

DEPARTMENT OF PSYCHIATRY

UNIVERSITY OF NAIROBI

PSYCHOTRAUMA TRAINING MODULE

FOR

TRAINERS OF TRAINERS

IN RWANDA

FOLLOWING THE 1994

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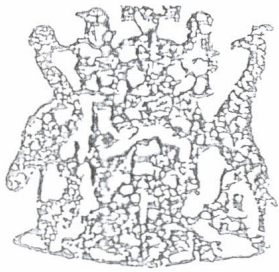


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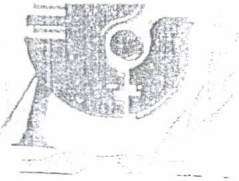
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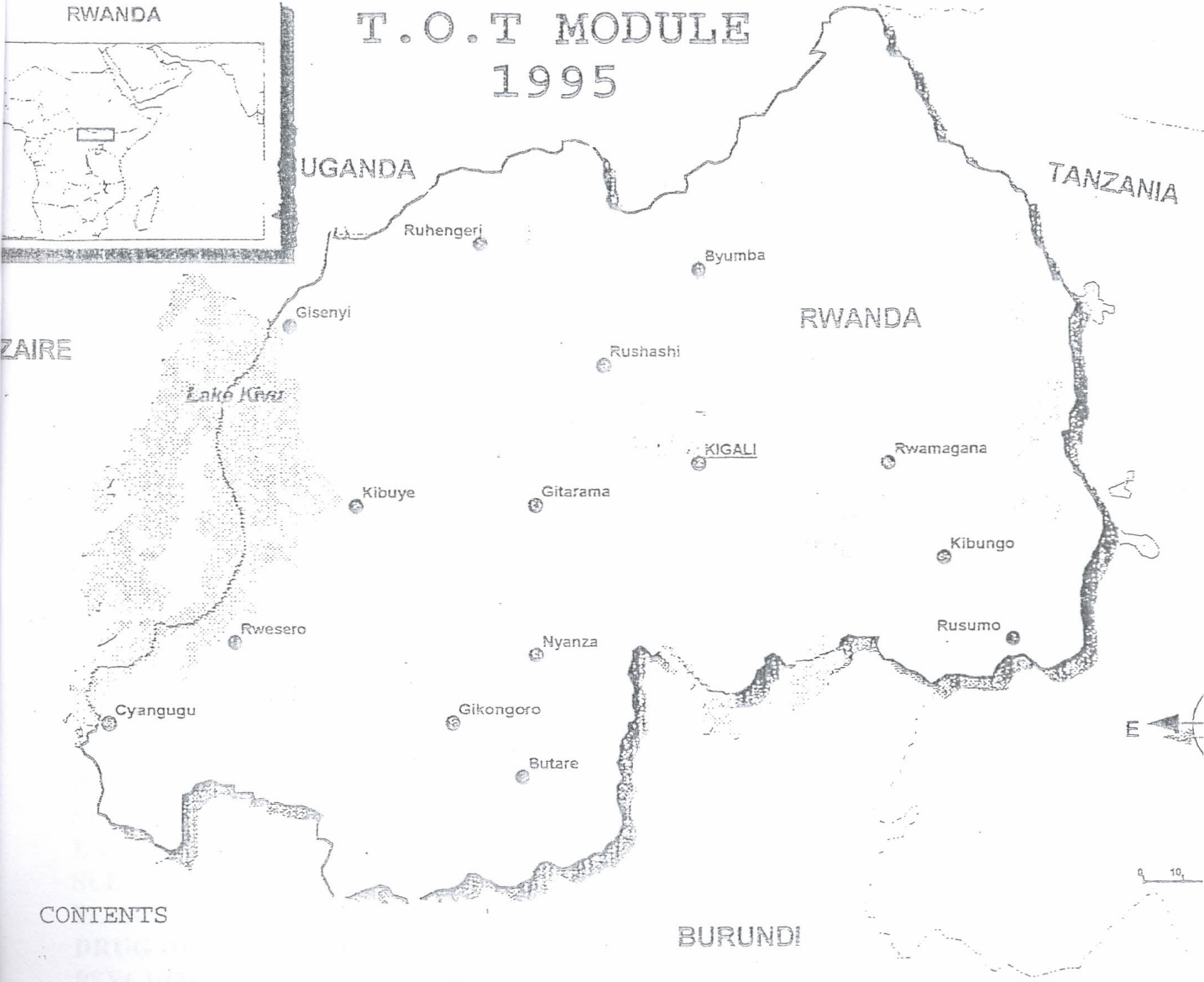
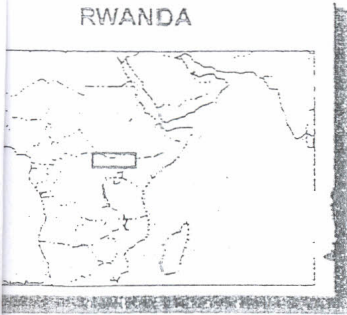


United Nations Development Fund for Women

UNIVERSITY OF NAIROBI

PSYCHOTRAUMA SEMINAR

T.O.T MODULE 1995



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TRAINING MANUAL

BY: DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF NAIROBI

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FOREWORD

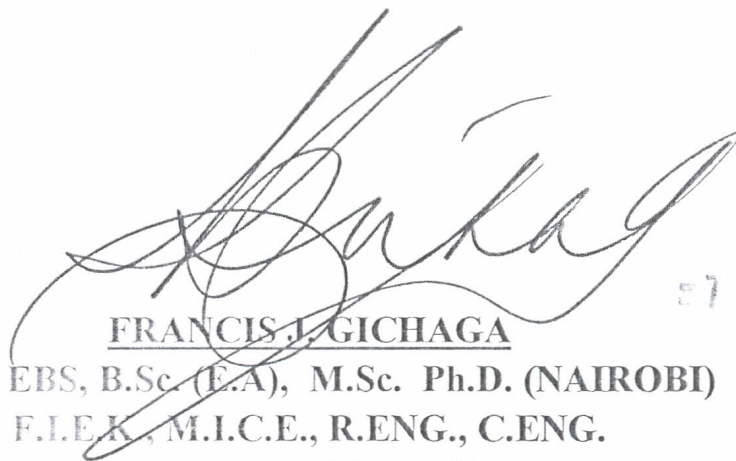
It is my greatest pleasure and honour to write a foreword for this training manual to be used to help Rwandese health professionals (doctors, nurses, psychologists, social workers) in the management of war-related emotional trauma resulting from the recent events in their country.

The University of Nairobi, has been playing a role in the training of manpower not only for Kenya but also for many African countries (including Rwanda) with special reference to Medicine where it has trained specialist doctors not to mention professionals from overseas countries who visit our medical school to gain experience in Medicine in the African setting. Whereas the tradition has been for those health professionals to come for full time training or visits to our medical school, the University of Nairobi is now going out of its own home ground to reach out the Rwandese health professionals in their own country in order to adapt the training to the local realities and to appreciate the problem better.

Hopefully, the professionals who will be trained by the team from the Department of Psychiatry will be equipped with knowledge and skills not only to help those who have been unfortunate but also to train others to keep ears and eyes open, even to experiences no one wants to hear or see. Although the human resources have been provided by the Department of Psychiatry, University of Nairobi, the logistics and financial support have been provided by (UNIFEM) United Nations Development Fund for Women and the Swedish Government to whom I express my greatest appreciation and gratitude.

We are honoured and pleased to help no matter how little in trying to restore happiness and hope to the Rwandese people where these have been eroded as a result of the war.

I hope this exercise will be a success.



27 AUG 1995

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Special thanks to UNIFEM and the Swedish Government for their financial support. The same thanks go to Ms Victoria Mutiso and Mrs Clare R. Kagwiria Buyu for availing their secretarial skills without which this module could not have been ready.

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It is not possible to acknowledge by name all those people who contributed in one way or another to make this exercise a success. Hence many thanks to anybody who assisted in any way towards the accomplishment of this training module.

DEDICATION

This module is dedicated to the victims of the recent Rwandese Genocide and Massacres who never lived to see the aftermath and to all those with similar experiences.

INTRODUCTION

The recent Rwandese war (1994) is considered as the most awful man-made disaster in our time. The killing and clashes were spread all over the country with a lot of casualties.

- (i) One million people killed (one seventh of the total population)
- (ii) Nearly 200,000 orphans
- (iii) 250,000 widows
- (iv) Several refugees and internally displaced (one third of the population)

One can easily say that almost every Rwandese fled his/her home, lost loved ones and/or properties and that everyone went through several traumatic events. Following such polytrauma and losses most victims are likely to suffer from traumatic stress syndromes as well as abnormal grief reactions. Furthermore the multiplicity and severity of traumatic events, the loss of social support enhance the rate of psychiatric morbidity: severe life events are related to a high list of mental disorders (Holmes and Rabe 1967) they are also known to precipitate relapse of existing mental disorders (Brown and Birley 1968) especially in a country without enough mental health services.

From evidence most of the victims have been subjected to attack on the body, the mind and their environment. Therefore, they present with somatic, psychological and social problems which require a holistic approach in the management, that is medical, psychological, social and spiritual. The present manual is a compilation of stress-related disorders and common mental problems likely to present during or after war time. Emphasis is given to special conditions of women who are a high risk group. Over two thirds of the population are widows according to the Ministry of Family (Kigali).

In view of the magnitude of the psychiatric morbidity and war-related psychosocial problems, this training module is the humble contribution of the Department of Psychiatry, University of Nairobi to the capacity building of health professionals in Rwanda. The herein problems are presented and dealt with in the African setting. We hope that this manual will be a reference for:

- (i) medical doctors
- (ii) nurses
- (iii) social workers
- (iv) counsellors and health professionals dealing with stress-related psychosocial problems in Rwanda.

We however appreciate our limits, as the extent of those problems can only be understood better by Rwandese themselves.



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CONCEPTS OF MENTAL DISORDERS

I. INTRODUCTION:

Specialists and lay people have very often different meanings when they refer to mental illness. The latter group refer to certain pattern of odd behaviour for which they do not have a rational explanation. Usually there is a tendency to find an understandable and acceptable cause of that behaviour:

- Cerebral malaria
- Head injury
- Witchcraft or poisoning

This is of course to be taken into consideration since a compelling literature documents that there is much "physical" in "mental" disorders.

II. DEFINITION:

The concept of mental disorder, like many other concepts in medicine and science lacks a consistent operational definition that covers all situations. A mental disorder is conceptualized as **"clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress e.g. a painful symptom/or disability i.e. impairment in one or more important areas of functioning or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom."** (DSM IV 1994)

- The syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one (grief reaction).
- Whatever the origin is, the syndrome must currently be considered as a **"manifestation of a behavioural, psychological or biological dysfunction in the individual"**.

III. MISCONCEPTIONS

- Non-specialists, when referring to mental illness, use different denominations such as
 - MADNESS
 - GOING CRAZY
 - BEING UNSOUND, FOOL

They often mean states of agitation, disordered talking, odd behaviour which are usually obvious to them.

A common misconception is that a classification of mental disorders classifies people when actually what to be classified are disorders that people have. The use of such words as "an alcoholic", "schizophrenic" are to be avoided, and replaced instead by: an individual with alcohol dependence or schizophrenia.

According to the DSM IV definition, neither deviant behaviour (e.g. political, religious or sexual) nor conflicts that are primarily between the individual and the society are mental disorders unless the deviance or conflict is a **symptom of a dysfunction of the individual**. Similarly, some reactions to overwhelming situations are considered as understandable, quite normal, since most of the people are exposed to such stressful events, would react in an expectable manner. (e.g. grief reactions, some post-traumatic reactions).

IV. STIGMA AND MENTAL ILLNESS

Several sociologists have noted that to diagnose someone as "mentally ill" leads to LABELLING (Scheff) and STIGMATIZATION (Goffman) of the person whose subsequent coping responses include:-

- Social withdrawal
- Feigning competence and
- Attempting to "pass as normal"

For those reasons, people fear anything related to Psychiatry (hospital even psychiatrists). Public attitudes to patients already labelled as "mad, crazy" constitutes a social disablement (Wing & Morris 1981). A study by Nunally in 1961 showed that public attitudes to the mentally ill were marked by fear, distrust and dislike. Psychotics were held in lower esteem than neurotics.

V. CONCLUSION

As the nervous system, the brain, is regarded as any other anatomical organ; its dysfunction (physical, biological or psychological) should be taken as any other dysfunction of the body. Terms like madness, going crazy; should be discouraged and mental illness considered equally like any other physical illness. This would facilitate social integration of psychiatric patients and reduce secondary handicaps due to stigma and labelling.

HISTORY OF PSYCHIATRY

AIM:

To familiarize the trainee with the origins of concepts in Psychiatry.

DEFINITION:

Psychiatry is the branch of medicine that deals with the treatment of mental disorders and mental subnormality.

Landmarks:

1. Pre-historic and Biblical times:

- medicine has always had difficulty in securing the right and power to care for the mental ill.
- early medicine was intertwined with religion; priests served as physicians
- all illnesses were perceived as mental and reflecting a spiritual disturbance hence ideas of possession by angry spirits, dangerous spells etc.
- mentally ill regarded as possessing supernatural powers and thought as sacred and too good.

2. Classical psychiatry

Greek-Roman era (20 B.C. - 200 A.D):

- medicine separated from religion, and natural explanations sought for events
- Hippocratic school of medicine approached the study of medicine in a holistic way (social, spiritual, physical, psychological)
- the capacity to feel, dream and think located in the brain
- Cicero (20 B.C. - 30 A.D.) classified mental illness as acute and chronic

Celsus advocated restraint and sudden fright as treatment for mental diseases.

- Galen (120 - 200 A.D.)
 - (i) Hypothesized that mental disease could be caused by a direct affliction of the brain or could be secondary to a disease process in another part of the body.
 - (ii) The seat of the soul located in nerve centres.

3. Dark ages

(early christian and middle ages)

- characterised by the fall of Roman Empire, epidemics and decline of scientific thinking.
- study of the mentally ill reverted to religion and superstition (Demonology)
 - (i) magic condemned
 - (ii) mental illness regarded as punishment for sin hence torture, prescribed to exorcise demons. In 1487 A.D. two Dominican monks published a book (Malleus Maleficarum - "the witches hammer") outlining various methods of torture for witches and mental patients.
 - (iii) Abnormal thought processes like hearing voices, odd beliefs attributed to the devil.

4. Renaissance and the Rise of Science (16th - 18th Century)

- Burning of witches and mental patients continued along side a return to a creative scientific thinking.
- 1782 A.D. the last witch to die in Europe for the same decapitated in Switzerland .
- Other inhumane treatments like blood letting, inducing vomiting and purgatives introduced.

5. Moral Treatment Era (19th Century)

- Restoration of dignity of mental patients through abolition of restraints.

- b. The Ego - that adapts the unconscious drives to the reality of life and situations.
 - c. Super Ego - comprising of values, morals or conscience that guide our behaviour and decision making.
- (ii) highlighted stages of normal psychological development and their relevance to personality, disturbances, and mental illness.
 - (iii) described two processes of thinking -
 - (a) illogical and directed by the unconscious mind as seen in dreams and psychotic states.
 - (b) Rational (normal thinking), that is adapted to reality.

7. Disciples of Sigmund Freud

Elaborated on theories of personality development and their relation to mental illness.

8. Beyond Freud

- Emil Kraepelin (1896) classified mental illness and hypothesized that it could be due to coarse brain disease.
- Eugene Blueeler (1911) coined the term "Schizophrenia"

9. Early 20th Century

- Community based approaches to mental health introduced e.g. mental hygiene, child guidance clinics, mental hospitals brought closer to the people.
- Physical treatment for major mental illnesses introduced as follows;
 - a) 1917 - Manfred Sakel - Malaria therapy for schizophrenia.
 - b) 1933 - Wagner Von Juarreg - Insulin coma therapy for schizophrenia.

- c) 1936 - Ega Moniz - Psycho-surgery (removing parts of the brain thought to cause mental disorder.)
- d) 1937 Cerletti and Bini - Electroshock therapy (passage of small currents through brain to induce a convulsion.)

- e) 1952 - Delay and Denikar - Chlorpromazine (largactil) introduced; had great impact in inducing mental hospital population.
- f) 1958 - John Kuhn - Impramine - antidepressant drug

- (iii) Social Therapy introduced as follows;
 - 1905 The first social workers engaged in the USA.
 - 1938 Family Therapy
 - 1946 Millieu Therapy

10. Past 35 years

- emphasis on research on biological psychiatry and specific psychotropic drugs to treat mental disorder.
- emphasis on biopsychosocial model of causation of mental illness and in its management.

Psychiatry in Developing Countries

- 20 - 25% of patients attending a primary health care centre hospital department or General Practitioners clinic have primarily a psychiatric illness.
- developments in psychiatry in the western world have been reflected in Africa and other developing countries.

- for the vast majority of the people in Africa and the third world ,traditional medicine is still the backbone of mental health services.
- mental health has been adopted by the World Health Organization and governments in Africa as an essential element of primary health.
- Africa lacks the infrastructure (adequate personnel, drugs, proper hospitals and community based) hence the need to integrate mental health services into pre-existing health facilities.

