FUNCTIONAL DISORDERS

DEPRESSION

- Depression is a mood disorder characterized by a feeling of intense sadness or loss of interest in pleasurable activities.
- It may follow a recent loss or other sad event but it is out of proportion to that event and persists beyond an appropriate length of time.

Prevalence

- Depression is a common mental disorder in occurring in one in every 5-10 people and is very common in primary health care setting, and the general clinical setting.
- However many people with this condition go undiagnosed and as a result the condition is not treated or managed properly.

Aetiology

- The causes of depression are not fully understood but a number of factors may make a person more likely to experience depression.
- Heredity or genetic predisposition
- Emotional upsetting events e.g. poverty, bereavement, adverse interpersonal relationships
- Physical illnesses e.g. AIDS, Tuberculosis, Syphilis, cancers, hypothyroidism etc
- Secondary to another psychiatric disorder e.g. Schizophrenia.
- Medication e.g. steroids, antipsychotics, contraceptives, mercury, cimetidine etc.
- Abuse of substances e.g. alcohol.

Signs and Symptoms

- Person may appear slow and sad or irritable and anxious.
- Person may withdraw, speak little, stop eating with poor sleep (vegetative depression) or a person may be very restless, over talkative, wringing hands (agitated depression).
- Loss of interest in the formally pleasurable activities.
- Feeling of worthless, useless, guilt and self blame.
- Loss of energy and unexplained body weakness

- Loss of interest in sexual activity.
- Reduced concentration, attention and poor decision making.
- Recurrent death wishes and acts of self harm or suicide.
- Low self esteem
- It may present with psychotic features; hallucinations, hearing voices telling him bad things. Delusions e.g. believing he is not worth living.

Management

Diagnosis

To make a diagnosis of depression the patient should have had a persistent low mood, loss of interest in the formally pleasurable activities for at least two weeks accompanied by at least four other symptoms of depression.

Psych education

- Depression is like any other illness and it affects both men and women so people should seek treatment for it.
- The more you open up and share your feelings the better men should be encouraged to do so.
- Avoid being alone and taking major decisions when you are depressed.
- The drugs are effective but they may take at least two weeks to act and a combination of therapies might be applied for quick and effective recovery.
- Treatment with medication should go on for at least 6-9months.

Medications

Antidepressants

- Antidepressants; these drugs work by elevating ones mood.
- The two main groups used in Uganda include the Selective Serotonin Re-uptake Inhibitors (SSRIs) and the Tricyclic Antidepressants (TCAs).
- The SSRIS are now the first line treatment in places were they are available because of the minimum range of side effects and low toxicity with overdose.

Medication

Generic name and class	Trade name	Dose	Side Effects
Amitriptyline (TCAs)	Laroxyl	50mg-100mg nocte (Max 300mg)	Sedation, dry mouth, constipation, blurring of vision, palpitations and dizziness
Imipramine (TCAs)	Tofranil	50mg-100mg nocte (Max 300mg)	See above
Fluoxetine (SSRIs)	Prozac, Trizac, Nuzac	20-60mg mane	Insomnia and anxiety
Sertraline(SSRIs)	Zoloft	50mg mane	

Psychotherapy

- Therapies used with any antidepressants can greatly enhance the results of medication; e.g. psycho education, simple counseling.
- Cognitive-behavior therapy focuses on identifying the negative cognitions to positive.
- Interpersonal Psychotherapy which may require referral to a clinical psychologist for complicated cases

Electro-convulsive Therapy

- This is used to treat severe depression mainly with psychotic features, and in those threatening to commit suicide, or refusing to eat food.
- It is also useful in depressions with comorbid medical conditions without major contraindications to anesthesia.
- The electrodes are placed on the head and an electric current is applied to induce a seizure in the brain. For reasons that are not properly understood the seizure alleviates depression.
- Usually 6-12 treatments are given every other day and the person is given general anesthesia to avoid pain and fractures during muscle contractions. This therapy may cause some temporary loss of memory.

Points to note

- It is very important to know what types of depression you are dealing with. If you are treating depression secondary to general medical condition or substance abuse or another psychiatric disorder, its important to address these issues.
- If it is psychotic depression you may use an antipsychotic.
- If it is bipolar depression a combination of a mood stabilizer and anti depressant may be more use full.

- Depression due to stress can be treated by psychotherapy.
- Depressive episodes have a tendency to re-occur and all patients who have had two all more episodes may require maintenance treatment to prevent recurrence.

Nursing Care

- Admit patients with severe depression on an open ward for easy monitoring.
- Establish good nurse-patient relationship
- Psychotherapy to the patient and relatives is very important.
- Educate patient and family about depression as being a sickness like any other and effective treatment is available
- In the course of treatment patient should not take any alcoholic drink
- Assess for the risk of suicide and if present admit and put on caution card.
- Help the patient come out of the stressor or cope with it.

Complications

- Depression if not properly managed can result into;
- Suicide and homicides
- Comorbid Anxiety disorders
- Psychotic features
- Alcohol and drug abuse

Prognosis

Depression can be treated and good prognosis depends on the following;

- ✓Drug compliance
- ✓Psychosocial support
- ✓Combination of therapies
- ✓Positive attitude towards recovery
- ✓N.B The opposite is true for poor prognosis

Not all
storms
come to disrupt your life, some come to clear your path.

MANIA

- Mania is a disorder of mood characterized by excessive physical activity and prolonged excessive happiness or irritability which is out of proportion to any positive life event.
- Mania is a distinct period of abnormally and persistently elevated ,expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day.

Prevalence

- Mania is estimated to affect 1-2% of the general population.
- In Uganda the figures are not specific but it is one of the leading diagnoses among patients who receive in-patient services this is partly because the condition presents with acute disruptive symptoms to an individual and the society hence calling for urgent hospital admission.

Types of mania

- **Hypomania**
- This is a mild form of mania
- **Acute mania**
- Acute, severe and heavy form of mania
- **Deli nous mania**
- Excitation characterised by confusion mainly found in organic psychoses.
- **Chronic mania**
- Mania that has occurred in the patient, it could be simple form but has failed to respond to various forms of treatment.
- It usually occurs in people 40years and above.

Etiology

- Mania disorder is caused by an interaction between biological psychological and social factors.
- **Biologically,** the illness is thought to have a strong genetic component with both family studies, as well as adoption and twin studies indicating that it runs in families.
- Studies of neurotransmitters also indicate that there is an imbalance in dopamine, serotonin, noradrenaline and other neurotransmitters.
- Disturbance in the biological clock or circadian rhythm has also been indicated in bipolar disorder

- Among the psychosocial factors, stressful events especially those that affect the circadian rhythm may precipitate manic states.
- Abuse of alcohol and other substances may cause mania (Mania Aputu).
- organic mania or mania secondary to a general medical condition may be precipitated by Infections like malaria, meningitis, syphilis, HIV/AIDS etc or Endocrine disorders like hyperthyroidism, brain tumors, cardiovascular accidents and other degenerative disorders.

Signs and Symptoms

- Elevated mood where by patient feels excessively happy than usual or feels irritable which may provoke aggression and violence.
- Increased energy and hyper-activity
- More talkative than usual or pressure to keep talking.
- Distractibility (they easily pull attention).s
- Excessive involvement in pleasurable activities like parties.
- Rapid and accelerated speech which may led to flight of ideas (changing from one topic to another)

- Decreased need for sleep. Patients may sleep late and wake up very early in the morning very refreshed and ready to start the day
- They have appetite for food but they have less time to eat as they do not want to waste time.
- Grandiose ideas and inflated self esteem
- Impaired judgment and impulsive behaviors like overspending and poor decision making.

