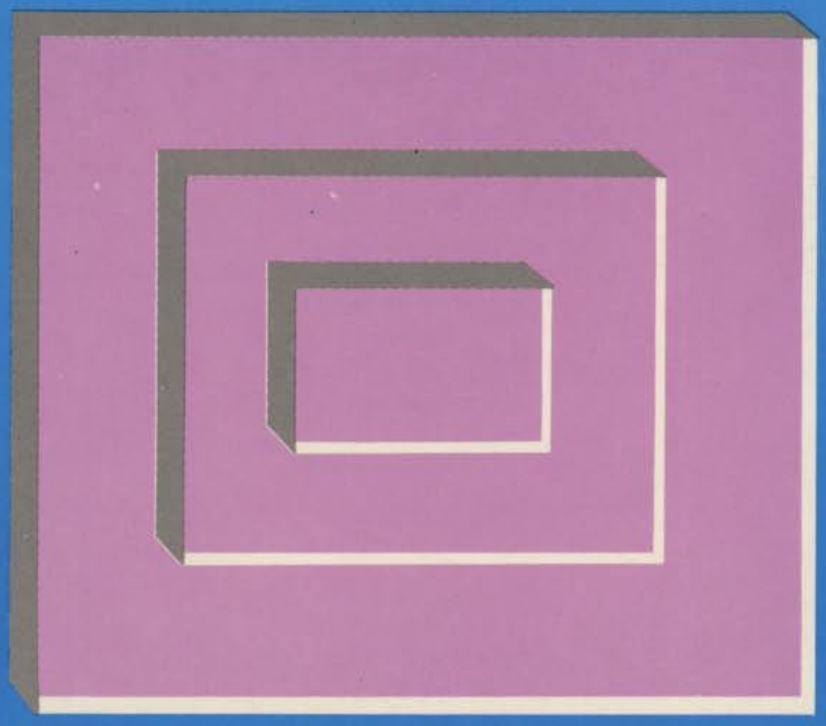
LECTURE NOTES
ON

BASIC PSYCHIATRY

By
Dr. EL Zain Abbas Omara



1987

DAR ASSAKAFA
Beirut

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BASIC PSYCHIATRY

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1987

DAR ASSAKAFA
Beirut

To Nadir, Nazim, Anne
Tamir, Noora and Iman
With Love

CONTENTS

5. **CHAPTER V**

SCHIZOPHRENIC PSYCHOSIS
Simple Schizophrenia - Hebephrenic Schizophrenia
Catatonic Schizophrenia - Paranoid Schizophrenia

6. **CHAPTER VI**

ALCOHOLISM AND DRUG DEPENDENCE
Definition of drug dependence - Types of drug dependence
Treatment and rehabilitation.

7. **CHAPTER VII**

ORGANIC BRAIN DISORDERS
Dementia - Confusional State - Epilepsy - Puerperal Psychosis

8. **CHAPTER VIII**

PSYCHIATRY IN GENERAL MEDICINE
Theories of Psychosomatic Reactions
Classification of Psychosomatic Reactions
Management of Psychosomatic Reactions.

9. **CHAPTER IX**

PSYCHIATRIC DISORDERS IN CHILDREN
Child development - Child Psychiatry Service - Some clinical syndromes - Psychiatric Assessment in children.

10. **CHAPTER X**

PSYCHIATRIC TREATMENT
Psychological treatment - Symptomatic treatment - Specific treatment.

PREFACE

Psychiatry is a rapidly expanding subject and the repeated alterations and amendments in World Health Organization (W.H.O.) classification of diseases (ICD) is a witness to this fact. Psychiatrists are becoming more and more aware of their clinical contributions in the various branches of medical practice.

The aim of this introductory book is to provide a rather handy «pocket-book» to those who mostly need it - the medical students who are currently receiving more formal instructions in their clinical years than it was the case before - to the general practitioners to whom psychiatry presents «the Doctor's dilemma» and the Social workers and Psychiatric nurses and Doctors in training.

The size of the text book was not the most important consideration in writing especially in a field where controversial points of view have generally influenced the teaching of the subject. It is difficult to be comprehensive, informative and yet conscise for that purpose where the primary objective is to provide some basic Psychiatric information which is urgently needed for students who want to know about Psychiatry especially those who hope to take Psychiatry as a line.

No references are given but a list of more detailed text books to which I have referred are included in the suggestions for further reading.

So, may I simply say that I owe more than what I can say to my former teacher - previously, Vice Dean of the Institute of Psychiatry, London University and currently Professor of Psychiatry, Nottingham University - Professor J.E. Cooper, whose continuous encouragement has made this dream come true. In Psychiatry it is more than enough to get the inspiration to make the attempt.

CHAPTER I

INTRODUCTION TO PSYCHIATRIC TERMINOLOGY

Psychiatry
Psychology
Psychopathology
Psychosis
Neurosis

INTRODUCTION TO PSYCHIATRIC TERMINOLOGY

To explain Psychiatric disorders in a logical manner one has to go through a number of humoral, demonic, astrological and physical theories ranging from Psychoanalytic theory to organic basis of Psychiatry.

The term Psychiatry in contradistinction to Psychology is derived from the Greek word «Psyche» - which means the mind and «iatry» -which means medical treatment. Thus the term, Psychiatry means treatment of mental illness. Psychology is derived from the same Latin origin which has been defined as = the Science which deals with the studies of the behaviour of man and other animals. This short definition includes a wide variety of subjects such as educational, industrial, experimental, social, statistical, comparative and medical Psychology.

The two terms are thus complementary to each other. It is difficult to form a good basic knowledge of Psychiatry without studying Psychology and it is even more difficult to deal with the patients from the Psychological point of view without a proper knowledge of Psychiatry, especially for the purpose of Psychopathology.

Psychopathology has been defined as the study of abnormal Psychic phenomena (Phenomenology or descriptive Psychopathology). It is thus concerned with observations on the form that the phenomena take in contrast with dynamic psychopathology which deals with the significance of the content of the experience. Until recently phenomenology was of interest mainly to continental Psychiatrists but the translation into English of Schneider's «clinical Psychopathology (1959)» and Jaspers' general Psychopathology (1963) has brought

this subject to the attention of the English-speaking world, Taylor (1966) and Fish (1967) have produced text books, Anderson and Trethowan (1967) have prepared a useful summary, while Taylor (1967) and Jaspers (1968) have written on the role of Phenomenology in Psychiatry.

INTRODUCTION:

Psychiatry is that part of medicine which is primarily concerned with disorders of:

1. Thought
2. Feeling
3. Behaviour

Psychiatric disorders could be primary or secondary to other illness or structural damage. Primary disorders are in the areas of communication and understanding of subjective experience or objective behaviour of the person in his environment, or the subtle physiological and bio-chemical changes in the body affecting these areas.

Secondary disorders often called Psychosomatic, vary from the normal reaction of the individual to illness to the abnormal effect of excessive emotional changes in the bodily function or structure. Thus Psychiatry has made one of its greatest contributions to clinical knowledge and understanding in the field of surgery, obstetric, general medicine as well as paediatric practice. The term organic means any brain insult or failure of function or development of nervous system due to injury or diseases. The term «functional» refers to illnesses arising from abnormalities of behaviour, failure of development or adaptation to physical or mental stress or some unknown causes whether hereditary or constitutional. Functional mental disorders can be divided into two groups:

1. Neurosis
2. Psychosis

Neurosis are generally the disorders of emotional and intellectual functioning which do not deprive the patient of contact with reality. Thus the depressed patient is often aware of his plight and can describe his sufferings in his own way in the context of his general malfunctioning in the environment. Psychosis are essentially disturbances in the patient's awareness and appreciation of his environment and his res-

ponse to it. Thus the depressed patient is not aware of what is going on inside him or his environment and can thus contribute his illness to various external powers. The difference between the two groups is often not that obvious and they can merge into each other.

In practical work this distinction is not that obvious and can often be misleading unless we exercise the greatest caution in categorizing the various groups. Every doctor in his general practice is bound to come across disorders of this kind in his patient and must be prepared to distinguish between the real and genuine complaint, and the one which reflects the inner emotional conflict of the complaining individual. This distinction should be drawn out after a careful and lengthy history, sympathetic handling and with good understanding for the patient. The patient's intelligence and verbal ability can greatly influence his presentation of his symptoms and his culture can equally determine the colour of his expression. It is the duty of the treating doctor to find out the discrepancy between the apparent distress and the real depth of the symptoms.

The role of understanding and treating psychiatric patient is difficult partly because of the gap between our ability to disentangle our own feelings from those of others, and partly because of our failure to free ourselves from preconceived ideas or previous personal experience which might influence our decision. The key to proper approach to such understanding of problems lies in the concept of the wholeness of the individual, Psyche and Soma or the mind and body, and the way in which the illness is affecting the patient's relationship with others and his ability to convey this experience to us. Thus Hippocrates in 400 BC evolved the concept of the man as a whole. He repeatedly emphasized that the physician's task was to study the diseased individual rather than to deal with the symptoms or disease as an abstract entity. The symptom is the expression of the individual in describing the alleged (diseased organ). Whether false or true this statement needs careful assessment rather than dispelling as imaginary or unreal. Psychiatric illnesses are becoming, generally speaking, increasingly common and a very important part of medicine as a whole. According to World Health Organization the following figures give only few guidelines of the dimension of the problem. At a conservative estimate about 35% of the complaints which take a patient to the general practitioner have prominent Psychological basis. Of the patients referred for consultation at Hospital or out-patient clinics or departments the pecentage is still higher. Mental Hospitals are on an average over-crowded by 4%.

Present facility for residential care is less than half the minium requirement of those who are currently under Psychiatric care. About 1/4th to 1/3rd of absence from work due to sick leave are caused by illness having primarily emotional component. Psychiatry presents a great challenge in the modern times and the degree of its proper understanding in medicine as a whole is the ultimate responsibility of the doctor and at the same time the precise distinction in calibre between only two practicing physicians. It lies in the impossibility of the treating the mind without the body and vice versa.

CHAPTER II

SIMPLE CLASSIFICATION OF PSYCHIATRIC DISORDERS

Brief Schema for Psychiatric History-taking
Outline for Psychiatric Examination
Psychiatric Assessment Sheet

A SYSTEM OF CLASSIFICATION

Simple Classification of developmental approach.

1. Disorders primarily due to failure of mental development:
   a) **Amentia :** In this group failure of normal development is most evident. The patients are labelled as mentally subnormal. This can be classified into severe, moderate or mild mental subnormality. For example:
      1. Mongolism
      2. Cretinism
      3. Other Biochemical Anomalies.

   b) **Immature personality :** Primarily emotional and not necessarily accompanied by any intellectual deficiency.
      For example:
      1. Psychopathic Personality
      2. Hysterical Personality
      3. Other forms of Personality disorder

   c) **Anomalies of Instinct :**
      1. Homosexuality
      2. Sexual Perversion
      3. Drug & Alcohol Dependence.

2. Disorders primarily due to abnormal development or reaction to internal or external stress, i.e. secondary to infection, exhaustion, structural and physiological changes as well as emotional experience.
   (1) Functional Neurosis:
      (a) Hysterical reaction
      (b) Obssessive Compulsive reaction

(2) Affective Disorders:
  (a) Anxiety State
  (b) Depressive Illness
  (c) Mania
  (d) Hypomania

(3) Schizophrenic Psychosis.
(4) Acute Confusional state and other Psychiatric emergencies.
(5) Psychiatric Emergencies :
  (a) Attempted Suicide
  (b) Acute Hysterical state
  (c) Acute Psychosis, Confusion, Delerium, Schizoid reaction
  (d) Acute Alcoholic Psychosis
  (e) Puerperal Psychosis
  (f) Psychosomatic reactions
  (g) Dementias

Child Psychiatry is seperately classified. It differs from general Psychiatry in certain clinical and therapeutic possibilities. Basically they share the same foundation with the parent subject as that of paediatrics with general medicine.

A USEFUL CLASSIFICATION OF PSYCHIATRIC CONDITIONS IN GENERAL PRACTICE

FORMAL PSYCHIATRIC ILLNESS :

1. Psychosis (schizophrenia, manic-depressive psychosis, organic psychosis)
2. Mental Subnormality
3. Dementia (deterioration of mental powers in excess of normal ageing process)
4. Neurosis (anxiety state, depressive, hysterical, phobic or neurasthenic reactions, others)
5. Personality disorder.

PSYCHIATRIC-ASSOCIATED CONDITIONS:

6. Physical Illness) where psychological mechanisms have
7. Physical Symptoms) been important in the development) of the condition.

8. Physical Illnesses) which have been elaborated or pro-
9. Physical Symptoms) longed for psychological reasons.

10. Other Psychological or Social problems.

Ref: Psychiatric Illness in general practice: M. Shepherd, B. Cooper., Oxford University Press 1966. A.C. Brown., G.W. Kalton

NOTTINGHAM UNIVERSITY MEDICAL SCHOOL
DEPARTMENT OF PSYCHIATRY
OUTLINE FOR PSYCHIATRIC EXAMINATION.

The place and circumstances of the examination should be indicated, e.g. in-patient unit, emergency clinic.

When the history is obtained from an **informant,** this should be recorded separately and not incorporated into the patients' account.

A. Patient's name B. Age C.Occupation D. Marital Status
E. Adress F. Source of referral.

1. REASON FOR REFERRAL.

This should be a succinct indication of the symptoms or events which led to the present examination. Reporting the events in the patient's own words can be of much value, because of the fact that they reflect accurately how the patient himself perceives his complaints. The statements under this heading summarize how it came about that the patient was presented for psychiatric examination. The dates of onset should be clearly indicated. This short statement will be amplified under «Present Illness».

2. FAMILY HISTORY.

Under this heading the patient's **father, mother, siblings** and **other relatives** living in his parental home should be described. Finally, the atmosphere of the home should be described, the financial, social and emotional circumstances, and the interpersonal conflicts and satisfactions should be enumerated which characterised the familiy as a unit.

Father: Age, health (including psychiatric disorder, alcoholism) or the age of death, its cause and patient's age at the time. Occupation and personality.

Mother: Age, health (including psychiatric disorder, alcoholism) or age of death, its cause and patient's age at the time. Occupation and personality.

Siblings: Enumerated in chronological order of birth, with christian names, ages, marital condition, personality, occupation, health or illness. Miscarriages and stillbirths to be included.

Home Atmosphere: Any salient happenings among parents and collaterals during patient's early years. Emotional relationship to parents, siblings, nurse, etc. Note particulars which might be required for further study, e.g. names of hospitals where relatives have been treated.

PERSONAL HISTORY:

I. **Pregnancy, delivery and post-natal period:** Date of birth and place. State if illegitimate, planned or unwanted. Mother's condition during pregnancy. Full-term birth. Normal delivery. Congenital handicaps. Feeding difficulties, and if so, breast or bottle fed.

II. **Infancy:** Delicate or healthy baby. Time of teething, walking, talking, age of bowel control and parental attitudes.
Disturbance of milestones.

III. **Childhood:** Health during childhood: Infections (especially if associated with high fever or mental symptoms), Chorea, Infantile convulsions. Play. Spontaneous games in childhood. Make-believe. Organised games. Sibling rivalry.
Neurotic Symptoms in Childhood: Night terrors, walking in sleep tantrums, wetting the bed, thumb-sucking, nail-biting, faddiness about food, stammering, mannerisms, Fear-states, model child (particularise these).

V. **School:** Age of beginning and finishing. Standard reached. Evidence of ability or backwardness. Special abilities or disabilities. Hobbies and interests. Relationship to schoolmates. (nicknames, bully or butt.) Attitude to teachers. Attitude to work. Aims and ambitions (self and family).

V. **Adolescence:** Passive or self-assertive. Over-sensitive, unduly aggressive or submissive. Daydreaming, fantasies, heroworship. Secure, withdrawn timid or shy. Passively dependent on parents. Feeling different from other children. Nicknames. Bully or teased. Effeminate or tomboy. Anti-social or asocial behaviour. Stealing or other delinquency.

VI. **Further Education:** Apprenticeship, technical training, University and professional training.

VII. **Occupations:** (In full detail) Age of starting work. Jobs held, in chronological order, dates, reasons for change. Present economic circumstances. Ambition. Satisfaction in work or reasons for dissatisfaction.

VIII. **Anti-Social Behaviour:** Deliquency and criminal offences. Drug abuse.

IX. **Service, war experience or military training:** Army service, duration, overseas experience, combat, P.O.W. medical or psychiatric discharge. Disability pension.

X. **Home Circumstances:** Accomodation, sharing of rooms, number of people in house. Financial circumstances.

XI. **Sexual History: Puberty:** Age of onset, mental reaction, how information acquired, masturbation (age, frequency, guilt, transient homosexuality, crushes, sexual fantasies, inhibitions, attitude to sex (prudishness, frankness). In females, age menstruation began, preparation for it, reaction to it.
Menstrual History: Regularity of periods, pain tension. Onset of menopause, and climacteric symptons. Sexual inclinations and practice: Masturbation, homosexuality; heterosexual experience apart from marriage; venereal disease; abortions.

XII. **Marital History:** Duration of acquaintance before marriage and of engagement. Husband's (of wife's) age, occupation, personality, compatibility. Frequency of sexual intercourse, sexual satisfaction or figidity. Contraceptive measures.
Marriage forced by pregnancy. Fidelity of partners.

XIII. **Children:** Chronological list of children and/or miscarriages (including abortions), giving names, ages, personalities, etc. of former. Attitude towards children. Psychiatric states of children.

4. PREVIOUS ILLNESS:

I. **Somatic:** Describe, chronologically and in detail, illnesses operations and accidents.

II. **Psychiatric:** Detail all psychiatric conditions for which treatment has been received giving dates, duration and nature of treatment given, in which hospital or out-patient department, or by which doctor. Detail all pscychiatric symptoms for which treatment has not been received (e.g.hysterical disturbances, preoccupation with bodily functions, insomnia, mood variations, psychosomatic disturbances, obssessional anxiety and subjective tension symptoms, etc.)

5. PREVIOUS PERSONALITY:

The examiner assesses the patient's personality in two ways. First he obtains a detailed account of the patient's relationships with the other people with whom the patient customarily interacts, at home, at work and in social activities. Secondly, the examiner studies the way in which the patient reacts to him in the interview situation.

Personality is commonly described under the following headings: in this description of the personality prior to the beginnings of the mental illness, do not be satisfied with a series of adjectivies and epithets, but give illustrative anecdotes and detailed statements. Aim at a picture of an individual, not a type. The following is merely a collection of hints, not a scheme:

I. **Social Relations:** To family (attachement, dependence); to friends (goups societies, clubs); to work and workmates (leader, follower, organiser, aggressive, submissive, adjustable). Friends: few and close; few and superficial; many and close; many and superficial. Prefers own sex. Prefers opposite sex.

II. **Activities and interest enjoyed:** books, plays, films. Quality of observation, judgement, critical faculty. Spends leisure time alone.

III. **Mood:** Cheerful, despondent, anxious, worrying optimistic, pessimistic, self-depreciatory, satisfied, over-confident, stable, fluctuating (with or without any occasion); controlled demonstrative.

IV. **Character Traits:** timid, sensitive, suspicious, resentful, quarrelsome, irritable, impulsive, jealous, selfish, egocentric, reserved, shy, self concious, strict, fussy, rigid, lacks confidence.

V. **Attitudes and values:** moral, religious, social political, economic, practical. Attitudes towards self, others, health, own body.

VI. **Initiative:** Energy, output sustained or fitful. Fatiguability. Decisive, Effectivenss. Ambition.

VII. **Fantasy life:** Day-dreaming, frequency, content.

VIII. **Habits:** Eating, (fads), sleeping, excretory functions; Alcohol Tobacco, drugs; specify amount taken recently and earlier.

6. HISTORY OF PRESENT ILLNESS.

THE MENTAL STATE.

This is the systematic and objective assessment of the patient's mental functioning as evident to the examiner in the course of the examination. (The history had dealt with the sequence of life experiences of the patient, leading up to and including the development of his illness).

1. GENERAL BEHAVIOUR: Description as complete, accurate, and lifelike as possible, of what we and the nurses observe in the patient's behaviour, especially anything abnormal.

The following points may be considered, though not exclusively: Does the patient look ill? Is he in touch with his surroundings in general and in particular? Relationship to other patients, to the nurses, to the doctor who examines and treats him. How does he respond to various requirements and situations? What gestures, grimaces or other motor expressions tics, mannerisms. Much or little activity? Is it constant or abrupt or fitful? Spontaneous and how provoked? Free or constrained? slow, stereo-typed, hesitant, or fidgety? Tenseness, scratching or rubbing. Do movements and attitudes have an evident purpose or meaning? Do real or hallucinatory perceptions seem to modify behaviour? Does the patient, if inactive, resist passive movements, or maintain an attitude, or obey commands or indicate awareness at all? Eating, sleep, cleanliness in general, and excreta. Way of spending the day.

If the patient does not speak, the description of his mental state may be limited to a careful report of his behaviour.

