotherapy, group, and behavioral therapies, such as assertiveness and social skills training, have all been used with success. Family therapy may also be helpful in supporting new needs of the dependent patient in treatment.

B. Dependent patients are at increased risk for mood disorders and anxiety disorders. Appropriate pharmacological interventions may be used if the patient has these disorders.



Obsessive-Compulsive Personality Disorder

I. DSM-IV Diagnostic Criteria:

A. A pervasive pattern of preoccupation with orderliness, perfectionism and control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and indicated by at least *four* of the following:

1. Preoccupied with details, rules, lists, organization or schedules, to the extent that the major point of the activity is lost.
2. Perfectionism interferes with task completion.
3. Excessively devoted to work and productivity to the exclusion of leisure activities and friendships.
4. Overconscientiousness, scrupulousness and inflexibility about morality, ethics, or values (not accounted for by culture or religion).
5. Unable to discard worn-out or worthless objects, even if they have no sentimental value.
6. Reluctant to delegate tasks to others.
7. Miserly spending style toward both self and others.
8. Rigidity and stubbornness.

II. Clinical Features of Obsessive-Compulsive Personality Disorder:

- A. Obsession with detail can paralyze decision making.
- B. Tasks may be difficult to complete. These patients prefer logic and intellect to feelings, and they are not able to be openly affectionate.

C. These patients are often very “frugal” with regard to financial matters.

D. The course of obsessive-compulsive personality disorder is variable and unpredictable. From time to time, persons may develop obsessions or compulsions in the course of their disorder. Depressive disorders, especially those of late onset, are common.

III. Epidemiology of Obsessive-Compulsive Personality Disorder:

A. The prevalence of OCPD is 1% in the general population and up to 10% in clinical populations.

B. The male-to-female ratio is 2:1.

C. Obsessive-compulsive personality disorder is more frequent in first- degree relatives.

IV. Differential Diagnosis:

A. Obsessive-Compulsive Disorder (OCD): Most patients with OCD do not meet criteria for OCPD, although the two conditions can coexist.

B. Personality Change Due to a General Medical Condition and Substance-Related Disorder: Acute symptoms are temporally related to a medication, drugs, or a medical condition. The

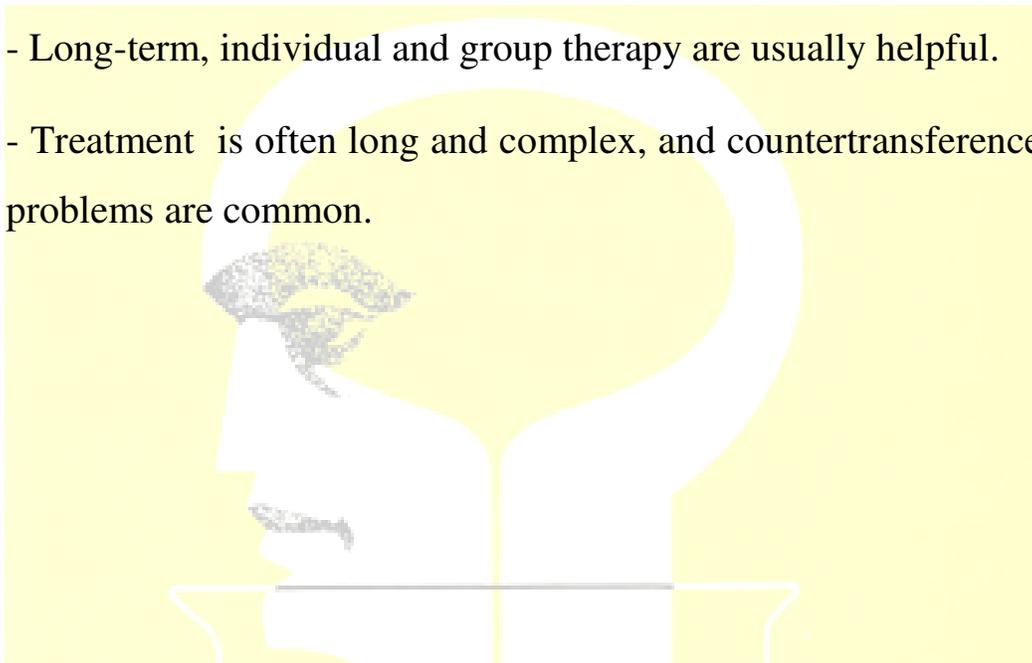
longstanding patterns of behavior required for a personality disorder are not present.