- Increased sociability and over familiarization.
- Excessive generosity i.e. they give out freely.
- Increased libido seen by having multiple sexual partners.
- There may be hallucinations and delusions but these when present usually rhyme with the patients mood (mood congruent delusions and hallucinations)

Diagnosis of Mania

- Abnormal and persistent elevated, happy, irritable, expansive mood for at least one week.
- The presence of at least three of the above signs and symptoms.
- The symptoms should not be due to physical illness or substance abuse.
- There should be impairment in social, occupational functioning of daily activities

Differential diagnosis

- **Schizophrenia;** the presence of psychotic features in mania but in schizophrenia are usually mood incongruent.
- Catatonic schizophrenia (excitement) due to increased hyperactivity but in schizophrenia there are other symptom suggestive of the disorder,
- **Schizoaffective disorder**; patient has an uninterrupted period of illness with a mood problem (depression or mania) with concurrent symptoms of schizophrenia.
- **Other Organic psychotic disorders.** The presence of an organic problem must be identified.

Psychotherapy

- Management of mania usually comprise of supportive therapy, and Patient education.
- If a patient has had more than three episodes it is advisable to keep on prophylaxis medication for life mainly mood stabilizers. Patients with one or more episodes with a strong family history of Bipolar illness may also need to stay on prophylactic medication.
- Bipolar manic patients usually get depressive episodes, so patient should be aware.

- Bipolar Mania is an episodic illness treated or not the patient will get better but treatment shortens the episode and prevents complications while prophylaxis treatment prevents or prolongs the occurrence of another episode.
- Mania predisposes the patient to a number of social problems like alcohol and substance abuse, crime, sexual over involvement, and other STIS.
- Patients should monitor the signs of relapse such as ; poor sleep and decreased need to rest so as to seek urgent medical help.
- Encourage patient to join social support group like the mood disorder clinics.

Medical Treatment

- **Antipsychotics:** These are used if a patient has psychotic symptoms (hallucinations and delusions) and in controlling the acute symptoms like excitement, aggression, irritability and lack of sleep to calm down the patient.

Generic name	Trade name	Daily Dose	Side effects
Chlorpromazine	Largactil	100mg-300mg, od, bd, tds	Sedation, tremors, parkinsonism, restlessness, blurred vision, dry mouth, hypotension, weight gain, dulling saliva, sexual dysfunction, constipation
Trifluperazine	Stelazine	5-30mg in divided doses bd tds	as of chlorpromazine
Haloperidal	Haldol	5-10mg bd, tds	apart from sedation the others are as of chlorpromazine.
Olanzapine, Quetiapine		10=20mg	Weight gain, sedation, Precipitation of diabetes and other metabolic conditions
Risperidone	Risperdal	2-6mg	Weight gain EPSE, Prolactin secretion

Mood Stabilizers

These are drugs used to stabilize the mood. They can be used in the treatment of acute manic episodes as well as in the prevention of frequent relapses.

Generic name	Trade name	Dose
Carbamazepine	Tegretol	200mg bd ,od
Lithium carbonate	Eskalith	400mg,bd or according to blood levels
Sodium valproate	Epilim/ Valparin	200mg,300mg,5000mg bd
Lamotrigine	Lamictal	50mg-400mg daily in divided doses (Weekly increments

Nursing care

- Admit a patient with acute symptoms in an open dormitory to avoid self injury.
- Establish a good working relationship by introducing yourself to the patient and let the patient tell you the preferred name and address him/her as so.
- Watch out for signs of violence and aggression and manage accordingly.
- Be confident never let the patient manipulate you.
- Give solid foods which they can eat while moving.
- Give prescribed medicines on time and monitor patient’s progress.
- Health educate the relatives on the nature of illness and need for drug compliancy and social support.

Prognosis

- Mania is an episodic illness and recurrent illness. Treated or not the patient may get better but early treatment shortens the episode of mental illness and prevents complication while maintenance treatment prevents relapse.
- Manic patients at one time may get a depressive episode hence the name bipolar affective disorder Prophylaxis medication is usually recommended.

Complications of mania

- If not properly treated mania can result into physical complications like; HIV/AIDS, STIS, fractures etc.
- Psychosocial stress to the family i.e. Separation and divorce, stigma and discrimination.
- Suicide and homicides plus being in conflict with the law.

BIPOLAR DIS ORDERS

- Bipolar disorder is a mood disorder characterized by one or more manic/hypomanic episodes with or without depression
- Bipolar disorder affects 1-1.5% of the population in most modern societies
- Prevalence is underestimated at 1%
  - The condition has a high rate of recurrence
  - Bipolar disorder recurs in 80% of patients

TYPES OF BIPOLAR DISORDER

- Bipolar I
- Bipolar II
- Cyclothymia
- Mixed states

BIPOLAR I

- A person affected by bipolar I disorder has had at least one manic episode in his or her life.
- The patient presents with a full episode of mania
- A manic episode is a period of abnormally elevated mood, accompanied by abnormal behavior that disrupts life.
- Signs of mania are presents mania
- for about 10 days
- The depressive symptoms may go un noticed

BIPOLAR II

- Individuals have one or more major depressive episodes accompanied by at least one hypomanic episode
- Bipolar II is often characterized by impaired social behaviors and occupational challenges.

MIXED STATES

- People with Mixed states bipolar experience symptoms of mania and depression at the same time
- Typically, someone with a mixed state will describe feeling activated but also full of anguish and despair

CYCLOTHYMIA

- characterized by numerous, hypomanic episodes and often less severe depressive episodes for at least two or more years with no major depressive or manic episode;

DSM-IV CRITERIA – MANIC EPISODE

A. A distinct period of abnormally and persistently elevated, expansive , or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
- More talkative than usual or pressure to keep talking

CONTINUED

- Flight of ideas or subjective experience that thoughts are racing
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

CRITERIA MANIC EPISODE CONTINUED

- C. The symptoms do not meet criteria for a Mixed Episode.

- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatments) or a general medical condition (e.g., hyperthyroidism).

-

CAUSES OF BIPOLAR

- The cause of bipolar disorder is unclear,
- But hereditary, biological, and psychological factors may play a part
- For example, the incidence of bipolar disorder among relatives of affected patients is higher than in the general population and highest among maternal relatives.

Genetics

- A multitude of controlled studies of bipolar patients and their relatives have shown that bipolar disorder runs in families.
- For example In the studies of identical twins with the same genes, reports show that if one identical twin has bipolar disorder, the other twin has a greater chance of developing bipolar disorder than another sibling in the family.

GENETICSCONTINUED

- The closer the relationship, the greater the susceptibility.
- Children with one affected parent have a 25% chance of developing bipolar disorder
- Children with two affected parents, a 50% chance.
- The incidence of this illness in siblings is 20% to 25%;

BRAIN CHEMICALS

- Three brain chemicals -- noradrenaline (norepinephrine), serotonin, and dopamine -- are involved in both brain and bodily functions.
- Noradrenaline and serotonin have been consistently linked to psychiatric mood disorders such as depression and bipolar disorder.
- Dopamine, is commonly linked with the pleasure system of the brain.
- Disruption to the dopamine system is connected to psychosis and schizophrenia,

BRAIN CHEMICALS CONTINUE

- Serotonin is connected to many body functions such as sleep, wakefulness, eating, sexual activity, impulsivity, learning, and memory.
- Abnormal serotonin levels contribute to mood disorders (depression and bipolar).

ENVIRONMENTAL FACTORS

- Environmental stressors also play a role in triggering bipolar episodes in those who are genetically predisposed.

- For example, children growing up in bipolar families may live with a parent who lacks control of moods or emotions.

- Some children may live with constant verbal or even physical abuse if the bipolar parent is not medicated or is trying to self-medicate the mood swings with alcohol or drugs.