PSYCHOLOGY: TERMINOLOGY & SCOPE

OBJECTIVES:

To introduce the subject of psychology to the trainees by:

1. Knowledge of scope of psychology
2. Describe the various types of psychology and their relevance
3. Discuss the history of psychology
4. Explore the various schools of thought employed in understanding human behaviour

DEFINITION:

Psychology is a science that studies, observes behaviour and relates it to unseen mental environment of an organism. Simply stated psychology is a science that studies behaviour and mental processes.

SCOPE OF PSYCHOLOGY

Psychology is about yourself, it is about those questions you have always wondered about for example, who am I?, Was I born the way I am?, am I the master of my fate?, why are some people more cheerful than others?, aggressive than others?.

BEHAVIOUR

Includes things like waking, yawning, stretching, dressing, eating breakfast, walking, studying, laughing and sleeping. These are things we normally do.

MENTAL PROCESSES :

It is an activity that includes:

- thinking of ideas, learning, remembering and forgetting
- emotional experiences, such as anger, fear, joy and sadness
- desires to accomplish, revenge and acquire friendship
- problems solving and motives

Factors that influence Behaviour and Mental Processes:

- the complex human behaviour and the peripheral nerves which send messages to the brain
- identity: behaviour is governed by the influences that are transmitted through generations in form of genes. They confer traits and tendencies which predispose one to certain behaviours.
- environmental factors: actions of the other affect our behaviour to a very big extent

THE VARIETIES OF PSYCHOLOGY AND PSYCHOLOGISTS

In our definition, psychology was said to be concerned with understanding of behavior and mental processes. However, some psychologists use the knowledge to predict the course of human behaviour. They use psychological findings to help society carry on its everyday tasks, tackle its problems and improve the quality of life.

1. Experimental psychologists

These ones study basic processes on how human beings learn, retain memory and get motivated.

2. Comparative psychologists

These ones study animal behaviours and extrapolate them on or compare them with those found in human beings.

3. Physiological psychologists

These ones study the role the brain and other body functions have on human behaviour

4. Developmental psychologists

These ones study how individuals grow and change during their life span

5. Personality and social psychologists

These ones study how people differ in their enduring inner characteristics and traits and how they influence and are influenced by others.

6. Educational psychologists

These ones study educational processes and techniques of reading and the impact these have on students.

The following examples of psychologists are interested in applied sciences. They translate knowledge provided by the above psychologists into practicals.

7. School psychologists

These psychologists deal with pupils and parents. They counsel, test, evaluate pupils and analyze their learning problems.

8. Industrial psychologists

These are interested in selecting and training workers for the jobs they best fit in, improve working conditions, morale and boost staff cooperation.

9. Community psychologists

They deal with social environmental and attempt to set ways through which such an environment could better solve human needs.

10. Environmental psychologists

These ones address such issues as overcrowding, pollution and these influence human behaviour.

11. Forensic psychologists

They mainly deal with behavioural issues of legal importance

12. Health psychologists

These ones focus on lifestyles and how they can be used to improve our health

13. Clinical psychologists

These ones are always involved in diagnosing deep-seated psychological problems. They are trained in a treatment technique called psychotherapy, "talking cure" which they use to treat such patients.

14. Counselling psychologists

These are trained to help people deal with mild problems such as school difficulties, choice of vocation, marriage conflicts and so on.

SCIENTIFIC APPROACH

Psychologists systematically study human behaviour through observations, interviews, case histories, questionnaires, tests and psychological measurements. They subject their data to statistical analysis to be able to make valid inferences. They no longer rely on philosophical imaginations like the ancient philosophers did.

DEVELOPMENT OF PSYCHOLOGY

The roots of psychology can be traced to the 4th or 5th B.C. It is started with the Greek philosophers, Socrates, Plato and Aristotle. They tried to answer such questions as, are people inherently rational or irrational? are people capable of free choice? what is consciousness? do people perceive reality correctly?. Hippocrates, "the father of medicine" was interested in the normal functions of the living organism and he observed that the brain controlled all the other organs of the body as well as the behaviour.

MODERN PSYCHOLOGY

Modern psychology began in 1879 in a Germany university when Wilhem Waundt opened the first laboratory where human behaviour could be studied systematically.

SCHOOLS OF THOUGHT USED IN STUDYING HUMAN BEHAVIOUR

Psychologists have approached the study of human behaviour by developing schools of thought through which the behaviour can best be understood.

Examples of such schools of thought are:

- Behaviourism
- Gestalt psychology
- Cognitive psychology
- Humanistic psychology
- Psychoanalysis

BEHAVIOURISM

This is a school of thought founded by an American, John Watson in 1915. He advocated that psychologists should study what people do and not what they think. Watson declared that "mental life" can not be seen and can not be studied scientifically.

B F Skinner followed Watson and expounded on behavioural concepts. He believed behaviour depends on the kinds of learning to which organisms are subjected particularly which of the actions have been rewarded.

Experiments

1. Classical conditioning

This type of behaviour was experimented on by a Russian called Pavlov (1927). He presented some food to a dog and at the same time collected saliva drops from the dogs salivary glands. He noticed that there was an increase in saliva production every time the food was presented to the dog. He then paired food with another stimuli which was a sound of a bell and he noticed that the dog produced saliva as well. At a later stage the sound of a bell was enough to initiate saliva production even if there was no food presented.

UNCONDITIONED
STIMULUS
Food

UNCONDITIONED
RESPONSE
Drooling saliva

CONDITIONED
STIMULUS
Bell

UNCONDITIONED
RESPONSE
Drooling saliva

UNCONDITIONED
STIMULUS
Food

CONDITIONED STIMULUS
Bell

CONDITIONED RESPONSE
Drooling saliva

The behaviour where the dog produced saliva in absence of food when the bell was rang is called classical conditioning. The key to classical conditioning is the reinforcement which was in this case the presentation of food.

Watson paired a white cat and a loud noise and subjected both to an eleven month boy called Albert. Initially Albert had no fear for white cats but later after the experiment he could cry when shown a white cat or anything that resembled it. This was as a result of classical conditioning where Albert associated the loud disturbing noise to the cat. Early life experiences like those of Albert may result in unexplained behaviour later in life, e.g. phobia for animals similar to cats or furry objects.

Operant Conditioning

An organism, apart from showing reflex behaviour such as salivating, it can also initiate a behaviour to bring some change in the environment. The organism is said to be operating on the environment around it. This type of activity is called operant behaviour. For example, a child in a cot would turn around scratch the cot, grasps things around it and so on. The child will tend to repeat that activity which may be associated with pleasant outcome. B.F Skinner (1938) left a rat in the cage and the rat over the time learnt that if it touched a certain bar as a part of its operant behaviour the bar when pressed down could release some grains which the rat enjoyed eating. This is a kind of an **operant behaviour** which is rewarded and it was repeated severally because of the positive reinforcement. If the rewarding stopped the behaviour was abandoned, or if the rewarding was unpleasant e.g. getting an electric shock instead of grains. This is a **negative reinforcement**. According to Skinner the concept of learning depends on operant conditioning even in human beings.

Gestalt Psychology

Gestalt is a German word translated in English as 'PATTERN OF CONFIGURATION'. This school of psychology originated around the same time Watson ideas were taking root in America. It emphasized that events must be considered a whole in studying any psychological phenomenon from perceptual process to personality because - "the whole is greater than the sum of its parts"

A	<u>13</u>	C	D
11	12	<u>13</u>	14

The underlined item in each row is of course exactly the same - but what you see in this case is quite different.

What do you see in row 1?

What do you see in row 2?

Cognitive Psychology

This type of psychology is interested in all ways we learn about our environment, store knowledge, and use it to think and act intelligently in new situations. These various forms of mental activities are also called information processing. We build mental models of reality from information about the world provided by our senses which we can then examine for meaning, guidance and behaviour. Cognitive psychology has borrowed a lot from Gestalt psychology.

Humanistic Psychology (currently very popular)

Stems from Gestalt psychology, Humanistic psychology states that we have values, goals and seek to express ourselves, grow, fulfill ourselves, find peace and happiness. Humanistic psychologists believe that people will always grow in a constructive way if their environment permits them to do so and they have advocated encounter groups, sensitivity training and other forms of mental and physical acting out in an effort to achieve unity of mind and body.

Psychoanalysis

Psychoanalysis was developed by Sigmund Freud and its objectives were to assist the patients bring into awareness the unconscious desires and conflicts. In summary the techniques involved were free association where the person was encouraged to talk out all that she had without censoring. The other technique was dream analysis since dreams were believed to reveal deeply hidden conflicts. Freud regarded dreams as the royal road to the unconscious.

Freud also identified a situation he called transference where the patient projected some of their childhood feelings onto the therapist. Counter-transference tends to occur when the therapists presents the patient's projected feelings and this may result in a failed treatment.

DEVELOPMENTAL PSYCHOLOGY

Objectives:

1. To Consider the developmental stages of human beings
2. Identify possible problems at every stage of development .

Definition:

This is an example of psychology whose aims are:

1. Tracing the life cycle of a human being from infancy to adulthood
2. Determine the reasons for each observed behaviour at every stage of development

HISTORY

Important names associated with developmental psychology:-

1. Sigmund Freud, who around 1915 postulated that our behaviour depends on libido and he outlined developmental stages where libido was seen as the main focus.
2. Erik Erikson accepted Sigmund's theory but also saw developmental potential at every stage, he outlined how motor development influences autonomy.
3. Jean Pigeat introduced the concept of structured tasks e.g. when does a child crawl, talk and referred to the milestones. His theories were based on sensorimotor development
4. Many others

PHASES OF DEVELOPMENT

From the work and theories advanced by these psychiatrists/psychologists human development can be classified as below:

2. Middle years (school period)

- language is well developed
- start experiencing dreams
- can have pathological dreams reflecting their emotional state

- thus divorce, adaptation, separation and death may trigger emotional disturbances characterized by poor performance in school and episodes of irritability

3. Adolescence

At this stage children will have achieved:

- Psychosexual development - explores opposite sexes
- Cognitive development - has abstract thinking, can make associations and understand proverbs.
- peer groups influence sets in and may manifest as:
 - a. Adolescence crisis which is an attempt to obtain identity. The child becomes mildly assertive.
 - b. Adolescence turmoil (is more serious form of adolescence crisis) and is characterized by:
 - (i) being rebellious
 - (ii) delinquent
 - (iii) academic failure
 - (iv) identifying with certain heroes

Moral development

If the adolescent crisis stage is well negotiated the adolescent accepts and

1. conforms to social rules and norms
2. is able to control his conduct
3. is able to choose a career thus he/she enters into the stage of adulthood.

Adulthood

This stage is associated with several problems:

Main problems:

1. occupation (unemployment)
2. marriage (divorce)
3. individuation - accepting one as a unique and distinct from others
4. parenthood - problems with single parents with emotionally deprived children

Late adulthood (old age)

Has its own problems:

- biological changes associated with age
- emotional problems of old age
- living with expected death

SOCIAL PSYCHOLOGY

OBJECTIVES:

1. To equip the trainees with necessary elementary knowledge on how people relate within groups or societies.
2. Enable trainees approach groups for relevant information on health within the societies groups or communities in which work.
3. To understand principles used in dealing with social problems.

DEFINITION:

SOCIOLOGY:

This is a Science dealing with groups life, and social organizations of societies. It deals basically with the societies norms, beliefs, interactions and interpersonal relations within a society.

SOCIAL PSYCHOLOGY:

Is one of the many scopes of psychology which specifically studies how people think, feel and perceive their social world and how they interact and influence one another. Social psychologists are professionals whose interests are systematic study of how human development in the context of others e.g. parents, siblings, playmates and schoolmates takes place. They also study behaviours of groups or societies. They do public opinion surveys and they therefore provide us with valuable information about the operational forces in a given community.

SOCIAL FACILITATION AND DEINDIVIDUATION

Social facilitation is a phenomenon in which an organism performs responses more rapidly when other members of its species are present. For example, in human beings individuals perform certain tasks much better if they are competing, or are evaluated and the presence of others tend to raise their drive. Thus in normal circumstances people will do better in terms of output if there is competition or evaluation. This is a good advantage of social facilitation. Social facilitation may be counter productive if the task being performed is complex and is just being learned. Thus an individual feels more relaxed performing a difficult task if he is not observed or competing. Once the task is mastered then facilitation may be useful to ensure increased performance.

It is often said that "the crowd is always intellectually inferior than isolated individual". The mob tends to give individuals a sense of having lost personal identities and merged anonymously into groups. This is the concept of deindividuation.

Consequences of deindividuation include:

- release of impulsive behaviour
- loss of tolerance and restraint or monitoring behaviour
- no concern about evaluation by others, planning becomes irrational

SOCIAL APATHY

Why do by-standers at times take no action in emergency situations? A number of reasons can be cited.

1. Avoidance of physical danger, sometimes, there may be real danger and people may wisely avoid such danger.
2. Avoidance of lengthy court proceeding which may mean frequent appearances in court. People may feel threatened by such appearance and are also considered a time wasting.
3. Indecisiveness, where individuals are horrified by the emergency and left unable to act swiftly. In cases where the emergency is so horrifying on lookers are at times overwhelmed or shocked to be able to act swiftly.
4. In such emergencies everyone expects the other to intervene thus leaving the emergency unattended, the responsibility becomes diffuse meaning that nobody feels responsible.
5. Action is postponed because people are unsure whether the emergency is real or just simple transient event. For example, on lookers may confuse a drowning victim for somebody swimming and delay taking action.

Social apathy is not a very good term and 'by-standers' apathy is a more appropriate term. If this emergency occurred while the by-stander was alone, he is likely to take action. This is because there is no pluralistic ignorance which is as a result of diffused responsibility.

HOW CAN BY STANDER APATHY BE REDUCED?

1. By providing information:

- Individuals who have had instructions on first aid may intervene in emergencies compared to those without information on first aid. This is likely to be the case even if all the other on-lookers display by-standers apathy.

INTERPERSONAL INFLUENCE

Minority groups tend to be influenced by the majority groups in the community and they conform to majority's beliefs even though they may be wrong. Resistance to majority opinion is sometimes very difficult and the individual who resists may believe three things:-

- (i) that his opinion may not be comprehensible
- (ii) that he may be viewed as incompetent
- (iii) that his dissent may be construed to mean challenge to the group

Obedience to authority is a form of conformity where individuals act, not on their volition but on orders from authorities which they dare not challenge. A historical example is the Nazi execution of Jews and Vietnam war. Social norms are very powerful instruments to conformity and dissenting from them may imply abnormal behaviour. However, in situations of deindividuation, social norm such as etiquette (being polite) disintegrate.

Obedience to authority is more enhanced if there is an accepted ideology even if it was wrong. In the case of Jews execution by Hitler, Germans had been convinced that Jews were impure and needed not live amongst the Germans hence the justification to execute them.

GROUP AND DECISION MAKING

Rules and regulations that govern institutions are made not by individuals but by groups of people who constitute committees. Such group interactions may have influences on the individual members and hence the type of decisions that are made by groups.

1. Before the group meets, each individual usually has got his/her pre-discussion notions and views of the subject to be debated upon
2. During the meeting, there is sharing of new information and listening to each other's agreement
3. Because of this interaction, the individual's attitude are shifted in response to the group's informational influence
4. After this influence the group members tend to arrive at decisions that are in the same direction but are more extreme than the pre-discussion individual decisions. This is called group polarization. This group polarization tends to result into more radical than individual decisions. Another concept in groups and group-decision making is what is called group think. Group think is a tendency of some members of the decision making groups to suppressive their own dissenting opinions in the interest of the group consensus, thereby producing an inadequate decision making process and poor decisions.

How can this be avoided?

1. The group leaders should allow free open debate
2. Group leader should not impose any decision before it is fully discussed
3. Outside expertise should be sought to provide more information
4. A second chance should be availed for members to reconsider their decisions and polish doubts if any are still lingering.

REBELLION

Rebellion is non-conformity with authorities. Disobedience when it is not criminally but morally, religious or politically motivated is always a collective act and it is justified by the value of the collectivity and the mutual engagement of the members.

THEORIES OF PERSONALITY

OBJECTIVES

DISCUSS:

- 1. PERSONALITY**
- 2. NATURE OF PERSONALITY**
- 3. HISTORICAL THEORIES OF PERSONALITY DEVELOPMENT**
- 4. THE INTEGRATED THEORY OF PERSONALITY DEVELOPMENT**

1. DEFINITION OF PERSONALITY

1.0: Personality represents a pattern of deeply embedded and broadly exhibited thoughts, emotions and behaviour that persist over extended periods of time. These emerge from a matrix of biological and experiential learning. Hence personality has two facets:

1.1: How the individual interacts with the demands of the environment.

1.2: How the individual relates to demands of the self. Therefore personality is the totality of biological dispositions and learned experiences of a particular individual which results in predictable structures of overt and covert behaviours.

2. NATURE OF PERSONALITY

2.0: Personality has been variously referred to as the character or temperament of an individual. An attempt is made to differentiate the three conditions.

2.1: PERSONALITY: This refers to patterns of thoughts, emotions and behaviour emerging from a complex of bio-environmental formative matrix. This pattern persists over extended periods of a time and is relatively resistant to extinction.