2. TALK: The form of the patient's utterances rather than their content is here considered. Does he say much or little, talk spontaneously or only in answer, slow or fast, hesitantly or promptly, to the point or wide of it, coherently, discursively, loosely, with interruptions, sudden silences, changes of topic, comments on happenings and things at hand, appropriately, using strange words or syntax, rhymes, puns? How does the form of his talk vary with its subject?

SAMPLE OF TALK: Conversation should be recorded with physician's remarks on left side of page, and patient's on right. It should be representative of the form of his talk, his response to questioning and his main preoccupations. Its length will depend on its individual significance. In later sections of the mental state, it will be desirable to record the patient's reported experiences (e.g.hallucinations, delusions, attitude to illness) in his own words, but the sample required at this point need not aim at being comprehensive.

MOOD: The patient's appearance may be described, so far as it is indicative of his mood. His answers to «how do you feel in yourself?» «what is your mood?» «How about your spirits?» or some similar enquiry should be recorded. Many varieties of mood may be present -not merely happiness or sadness, but such states as irritability, suspicion, fear, unreality, worry, restlessness, bewilderment, and many more which it is convenient to include under this heading. Observe the constancy of the mood, the influences which change it; the appropriateness of the patient's emotional state to what he says. Thought content and nature of dominant thoughts. Are they gloomy or optimistic?

Delusions and Misinterpretations: What is the patient's attitude to the various people and things in this environment? Does he misinterpret what happens, give it special or false meaning, or is he doubtful about it? Does he think anyone pays special attention to him, treats him in a special way, persecutes or influences him bodily, or mentally, or ordinary or scientific or preternatural ways? Laughs at him? shuns him? Admires him? Tries to kill, harm, annoy him? Does he depreciate himself in any regard, his morals possessions, health? Has he grandiose beliefs? These matters may be complicated or concealed and may need much enquiry. If a whole conversation dealing with them is reported here, resume the main points at the end.

Hallucinations and other disorders of perception: Auditory, visual, olfactory, gustatory, tactile, visceral. The source vividness reality, manner of reception, content, all other circumstances of the experience are important; its content, especially if auditory or visual must be reported in detail. When do these experiences occur, at night, when falling asleep, when alone? Any peculiar bodily sensations, feeling of deadness? Unreality?

Compulsive Phenomena: Obsessional thoughts, impulses, or acts. Are they felt to be from without, or part of the patient's own mind? Does their insistence distress him? Does he recognise their inappropriateness? Relation to his emotional state? Does he repeat actions, such as washing, unnecessarily to reassure himself?

Orientation: Record the patient's answers to questions about his own name and identity, the place where he is, the time of day, and the date. Is there anything unusual to him in the way in which time seems to pass?

Memory: This may be tested by comparing the patient's account of his life with that given by others, or examining his account for intrinsic evidence of gaps or inconsistencies. Information which he gave about his previous life, his personality, sexual experiences, etc should not be inserted here but included as a supplementary part of the history, and its source indicated. There should be a special enquiry for recent events such as those of his admission to the hospital and happenings in the ward since. Where there is any selective impairment of memory for special incidents, periods, recent or remote happenings, these should be recorded in detail, and the patient's attitude towards his forgetfulness and the things forgotten specially investigated.

Record the patient's success or failure in grasping, retaining, and being able to recall spontaneously or on demand three or five minutes later a number, a name and address, or other data. Give him digits to repeat forward, and then others to repeat backwards, and record how many he can repeat immediately after being told.

(In describing the state of the patient's memory, do not merely record the conclusions reached but give the evidence first, in full, and describe at appropriate length such facts of behaviour as seem to indicate whether he was attending, trying his hardest, being distracted by other stimuli, etc).

Attention and Concentration: Is his attention easily aroused and sustained? Is he easily distracted? Pre-occupied? To test his concentration ask him to tell the days of the months in reverse order, or to do simple arithmetical problems requiring «carrying over» (112-25), subtraction of serial sevens from 100 (give answers and time taken).

General Information: Tests for general information and grasp should be varied according to the **patient's educational level** and his **experiences** and **interests,** but the answers to the following should be recorded in all cases.

Name of the Prime Minister
Date of the beginning and end of war.
Familiarity with recent events.

Intelligence: Assess the patient's intelligence. Use his history his general knowledge, problems of reasoning. You may employ standarised tests. Observe discrepancies in the results of various methods, and try to interpret them.

Insight and Judgement: What is the patient's attitude to his present state? Does he regard it as an illness, as «mental» or «nervous», as needing treatment? Is he aware of mistakes made spontaneously or in response to tests? How does he regard them and other details of his condition? How does he regard previous experiences, mental illness, etc.? What is his attitude towards social, financial, domestic, ethical problems? Is his judgement good? what does he propose to do when he has left the hospital?

INTAKE SUMMARY.

(This should not generally exceed one sheet of A4 in length)

This should be written as soon as a satisfactory informant has been interviewed., or at the latest within two weeks of the patient's admission. It should be under the headings: 1.Reason for referral; 2. Family History; 3. Personal history; 4. Previous Illness (Psychiatric and physical); 5. Previous personality; 6. Present Illness 7. Mental state; 8. Initial formulation.

CONFERENCE AND WARD-ROUND NOTES.

Whenever the patient is presented at a conference, the doctor will summarize the presentation and discussion, giving the data, and setting out in more detail the recommendations made and the conclusions reached.

TRANSFER OR TERMINATION.

When the treatment ends, or the patient is transferred to another ward or doctor, a brief summary is made. This is to summarize the illness, the treatment, progress of the case, and present clinical status; final diagnosis, degree of symptomatic improvement, and disposition of the case should then be stated.

CONSULTATION:

Whenever a consultant is called in to give a specialist opinion about some aspect of a case, the question put to him about the patient is to be recorded under the relevant date and a note made of his recommendation.

DISCHARGE SUMMARY.

This should be completed within a week of the patient's discharge. It should consist of: - 9. Further information; 10. Treatment given; 11. Progress in hospital; 12. Outcome; 13. Diagnosis - a) type of disorder; b) formulation of interplay of aetiological factors; 14. Prognosis; 15. Further action.

DISCHARGE/LETTER TO PATIENT'S DOCTOR.

This may be brief and be accompanied by a copy of the summary, or where more appropriate may be more lengthy and not accompanied by a summary.

CLINICAL TESTING OF INTELLECTUAL FUNCTION.

(Not social or behavioural function)

ORIENTATION.

1. Date - am/pm/Day/Date/Month/Year
2. Place - Hospital? Home? (ie.not the name but the nature.)
3. Person - What do I do? What does she (ie. nurse) do?

ATTENTION / CONCENTRATION:

4. Days of week backwards
5. Months of Year backwards
6. 'Carrying over' sum eg. 112-25
7. Serial 7's

Progressive difficulty

MEMORY SHORT TERM:

8. Place name eg. «St.Francis Hospital» «Dr. House»
9. Fictitious name & address 'John Brown'
   42 West St. Liverpool'
10. 6 figure number «183729»

LONG TERM:

11. Date of birth Age
12. Home address (Preservation often shows here)
13. Monarch/Prime Minster
14. Dates of WWI/WWII

LANGUAGE FUNCTION:
(check vision 1st)

15. Write your name and address
16. Object naming **(pen, keys, yale key, stethoscope)**
    increasing difficulty.
17. Reading a passage. What does it mean?

VISUO-SPATIAL FUNCTION:

18. Watch dressing
19. Obeying commands - «When I put my pen down»
    put on your glasses» etc.
20. Design copying

NB. This is not a «test» for which there is a «score». It is a **clinical** search for areas of disability.

A BRIEF SCHEMA FOR PSYCHIATRIC HISTORY TAKING

REASON FOR REFERRAL.

1. **Circumstances** eg GP referral to outpatients, emergency admission domiciliary visit.
2. **Presenting complaints** in patient's own words

   At this stage it may be appropriate to proceed to a history of the present illness, or to continue with format as presented. This schema represents the outline for the **recording** rather than for the taking of a psychiatric history.

FAMILY HISTORY:

1. **Parents:** Age, health, occupation. Patient's observations as to parent's relationship with each and their behaviour as parents.
2. **Siblings:** Age, names, health, occupation. Patient's observations as to general family atmosphere in early years, and current relationships.
3. **Other relatives:** who live nearby or are emotionally significant.
4. **Family medical history:** especially details of psychiatric care.

PERSONAL HISTORY.

1. Pregnancy/labour: major difficulties; prolonged hospitalisation.
2. **Infancy:** medical problems, milestones; periods of separation.
3. **Childhood/adolescence:** education - standard reached; type of schoolds; attendance problems.
   contact with agencies - social service, child guidance, psychiatrist.
   Antisocial behaviour - police trouble; drugs; institutional care; relationship with peers.

4. **Adult:** Age of leaving school/parental home
   brief job history/further education history
   current home circumstances, finances, job.
5. **Marriage:** age, duration of courtship; personal details of spouse current relationship - children ages, names; problems (as above).
6. **Sex:** Rarely appropriate to ask for other than recent changes in interest.

PREVIOUS ILLNESSES.

1. Physical
2. Psychiatric - include dates and location of specialist contacts; overdoses; specific treatments (drugs, ECT, psychoterapy, etc).

PERSONALITY.

1. hobbies, pastimes, social network
2. Character traits and usual mood state
3. Use of alcohol, tobacco, other drugs.
   If specific attitudes or beliefs (religious, political etc) are voiced spontaneously; allow patient to expand on them.

HISTORY OF PRESENT ILLNESSES.

1. Onset - date when where you last well
   - precipitants - apparent from history, or perceived by patient ie. other events going on at the same time.
   - gradual or sudden.
2. Course - Fluctuating, stable
   - slow progress, rapid, rapid decline etc.
   - response to previous treatments or circumstances
3. previous similar espisodes
4. Treatment - all treatments given by others during this illness, including dosages. Current treatment, nature and duration.
5. Circumstances finally leading to presentation - deterioration insistence of Gp or family etc...

AN OUTLINE OF THE MENTAL STATE EXAMINATION.

GENERAL BEHAVIOUR:

(i) **Appearance:** clothes; make-up; cleanliness; attention paid to presentation.

(ii) Movement: spontaneous; restricted, bizzarre; reflecting anxiety

(iii) Social skills: eye-to-eye contact; friendliness.

SPEECH:

1. FORM: Rate, spontaneity; coherence etc. If at all abnormal quote a verbatim sample
2. CONTENT: Reflecting mode of responding to questions, preoccupations, etc.

MOOD:

1. Subjective: patients description of mood and its variations with time. Include here descriptions of anxiety (somatic & Psychic) and biological symptoms of depression, anorexia, weight loss, insomnia, early morning waking, etc).
2. Objective: Tearfulness; agitation or manifest anxiety; marked variability; modification by content of interview.
3. Suicidal ideas: including specific plans.

OBSESSIONALITY:

1. Ideas, thoughts, images: repetitive, intrusive, resisted, recognised as nappropriate.
2. Rituals: washing, counting, checking.

DISORDERS OF PERCEPTION.

1. Distortions - illusions; depersonalisation; deja vu.
2. Hallucinations - describe exact content; mental state and level of consciousness at the time; patients awareness **at the time** of the unreality of the experience.

DELUSIONS AND MISINTERPRETATIONS.

CLINICAL TESTING OF INTELLECTUAL FUNCTION

(Not social or behavioural function)

ORIENTATION

1. Date - Am/PM/Day/Date/Month/Year
2. Place - Hospital? Home? (ie. not the name but the nature)
3. Person - What do I do? What does she (ie.nurse) do?

ATTENTION/ CONCENTRATION.

4. Days of week backwards
5. Months of year backwards
6. «Carrying over» sum eg. 112-25
7. Serial 7's

} Progressive difficulty

MEMORY: Short Term:

8. Place name eg. «St. Francis Hospital» «Dr. House»
9. **Fictitious name & address «John Brown» 42 West St. Liverpool'**

LONG TERM:

10. 6 figure number «183729»
11. Date of birth Age
12. Home address (preservaration often shows here)
13. Monarch/Prime Minister
14. Dates of WWI/WWII

LANGUAGE FUNCTION: (check vision 1st)

15. Write your name and address
16. Object naming (pen, **keys, yale key, stethoscope)** increasing difficulty)
17. Reading a passage. What does it mean?

VISUO-SPATIAL FUNCTION:

18. Watch dressing
19. Obeying commands - «When I put my pen down, put on your glasses» etc
20. Design copying.

N.B. This is not a «test» for which there is a «score». It is a **Clinical** search for areas of disability.

SAMPLE

CASE REPORT

(Name) _____

(date) _____

Medical Student to _____

Introduction

I saw Mr. Gordon Bennett at the city hospital where he had been admitted on the previous day having taken an overdose of aspirin.

CLinical Summary

Mr. Bennett a 59 year old with no previous psychiatric history. He is married with two children in their late teens and works as a coal-miner in Hucknall. He has been under some stress this year, with short-time working at the pit and with worry over his elder son, who was cautioned for shop-lifting in January and whom he suspects has recently started illicit drug use. Three months ago he went to his GP with complaints of anxiety and insomnia and was started on a benzo-diazepine hypnotic. For two months prior to presentation he had significant biological symptoms of depression. When seen he was agitated and tearful, and expressing ideas that he was inadequate as a father to his children and as a provider to his family.

Formulation:

This is the first presentation with a major depressive illness of a middle-aged man who has been under financial and family stress recently.

Management:

Mr. Bennett was admitted to the ward informally and treated with antidepressant and ECT. I interviewed his wife when she came to visit him and discussed the case with the social worker, who visited the family at home to assess the problem with the children.

Follow-up:

Mr. Bennett responded well to a short course of ECT and was discharged to the outpatient clinic with no significant symptoms. Our social worker arranged to follow the family up to help with what appeared to be temporary adolescent behaviour problem in the younger boy.

PSYCHIATRIC EXAMINATION SHEET.

Date ..... No. .....
Address ..... Name .....
Occupation ..... Nationality .....
Children ..... Marital Status .....

Diagnosis

Result

HISTORY

1. Source & Cause of Referral

2. Complaint
   A. Patient

   B. Informant

   C. Attendants.

3. History of present illness (detailed & chronological: any precipitating cause either physical such as influenza or psychological such as bereavement, quarrels, troubles; any change in behaviour, habits, sleep, appetite, etc)
   Duration Onset Course

4. Personal (past) history:

A. Medical History:
   1. Previous attacks of a like or unlike character (detailed)
   2. Record all illnesses (fevers, operations, ...etc)

B. Developmental date:
   1. Birth history (age & health of mother during pregnancy labour, attitude or parents & whether wanted or attempted abortion, parent's feelings regarding the sex of child)
   2. Infancy history (feeding, weaning, teething, sitting, walking, sphincter control, illnesses esp. convulsions chorea).
   3. Childhood & adolescence (health, any traumatic events, social adaptation, neurotic traits, antisocial traits)

C. School History:

D. Work Record:

E. Psychosexual of Development (detailes)
   1. 1st awareness of sex, how?
   2. Masturbation
   3. Heterosexual, homosexual inclinations, sexual fantacies
   4. Marital history (circumstances of marriage, characteristics of both mates, mode & frequency of sexual satisfaction or frigidity or impotence, any contraceptive measures & concern aroused by their use, any family problems)
   5. Menstrual history, pregnancies & abortions:

F. Personality traits before illness:
   1. Social life, including hobbies, interests, interpersonal relationships:
   2. Mood
   3. Character & moral:
      Any addiction to drugs (alcohol, hashish, opium, hypnotics & if alcoholic state the exact amount, the nature of alcohol & duration of the habit):
   4. Family History:
      A. Parents (health, age & cause of death, occupation & personality):

B. Sisters, siblings & other relatives (their personality traits).
C. Children (ages, occupation, personality traits).
Any nervous or mental disease:
Interpersonal relationships of family members:
Home atmosphere (step-parents? dissention between parents, economic conditions, sleep-arrangements, parental over solicitude or over-severity, stress on religion).

EXAMINATION

A. PRESENT MENTAL STATE.

1. General appearance & behaviour (accessible or negativistic conditions of dress & toilet, expression of face, gait posture and voice, bodily movements)
2. Stream of talk (form, i.e. stammer or lips, amount & rate)
3. Mood (excesses or deficiences, constant or changeable appropriateness)
4. Perception
   (a) Hallucinations (type, source, time of occurence & contents)
   (b) Illusions:
   Ideas of reference:
   Illusions of unreality (derealization, depersonalization).
5. Thought process (obssessions & compulsions, delusions, passivity feeling, familiarity and unfamiliarity feelings, dreams and nightmares etc).
6. Consciousness (confusion, stupor) & orientation for time, place and person:
7. Memory:
   (a) future events (appointments)
   (b) Recent events (events of the past 24 hours, repeat name, address, flower after 3-5 minutes, retention of digits)
   (c) Remote events (birthday, date of marriage)
   Test for retnetion & recall (same tests as for recent events)
   Hypermnesia:
   Paramnesia - Confabulations

8. Attention & concentration (ask pt. to tell the days or months in reverse order, digits to repeat forwards and backwards).
9. Scholastic and General Knowledge:
   a. Name of Prince
   b. Facts of geography (capitals of Egypt, Iraq, England)
   c. Fact of history.
10. Calculations (exp. for Egypt, Iraq, England)

    100-7 & then substract 7 consecutively
    100 Joffray's sing 123
    ——— 8
    7 ———
    81624

11. Intelligence
12. Judgement
13. Insight (awareness of illness, opinion of nature of illness. prepared to cooperate with treatment)
14. Evidence of brain damage (aphasia, acalcullia, agraphia, apraxia)

B. PHYSICAL EXAMINATION

C. SPECIAL INVESTIGATION

1. Lab:
2. Psychological Tests:

D. DIAGNOSTIC FORMULATION

E. TREATMENT

F. RECOMMENDATIONS

CHAPTER III

FUNCTIONAL NEUROSIS

Hysterical Reaction
Anxiety State
Obssessive
Compulsive Neurosis
Anorexia Nervosa

FUNCTIONAL NEUROSIS

This can be grouped into two distinctive categories:

1. Hysterical Reactions
2. Obssessive-Compulsive Reactions.

DEFINITION:

Hysterical reactions or hysterical symptoms are attempts produced and maintained by motives of the individual who is fully unconscious of them, directed towards some real or imagined gain. It is the relief of the intolerable stress which is the unconscious motive or primary gain of hysterical reaction. It is not a deliberate attempt that is very important to distinguish a hysterical reaction from malingering which is mainly a conscious process. Hysterical reactions have been the subject of great controversy in Psychiatry, while some Psychiatrists deny the mere existence of the concept of hysteria, others put too much emphasis on the intolerable mental stress which produced hysterical symptoms. In fact, some Psychiatrists labelled hysteria as the discription of women in the words of men, but recent studies have shown that hysteria can occur in men as well as women but to a lesser degree.

AETIOLOGY:

It is said that given sufficient stress everybody has got a breaking point. All individuals behave in some way or another in a hysterical fashion to an intolerable stress. There is a great deal of variation in the expression and experience of the symptoms of the illness while acknowledging the constitutional disposition of the hysterical personality, environmental factors may play part in this way:

(a) **Emotional Stress:** The life of the individual can make the situation intolerable and thus the individual resorts to hysterical manipulations.
(b) The direct effect upon the patient's equilibrium of structural disease or damage to brain or any part of the body. This makes it too important to distinguish between primary hysterical reactions and those secondary to an underlying organic body disease.
(c) The indirect effect upon the patient's overall equilibrium of the structural damage or disease to any organ of the body.
(d) The effect of psychiatric illness improperly diagnosed or inappropriately treated.

The dissociation phenomena refers to the seperation of conscious activity from the unconscious area of mental life. Thus the effect of suggestion upon the patient can not be controlled by any conscious mechanism on the part of the patient to comprehend and understand the nature of his experience and thus be able to modify his behaviour. The individual capacity to do so becomes increasingly limited due to the stress.

It may indeed be difficult to draw a hard and fast line between deliberate and conscious malingering on the one hand and the hysterical reaction on the other. It is not that easy.

CLINICAL FEATURES:

The simplest form of hysterical reaction shows in the area of motor or sensory function:

a) Blindness, deafness, aphonia, anaesthesia or paraesthesia.
b) Motor function: disturbed reflex motor activity.
c) Symptoms may be psychological rather than primarily physical i.e. disturbance of consciousness or coma or stupor or memory loss or even hysterical hallucinations.
d) Symptoms would take part of the colouring from the stress which has precipitated the reaction.

In hysterical reaction it is always important to take the trouble of understanding the patient's complaint in the context of the presenting illness of the individual. Thus the culture and intelligence of the individual to a large extent form the symptoms of the illness. It is thus said that the hysterical reaction are more common in persons of below average interlligence. It helps a great deal to understand the capacity of the symptoms to provide some immediate relief to the person from the underlying emotional stress as well as their symbolic signifiance.

CLINICAL FEATURES:

From the aetiological factors so far mentioned in clinical practice one can draw a number of conclusions which describe the clinical features of hysteria.

1. Hysterical reaction to the patient's life situation: i.e. of the individual who is finding it difficult to keep up with his job and develops some motor disability to keep him away from work like writer's cramp.