TREATMENT OPTIONS FOR BIPOLAR DISORDER

- Hospitalization for mania, severe depression
- Mood stabilizers, antipsychotics and antidepressants
- ECT – most effective treatment
- Supportive psychotherapy and CBT
- Lifestyle change
- Substance abuse treatment

MOOD STABILIZING DRUGS

- Lithium (**lithium carbonate**)
- 900 – 1500 mg/day
- Most effective medication
- **Side effects**

teratogenicity, tremor, renal dysfunction, acne, hypothyroidism, gastric upset, cardiac conduction problems, cognitive impairment

LITHIUM CONTINUE

- May not be an effective long-term treatment option for rapid cyclers
- They tend to develop a tolerance for it or do not respond,
- Prolonged lithium use may also cause hyperthyroidism

CARBAMAZEPINE

- Is an anticonvulsant drug
- 400 – 1000 mg/d
- Most effective for mixed states, rapid cycling
- **SIDE EFFECTS**

sedation

ataxia

aplastic anemia

agranulocytosis

- Check CBC every 3months

SODIUM VALPROATE

- It has been proven effective in treating rapid cycling bipolar and mixed states patients.
- **Side effects**;

GI upset

weight gain

Teratogenicity

liver problems

- Its Ineffective for depression

ATYPICAL ANTIPSYCHOTICS

- Olanzapine – 2.5-20 mg/day very effective; significant wt gain in some patients

- Risperdal - .5-4.0 mg/day more EPS and increased prolactin in some patients
-
- Clozapine - can be remarkably effective but Slow response, serious Side effects profile and significant wt gain

PSYCHOSOCIAL INTERVENTIONS

- Because bipolar disorder is thought to be biological in nature, psychological therapy is recommended as a companion to pharmaceutical treatment of the disease.

- **Cognitive-behavioral therapy**, can be a useful tool in helping patients and their families adjust to the disorder

- In encouraging **compliance** to a medication regimen

- In reducing the risk of **suicide**.

COURSE OF BIPOLAR DISORDER

- Bipolar disorder most commonly begins with depression(75% women, 67% men)
- Most patients experience both manic and depressive episodes
- But 10-20% experience only manic episodes
- An untreated manic episode lasts up 3 months
- 90% of persons who have a single manic episode are likely to have another

SCHIZOPHRENIA

- Schizophrenia is defined as a functional psychosis characterised by disturbances in thinking, emotion, and perception.
- Someone with schizophrenia may have difficulty in distinguishing between what is real and what is imaginary, may be unresponsive and may have difficulty expressing normal emotions in social situations.
- The vast majority of people with schizophrenia are not violent and do not pose danger to others. Contrary to public perception, schizophrenia is not split personality or multiple personality.

causes of schizophrenia

- Genetics or hereditary; schizophrenia tends to run in families and that a person inherits a tendency to develop the disease.
- Biology; it is believed that people with schizophrenia have imbalances in the neurotransmitters that allow nerve cells in the brain to send messages to each other.
- The imbalance of these chemicals affect the way a person's brain react to stimuli that's why a person with schizophrenia may be overwhelmed by sensory information which other people can handle like loud sounds and bright lights.

CAUSES CONTINUE

- Viral infections and immune disorders; schizophrenia can be triggered by various viral infections and immune disorders for example babies whose mothers get flue while pregnant are at higher risk of developing schizophrenia later in life. And people who are hospitalised for severe infections are also lost at higher risk.
- Psychological factors; people who are withdrawn and have very few social contacts are more prone to develop schizophrenic illness.
- Social or environmental factors; people of low social class, separated families e.g. after divorce

CLINICAL PRESENTATION OF SCHIZOPHRENIA

- A mental health professional may use the following terms when discussing the symptoms of schizophrenia.
- **Positive symptoms of schizophrenia**; these are disturbances that are added to the persons personality.
- Delusions patients may think that some people are spying on him(paranoid) or her or that they are a common figure (grandiose delusions)
- Hallucinations; they mainly experience hearing imaginary voices that are commanding or comments to the individual.

CLINICAL PRESENTATION CONTINUE

- Disordered thinking and speech; patients have tendencies of moving from one topic to another. They also make words or sounds in a way that doesn't make sense or repeat words and ideas
- Disorganised behaviour; this can range from routine behaviours like hygiene or choosing appropriate clothing
- Bizarre behaviour; the patients behaviours are out of ordinary or far from normal in that the behaviour is markedly unusual and unexpected in a person.
- Grandiosity
- Hostility
- Excitement
- Suspiciousness
- Aggression

NEGATIVE SYMPTOMS

- These are capabilities that are lost from the person's personality
- Social withdrawal
- Extreme apathy (lack of interest or enthusiasm)
- Lack of drive or initiative
- Emotional flatness
- A volition; this is decrease in the motivation, will power, drive and ambition to perform self-directed purposeful activities
- Stereotyped thinking; a negative thinking towards a group of people e.g. all nurses are rude
- Lack of spontaneity; patients cannot do anything in a natural way that is, they cannot do things spontaneously.

FUNDAMENTAL SIGNS AND SYMPTOMS OF SCHIZOPHRENIA

- Thought disturbance; i.e. Mutism, neologism (creating new words that don’t exist), incoherence, thought block etc.
- Autistic behaviour; Autism is a slow progressive withdrawal from reality. The patient loses interest in his environment, is remote and preoccupied with fantasy.
- Volitional disturbance; this is deterioration in will power and self-drive apathy may become so profound that self-neglect occur

FUNDAMENTAL SIGNS CONTINUE

- Emotional disturbance; i.e. depression, elation, ecstasy (a state of extreme happiness), perplexity (a state of feeling confused and frustrated because one doesn’t understand something)
- Perception disturbance; mainly auditory hallucinations
- Behavioural change; commonly occurring behaviours are catatonic stupor, echolalia, echopraxia, mannerism etc.

TYPES OF SCHIZOPHRENIA

- **Paranoid schizophrenia**
- Here the patient has persecutory delusions that individuals or group of people want to harm him. They always spend time thinking about ways of protecting themselves from such people. Associated features include unfocussed anxiety, anger, argumentativeness and violence.

Hebephrenic (disorganised) schizophrenia

- Disorganised thinking and behaviour are the essential features here. The person may have incoherent and illogical thinking and speech. This makes it difficult to perform daily activities like bathing, washing, preparing and taking meals

CATATONIC SCHIZOPHRENIA

- Psychomotor disturbance is a common feature here. They may take form of catatonic stupor or catatonic excitement.
- **Catatonic stupor** is characterised by a state of extreme psychomotor retardation, there is decrease in spontaneous movements and activity. Mutism, negativism and waxy flexibility are very common
- **Catatonic excitement** is a state on extreme psychomotor agitation. The movements are purposeless are usually accompanied with continuous incoherent verbalisation and the patient is usually aggressive, and destructive.

RESIDUAL SCHIZOPHRENIA

- This occurs when an individual has ever had an episode of schizophrenia with prominent psychotic symptoms (delusions, hallucinations or violence). At a residual stage, there is continuing evidence of the illness although there no psychotic symptoms. Patient may have symptoms like; impairment in personal hygiene, illogical thinking or apathy

SCHIZOAFFECTIVE DISORDER

- This disorder is manifested by behaviours of schizophrenia with strong element of symptoms associated with mood disorders (mania or depression). The patient may present with depression, psychomotor retardation and suicidal ideations or euphoria, grandiosity and hyperactivity but with presence of schizophrene symptoms like incoherent speech, bizarre delusions or prominent hallucinations

SIMPLE SCHIZOPHRENIA

- This is uncommon with insidious onset. Here patients have wondering tendency, idle and do aimless activities.

UNDIFFERENTIATED SCHIZOPHRENIA

- Here patients have prominent psychotic symptoms that cannot be classified under any previous types.