V. Treatment of Obsessive-Compulsive Personality Disorders:

- Unlike patients with the other personality disorders, those with obsessive-compulsive personality disorder are often *aware of their suffering, and they seek treatment on their own.*

- Long-term, individual and group therapy are usually helpful.

- Treatment is often long and complex, and countertransference problems are common.



MCQS AND CASES

1-A 37-year-old woman is referred to your office for psychotherapy. She is preoccupied with thoughts of her husband leaving her and being left alone with nobody to take care of her. She feels sad and hopeless when alone, lacks self-confidence, and has great difficulty making decisions.

You believe she suffers from a personality disorder. In which cluster does the patient's most likely diagnosis belong?

- A. Cluster A
- B. Cluster B
- C. Cluster C
- D. Cluster D
- E. Cluster E

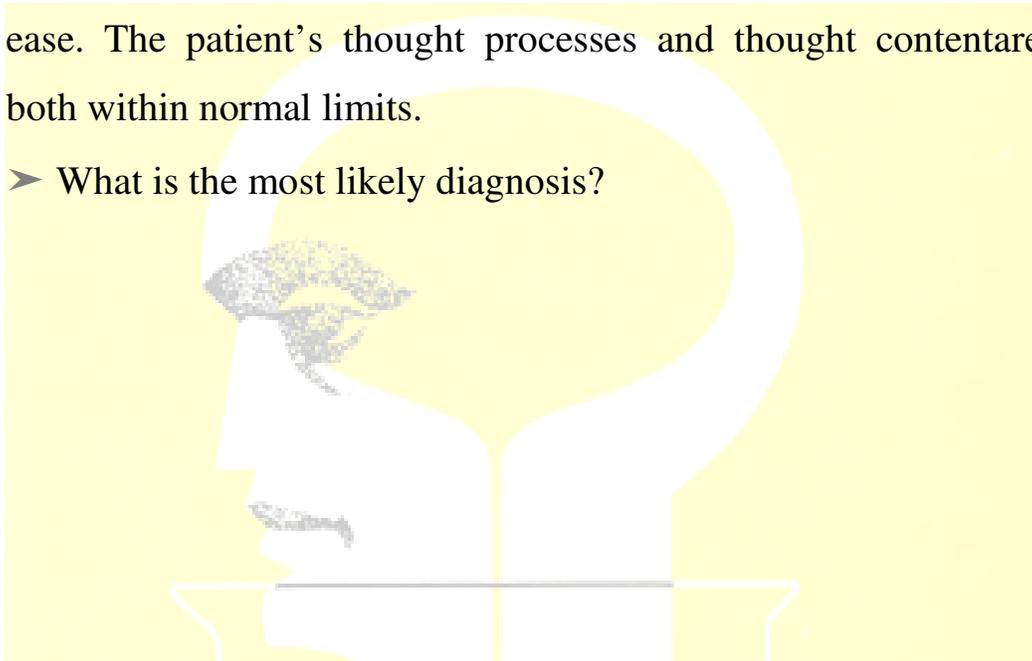
2-A 47-year-old man is referred to a psychiatrist at his employment assistance program because of continuing conflicts on the job. This is the third time the patient has been referred to a psychiatrist under just such circumstances. He lost two previous jobs because of conflicts with coworkers. The patient states that people do not like him and would like to see him fail. He cites as an example one instance in which one of his colleagues was late in sending him some material he needed, resulting in the patient being unable to complete his assignment in a timely fashion.