2. Hyterical reaction following head injury:
   It is understandable in any form of trauma to the brain even when undetectable would lead to disturbance of mental functioning to a degree that would show high correlation with the presenting symptom. Thus any form of brain injury would be partially responsible for the hysterical reaction while the rest can only be understood in terms of Psychological trauma. The constitution or disposition of the individual as well as the environmental factors can cause a form of hysterical reactions that is presenting to the doctor. This sould be observed in cases of Neurosis following head injury which form a distinct syndrome called «Compensation Neurosis» seen after medico-legal cases.

3. Hysterical reaction following injury to the other parts of the body:
   It is common to see such cases involving compensation issues in the court procedures to maintain their symptoms even after the problem of compensation has been settled.

4. Compensation Neurosis: This refers to a group of hysterical reactions characterised by somewhat growing disability following injury in any part of the body and involves compensation which has not been adequately settled or improperly handled. The primary disability or the extent of injury are exaggerated by the unconscious motives of the patient for the financial gain and this may make the patient even more severely disturbed with the accompanying anxiety.

   Some of these symptoms though seem sufficiently disabling to the patient they look readily acceptable to him by an astonishing sense of complacence which Piaget Janet has explicitly described and gave it the name «belle indifference» referring to the mental attitude of the patient towards the severely distressing but the apparently

indifferent behaviour that Janet describes as the underlying mechanism in such cases-usually a sincere conflict in the mind of the patient which he is unable to solve, i.e. it is basically the desire to resume work and accept recovery on the one hand as opposed by grave misgivings on the other hand and whether he would really be fit enough to resume work and if he did whether he would be able to furnish a valid claim for compensation.

Those cases have presented a challenge to the physician because a great deal of the treatment depends on the asset of the patient, his confidence on the physician and the settlement of compensation. They thus tend to be chronic and drag on until the question of compensation has been properly settled.

It is important to note that common psychiatric illnesses like chronic anxiety or severe depression, schizophrenia, dementia can release a hysterial reaction and such hysterical reactions should be considered as an early manifestation to the underlying psychiatric disturbances. It is unfortunate that in some cases the financial settlement of the compensation issues is not the real remedy for recovery. Some patient retain some hysterical reactions for a considerable time after that apparent period of false recovery.

5. Some symptoms can complicate the psychiatric illness, such as depression or shizophrenia, or chronic anxiety state or chronic physical illness, i.e. Parkinsonism, multiple sclerosis or epilepsy.

TREATMENT:

In treatment one has to excercise the greatest caution in the management of hysterical reaction. Too often the underlying mechanism is only partly apparent and the provocative stress is visible. Accordingly analysis of the patient's life situation, general health, physical examination of any recent illness or injury or other structural disorders:

1. Supportive and interpretive individual Psychotherapy.
2. Treatment of the accompanying anxiety or physical illness.
3. Some additional measures like hypnosis or other methods involving controlled suggestion may be employed.
4. Hypnosis and related procedures for specific reversal of symptoms can be of some use.

ANXIETY STATE

Anxiety is a common healthy universal human phenomena. All normal people are bound to develop this reaction in response to a threatening situation that affects their style of life, their confidence or general well-being. It only becomes abnormal or pathological if it exceeds in degree or duration an understandale response of the normal individual to that threat. It is probably the commonest Psychiatric disorder at all times and constitutes the greatest percentage of those attending the out-patient clinic and general hospital departments. It could be the cause of a great wastage of money, time and man-power through the amount of time and investigations done to those patients at the expense of other Psychiatric and general medical illnesses. If unsuccessfully treated it tends to become chronic or associated with other disorders like depression and Psychosomatic reactions.

DEFINITION:

Anxiety is a state of irrational fear and apprehension out of all proportion to an understandable cause of stress. It ranges from a minor feeling of apprehension to an acute panic attach accompanied by multiple physical symptoms of endocrine and autonomic origin with secondary effects on higher mental functions such as concentration, attention, learning and judgement.

AETIOLOGY:

Constitutional and personality factors play a great role in the predisposition of the individual to such a reacion. Normal people respond to stress in a different manner. The type of reaction is decided by the vulnerability of those people which is genetically and environmentally

determined. Thus an already anxious person may respond to a personal disaster very unfavourably if the emotional factors are working in that direction. Conversely he may adjust reasonably if his surrondings were not conducive to an exaggerated reaction.

CLINICAL PICTURE:

In an anxiety state practically every part of the body is affected due to the autonomic and endocrine disturbance, besides, the subjective feeling of a disturbed mental function. There are objective pattern of psychological changes occuring in the body system due to the activity of the adrenergic component of the anxiety. Usually the patient experiences both aspects of feeling and physical symptoms like tachycardia, breathlessness, chocking sensation or suffocation or loss of appetite, insomnia, sweating and tremulousness.

The anxiety could be diffuse or specific. In the diffuse type there is an exaggeration of those stimulus-response reactions of all bodily organs especially the cardio-vascular or abdomonial symptoms. The anxiety may pervade the life of the individual to much an extent that he may be unable to function normally in the society. The specific type could be linked to place or an object. The patient may have fear of staying alone or being in a closed place (claustrophobia) or he may develop fear of open spaces, height, gathering (agrophobia) or he may have fear of certain objects like snake, knife which are called specific phobia. Phobic states are usually regarded as part of the anxiety state and as such are rarely seen separately and the picture is usually of the basic anxiety state which is exaggerated by the specific phobic reaction.

ANXIETY SYMPTOMS:

The physical feature could be decided according to the body system affected and those are usually accompaniment of the autonomic components of the anxiety. There are important symptoms which are characteristic of anxiety state:

1. **HEADACHES:** This is the characteristic headache that «perplexes the doctors» as it does not respond to analgesic. The classical description of the patient of a tight bond round his head due to spasm of front-occipital muscle (Tension headache). The patient experiences pain over the vault of the scalp of a throbbing nature of

«nails on the head» with tenderness of the skull. It is worsened by noise and bursting in character or stabbing behind the eyes. It is often mistaken for migraine to which it is closely related and extensive investigation usually reveal no abnormality.

2. **INSOMNIA:** This is characterised by a typical early sleep disturbance where the patient finds difficulty to get off to sleep and remains awake or preoccupied by worrying thoughts. He may go to sleep interruptedly getting up at night disturbed by horrible dreams or awakened by a feeling of choching sensation, by feeling of suffocation gasping for breath. Thus the patient always gets up unrefreshed and claims that he has not slept all night.

3. **HYPOCHONDRIASIS:** The anxious patient tends to complain of various multiple aches and pains all over the body. They have irrational fear of being the victim of body cancer, tuberculosis or brain tumor. They experience thus funny sensation of feeling of being unwell and they express their fear of going mad.

PSYCHOPATHOLOGY:

The anxiety reaction is related to the unconscious repressed emotions of fear of past experience. This mechanism of repression which is unconscious is released by the conscious defence force of the immediate threatening situation. Thus is could be expressed directly as follows:

1. Primary features related to the autonomic and endocrine disturbance of physical symptoms as palpitations, restlessness, headache, etc.

2. Secondary features related to the secondary gain of the symptoms to serve the unconscious motives of the patient to escape from the intolerable situation. The example, of the «housebound wife» who cannot leave the house alone would force the husband and the relatives to give her more care and attention and this unconsciously alter the dynamic relations of the family. This could be mixed with hysterical conversion symptoms. Thus anxiety is considered into the differential diagnosis fo most psychiatric disorders. In fact, it could preced or accompany of follow all Psychiatric illnesses and sometimes it can only be treated following treatment of the underlying illness, i.e. depression.

TREATMENT:

1. **Psychotherapy:** The anxiety is basically an irrational reaction to a normal stimulus which needs exploration and explanation of the symptoms to the patient. These patients respond well to reassurance and suggestion of the «talking cure». They often respond to a placebo if handled probably by a sympathetic Doctor who manages to illicit the confidence of the patient. Superficial and supportive psychotherapy may help a great deal in reducing the tension and severity of the accompanying symptoms.

2. **Symptomatic Medical Treatment:** It is important to note that tranquilizers especially the benzodiazepine group help to reduce the anxeity. It should not be a substitute for psychotherapy as in such a case all psychotropic drugs can be used in anxiety with little or no effect at all. Whether diffuse or specific, primary of secondary to other psychiatric disorders there is a room for using sedatives, hypnotics or antidepressants as well as vitamines as the case may be.

   In chronic cases where the anxiety is accompanied by tremulousness, loss of weight or appetite, substantial improvement may be obtained by increasing the patient's weight and improving his general health. This can be achieved by modified insulin treatment which consists of giving small doeses of insulin followed by parental glucose in bed in divided sessions over weeks, thus reducing both subjective and physiological tension and increasing the body weight.

3. **Abreaction or Psychological Ventilation:** Abreaction or psychological ventilation helps to alleviate the inner feeling of uneasiness and distress. The patients are made capable of expressing their feelings by relaxation induced under intravenous barbiturate, i.e. 1/2 gram of i/v thiophentone. The continuous sleep previously induced by physical methods of high doses of tranquilisers and hypnotics is now becoming gradually replaced or supported by electric induction with «Somlec Machine» which produce electro-sleep under suggesion.

Hypnosis was employed extensively in the past using specific type of hypnotic phenomena technique to provide confort and relaxation. Although time-consuming tool of psychoanalysis it has been replaced by more vigorous methods of treatment like desensitization and «implosion» techniques. This is not an alternative but an adjuvant to

exploration of the dynamic mechanism. It should not aim at suppressing symptoms only, otherwise it would become self-defeating method of treatment.

Prognosis depends on the stage of treatment as well as the patient's psychological resources. The acute early cases following immediate treatment carry good prognosis while the chronic cases complicated by depression or hysterical reaction remain crippled by their symptoms.

OBSSESSIVE - COMPULSIVE REACTIONS.

DEFINITION:

These two terms are used respectively for the sensory and motor component of this syndrome. They often occur together and are rarely seen separately though people tend to speak of obssessive illness in general meaning, the entire syndrome. Obssessive reaction is the repetitive subjective feeling or an idea or thought or an impulse occuring in the mind of the patient which he realizes as foreign to him but he is unable to resist them. Compulsion is an irresistible desire to carry out the act while retaining the insight into the nature of it. It is important to differentiate between the obsessive reaction and schizophrenic delusion, the latter is held with strong conviction. The cardinal difference is the insight into the nature of the illness.

AETIOLOGY:

It is not uncommon for normal people to show some obssessive preoccupation in ordinary life. It is important to note the difference of an obssessional trait, symptoms or illness. Obssessional trait of personality characterise people with a tendency to perfectionism or meticulousness. Obsessional preoccupation is increased by fatigue, tension or depressive feeling of a strong nature and obssessive symptoms is the subjective feeling of inner restelessness due to irresistible desire to carry out or dismiss the idea or act. Obssessive illness is the whole gummata of subjective feeling and objective behaviour which are characteristic of this syndrome. Thus the illness has a strong constitutional basis which is to some extent environmentally produced. It is related to strict parental attitude and early-up-bringing with excessive concern about the early toilet training. The parents themselves might have been obssessive and thus set an examle to the child, and it could

be released by brain damage following head injury or infection like «Encephalitis». It is commonly noted in patients suffering from brain damage or mentally retarted children who show some obssessive features and ritual behaviour. In fact, one of the most common features noticed in autistic children is the obssessional preoccupation with inanimate objects. In cases of depression obssessional reaction could be a secondary feature of the illness which desappears following treatment of the illness especially after ECT.

CLINICAL FEATURES:

The nature of such illness could be very bizzare and diffuse, and thus pass un-noticed by the doctor. In history taking unless the Psychiatrist looks for obssessive traits or symptoms or illness they could remain undiagnoses. It could be specific and readily expressed by the patient when it involves certain areas of mental functioning. When the compulsive component is obvious like rituals or excessive hand-washing for fear of dirt the picture becomes clear. If the patient is intelligent and verbally expressive he could tell about the sensory component of idea or thoughts that come to the mind and tries in vain to dismiss them as rediculous and absurd.

The diffuse type is only noticed in day to day life like cheching and recheck the tap or the lights to make sure that things are in order. The patient realizes that it is so but it gives him no mental rest unless he repeats the act. Any resistence on the part of the patient is met with excessive anxiety and tension and thus it evolves into a vicious circle with repeated doubts and endless checking.

The specific type can be seen in the area of sexual activity or aggressive tendencies or fear of contamination and infections. The sexual urge could be characterised by the fear of pregnancy in women while aggressive impulses could be noticed in the irrational fear of seeing pointed objects or knives around lest they should hurt somebody. Fortunately, very rarely do the obssessive patients carry out these thoughts or impulses. Under tremendous pressure of anxiety or feeling of depression they might attempt suicide and this could be an attemp to put an end to their sufferings rather than a reaction to obssessional compulsive ideas. As stated earlier, the patients realize the absurdity of their symptoms trying hard resist or dismiss them as illogical but they often fail to do so and this sense of compulsion makes them feel tense and tormented. This self-restrain tends to complicate their day to day life and becomes crippling to the patients who usually seek treatment

rather late or only when their life becomes intolerable. There is a great tendency for the syndrome to develop into a conditioned reflex like glove-wearing to avoid contamination or hand-washing for fear of contaminating other people or getting rid of imagined dirt.

PSYCHOPATHOLOGY:

Although obssessions are symbolic symptons of unconscious origin the patient is fully conscious of their nature. It is not like hysteria where hysterical reaction is a symbolic symptom of unconscious origin for the patient. While the primary and the secondary gain in hysteria could be very obvious for both the doctor and the relatives, it could remain quite out of sight for the patient. From the analytical point of view rituals represent a regression to an early infantile primitive thinking at the stage of early toilet-training. Thus the feeling of compulsion to control or dismiss the obssessional symptoms gives a subjective feeling of power to overcome a threatening situation. By so doing this conditioned reflex is transformed into automatic behaviour which becomes repetitive, distressing and intolerable for the patient.

TREATMENT:

1. **Psychotherapy:** On the whole deep psychoanalysis should be avoided as it may lead to worsening of the symptoms. Naturally, if cases are seen at an early stage they can benefit from superficial exploration. Chronic cases do need sympathy, understanding and better communication. Those people are already aware of their absurd symptoms and it does not help them to emphasize that or make them feel ridiculed. Already they feel guilty for what they are doing for themselves and other people, and need constant reassurance that they are not going to break down. Those cases which are secondary to depression or brain damage require treatment in their own right.

2. **Symptomatic Medical Treatment:** The most distressing complaint is the anxiety accompnying the illness and this can be relieved by minor tranquilizerz especially Benzodiazepine group of drugs. Other cases complicated by depression could de well following a course of ECT. In chronic cases not responding to various sorts of treatment accompanied by severe degree of tension and dragging on far a long period need surgical intervention following careful psychometric assessment. Neuro-surgical procedure like Bimedial Leucotomy (Cingulectomy) or fronal leucotomy is indicated.

PROGNOSIS:

Generally speaking prognosis of obssessive compulsive neurosis is guarded. They tend to improve with age and they can tolerate their illness for a long time before seeking treatment. By the time they have sought sonsultation they would have been suffering for at least two years before coming to see a doctor. After the age of 50 years a great percentage of their symptoms improve and the tension becomes less distressing. Nearly 1/4 th of the cases seen earlier in life and childhood respond to psychotherapy and medical treatment. Another 1/4 th might respond to ECT and the remainder would need long intensive treatment along with Psychotherapy until eventually leucotomy is performed to bring a lasting cure.

ANOREXIA NERVOSA

This is a pathological state of mind where there is prolonged food refusal, with profound loss of weight and severe self-starvation. There is no evidence of physical disease. The condition is characterised by an astonishing disturbance of body image due to a denial mechanism leading to severe emaciation and even death, especially in cases complicated with infection and severe dehydration.

AETIOLOGY:

There is particular aversion to fattening foodstuff and occurs mainly in adolescent girls though not uncommon in boys. It is a neurotic condition, less often there is depression of Psychotic nature and occasionally the condition is an early manifestation of Schizophrenia. Some studies have shown that the condition was hysterical in 75% Schizophrenia in 20% while 5% of the remaining a typical conditions were depressive and obssessive conpulsive disorders.

CLINICAL FEATURES:

1. Essentially a disease of adolescents rather than childhood.
2. Progressive weight loss.
3. Self-denial and subjective feeling of well-being
4. Strict dieting and often self-induced vomitting
5. There are usually serious familly problems with great hysterical neurotic reactions to family stress.
6. No other primary pathology
7. Amenorrhoea is a constant feature

In primary anorexia nervosa it should be differentiated from endocrime disorder like hypopituitarism or physical conditions like miliary tuberculosis. In anorexia nervosa unlike endocrine disorder there is no loss of secondary sexual characteristics such as public and axilliary hair distribution or breast and general body contour.

Anorexia Nervosa could be considered as a «culture bound-phenomena» seen most commonly in Western Society where women are very obssessed with slimming as «slimmliness is next to godliness» and young girls start dieting early enough to avoid overweight. In my practice for twenty years in this society I have not seen any single classical case of anorexia in female or male. Being closely related to the affluence of the society one would imagine that in a decade or two anorexia nervosa would be a common disease concept in the practice of developing countries.

TREATMENT:

Anorexia Nervosa is not an easy condition to treat because thes patients are evasive, escapy and suicidal. They do not accept treatment readily. The primary target should aim at resolving the underlying psychopathological disorder of:

1. Unwarranted slimming
2. Unresolved conflict
3. Unusual distortion of body image

Treatment should start immediately in hospital and in bed. It should aim at restoring normal body weight by good diet, sympathetic nursing and careful handling of these patients especially their tendency to hide their motives. If sufficiently treated the outcome is good but a prolonged course of illness with remission from severe cachexia or committiong suicide or developing into a chronic invalid person with hysterical manipulative personality disorder.

Anorexia Nervosa has been discussed briefly with this group because as it had been mentioned earlier it is a common disease of young people in Europe culture. A great deal of research is being carried out to determine the aetiology of this condition - the social, family, biochemical as well as personality factors.

In fact, while I was doing my post-graduate training in the Institute of Psychiatry in London, I was working in the biochemical unit under Professor G.Russell, who is a world expert in anorexia nervosa and

his research into the biochemical aspect of this condition was astonishing. Again my clinical examination for the D.P.M. was a case of anorexia nervosa and the examiner was Professor Crisp, another world expert in the subject at St.Georges's Hospital in London in 1972. In fact any doctor in Psychiatric training should be familiar with the clinical presentation of this condition.

CHAPTER IV

AFFECTIVE DISORDERS

Simple depression
Recurrent depression
Unipolar/Bipolar
Mania
Hypomania
Involutional Melancholia

AFFECTIVE DISORDERS

The classification of the affective disorders is very complex not completely satisfactory with a great deal of controversy in the subject as witnessed in the internal classification of diseases (ICD). They are disorders primarily due to abnormal reaction, internal or external stress whether structural and physiological or emotional experience as well as infection and exhaustion. They are a group of functional psychosis as opposed to organic psychosis and include the following variety mental disorders.

1. Depressive Illness
2. Mania
3. Hypomania
4. Mixed state, i.e. agitated depression
5. Others:
   Manic/depressive,
   Schizio/affective or
   Bipolar/Unipolar type.

The Neurosis include the following disorders:

(1) Anxiety state
(2) Hysterical reactions
(3) Obssessive - Compulsive

CLASSIFICATION:

Affective disorders are divided into two main groups:

1. Endogenous depression, i.e. occuring out of the blue
2. Reactive depression, i.e. a response to environmental stress

There are three main clinical types:

A. Simple depression
B. Recurrent depression or manic/depresive illness
C. Involutional melancholia.

1. SIMPLE DEPRESSION:

This is characterised by low mood, general slowing of all activity and loss of interest as in the case of bereavement or normal grief. There are no delusions or hallucinations which are commonly seen in the severe type.

2. MANIC/DEPRESSION: Being a Psychotic disorder it is characterised by loss of touch with reality as well as delusions and hallucinations.

3. INVOLUTIONAL MELANCHOLIA: By definition this type of depression occurs in middle and late life, thus it is called involutional.

While some Psychiatrists deny the mere existence of such diagnostic entity it is a useful idea to retain it in the classification of offective disorders. It is characterised by agitation with marked restlessness delusions of poverty, unworthiness, guilt feeling as well as hypochondrical ideas. Suicidal thoughts which can effectively be carried out by those patients should be taken seriously as they occur in fairly high percentage of cases.

DEPRESSIVE ILLNESS:

Depression is a primary disturbance of mood. Depression could occur secondary to bereavement or any serious personal form of loss or an associated physical illness. Depression could be classified also as reactions to environmental factors often called reactive depression or for no apparent reason often described as endogenous depression. Although it is difficult to separate the cause and effect in a single case of depression as the two factors often co-exist it is a useful concept to retain the descriptive term of endogenous and reactive types. The first could be synonymous with biochemical or physiological factors as for example hormonal changes with consequent depletion of dopamine derivatives or serotonin in the brain «5-Hydroxy-Tryptamine» while reactive type could be a response to any emotional or physical stress. It is rare to find the two extremes in pure forms as the one merges into the other depending on the patient's response to stress. This is partly genetically determined as the recent studies have shown high correlation of positive family history especially in the endogenous type. Some Psychiatrists go as far as postulating that each type of depression res-

ponds to specific type of drug treatment. They claim that the reactive depression responds to monoamine-oxidase-inhibitors while endogenous type responds to tricylic anti-depressants.