CLASSIFICATION OF SCHIZOPHRENIA

- **Acute schizophrenia**
- The time from which the patient begins to show signs of the illness and the beginning of the illness is at least 6 months and not more than 2 years.
- **Chronic schizophrenia**
- The time between the contract of the illness until when symptoms begin to show is more than 2 years

Management of schizophrenia

- This can be divided into the following;
- Diagnosis
- Psychosocial support
- Medical treatment
- Nursing care

Diagnosis

According to the DSM-IV the diagnosis of schizophrenia is made on the following grounds.

- Two or more of the following major symptoms.
- -Delusions
- -Hallucinations
- -Disorganized or catatonic behavior
- -Disorganized speech
- -Negative symptoms ie flat affect Alogia and lack of drive

- Impaired social economic functioning
- The illness is not due to physical condition.
- The duration of symptoms should be at least for one month for active symptoms and six months for non-active illness.
- The illness is not due to a physical condition

Psychosocial management

- The disease tends to become worse as time goes on the main goal of treatment is to reduce on the severity of psychotic symptoms.
- Schizophrenia is the most difficult mental disorder to treat management requires team work and patients cooperation.
- Support groups are very important for the family and patient as well. ,e.g.; the hearing voices group, schizophrenia fellowship etc
- Use of antipsychotics to treat psychotic features
- The side effects of antipsychotics use Artane (Benzohexol, promethazine, Procydline, or Tetrabenazine.
- The negative symptoms should be treated by occupational therapy and behavior therapy.

Medical management

Generic name	Trade name	Daily Dose	Side effects
Chlorpromazine	Largactil	100mg-300mg, od, bd, tds	Sedation, tremors, parkinsonism, restlessness, blurred vision, dry mouth, hypotension, weight gain, dulling saliva, sexual dysfunction, constipation
Trifluperazine	Stelazine	5-30mg in divided doses bd tds	Sedation, tremors, parkinsonism, restlessness, blurred vision, dry mouth, hypotension, weight gain, dulling saliva, sexual dysfunction, constipation
Haloperidal	Haldol	5-10mg bd, tds	As of chlorpromazine
Olanzapine, Quetiapine		10=20mg	Weight gain, sedation, Precipitation of diabetes and other metabolic conditions
Risperidone	Risperdal	2-6mg	Weight gain EPSE, Prolactin secretion

Use of deport ant psychotics like; for patients with poor drug compliance and severe symptoms.

Drug	Dose	frequency
Fluphenazine decanoate	25mg-100mg	3weeks-4weeks
Haldol decanoate	50mg-100mg	3weeks-4weeks
Fluanxol depot	20mg-40mg	3-4 weeks
Clopixol depot	200-400mgs	3-4 weeks
Clopixol Acuphase	50-100mg	In acute phases 72hours

Nursing care

- **Nursing care**
- It is advisable to admit patient for proper diagnosis and management.
- Ensure that patient gets treatment as prescribed.
- Encourage self care.

Differentials

- Delusional disorder
- Depression and mania
- Personality disorder
- Epilepsy
- Substance abuse

Prognosis

- In the past prognosis was taken to be poor but this has been reversed with the help of the following;
- New medicines
- Family psychosocial support is good
- Sudden onset.
- Absence of family history of mental illness.
- Good personality of an individual is suggestive of good out came.
- **The reverse is true for poor prognosis**

ORGANIC BRAIN DISORDERS (OBD)

or

ORGANIC BRAIN SYNDROM(OBS)

Introduction

- These are mental illnesses that arise due to physical illness that affect the brain either inside or outside the brain activity.

Prevalence

- According to (Ovuga 2006) 48% of the mentally ill in Africa suffer from organic brain disorders (OBD).

Classification

Organic mental disorders can be classified as follows;

- Delirium
- Dementia
- Amnestic disorders
- Organic affective disorder
- Organic psychotic disorders
- Organic anxiety disorder
- Alcohol and drug abuse
- Epilepsy

DEMENTIA

Introduction

- Dementia is a chronic organic mental disorder with decline in mental ability that usually progresses slowly in which memory, thinking, judgment and inability to pay attention and learn are impaired and the personality may deteriorate.

Prevalence

- It is a disease associated with older people usually above 65 years this is referred to as Senile Dementia.
- In people below 65 years it is called pre-senile dementia.
- According to (Nakasujja 2002) in Uganda about 30% of HIV/AIDS patients have dementia.

Classification and A etiology

- It is classified according to the cause and the commonest cause is Alzheimer’s disease. Alzheimer's Disease is a disease of older people thus the names senile dementia if it occurs in those above 65 years and pre-senile dementia in those below 65 years . Causes of Alzheimer's disease include;

- The cause of senile dementia is associated with the weight of the human brain. It decreases by approximately 5% by the age of 30 and 70 years, it further decrease by 5 % by the age of 80 and by another 20% by the age of 90 years. and there is some loss of nerve cells As well as widening of the ventricles and flattening of the cortical sulci.
- Hypoactivity of neurotransmitters especially acetylcholine has been associated with Alzheimer's disease. There is loss of cholinergic neurons

Other causes of dementia include

- Vascular dementia or stroke
- Alcohol drugs and toxins
- Hydrocephalus
- Head trauma
- Degenerative diseases like Parkinson’s disease
- Infections like AIDs and Neurosyphilis
- Brain tumors
- Nutritional deficiencies like Vitamin B12 and Folic acid
- Metabolic disorders like Hypothyroidism

Signs and Symptoms

- Dementia in most cases has a gradual onset and worsens over time.
- There is memory impairment since they are unable to learn new thing or recall new information.
- Patient is disoriented even in places of residence, friends and family.
- Impairment in intellectual functioning, they complain about difficulty in concentration, being unable to perform duties that require thinking, planning, organizing and sequencing events.

- They have mood changes they are usually irritable.
- Language is affected with difficulty in finding words or naming objects and inability to construct meaningful sentences.
- Changes in behaviors usually they regress to childhood behaviors.
- They may loss motor functioning as individuals may fail simple motor activities such as walking.

Diagnosis

- **Forgetfulness is usually the first sign**
- **Diagnosis may depend on overall situation basing on age, family history and onset of symptoms**
- **A computed tomography (CT) or magnetic resonance imaging (MRI) scan could rule out a brain tumor, hydrocephalus or a stroke. In Alzheimer's the brain CT may show brain atrophy.**

Patient Information

- Dementia is progressive deteriorating disease treatment and other therapies only slow down the rate of deteriorating.
- **Nursing Management**
- Maintain a familiar environment as it helps the person to stay oriented.
- Establish a regular routine for all activities like bathing, eating a well balanced diet, sleeping gives person a sense of stability.
- Avoid scolding or punishing a person as it may worsen the situation.

- Ensure adequate nutrition and fluid intake.
- Teach patient on self care.
- Psychotherapy to family to be tolerant to patient’s behaviors and constantly remind patient on what to do and on what happened before.
- Respect and protect the dignity of the patient.
- Investigate fully the patient to rule out organ failure and other infections.

Medical Management.

- Treat underlying physical illnesses
- Use of high potency vitamins like B1,B2,C,E would help in intellectual functioning
- Symptomatic control like use of antidepressants in case of depression, antipsychotics in case of psychotic features may be used.
- A few drugs such as Donepezil are now available to treat dementia by these are thought to rather slow the progress of the disease and require treatment by specialists.
- Refer to a mental health worker for advise on further management.

Prognosis

- Dementia is a progressive irreversible deteriorating disorder no much treatment is available to reverse the symptoms.
- Family social support is important to show love and care plus frequent visiting of the affected person.