2.2: TEMPERAMENT: Is the biological foundation of personality. It is the factor which accounts for the behavioural differences demonstrated by newborn infants. Some cry too much, are over active and irritable. Others are docile and easy to handle. These differences have a biological origin since these new borns have not yet learned from the environment any behaviour modifying factors. Therefore temperament can be considered as the raw biological materials from which personality will ultimately emerge. This may include the neurological, endocrine and even biochemical substances from which personality will begin to be shaped.

2.3: CHARACTER: Character may be thought of as the persons adherence to values and customs of the society in which he lives. Hence character has come to reflect a moral judgment of a person's behaviour. Meaning the extend to which a person conforms to and manifests the social morals, ethics and customs of his society. Therefore character reflects numerous and diverse environmental influences.

3. HISTORICAL PERSPECTIVES OF DEVELOPMENT OF PERSONALITY DISORDERS

3.0: The shifting sand of personality development has moved in many ways with time in order to accommodate the various concepts of human personality development. It is our intention to review some of the major and popular theories of personality which have been considered in time.

3.1: THE PSYCHOANALYTIC APPROACH

3.1.0: SIGMUND FREUD

3.1.0.1: PSYCHOSEXUAL DEVELOPMENT

According to Freud (1896) personality development followed the oral, anal and phallic psychosexual stages of human sexuality development. If these stages were properly negotiated during a child's development, the final developmental stage was a well adjusted adult. Fixation at any stage of psychosexual development led to abnormal behaviours and hence deficit personality. For instance, fixation in the oral stages led to narcissistic dependence and jealous behaviour. Fixation at the anal stage resulted in obsessiveness, orderliness, obstinacy, frugality, poor anger control and sadomasochistic behaviour. The phallic stage fixation led to competitive and ambitious behaviour.

3.1.0.2: ID, EGO, SUPEREGO DEVELOPMENT

Under normal circumstances, the mind is divided into three units. The ID, the EGO and the SUPEREGO. The ID part of the mind is concerned with immediate satisfaction of immediate pleasures no matter the consequences or circumstances. The EGO is conscious and considers the prevailing circumstance and consequences of action demanded by the ID and then allows or denies the ID demands. The SUPER EGO is the mental policeman. It is primarily concerned with normal behaviour and neurotic conflict. Hence under stressful situations, the Superego/Ego/ID conflict can result into failure of the normal psychological defense mechanisms resulting in overt abnormal behaviour mentioned earlier.

Hence the self-criticizing mental agency of the super-ego acts as the censor to deny unacceptable ideas entry into the consciousness all on moral grounds. This way, normal culturally acceptable behaviour is maintained.

3.2: OTHER PSYCHODYNAMIC THEORIES OF PERSONALITY DEVELOPMENT

3.2.0: ALFRED ADLER (1870 - 1937)

3.2.0.1: According to Addler, personality is the individuals active adaptation to the social milieu. Hence man is constantly struggling against environmental forces and his ability to adapt to their influences determines man's life style. The abnormal person has low social interest and low activity to adapt in his social setting. Hence he becomes discouraged and continues to feel inferior. The ideal normal person has high social interest and activity and strives for superiority.

3.2.1: Karen Horney (1885 -1952)

3.2.1.0: According to Horney, the individual is a biological entity set in the highly perennial environment of the family and culture and striving to develop his/her own potentialities. Every one has a "real self" which confers a sense of identity. This real self allows one to make choices and accept consequences. The real self endures despite change and growth, self realization; the unfolding and development of human potential into activities and relationships, leads to healthy activities such as self-sufficiency. If parents do not provide enough warmth and acceptance, a child may develop character neurosis as a result of abnormal personality development. Horney also observed that females were not biologically predestined to be submissive. The female normal behavior of that time (fearfulness, dependence, submissiveness, self-effacement) was culturally determined. Horney concluded that male/female character structures were products of culture and not genetics.

3.2.2: Harry Stack Sullivan (1892 -1942)

3.2.2.0: As per Sullivan, human personality is the relatively enduring pattern of recurrent interpersonal operations that characterize a human life. It is not static but subject to modification throughout life.

He states that personality development is based on the attempts of fulfilling biological needs (food, sleep, shelter, physical presence of others and sex expressions) and security needs (finance, recognition, self-esteem and power in dealing with others). If there is any adult disapproval of how one goes about fulfilling these needs, the result is development of anxiety. The process of resolving this adult disapproval anxiety is considered by Sullivan as the actual process of personality development.

3.2.3: Erik H. Erikson (1902)

3.2.3.0: Erikson's model of personality development involves three different aspects; somatic, ego and cultural - historical aspects of personality development.

According to him, the ego is formed by precipitates of abandoned relationships with loved objects (e.g. mother). He believes that one's various relations are very important in ego formation and that the person's specific qualities are of great importance in ego formation. Erikson also recognizes the psychosexual stages of development advanced by Freud. However, Erikson's personality development theory is an 8 stage dynamic theory of a life-cycle which starts from birth to death. Each stage has two extremes of possible development and the personality development can be determined by the development or lack of development of a part of the particular life cycle stage.

The following are the 8 life-cycle developmental stages with approximate timetable of origin.

3.2.3.1: Basic trust versus mistrust

- From birth to 2 years of age
- Mainly develops awareness of consistency and continuity leading to ego identity

3.2.3.2: Autonomy versus shame and doubt

- From 2 to 3 years of age
- Also the muscular/Anal stage
- Development of self control versus loss of self - esteem

3.2.3.3: Initiative versus guilt

- Corresponds to the oedipal age (3 -5yrs)
- Also locomotor/genital stage
- Develops ability to plan tasks but failure leads to guilt

3.2.3.4: Industry versus inferiority

- 6 - 13 years
- Latent period psychosexually
- Recognition is won by doing things for others
- The possible danger is inferiority

3.2.3.5: Identity versus identity confusion

- 13 - 21 years
- Puberty to start of young adulthood
- Problems of identity crisis

3.2.3.6: Intimacy versus isolation

- 16 - mid 20s
- Develops capacity to commit oneself to others

3.2.3.7: Generativity versus stagnation

- Adulthood
- Mid 20s to late 40s
- Productivity, creativity and self absorption

3.2.3.8: Integrity versus despair

- Maturity
- Awareness of closeness of death

3.3: PERSONALITY THEORIES FROM PHILOSOPHY AND PSYCHOLOGY

3.3.0: Plato 5th Century BC

Postulated that the human body was the main contributor to mental disorders when in disease. He went further to declare that there were only two major mental decompensations so caused; madness and ignorance. He believed that after the treatment of the underlying physical disorder, the mental illness resolved.

3.3.1: Hippocrates

He believed that the body had four humours:- blood, black bile, yellow bile and phlegm. Depending on which fluid was predominant, the body's demonstrated behaviour was specific to the biological situation. Hence sanguine (blood) choleric (yellow bile), Melancholic (black bile) and then phlegmatic were the four types of personalities noted from types of personalities noted during those early times. Hippocrates prescribed ways of extracting the extra fluid specific from the body so that the body and behaviour may return to normal.

3.3.2: William Sheldon (1899 - 1977)

Sheldon believed that there were three basic somatotypes through which individuals pass in a dynamic fashion through their lives. These are endomorphy, mesomorphy and ectomorphy. The endomorphs are said to develop from the inner or endodermal embryonic layer. They are round bodied and heavier than the other types. Mesomorphs originate from the middle embryonic layers and have overdeveloped muscles and have athletic physique. The ectomorphs have increased skin surface and nervous systems. They are fragile, thin and linear. Sheldon also believed that his somatotypes could explain personality patterns. The endomorphs were seen as having viscerotonic temperament (relaxed, friendly, tolerant, positive, food and comfort loving and extroverted.) The mesomorphs were somatotonic in temperament (bold, risk seeking, assertive, dominant, callous, action oriented and macho). Ectomorphics are cerebrotonic in temperament (restraint, apprehensiveness, tension, secretiveness and introversion).

3.3.3: B F Skinner (1904)

Skinner's approach to personality is a derivative of his basic beliefs about behaviour. To him, personality is not different from any other sets of behaviour; it is acquired, maintained and strengthened or weakened according to the same rules of reward and punishment that alter any other forms of behaviour. In behaviourism, there is no self, no ideas, no ID, ego or super ego.

There is no mind. There is only a brain that learns as a response to internal or external stimuli.

Through the process of operant conditioning and the application of basic principles of learning people are believed to develop sets of behaviour that characterize their responses to the world of stimuli with which they are faced in their lives. This set of responses is called personality.

4: LATER THEORISTS

4.0: This constitutes the humanistic, existential, cognitive and perceptual perspective of personality development. The humanistic - existential movement as per Carl Rogers, Roll May, Binswager, Fritz Perls, Abraham Maslow, Erich Fromm and Irwin Yam conceptualizes personality as built on the belief that people have inherent capacities to become healthy, fully functional individuals. Psychotherapy only involves efforts to free individuals so that they may once again grow and function in an unimpeded manner.

5. INTEGRATED BASIS OF PERSONALITY DEVELOPMENT

Personality development is a function of complex interaction of biological and environmental factors. The relative impact that each set of factors will have on a given individual personality development will depend on the potency and chronicity of each factor's influence. However, it is safe to say that biological factors set the foundation on which stands personality development whereas environmental factors act to shape the form of their expression. Hence biological factors set the parameters for personality development but environmental factors serve to refine and ultimately dictate what we believe constitutes the essence of human personality. (see fig 1)

5.1: Basic Biological Factors

These take two major forms; heredity and prenatal maternal factors.

5.1.0: Heredity

This is the genetic factor that results into passage of certain biological determinants of behaviour from one generation to another. Psychopathological conditions such as bipolar affective disorders, schizophrenia, Pick's disease, pathological risk taking behaviour and some stress - related disorders appear to have genetic foundations.

It is generally felt that the genetic foundation of behaviour are dramatically shaped and molded by the forces of the environment. The specific mechanisms by which the environment acts to shape genetic undergoings is still unclear.

Basic Biological factors + Bioenvironmental Factors + Environmental Factors -
Personality patterns

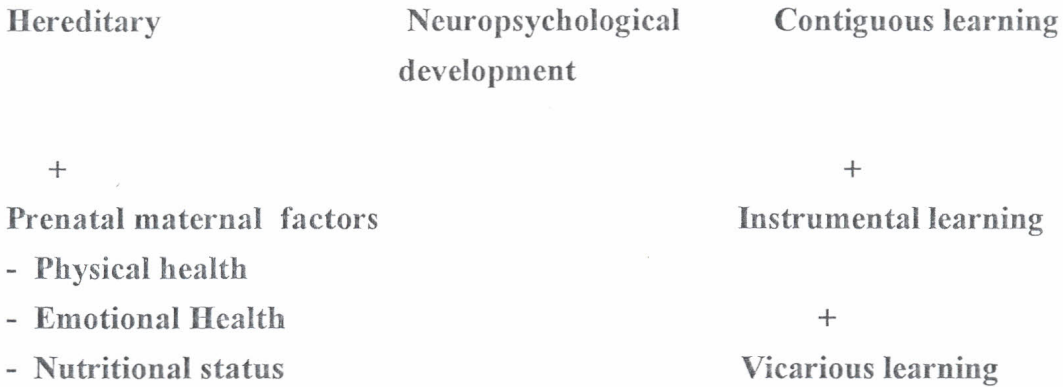


Fig 1 The Origins of Personality

5.1.1: Prenatal Maternal Factors

It is well known that foetal development can be adversely affected by various pregnancy complications or the poor health nutritional status of the mother.

There is evidence, for example, that caffeine consumed by the mother will stimulate the nervous system of the foetus; alcohol consumption by the mother may lead to temporary reduction in foetal cerebral blood flow as well as mental retardation and foetal alcohol syndrome in the child.

Alcohol is also thought to depress foetal cerebral neural propagation temporarily. A mother's cigarette smoking may lead to premature delivery and low birth weight.

Cortisone taken by a pregnant mother may lead to placental abnormalities and still birth; maternal malnutrition may lead to mental retardation and dental caries. The specific mechanisms by which prenatal maternal factors affect the personality development of the child are still unclear.

However, the common belief is that such factors do indeed influence the formation of healthy personalities as well as various personality disorders.

The phenomenon of temperament seems to be greatly affected by these prenatal maternal factors.

5.1.2.0: Neurological Development

Normal neuropsychological function depends on normal neurological maturation. This in turn depends on pre- and post-natal environmental factors. The human neurological development is incomplete at birth. The greatest maturation spurts are during pre-natal and the first five years of the post-natal period. Environmental factors do exert some influence on this maturation. This influence is only exerted during this neurological growth spurt period and have no influence thereafter. But both pre-natal and post-natal neurological development depends on nutrition. This nutrition does not only refer to protein, fats, carbohydrates, vitamins and other metabolic factors but also on experimental nutrition as well. Stimulus nutrient is the process by which environmental stimuli can exert an influence on the biochemical composition and functional anatomy of the neurological patterns within the brain. The notion that there exists "sensitive" periods of neurological development argues that there exists limited time periods during which particular stimuli are necessary for full maturational development. If these stimuli are experienced before or after those sensitive periods or if the stimuli nutrients is inadequate or excessive, developmental inadequacies or dysfunctions are likely to occur.

The neuropsychological stages of development may be delineated based on three major sensitive periods in the developmental process. These stages are:

5.1.2.0.1: Sensory attachment stage

From birth to about 18 months. This stage is dominated by fundamental sensory processes that serve to aid in neurological development and attachment processes.

These merely reflect the degree to which the newborn child is dependent on others for survival, stimulus impoverishment at this stage results in apathy, deficits in social attachment, social alienation and depression. Extreme sensory impoverishment is likely to result in sensory retardation as well.

Excessive stimulus nutrients at this stage is likely to result in hypersensitivities, stimulus seeking, highly demanding hyperactive behaviour and abnormal interpersonal dependencies.

5.1.2.0.2: Sensorimotor - Autonomy

Begins from 12 months of age and may range through 6 years. It is characterized by refinement of gross muscular activity into fine motor - controlled behaviour. Abilities for verbalization, locomotion and fine motor manipulation increase and the child becomes autonomous. Stimulus impoverishment is likely to result in timidity, passivity and submissiveness. Excess stimulus nutriment is likely to result in uncontrolled self-expression, social irresponsibility and narcissism.

5.1.2.0.3: Intracortical - Initiative stage

Ranges from about 4 years of age through adolescence. A rapid growth in higher critical brain function occurs. The child can plan, organize and act on his own behalf. Thought processes develop beyond concrete thought into the domain of abstract thoughts. Abstract thoughts process allow the child to develop both an internal base and an introspective ability to attempt to act upon his environment. Stimulus impoverishment at this stage is likely to result in inability to find direction in one's life, a lack of discipline and an impulsive behaviour pattern. Furthermore, the individual tends to demonstrate the inability to mobilize and direct resources in a productive manner often behaving in irresponsible and immature ways. Excessive stimulus nutriment during this stage is likely to result in suppressed spontaneity flexibility and creativity. The result is a rigid, restrained individual. These neuropsychological stages are progressive in their development.

They also reflect an interaction of biological and environmental elements. Each stage sets the basis for subsequent stages. If processes are incomplete or dysfunctional at one stage, the subsequent stages are likely to be adversely affected as well.

In summary, the origin of personality is determined by biological potential of each organism as defined by genetic factors. However, the rate and ultimate level to which these potentials are achieved will be shaped by environmental factors that influence the biochemical composition and functional anatomy of the biological substrates themselves.

5.1.3: Environmental Factors

Natural psychological development and function depends on an orderly substrate of neuronal connections.

The basic foundation of these biological networks is laid down through genetic programming. However, these networks are then modified through environmental experiences or stimulus nutriment.

These processes collectively shape the biological foundation for personality development. An additional role that environmental factors play in the development of personality is in the context of LEARNING. Learning is hereby considered the acquisition of various cognitive affective and overt behavioural responses that an organism did not initially possess. These acquires cognitive, affective and overt behavioural responses become the manifestation of personality itself. Hence the need to know how the majority of such responses are acquired. Most learning relevant to personality development may be categorized under three headings; contiguous learning, instrumental learning and vicarious learning.

5.1.3.0.1: Contiguous learning

This represents the simplest way of acquiring new cognition's, affects and overt behavioural patterns.

The principle of contiguous learning is that any set of environmental elements which occurs simultaneously as in close temporal order will become associated with each other. (Pavlovian conditioning)

5.1.3.0.2: Instrumental learning

This type of learning is the most powerful method of acquisition yet demonstrated (Edward Thorndike, B F Skinner 1953) The bases of instrumental learning can be summarized in Thorndike's law of effect. This states that behaviour that is followed by consequences that the individual finds punishing or unpleasant will be reduced.

According to Skinner, all behaviour is determined by reinforcement or punishment, that is the consequences provided by the social environment. Other authors (Albert Ellis 1962, Richard Lazary 1966, 1976) also mention that some learning principles that apply to overt behaviour govern covert behaviour.