DEFINITION:

Depression is a state of unhappiness and despair which occurs spontaneously or in response to a normal stress which exceeds the understandable reaction of a normal individual to that stress. This state of unhapiness is expressed in subjective experience or guilt feeling and despaire or in symptoms of loss of interest in internal or external surroundings.

AETIOLOGY:

Hereditary and constitutional factors play an important role in the causation of depressive illness. Thus there is a high incidence of positive family history in the diagnosed cases. The incidence of depressive illness is 0.4% in the population as a whole. As depression can occur in reaction to environmental factors which could be illicit from the patient history, it can only be coined as depression if the reaction is seen as inappropriate to the total life situation. Depression can also be caused by chronic debilitating illness like Carcinoma or endocrinological disturbance like myxodema, previously called «Myxoedematous madness» by Asher. Depression can be so severe as to be confused with dementia where it is decribed as «psuedo-dementia».

CLINICAL FEATURES:

Depression can be conveniently classified into three common reactions:

1. Mood Disturbances
2. Poor Response to environmental stimulations
3. Malfunctioning of autonomic nervous system.

1. Mood Disturbance:

a. Consistent sadness
b. Loss of interest in surroundings
c. Overall slowing of movements and speech
d. Loss of concentration and subjective feeling of poor memory and learning
e. Feeling of guilt and unworthiness

f. Delusions: those are commonly seen in the expression of poverty, ill-health or guilt feeling. Thus they are called hypochondrical or nihilistic delusions.
g. Hallucinations that can be accusatory or reproachful.

2. Poor response to stimulations:

These are forms of underestimation of the intellectual and physical resources or the inability of the patient to perform with vigour and alertness. The activity is reduced to the minimum with ambivalance in decision taking or indecisiveness, appropriate thinking and adequate performance.

a. **Smiling depression.** This is an apparent cheerful mood masking a tendency to burst into tears often called masked depression.

b. **Agitation:** This is an exaggerated state of restlessness in response to an otherwise ordinary daily trivial problems.

3. Autonomic Malfunctioning:

a. **Disturbance of sleep** rythems with early morning waking which is more common in the endogenous type as opposed to reactive depression or anxiety where early insomnia is a predominat feature. Loss of appetite, weight and this can go to the extreme of food refusal and starvation.

b. **Constipation and dyspepsia** due to sluggish movement of bowel and general retardation of bodily activity. They can be secondary to hypochondimoracal dilusions.

c. **Headaches:** Description of tight band round the head with hysterical overlay often accompnied by anxiety.

d. **Diurnal Variation:** The patient feels worse early in the morning and the mood lifts up gradually towards afternoon in endogenous type. In severe cases of depression those symptoms can be very complex and can even be accompanied by suicidal tendency. Suicide is a real danger in any case of depression and the patient may need admission to the hospital, or even electrical treatment to help him overcome this sense of despair. It is generally recognised that all severe cases of depression attempted suicide sometime during treatment for illness and about 20% attempted suicides while 10% did commit suicide. Recent studies of suicide

have shown that in committed suicide about 25% of cases were depressed and that less than 10% have seen a psychiatrist before committing suicide. Early diagnosis and prompt treatment could save a lot of those committing suicide.

PSYCHOPATHOLOGY:

Depression could be a primary biochemical disturbance of neuro-endocrine origin which could be treated by drugs or secondary to the subjective feeling of unhappiness which is reflected in the patient's attitude to life in general. He becomes increasingly pessimistic and seeks tragic interpretation for the ordinary life difficulties.

TREATMENT:

1. Supportive Psychoterapy
2. Specific anti-depressants and symptomatic medical treatment
3. Electrical treatment

The risk of suicide should always be in mind in the assessment of the depressed patient and the patient should be asked specifically about any suicidal thoughts or feelings of unworthiness, i.e. «life is not worth living» or «I wish I could die», etc. In severe cases electrical treatment is indicated at the initial stage to be carried out in hospital and if necessary followed up on out-patient basis.

4. Leucotomy: In servere or uncontrollable chronic cases, especially with prolonged distress and pain the patient might benefit from neuro-surgical procedures.

HYPOMANIA:

DEFINITION:

This represents the opposite side of the coin for depression i.e. elated mood and excessive energy that might eventually lead to severe exhaustion and even death.

AETIOLOGY:

Constitutional predisposition is an important factor in the causation of mania. It constitute 1/5 th to 1/4 th of depressive illness at least in European communities.

CLINICAL FEATURES:

a. Elated mood - unwarranted feelings of happiness.
b. Acceleration of thoughts - This is described as racing ideas jumping into the patient's mind with no connection of common theme.
c. Flight of ideas, i.e. changing subjects or suddenly diverting from one to another with illogical association or in response to any essentially unrelated stimulations.
d. Pressure of talk - Uninterrupted stream of speech or talking too much while actually saying nothing.
e. Excessive energy - trying every job without finishing any.
f. Restlessness and excitalility - Outgoing and forceful. and if hindered would be very irritable or violent.
g. Insomnia - They can go on without sleep for 2-3 days and unless properly sedated this might lead to exhaustion and death.
h. Infectious gaiety - Humor that is uncontrollable in nature with unique ability to make other people join them in their happy mood inspite of tremendous self-restraint. In managing this patient tactful handling is very necessary and gentle, understanding attitude is the only way to establish rapport or secure admission to hospital or get the consent for accepting treatment.

MANIA:

This is the severest form of this type of affective disorder.
a. Uncontrollable excitement that might need physical restraint.
b. Flight of ideas.
c. Pressure of talk.
d. Incoherance of speech due to high stream and racing against time.
e. Violence that might lead to homicide.
f. Hallucinations and delusions especially of grandeur.

TREATMENT:

This is essentially the same as in the case of depression with special emphasis on:

1. Establishment of rapport with patient and family.
2. Admission to hospital especially in severe Hypomania.
3. Specific medical measures including continuous sleep to avoid exhaustion and vitamine saturation to avoid dehydration and infection.
4. Symptomatic medical measures like major tranquilizers.
5. Electrical treatment especially in severe cases of excitement or failure to control by psychotropic drugs.

Lithium Therapy:

Lithium salts are now commonly used in the treatment of mania and to prevent recurrences of Psychosis in manic/depressive subjects. The most widely used preparation is the carbonate (Priadel), although the citrate and acetate are as effective. The plasma concentration remains fairly constant throughout the 24 hours after a single morning dose. Lithium is excreted almost entirely in the urine and thus it is toxic to the kidneys. The therapeutic level is very near to the toxic level of above 1.6 mea/litre of serum level. The average prophylactic dose is 750 - 100 mgm. daily.

PROGNOSIS OF AFFECTIVE DISORDERS:

This is generally good with early diagonsis and effective treatment. The commonest age for anxiety is the early twenties while depression is seen more commonly in thirties and above. Depression occuring in late life should be considered seriously to eliminate any underlying physical illness or early incipient dementia. In about 85% of cases remission would occur within weeks of months of treatment while about 20% of depressive cases relapse. Of the remainder 5% show regular series of remission and relapse becoming increasingly resistant to all form of treatment including ECT.

Prognois of Hypomania is less favourable despite remission for a single attack and that with repeated attacks of Hypomania the prognosis becomes favourable. On the whole 5% show recurrent relapse.

CHAPTER V

SHIZOPHRENIC PSYCHOSIS

Simple Schizophrenia
Hebephrenic Schizophrenia
Catatoni Schizophrenia
Paranoid Scnizophrenia

SCHIZOPHRENIC PSYCHOSIS.

The word Schizophrena is derived from the two latin word, «Schizo» means division or slipt, and «phrenia» which means personality, i.e. split personality. This is commonly confused in the mind of lay people as meaning the split of personality in two individuals as the case of the famous novel «Dr. Jackel an Mr. Hyde». This is not true. Split personality refers to the disintegration of the higher mental functions like judgement, thinking. behaviour and emotion. Thus the core of the personality is shatterred into pieces according to the degree of dismantlig of those mental abilities. Being a Psychotic illness the individual is also deprived of the appreciation and contact with reality. Thus Schizophrenia can express itself in various forms of mental disturbance which eventualy all lead to a progressive deterioration of the personality. The WHO has been launching an extensive research canpaign with world-wide psychiatric experts in the «Pilot-study» of Shizophrenia (1973) to explore the prevalence, symptomatology, cause of the illness and the ouctcome as well as the local diagnostic criteria of Schizophrenia which is posing a great challenge in Psychiatry.

Schizophrenia can be considered as a group of disorders and not a single disease entity. This current research approach is contributing widely to the determination of the causation of each Nosological entity.

DEFINITION:

Schizophrenia can be defined as a group of mental disorders which lead to disintegration of higher mental functions and loss of touch with reality with consequent deterioration of personality and secondary inpairement of social ships and congnitive functions.

AETIOLOGY:

Both genetic predisposition and hereditory factors are important. The nature of the specific constitutional defect is not yet fully known. There are various theories implicating nervous transmitters, enzyme activity or endocrine imbalance. Although the evidence for these hypothesis is still under the test, there is ample evidence seen in types of Schizophrenia like syndrome induced by drugs, i.e. Amphetamine -like Psychosis, toxic confusion state or organic brain damage like cases of epilepsy and chronic alcoholism or endocrine disturbance as shown by the hign incidence of Schizophrenia in puberty, pueperium or menopause.

The theories of aetiology of Schizophrenia are various and complex and have been divided into genetic, metabolic, biochemical, endocrine, neurological, social and psychological. These are research topics and should be looked for in detailed text books of psychiatry given in the reading list.

INCIDENCE:

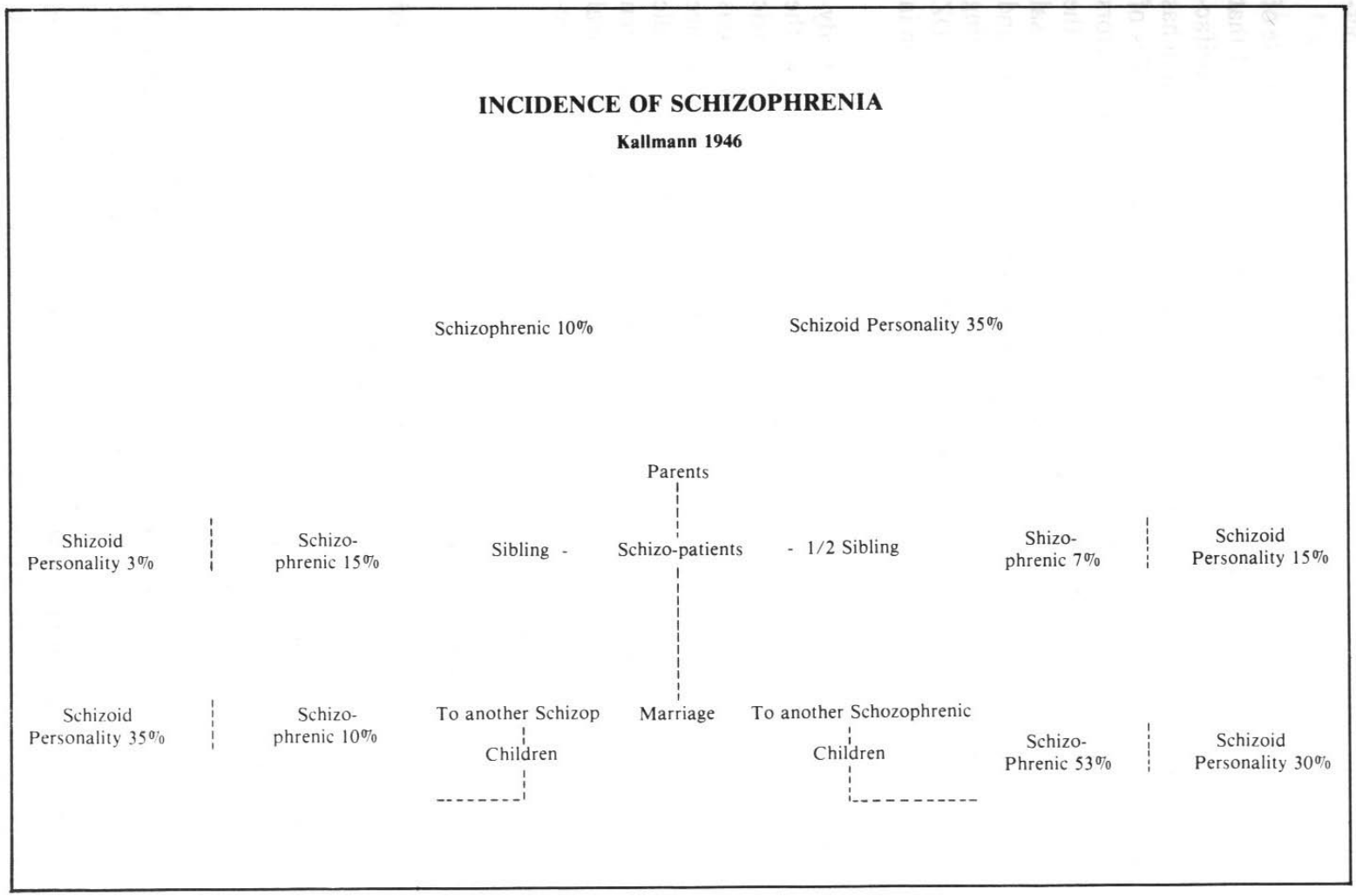
The incidence of Schizophrenia is about 0.85% of the general population. As it is the case with other disorders it is useful to differentiate betwen Shizoid personality trait, Schizoid symptoms or Schizophrenic illness. Schizoid personality occurs in about 3% of the general population characterised by traits like thin asthenic body-built, cold callous emotion, sensitive suspicious tendency, introvert and eccentric behaviour. There is some evidence to suggest that nearly half the people who develop Schizophrenic illness had previous history of Schizoid personality. It is not easy to establish a causal relatinship between schizoid personality and schizophrenia and it is difficult to distinquishi between the premorbid personality and the prodromal phase of a slowly developing illness. The strong positive family history in the relatives suggests a strong genetic component. Kallman's work in 1946 has shown that adding the total incidence of Schizophrenia and Schizoid personality he obtained the following figures:

a. The parents 50%
b. The siblings 50%
c. The half siblings 24%

He concluded that homozygous individual (carrying perhaps two abnormal genes) would become Schizophrenic while the Heterozygous

INCIDENCE OF SCHIZOPHRENIA

Kallmann 1946



(with one normal and one abnormal gene) would be of Schizoid personality.

«Slater» studies of uniovular twins (1953) has shown that the rate of Schizophrenia in concordant twins was 75%, thus he concluded that the genetic component in Schizophrenia is almost certainly multifactorial and recessive. But the weight of evidence of endocrine origin has not so far been convincing inspite of the developmental anomalies of sexual characteristic of Schizophrenic patients. The metabolic factors in the causation of Schizophrenia have been mainly derived from the observation that chronic Schizophrenics tend to have distrubed basal metabolic rate, anamalous response of blood pressure, pulse rate and electrolytes as well as maladaptive phenomena resembling hibernating animal. Recent studies have shown the concordance rate of MZ: DZ ratio of 42: 9 which are much lower than the previous figures given in earlier studies.

Krestschmer theory of personality type which has divided the body-built into asthenic, athletic and pyknic type has associated the asthenic type with 70% incidence of Schizophrenia. Multiple toxic substances have been claimed to affect the brain by chemical reactions altering the cortical enzyme system. The nature of the toxic substance is as yet uncertain. A sub-group of Schizophrenia described as periodic catatonia by Gjessing was supposed to be due to disturbed nitrogen metabolism. Thus all those endocrine autonomic and biochemical hypothesis remain to be established as evidence for or against the specific theory of Schizophrenia.

CLINICAL FEATURES:

The cardinal features of Schizophrenic disorder can be summarised into the disturbance of four mental functions:

1. Disorder of thinking
2. Disorder of emotion
3. Disorder of contact with reality
4. Disorder of behaviour

Some of the following disturbances were described as the most important symptoms of Schizophrenia. They are rarely found all together in one patient but their presence is of vital diagonistic criteria.

THOUGHT DISORDER: This is characterised by either sudden interruption of talk or inability to continue conversation, i.e.

«Thought block» or feeling that their ideas are being taken away from their mind (thought withdrawal) or that strange new ideas are being put into their mind which do not belong to them (Thought insertion).

a. **Delusions of Reference:** These could be of persecutory nature where the patient feels that everybody is against him or is trying to do him harm, thus the paranoid contents of the idea tend to make the patient feel alienated and withdrawn. The patient may feel ordinary conversation by people or broadcast in radio are made about him and that these ideas are of convincing nature that the patient might retaliate or act accordingly by assaulting other people.

b. **The Passivity Phenomena:** Sometime the patient feels that his body or mind is being interfered with by imagined outside forces or that he is made to do things automatically against his will (ideas of interference). These passivity phenomena are seen commonly in the catatonic type where the patient can assume very abnormal postures or maintain them for long time. This is the motor component of loss of will-power. The sensory part is seen in the conviction that they are being influenced by external agent like radio, television. magic, witchcraft according to the patient's intellignece and culture. The patient may feel that there is a bugging device in the room or electrical wired are being connected in a mysterious way to his body, etc.

c. **Primary Delusions:** A delusion is a false unshakable belief held by the patient with a strong conviction the content of which is illogical and not understandable in the context of the intelligence or culture. It occurs out of the blue as opposed to secondary delusion and shows mystical changes in the surroundings or inside the body.

d. **Secondary Delusions:** These are delusions arising out of the patients attempt for the interpretation of the surroundings in a way to make rational explanation of his odd experience or to organise the chaos of his thoughts which indicate a relative preservation of judgement.

e. **Neologism:** This is synonymous to a new language which the patient invents to express his thoughts which have become so nebulous and disjointed that they convey no meaning except to the patient only.

2. DISORDER OF EMOTION:

Emotional Incongruity: This is one of the cardinal features of Schizophrenic disorder. It is exemplified in the distressing lack of emoton in response to personal catastrophies to the patient or his family.The patient may tell you about the death of his most intimate relative with the utmost lack of affection and callousness while smiling inappropriately or with silly giggling. It is often described as poor rapport or as if there is a sheet of glass separating the patient and the doctor throughout the interview, often referred to as flattening of affect.

3. **Hallucinations:** These are defined as sensory preceptions in the absence of external stimuli, i.e. hearing voices where there is no one speaking at all. These could be visual, tactile or auditory which are the most common in Schizophrenia. Voices usually occur in the third person making running commentary or discussing the patient. Hallucinations are the most distressing features of the illness and account for a great deal of the withdrawal and mental preoccupation of the Schizophrenic patient. They are responsible for a high percentage of the bizzare behaviour of the patient. The role of the phenothiazine is probably by acting on the reticular formation and cutting off the sensory stimuli and perceptions going upto the cortical level of the brain.

4. **Disorder of Behaviour:** The common example of the catatonic is often noticed by the lay man and described as classical madness - the impossible postures described as (waxy flexibility) that these patients can be made to maintain for long periods point to the loss of volition and behaviour disorder. The bizzare movement of the tongue and lips (facial grimmaces) of the repetitive purposeless movements up and down the corridor with funny gestures are examples of the stereotyped behaviour of such patients.

DIAGNOSIS OF SCHIZOPHRENIA:

Schizophrenia presents a great diagnostic problem which suggests international disagreement in the concept of Schizophrenia as well as the disagreement between individual psychiatrists. This indicates that Schizophrenia is not a clear-cut diagnostic entity and that this state of affair is likely to continue until some objective method of diagnosis is established like the demonstration of a specific biochemical or psychological disturbance. Some Psychiatrists put too much emphasis

on a group of symptoms while other psychiatrists shift the weight of evidence towards another group of symptoms. There is a big variation in the diagnosis of Schizophrenia between European and American Psychiatrists and even greater difference between British and American Psychiatrists and this suggests that no system of classification is ideal.

The study of abnormal psychic phenomena is concerned with observations on the «form» that the phenomena take in contrast with dynamic psychopathology which deals with the significance of the «content» of the experience. Part of this variation is due to the differences between Psychiatrists in the use of the diagnostic terms and to bridge this gap both the American Psychiatric Association and the General Register Office in Britain have produced glossaries defining the psychiatric terms used in the World Health Organization International Classification of Disease (I.C.D.) but even so the glossaries sometimes differ in their definitions.

There are certain specific abnormalities which are important to make the diagnosis of Schizophrenia with some confidence. These abnormalities include Schizophrenic thought disorder, passivity phenomena, catatonic symptoms, flattening of affect and certain types of delusions and hallucinations. These are listed in detailed text books of psychiatric but a summary could be given here for illustration. The most important abnormalities in order of significance to the diagnosis was thought disorder, incongruity of affect, paranoid delusions, stereotype and delusions in general.