Although the colleague apologized for the mistake, the patient says that he knows that this man is "out to get me fired." He has since broken off all contact with this coworker and refuses to speak with him directly, preferring to use only written communication.

On a mental status examination, the patient appears somewhat angry

and suspicious. He glares intently at the interviewer and sits with his back to the wall. He repeatedly requests a clarification of questions, often asking, “What will this material be used for? I bet you are going to use it against me so that I will be fired.” When the interviewer’s pager goes off, the patient accuses him of trying to shorten the time allotted to him by arranging to have the pager interrupt them. The patient’s mood is described as “fine,” but his affect is tense and he appears suspicious and ill at ease. The patient’s thought processes and thought content are both within normal limits.

➤ What is the most likely diagnosis?



Schizophrenic disorders

Schizophrenia is a syndrome that is heterogeneous in its cause, pathogenesis, presenting picture, course, response to treatment, and outcome.

Epidemiology:

-Schizophrenia has a worldwide distribution more common in late adolescence or early adulthood.

-Equally affecting males and females

-Life- time prevalence ranges from 0.1% to almost 3%.

Aetiology:

The aetiology is still obscure, though there are theories:

1.Genetic Factors:

a) *Family studies:* the incidence to develop schizophrenia is: 5% if a sibling is schizophrenic; 15% if the patient has one parent and 30 to 40% if both. parents are affected.

b) *Twin studies:* The concordance rates for monozygotic twins and for dizygotic twins are about 40% and 10% respectively.

c) *Adoption studies:* Schizophrenia will more likely develop if there is a history of affection in the biological families than the adoptive ones.

2.Premorbid Personality:

Although no specific personality is seen in all cases, many patients show such traits as sensitivity, shyness and unsociability.

3. Psychosocial Factors:

Abnormal rearing: loss of parents, odd parents and abnormal parent-child relationships are said to increase the disorder. Both overprotection and

rejection are claimed to be seen more in families of schizophrenics. Life events: adverse life are more common within the 3 weeks before an episode.

4-Biochemical Dysfunction

Dopamine hypothesis: there is evidence of dopamine hyperactivity in schizophrenics as phenothiazines block dopamine receptors and drugs that increase dopamine activity like amphetamines produce a schizophrenic — *like* picture.

Other

neurotransmitters:

Imbalance in other neurotransmitters is thought to be while auditory hallucinations are the most related to the disorder notably in nor adrenaline, acetyl choline, serotonin, GABA and endorphin.

Clinical Picture: Careful history-taking will reveal ;

1-a prodromal period of weeks or months of increasing withdrawal and disorganization of the previous functioning.

2- active phase; includes

-Delusion; false fixed belief ex. Delusion of persecution, delusion of grandiosity, delusion of reference

-Hallucination; false perception of nonexisting stimulus

-Disorganized speech

-Disorganized behavior

A residual phase: often follows the active phase and may be similar to the prodromal phase.

Types of Schizophrenia:

1-Disorganized: (*Hebephrenic*) all symptoms can present especially disorders of thinking.

2-Catatonic: disorders of movements predominate.

3-paranoid mainly delusions and hallucinations.

4-Residual: includes a history of previous episodes of schizophrenia with chronic psychotic symptoms such as blunted affect, social withdrawal and poverty of thoughts.

5-Undifferentiated: when there are criteria that don't meet with any other or more than one type.

Prognosis:

1/3 of cases are completely cured and return to normal

1/3 of cases improve with the presence of symptoms and signs

1/3 of cases do not respond and remain as such

Factors affecting prognosis

Bad prognosis	Good prognosis	Factor
older age	younger age	1. age of onset
gradual or insidious	acute	2. onset
absent	present	3.precipitating event
Low	high	4. intelligence
less adjusted	adjusted	5.premorbid personality
POSITIVE	NEGATIVE	6. +ve family hi story
7- EE INDEX	LOW	HIGH

Management

1. Medication:

Antipsychotics, also known as neuroleptics, control the symptoms of schizophrenia.