EPILEPSY

Introduction

- Epilepsy is a neurological condition characterized by recurrent abnormal electrical discharges from the brain which are repetitive, and cause disturbance in body movements, behavior perception, sensation, emotions, with or without loss of consciousness. It occurs suddenly, disappears spontaneously and has a tendency to re occur.
- It is commonly known as a falling sickness.

Prevalence

- It is estimated that 0.5% of the global population is affected by epilepsy. Ovuga eta l (1992) found the prevalence of epilepsy in Uganda range from 0.21-2% of patients attending out patient. It is one of the commonest health problems seen in general out patients and psychiatric out patients. Studies showed that 40%- 60% of cases attending psychiatric outpatient have epilepsy (Ovuga eta l 1992).

- The reason as to why we look at epilepsy in the psychiatric setting is that it affects the brain, some of the signs and symptoms mimic psychiatric disorders and the complications of epilepsy usually end up as psychiatric disorders.

A etiology

- **The cause of epilepsy is not known in majority of the cases** However the following are considered to be the risk factors.
- Hereditary or genetic factors as it tends to run in families
- Birth injuries which may include delayed delivery causing asphyxia to the child, head injuries during the process of birth.
- Febrile fits may predispose to epilepsy

- Tumors and other space occupying lesions
- Stroke/ cerebral vascular accidents
- Head injury
- Infections that affect the brain e.g., meningitis HIV and AIDS, Brain abscesses, and encephalitis.
- Alcohol and other substances of abuse

Triggering factor of a seizure/ fit

- Emotional arousal like fear, anger, excitement.
- High fever
- Fasting and starvation
- Flickering lights
- Alcohol intoxication and withdrawal
- Fatigue and boredom
- Monthly periods in women

Classification

- Epilepsy can be classified into two main groups:- Generalized seizures and Partial seizures.
- Partial seizures may be secondarily generalized

Generalized seizures

- **Grand mal Epilepsy (Generalized tonic – clonic seizure** This is the commonest type of epilepsy characterized by sudden attacks with loss of consciousness, muscle rigidity and body jerking's lasting for 3-5 minutes. During the seizures the person may sustain injuries like tongue biting or may pass urine or feaces, or may present with frothing in the mouth. At the end of the fit the person may wake up confused, wander away, become aggressive or go into a deep sleep..

- **Absences seizures (petit mal epilepsy)** These are characterized by temporary brief loss of consciousness and hence loss of concentration in the activity being performed. This loss lasts for a few seconds and may be noticed as “stare periods” or “absent mindedness”. It may be repetitive though some one does not fall though the objects held may drop hence (drop attacks). This condition is more common in children

- **Status epileptic us** (Continuous fits) this is usually a complication of grand-mal epilepsy it is both a medical and a psychiatric emergency. Here fits follow one another in succession without the patient regaining consciousness between them.

Partial Seizures

- **Simple partial Seizures** (**Jacksonian fit).** this is a focal type of epilepsy affecting a specific part of the body. The seizures have a specific origin in the brain supplying a particular part of the body hence causing that part to jerk.
- If the origin is in the motor part supplying the hands it is only the hands that will jerk though the fit may slowly spread from one figure and involve the whole arm then the whole body becoming generalized. Simple Partial seizures may be thus present with motor symptoms, sensory symptoms or autonomic symptoms.

- **Temporal lobe epilepsy (psychomotor seizures /Complex partial seizures /. In this type of seizure** the abnormal electrical discharges originates from the temporal lobe of the brain. It is characterized by alteration in the level of consciousness, loss of memory, mood swings, strange behaviors, perceptual disturbances, with in coordinated movements. A person may perform complex activities and may not remember what they did after the attacks.

Diagnosis of epilepsy

- The diagnosis of epilepsy is not readily accepted mainly by the career of the patient with the condition.it is therefore important that the correct diagnosis is made early to prevent neurological and psychiatric complications, promote adequate control and improve patients wellbeing and quality of life for those affected.

- The diagnosis is mainly clinical based on detailed history taking investigating the clinical signs and symptoms.
- Electro encephalography (EEG) may reveal epileptiform activity however a normal EEG does not necessarily mean a person is okay as some forms of epilepsy will not show.
- CT scanning of the brain may show the presence of a tumor or any other space occupying lesion
- Skull x-ray may show injuries to the skull and lesions such as calcification or increased intracranial pressure.

Differential diagnoses

- Fainting (Syncope)
- Hysterical fits(Conversion Disorder with Pseudo seizures
- Bronchial asthmas
- Migraine headache

Management of epilepsy

- Carry out a detailed assessment including specific biomedical and psychosocial investigations.
- Clearly explain the disease to the patient and care givers.
- Explain the need for daily compliance with treatment.
- Explain the outcomes of medication.
- Advise the patient to keep a diary of the fits, the time they occur, their duration and complications and encourage them to bring it at every visit to the hospital.

- Explain the triggering factors and the need to avoid them.
- Explain to the care givers that epilepsy is not infectious so that can give support to the patient.
- Explain that the purpose of medication is to control seizures by reducing their frequency till when the doctor decides to stop the medication which should be at least 2 or three years after the last fit. Refer to the if no change is seen after an adequate dosage for a specific duration of time.

Generic Name	Trade Name	Indication	Dose	Side effects
Phenytoin	Epanutin	Partial and generalized seizures and status epileptic us	Adult200mg-600mg/day 24 or 12 hourly. Children 5-6mg/kg	Ataxia, drowsiness, double vision, slurred speech, gum hypertrophy
Carbamezepine	Tegretol	Partial and generalized seizures	Adult 300-1600mg/day 8-12hrly	Ataxia, drowsiness, nausea and vomiting, hyperactivity, Steven Johnsons syndrome do not give in pregnancy.
Phenobarbitone	Luminal	Partial, generalized and status seizures	Adult 60-240mg/day children 4-5mg/kg/day with in 12hrs	Drowsiness, ataxia, drowsiness, aggression in children, hyperactivity, insomnia, and liver damage
Sodium valproate	Epilim/Valparin	Absence seizures and all other types	Adult 500-3000mg/day children 20-50mg/kg/day within 12 hours	Tremors, irritability, nausea and vomiting do not give in pregnancy
Ethosuximide	Zarontine	Absence seizures	Adults1-2G/day/children 20-40mg/kg/day within 12hours	Abdominal
Lamotrigine	Lamictal			

Management of a grand mal fit

- Keep calm do not panic
- Protect the patient from not hurting him/herself by removing him/her from danger or removing danger from patient’s environment.
- Loosen tight clothing’s
- Protect the patients head with a soft ground or put your palms for him/her to hit the head and let him not obstruct the airway.

- After the fit put patient in a semi prone position to help in breathing and recovery.
- Stay with the patient till recovery.
- Reassure the patient so that is not ashamed or embarrassed.
- Clean the patient and take care of injuries if any.
- Orientate the patient of the surroundings and Let him/her know what happened.
- NB. During the fit **DONOT** give anything by mouth it might suffocate the patient.

.

- N.B In the treatment of status epilepticus is, follow the above treatments but add on;
- Children 10years or less give rectal diazepam (valium) 5mg immediately and refer.
- Adults Rectal diazepam 20mg or IV 15mg and refer.

Information to the community

- Epilepsy can be controlled on treatment
- It is not an infectious disease
- It is not caused by witch craft
- A person with epilepsy is not mad
- There is no lizard in the patients head.

ANXIETY DISORDERS /NEUROSISES

- All people face fear and anxiety. Fear is an emotional, physiologic and behavior response to a recognized external threat.
- Anxiety is unpleasant emotional state that has a clear source. It is often accompanied by physiological and behavioral changes similar to those caused by fear and because of this people always use these terms interchangeably.

Prevalence

- Anxiety disorders are the most common mental disorders and at least 9% of the general population suffer from anxiety disorders (Ovuga 2006).