Schneider (1959) has listed those symptoms which he regards as being of first-rank importance in distinguishing Schizophrenia from other functional psychosis and he asserts that if a person with no relevant organic disease experiences any of them, the diagnosis is Schizophrenia. Schneider first-rank symptoms are:

1. Certain types of auditory hallucinations, i.e. audible thoughts, voices heard arguing and voices giving a running commentary on the patients actions.
2. Somatic Passivity phenomena - the experiences of influences playing on the body.
3. Thought withdrawal and other interferences with thought.
4. Diffusion of thought or (thought broad-casting) where the patient experiences his thoughts as being also thought by others.
5. Delusional perceptions.

6. All feelings, impulses (drives) and volitional acts that are experienced by the patient as the work or influence of others.

All other abnormal subjective experience in schizophrenia are according to Schneider of much less diagnostic importance and he calls them sceond-rank symptoms.

Failure to illicit the first-rank symptoms does not exclude the possibility of schizophrenia as most of these symptoms tend to become less evident with the progress of the disease.

While most Psychiatrists have very little difficulty in diagnosing typical cases of schizophrenia there are many patients whose mental disorder is not typical but seems to merge with other mental illness.

The differential diagnosis of schizophrenia would need to distinguish paranoid schizophrenia from involutional parapheria and from acute paranoid reactions. Schizo-affective and affective psychosis are sometimes hard to differentiate as are latent schizophrenia and schizoid personality. Occasionally the mental abnormalities seen in other conditions such as hysteria or obssessive compulsive neurosis may be unusual and raise the possibility that the illness is Schizophrenic as in organic condition such as chronic alcoholism and temperal lobe epilepsy.

CLINICAL FEATURES:

For the sake of simplicity these clinical varieties can be grouped into four types, the first two of which Kreaplin has described as dementia preacox referring to the evential intellectual deterioration of the illness occuring in the early adult life or puberty. Now it became clear that not all varieties occur in puberty nor do they all end with dementia.

1. **Simple Schizophrenia:** This usually occurs in the early years of school age with gradual deterioration in school performance, social relationship and behaviour disorder. The case may pass undiagnosed or may be given different diagnostic labels until they reach the stage where personality features show gradual disintegration. There is a high tendency for chronicity and progressive deterioration. So it might be very rewarding to consider the possibility of simple Schizophrenia in any youngster showing abnormal behaviour or any unexplicable change in life style.

2. **Hebephrenic Schizophrenia or Hebephrenia:** This word is derived from the latin origin where «Hebe» means young and «phrenia» means personality, i.e. disease of young people. They are characterised by neglecting the appearance and personal cleanliness with indulgence in alcohol drinking, drug abuse, law-breaking and gang making. The label «Hebes» is often used to refer to such a group of youngsters with classical gangbehaviour living in slums and wandering around hitch-hiking from one place to another. They convey the description of such a group with a bad prognosis as in simple Schizophrenia.

3. **Catatonic Schizophrenia:** This is the classical example commonly seen in the streets. They are usually referred early to mental hospitals and they respond well to electrical treatment, especially when they go in catatonic stupor where parental feeding and proper nursing care are needed. Though prognostically they are better than the former group but socially they are the worse off in the eyes of the relatives who easily lose hope in their treatment and send them to mental asylums or keep them in chains at home.

4. **Paraphrenia or Paranoid Schizophrenia:** This is a group of disorders formerly described as Paranoia. Paraphrenia refers to Schizophrenia that occurs late in life for the first time. The most striking feature of this group is the relative preservation of the personality which remains intact for a considerable period inspite of the pathalogical process. The delusions which could be persecutory or grandiose seem logically knitted and well-systematised often described as «encapsulated delusions». Apart from this delusional area the patient makes a good show of his personal assets. The disorder takes insidious and progressive course with gradual development of thought disorder and emotional disturbance with hallucinations. Only then can the diagnosis become obvious or the behaviour seems distressing enough to warrant medical consultation; otherwise the patient may get into trouble with the police who may often then refer them for psychiatric opinion.

TREATMENT:

The effective, authoritative treatment of Schizophrenia is handicapped by the ambiguous nature of the underlying cause and the yet not fully understood mechanism of action of the various drugs in the variety of such disorder.

1. **Psychoterapy:** Simple supportive and not analytical type is needed. Contrary to a lot of expectations some Schizophrenics in the early stage of the illness need reassurance and understanding to help them find some order in the chaos of their life and develop confidence in the treatment.
2. **Specific Medical Measures:** These include the major tranquillizers especially the Phenothiazine group like Chlorpromazine and in high doses (anti-halluciogenic). They help to reduce the distress.
3. Electrical Treatment especially in severe excitement not responding to drug or cases complicated by depression or catatonic stupor where results are very rewarding.
4. Prefrontal leucotomy is indicated in chronic intractable cases resistant to all sorts of treatment and accompanied by distress and suffering.
5. **Deep Insulin Coma:** This has now become obsolete since it was introduced by Sakel in 1927. It has become obsolete following the introduction of modern Psychotropic drugs. The idea was based on the assumption that epileptic patients do not develop Schizophrenia probably due to the convulsive fit. It was then thought that if a similar condition could be induced by hypoglyceamic coma this would provide cure. A full course comprised of 30 - 40 comas used to be given. Now it has been established that epileptic patients can develop Schizophrenia-like-Psychosis while ECT can give a well controlled modified fits to improve their condition. In brief one should add that Schizophrenia remains one of the greatest challenges in Psychiatry as cancer remains one of the greatest challenges in general medical practice.

PROGNOSIS:

Manfred Bleuler, the Swiss Psychiatrist, has done a great historical study in 1941 of the prognosis of Schizophrenia which would remain as one of the corner-stones in the research of Schizophrenia. He divided them into two equal percentage, i.e. 50% :

Of the first 50% -25% would recover from the first attack 25% would show marked improvement with slight residual defecit.

Of the 2nd 50% -25% show some improvement but with severe residual deficit.

25% No recovery and can only benefit from leucotomy after 20 years of prolonged suffering.

Wing and others have recently investigated the clinical and social outcome of Schizophrenia and compiled a list of symptoms with good and bad prognostic features.

REHABILITATION OF CHRONIC SCHIZOPHRENIA:

The WHO and the various Health Organizations are at present engaged in an extensive research into the rehabilitation of chronic Schizophrenics since they constitute from 60 to 80% of the inmates of big mental hospitals. Since the emergence of the concept of institutional neurosis people have become more aware of the danger of keeping Schizophrenic in the mental hospitals for long period. The term «Institutional neurosis» refers to the clinial condition of chronic or long-stay patients in mental hospitals who suffer from understimulation, lack of socialisation and poor environmental condition. These patients show poverty of speech, loss of touch with surroundings, defectve cognitive function and failure to adjust to life outside the hospital, i.e. they become institutionalised. The work of «Clark» in therapeutic community and the provisions in the English Mental Health Act 1959 regarding the rehabilitation and after-care facilities under the local authorities, every country is providing legislation to cater for primary, secondary and tertiary health care within the frame-work of community Psychiatry as a whole. The therapeutic community refers to the treatment milieu in which the patient receives an intensive rehabilitating programme like active involvement in occupational therapy, participation in social activities inside and outside the wards, outgoing trips organised by voluntary agents, token economy programmes of behavioural therapy, working in sheltered work-shops with nominal fee etc. It is the movement towards the recent trend of open-door policy of mental hospital as opposed to the old closed mental asylums. The social aspect of the treatment in the rehabilitation of chronic Schizophrenic is receiving greater emphasis in the family and community. It involves the area of accommodation, work, social readjustment, improvement of family contacts, etc. The increasing number of out-patient departments in general hospitals are being built with the closure of big mental hospitals, provision of day hospital and moderate clinics or suitable half-way homes or hostels on trial leave basis for the gradual integration of the patient in the community and replacements of the old fashion locked door policy into seclusive wards or bed in chains. The primary aim of modern therapeutic intervention is to consider disposal action from the first interview. The greatest con-

tribution of those undertaking Psychiatric treatment as a team is to return the patient back to the society into a sheltered environment and a regular secured job that is suitable to his mental and physical resources.

CHAPTER VI

ALCOHOLISM AND DRUG DEPENDENCE

Definition of drug dependecne
Types of drug dependence
Treatment and rehabilitation

ALCOHOLISM AND DRUG-DEPENDENCE.

Alcoholism is increasing rapidly due to the psychological stress imposed on the individual in a competitive complex society. It is becoming a medical and social problem. Probably because of the natural tendency of progression to hard drugs alcoholism is becoming apparently of secondary importance to drug addiction. Since the latter causes far greater damage to the individual's phsysical health, psychological stability, social relationship and personal work record. As alcoholism and drug-dependence are closely related they should be discussed together. It is not uncommon for an alcoholic to be abusing other drug substance as well and this should be borne in mind when making the diagnosis of alcoholism. There is also some cross-tolerance between alcohol and other drugs producing dependence of the barbiturate type. Thus alcoholism and drug-dependence can co-exist.

Alcohol itself is a drug (ethyl alcohol CH_5 OH) and taken initially for socialisation or relief of psychological tension there is a great tendency for abuse of the substance. The modern society has introduced among other things the wide spectrum of drugs of addictive quality ranging from Hypnotics «sleeping pills» cerebral stimulants like «amphetamine derivatives» or Hallucinogenic drugs like LSD. There is now a great empire of drug-pushers and smugglers working in an organised network all over the world with drug trafficketting and marketing. Young people are becoming the primary victims of such booming trade.

The WHO defined the problem of addiction and dependence in more precise terms though Psychiatrists working in this field especially in the third world still prefer to retain the term of addiction besides dependence because of its special appeal to the workers in this field as

well as its well-understood nature by the patient and the public. The WHO Expert Committee of Addiction - Producing Drugs (1957) defined drug addiction and drug habituation but later (WHO 1964) recommended their replacement by the term drug dependence. The 1957 definition included:

DRUG ADDICTION: Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. An overwhelming desire or need (compulsion) to continue taking the drug and to obtain it by any means.
2. A tendency to increase the dose.
3. A psychic (psychological) and generally a physical dependence on the effects of the drug.
4. Detrimental effect on the individual and the society.

DRUG HABITUTAION:

Drug habituation is a condition resulting from the repeated consumption of a drug. Its characteristics include:

a. A desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders.
b. Little or no tendency to increase the dose.
c. Some degree of psychic dependence on the effect of the drug but absence of physical dependence and hence of an abstinence syndrome.
d. Detrimental effects, if any, primarily on the individual.

DFUG DEPENDENCE:

Drug dependence is a state of psychic or physical dependence or both on a drug arising in a person following administration of that drug on a dperiodic or continuous basis. The characteristics of the drug dependence often vary with the drug used. The WHO had described eight type of drug dependencies:

1. Alcohol type
2. Amphetamine type
3. Cocaine type
4. Morphine type
5. Barbiturate type
6. Cannabis type
7. Khat type
8. Hallucinogenic type

CHARACTERISTICS OF DRUG DEPENDENCE:

1. Psychic dependence characterised by a psychological need to continue taking the drug either to produce a feeling of pleasure or well-being or to avoid discomfort.
2. Physical dependence characterised by a physiological state which is expressed following withdrawal of drug or administration of specific antagonists.
3. Tolerance charactersied by a diminution in the effect of the drug after repeated use of the same dose and a tendency to increase the dose to produce the same initial effect.
4. Detrimental effect on the individual and society.

DEFINITION:

Alcoholism and drug dependence is a condition where the state of dependence on alcohol or drug has gone beyond the patient's ability to control his desire to exceed or to stop once started drinking and has led to a physical destruction of health, psychological disturbance, disruption of social life and deterioration of personal relationship.

The danger of any drug abuse is the progression to hard drugs such as amphetamine, producing schizophrenia-like-psychosis or a paranoid state or heroin leading to a considerable misery and destruction of total life of the individual. In alcoholism there is a substantial affinity with the barbiturate type of dependence.

The incidence of alcoholism is increasing rapidly over the past few years and thus it is difficult to assess with any degree of precision the magnitude of the problem due to the scarcity of statistics, the changing pattern of drug traffic and the secretiveness of the alcoholics as well as the attitude of the society towards such a sensitive moral, social and medical issue.

Generally, alcohol and drug abuse account for more than 5% of all mental illness requiring admission to hospitals. This is only the tip-of the iceberge as these patients are very resistant to hospital admission and occasionally even to out-patient treatment due to absolute secretiveness until they are dangerously affected by the problem of addiction.

AETIOLOGY:

1. Constitutional factors
2. Environmental factors

Constitutional Factors:

a. Specific predisposition due to inherited biochemical need which can only be satisfied by alcohol intake thus the incidence of alcoholism is found high in the patient's family, especially the father.

b. General: This is an individual readiness to indulge in alcohol intake due to psychological immaturity or personality failure to develop satisfactorily to resist an impulsive desire to resort to alcohol to relieve tension.

c. The symptomatic use of alcohol or drug to alleviate pain or relieve suffering during a serious illness, i.e. carcinoma or in crisis following surgical operation.

Environmental Factors:

a. Occupation: The typé of job held by the individual contributes to the intake of alcohol or drug as well as relapse following treatment, because of easy access, lack of supervision, temptation of trial, etc. Examples of these are:
   1. Barmen
   2. Commercial travellers
   3. Professional people having access to drugs, like doctors, pharmacists, nurses or else due to social isolation.
   4. **Family Background:** There was a high incidence of profound disturbance in the home during childhood. The rate of psychiatric disturbance, addiction to other drugs, alcoholism and criminal behaviour was more common in these families. The parents of the addicts were more often absent from home.
   5. **The addict personality:** There was a profound disorder of personality in young people. This was associated with poor school performance and persistent truancy or frequent ivolvement with gang behaviour and social deterioration. There was also a high incidence of psychiatric disorder not only due to drug abuse with multiple appearances before the court for other offences of delinquent behaviour. Sexual disorder is a fairly constant feature and homosexuality is not uncommon.

CLINICAL FEATURES:

Drunkenness is readily recognised by the layman but lesser forms of drinking can only be recognised chemically when the concentration of alcohol in the blood reaches 0.2% by volume. There is a great individual variation depending on the personal tolerance. There is synergic effect between alcohol and other drug like sedatives and hypnotics. They potentiate the effect of each other so it is dangerous to take drugs with alcohol. The clinical picture of the drunk alcoholic is grouped into five stages:

1. Initial stimulation (social drinking)
2. Elation of mood or euphoria
3. Retardation or slowing down of movement due to central nervous system depressant effect.
4. Quarrellousness where the patient becomes aggressive and abusive.
5. Stupor or even intoxication and coma.

EFFECTS OF ALCOHOL ON CENTRAL NERVOUS SYSTEM:

1. Direct toxic effect, i.e. Pathological intoxication.
2. Vitamin deficiency, i.e. Wernick's Encepathalophaty.
3. Neurological disorder, i.e. Cerebellar Syndrome or ataxia, slurred speech and nystagmus or peripheral neuropathy.

SUMPTOMS AND SIGNS OF ALCOHOL WITHDRAWAL:

1. **MOTOR:** Tremor, ataxia, overactivity, restlessness and muscle cramps.
2. **AUTONOMIC:** Sweating, fever, dilated pupils, tachycardia.
3. **SLEEP:** Insomnia, nightmares, vivid dreams.
4. **GASTRO-INTESTINAL:** Anorexia, nausea, vomiting, diarrhoea
5. **PERCEPTUAL:** Visual and auditory perceptions, illusions and misinterpretations, visual auditory, gastatory and olfactory hallucinations.
6. **CONFUSION:** Disorientation for time, place and person.
7. **OTHERS:** Severe anxiety, delusions and epileptic attacks.

The common types of drug dependence that are of special interest in this part of the world are the opiate (morphine type), stimulants (amphetamine type), barbiturate, cannabis, sedatives and hypnotics and the solvents like glue sniffing or petrol inhalation.

1. **Morphine Type:** Dependence on opium or its preparations morphine, heroin and other morphine derivatives or on synthetic substances with morphine like effects such as pethidine, methadone etc. This is characterised by:
   a. Strong psychic dependence, an overpowering drive or compulsion to continue to take the drug.
   b. The development of tolerance and a notable tendency to increase the dose.
   c. The early development of physical dependence which increases in intensity as the dose increases with a specific abstinence syndrome on withdrawal or on administration of a morphine antagonist such as nalorphine.
   d. Detriment of the individual (personal neglect, physical complication etc) and to society (disruption of interpersonal relationships, economic loss, crime, etc.)

2. **Stimulatns** (Amphetamine type): Dependence on amphetamine, dexamphetamine etc is characterised by:
   a. Psychic dependence on variable degree
   b. No definite physical dependence although some mental and physical symptoms may develop on withdrawal.
   c. The slow development of tolerance to certain of its pharmacological actions.
   d. An adverse effect on the individual (mental and physical complications) and on society.

3. **Barbiturate Type:** Dependence on pentobarbiturate, amylobarbiturate, quialbarbiturate and other barbiturate, paraldehyde, chloral hydrate, meprobamate, glutethimide, methaqualone (Mandrax), chlordiazepoxide (librium) diazepam (valium) etc. This is characterised by:
   a. Strong psychic dependence
   b. The development of tolerance and of some cross-tolerance with alcohol.
   c. Very slowly developing physical dependence with specific abstinence syndrome similar to that associated with alcohol dependence.
   d. An adverse effect on the individual (impairment of mental ability, confusion, emotional instability etc) and a slightly detrimental effect on society.

Barbiturates are very notorious for cases of accidental overdose or attempted suicide. As far as possible they should be avoided unless there is a strong indication. Also withdrawal fits are common following cessation of the drug. Cross-tolerance with alcohol is another complication.

Cannabis Type: Dependence on cannabis leaf and resin and its preparations (marijuana, hashish etc) is characterised by:

a. Moderate to strong psychic dependence
b. Absence of physical dependence, and
c. Absence of tolerance.

There is no definite evidence of a detrimental effect on the individual or on society, but it possibly predisposes to the morphine type of dependence. Although it is stated that there is no detrimental effect on the individual in practice many of those using cannabis show psychotic episodes or criminal behaviour under the effect of cannabis. But whether it is a release phenomena of an underlying psychotic illness triggered by cannabis or a disturbance precipitated by it is not clear, although the causal relationship is not yet fully established there is a strong evidence of progression to hard drugs.

Hypnotic and Sedative Type: The Benzodiazepine groupe of sedatives are the most commonly type of drugs. They are more freely prescribed by general practitioners because they are safer than hypnotics and given in big doses they have got a hypnotic effect. Patients tend to abuse the drug by inceasing the dose and over a prolonged period they might develop moderate dependence. Withdrawal psychosis closely resembling delerium tremens have been reported following use of other sedatives like Meprobamate, Methoqualone (Mandrox) etc. In addition withdrawal was a possible cause of some mental disturbance or seizure in some patients following prolonged use of chlordiazopoxide (librium) and Diazepam (Valium).

The benzodiazepine groups of drugs are very effective in phobic anxiety state and they are used very frequently by psychiatrists for the relief of tension and fear. Even in therapeutic doses they can cause dependence in some patients. They are becoming a common cause of overdoses or attempted suicide especially in young age group particularly females who use them far morethan other dependence-producing drugs.

Nitrazepan (Mogadon) is usually prescribed as hypnotic in sleep distrubance as well as barbiturate (sodium amylobarbitone) when other

anxiety relieving drugs have failed. These account for a high proportion of dependence in general medical practice.

The «Solvents» Type: The problem of glue sniffing and petrol inhalation is becoming increasingly alarming to families, educational authorities., police and society at large. Increasing number of young children and adolescents are getting involved in the problem of glue sniffing and petrol inhalation. As a result, they abscond from school or join gangs in criminal behaviour of stealing, breaking or assaulting others to get the substance. This is very frequently associated with other delinquent behaviour. The danger of this problem is the disruption of school career , social maladjustment, court convictions and family disharmony. It causes some degree of dependence, physical complications like respiratory tract infection, loss of appetite, mild drowsiness and confusion with consequent memory disturbance and learning problem. The tendency to abuse other drugs is not uncommon.

Complications of Drug-dependence:

These complications can be divided according to the criteria of dependence into:

1. Physical
2. Psychological
3. Social

1. **Physical Complications of Drug Abuse:**
   a. Septic complications, i.e. absces, Septicaemia, Pyrexia or Syringe-transmitted syphilis.
   b. Hepatitis - hepatatoxic effect of drug with chronic liver dysfunction.
   c. Overdose of drugs.
   d. Others, i.e. Needles broken, tuberculosis, barbiturate withdrawal fits, cocaine rash, nerve palsy due to self-injection.

2. **Psychological Complications:**
   a. Impotence with marital disharmony, separation or divorce.
   b. Morbid jealousy
   c. Psychiatric disorder, i.e. anxiety or depression or paranoid delusions.
   d. Criminal behaviour
   e. Abuse of other drugs
   f. Absence from home

3. **Social Complications:**
   a. Disrupted personal and family relationships
   b. loss of job
   c. broken homes.

Alcohol Complications:

1. Alcohol tremulousness, i.e. morning shakes in advanced stage
2. Alcohol hallucinations: mainly auditory voices like those of Schizophrenia in 30 - 50% of cases often called alcoholic paranoia
3. Alcoholic epilepsy: to the extent of 10 - 12% higher than general population associated with head injury, focal cortical lesion or idiopathic epilepsy and withdrawal of alcohol (withdrawal fits).
4. Alcoholic delerium tremens - this is discussed with confusional states in other chapter. often coined D.T.
5. Alcoholic dementia.