5.1.3.0.3: Vicarious learning

According to Bandura (1974) as social beings, people observe the conduct of others and the occasions on which it is rewarded, disregarded or punished. They can therefore profit from observed consequences as well as their own direct experiences.

Hence people learn by observing as well as doing. This type of learning is known as vicarious learning, it maintains that human conduct is better explained by the rational influence of observed and direct consequences rather than either factor alone. Under normal circumstances all three forms of learning combine ultimately to shape the formation of a normal healthy personality.

EMOTIONS

OBJECTIVES

DISCUSS: 1. MOOD

2. AFFECT

3. BASIC EMOTIONS

4. COMPLEX EMOTIONS

5. COPING BEHAVIOUR

6. MOOD DISTURBANCES

1: MOOD

Is a sustained feeling tone or range of tones, pleasurable or unpleasurable, experienced by a person for a period of time lasting for hours, days, months or even years. It may be likened to the range of notes on a musical instrument.

2: AFFECT

The moment-to-moment feeling state sometimes rapidly shifting, that can be observed by a clinician. This may be likened to the specific notes played on a musical instrument to form a song.

3. EMOTIONS

Are the moods and affects that are connected to specific ideas.

4. FUNDAMENTAL EMOTIONS

4.0: Ten types of basic (fundamental) emotions have been described.

These are:-

4.0.1: Interest - excitement

4.0.2: Enjoyment - joy

4.0.3: Surprise - startle

4.0.4: Distress - Anguish

4.0.5: Anger - Rape

4.0.6: Disgust - Revulsion

4.0.7: Contempt - Scorn

4.0.8: Fear - Terror

4.0.9: Shame - Humiliation

4.0.10: Guilt

4.0.11: These fundamental emotions represent several broad behaviour patterns that serve vital adaptive functions. Thus anger is thought to accompany impulses to destroy barriers while contempt/disgust goes with riddance reactions.

5. SPECIFICITY OF EXPRESSIONS OF EMOTIONS

The same expressive facial signals, (smile, laugh, weep, cry, frown, snarl, grit teeth), are used and recognized in many cultures as expressions of the fundamental emotions. These social signals emerge at a very early age in childhood, they are displayed even by blind and deaf children who could not have learned them by observation. Hence they must be regarded as part of our built-in human heritage.

However, the cultural norms do have influence on the display rules of these emotions , hence culture determines when and how such social signals may or may not be shown overly. Examples are;

- a. Frowning as a greeting (in Melanese Chiefstains)
- b. Smile on hearing bad news (mothers of dead Samurai soldiers)

6. COMPLEX EMOTIONS

The fundamental emotions are not only human but are also shared with our primate predecessors. But there are some emotions that seem peculiarly human for they define a level of symbolic processing that is probably restricted to our own species. Such emotions are; jealousy, loneliness, embarrassment, vengefulness, pettiness, self-righteousness and smugness.

7. COPING BEHAVIOUR

Emotional states motivate a variety of coping behaviour leading to drive reduction, satisfaction and achievement. Through classical psychological defense mechanisms, cognitive self-regulations and mood modification through use of chemical substances, unpleasant states of arousal and emotion are dealt with. Individuals sometimes deliberately display false emotions in social situations, attempting to hide the true feelings. Similarly, people try to hide certain unacceptable feelings from their own awareness through self deception mediated by denial repression or dissociation. Ambivalent persons often alter their emotional state between feeling positive and negative about a given situation . Alexithymia refers to persons who ordinarily express very little emotion or fantasy, even in situations likely to generate strong emotions in most people.

8. DISTURBANCES OF MOOD

The following conditions occur as a result of disturbance of emotions, mood and affects.

8.0: ANXIETY

As a disagreeable emotional state, it often signals an impending threat. It has cognitive, affective and somatic features. It is usually associated with hyperarousal and hypervigilance. It can be specific or free floating.

8.1.: DEPRESSION

Feeling sad accompanied by low mood, hopelessness, worthlessness and helplessness. Has low energy and poor concentration (see chapter on mood disorders).

8.2: HYPOMANIA

A state in which pleasurable feelings are excessive, prolonged and accompanied by unusually high energy (see chapter on mood disorders)

8.3: MANIA

A more extreme pleasurable state in which judgment and sleep are impaired, mood is elated, expansive, jocular, irritable or angry. (see chapter on mood disorder)

8.4.: TEMPER TANTRUMS

Inability to control one's anger leading to outburst of glaring, snarling, yelling, shouting, intimidating, sulking and at times being physically violent.

8.5: DISPLACED RAGE

Such as cruelty to animals, fire setting, rape, intimidation, terror, humiliation, sadism, (socially sanctioned at times).

8.6: SELF MUTILATION

- Eye enucleation, self castration
- Repeated cuts and burns
- Self bites

8.7: OTHER DISTURBANCES OF MOOD

8.7.0: Blunt/flattened affect

- In schizophrenia

8.7.1: Anhedonia

- Lack of pleasurable feeling from pleasurable activities

8.7.2: Inappropriate affects:- Incongruency of affective expression and thought content.

8.7.3: Ambivalent affect:- Mixed feelings of opposing valence to a given idea.

STRESS AND COPING

Definition:

Stress occurs when people are faced with events they perceive as endangering their physical or psychological well being. The events are called stressors and the peoples' reactions are called stress responses.

Objectives:

1. to introduce the trainee to concept of stress and discuss
 - a. normal coping mechanism
 - b. abnormal coping mechanisms
 - c. strategies of managing stress

Causes of Stress

1. Causes of stress vary from one person to the next and examples are such as bereavement, divorce, catastrophies such as earthquakes. These are external causes of stress.

2. Internal causes are from within the individual for example, frustration where the motives are not achieved. Sometimes two motives are held simultaneously and they happen to be incompatible resulting in unpleasant emotions such as anxiety or anger.

Individuals may also experience conflicts and examples of common conflicts which may lead to stress are:

- (i) Approach - approach conflict (seeking two desired goals)

In this life situations an individual is faced by two alternatives which are both pleasant, the problem is that they can only be carried out simultaneously. For example an individual is faced with the choice of either sitting back in his room and studying for the following day's test or go out for movies with friends.

The first choice is good in that the student will certainly excel if he revises for his tests. Going out with friends is also a good experience but if the choice is opted for the student may regret later. Thus in approach - approach conflict the individual is often torn between alternatives each of which would be thoroughly pleasant except for his regret over losing the other.

(ii) Avoidance - Avoidance (seeking to prevent two undesirable alternatives)

To illustrate this situation this of a student who is due for an examination, the following day, however due to anxiety the student becomes sleepless and tosses too much in bed. He could easily take a sleeping pill but he is also afraid that he may be very drowsy during the examination. Thus the threat of an examination and affects of the pill are both undesirable to the student.

(iii) Approach - Avoidance conflict

This situation involves fulfilling a motive which has both pleasant and unpleasant outcomes. A person might want to get married because marriage has some good attractions, however by so doing one also would have to bear with added responsibilities.

(iv) Double approach - avoidance conflict

To illustrate this type of conflict take a young girl who has a career which can only be found in big cities (e.g. accountant) she however likes living in country side. She is also interested in marriage and her fiancée has a business within the country side. This young girl is torn between marriage and her career though marriage would ensure her living in a country side environment but she also wants her career.

PSYCHOLOGICAL REACTIONS TO STRESS

Include:

- (i) Anxiety
- (ii) Anger
- (iii) Discouragement
- (iv) Depression

Anxiety: (apprehension, tension and fear which are very unpleasant emotions.

Post-traumatic stress disorder is as a result of severe anxiety. It follows traumatic experiences. Clinically all body organs may be affected in anxiety states (rapid heartbeats, sweating, difficulties in breathing and so on.)

Anger: is directed at the obstructing object, which prevents the motive from being achieved and aggressive behavior at times occurs.

Apathy/depression: some individuals develop learned helplessness. The individual just sits and does nothing about the source of stress. Some individuals are unable to perform well mentally as a result of high level of anxiety leading to depression.

POST TRAUMATIC STRESS DISORDER

Effects of combat and captivity (the psychological aftermath) is commonly seen in people who have had trauma leading to extreme stress. (This disorder will be discussed in much more details elsewhere).

STRESS AND ILLNESS

Psychosomatic disorders are physical disorders in which emotions are believed to play a central role. The timing of such physical symptoms show that there were preceding psychological stressors.

Examples of illnesses called psychosomatic disorders

- Hypertension - this is persistent elevation of blood pressure
- Ulcers - manifests as wounds on the lining (mucosa) of the stomach and duodenum - individuals complain of abdominal pain, especially around the epigastric.
- Rheumatoid arthritis - manifest as swollen painful joint especially those of the fingers
- Migraine - manifests as severe headaches with disturbances in sight and vomiting may occur
- Others examples, bronchioasthma, diabetes mellitus, dermatitis etc.

Not everybody becomes ill despite being under stress. This may be explained in that each individual has inbuilt potential for handling certain levels of stress and that a certain critical level of stress is required for illness to occur.

Stress is also known to reduce our immune responses. Immune responses defend our bodies against disease and stress is known to lower the immunity and hence frequent infection.

Our personalities determines what kind of illness we get. Two types of personalities are described:

Type A individuals are typically hard working and successful. They have high achievement motive and they believe that they can overcome any obstacle. They are ambitious, competitive and have a sense of urgency.

These individuals suffer from stress related diseases e.g. heart attacks more than type B personalities who are opposite of type A behaviour.

COPING MECHANISMS

Coping is the way individuals deal with the causes of stress:

Problem focused coping mechanism:

- (i) Coping assertively
- (ii) Staying in control

Emotion focused coping mechanism

- (i) Use of social support
- (ii) Optimism

Multiple coping strategies:

The individual uses a combination of several coping strategies.

Constructive attempts to deal with stress is referred to as assertive coping. Some individuals e.g. prisoners of war use certain strategies such as counting insects in their cells, learning new languages, doing exercises and so on. In real life situations, one seeks a solution e.g. changing a flat tyre as quickly as possible not to get late to an important appointment. In summary we change the environment, our behaviour and if all these fail we convince ourselves that we have not lost control of our lives, that there is hope. This last aspect is difficult but people in severe situations of genuine helplessness have been known to control their emotions and remained sane, hoping for a brighter future. Being responsible for ones destiny may be the only way to cope "giving in" just accelerates the physical and psychological response to stress thus causing rapid harm.

Damaging effects of stress can be managed and controlled if the individual is within a social support network where they seek solutions to stressful events. Supportive environment include devoted family, friends, colleagues or fellow members of organizations, where individuals with similar problems meet to counsel each other on how to solve their difficulties e.g. alcoholic anonymous.

People with pessimistic negative attitudes towards life tend to cope fairly badly with stress. They make no attempts to change their environment and tend to blame themselves for their predicament, Optimism is a powerful coping strategy where the individual's attitude is positive and hope for bright future despite prevailing stressors.

DEFENSE MECHANISMS

These are self deceptive strategies. Though the individual copes temporarily the long effects are more damaging. These mechanisms lie between normal and abnormal behaviour.

1. Rationalization
2. Repression
3. Sublimation

4. Identification
5. Reaction formation
6. Projection
7. Other defective mechanisms

Rationalization

People resort to rationalization to reduce stress and anxiety caused by conflict between motives and inner standards. It is the "sour grapes" story. The fox being unable to pluck grapes because they were high up in the vine consoled itself by saying that the grapes were sour after all.

In this case the fox motives were frustrated and rather than the fox being assertive and changing the environment only consoled itself by rationalization.

Repression

Internal motives such as sex, when unfilled may cause stress. Individuals subconsciously subdue their desires so that they seem unaware of any sexual feeling or desire at all. They even suffer amnesia of such desires. This is an act of repression.

Sublimation: In sublimation a motive that causes anxiety and stress is subconsciously converted into a more acceptable motive to self and society. Examples are such as surgeons, prosecuting attorney or teachers who may sublimate their urges towards cruelty into socially approved motives.

Identification: Individuals tend to agree with the persons who may be source of their anxiety or a person who suffers from no anxiety and is a hero. By so doing the individual has a feeling that he/she is what in reality is not but such identification minimizes their anxiety.

Reaction formation: Hostile motives may be masked by exaggerated politeness. An individual with hostility may conceal it by being apologetic, agreeable, always smiling and so on.

Projection: Some individuals have motives which cause them anxiety and stress and rather than accept them as theirs, they attribute them to others. A person with urges of infidelity may accuse the partner of dual acts of infidelity.

Denial: In denial the individual reduces anxiety by totally refusing to accept reality e.g. in cases of bereavement an individual may refuse to accept that death has occurred.

Displacement: This is a mechanism through which unwanted feelings are transferred to things in the environment. Anger against the boss may be directed towards pets, spouse etc. Acting out constitutes impulsively releasing out the stress without wasting time to consider options. The time spent looking for options may be unbearable.

Regression: Tends to manifest as journey backwards to infancy where the individuals feel secure as a child. Defense mechanisms described are used on and off but when these defenses fail the individual's personality falls apart and individual may show signs of mental illness.

MANAGING STRESS

1. Biofeedback: this is a way of controlling our body functions e.g. heart rate with the help of machines which display the heart activity.
2. Relaxation training: Teaches the individuals how to contract and relax group of muscles from toes to the front facial group of muscles.
3. Aerobic exercises: Persons to do oxygen consuming activities for a prolonged period e.g. jogging
4. Changing cognitive responses to stressful situations. The person is asked to identify situations that lead to stress and tension and is encouraged to provide rational ways of handling these situations (problem focused coping).

PSYCHOLOGICAL DEFENSE MECHANISMS

OBJECTIVE

DISCUSS:

- 1. THE CONCEPT OF PSYCHOLOGICAL DEFENSE MECHANISMS**
- 2. COMMON DEFENSE MECHANISMS**
- 3. CONSEQUENCES OF FAILURE OF EFFECTIVE USE OF DEFENSE MECHANISMS**

1. THE CONCEPT

Defense mechanisms are universal phenomena which all of us use at times to limit and constrict awareness so that life threatening and anxiety causing cues either from the inner or outer environment can be excluded. They are invoked automatically as psychological measures which allow stressful situations to be coped with by distorting reality.

Inadequate use of defense mechanisms is said to lead into overt anxiety or depression.

2. COMMON DEFENSE MECHANISMS

2.0: Repression: This is considered to be the central and basic psychological defense mechanism. Other defense mechanisms only came in to operation when repression started to fail. Thoughts or feelings which our consciousness finds unacceptable are repressed from the consciousness. Thus repression is a way of dealing with unbearable aspects of inner life; so that aggressive or sexual feelings, fantasies or desires are thrust out of the consciousness and into the unconsciousness. It is considered to be a mental process arising from the pleasure principles (ID) and the reality principle(ego) indicating that when impulses and desires are in conflict with enforced standards of conduct (super -ego) painful emotions arise and the conflict is resolved by repression. Hence normality is once again attained and sustained.

2.1: DISPLACEMENT: This is the transfer of affect, usually fear or anger from one person, situation or object to another to which it does not belong. An example is the wife who, furious and irritated by her husband for always coming home late or giving her no support with the children, vents her anger not on her husband but on the children instead. The irate child turns on the household pet which may be smashed against the wall and one can only assume "wonders why!"

2.2: RATIONALIZATION: The process of justifying by reasoning after the event. The act of providing logical and believable explanations for his behaviour to persuade himself and others that his irrational behaviour is justified and therefore should not be criticized.

2.3: PROJECTION: In this case, an individual unconsciously disowns an attitude or attribute of his own and ascribes it to somebody else.

For instance a child telling the mother "Mummy the dog will bite you" while he is the one who feels like biting the mother. Also "I hate you" becomes "you hate me".

2.4: ISOLATION: In this defense mechanism, dangerous memories are allowed back into the consciousness but the associated motives and emotions are not recalled. Hence the memories are isolated from their associated feelings. This mechanism is sometimes seen in people who suffered severe physical/psychological trauma such as in concentration camp life or in rape victims.

2.5: DENIAL: This is the involuntary and automatic distortion of an obvious aspect of external reality. For instance when a patient is informed by a doctor that he has cancer, this fact may be denied at subsequent interviews even though a clear concise explanation was given which the patient obviously understood.

2.6: REACTION FORMATION: In this case, the repressed wish is warded off by its diametrical opposite. The young girls who hated her sister, was punished many times for this behaviour, may turn her feelings into opposite and shower her sister with exaggerated love and tenderness but the repressed hostility can still be detected underneath the loving exterior.

2.7: SUBLIMATION: This occurs when potentially dangerous urges are given a socially acceptable expression. Thus sexual or aggressive impulses instead of being given free expression are sublimated to other activities which are carried out with great vigor and often with great success.

2.8: INTROJECTION: In this defense mechanism the victim takes in and "swallows" the values of others. For instance, in concentration camps, some of the prisoners deal with overwhelming anxiety by accepting the values of the enemy through identification with the aggressor. The same issue obtains when a father who was a victim of child abuse practices same on his child.

2.9: IDENTIFICATION: People who feel basically inferior may identify themselves with successful causes, organizations or persons in the hope that they will be perceived as worth while. In this case, identification is utilized as a defense mechanism against anxiety of inferiority.