A etiology

- Primary anxiety is associated with genetic causes, stressful events and personality factors.
- Anxiety may also be secondary to psychiatric disorder e.g. depression ,schizophrenia
- General medical condition like hypertension, hyper thyroidism, temporal lobe epilepsy etc.
- Medications like excessive use of caffeine, substance abuse e.g. alcohol withdrawal.

Types of Anxiety Disorders

- Generalized anxiety disorder (GAD)
- Selective mutism
- Separation anxiety
- Panic attacks
- Phobias
- Obsessive Compulsive Disorder (OCD)
- Post Traumatic Stress Disorder(PTSD)

GENERALIZED ANXIETY DISORDER (GAD)

- Generalized anxiety disorder consists of excessive, almost daily anxiety and worry (lasting 6 months or longer about a variety of activities or events.
- The anxiety and worry are extreme that they become difficult to control.

Common signs and symptom

- Restlessness
- Easy fatigue
- Difficult in concentrating
- Muscle tension
- Disturbed sleep
- Tearfulness
- Feeling dreadful
- Irritability
- Physical symptoms like; chest pain ,headache, stomach pain nausea, dizziness, vomiting, diarrhea, etc.

Management

- Supportive psychotherapy
- Ensure that anxiety is not due to medical or medication if so treats accordingly.
- Do muscle relaxation
- Breathing exercises
- Use an anxiolytics drug like; diazepam 5-10mg tds for not more than two weeks
- Low dose of Antidepressants e.g. Amitriptyline 25mg o.d or Fluoxetine 20mg Od.

SELECTIVE MUTISM

- This is a complex childhood /adolescence anxiety disorder characterized by child's consistant failure to speak in specific social situations in which there is an expectation for speaking e.g. at school, despite speaking in other situations.
- Child can fluently speak and communicate when they are comfortable secure and relaxed.
- It is painful to the child as the child has an actual fear of speaking and of social interaction,

causes

- 90% they have social phobia or social anxiety.
- Genetic predisposition to anxiety/temperament, easily cry, moodiness, sleep problems, shyness.
- Inhibited temperament
- Culture e.g. girls/women are trained to be submissive to men, children submissive to their parents etc.

Signs and symptoms

- Failure to speak
- No facial expression child's face is usually blank.
- Child maintains stiff body posture
- Child avoids eye contact
- Failure to play with friends/peers child has few friends.
- Child is timid.
- Child has social anxiety easily tensed or criticized by others.
- child presents with motor, communication and social development issues.
- Bowel/bladder syndrome issues due to failure to speech .
- However they are highly intelligent since they focus on academics.

Diagnosis

- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month.
- Failure to speak is not attributed to a lack of knowledge of ,or comfort with the spoken language required in social situations.
- The disorder is not better explained by communication disorder it does not occur exclusive during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

management

- Educate the parent to be understanding not to put pressure on child to speak but praise the child to any efforts made.
- Seek therapy from child psychiatrist/ clinical psychologist
- Treat anxiety
- Encourage social interaction
- Encourage non verbal communication.
- Behavior therapy positive and negative reinforcement
- Engage child in play therapy since this helps to relax and open up.
- Cognitive behavior therapy –redirect fears and warries into positive thoughts.

SEPARATION ANXIETY

- This is an anxiety disorder In which an individual develops inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached.
- The fear or anxiety is or evidence is persistent, lasting at least 4 weeks in children and adolescence and typically 6 months or more in adults.
- The disturbance causes clinically significant distress or impairment in social occupational or other important areas of functioning
- Disturbance is not better explained by another mental disorder ,such as hallucinations, delusions, autism spectrum disorders e.tc.

causes

- Psychological disturbance and excessive attachment to attached figure and other care givers (mother-child separation).
- Environmental factors e.g. stressful life events, loss of a loved one or a pet, parent divorce, change of school, neighborhood, natural disasters.
- Genetic factors e. child is always timid, shy, prone to anxiety.

Signs and symptoms

- Recurrent excessive distress when anticipating or experiencing separation from home or from major attached figures
- Persistent excessive warry about loosing major attachment figure or about possible harm such as; illness, injury, disaster or death.
- Persistent and excessive worry about experiencing traumatic event e.g. getting lost, being kidnapped, having an accident, becoming ill, that causes separation from a major attached figure.

- Persistent reluctance or refusal to go out, away from home, school, work or else where because of fear of separation
- Persistent reluctance or refusal to sleep away from home or to go sleep without being near attached figure.
- Repeated night mares involving the theme of separation
- Repeated complaints of physical symptoms e.g. headaches, stomachaches, nausea, vomiting when separation from attached figure is anticipated or occur.

management

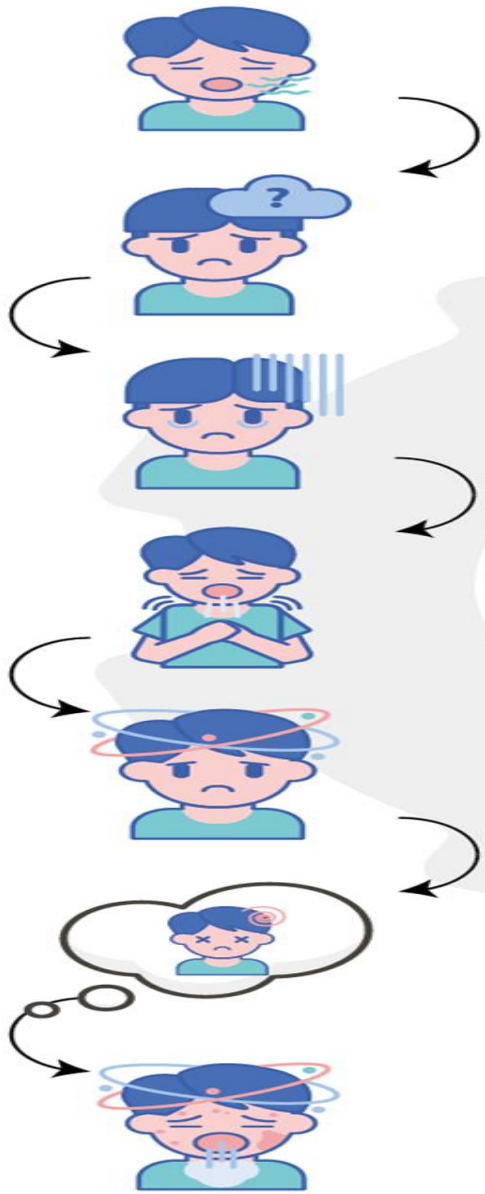
- Counseling
- Psychoeducation to the child and family to be aware of the disorder
- Positive and negative reinforcement.
- Frequent socialization arrange frequent visits to social gatherings church ,schools etc.
- Ignore child's fake illnesses and do not give attention.
- Spiritual therapy as you teach the child to let things be as God is in control.

PANIC ATTACKS

PANIC ATTACKS

- Panic is an acute and extreme anxiety with accompanying physiological symptoms. The attacks occur spontaneously and unexpected and they may range from several attacks a day to a few attacks a year.
- These attacks should not arise from substance abuse, medical condition or other mental disorder.

How a panic attack develops



Notice a body sensation
"My breathing feels odd"

Have a thought about it
"Could this be dangerous?"