Apart from acute alcohol intoxication which needs immediate measures of resuscitation, the chronic case may lead to deterioration of memory or Korsakov Psychosis with loss of recent memory and the catastrophic reaction characteristic of a form of dementia. Alcoholism could lead to a release phenomena whereby inherent personality traits which have been commonly suppressed gradually come to the surface due to removal of inhibitory cortical control. Sexual and aggressive tendencies become very often. Chronic alcoholism might lead to impotence either due to the physical effect of alcohol on central nervous system (Neuropathy) or due to psychological effect of disrupted social relationships. Cases of pathological amnesia where patients commit acts of violence or crime with total loss of memory to the incidence is very common in court cases. Alcoholic psychosis as witnessed in cases of sever excitement and violence or murder is a common example and conditions similar to schizophrenic psychosis have been reported in chronic alcoholism.

DIAGNOSIS:

This can only be made by taking a good history from a cooperative motivated patient and an informed sympathetic friend or relative. In the absence of characteristic symptoms or signs and the readiness of these patients to deny and refuse help it could be difficult to establish the diagnosis regarding the duration and severity of the condition. It is always important to elucidate the type of alcohol, the amount taken, the frequency and the duration as well

as the ability to stop once started drinking. A detailed social history is important. Physical and especially neuorological examinations are vital. Laboratory investigation for impaired liver function and electrolyte disturbance should be carried out immediately in hospital.

TREATMENT:

It is no use treating an alcoholic patient who has been brought by his relatives or friends and denies that he has got a drinking problem. The patient must be personally motivated and looking for help to give up alcohol. There are many ethical issues involved. The cases which are referred by the police or those seeking medical opinion or individuals coming in crisis need help in their own rights. Effective treatment means complete abstinence from alcohol in hospital from the start. The rationale of the treatment consists of short and long term policy.

The short term plan is to detoxicate or dry up the patient and deal with the toxic confusion or withdrawal symptoms. General measures include nursing in a well-lit room with high potency parentrovite intravenously, anti-convulsant drugs, correction of electrolyte disturbance as well as treatment of co-existing injury or infection.

The long term plan would include:

1. Psychotherapy - Supportive and interpretive in individual and group sessions.
2. Vitamine Saturation - with vitamine C and B-complex or Thiamine B1 given in high doses.
3. Specific measures to reinforce abstinence include two types of treatment:
   a. Drug Therapy:
      1. Drugs that are incompatible with the metabolism of alcohol like (antabuse) - Tetra ethyl thiurum disulphide or (abstem) - i.e. Citrated calcium carbamide. These would lead to violent side effects if later taken with alcohol within 48 hours.
      2. Drugs that are involved in a conditioned reflex reaction with alcohol, i.e. Apomorphine by mouth or injection leading to nausea and vomiting with consequent aversion to alcohol.
   b. Aversion Therapy: These are conducted by giving electrical shocks in association with intake of alcohol or drug. It is a cha-

racteristic form of therapy by deconditioning. Treatment of alcoholism should be initiated in hospital to regulate the dose, monitor the side effects and assess the resources of the patient to cooperate with the treatment.

REHABILITATION:

The treatment of alcoholism in hospital is usually a sort of crisis intervention. The long term management and reinstatement of the individual in the society should be the ultimate objective of any successful treatment. This would include follow up in a day hospital where the patient comes for regular follow-up. The set up of the specialised drug addiction unit in every Psychiatric hospital is becoming a very essential part of rehabilitation, as well as the establishment of small detoxification centre in every psychiatric unit in a general hospital. The idea of Alcoholic Anonymous (A.A.) should be encouraged to enroll the cooperation of ex-addicts in the treatment programme as well as the Samaritan Groups to help the patient in crisis and to get them for treatment. The Alcoholic Anonymous (A.A.) is a voluntary organization whose members have considerable knowledge of alcoholism through previous personal experience and have become experts in preventing recurrence. They hold meetings and discussions with new members to help them restore confidence and self-esteem and tide the patient over crisis on certain social occasions. The Samaritan Organization is a voluntary agent which helps the socially isolated the drifting, impoverished, unemployed, depressed alcoholics who resort to alcohol during crisis or contemplate suicide following a depressive episode. They provide counselling and social help and arrange for hospital admission or medical advice. Regular home visits by a domiciliary team of experts like experienced social workers, welfare officers and health visitors is important for the social support of the patient. The single most important factor in the effective management of the alcoholic is the care-taker or the concerned person who would take the reponsibility of looking after the patient following discharge and serve as the link between the patient and the various agencies involved in the treatment programme.

PROGNOSIS:

This is generally guarded as 30 - 40% relapse. It depends on the following factors:

1. Individual's motivation for treatment.
2. Basic personality
3. Environmental factors
4. Social rehabilitation and adjustment programmes.

CHAPTER VII

ORGANIC BRAIN DISORDERS

Dementia
Confusional State
Epilepsy
Puerperal Psychosis

ORGANIC BRAIN DISORDERS

This is an umbrella term used to include a wide range of impaired mental functions due to cerebral damage or insult often called brain damage syndrome most commonly seen in children. Any brain damage may occur with no obvious mental changes, most patients with neurological signs of cerebral damage would show minor psychological defecit and the mental changes may continue even after the physical signs have disappeared.

Organic brain disorders could be acute, subacute or chronic. Not all cases of brain damage are seen by the psychiatrist but there are clinical varieties which are of psychological importance showing certain common features, namely:

1. Learning disorder, i.e. speech, hearing.
2. Motor disorder - overactivity in coordination, involuntary movements
3. Emotional disorder - mood swings, impulsive behaviour, catastrophic reactions, antisocial behaviour.
4. Congitive disorders - poor memory, poor concentration. specific defects due to local lesions.

DEMENTIA:

Dementia is a disorder of all mental processes with progressive deterioration of a previous normal intellectual function secondary to brain damage or disease. Dementia is essentially subacute a chronic or primary and secondary.

AETIOLOGY:

1. Primary dementia - In this condition the cause is largely unknown.
2. Secondary dementia is essentially symptomatic or a sequelae of an associated brain dysfunction due to the following causes:
   a. Degenerative
   b. Inflamatory
   c. Traumatic
   d. Neoplastic
   e. Cerebrovascular
   f. Toxic or metabolic.

So, the differential diagnosis would include the following disorders:

1. Deficiency diseases - such as wernick's encephalopathy due to thiamine deficiency or following chronic alcoholism and hypermesis, gravidarum or dementia associated with B. 12 deficincy.
2. Metabolic disorders such as hypoglycaemia or hypothyroidism or chronic liver disease.
3. Cerebral tumor - a prefrontal cerebral tumor may present with mental changes.
4. General paralysis of the insane with positive W.R. and active C.S.F. confirm the diagnosis.
5. Head injury with a profound concussion or prolonged unconsciousness is often associated with mental changes. Elderly people or children suffering apparently minor head injuries should be watched carefully for a chronic subdural haematoma as this would gradually lead to organic mental deterioration. Repeated minor head injuries as in boxing have recently been implicated for causing incipient dementia.
6. Repeated convulsive fits with episodic hypoxia of uncontrolled epilepsy may end up with epileptic dementia.

PRESENILE DEMENTIA.

This is a general term describing a primary dementia occuring before the age of 60. There are two specific forms namely, Alzheimer and Pick's disease. These are pathological diagnosis which should be made only by exclusion as the differentiation between the two is difficult and there is no treatment.

Alzheimer disease is a generalised cortical atrophy associated with epilepsy while Pick's disease is characterised by intellectual impairment rather than focal lesions.

CLINICAL FEATURES:

Dementia is characterised by three forms of mental disturbances:

1. INTELLECTUAL IMPARMENT.

This is seen more commonly in recent memory failure compensated for by confabulations which are attempts to fill the gaps due to the loss of sequence of events and time relationship. There is obvious loss of insight with disorientation for time and place. There is a characteristic emotional lability with sudden bursts of weeping alternating with an episode of inappropriate elation of mood. There is often neurological complications like nominam aphasia, agnosia, etc. Korsakoff psychosis is a from of dementia with severe impairment of memory due to organic brain disease but a clinically similar condition may occur with other types of brain disease. This is also characterised by three main disturbaces:

A. Memory disturbance for recent events while that for remote events remains relatively intact until finally both are affected.
B. Distortion of time sense
C. Confabulations.

It has been discussed before and is commonly due to chronic alcoholism or Vitamine B.1 deficiency.

2. EMOTIONAL DISTURBANCE.

The degree of emotional lability is complicated by the catastrophic reaction described by Goldstein as severe agitation and aggression when the patients are confronted with a task beyond their failing capacity like answering a question or performing a test. There are secondary hysterical or depressive features. Delusions of persecution or hypochondriasis are common while the appearance of indignant personal habits and devious personality traits come clear to the surface like meanness, rigidity , inflexibility, uncontrolled sexual impulses, suspiciousness and false accusations to other people, etc.

3. BEHAVIOURAL DISTURBANCE.

These are the end state of a previously dignified person into a state of total pity and misery with self-exposure, micturition in public, deterioration of personal habits in the way of eating, drinking, sleeping, etc.

DIAGNOSIS:

There are certain steps which should be make in the investigation of dementia especially that occuring in the middle age:

1. Detailed history from the patient and the relatives.
2. A complete general and neurological examination.
3. A full psychological assessment of intellectual functions by psychometric testing.
4. W.R.
5. Radio isotope scanning
6. Serum B. 12
7. Electro-encephlography and arteriography.
8. C.S.F. examination and air encephlography.
9. Cortical Biopsy.

Before embarking on such heroic invetsigation one has to assess each case individually and to weigh the risk of disadvantage of the investigation with the advantage of finding a treatable cause because some of the investigations are dangerous and should not be taken lightly.

TREATMENT:

This depends entirely on management of the underlying cause while in primary dementia treatment is entirely symptomatic. The general principales are as follows:

1. Adopting a very sympathetic attitude towards the patient putting into mind the limited personality assets.
2. Family therapy - counselling the relatives and explaining to them the nature of the illness and helping them to cooperate in managing the difficult situation of caring for such a person at home. This might involve an in-patient adminssion period to relieve pressure from relatives into a psychogeriatric unit or an old people home.
3. Vitamin supplement with high doses of B. Complex and B.1
4. Treatment of intercurrent infection or fractures.
5. Treatment of co-existing depression by antidepressant or even ECT.
6. Environmental manipulation by providing domiciliary service, home visit, etc.

CONFUSIONAL STATES.

Confusional states are not uncommon but potentially treatable conditions which occur as Psychiatric emergencies inside any hospital ward or from the outpatients and through the accident unit. Very often the casualty doctors are called late at night to deal with such cases in the outpatient department or the duty doctor is asked in the small hours of the morning to see such a patient in the general ward. It is the duty of every practising doctor to get very acquainted with the management of confusional state as if not promptly and properly treated they might lead to a considerable disaster. It usually happens that general practitioners when confronted with a patient behaving strangely in the ward to call a Psychiatrist for a second opinion. This is a good approach but should not be a substitude for good ability to deal effectively with such cases as they constitue a fairly high percentage of Psychiatric emergencies like status epileptics.

The differential diagnosis of acute Psychotic episode from toxic confusion states or delerium tremens should be made relatively easy on the following grounds:

1. The full history and account from the relatives to elucidate previous evidence of Psychiatric disorder.
2. The absence of clinical features of toxic confusion state.
3. The clinical picture of the illness. Basically the general management is the same but it is important to differentiate the various groups of acute Psychotic reactions to be able to deal with the underlying cause effectively. These episodes of excitement or disturbed behaviour comprise the following Psychiatric emergencies:
   a. Acute Schizophrenic reactions
   b. Acute Depressive reactions

c. Acute Mania
d. Acute Mystical reactions.

While these reactions normally-from the history taken-are found to be released by environmental stress or by medical or surgical crisis, they can occur in near normal pscychological equilibrium and last longer than acute toxic reactions. On the other hand acute toxic reactions could be differentiated by the following features:

1. Cloudiness of consciousness
2. Disturbances of recent memory
3. Disturbances of attentions, concentration and judgement.
4. Disorientation of space, time and person
5. Emotional lability
6. Hallucinations and illusions, i.e. misinterpretation of external stimuli.

As a result of these disturbances of higher mental function the individual patient would show evidence of:

a. Delusion
b. Excitement
c. Panic attack
d. Disturbance of behaviour with loss of touch with his environment and behaving dangerously.

AETIOLOGY:

This could be divided into:

1. Direct causes
2. Indirect causes

1. **DIRECT CAUSES:**

a. Lack of oxygen affecting the cortical neurons, i.e. following concussion or cerebral anoxia.
b. Some biochemical disturbance leading to inhibition of brain enzyme activity.
c. Toxic metabolic substance accumulating in the brain, i.e. high blood urea level as in the case of impending renal failure or toxic drugs injected unwittingly.
d. Hypoglycaemia leading to depletion of cellular glucose in the brain with characteristic features of hypoglycaemic behaviour disturbance.
e. Electrolyte disturbance in the body fluid as in the case of steroid therapy.

f. Toxic drug effect like amphetamine or hallucinogenic drug or beladonna preparation.

It is very important to take a good history and make a careful physical and ancillary assessment to find out whether the patient was taking drugs like amphetamine or alcohol or had sustained head injury following an epileptic fit. There is a great association of alcohol epilepsyhead injury and confusion state. It is necessary to establish which is the cause and effect in this relationship. Epilepsy in alcoholics is very common and thus involves a great deal of medico-legal procedures after discharge.

2. **INDIRECT CAUSES:**

a. Infections producing toxic substances leading to confusion state like typhoid fever delerium which is a classic example in the general wards.
b. Cardio-vascular disturbance following heart attack and cerebral anoxia.
c. Pulmonary embolism or respiratory distress with resulting hypoxia
d. Established vitamine deficiency following chronic debilitating illness or malnourishment as in pellagra (thiamine deficiency) or chronic alcoholism (dilerium tremens).
   Delerium tremens is a state of disturbance of consciousness characterised by loss of touch with reality with hallucinations delusions and marked tremor due to infection causing high fever or due to toxic effect of a drug.
e. Following anaesthesia and shock after surgical operations with consequent cerebral hypoxia.
f. Metabolic diseases like diabetes mellitus, hepatic failure or uraemia.
g. Endocrine disorders notably puerperal psychosis in obstetric wards or myxoedematous crisis in medical wards.

TREATMENT:

The general principle of management of confusion state is the same except that early diagnosis and establishment of the underlying cause is the key to proper management. In all cases sympathetic, gentle handling is the best approach to a frightened, potentially violent and aggressive patient. The primary nursing aim lies in the confinement in a separate well-lit-room with minimum distraction and external sti-

muli. The attending nursing person should be a familiar good companion or a regular constant nurse because changing faces and surroundings increases the tendency to minsinterpretation and illusions. The secondary nursing aim is to attend to the cerebral hypoxia if any by oxygen administration and adequate respiratory ventilation by drugs like aminophythine, ephedrine etc. The third nursing aim is the question of hydration by fluid intake by mouth or glucose intravenously with vitamine supplement like Vitamine B complex and ascorbic acid, preferably high potency parentrovite intravenously twice daily in glucose drip of 5% dextrose in normal saline depending on the diagnosis. Haldol (Haloperidol) drops in the same drip can be a safe and effective combinations. The fourth aim should be that of sedation-barbiturates should be avoided as they are cerebral depressants and can potentiate the effect of alcohol and increase the cerebral hypoxia. A safe sedative is oral chloral hydrate, paraldehyde or chlorpromazine. In serve excitement chlorpromazine intramascular may help the patient to settle down with the minimum physical restraint.

Confusion state is one of the commonest psychiatric emergencies and medical problems in the general wards. Although Psychiatric opinion is necessary it is not mandatory to starting management of such cases by any doctor practising in the general hospital. An experienced physician can anticipate the occurance of such emergency in a vulnerable patient who appears restless in the evening and potentially violent at night.

EPILEPSY

Epilepsy is the classic example of a neuro-psychiatric disorder where the border between psychiatry and neurology are blurred, often shared, always complementary and not mutually exclusive. The psychiatric complications of epilepsy are so varied and complex that the psychiatrist should not relegate his role to deal with epilepsy before such complications arise.

Epilepsy comprise a group of conditions which are characterised by recurrent paroxysomal disorders of brain functions. Epilepsy occurs in about 1 in 200 in the general population.

There are predisposing factors and precipitating factors:

1. Predisposing factors include - constitutional predisposition, prenatal disorders and birth injuries or neo-natal disorders, like trauma, infections, cerebrovascular lesions or tumours.
2. Precipitating factors include psychological stress, exhaustion, cerebral anoxia, hypoglycaemia, hypocalcaemia, overhydration drug withdrawal or alkalosis due to pH changes resulting from hyperventilation.

It is very important to establish the diagnosis of epilepsy with the utmost care as the social stigma, the treatment complication and the effect on the social and psychological aspects on life and work record is tremendous. Once the patient is labelled as Epilepic it is difficult to alter the diagnosis once the treatment is started. Very often in the follow-up the attending physician even in the absence of organic base would find it difficult to stop medication lest he should precipitate a withdrawal fit and the patient continues to carry on with treatment for ages.

It is the duty of the attending physician from the beginning to establish the proper diagnosis on positive eveidence and not by exclusions as it is wrongly practiced in hysterical fit.

DIAGNOSIS:

1. Good History-taking
2. An Eye Witness account

It is always worthwhile asking the question - is it a faint or a fit. The differential diagnosis include:

1. Drop attacks - A form of epilepsy or basilar insufficiency.
2. Narcolepsy - Irresistible desire to go to sleep.
3. Hysterical fits - typical features but can co-exist with epilepsy
4. Hypoglycaemia - cerebral depletion of glucose of various causes.
5. Syncope - transient loss of conscionness due to cerebral ischaemia.

Epilepsy is a symptom and not a disease - it may be a symptom of:

a. Congenital neuronal dysfunction
b. Systemic metabolic disorder
c. Structural brain disease

CLASSIFICATION:

Epilepsy can be classified according to aetiology or clinical picture or EEG recording:

AETIOLOGY	CLINICAL	EEG
Idiopathic Epilepsy	Primarily due to congenital neuronal instability	Centre-Encaphalic
Symptomatic Epilepsy	Primarily due to Metabolic or toxic Disorder	Generalised fit (major or minor)
	Primarily due to Structural brain disorder	Focal attack / Focal Epilepsy

The general clinical features of each type of epilepsy would be found in more detailed text books.

The Grand mal type or the classical epileptic fit which can be recognised by the lay person consists of an aura followed by tonic phase of muscular contraction and the clonic phase of violent conulsive movements of the body. The urinary and less often the faecal incotinenc is due to the excessive relaxation of the sphincters and contradiction of abdominal musles. This period would be followed by complete relaxation where the patient would go to sleep or rouse gradually.

The EEG changes would show synchronous high voltage fast waves over all parts of the brain. This could pass into serial epilepsy with intermittent gain of consciousness or develop into statuts epilepticus where there is no gain of consciousness between the attack and this constitute a medical emergency which needs active intervention.

The Petit mal type - This is seen commonly in children with characteristic EEG change of 3C.P.S and with characteristic EEG spike and wave discharge synchronous in both hemispheres. They are called «abscences» referring to the specific nature of very short period of loss of consciousness in children which adversely affect their attention and school performance. The petit mal type may be accompanied by major seizures. It is said that if the petit mal continues after adolescence or the EEG change remains non-specific of spike and wave or it does not respond to ethnosuxanide drug, one should reconsider the diagnosis.

Focal Epilepsy: These are symptomatic of focal brain lesion. Durring the focal attack which involves a certain part of the body the patient remains generally conscious and is called minor epilepsy or it may pass into generalised type.

Temporal Lobe Epilepsy: This is the commonest type seen in Psychiatric practice as they are often preceded or accompanied or followed by behaviour disorder.

They are complex disorders of the sensations of sight, sound, taste, smell. touch and memory. So hallucinations and delusions secondary to these sensory disturbances are common manifestations of this disorder. Hallucinatory voices and visions are not uncommon. During the attack the patient does not fall unconscious but continues to behave strangely in a dreamy state often called fugue state. This is accompanied by complete amnesia for these events after the attack.

The EEG changes include abnormal record of slow waves and polyspike discharge seen bilaterally especially using sphenoidal lead technique to detect subtle changes. It is important to localise the ana-

tomical lesion to decide on drug or surgical treatment. Lesions affecting the temporal lobes due to high fever in childhood with continuous attacks not responding to drugs would need surgical removal of the defined focus in early adolescence by operation called temporal lobectomy.

Psychiatric Sequencle of Epilepsy:

a. Schizophrenia-like-Psychosis
b. Epileptic Psychotic excitement
c. Epileptic Personality disorder
d. Epileptic Dementia

TREATMENT:

The primary objective is to correct the underlying metabolic or structural disorder. The symptomatic treatment depends on the type of seizure and the relevant drug. The secondary objective is to help the patient in leading a normal active life maintained on specific therapy with regular follow up in epileptic clinic like modecate clinic for Schizophrenic or diabetic clinic. The third objective is counselling and guidance regarding jobs, driving licence, and marital counselling. Children should continue their ordinary schooling with the pertinent advice regarding caution in swimming, riding bicycles, avoiding playing in high places, receiving regular medical care, etc.