2.10: COMPENSATION: This consists of the masking of perceived weaknesses or developing certain positive traits to make up for limitations. People who are intellectually inferior may develop the physical aspects of their bodies. People who are socially incompetent may develop their intellectual capacities and spend most of their time in lonely academic pursuits.

2.11: RITUAL AND UNDOING: Anxiety is sometimes lessened when somebody uses methods to right a wrong or take away the guilt he feels for some perceived misdeed. A rejecting father may attempt to alleviate his guilt by showering his child with material goods. He attempts to demonstrate his caring through this showering act.

COMMUNICATION SKILLS

INTRODUCTION

Communication is a general term used for exchange of information and feelings between two (or more) people.

OBJECTIVES:

- a. To acquaint the trainee with knowledge of types of communication
- b. The trainee should acquire skills on how to communicate effectively.

TYPES OF COMMUNICATION

Two broad types of communication can be identified as Verbal communication and non verbal communication. Verbal communication is either spoken or written, while non verbal communication is through bodily actions and signs. The language of the deaf and dumb is non verbal.

VALUE OF INFORMATION FLOW OR EXCHANGE

Information flow or exchange (communication) serves very important roles in societies.

1. Allows organisms to relate with each other especially emotionally, marital or sexual partners sustain their relations if partners communication is effective.
2. Is a means of educating others either through speeches or any other form and enhances conformity to social norms or socialization.
3. Through exchange or enquiry one learns new skills that are necessary for adjustment in the society

4. Communication has a instinctual survival value where a facial expression of aggression signals danger to the would-be victims who consequently take precautions against being harmed. Darwin noted this concept and many psychologists have studied the role of communication in survival.

TOOLS OF VERBAL COMMUNICATION

1. Language is a way of passing messages, that is to establish communication and enabling people to understand each other, work, play, live together and let known feelings, desires and motives.

The origin of language is not known but it is made up of unlimited number of sounds called Phonemes which when put together form meaningful morphemes (or words). These words may have varying meanings referred to as semantics. So depending on how a word has been used it may portray different meanings from the conveniently accepted meanings.

There are rules governing use of morphemes and these rules are called grammar, syntax is the rule that governs the way nouns, verbs, adjectives, adverbs are placed in order to form phrases. A third aspect of language is pragmatics, that is to say the actual meaning of what we say may depend largely on the situation in which we say it.

It is important to state that semantics syntax, and pragmatics give our utterances a structure and range of functions that set human communication far apart from that of other species.

2. NON VERBAL COMMUNICATION

Apart from use of language communication can be done through other ways

1. Signs
2. Gestures
3. Facial expressions
4. Overall actions/behaviour of an individual

Signs such as no smoking, railway crossing, hospital are known to convey the same message all the time. Highway codes are examples of non verbal communication where the individual receives messages through such signs. However initial training through verbal communication is necessary.

2. Gestures convey certain messages for example the partial closure of eyelids or the turning away of the eyes or of the whole body may convey a message that the despised person is not worth looking at. Spiting may imply contempt or disgust.
3. Intertwined with gestures are facial expressions which may convey happiness , joy, sadness, aggression and so on.
4. The walking out of a meeting, or non-attendance of an important meeting may convey strong messages depending on prevailing circumstances. Thus the behaviour of an individual too has a message to convey.

COMMUNICATION SKILLS

Communication is a two way process and requires a very close co-operation between the speaker and listener.

We shall examine what a speaker must achieve for effective communication to occur.

- a) The speaker must generate some messages but before anything else the speaker should first of all think of the meaning he wants to convey.
- b. During this stage one should avoid "functional fixedness" that is assuming that an object behaves or functions only in one way thus ignoring the fact that there could be other ways. One should be flexible.
- c) One should also engage in "information manipulation". This entails searching the memory store house for all kinds of information and relying on the most readily available information actually leads to one only thinking what one is prepared to think,

d. The speaker should also consider:

(i) The source of the information that is being conveyed.

Source must be fair, objective and not interested in wielding influence. The source must be of high credibility in other words, who is talking what?

The speaker should be aware that there is an inherent problem of selective exposure where certain people only listen to what they have already planned to .

ii. Consider who is listening and note the following aspects of the listener.

Fairly intelligent well educated audience usually like messages which portray the pros and cons and if these messages are not communicated the audience tends to regard the communication as ineffective.

For less intelligent well educated audience the most appealing aspect of the message may suffice since more information may just lead to confusion.

Also remember that high esteemed individuals are difficult to convince compared to low esteemed.

Anxious people are more receptive and especially if in need of help.

After generating the messages, the speaker should plan his message, what should be presented when. This is basically the way the information must flow for easy consumption by the audience.

Use of various teaching aid is necessary in conveying messages.

Persuasive communication is basically the transmission of information and appeals to emotion in an attempt to change other person's attitude.

The speaker may choose to use:

- lecture where verbal and non verbal communication is used.
- audiovisual skills
- flip charts
- group discussion at the end of the lecture.

LISTENER (AND DY)

During a communication session certain things happens to the listener.

1. Listeners do some information processing resulting into
2. Formation of concept which are mental representative of similarities between objects or events.
3. And finally draw conclusions.

DEATH AND DYING

OBJECTIVES

- DISCUSS:**
- 1. DEATH**
 - 2. COPING WITH DYING**
 - 3. SHARING INITIAL BAD NEWS**
 - 4. INITIAL TREATMENT DECISIONS**
 - 5. FROM CURE TO CARE**

1. DEATH

1.0: Legally, an individual who has sustained either irreversible cessation of circulatory and respiratory functions or cessation of functions of the entire brain, including the brain stem, is dead. The Causation of death is whatever pathological conditions prevail to cause these cessations. These causes may be natural or unnatural. The former are illnesses whereas the latter are composed of accidents, homicides and suicides. The concept of death is coloured by our cultural and psychological attitudes of death and not merely the concept of end stage of biological processes. Hence the concept of death is highly subjective and exceedingly complex and culture dependent. No matter the cause, in some cultures, death must have an unnatural explanation of causation, hence blame must be allocated to some-body as the real cultural etiology of a death.

1.1: COPING WITH DYING

The chronically terminally ill patients usually pass through 5 stages of the dying process in coming to terms with impending death.

These stages are detailed below:-

1.1: STAGES OF DYING (ELISABETH KUBLER - ROSS)

1.1.0.1: STAGE 1 - SHOCK AND DENIAL

On being told that one is dying, there is an initial reaction of shock. The patients may appear dazed at first and may then refuse to believe the diagnosis or deny that anything is wrong. Some patients never pass beyond this stage and may go from doctor to doctor until they find one who supports their position.

1.1.0.2: STAGE 2 - ANGER

Patients become frustrated, irritable and angry that they are ill. A common response is "why me?". They may become angry at God, their fate, a friend or a family member.

The anger may be displaced onto the hospital staff or doctor who are blamed for the illness.

Patients in this stage are difficult to manage. The doctor who has difficulty dealing with dying patients may withdraw from the patients or transfer the patient to another doctor's care.

1.1.0.3: STAGE 3 - BARGAINING

The patient may attempt to negotiate with physicians, friends or even God, that in return for a cure, the person will fulfill one or many promises such as giving charity or attending church regularly.

1.1.0.4 : STAGE 4 - DEPRESSION

The patient shows clinical signs of depression, withdrawal, psychomotor retardation, sleep disturbances, hopelessness, and possibly suicidal ideation . The depression may be a reaction to the effects of the illness on his or her life. (e.g loss of job, economic hardship , isolation from friends and family)or it may be in anticipation of the actual loss of life that will occur shortly.

1.1.0.5: STAGE 5 - ACCEPTANCE

The patient realizes that death is inevitable and accepts the universality of the experience. Under ideal circumstances, the patient is courageous and is able to talk about his or her death as he/she faces the unknown. Those persons who have strong religious beliefs and are convinced of a life after death can find comfort in these beliefs and in ecclesiasticism: fear not death, remember those who have gone before you and those who will come after .

2: PSYCHOSOCIAL CARE OF THE DYING

This is more in line with the care of the chronically ill patients no matter the case. The patients have a right to know what ails them. They also have a right to know the various options in terms of medical care. The patients have the right to be the final decision makers with respect to what option for medical care (unless they are mentally unsound). The multidisciplinary team approach (physicians, nurses, psychologists, social workers, the clergy) is the best approach to the terminal care of the chronic terminally ill.

3: SHARING INITIAL NEWS

3.0 : Usually the physician communicates the bad news of a terminal illness to the patient. This job may be delegated or assumed by others in the patient's care situation; in which case, the bearer of the bad news must be a good counsellor in fact and practice.

His task at this point is to communicate effectively to the patient. The basic information about the life threatening illness, the diagnosis, the potential to death and the treatment options must be considered. This communication entails the giving of appropriate results of investigations done, supportive facilitation of the patients emotional responses, the realistic reassurance that now the life threatening conditions has been determined, the patient will not be abandoned.

3.1: The patient's reactions to the disclosure may be devastating. The counsellor may also be uncomfortable with the disclosure of the bad news especially if one is not well trained in handling such stressful matters. Hence the counsellor needs to effectively manage his own emotional discomfort without emotionally distancing oneself. Empathy must be well developed in order to handle the process of breaking bad news to patients.

However the process of breaking bad news can be much well improved by the initial selection of persons with empathic dispositions for initial induction into the process of training as counsellors and hence effective bearers of bad news.

4. INITIAL TREATMENT DECISION

4.0: Usually there are various treatment options in any chronic terminal illness situation. The option most suited to the patient is that which guarantees good quality of life at an affordable rate. The duty of the counsellor is to provide information on treatment options understandably, openly and without hidden agenda.

4.1: It is appropriate to enlist the families in support of decision making for treatment options. This reduces the sense of helplessness in the patient and also brings out the family emotions towards his terminal condition.

4.2: Patients referral to specialist care should not mean separation with their initial trusted support person. This support should be continued in order to avoid the feeling of abandonment by a familiar person in whom they have placed their trust.

5. FROM CURE TO CARE

5.0: Chronic terminally ill patients exercise many types of coping mechanisms. Denial of the dying process is paramount as defense mechanism. However, along the trajectory of dying, physical decline and deterioration make denial very difficult to maintain. Hence the change of focus of clinical care from cure to care has to be made. This is a difficult decision for both the patient and the physician. The guiding thought should be the quality of life. If continued cure efforts result into a quality of life unacceptable to the patient, then it is time to shift focus into care to ensure acceptable quality of life.

5.1 Control of pain and provision of comfort are the main two elements of focus in the provision of palliative care. Symptom control is of primary importance. Such problems as vomiting, constipation, nausea, diarrhoea, dyspnoea, palpitations are quite common and need control. Depression, anger and other psychological disorders are noted in 25 to 50% of all terminal care patients.

5.2 The transition from cure to care also affects the physician whose focus of training and practice has always been that of the primary warrior in these settings. Hence the shift to palliative care may be resisted to the detriment of the patient's welfare. It is now a well established fact that death of the chronic terminally ill patient is best when it occurs at home under familiar surroundings. This leads to fewer post bereavement difficulties as compared to in-hospital deaths of the chronic terminally ill.

BEREAVEMENT

OBJECTIVES

DISCUSS:

- 1. TERMINOLOGIES RELEVANT TO THE UNDERSTANDING OF BEREAVEMENT**
- 2. CLINICAL PRESENTATION OF POST-BEREAVEMENT CONDITIONS**
- 3. COMPLICATIONS OF BEREAVEMENT**
- 4. MANAGEMENT OF POST BEREAVEMENT COMPLICATIONS**

1. TERMINOLOGIES

1.0: GRIEF

This is a clinical syndrome characterizing physiological, psychological and behavioural responses to bereavement. It is otherwise referred to as bereavement reaction or the bereavement process.

1.1: ANTICIPATORY GRIEF: Grief in anticipation of one's own death or of bereavement.

1.2: GRIEF WORK: A complex mental process in which withdrawal of attachment to a lost object as well as working through the associated pain of the loss is actively undertaken. It is otherwise referred to as the grieving process.

1.3: BEREAVEMENT: Refers to loss through death of an object to which there is an emotional attachment.

1.4: MOURNING: The societal/cultural expression of post bereavement behaviour and practices (bereavement behaviour)

1.5: ACUTE GRIEF: From studies of the survivors of the Coconut Grove night-club fire in Boston in mid - 1940, the modern cataloguing of the parameters of the acute grief were made. Symptoms of acute grief include intense somatic distress at less than hourly intervals. Preoccupation with the image of the deceased, a sense of abandonment with accompanying guilt, irritability and anger; and the loss of habitual patterns of conduct. Within weeks as the immediate effect of bereavement subsides, a second cluster of reaction manifests itself. This includes tenacious clinging by the bereaved person to thoughts and images of the deceased. Efforts to make the bereaved let go are often resisted and resented. This is followed by diminishing of the protest reactions. The despair precipitated by emotional awareness that the deceased is indeed lost takes its place. Anxiety depression and disintegration pave the way for eventual resolution of the loss. Detachment is the final phase of acute grief.

During this time, there is a redefinition of one's role and reorientation towards others than the deceased. Eventually, the bereaved person is enabled to resume a satisfying life. This whole process may take months or years.

1.6 MOURNING: Is a societal expression of both grief and post-bereavement behaviour and practices. Hence one needs to know the expected normal mourning behaviour specific to a certain cultural setting. Ritualization of post bereavement behaviour tends to strengthen interactional support and group ties. In some societies, only the funeral reinforces the reality of death, provides social support for the expression of grief and furnishes a forum in which to place the meaning of the death into a philosophical perspective.

2. COMPLICATIONS OF BEREAVEMENT

2.0 These include somatic, psychological and behavioural complications to bereavement.

2.1 SOMATIC

2.1.0 Increased health service consultations as a post bereavement complication purely for physical ailments.

2.1.1 Cardiovascular disease and osteoarthritis are the most commonly found physical illnesses.

2.1.1 Greater use of medications, poorer health rating than controls.

2.1.3 MORTALITY

2.1.3.0 Increased mortality has been confirmed among younger widows and widowers as compared to controls.

2.1.3.1 Death from CNS vascular lesions and from atherosclerotic heart disease.

2.1.3.2 The most vulnerable period is the first 5 year period post-bereavement.

2.2 PSYCHOLOGICAL AND BEHAVIOURAL

2.2.0 ABSENCE OF GRIEF

2.2.0.1 Those who do not show grief symptoms post-bereavement are either coping by strong denial or are actually grieving but not showing it honestly. If denial lasts much longer than a few weeks then it becomes dysfunctional. Absence of grief and failure to engage in grief work in the presence of profound loss are likely to prevent a healthy assimilation of the loss - which may lead to self defeating choices of action, that in turn thwart the establishment of satisfying living patterns. In the absence of serious psychopathology, treatment is begun reasonably by a gentle explanation of the bereaved individual reality surrounding the deceased. Conflict points are likely to be elicited, confirmed and clarified with the assistance of an experienced therapists. These conflicts must be handled with extreme sensitivity and details surrounding the loss painstakingly approached in a supportive and non challenging manner.

2.2.1: DELAYED GRIEF

This is a grief - like syndrome that appears spontaneously as long as years after the loss.

2.2.2: CHRONIC GRIEF (Pathological Grief) (Unresolved Grief)

2.2.2.0: Prolonged severe grief, symptoms are qualitatively same as those of acute grief but are persistent and excessively intense. The victims actively resist any change to their feelings. They are unable to engage in grief-work and hence can not resolve their grief. Underlying chronic grief is unresolved ambivalence towards the deceased. There are both strange, negative and positive feelings towards the deceased. It is the negative feelings which together with self blame and guilt hinder grief resolution.

2.2.2.1: Dysfunctional hostility also is part of chronic grief. Anger, an integral part of grief if not well managed, frequently becomes dysfunctional and results in major problems of bereavement. The subsequent hostility drives away potential help only when most needed. Predictors of those who will wind up in chronic grief are not clear. However, concern should arise if daily routine (self care, house care, back to work) have not resumed to some extent within a month post-bereavement. Taking into account the cultural limits of mourning, if day-to-day activities have not yet resumed within a month Psychiatric referral may be in order.

2.2.2.2: Treatment of chronic grief is often resisted by people affected. Hence treatment outcome is generally poor. The therapeutic focus is on work on the meaning and magnitude of the loss. The initial phase of psychotherapy should include acknowledgement and resolution of negative feelings towards the deceased.

Anger and hurt should be ventilated with reduced guilt in a safe environment. Do not criticize and avoid identification with forces that deprived the bereaved person of their lost loved object.

The above detailed is good enough to allow the bereaved assume and continue grief work.

2.3: CLINICAL DEPRESSION

2.3.0: Another pathological outcome of bereavement. Should be differentiated from uncomplicated bereavement. Marked worthlessness, psychomotor retardation and suicidal ideation may be pointers to clinical depression.

2.4: FLIGHT OF ACTIVITY

2.4.0: Losing oneself in activity to gain respite from confrontation with bereavement may enhance grief work. When the activity is overwhelming and accompanied by a devil-may-care. Pseudocheerfulness, clearly constitutes another form of grief pathology. The "merry widow" is also a variant of this complex. Underlying these two behaviours are the urge to flee the painful loss with its helplessness and hence leave behind entirely the old shattered life. Rarely clinical mania may be precipitated by bereavement.