Feel apprehensive

Anxiety strengthens the body sensations
Have more thoughts
"This is really bad"

Pay more attention to the body
Feel more apprehensive

Have even more catastrophic thoughts
"This is getting even worse"
"I think I'm going to pass out"

Feelings of panic reach their peak

Signs and Symptoms

- Sweating
- Palpitations
- Trembling
- Sense of shortness of breath
- Chest pain
- Dizziness
- Fear of losing control

- Fear of dying
- Tingling sensations
- Chills and hot flashes
- Feeling of chocking
- It may be accompanied by fear of places or situations without immediate escape in case of a panic attack (Agoraphobia)

Management

- Most people recover without treatment
- Breathing expired air in a polythene bag may prevent stop an attack
- Psychotherapy to resolve psychological conflict
- Discourage use of caffeine and alcohol.
- Refer to clinical psychologist for CBT

PANIC ATTACK

- Symptoms are more intense and can cause a major disruption in your day.
- Characterized by 4 or more of the following symptoms:
  - Heart palpitations, pounding heart
  - Excessive sweating
  - Trembling or shaking
  - Sensations of shortness of breath, difficulty breathing
  - Feeling of choking
  - Chest pain or discomfort
  - Nausea or abdominal distress
  - Feeling dizzy, unsteady, lightheaded or faint
  - Feelings of unreality or being detached from oneself
  - Fear of losing control or going crazy
  - Fear of dying
  - Numbness or tingling sensations
  - Chills or hot flashes

ANXIETY ATTACK

- Anxiety intensifies over a period of time.
- Stress may reach a level that is overwhelming and feel like an "attack".
- Symptoms of anxiety may include:
  - Muscle tension
  - Disturbed sleep
  - Difficulty concentrating
  - Fatigue
  - Restlessness
  - Irritability
  - Increased startle response
  - Increased heart rate
  - Shortness of breath
  - Dizziness
- Symptoms may be persistent and very long-lasting

- Drugs used include antidepressants like; fluoxetine 20mg mane once a day, Imipramine 25mg-50mg once a day.
- Anti anxiety drugs like; benzodiazepines e.g. Diazepam 5mg-20mg once a day but do not exceed two weeks for fear of addiction.

PHOBIAS

❖Phobias are persistent, unrealistic, intense anxiety and fear in response to specific external situation or object that produces a conscious avoidance of a feared situation/ object.

cause

❖Exposure to the feared situation or object evokes strong anxiety symptoms.

The common types of phobias are;

- **Social phobia** here a person has a strong and persistent fear of a situation in which embarrassment can occur usually a person has problems with crowds, public speaking or eating in public, etc.
- **Agoraphobia** fear of being in closed places where exit is not so easy to access.
- **Specific phobia** is a persistent fear of an object or situation the common ones include; fear of animals, fear of natural environment, fear of blood injections, fear of situations like future plans

- **Systematic Desensitization** ,the client is gradually exposed to the feared situation or object till the fear disappears.
- **Cognitive restructuring-** this focuses on the critical analysis of a feared situation or object find justification for your anxiety.

Medication

- Use of an anxiolytic may reduce on the problem but these drugs should not be used for more than two weeks.
- Diazepam 5-10mg tds for not more than two weeks.
- Chlordiazepoxide 10-20mg daily.
- **N.B Getting this problem treated can help a person feel better, relaxed. Try to help the person to stay positive and encourage them to face their fears.**

OBSSESSIVE COMPULSIVE DISORDER

- Obsessive compulsive disorder is characterized by the presence of recurrent, unwanted, intrusive ideas, images or impulses that seem silly, weird, nasty or horrible (obsessions) with an urge or compulsion to do something that will relieve the discomfort caused by an obsession.

- Obsessive compulsive disorder occur in about 2.3 percent of adults and occur equally in both male and females.
- These people are aware of that their obsession do don’t reflect actual risk and that their behavior is bizarre but they have no control over it.

Clinical picture

- **Obsessional symptoms include**
- Thoughts
- Ruminations
- Impulses
- Phobias
- Compulsive rituals
- Abnormal slowness
- Anxiety
- Depression
- Depersonalization

- **Obsessional thoughts**, theses are unpleasant words, ideas and beliefs organized by the patient as his own that forcefully intrude his mind.
- **Obsessional ruminations**, these are internal debts with arguments for and against actions that may not have been completed accurately like closing the door, turning off gas that individual keeps on checking over and over.
- **Obsessional impulses**, these are urges to perform acts usually of violent or embarrassing like injuring a child, shouting in front of people.
- **Obsessional rituals**, these include mental activities like counting repeatedly, washing hands over and over.
- **Obsessional phobias**, theses could be obsessional thoughts about harming other people so individual avoids places where knives are kept.

Treatment

- It is important to remember that compulsive disorder is accompanied by depression so identify it and treat concurrently.
- Exposure and Response prevention therapy where a person is exposed to the situation or people that trigger obsessions, rituals or discomfort anxiety gradually will diminish if a person is prevented from performing a ritual, or discomfort.

- Cognitive therapy seeks to reduce attempts to suppress and avoid obsessional thoughts.
- Anti depressants like fluoxetine, sertraline reduce on obsessional symptoms.
- Anxiolytic drugs give short relief but they should not be prescribed for more than 3weeks if needed longer small doses of antidepressants should be used.

POSTTRAUMATICSTRESSDISORDER (PTSD)

- This is an anxiety disorder caused by exposure to an overwhelming, traumatic event, in which the person later repeatedly re-experiences the event as if it is happening.
- The individual must have been the victim, witnessed or the perpetrator to suffer from this disorder.

Causes of PTSD

Natural disasters

- Earthquake
- Storm
- Floods
- Bush fire
- Accidents

Manmade disasters

- Rape and Defilement
- Domestic violence
- Armed conflicts
- War
- Hostage and kidnapping
- Suicide bombing
- Political torture

Symptoms of PTSD

- Terror the intense fear that the situation is happening again.
- Disconnection as if one is in his or her own world.
- Disbelief which is un willingness to accept what has happened.
- Sleep disturbance with frightening dreams about the event.
- Emotional numbness one cannot feel joy or sadness
- Flash backs experiencing the events of trauma in full awakening.
- Avoidance of situations that remind them of trauma

- Hyper arousals at any startle response.
- Irritability
- Unpredictable reactions of aggression and violence.
- Depression, anxiety, substance abuse and suicidal behavior are common.
- Loss of appetite
- Multiple body complaints.
- Loss of function of some body parts like becoming deaf, blind or paralyzed.

Treatment

- Management of trauma involves a combination of therapies like drugs behavior therapy and psychotherapy.
- In behavior therapy the client is exposed to situations that may trigger memories of painful experiences. Initially client will be uncomfortable but with time the distress will lessen.
- Psychotherapy will focus on the negative feelings the client have and try to focus on the positive side so that the client comes to time with what happened.

- Encourage client to talk about their stories or write about them over and over.
- Relaxation exercises may be of great importance to take away the tension.
- Drug intervention is not the best way to treat PTSD but you use them when there is need. This could be antidepressants to treat depression and anxiolytics in case of anxiety features.
- **N.B** All therapies should aim at helping the client regain sense of control and hope to recover. Focus on the immediate needs encourage client to review the trauma over and over and assess the risk of recurrent trauma and prevent it

MENTAL HEALTH AND HIV

Introduction

- **HIV** stands for Human Immune Virus and **AIDS** for Acquired Immune Deficiency Syndrome. AIDS is a late manifestation of HIV infection.
- This is a pandemic that has far reaching psychosocial effects and yet its treatment has been largely Biomedical.
- The biomedical models limits the assessment of HIV and AIDS health workers should know that patients may have mental health problems and if these are not addressed, the general overall outcome remains wanting.
- On the other hand persons with mental illnesses may require additional specific HIV intervention to meet patients needs.

Relationship between HIV and AIDS and Mental illness.

- The relationship between HIV and mental illness is a bi directional one with HIV/AIDS predisposing to mental illness and mental illness predisposing to HIV/AIDS.

HIV and AIDS  **Mental Illness**

Causes of mental illness among patients with HIV/AIDS

The effects of HIV/AIDS on the brain fall under the following categories;

- **Direct viral effects on the brain**. The virus invades the brain up to 90% of cases and these results into acute inflammation, abscesses and other degenerative changes.