These medications presumably work by to tailor a treatment program, blocking dopamine receptors, especially the D-2 type, in the mesolimbic system.

Antipsychotics are:

a. classical as stelazing (trifluoperazine), largactil (chlorpromazine), safinace (halopridol), are given in suitable doses, long-acting depot as modecate and clopixol is given in case of poor compliance especially in cases.

b. Atypical or Novel as Lepenex (Clozapine), (risperidone), zyprexa (olanzapine), seroquel (quetiapine). Antiparkinsonian drugs as parkinol, cogentin are prescribed to avoid the development of extrapyramidal manifestations.

2. ECT is given in the following conditions:

a-acute cases

b-catatonic and schizo-affective subtypes.

c-excitement or severe violence.

3-Psychotherapy, counseling, social or occupational Management: therapies token economy family therapy and group therapy may be useful according to the Clinical status.

CHILD PSYCHIATRY

Attention deficit hyperactive children: "ADHD"

G1 inattention: at least 6 of the following symptoms Of inattention have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

- Often fails to give close attention to details, or makes careless errors in schoolwork, work or other activities

- Often fails to sustain attention in tasks or play activities

- Often appears not to listen to what is being said to him or her

- Often fails to follow through on instructions or to finish school work, or duties in work place

- Is often impaired in organizing tasks and activities

- Often forgetful in the course of daily activities .

- Often easily distracted by external stimuli

- Often loses things necessary for certain tasks or activities, such as school assignments, pencils, books, toys, or tools.

- Often avoid or dislikes tasks that require sustained medical attention

G2. Hyperactivity: at least 3 of the following symptoms of hyperactivity have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

- Often fidgets with hands or feet or squirms on seat

- Leaves seat in classroom or in other situations in which remaining seated is expected

- Often runs about or climbs excessively in situations in which it is inappropriate

- Is often unduly noisy in playing or has difficulty in engaging quietly in leisure activities

- Exhibits a persistent pattern of excessive motor activity that is not sustainably modified by social context or demands

03. Impulsivity: at least one of the following symptoms of impulsivity has persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

- Often blurts out answers before questions have been completed

- Often fails to wait in lines or await turns in games or group situations

- Often interrupts or intrudes on others

- Often talks excessively without appropriate response to social constraints

G4. Onset: is no later than the age of 7 years

05. Pervasiveness: the combination of both inattention and hyperactivity should be present both at home and school or wherever the child goes.

G6. the symptoms should cause significant distress social and academic.

Treatment:

• **Behavioral therapy**

• **Pharmacological therapy:** ritaline (amphetamine); however usually avoided because of fear of dependency; other drugs are used to help control impulsivity and hyperactivity as tegretol and safinace

• **Play therapy**

• **Family education**

Mental retardation

The two main components of mental retardation, namely low cognitive ability and diminished social competence..

Level of social competence

To be compared with social and cultural norms; there are the Vineland social maturity scale in American and European culture.

Behavior

Causes of mental retardation:

- *Genetic: inborn errors of metabolism; chromosomal abnormalities (down's syndrome)*
- *Others: sequelae of infection, toxin or brain trauma or anoxia sustained prenatally or later e.g., congenital rubella or fetal alcohol syndrome (microcephaly, short stature, cardiac defects)*

Treatment:

-Educational: special schools or classes

-Pharmacological: according to the need if epileptic or ADHD symptoms or depression, anxiety, or any aggressive behavior is present.

-supportive psychotherapy also help to overcome low self esteem in elder children or adults .

-Psychological: behavioral, play therapy, parental and family counseling, activity groups to improve socialization .