In psychotherapy explore all the feelings (helplessness) which underline the flight of activity and postpone any impulsive action until judgment is less emotional.

GROUP WORK

Tom was a 36 yrs old accountant married to a primary school teacher. They had two children, a son and a daughter aged four and two years. They were both strong Catholics. Tom worked for an international N.G.O. in Kigali. He was a Hutu and his wife was a Tusti. Last night as he sat in a pub in Kigali an intertribal argument started between some Hutu and Tusti patrons within the bar. After listening for a while, he joined in the discussion. Eventually the argument resulted into a physical fight and unfortunately Tom was killed in the fight.

Discuss the grief reaction and mourning process Tom's relatives will have to go through for proper restitution to normal life.

(3 groups of 6 each with a final report per team)

PSYCHOPATHOLOGY

I. OBJECTIVES:

- enable the trainee to understand the terminology used in mental disorders .
- enable the trainee to describe the behaviour and mental experiences of a patient.

II. DESCRIPTIVE PSYCHOPATHOLOGY

A. DEFINITION:

Attempt to describe and understand the patient's state of mind and subjective experiences without reference to theoretical models of causation.

B. CLASSIFICATION:

The psychological symptoms of psychiatric disorders can be divided in :

1. Disorders of consciousness
2. Movement and Posture
3. Emotion
4. Thought and Speech
5. Perception
6. Memory and Insight

(1) DISORDERS OF CONSCIOUSNESS

Definition: State of mental alertness and awareness of the self and the environment.

A. Delirium:

Confusion and disorientation for time, place and person, when severe. Delirium is characteristic of acute or subacute organic conditions toxic states, delirium tremens (not alcohol hallucinosis) and Wernicke's encephalopathy (not Korsakoff's syndrome.)

B. Restriction of consciousness

- Some lowering of consciousness
 - Apparently normal behaviour
 - Memory impaired by restricted attention.
 - Twilight states: In hysterical states the memory loss is associated with strong emotional events of personal significance.
 - Fugue states: Wandering, superficially normal behavior and some loss of memory.
- This can occur as a dissociative state in depression or after a seizure.

C. States of hyperalertness

High arousal states physiological alertness, they are seen in mania and anxiety.

D. Stupor

Consciousness is retained although there is a lack of response to stimuli.

E. Dementia

Global deterioration of cognitive and intellectual function in the presence of clear consciousness.

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(2) DISORDERS OF EMOTION

Definition:

Feeling: positive or negative subjective reaction to an experience.

Emotion: includes the physiological state accompanying such a feeling.

Emotion are of two main types:

Affect: lasting and dominant emotional response which colors the whole psychic life.

Mood: short lived emotional response to an event

The mood can be elevated (mania) depressed or a mixture of both.

A. The elevated mood can pass through the following stages:

- Euphoria:** Increased sense of psychological well-being and happiness not in keeping with on going events (not infectious to the observer) e.g (organic states, frontal lobe disorders).
- Elation:** Moderate elevation of mood. Feeling confidence and enjoyment along with increased psychomotor activity.
- Exaltation:** Severe elevation of mood. Intense elation with delusions of grandeur.
- Ecstasy:** Intense sense of rapture with agitation .e.g epilepsy, mania, schizophrenia.
- Expansive:** unceasing and unselective enthusiasm for interacting with people and surrounding environment.
- **Irritable:** aggressivity when the person is stopped from doing what he/she wants.

B. The depressive mood: the most important feature is sadness; Anhedonia (inability to feel pleasure and lose his normal interest.)

Depressive ideation:

- Hopelessness (pessimism, no hope in future)
- Helplessness (nobody can help in one's present condition.
- Worthlessness (feeling of inadequacy and inferiority)

C. Morbid anxiety

- **Anxiety:** State when expecting danger. anxious patients are fearful and physiologically aroused.
- **Neurotic anxieties:** Morbid anxieties that are objectively unjustified or is proportionate and the patient is aware that the anxiety is wholly or largely irrational.
- **Free-floating anxiety:** The patient does not identify a particular object or situation as responsible.

- Phobias: Recurrent ,intrusive fears, recognized by the patient as being out of proportion to any real danger of specific or multiple objects, situations events or activities leading to avoidance of the feared element.

D. Abnormal emotional expression

- Blunted affect: Absence of appropriate emotional expression usually seen as a neutral or flat response to a distressing stimulus.
- Incongruity of affect: The affective response is inappropriate to external events, although it may be congruous with the patient`s own thoughts.
- Dissociation of affect: Lack of fear or anxiety in conditions that warrant such motions.
- Liability of affect: Persistent swings in mood states between sadness and happiness.

(3) DISORDER OF MEMORY AND INSIGHT

Amnesia (loss of memory)

- Organic: retrograde: amnesia embraces events just before the injury.
 - anterograde: failure to make permanent traces for on coming events (after the injury).
- Psychogenic:
 1. Anxiety amnesia: Anxiety tends to impair perception, concentration, understanding and consequently memory. Depressed anxious patients frequently complain of memory.
 2. Dissociative amnesia:
 - Selective: inability to recall all the personal events during a certain period while some others may be recalled in the same period.
 - Circumscribed: amnesia during a circumscribed period of time usually corresponding to a stressor.

Distortion of memory (Dysmnnesia)

- distortion of recall (paramnesia)

1. Confabulation: detailed, completely false of past fictitious events.
2. Delusional memories: delusional interpretations of previous experience.
3. Delusional confabulations: impossible often fantastic accounts of past experience. e.g. memories of being born.
4. Retrospective delusions: when delusions are backdated.e.g. a patient with a recent persecutory delusion claiming that the persecution has been going for years.
5. Retrospective falsifications: memories modified to be consistent with general attitudes, mood or belief(e.g depression).

-distortion of recognition

1. Illusion of familiarity (deja vu) or unfamiliarity (jamais vu) feeling of having (or not) experienced the current familiar situation before.
 2. Positive misidentification: strangers are recognized as friends relatives or acquaintances.
 3. Negative misidentification: friends, relatives or acquaintances are recognized as strangers.
- Capgras'syndrome: the patient insists that every person whom he meets is a double of the person whom he claims to be. Friends, relatives or acquaintances are look-alike strangers or double.

- Amphitryon illusion: patients claim that their spouses are double.

- Sosias illusion: other people as well as the spouses are double.

Impaired insight

Definition:

The individual's awareness and understanding of his or her mental states.

4. DISORDER OF MOVEMENTS

- Mannerisms: Repeated, usually odd, goal directed movements. {schizophrenia, mental impairment}
- Stereotypies: Repeated, non goal directed movements (head banging)
- Myoclonus: Sudden shock-like movement of a muscle.
- Tics: Repetitive, coordinated movements of small groups of muscles.
- Tremor: rhythmic, repetitive movement.
- Spasmodic torticollis: A spasm of the neck muscles pulls the head towards one side and twists the face in the opposite direction.
- Extrapiramidal abnormal movements: Parkinsonism, akathisia, dystonia, tardive dyskinesia are side effects of anti psychotic drugs.
- Rigidity: Maintenance of a rigid posture against efforts to be moved.
- Negativism: An apparently motiveless resistance to all commands, if attempts to be moved doing the opposite.

- Posturing: Voluntary assumption of an inappropriate and often bizarre posture for long periods of time.
- Stupor: akinesia (no movement) with mutism but with evidence of relative preservation of conscious awareness.
- Echopraxia: Repetition, echo or mimicking of observed actions.
- Waxy flexibility: Parts of the body can be placed in position that will be maintained for long periods of time even if very uncomfortable.
- Ambitendency: due to ambivalence (conflicting impulses) tentative actions are made but no goal directed action occurs.

(5) DISORDER OF THOUGHT AND SPEECH

Disorders of thought content

- Delusion: False unshakable belief out of keeping with the patient's social and cultural background.
- Primary delusions: A new meaning arises fully formed without a preceding abnormal psychological event.
 - delusional perception occurs when a full delusional meaning is attached to a normal perception with which it has no logical connection.
 - sudden delusional idea: is the occurrence of a fully formed delusion as in delusional perception, but without a preceding perceptual experience.
 - delusional mood: the patient feels the environment has changed in an inexplicable unpleasant and self-referential way.
- Secondary delusion: they arise from other morbid experiences.
 - Persecutory (paranoid psychosis, schizophrenia, depression)
 - Grandiose (hypomania, mania, schizo)
 - Hypochondriacal (depression, schizo, hypochondriasis)
 - Nihilistic (Cotard's syndrome, depression)

- Jealousy (paranoid states)
- Erotomanic (schizo, mania, paranoid states)
- Delusions of reference: Belief that remarks, events or objects have a personal significance.
- Passivity (delusions of control) experience of being under external control which may apply to:
 - movement(motor passivity, made acts)
 - sensation(somatic passivity, made sensations)
 - emotions(emotional passivity)

Disorder of the form of thought

- Formal thought disorder: disorder of the process of thinking and the expression of thoughts.
- concrete thinking: impairment of abstract or symbolic thinking.

Disorders of thought possession(thought alienation).

Definition: disturbances of the experience of personal possession of thinking. They are not delusions.

Thought insertion: the experience of having thoughts inserted into the mind; recognized as foreign and coming from outside.

Thought withdrawal: thoughts suddenly disappear so that the patient's experience is that they have been removed by an outside influence.

Thought broadcasting: Thoughts become available to others by diffusing out from the confines of personal thinking.

Disorders of the stream of thought

Thought block: sudden interruption of thought (speech)

Perseveration: persistent repetition of words beyond their relevance.

Retardation(Inhibition): the train of thought is slowed down the number of ideas decreased (poverty of speech.)

Circumstantiality: Rambling and digression by a speaker who also add unnecessary trivial details but finally the point is reached.

Pressure of thought: Rapid movement of thought the mind.

Flight of ideas: rapidly produced speech with abrupt shifts from topic to topics usually there is connection.

NB:

Obsession: Recurrent, persistent and intrusive thoughts, impulses or mental images that the individual tries to resist, finds unpleasant and recognizes as senseless. It causes great anxiety to the sufferer.

Compulsion: illogical act that the subject feels forced to carry out repetitiously.

Disorders of the production and content of speech

Dysarthrias: produced by mechanical disorders of the anatomical structures necessary for the articulation of speech.

- Stammering (stuttering)
- Mutism: Refusal to speak(elective mutism occurs in children.)
- Pressure of speech
- Neologisms: new words made up by the patient
- Talking past the point (vorbeireden)

The patient`s reply to questions shows that he understands what has been asked and is deliberately talking about an associated topic.

Aphasias: receptive: the patient hears words but cannot understand them.

- expressive: patient had difficulty into putting his thoughts into words.
- nominal: patient cannot name objects although he has plenty of words at his disposal.
- Word approximation(paraphasia)
Normal words are used in an unconventional or distorted way but the derivation can be understood, even if bizarre. (e.g. describing a stomach as a food vessel)
- Echolalia: repetition or echo by the patient of words or phrases of the examiner.
- Verbigeration: senseless repetition of the same words or phrases over and over.
- Glossolalia: speaking in tongues(verbal expression that may appear strange)

- Tangentiality: the patient in his speaking or thinking goes on all kinds of tangents and never gets to the point.

(6) DISORDER OF PERCEPTION

- deceptions:- hallucination
 - illusions
- distortions

Deception

- Illusion: misinterpretation of actual real perception, stimulus.
- Hallucination: perception without object. The perception arises from within the individual.
- Eidetic images: very vivid mental visual images
- Auditory hallucinations:
 - second or third person hallucination
 - running commentary
 - thought echo (repetition of thought)

- Visual hallucination
 - lilliputian (miniature people)
 - gulliverian (giant people)
 - hypnagogic: when falling asleep
 - hypnopompic: when waking up

- Gustatory (olfactory hallucinations)
- Tactile hallucinations (haptic)
 - Formication: experience of feeling small animals crawling on the skin.
- Special hallucinations
 1. Functional: provoked by a stimulus but experienced along with the background stimulus. (e.g. voices from a running tap.)
 2. Reflex hallucinations: occur when a stimulus in one sensory modality produces a hallucination in another.
 3. Extracampine hallucinations: are experienced as located outside the limits of the sensory field (hearing someone talk on the other side of the world.
 4. Pseudo-hallucinations: occurring within the mind rather than external space. there is no voluntary control.
 5. Dissociative: intense feelings and knowledge of being in the presence of someone or something, which the individual feels they can "almost see and hear". The term can be also applied to the hallucinations occurring in 2 sensory modalities. e.g.(the vision that speaks.) they are normal in grief.
 6. Autoscopie: hallucinations or the phantom mirror-images.
 7. Negative autoscopia: the patient looks in the mirror and see no image.(Epilepsy, Schizophrenia or organic states).

Distortions

Definition:

Change in intensity of perception which may result from changes in physiological thresholds or mental states(emotions).

- Dysmegalopsia: changes in the spatial form of visual perceptions.
- Depersonalization, the self, and in Derealization (the world) seem unreal (occur in anxiety, depression temporal lobe epilepsy, schizophrenic and in normal people.)

III. DYNAMIC PSYCHOPATHOLOGY

Some definitions

- Freud Sigmund (1856-1939) argued that the mind has 3 components
 1. ID: instinctual drives with which an infant is born. It is pleasure seeking and unaware of social reality.
 2. EGO: part of the personality that perceives and evaluates reality. It is a part of the ID which has been modified by the direct influence of the external world. It is reality seeking, respecting contradictions of space and time.
 3. SUPEREGO: part of the ego in which parental values are introjected where self-observation, self-criticism, self-praise develop.
- Libido: sexual instinctual forces and drives (sexual used in the widest sense)
- Empathy: a feeling for another human being.
- Transference: feelings initially directed to an earlier significant person are transferred onto a person in an immediate present relationship.
- Countertransference: conscious and unconscious emotional response of the therapist to the patient in treatment.
- Regression: return to earlier patterns of behavior following a severe stress or as a manifestation of emotional disorder.
- Ambivalence: conflicting and contradictory feelings toward the same object.

- Catharsis: release of previously unconscious feelings with outward expressions of feelings.
- Fixation: arrest of emotional development before full maturity and may occur at any stage of personality growth.

Defense mechanisms:

Sometimes an individual reduces anxiety by distorting the reality of the situation. Which or she cannot handle effectively.

The strategies used are called Defense Mechanisms:

All persons use them at times, it becomes abnormal when they are the predominant way of coping with problems.

Different defense mechanisms

1. Repression: the unconsciously motivated blocking of unacceptable feelings from awareness. As repression is seldom fully successful, the repressed impulses threaten to break through into conscious. The individual becomes anxious and employs other defense mechanisms to keep the partially repressed impulses from awareness. (to aid repression)
2. Conversion: the emotional conflict is kept out of awareness but is expressed (converted) in a physical symptoms. {A soldier fearing fighting may develop a arm weakness}.
3. Denial: intolerable reality is blocked out of awareness e.g. approaching death may be denied because recognition of this reality produces unbearable anxiety.
4. Displacement: the emotion is unchanged but directed to a more tolerable focus. e.g. an angry child who kicks the cat or a Younger sibling as it cannot comfortably be angry at a parent.
5. Identification: the individual integrates into her own personality selected qualities of significant people in her life.

6. Introjection: the subject takes into his own personality external qualities or identities of the people around him. This is a more primitive less selective form of personality development than identification.

7. Intellectualization: use of logical explanation or rationalization for behavior or feelings prompted by repressed feelings.

8. Regression: return to early patterns of behavior occurring in normal people under stress. The ill child may go back to thumb sucking or enuresis after a new baby is born.

9. Reaction-Formation: the intolerable feeling is kept out of awareness by the overemphasis of the opposite emotion or drive. e.g. the person who finds his/her angry or aggressive feelings too anxiety-provoking becomes overly sweet, friendly.

10. Projection: unacceptable personal feelings or qualities are externalized outward and projected onto other persons. e.g. aggressive people who become paranoid.

11. Sublimation: an unacceptable emotion or urge is channelled into a socially approved behavior. e.g. Aggressive person who becomes a boxer.

CLINICAL ASSESSMENT

PSYCHIATRIC INTERVIEW HISTORY AND MENTAL EXAMINATION

OBJECTIVES:

To introduce the trainee to techniques of interviewing and examining in psychiatry.

To equip the trainee with skills in:

- a. patient-therapist relationships
- b. recording data
- c. interpreting the data recorded in history

INTRODUCTION:

Psychiatric interview is usually an intimate and private encounter between the clinician and the patient and has some special issues rarely seen in other types of interviews. Because the encounter involves the patients revealing the most painful aspects of his/her life it is important for the clinician to consider the following:

1. The patient must be assured of confidentiality, and this is vital in ensuring that the patient reveals all information necessary for proper diagnosis to be made.
2. Proper time use: consultation should be around 30 minutes and not less and need for subsequent interviews should be considered. The clinician should not also keep the patients waiting for too long for the interviews.
3. Use of interviewing skills is paramount and the clinician should be good listener, nodding to show appreciation and it is only through listening carefully that one is able to detect themes which may be vital in diagnosis and therapy.
4. Note taking is important for various reasons, one legal and secondly for aiding the clinician's memory during subsequent interviews.