❖**Indirect effects may occur as result of**

- Opportunistic infections like tuberculosis, cryptococcal meningitis, toxoplasmosis and progressive multifocal leukoencephalopathy.
- Malignant tumors (neoplasms) like lymphomas and Kaposi’s sarcoma
- Side effects of the medications like, Efavirenz and zidovudine, and anti TB drugs which can also cause psychiatric disturbances.
- The nature of the HIV/AIDS as an illness that is chronic, fatal and associated with a lot of stigma also predisposes patients to mental illness.

Individual psychological reactions

- **Acute stress reactions.** These manifest after individual has learnt that she/he is HIV positive they are psychologically tortured to the diagnosis.
- They are not due to effects of the virus to the brain tissue.
- They are common in almost 90% of people who are newly diagnosed
- Individual expresses shock, despair, grief, guilt, anger, shame, worry, anxiety and depression.
- This kind of reaction may last for several weeks so supportive counseling is important.

- **Adjustment problems** The individual fails to cope with the fact that he/she is infected and the acute stress reactions is prolonged and presents with significant psychological emotional or behavior symptoms like; anxious mood, depressed mood , mixed emotions or conduct disturbance such as violation of others rights e.g. fighting, promiscuity ,alcoholism and others.

- **Anxiety disorders** These occur in about 20% of AIDS patients.
- Episodes of anxiety may take several months and present with worry, muscle tension autonomic arousal restlessness irritability difficulty in concentrating poor sleep, fear of dying and other physical symptoms.
- Obsessive compulsive disorders may also occur These symptoms become increased during time of stress such as at sero conversion or at the onset of physical symptoms or with advanced symptoms of the disease.

- Use of supportive therapy, and use of anxiolytics like diazepam 5-10mg bd, Alprazolam 0.5mg-1mg tds may help.
- Some patients may require antidepressants such as Fluoxetine (20-40mg per day) if the symptoms persist
- Adequate pre and post counseling may prevent most of these psychological reactions.

Pre-morbid Psychopathology and causes of HIV among patients living with mental illness

- A number of personality, behavior, occupation and family factors have been associated as posing high risk to acquiring HIV/AIDS. Pre existing psychiatric illnesses may predispose their victim to HIV/AIDS or confuse the diagnosis example being;
- **Mania** these patient have behaviors associated with high libido and sexuality. Impulsive over involvement in joyous activities making it easy to contract HIV/ AIDS or spread it.
- **Psychotic disorders** these usually include total distortion of realty with false beliefs (delusions) and false sensations(hallucinations) this may worsen drug compliance or make one easily to acquire HIV/AIDS.

- **Mental retardation** where ones intellectual ability is below what is expected for the chronological age. These people are easily manipulated by the normals in the society and may be sexually taken advantage of and may contract HIV/AIDS.
- **Substance Abuse** intoxication of substances impairs ones judgment and reasoning which makes people predisposed to HIV/AIDS. Sharing of needles among intravenous drug abusers and accidents, prostitution to finance the addiction all predispose the person to the disease.
- **Delirium** the acute confessional states might make some one wonder around hence predisposing her to HIV and AIDS
- **Dementia** due to memory impairments one may wonder around hence predisposing one to HIV and AIDS.

Other psychiatric problems and HIV/AIDS can be classified as follows

- Psychiatric Syndromes associated with HIV/AIDS
- Pain syndromes
- Social and family reactions

Psychiatric syndromes associated with HIV/AIDS include

- Organic affective disorders
- HIV related depression
- HIV related Mania
- HIV related Psychosis with Schizophrenia like features
- HIV related delirium
- HIV related dementia with Neurocognitive symptoms which may include
- Impaired attention and concentration
- Memory impairment leading to being forgetful, misplacing items etc.
- Psychomotor agitation or slowness.
- Problems with language
- Visual and partial impairment
- Psychotic features like hallucinations, illusions

Pain Syndrome

- Pain is one of the most under diagnosed and undertreated complication of late stage of AIDS. Acute pain is associated with medical crises like pneumocystis, carinii pneumonia, headache syndrome, rheumatologic pain etc

Social and Family Reactions

- HIV/AIDS affects everyone in the family. Family members may develop stress, depression, anxiety, on knowing what is happening. This is mainly caused by the stigma and the nature of the disease being fatal, and chronic in nature.
- HIV/AIDS may lead to separations, divorce, family neglect, loss of employment due to frequent illnesses and absenteeism.
- It also leads to increased number of orphans and street children with associated child headed households and homes headed by the elderly who also lack employment and may not be in position to look after the orphans

Diagnosis

- The following may give a clue as to whether one is dealing with HIV related mental illness rather than a functional psychiatric illness.

- **Positive laboratory results of HIV**
- **Presence of Physical and neuropsychiatric symptoms of HIV/AIDS cough for 1/12,weight loss 10%, herpes zoster, orolphygeal candidiasis, herpes simplex, generalized lymphadenopathy etc.**
- **Presence of mental symptoms after onset of HIV/AIDS**
- **Absence of a family history of mental illness**
- **Presence of cognitive impairment**
- **Early age of onset of symptoms of dementia**
- **Late age of onset of symptoms of mania**

Management of HIV/AIDS related Psychiatric illness

- Assess the clinical status to determine the nature of current mental state.
- Develop a patients care plan depending on the needs
- Link the patient to available services to access laboratory for CD4/CD8, Toxoplasmosis, serum crag and where to access other services
- Monitor patients progress as it is likely to change as the disease progresses.
- Promote positive living and reduce risky behaviors like alcoholism, multiple sexual partners, good nutrition etc.
- Involve patient and significant care provider in his social support.

Key issues to be addressed in psychotherapy

Individual patients may experience or bring several issues to psychotherapy as follows;

- **Self –esteem,** individuals with HIV and AIDS may experience loss of self esteem, shame, guilty and self blame for having been infected by HIV. This experience may contribute to depression and suicide.
- **Parenting,** the demands associated with HIV and AIDS may disrupt normal parenting hence affecting the family relationship.

- **Fear,** people living with HIV and AIDS may experience excessive fear regarding rejection and loss of social support, disease progression and impact on their lives, pain of death and dying etc.
- **Disclosure**, as a result of fear one may fail to disclose his/her status and risk infecting spouse or giving birth to an infected newborn.
- **Loss of loved ones**, bereavement as a result of the disease may worsen psychological trauma of a person living with HIV survivors guilty may be evident.
- **Issues of compliance,** the individual who has a duo co-mobidity since patient must now take ART, psychiatric treatment, treatment for opportunistic infections if any etc.

- **Religious beliefs,** people living with HIV often develop strong religious beliefs and spiritual beliefs that help them to cope with their situation. On the other hand others may reject medications o the belief that they have been (cured by Christ) it is therefore important to evaluate these beliefs to help them accept the reality of the disease.

- **Lazarus syndrome**, an individual who has been living positively with HIV virus may experience significant improvement and reduction of symptoms. On re testing for HIV it might turn out to be negative because the virus has been suppressed **(increased antibodies + reduced viral load = increased immune system).** This person might think they have been cured and because of so they stop medications.
- But on doing this the viral load will shoot high suppressing the antibodies **(reduced antibodies + increased viral load =reduced immunity)** and this might end up killing the patient.

- **Note; THE HIV VIRUS HAS NO COMPLETE CURE THEREFORE PREVENTION IS BETTER THAN CURE.**
- More emphasis needs to be put on empowering the negatives to stay negative by reinforcing health behaviors, importance of avoiding infections and transmissions.
- Those who are positive we encourage positive living; treatment compliance, good nutrition, having one sexual partner, avoid substances of abuse, exercise, enough rest, importance of avoiding infections and transmissions and regular hospital visits.