DRUG TREATMENT:

Drug treatment of epilepsy should not be a substitue to Psychotherapeutic intervention when these frightened patients need constant reassurance about the nature of the fit and the future of the illness especially with prolonged treatment.

The drug regime depends on the type of the fits, the patient's response and the side effects produced. The drug should be introduced with the smallest dose increasing gradually until the fit is controlled or side effects are obvious. A combination of drugs should only be made after careful assessment and if possible it should be avoided. Phenobarbitone is the drug of choice but very often a combination with primidone and or phenytoin is necessary. This is a good combination for grand mal while troxidone is the drug of choice for petit mal and carbamazepine for temporal lobe epilepsy.

PUERPERAL PSYCHOCIS

It is generally accepted that post-partum psychosis do not constitue an entity distinct from other non-puerperal psychosis. The WHO'S classification I.C.D. (1967) allocates them to categories which are independent of any relationship to child-birth and most cases can be classified as schizophinic, affective and organic disorders. These psychosis show a great variation in their severity and the rate ranges from 0.8 to 2.5 per 1000 deliveries. Most of them are mild and transitory and only a small proportion are severe enough to require hospital adminssion. These psychosis can occur upto one year following child-birth.

AETIOLOGY:

1. Psychological stress of pregnancy, delivery and emotional changes in the pueperium.
2. Biochemical and endocrinological changes such as progesterone level following delivery.

The symptoms could be minor occuring in the first few days as a normal reaction to the emotional aspect of child-birth or severe occuring under tremendous stress and losing longer in high percentage of cases.

CLINICAL FEATURES:

The picture is essentially not different from that occuring in similar illness. However, in the early stage of the illness the clinical picture is often not typical. Symptoms like insomnia, restlessness, depression may last for few days. These may proceed to euphoria, food refusal or disturbing behaviour. The diagnosis of schizophrenic, affective or organic types of mental reaction may occur only later in the course of

the illness. An important feature is the clouding of consciousness which occurs particularly in the early stage of the illness, a more common than in non-puerperal functional psychosis. Only within one or two weeks of the illness can the diagnosis be made with certainty. While recent studies show declining percentage of schizophrenic and depressive reactions they still show a much lower prevailance of organic reaction. The occurance of delerium, clouding of consciousness and confusion in puerperal psychosis may lead one to misdiagnosis. Cerebral thrombophlebitis with hemiparesis epileptic fits, dysphasia and severe headache can occur as serious complications. Puerperal psychosis is rarely diagnosed before the third day of puperium. The overall prognosis of puerperal psychosis is probably like that of similar non-puerperal illness and it is better in affective disorders. The organic mental type of illness is best if they servive the first acture phase of the illness in the first few days. This is partly due to the modern methods of treatment particularlry ECT and phenothiazine. Modern trends in treatment included the establishment of mother-baby units where joint admission of mother and baby has proved beneficial to both. Relapse rate of puerperal psychosis is approximately 1 to 5 cases while the risk is 100 times larger than that associated with pregnancies in the general population.

Treatment is similar to that management of acute psychotic reactions mentioned earlier.

CHAPTER VIII

PSYCHIATRY IN GENERAL MEDICINE

Theories of Psychosomatic Reactions
Classification of Psychosomatic Reactions
Management of Psychosomatic Reactions

PSYCHIATRY IN GENERAL MEDICINE

Psychosomatic Disorders:

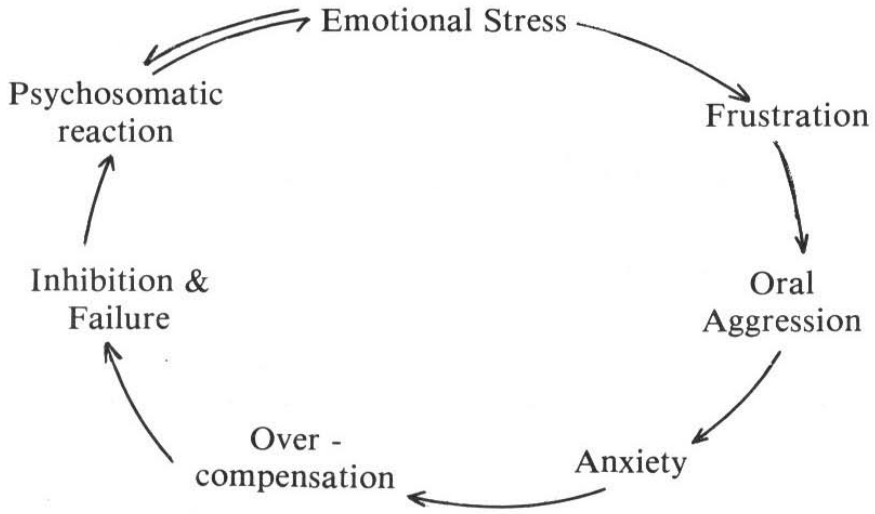
These are physical disorders in which emotional factors play an important part. It is evident that emotional factors play an important role in all diseases but in essentially physical conditions their role is less prominent. So generally speaking, psychosomatic disorders are defined as «those conditions in which disordered physiology and psychopathology are so intimately interwoven that both components actively and concurrently contribute to the natural course of the disorder». Classical examples are bronchial asthma, peptic ulcer, migraine and ulcerative colitis.

Emotional factors may be defined as a combinations of subjective experience and objective physiological changes which provide a normal and universal example of psychosomatic reaction. These emotional factors can initiate, exaggerate or precipitate a permanent structural change in body organ.

Attention must be paid to the entire life situation of the individual concerned, to his social background and past history as well as to his presenting symptoms or complaints.

Thus the best psychiatric approach is to construct a life chart for the individual. There are many other theories to explain the basis of Psychosomatic disorders. They are based on the concept of the emotional stress on body system. It is said that given sufficient stress everybody has got a breaking point. The determinents of this point are the patients physiological vulnerability, constitutional make-up and genetic predisposition. So the occurence of Psychosomatic reaction in families is a common observation, i.e. migraine or brochial asthma.

The emotional theory postulates that emotional stress by accumulation leads to frustration - oral aggressive responses and guilt - anxiety -over-compensation for oral aggression by the desire to give and accomplish - inhibition and failure of the effort to give and accomplish - Psychosomatic reactions.



Emotional Theory of Psychosomatic reaction

Constituting a personality profile in patients with Psychosomatic disorder, would include:

1. General adjustment in life, i.e. education, work, record, income, vocational level, social relationships, sexual adjustments and attitude towards family.
2. Characteristic behaviour pattern
3. Neurotic traits
4. Hobbies and interests
5. Life style immediately prior to onset of illness
6. Specific individual reaction to illness
7. Focal conflict area and characteristic reaction.

The Psychosomatic formula is based on certain criteria:

a. Emotion as a precipitating factor causing remission and relapse.
b. Personality type: there was a high association of certain personality type with specific illness type.
c. Time specificity or relationship with other Psychosomatic reaction in the same individual at the same time of illness or some other specific time during life history.

d. Family history: There is a high percentage of the same disorder occuring in the individual in the parents or the relatives and siblings.
e. Sex ratio: There is a disproportion in sex-ratio, distribution, thus while nocturnal enuresis occurs in the order of 3:1 the incidence of ulcerative colitis is higher in females 3:1 respectively.
f. Periodicity: These illnesses occur in phases characterised by certain time charts pattern.

The effects of emotion on bodily functions are familiar to everybody and in the (folklore) people express themselves in Psychosomatic language describing the emotional components in their subjective experience symbolising the relatioship between emotions and bodily changes, i.e. «It gives me a headache», «It makes me sick», «It frightens me to death» or «scared stiff» or «shaking with laughter» etc.

Cannon (1939): Studied the effect on the autonomic system and the bodily changes in pain, hunger, fear and rage and suggested that the sympathetic stimulation prepares the body for fight or flight indicating the importance of the autonomic nervous system and the medulla of the suprarenal glands in these reactions. Laboratory confirmations came from the study by Wolff and Wolff on the volunteer Tom called (Tom Stomach) which illustrates the effect of emotion on body organ.

Salye's Theory of the Stress-adaptation Syndrome:

This is based on the adrenocortical response to physical and emotional stimuli as producing stress. The concept of stress in the psychosomatic sense is regarded as the result of a frustrating experience which the individual is unable to influence or where there is a mental conflict expressed in somatic form.

Adler (1924) Theory of «Organ Inferiority» postulates an underlying weakness of the organ concerned with the continuous stress in relation to it, i.e. a relationship between stressful life situation and exacerbation of organ reaction to it.

Thus there are several stages in the response to stress:

1. The organism can meet the need of the stress.
2. The organism can meet the need but only for a period which may not be sufficient.
3. The organ can meet the need without abandoning at least for the time being, the effort to pursue or evade some other relationship.
4. The organism connot meet the need at all.

ANATOMICO-PHYSIOLOGICAL BASIS FOR PSYCHOSOMATIC REACTION.

The central nervous system, the autonomic nervous system and the neuro-endocrine system whose pivotal centre can be regarded as the pituitary represent three inter-related systems of communication whereby the individual maintains equilibrium respectively between himself and his external environment and within his own organism. The cerebral cortex and the central nervous system are primarily responsible for mediating subjective experience and objective behaviour. The autonomic nervous system is responsible for maintaining internal physiological equilibrium and relating it to the demands of the external experience.

The neuro-endocrine system and the autonomic nervous system are linked together through the link between the hypothalamus and the pituitary gland.

1. Incoming sensory information from a) Special senses
   b) Other sensory tracts
2. Thalamo-parietal - Parieto-frontal - fronto-thalamic
   These two-ways connections would restore equilibrium and stability within the body.

Thalamo-Parietal

Fronto-
thalamic

Parieto-
frontal

Two way System

3. Direct connections between thalamus and hypothalamus:-

Thalamus ⟷ Hypothalamus
↕
Pituitary
↕
Autonomic
Nervous System ⟷ Endocrine
System

RESULTS:

1. Communication between human beigns (including Psychotherapy and hypnosis can affect the function of the entire relay system.
2. Physiological stimulation of the cortex and mid-brain can have a similar effect.
3. Both the fronto-parietal and fronto-thalamic tracts can be served in the operation of bimedial leucotomy.

Simple classification of Psychosomatic disorders:

The syndromes of particular importance with emotional components are as follows in the different body systems:

1. Gastro-intestinal system:

a. Peptic Ulcer: the stress increases acids and peptic secretion mediated by a hormonal mechanism through the hypothalamus pituitary - adrenal - gastric axis.
Example of - occupation is the bus driver with continuous stress and gastric secretion.
Treatment - Sedatives and hypnotic relaxation and suggestion.

b. Colitis (mucous colitis) irritable colon (colon neurosis)
Psychopathology: Parent are usually dominating young women -the colon biopsy reveals no abnormality and the F/M sex ration 2:1 with hypochondriasis and tendency to chronicity as well as failure to seek psychiatric help early during the illness.

c. Ulcerative Colitis - this is different and dangerous to life. Diagnosis may be difficult to make even after barium enema and sigmoidoscopy.
Psychotherapy can be the best method of treatment. They seek Psychiatric help earlier than the former group.

2. Cardio-Vascular System:

a. Hypotension anxiety and irregular pulse rate in response to stress. This is a postulation of hyperdynamic beta adrenergic circulatory state, which theoretically may be controlled by propranold, the beta receptor blocking agent».
Treatment: Psychotherapy and small doses of barbiturate.

b. Coronary artery disease (Russek) found that 91 out of 100 patients who developed coronary heart disease had a sever emotional stress preceeding the attack and that these patients had an

internal desire for recognition, were compulsive about time, overscrupulous and blind to their own limits. They over worked themselves, could not relax and felt guilty when trying to do so.

3. **Skin Disorders:**
   «Skin is the mirror of the mind» i.e. blushing and sweating. Alde (1924) theory of «organ inferiority» postulates an underlying weakness of the organ concerned with the continued emotional concern (high drive) in relation to it:
   a. Chronic urticaria: There is a relationship between stressful life situations with relapses and exacerbation of the condition. There is a repressed aggressiveness and regressed revival of infantile skin eroticism were often encountered.
   b. Psoriasis
   c. Acne vulgaris and seborrhoea dermatitis.
   d. Atopic eczema
   e. Specific skin conditions, i.e. itching
      Ano-genital pruritis
      Excessive Sweating
      Alopecia Areata

4. **Respiratory System:**
   a. Allergic Rhinitis (hay fever)
   b. Bronchial Asthma.

This is one of the most challenging psychosomatic disorder -Psychoanalytically it is said that the «attack is due to a reaction to the danger of separation from the mother, secondly attack is a sort of equivalent of an inhibited and repressed cry of anxiety or rage, thirdly that the sources of danger of losing the mother are due to some temptations to which the patient is exposed.

TREATMENT

Psychotherapy and Hypnosis
Suggestion under relaxation

For a more detailed account on this important subject of Psychosomatic disorders the reader should refer to the comprehensive books of Psychiatry given in the reading list.

CHAPTER IX

PSYCHIATRIC DISORDERS IN CHILDREN

Child development
Child Psychiatry Service
Some Clinical Syndromes
Psychiatric Assessment in Children

PSYCHIATRIC DISORDERS IN CHILDREN

Children are not miniature of adults, and they are not small men. They have their own problems to solve, their particular need to satisfy and their characteristic behaviour to be understood in the context of the family environments. So childen do not require smaller doses of the therapeutic tool used for adults but they need special measure of a comprehensive therapeutic plan taking into account their hereditary predisposition, their emotional resources and their personality make-up. Children very often find difficulty in verbalising their symptoms and so they tend to express their inner feelings and subjective experiences in an overt behaviour which need careful assessment and evaluation to formulate a dignostic tool to help construct a positive treatment.

It is often said that there are no problem children but there are problems parents and it is a useful golden rule to try to answer the question in every case «why this particular child was referred to me in this particular way by this particular parent at this particular time? Very often the answers to these questions reveal that a diseased child is a symptom of a diseased family. A girl aged 9 years referred to the psychiatrist by her mother for bedwetting for the first time would often reveal a brother of 13 years suffering from the same problem but his father maintains that he would grow out of it. This is a gross pathological family situation which needs careful working through to resolve the underlying family conflict before embarking on treating the unfortunate young girl.

There are general principles in the management of psychiatric disorder in children. These are:

1. Identifying and treating the psychiatric illness as early as possible.

2. Treating chlidren in early life would prevent neurosis in adult life. So with the emergence of the modern trends in community psychiatry, primary health care and primary, secondary and tertiary prevention programmes a great deal can be done to reduce psychiatric morbidity in general population by dealing with children problems at the earliest possible age.
3. The average referral age for children is between 5 and 6 years and the range should usually be set from as early as 6 months because psychological disease with a child can start as early as that period although proper consultation would be more appropriate at 1 1/2 years - 2 years of age.

   Still the management of psychiatric disorder in children generally follow the same guidelines as in the adult except for certain special problems which are characteristic of this age due to:

   a. The problem of communication - it is through an agent that we communicate with children and assess their problems.
   b. The problem of multiple causation - very often psychiatric complaint in children is the tip of the ice-burg and multiple causative factors would be operating at the same time.
   c. Childhood is a period of continuous growth or a process of maturation where children of different ages react differently to the same psychological upset. For example mental deprivation in early life may later result in educational retardation.

CHILD DEVELOPMENT:

The aetiological factors can be divided into two main groups:

1. Those arising in the individual
   (a) Genetic factors (b) Aquired factors
2. Those arising in the environment.

Genetic factors would include:

a. Intelligence
b. Sex
c. Individual differences, i.e secondary sexual characteristics
d. Sever stress in an area of development is likely to slow down growth in other areas.
e. Physical growth - this would usually continue until the early adult life.
f. Intellectual growth - there is evidence that intelligence as mesured by 1.Q. would reach ceiling by the age 16 - 18 and hence by accumulation of previous experience and wisdom of older age children continue to improve in their intellectual performance.

g. Emotional growth - children show immaturity of brain cells as evidenced by the electric brain activity of a normal awake base line of EEG recording which show slow theta activity 4 - 7 /CPS dominating all cerebral cortex. This would tend to disappear as maturation process goes on and become replaced by alpha 8-12 CPS, characteristic of adult recording by the age of 35 years. So any discrepancy between chronological age, physical age, emotional age and intellectual age would result in psychiatric disorder in children.

ENVIRONMENTAL FACTORS:

1. Organic brain damage - prenatal, neonatal or postnatal period noticably drugs (thalidomide) rubella, malnourishment or child birth trauma.
2. Educational opportunities in secure home with warm parental relationship or disruptive home surroundings would affect the psychological equilibrium of the child.
3. Consistent behavioural pattern of upbringing where there is no oscillation or ambivalance or lack of stable moral code whereby the child can learn to adopt acceptable behaviour models.
4. Learning and mixing with other children - learning is a process of emotional stimulation while mixing is a means of socialization.
5. Setting the limits - given the chance children need to test their environment and explore the limits of freedom given to them and unless these limits are set clear, they often tend to take chances and run uncalculated risks.
6. The very early years of a child life have proved vital for the development of a normal personality.
7. Imprinting - emotional or any sensory deprivation in the early formative months, i.e. 6 months of age are crucial for the development of a satisfactory personality later in life.
8. Parental relationship while the mother plays the most important role in the early five years of development to meet the biological and psychological needs of the child, the crucial period for the father are in later childhood and adolescence but in the early 4-6 years the reinforcement of the superego needed and this could set the ground for delinquent behaviour if not adequately dealt with.

It is estimated that one out of every ten children suffer from psychiatric illness severe enough to warrant psychiatric consultation, and 5 - 10% of children at school age show some form of psychiatric disturbance.

CHILD PSYCHIATRIC SERVICE:

There is now increasing tendency for the integration of child psychiatric services with general adult psychiatry. Psychiatrists are becoming more aware of taking more positive attitude towards psychiatric morbidity among children as preventive measures directed towards early intervention would relieve the load of work in adult consultation. Now child guidance clinics are being established under the supervision of a psychiatrist with special training as well as psychologists and social workers. In schools and educational institutions child guidance centres are being built and staffed by non-medical personnel under the supervision of educational psychologists to provide counselling for educationally subnormal children and assessment for children who need remedia education or speech therapy or a transfer to mentally handicapped centres. Day centres are being set up in general hospitals under the supervision of the psychiatric unit to provide services for behaviour disorders, adolescent turmoil delinquent or antisocial conduct or epileptic coming for family counselling or group therapy. Increasing number of outpatient clinics are being built in psychiatric departments with baby-mother care unit as well as small bedded inpatient units for crisis intervention, assessment and proper management Delinquent centres for those who cannot be contained at home or school or are being sent under care by courts are being sponsored and catered for by local authorities or Ministry of Labour and Social Affairs.

CLINICAL ASSESSMENT:

This would necessarily mean taking good history and establishing good rapport with the patient to reach a diagnosis. The following scheme might be found helpful in an initial interview to evaluate the presenting problem.

CLINICAL DATA:

Out of the core of children population presenting with probable psychiatric disorder the following statistics could be obtained. 50% would show behaviour disorder, 30% would show problems presenting with physical symptoms associated with physical illness while the remaining 20% would have deucational problems. The diagnosis would depend on several factors:

a. Child personality
b. Physical stress
c. Psychological stress
d. Specific response to stress
e. The child and family resources for treatment.
f. The type of treatment.

There are certain criteria which should be considered to decide whether a symptom is normal or abnormal:

1. Severity of the symptom
2. Frenquency of the symptom
3. Age of the child
4. Place of occurence
5. Social class
6. Cultural background

In making a diagnostic formulation there are certain principles to be remembered.

1. A neurotic behaviour is unlikely to show in one aspect of behaviour only.
2. A single or focal area of disturbance suggests an organic rather than a psychological cause of illness.
3. Psychiatric illness must be only diagnosed on positive psychiatric evidence and not by means of exclusion or negative findings.
4. A general medical and neurological examination must always be carried out.
5. Psychological investigations and assessments are the province of the clinical psychologist and should serve as ancilliary diagnostic tool -children can communicate better with play and drawing and can express temselves better by indirect perceptual tests. There are certain psychological tests which are of importance in children assessment and include «draw a man test» - Bender Gestalt visuomotor test, Projective tests as well as drawings and paintings.

The general guidelines for treatment are essentially the same as for adult psychiatry with allowances made for certain special problems mentioned earlier. Drug treatment utilises the same psychotropic drugs with age/weight relation dose regime. The case-work with experienced social worker is important especially when contemplating psychotherapy like family therapy or individual psychotherapy with adolescents.

The Main Clinical Syndromes are divided into four Groups:

1. Neurosis - These include disorder of behaviour, food intake, elimination, sleep, emotion, delinquency, sexual disorder, cardio respiratory disorder, psychosomatic disorder, sensory disturbances, emotional deprivation and accident-proneness.

2. Psychosis - Schizophrenia
   Autisim (1) Infantile
   (2) Symbiotic
3. Organic States - Cerebral damage
   Epilepsy
   Amentia, i.e. Mongolism or chromosomal abnormality
4. Educational Problems.