5. A conducive quiet environment should be provided so that the doctor-patient encounter is as private as could be.
6. The clinician with permission from the client should obtain collateral history from significant others especially relatives so as to obtain a complete history.
7. One should be aware of special cases that would be encountered and which pose problems. These include depressed, suicidal, violent and delusional patients. These kind of patients may require a prompt referral to a psychiatrist.

Thus the clinician aims at establishing what is sometimes referred to as therapeutic alliance which is a close relationship between the patient and the clinician and it is important to the treatment process.

8. Following a standard format in which notes are recorded and diagnosis made after interpreting all available information.

HOW TO APPROACH A PATIENT

Take a psychiatric history to include:

1. Identifying data, i.e. name, age, marital status, religion, and address of the patient and that of next of kin
2. Chief complaint (what brings the patient to seek help?)
3. History of present illness: when, how did problem start, what has happened to the patient so far?
4. Previous illness - a) Psychiatric
b) Medical/surgical and the type of treatment administered.
5. Personal history
 - a) Prenatal and post natal - find if mother had any medical problem and if the delivery was normal and if so how?
 - b) Early childhood (through age 3) record if the milestones were normal, (social smile, neck support, crawling, sitting with support, sitting without support, standing with support, standing without support, walking, name calling, sentences development..

- c) Middle childhood. (age 3-11) school age, how child performed academically and socially.
- d) Late childhood (puberty through adolescence) school age, adolescence related crises and issues.
- e) Adulthood, recording details about the following aspects of the individual, which usually reflect the state of one's mental health.
 - i) Occupational history (jobs held, training done and level of achievements)
 - ii) Marital and relationship history
 - iii) Educational history
 - iv) Military history (where relevant)
 - v) Religion
 - vi) Social activities, e.g. membership in clubs or organizations
 - vii) Current living situations: this is very important and will assist the clinician in understanding the patients presenting symptoms of illness. Make a summary of dreams, fantasies and values.
 - viii) Psychosexual history: Find if the client was sexually abused at childhood and how they learned about their sexual development. Also enquire about difficulties in sex (impotence, premature ejaculations) and deviant sexual practices such as homosexuality, sexually transmitted diseases and A.I.D.S may also be inquired about.
 - ix) Family history: a brief statement of psychiatric, medical illness in the most immediate family members and if there is alcoholism or drug abuse in the family. Family order and achievement in every member for comparison is noted.

MENTAL STATUS EXAM

This is a systematic technique of identifying abnormal psychological feelings/aspects and thoughts in a client. It sums up the psychiatric interview and history.

1. GENERAL DESCRIPTION

Under this include:

- i) Appearance (posture, poise, clothing and grooming)
- ii) Behaviour and psychomotor activity (the qualitative and quantitative e.g gesture restlessness)
- iii) Attitude towards examiner, is patient co-operative, interested, seclusive hostile etc.

2. MOOD AND AFFECT

Mood is defined as a pervasive and sustained emotion that colours the person's perception of the world, e.g. depressed, despairing, irritable, anxious and angry.

Affect is what the examiner observes on the patient's facial expressions. It is flat, euphoric, fearful, anxious, expansive, and so on.

Appropriateness refers to whether the affect is congruent with what the patient is saying e.g. talking of one bereavement and laughing at the same time is inappropriate.

3. SPEECH

Speech is described in terms of its:

- Quantity (talkative, voluble and unspontaneous)
- Rate of production (rapid, slow, pressurized, hesitant)
- Quality (mumbled, monotonous, monosyllabic)

4. PERCEPTUAL DISTURBANCES

These are disturbances where one perceives a perception without a stimuli.

Examples are:

- i) Auditory hallucinations, which are hearing without a stimulus in the environment
- ii) Visual hallucinations which are seeing without a stimulus in the environment
- iii) Olfactory hallucinations which are smelling without a stimulus in the environment
- iv) Tactile hallucinations which are touch without a stimulus in the environment
- v) Gustatory hallucinations which are tasting without a stimulus in the environment

Other disturbances include depersonalization and derealization where the individual feels detached from self and environment.

5. THOUGHT

i) Process or form of thought:

This refers to the way in which a person puts together ideas and associations, the form in which a person thinks. Thoughts may be overabundant or may be vague

Examples are:

- Loosening of associations or derailment (unrelated ideas) LAO
- Flight of ideas (FOI)
- Tangentiality where patient loses the thread of conversation
- Circumstantiality is non goal directed thinking, includes many irrelevancies.
- Word salad or incoherence refers to incomprehensible connection of thoughts
- Neologisms (fabricated words)
- Clang associations (associations by rhyming)
- Punning (association by double meaning)
- Thought blocking, insertion, withdrawal, broadcasting and vague thoughts

ii) Content of thought:

This is what the thoughts are all about and disturbances include:

- Delusion - false, unshakable belief which is inconsistent with one's educational, cultural and social background e.g. paranoid delusion which is a false belief that one is being persecuted or harmed.
- Pre-occupation - obsessions and compulsions: these are ideas which are known by patients to be from self and intruding patients' minds. The patient acts to reduce the stress caused by these intruding thoughts.
- Phobias are fears whose presumed cause is not reality that dangerous, e.g phobias for heights, open ground, insects etc.
- Suicidal and homicidal ideas where people are pre-occupied with death.
- Ideas of reference and influence: these are ideas that everything that is taking place has some relevance to the patient.
- Poverty of content: is seen when the patient fails to engage in meaningful thought processes

7. SENSORIUM AND COGNITION (COGNITIVE FUNCTIONS)

Alertness and level of consciousness are measured using the following parameters:

- i) Orientation in person, place and time
- ii) Memory
 - remote memory is tested by asking about events that took place long time ago
 - recent memory is tested by asking about events in the last few months
 - immediate memory is tested by asking about events in the last few hours
 - retention and recall can be tested by asking the patient to recall a digit span or a name given a few minutes ago
- iii) Concentration - the patient is asked to do serial 7 test where patient subtract 7 from 100 serially this requires concentration and cognition capacity
- iv) Abstract thinking - this is the ability of the patient to deal with concepts e,g proverbs.

8. FUND OF INFORMATION AND INTELLIGENCE

The patient's ability to handle general information and difficult concepts. Test him on important dates or events and general issues in his environment.

9. IMPULSE CONTROL

Tests the patient's awareness of socially appropriate behaviour - such impulse include sexual aggressiveness etc. is he capable of controlling them?

10. JUDGEMENT AND INSIGHT

- Judgement: does the patient understand the likely outcome of his or her behaviour?
- Insight: this refers to the patient's degree of awareness and understanding that they are ill
- Reliability: is the patient able to report accurately about his illness?

11. PHYSICAL EXAMINATION

This should be done on every patient

12. MULTI-AXIAL DIAGNOSIS

Once the clinician has taken all the history he should then record the diagnosis under the following format:

Axis 1: The main psychiatric syndrome

Axis 2: The main developmental disorder e.g mental retardation, personality disorder

Axis 3: Any physical/medical disorder

Axis 4: Any psycho-social stressors which affect the patient in any way

Axis 5: Global function: the clinician judges the level of functioning in the last one year.

90 points represent the highest level of functioning.

The clinician then assesses and draws a management programme after deciding what investigations are necessary either the social, physical or psychological.

SCHIZOPHRENIA

OBJECTIVES:

To enable the trainee to recognize and manage patients with schizophrenia.

Schizophrenia is the most common serious Psychiatric illness,. It is an illness which interferes with the individual's personal and social functioning and if untreated, runs a chronic course.

EPIDEMIOLOGY

The incidence of Schizophrenia is between 0.3 and 0.6 per 1,000 persons. The life time prevalence is about 1%. Schizophrenia usually starts in the age group of 15- 20 years. this peak age of onset for men is between 15 and 35 years. This is no different in the prevalence of schizophrenia between males and females . The onset can be acute or insidious. Sometimes the onset may be precipitated by a stressful event. The illness generally runs a continuous and chronic course.

AETIOLOGY

The aetiology of schizophrenia is multifactorial basically a person may have a specific vulnerability and when acted on by some stressful environmental or biological influence, the symptoms of schizophrenia develop.

Genetic Factors

Family studies show that schizophrenia tends to aggregate in families.

Prevalence of schizophrenia in specific population

	Prevalence (%)
General Population	1
Non sibling of a schizophrenic patient	8
Child with one schizophrenic patient	12

Dizygotic twin of a schizophrenic patient	12
Child of two schizophrenic parent	40
Monozygotic twin of a schizophrenic patient	47

Twin studies concordance rates of 50% among monozygotic twins and 17% among dizygotic twins, therefore MZ twins (who share the same genetic information) have the highest concordance rate.

PSYCHOSOCIAL FACTORS

Although patients with schizophrenia have a significant genetically based vulnerability, Psychosocial factors are also important in the development, expression and course of the disorder. Life stresses often act as precipitants of schizophrenia.

Schizophrenia is over presented among people of low socio-economic status. These findings may be of aetiological importance, but more recent evidence suggests that they could be a consequence of illness. Social isolation may also be important (living alone, unmarried and with few friends). Pathological families have also been implicated in the causation of schizophrenia, especially families with disordered communication. Physical illness and child birth are biological stresses that may precipitate the onset of schizophrenia.

Some case histories will illustrate the schizophrenic illness.

Mr. A is a 21 yr old man from a rural area who completed primary school and started assisting in the "shamba" of his family. He was a quiet and calm person with only few friends.

His relationship with others in the family and village and his work was considered satisfactory. Since the last few weeks, he has been quiet and withdrawn, not caring to talk to others, even at home. He has not been working well too. He looks different as if he is in his own world not aware of what is going on around him. He is irritable. On enquiry the relatives mention that, he mutters and smiles to himself. His answers to questions asked do not make any sense (inappropriate and ununderstandable.)

At times he acts in a very strange manner.

He looks at the roof and mutters. Sometimes he looks scared. He has been neglecting his personal hygiene.

On talking to him, he claims that his thoughts and actions are controlled by some external force. He hears commanding voices ordering him to do certain things. His parents report that there have been no life changes preceding the onset of illness.

Mr. B is a 24 yr old male. He has been reported to be talking and behaving strangely since the last several days. He is restless and hostile to people around him. He abuses them and even attempts to assault them when he gets irritated. He keeps talking to himself and shouts at times. He has stopped working. On enquiry if the relatives mention that he is unduly suspicious of everybody and everything around him. He says other are talking about him. He believes that people stare at him and watch his actions. He suspects that some people are plotting to harm and destroy him. He hears the conversation of these people who are against him. Some of them are people he knows while others are strangers. Some times he hears his own thoughts as if somebody is shouting from somewhere. At other times he hears a running commentary of his own actions e.g because of these experiences he is scared to move around.

Mrs. C is a 34 yrs old married female, who has been deserted by her husband, presently living with her old parents. She has been ill for the last 5 yrs with several episodes of exacerbation of her symptoms. She has never been completely well at any time during this period. Her illness started a few years after her marriage. Presently she does not do any work regularly. She eats and sleeps as she likes. She stays at home and in her village for a few days of the month, and begs around in the near and far villages. She is known as a "mad woman" by everybody including the children of these villages. After she became sick, her husband took her for traditional treatment but she continued to be ill. He sent her to her people who believe there is no treatment for her "madness".

SYMPTOMS

Schizophrenic illness is characterized by abnormality of thinking, perceptions and emotions resulting in abnormal behaviour, action and talk.

Schizophrenia has many symptoms, of which none is found only in schizophrenia. When taken together, however, the symptoms usually make the diagnosis quite clear.

Premobid symptoms

Typically the history is that of a schizoid personality - quiet, passive, with few friends as a child, day dreaming, introverted and shut in as an adult. The child is reported to have been especially obedient and never in any mischief.

APPEARANCE AND BEHAVIOUR

- Some patients with acute schizophrenia are entirely normal
- Others seem awkward in their social behaviour, pre-occupied and withdrawn or odd
- Some patients smile or laugh without obvious reason
- Some are restless, noisy or slow, sudden and unexpected changes or behaviour, such as violence
- Others retire from company, spending a long time alone
- some may exhibit bizarre postures

DISORDERS OF THOUGHT AND DELUSION

The schizophrenia has abnormal ideas and thoughts of various kinds which he firmly believes in these beliefs are unshakable (Delusions).

Persecutory delusions are common, delusions of reference, of control and delusions about the possession of thoughts. (Refer to psychopathology chapter)

Schizophrenia is also characterised by formal thought disorder resulting in looseness of associations, incoherence, neologisms, echolalia and mutism.

HALLUCINATIONS

Schizophrenics may perceive things which do not really exist (e.g. hears voices and sees visions which are non-existent - hallucinations)

Auditory hallucinations are the most common in schizophrenic patients. Patients may complain of hearing voices, which may be threatening, obscene, accusatory, or insulting. Visual hallucinations occur less frequently. The schizophrenic may also misinterpret the environment and accord special meanings for various things of normal occurrence.

SPEECH

Because of these his talk (speech) and action might become un understandable and irrelevant. He may either talk too much or too little or not talk at all. He may be found talking and laughing to himself. This may be his responding to the voices he hears. He may become suddenly hostile, abusive and violent in response to unpleasant thoughts or voice. Phases of excitement may be followed by extreme withdrawal when the patient may remain in uncomfortable and bizarre posture for long periods of time.

SLEEP

Varying degrees of sleep disturbance will always be present.

MOOD

Abnormalities of mood, characteristically , blunting of affect also known as flattening of mood - essentially this is sustained emotional indifference or diminution of emotional response. Incongruity of affect whereby emotions not in keeping with mood ordinarily expected e.g. laughing when told about a bereavement. Other symptoms include, anxiety, bereavement, depression, irritability, loss of interest, loss of concentration, suspiciousness and disordered thoughts.

IMPULSE CONTROL, SUICIDE AND HOMICIDE

Schizophrenics may be quite agitated and have little impulse control when acutely ill. They may also have decreased social sensitivity e.g grab another patients's cigarettes, or throw food on the floor. Some impulsive behaviour includes suicide or homicide attempts and these may be in response to hallucinations commanding the patient to act so. 50% of all schizophrenics attempts suicide and 10% of them succeed.

Orientation Schizophrenics are usually orientated in person, time and place

Memory is usually intact

Judgement and insight Classically, schizophrenics have little insight to their illness

It is essential to remember that in actual clinical practice only some of the above features may be present in any given patient. But diagnostically one of the most important finding is that when examining the patient you find that you cannot share, understand the patients experiences and meaningfully communicate with the patient.

COURSE AND PROGNOSIS

Schizophrenia often begins insidiously, when the person may begin to complain of somatic symptoms such as headache, back and muscle pain, weakness and digestive problems. Relatives and friends may eventually notice that the person has changed and is no longer functioning well in occupational social and personal activities. The onset of more pronounced symptoms may be acute (days) or gradual (a few months). The classic course of schizophrenia is one of exacerbations and relative remissions. The major distinction between schizophrenia and mood disorders is the failure to return to baseline functioning after each relapse in schizophrenia . Deterioration progresses for an average of five years, at which point most patients reach a plateau.

Positive symptoms (Hallucinations, delusion) tend to become less severe with time, but the socially debilitating negative symptoms (social isolation, apathy, lack of violation) may increase. The patient's life is characterized by aimlessness, inactivity, homelessness and poverty.

Prognosis A variety of factors are associated with good and poor prognoses.

Features weighing toward good or poor prognosis in Schizophrenia

Good prognosis

Late onset

Obvious precipitating factors

Good premorbid social, sexual and work history

Affective symptoms e.g depression

Family history of mood disorders

Good support systems

Poor prognosis

Early onset

No precipitating factors

Insidious onset

Poor premorbid social sexual and work history

Withdrawn, autistic behaviour

Family history of Schizophrenia

Poor support systems

Positive symptoms

Married

Neurological signs and symptoms

History of perinatal trauma

No remissions in three years

Many relapses

History of assaultiveness

MANAGEMENT

RECOGNITION

The most important guideline (indicator) for recognition is a rapid (recent) change in someone's personality. The relatives and neighbours report that the patient has become "a different man". They no longer understand him or share the behaviour and thinking of the ill person. The more severe cases, are easier to recognize as their behaviour will be very different from others. Consider the possibility of such psychoses in the following situations. When someone is mentioned to have excitement, violent behaviour or socially unacceptable behaviour

What to do after the diagnosis?

A schizophrenic patient will often need to be referred to a doctor or to a psychiatrist unit for treatment.

HOSPITALIZATION

The primary indications for hospitalization are for

- diagnostic purpose
- Stabilization on medications
- Patient safety because of suicidal or homicidal ideations
- And grossly disorganised or inappropriate behaviour, including the inability to take care of basic needs, such as food, clothing and shelter.

Hospitalisation decreases stress on a patient and helps him/her structure daily activities.

DRUG THERAPY Antipsychotic drugs

There are five major guidelines for the use of antipsychotics in schizophrenia

1. The clinician should carefully define the target symptoms to be treated.
2. An antipsychotic that has worked in the past for the patient should be used again.
3. The minimum length of an antipsychotic trial is four to six weeks at adequate dosages.
4. Polypharmacy should be avoided.
5. Maintenance dosages of antipsychotics are usually lower than the dosages necessary for acute episodes.