For a full account of these disorders the student should consult a detailed textbooks of child psychiatry. But there are some important syndromes which require mentioning because of their common occurence and distressing sequences on the family especially the parents. The commonest cause of behaviour disorder in a child is mishandling by his parents. The reasons behind an abnormal attitude of a parent are variable but Kanner has summarised the main parental attitude and the behaviour upsets commonly found in the children in Kanner textbook of child psychiatry in the following chart:

KANNER CHART (1955)
PRINCIPAL TYPES OF PARENTAL ATTITUDE

Attitude	Characteristic Verbalization	Handling of the child	Reaction of the child
1. Acceptance a affection	It is the child that makes the home interesting	Fondling, playing pateience	Security, normal personlity development
2. Overt rejection	«I hate him, I dont bother with him»	Neglect, harsh ness avoidance of contact severe punishment	Aggressiveness Delinquency shallowness of affect
3. Perfection-ism	«I do not want him as he is, I must make him over	Disapproval fault finding Coercion	Frustration, lack of self-confidence obssessiveness
4.Over-protection	Of course I like him, see how I sacrifice myself for him	Spoiling, nagging overindulgence of hovering domination	Delay in maturation, and emancipation protracted dependence on mother, spoilt child behaviour

KANNER, L. Child Psychiatry (Illionois Charles C. Thomas 1955, P.131)

SOME IMPORTANT SYNDROMES:

1. Behaviour Disorder
2. Nocturnal Enuresis
3. Truancy and School phobia

1. BEHAVIOUR DISORDER:

This is the commonest cause for referring a child to a psychiatrist. It usually becomes so intolerable to the parents that they seek an outside help to control the outrageous behaviour of the child. The basic disturbance as mentioned earlier is strained relationship with the parental figure then other siblings or the whole environment. Children find it easy to express their feeling in motor activity rather than verbal communication. So prolonged repeated and sustained naughtiness is a medical problem and indicates a deeper expression of his unhapiness and reactions to stress. The clinical picture depends on the personality of the child, the home atmosphere and the age. In the first three years of life the most common are disorder of food intake, elimination, sleep and emotion. After 5 years problems of fears, phobias, masturbation, nightmare, bed-wetting, aggressiveness, overacting and severe jealousy becomes obvious. At about 9 years psychiatric disorder like involuntary tics, conduct disorder, stealing, lying and sexual disturbance are the commonest problems. In adolescence a number of major problems become noticable especially those of role diffusion (Erikson) i.e. anxiety about sexual role, moral and social standards, dependence/independence, conflicts with parents as well as the common concern about sexual anxieties. Traunc y and school phobia are common. These fears should be handled with the utmost care and sympathy as adolescants are often very suspicious of all figures of authority including doctors.

2. NOCTURNAL ENURESIS:

This is a condition of persistent bed-wetting after the age of 5 years. When the child has obtained control of the bladder at an earlier age it should be considered as abnormal even at the age of 3 years. The incidence of the condition is 15 - 25% of children age 4 - 12 years. It may continue upto 16 years especially in boys and may go on to early adult life in lower social class groups. The wetting may persist from infancy in which case it is primary while it may follow a good period of bladder control in which case it is considered secondary. It may occur alone at night or during heavy sleep during the day time in 30% or it may be

combined with encopresis in which case the condition should be taken seriously and needs active intervention. Enuresis is so distressing to parents who often complain of the naughty behaviour of the child. All attempts of punishments and rewards are usually made before the child is brought for consultation usually with secondary anxiety symptoms and strained family relationship.

Enuresis usually starts as a regression phenomena at a time of emotional stress like admission to hospital, separation from the mother, the birth of sibling or starting school. The parents rarely volunteer to give a reason for the condition and they blame the child for deliberately wetting his bed and usually excercise very strict discipline like preventing them from fluids in the evenings, waking him up at night several times. The neurotic children usually show regressive behaviour like starting bottle feeding, food fads, temper tantrum, delayed speech or specific phobias.

AETIOLOGY:

Most cases show a multifactorial basis for their occurence in an essentially developmental abnormality.

1. **Anatomical abnormalities** - the most common is spina bifida. There is evidence to suggest that spina bifida as such is not the primary cause of the condition though its presence might delay treatment. Abnormalities of the ureter, bladder and urethra are rarely seen but when found they need surgical correction like lower implantation of the ureter especially in chronic or complicated cases.

2. **Developmental Abnormality** - This is the case of delayed maturation where evidence of this delay is noticed in other areas of development or milestones early in infancy. The support comes from the positive family historyof other siblings in the same family or in high percentage of one parent having suffered from the same problems in childhood.

3. **Faulty training** - Strict early toilet training may result in child-parent conflict and persistence of symptoms or contrary to this we notice inconsistence or neglecting proper training leading to secondary neurotic habits in which case enuresis is only part of the general behaviour disorder.

4. **Neurotic disorder** - There is a clear association between enuresis and emotional stress especially at 1½ - 2½ years when it causes disrup-

tion of bladder control habit and it will thus persist event after the neurosis has settled.

TREATMENT:

Psychotherapy: This is usually the first and most important aspect of treatment as the parents are usually very anxious and disturbed by the condition or they are secretive and ashamed or very sceptical about the role of drug treatment especially in familial type. Family therapy is important to ease the tension inside the family atmosphere.

Drug treatment is essential especially when the condition has persisted for some years. The drug of choice is imipranine (tofranil) in the dose of 25 mgm nocturnal daily for a period of at least six months from the start where the patient remained dry for at least two months from the last dose which ever is earlier. High doses may be needed for their anticholinergic effects and side effects must be monitored. Most cases would respond to a dose 75 mgm daily for about three months.

Behaviour Therapy: The bed and buzzer therapy is most useful in older cases who can cooperate as the most important element is understanding and cooperation of the patient and family. Failure of treatment would lead to disastrous results and damaging effect of both. Heavy sleep, faulty apparatus or discontented parents might produce failure of treatment. This is a deconditioning technique and it needs strong reinforcement procedures where the success rate could be 90%. Waking the child at night to empty the bladder and fluid restrictions could be adjuvant to the main therapy of drug or conditioning but they should be done in the early stage of the treatment to help relieve the anxiety and enlist the interest and cooperation of the parents but they are not mandatory.

PROGNOSIS:

There is a tendency for children to grow out of the habit but treatment should not be delayed waiting for this hope. Secondary emotional disorders and anxieties should be dealt with as well. Adminssion is rarely necessary for instituting conditioning therapy.

3. NON-ATTENDANCE AT SCHOOL:

There are two main groups - Truancy which is running away or avoiding school and school Phobia or (school refusal) which is due to fear of leaving the home.

TRUANCY: There are various push factors and pull factors involved in truancy. The push factors are those that keep the child away from school. These include:

1. Learning difficulties - a large number of truant children have reading and writing difficulties.
2. Bullying by other children or staff.
3. Anti-authoritarian attitude - where the truancy is seen as a defiance to authority figures - those children usually comes from disrupted home back grounds.
4. Bad teaching and inappropriate curriculum
5. Overcrowded class with a lot of conflict
6. Boredom and lack or recreational facilities

Pull factors operate towards attractions outside school:

1. Gang effect and desire to conform to the demand of the group
2. Parental attitude of neglect and lack of encouragement with poor motivation or else encouraging the child to stay away to help the parents at home or at work.

TREATMENT:

This ranges from simple adjustment of school situation or special coaching to psychiatric treatment and special schooling, like remedial education. Persistent truancy leads to delinquency.

School refusal or (School Phobia): It is not fear from shool rather than fear from leaving home. It is different from truancy. The child is dependent and over-protected by a very anxious mother. There are often severe emotional difficulties between the parents. It usually begins at school age 5 - 6 when the child starts schooling. It might improve and recur at a later stage following illness and hospital admission or tragic happening at home or severe emotional conflict with parents and fear of loss.

Treatment consists of sending the child back to school whatever were the circumstances. At the same time it involves dealing with the anxiety of the child and the mother by family therapy and minor tranquilities. Involving the teacher and the school social worker is a necessary tool of treatment and follow up.

CHILDREN IN-PATIENT TREATMENT:

In certain circumstances children may need to be admitted to hospital for special treatment. The factors that influence the outcome of the admission include the age of the child, his personality, the attitude of the nursing staff and the length of stay in hospital. The younger the child the more traumatic is the experience of hospital admission and the modern tendency of admitting the child and mother has helped a great deal in relieving the anxiety and the modern tendency of admitting the child and mother has helped a great deal in relieving the anxiety and tension. Admission should be as short as possible with frequent visiting avoiding social isolation and promoting a spirit of mutual cooperation between hospital and home. The health visitor and social worker are particularly important to explain to both child and parent the rational of the treatment as well as giving support to the hospital staff.

PSYCHIATRIC ASSESSMENT OF CHILDREN.

Reason for referral:

History from parents:

Developmental History:

Family History:

School report:

ASSESSMENT OF THE CHILD:

(1) General appearance:

(2) Motor function:

(3) Speech:

(4) Content of talk and thought:

(5) Intellectual function:

(6) Mood and emotional state:

(7) Attitude to family:

(8) Attitude to school:

(9) Enquiry into fantasy life:

(10) Attitude to referral:

(11) Indications of social adjustment:

(12) Play:

1. Physical Examination:

2. Diagnostic Formulation:

3. Treatment:

4. Recommendation:

CHAPTER X

PSYCHIATRIC TREATMENT

Psychological treatment
Symptomatic treatment
specific treatment

PSYCHIATRIC TREATMENT

There are however, Psychological treatment and physical treatments. This does not mean that disease entities are divided into two categories of those that respond to psychological or physical treatments respectively. Very often at any given time, a single illness may need a combined treatment of both types the dominance of which depends on the specific underlying psychopathology.

Psychological treatment aims at improving communication with the patient by reassuring, interpretation and explanation to help him comprehend better the nature of his illness and react in a healthy way to the internal and external stress. This is called Psychotherapy, an umbrella term used to combine both the Psychoanalytical school or «Fruedian theory» and the behavioural school or conditioning theory of Pavlov and Skinner.

The history of physcial treatment in psychiary goes back as long as any form of medical treatment. The primary objective is to produce a change in the patient indirectly by altering the psysiological and biochemical basis of brain functions. All various forms of physical treatments have been employed to relieve the suffering or to cure mental illness in the patient. The various techniques of electrical therapy, drug therapy, deep narcosis, abreaction and the neuro-surgical techniques vary widely in their applications and specific aims.

Psychiatry has passed the era of mystical concepts of possession by demon and magical control by straight-jacket or shock treatment. Modern electrical treatment carried out under general anasthesia is neither shocking nor unpleasant.

After careful assessment both clinically and psychologically one has to set up a therapeutic plan for the patient. This plan has three guidelines:

1. Psychological treatment
2. Symptomatic treatment
3. Specific treatment.

Psychological treatment can be of two types:

1. Psychoanalysis
2. Behaviour therapy

Psychoanalytic Psychotherapy: could be superficial or deep Specific Psychotherapy could be:

a. Supportive Psychotherapy which is simple understanding and sympathetic handling without indulgence into more heroic analytic deep approach. This can be tried with all patients.
b. Interperative Psychotherapy - This aims at improving the health as well as to a more mature and developed personality. It is defined as «any process which makes availables to individual consciousness the true significance of emotional conflicts and tensions hitherto repressed and would produce high awareness and increased stability and emotional control to achieve an awareness of himself which would help him face his difficulties.

2. **Deep Analytic Psychotherapy.** It is the task of the patient to express freely and absolutely without suppression or inhibition the ideas, anxieties and preoccupations, that come foremost in his mind. Patients are encouraged to relax completely, lying down comfortably and think about nothing in the external surroundings with no distraction or interruptions. The concept of lay people in the mass media about the true nature of this form of treatment has fallen in disrepute and led to a great distortion of the image of Psychiatry in the eyes of ordinary people. It requires special training for the understanding of its concepts and techniques. Psychotherapy could be conducted with the patient alone or family or a group of patients with similar problems called individual psychotherapy, family therapy or group therapy respetively.

BEHAVIOUR THERAPY:

This is based on the learning theory of Pavlov work on conditioning. It consists of empirically developed methods of unlearning the phobias and retraining the patient in desired form of behaviour. The

aim is to abolish faulty conditioned reflexes and set up wellconstructed conditioned reflexes to replace the old ones by extinction Some example, are «token economy» for rehabilitating patients with Schizophia, «desensitisation and exposure» for anxiety and obssessive compulsive disorder and the electric bell and pad for bed-wetting.

The target behaviour is discussed with the patient who would cooperate fully in the treatment if any success is expected. Unlike Psychoanalysis it aims at treating the symptoms and not the cause and there are areas of major conflicts between the two school of thoughts. Both are sceptical about each other but for the experienced observers the two methods can be used with some discretion in the same illness. The commonest forms are aversion therapy by apomorphine discussed in alcoholism or electric shock for sexual disorders as in homosexuality transvestism or fetishism. Desensitisation techniques described by Wolpe stated «if a response inhibitory to anxiety can be made to occur in the presence of anxiety-provoking stimuli, it will weaken the bond between these stimuli and the anxiety». This can be achieved either by placing the subject directly into the anxiety-including situation or by desensitisation in imagination by discussion. These methods are now more commonly used than aversion therapies.

PHISICAL METHODS OF TREATMENT:

1. **Symptomatic Treatment:** As the name implies it aims at reducing the severity of the symptoms which are distressing to the patient like insomnia or tension.
   a) **Sedation:** diurnal sedation or nocturnal. It should be noticed that barbiturates are dangerous as they are toxic. They can cause addiction and lead to suicide. Continuous use of barbiturate could interfere with carbohydrate metabolism and concomitant administration of vitamine is essential. In cases of continuous sleep which is rarely now used heavy sedation by chlorpromazine or chloral hydrate is supplemented with adequate hydration, vitamine supplement and intensive nursing care and adequate respiratory ventilation. Benzodiazepine are the commonest group of sedatives now used for day and night purpose.

TRANQUILIZERS:

Transquilizers have a sedative effect without as a rule lowering the level of consciousness and although their direct effect may be similar their pharmacological actions may vary. Though they are used widely

in psychosis (major tranquilizers) they are often prescribed for neurosis as minor tranquilizers. The most common type are major tranqualizers, ie. Chlorpromazine. These are used widely in:

a. Mental illness, ie. Schizophrenia or Mania for agitation and restlessness.
b. Post-operative excitement and confusion, as post-leucotomy behaviour disorder.
c. Mixed Psychotic reactions.

Therapeutic effects:

1. Anti-psychotic
2. Anti-hallucinogenic
3. Anti-cholinergic

Side effects include:

1. Jaundice, dermatitis, and urticaria, leucopenia, parkinsonism, dystonic reactions, photosensitivity, pyrexia, hypotension and lactation.

Other phenothiazine, ie. perphenazine, tricluoperazine, fluophenazine or long acting fluophenazine decanoate (modecate) used in chronic Schizophrenia.

BUTYROPHENONES: (haloperiodol) is anti-excitement and in high doses is similar to phenthozine with negligible adrenergic activity and no significant side effects except for dystonic reaction, psuedoparkinsonism and motor restless or akathisia.

STIMULANTS:

Amphetamine derivatives, ie. dexamphetamine and methylamphetamine are symptomatic anti-depresants and cerebral stimulants but they cause insomnia and lead to addiction and acute psychotic episodes. Their effect is better limited to cases of behaviour disorder. In cases of brain damage in children it has a paradoxical effect of sedating, these patients while barbiturates cause agitation and excitment by the same token. Their use in nocturnal enuresis, narcolepsy, slimming, and epilepsy with behaviour disorder is not without danger.

SPECIFIC MEDICAL TREATMENT.

Anti-depresant drugs:

The principal anti-depresant drugs are now divided into two main groups:

A) **Tricyclic drugs** and B) **Monoamine Oxidase**

A) **The Tricylic Drugs** are closely chemically related to chlorpramazine Imipramine (tofranil) and Amytriptyline (Tryptazole) are the best two effective of the whole range. A new Tetracyclic version of the drug is being introduced claiming less side effects especially the cardiotoxic properties of the drug. Some Psychiatrists claim that the patients who benefit mostly from the Tricyclic drugs are typically suffering from endogenous type of depression with the classical signs and symptoms as opposed to reactive depression. The tricyclics seem to act by preventing the inactivation and rebinding of the catecholamines, noradrenaline and dopamine at nerve ending. Ther are contraindications like Glucoma prostatic enlargement and retention of urine. Troublesome side effects like cardio toxic effects should be carefully assessed in patients suffering from mycardial infarction. The patients should be warned in advance of these possible side effects lest they should be deprived of what could be a life-saving treatment. It takes 10 - 15 days to act and 10 - 12 weeks to get a lasting improvement. Long-term maintenance may be necessary to avoid recurrance.

B) **M.A.O.I.**

They increase the amount of amine turnover in the receptor site of the C.N.S. by inhibiting the monoamine oxidase an enzyme which is widely distributed in the body to oxidize catecholamines to inactive form excreted in the urine. Some examples of the group arew:

Phenelzine (Nardil) 40 - 90 mgm daily
Iscocaboxoside (Marplan) 10 - 30 mgm daily
Traylcypronine (Parnate) 10 - 60 mgm daily

These are the most commonly used drugs in the reactive depression type and in typical cases in which phobias and anxiety symptoms are prominent. There are more severe restrictions to the use of these drugs than the tricyclic especially as far as food is concerned particularly those rich in amine. Side effect include hypertensive crisis with food containing dopa, hypertension, liver damage, allergic conditions retrobulbar neuritis. Tricyclic drugs should not be given before two weeks of the last dose of M.A.O.I. as there is a synergism between the milder side effects shared by both types of drugs. An acute syndrome of hyperpyrexia, excitability, fluctuation in blood pressure which can lead to coma and death has been described. The patients should carry a card with these instructions for the danger of any emergency requiring anesthesia or ECT.

ELECTRO-CONVULSIVE TREATMENT (ECT)

The use of this common method of treatment is empirical. There is evidence to suggest that the beneficial effect involves the cerebral cortex, mid-brain, hypothalamus, the anterior pituitory and autonomic nervous system. In depressed patient it probably increases the amount of 5-hydroxy tryptamine in the brain-stem. The treatment consists of passing an electric current through the skull between the two electrodes placed on the temple under complete general anesthesia. It should produce a convulsion as it is thought that the epileptic fit is an essential part of the treatment. Now more Psychiatrists are using the unilateral techniques more than the bilaterial one to diminish the side effects of post-epileptic amnesia. Given in standardised form for ECT is very effective and safe procedure with good results, especially in acte psychotic depression with suicidal tendency, depressive stupor, catatonic stupor or sever excitement not responding to other major tranquilizers.

CEREBRAL SURGERY:

Prefrontal leucotomy: This surgical procedure depends on severing the fronto-thalamic connection to the rest of the brain, thus cutting off the incoming sensory information going to the frontal lobes. Thus the emotional quality and interpretation of the associated feelings are affected and thus the patient's subjective feeling of pain and anquish and consequent objective behaviour disturbance are modified. The principal indications for this operation:

a. Chronic recurrent affective disorder with considerable agitation and tension not responding to other forms of treatment.
b. Severe obssessive compulsive disorder with distressing rituals and ruminations.
c. Chronic resistant case of Schizophrenia with fear of grave state of institutionalisation.

The decision to perform such an operation is one of the most difficult tasks of the psychiatrist as to the suitability of the case, the irreversibility of the operation, the prognosis and the ethical issue of the whole management of the case under consideration.

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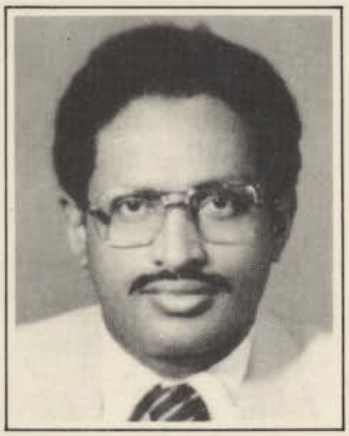

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He was born in Sudan in 1939. He graduated from Faculty of Medicine, University of Khartoum in 1965. He worked as a Psychiatric Registar in the Ministry of Health in the Sudan until 1970. He studied in the Institute of Psychiatry in London University where he got his Diploma of Psychological Medicine (D.P.M.) in 1972. He continued to study in England until he got the Membership of the Royal College of Psychiatrist in 1974 (M.R.C.Psych.). He became a member of Childs Psychiatry Specialist section of the Royal College in 1977. He became a member of the External Scientific Staff of the Psychological Department of the Faculty of Education in U.A.E. University and a member of the teaching staff of the Department of Psychological Medicine - Faculty of Medicine - University of Khartoum. He worked as a Consultant Psychiatrist in England, Sudan, Bahrain and United Arab Emirates where he is currently working as a Senior Consultant Psychiatrist and the head of the Psychiatric Department in the Ministry of Health. He has published nine books in Arabic in different subjects including Psychology, Psychological Medicine, Literature and Poetry.

For several years, interested has he been in Transcultural Psychiatry.