Chlorpromazine (Largactil) - an average dose for a hospitalized overactive patient would be 100 - 150 mg three times daily.

Others: Stelazine (trifluoperazine) Haloperidol 1.5 - 3mg three times daily

After a patient has improved from an episode of schizophrenia, he should be maintained on a reduced dosage of the effective antipsychotic for one or two years. The need of continuing medication should be impressed upon the patient and his family, follow-up visits should be arranged.

Depot Mofectate - long acting injection, is an appropriate maintenance medication.

ELECTRO CONVULSIVE TREATMENT

Is used in the treatment of certain schizophrenic patients.

It is helpful in withdrawn catatonic patients and may save the patient's life.

If schizophrenic patients refuse to eat, are losing weight and strength, they should be referred to a psychiatrist for ECT.

PSYCHOSOCIAL TREATMENT

Regular drug administration is only one aspect of treatment of schizophrenia.

Psychosocial treatment should augment the clinical improvement.

All efforts should be taken to rehabilitate the patient to do some work regularly and the family members counselled to facilitate supportive psychotherapy.

Behaviour Therapy

Behaviour techniques use token economies and social skills training to increase social abilities, self sufficiency practical skills and interpersonal communication.

Adaptive behaviours are reinforced by praise or tokens. Consequently the frequency of maladaptive behaviour - such as talking loudly, talking to oneself in public and bizarre posture is reduced. Other psychosocial treatments include family therapy, group therapy, individual psychotherapy and rehabilitation.

MOOD DISORDERS

AIM:

To familiarize the trainee with the presentation of mood disorders in an African setting and to equip him with the skills necessary to initiate basic and appropriate interventions.

Definition:

Characterized by pervasive disturbance of mood either abnormally lowered and elated.

There is a continuum with normal mood.

Interferes with social and occupational functioning.

CLASSIFICATION

Mood disorders can be classified as:

- (i) Primary
- (ii) Secondary - to an organic condition

International Classification as set forth in DSM III R

3 major divisions

Bipolar illness - Patients with features of swings of mood from abnormally elated to abnormally depressed mood, on different bouts of illness.

Depressive disorders: features depressed mood for every bout of illness

Mixed disorders:

Patients present with both with both features of a bipolar illness and depressive illness at the same time.

Epidemiology

Lifetime prevalence is estimated at 9.2% of the population (USA)

Kenya's Asylums:

- i. 30% of newly admitted patients to a mental hospital have mood disorders.
- ii. Of the above 13% present with depressive disorders and 31% are found to have bipolar illness.

Age

Depression increases with age with peaks in the 50's and 70's

Bipolar illness common in young adults (20-30)years.

Sex

Equal sex incidence for bipolar illness

More females suffer from depressive disorder

Social class

Bipolar illnesses and severe depressive disorders are commoner in higher social classes.

MAJOR DEPRESSION

(Signs and symptoms of depression with relevance to an African setting)

Considerations

- it is a clinical syndrome comprising of disturbances in behaviour, thinking and emotions.
- expression modified by culture and religion
- there is changing presentation with westernisation
- lack of descriptive terms in several African languages favours expression in physical terms.

International criteria for diagnosis (DSM IV)

Illness present for at least 2 weeks with at least one of the following symptoms:

- (i) Depressed mood
- (ii) Loss of interest

And at least five of the following symptoms:

- (i) Disturbed sleep
- (ii) Significant weight loss when not dieting, or a decrease or increase in appetite, constipation
- (iii) Agitation or slowing in functioning as observed by others
- (iv) Feeling of worthlessness and guilt
- (v) Diminished ability to think, concentrate, make decisions
- (vi) Thoughts of dying and death including suicide and/or specific plan to carry them out
- (vii) Hearing accusatory and denouncing voices

Besides the above mentioned symptoms the following are commonly seen in African settings:

- headaches, felt on top of the head
- lightness of the head
- sensations of internal heat (heat in the head, heat in the neck, and low back heat)
- feelings of heaviness of limbs
- sensations of something moving in the body
- migratory pains in the body
- fark blood
- insufficient blood
- water in the head
- insufficient ejaculations
- inability to see well
- feelings of eyes being pulled inwards

- symptoms being ascribed to witchcraft, "evil eye"
- depressed mood may be totally masked by physical symptoms

DYSTHYMIA

- refers to less severe degrees of depressive illness lasting at least 2 years.
- there are no psychotic symptoms

Etiology of Depressive disorders

i Biological

- a) genetic (inherited)
- b) disturbances in levels of stress hormones
- c) functional deficits in levels of neurotransmitters in the brain

ii Psychological

- learnt maladaptive ways of behavior
- a pessimistic and distorted ways of perceiving life.

iii Social

(a) Predisposing factors

- being female
- being in first born
- lacking a regular income (Kenya)

(b) Precipitants (life events)

- can be related to education, health (Kenya)

(c) Breakdown of social support systems

Management

A. Indications for hospitalization

(i) Self neglect

- (ii) Suicidal behaviour
- (iii) Depressive stupor

B. Treatments

- (i) Drugs - antidepressants; antipsychotics and anxiolytics where necessary
- (ii) Electroconvulsive therapy for severely ill or suicidal patients
- (iii) Psychotherapy, counselling
- (iv) Social therapy (environment manipulation)

NB: minor depressive disorders require only counselling and anxiolytics

Outcome

- great individual variation
- normally recovery with return to work
- 20 % of depressed patients chronically ill
- suicide (70% of people who commit suicide are depressed)

BIPOLAR ILLNESS

I. MANIA

Generally regarded as the opposite of depression.

International diagnostic criteria (DSM IV) are as follows:

- episodes of persistently elated, expansive or irritable mood

And at least 3 of the following accompanying

- i inflated self-esteem
- iii decreased need for sleep
- iii more talkative than usual
- iv hyperactivity
- v distractibility

- (ii) Suicidal behaviour
- (iii) Depressive stupor

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vi excessive involvement in pleasurable activities e.g alcohol intake overspending, sexual intercourse

In addition to the above, the patient requires hospitalization as a result of impairment in social and occupational functioning.

Less severe degrees of manic illness are referred to as Hypomania

Manic illness may alternate with depressive illness

2. CYCLOTHYMIA

Refers to hypomania alternating with less severe depressive illness for at least 2 years.

Etiology of bipolar illnesses

- inherited

MANAGEMENT

Acute illness

- (a) Drugs
- Phenothiazines
 - Lithium
 - Carbamazepine

- (b) Electroconvulsive treatment

Prophylaxis

- Carbamazepine in the drug of choice
lithium is a useful alternative

OUTCOME

- great individual variation
- normally self- limiting (lasts about six months)
- Bipolar patients get more and prolonged depressive episodes as they grow older
- suicide (estimated at 15%)

MIXED STATES

- symptoms of mania and depression co-exist at the same time
- thought to be inherited
- treatment includes mood stabilizers e.g. lithium, carbamazepine, electroconvulsive therapy
- the course similar to bipolar illness

ANXIETY DISORDERS

AIM:

Acquaint the trainee with the presentation of anxiety disorders and methods of intervention.

DEFINITION:

Anxiety is characterized by a subjective feeling of anticipation dread or apprehension or a sense of impending disaster associated with varying degrees of arousal.

- Severe anxiety leads to maladaptive social, occupational and psychological functioning.
- Anxiety can be generalized or situational
- Its expression is modified by culture and religion
- Any physical disorder mimicking the symptoms of anxiety must be ruled out

EPIDEMIOLOGY

- Prevalence in general population estimated at 2-4%.
- Lifetime prevalence 10-25%
- 17-22% of all medical patients have a definable anxiety disorder

It is twice as common in women.

It is commoner in young adults and children.

(Peak age of onset before 30 years.)

ETIOLOGY

1. Psychological

- maladaptive use of defense mechanisms or their breakdown.
- psychic Trauma

2. Biological

- Familial
- Hyperactive autonomic nervous system.
- Inadequate inhibitory systems to counteract the alerting mechanisms

3. Learning theory

- anxiety as learned maladaptive process that can be modulated by reward and punishment.

4. Environmental deprivation

- poor education
- poor housing
- poverty
- noise pollution

Signs and symptoms using the DSM III R

Anxiety has two components

- (i) psychological
- (ii) somatic

(a) Motor tension

- trembling
- restlessness
- easy fatigability

(b) Autonomic hyperactivity

- shortness of breath
- palpitations (accelerated heart rate)
- sweating
- dizziness
- nausea, diarrhea
- hot flushes or chills
- frequent urination
- trouble swallowing

(c) Vigilance

- feeling tense
- exaggerated startle response
- difficulty concentrating
- " mind going blank"
- trouble falling asleep or staying asleep
- irritability

Medical conditions associated with anxiety

- (i) Endocrine - e.g Hyperthyroidism
- (ii) Metabolic e,g Hypoglycemia
- (iii) Cardiovascular e,g Hypertension
- (iv) Neurological e.g Temporal lobe epilepsy
- (v) Drug ingestion or withdrawal e.g. psychostimulants, alcohol

MANAGEMENT

- (1) Rule out organic basis for symptoms

- (2) Psychosocial therapy (help patients with their social problems)
 - supportive psychotherapy
 - relaxation training

- (3) Use drugs sparingly:
 - Benzodiazepines
 - Beta-blockers
 - Tricyclic antidepressants
 - Neuroleptics in small doses

TYPES OF ANXIETY DISORDERS

1. POST TRAUMATIC STRESS DISORDERS

Defined by the temporal relationship between a recognizable traumatic event and the development of symptoms that cause impairment in psychological and physical functioning. The traumatic event in general regarded as being outside the range of normal human experience. Anybody given sufficient trauma can develop the disorder.

Types of Stressors:

- (i) Torture
- (ii) fire
- (iii) rape
- (iv) floods
- (v) war
- (vi) road , train, air, accidents etc.

Phases of Response to trauma:

1. Outcry phase
 - alarm
 - shock
2. Denial phase:
 - amnesia
 - somatic symptoms
 - withdrawal
3. Intrusive phase
 - exaggerated startle response
 - vivid recollections of the traumatic event
 - labile affect
 - chronic arousal state with sleep disturbance
 - fear of going insane

4. Working through phase
 - searches for meaning in the traumatic event and considers new plans for coping.
5. Completion phase
 - recognizes of the trauma on his or her own psyche and resumes work and leisure activities

Abnormal reactions to trauma

- i. Symptoms that do not resolve in a few weeks
- ii. Symptoms that are severe
- iii. Maladaptive responses including withdrawal, psychoses, substance abuse, depressive states, dissociative states

AETIOLOGY

- i. Nature of trauma
- ii. Pre-existing mental disorder
- iii. Age - children, young adults and the elderly are more prone to stress.
- iv. Social support. Adequate social support may decrease the long term effects.
- v. Personality traits - individuals with secure self concepts recover quicker

SIGNS AND SYMPTOMS

Traumatic is experienced in at least one of the following ways:

1. Recurrent intrusive recollections thoughts, distressing dreams, sense of reliving the experience and distress at exposure to situations that symbolize the event, including anniversaries.
2. Efforts to avoid thoughts situations, feelings, activities that are associated with trauma. Feelings of hopelessness and withdrawal.
3. Persistent symptoms of autonomic arousal as outlined under symptoms of anxiety.

The disturbance having been present for at least one month.

PREVENTION AND TREATMENT

1. Assistance immediately following a disorder.
 - Reassurance, ventilating emotions,
 - Shelter
 - Locating relatives etc.
2. Support groups
 - Ventilate feelings and reassure victims
3. Psychiatric referral for severe cases

OUTCOME

Acute forms (onsets and duration less than 6 months) - good prognosis.

- Chronic and delayed forms have poor prognosis. Subjects experience exacerbation of symptoms during stressful periods with lack of improvement over time.

Early intervention minimizes the impact of traumatic events.

NB: Post-traumatic stress disorder will be discussed later in details.

2. ADJUSTMENT DISORDER

Described as mild and transient distress following life changes or stressful events.

Symptoms develop within 3 months of the life event

Stressors are less severe than in post-traumatic stress disorder

Types of life events:

- emigrating
- change of school

- retirement
- physical illness
- marriage etc.

Epidemiology:

- 30% of adolescents
- 10% of adults
- 5% of newly diagnosed psychiatric patients

Symptoms include:

- anxiety, worry, irritability, mild depression
- core symptoms of depression (poor appetite, sleep disturbance fatigue) are absent.

Management

- supportive psychotherapy
- self-help groups
- family therapy

PANIC DISORDER

DEFINITION:

- Episodic and sudden onset of overwhelming anxiety without clear precipitants.
- People experiencing panic attacks think they are going to die, lose control or go "insane"
- Disorientation, depersonalization and derealization are common.
- Symptoms last a few minutes to hours.
- Diagnostic criteria includes symptoms described under anxiety
- At least four episodes occurring in a 4-week period or having one attack that was followed by persistent fear of having another one for at least one month.

Epidemiology

Age peaks between 25 and 44 years

Sex ratio 2:1

Etiology

1. Biological

- Familial
- Hypersensitive alarm symptoms

2. Psychological

- thoughts of dying or going insane reinforces fear, avoidance and other disabling aspects of panic attacks
- separation anxiety disorders in childhood predispose to panic attacks.

Management

1. Drugs

- See under anxiety disorders
- Tricyclic drugs such as imipramine have specific effect on panic attacks

2. Psychological

- relaxation training
- cognitive therapy (encourage the patient to discard maladaptive thoughts such as fear of dying or going insane and replacing them with positive ones)

OUTCOME

- 50% recover
- 30% chronically ill
- 20% are relapsing course

HYPOCHONDRIASIS

- Defined as morbid, persistent preoccupation with the possibility of having one or more serious physical disorders.
- Complaints are often vague, wax and wane throughout the patient's life
- Physical examination does not support the diagnosis of a physical disorder
- Hypochondriasis could be symptomatic of depression, schizophrenia or personality disorder.

Epidemiology

- 1% of psychiatric patients
- Sex ratio equal
- Peak incidence in the 30's for men and 40's for women

Etiology

Psychological

- coping mechanism against low esteem

Management

- Rule out organic basis of symptoms.
- Supportive psychotherapy
- antidepressants or neuroleptics if part of major psychiatric disorder
- some patients benefit from physical exercises

HYSTERIA

- A term used to indicate the presence of a physical symptoms (usually neurological) produced by mental mechanism.
- Serves to relieve emotional pain (primary gain) and secondly, patient is able to avoid unwanted duties or situations (secondary gain)
- Symptoms not culturally sanctioned

Types

- i. Conversion - paralysis, seizures, aphonia, dysphagia, blindness, parasthesia
- ii. Dissociative - stupor, fuge, amnesia

Epidemiology

- onset in adolescence or early adulthood
- sex differences not known

Etiology

Predisposing factors:

- antecedent physical disorder
- exposure to others with physical symptoms
- severe psychological stress
- histrionic and dependent personalities
- parenting (overprotective)
- brain disease

Management:

- rule out organic cause, major psychosis, malingering
- assess interpersonal relationship
- prove gain

Treatment

- remove secondary gain
- anxiolytics
- get patient to talk especially if traumatic events are recent

OUTCOME

- Variable
- Majority resolve without treatment

ADJUSTMENT DISORDER

OBJECTIVES:

DISCUSS:

1. THE PHENOMENON OF ADJUSTMENT DISORDER
2. NATURE OF STRESSORS
3. EPIDEMIOLOGY
4. CLINICAL SIGNS AND SYMPTOMS OF THE VARIOUS SUBTYPES
5. TREATMENT

1. DEFINITION

1.0: Reaction to identifiable psychological stressor that occurs within 3 months of onset of the stressor.

1.1: Maladaptive nature of the reaction is indicated by either of the following:

1.1.0: Impairment in occupational (including school) functioning or in usual social activities or relationship with others.

1.1.1: Symptoms that are in excess of a normal and expectable reaction to the stressor.

1.2: The disturbance is not merely one instance of a pattern of over-reaction to stress or exacerbation of one of the mental disorders previously described.

1.3: The maladaptive reaction has persisted for no longer than 6 months.

1.4: The disturbance does not meet the criteria for any specific mental disorder and does not represent uncomplicated bereavement.

2. NATURE OF STRESSORS

2.0: The stressors may be single e.g divorce, or multiple e.g marked business difficulties and marital problems. They may be recurrent e.g associated with seasonal business crises or continuous e.g residence in a deteriorating neighbourhood or psychological stress associated with chronic illness. They can occur in a family setting e.g in discordant intrafamilial relationships.

2.1: They may affect only a particular person e.g psychological reaction to physical illness, or may affect a group of community e.g as in a natural disaster or persecution based on racial, social religious or other group affiliation. In some stressors may accompany specific developmental stages e.g going to school, leaving parental home, getting married, becoming a parent, failure to attain occupational goals and retirement.

3. EPIDEMIOLOGY

3.0: Out of 2,699 psychiatric admissions only 5 % were assigned this diagnosis.
(Kaplan 1992)

3.1: 59% of the sample were adolescents and 59% of them had the stressor for one year.

3.2: Among the adults 36% of the stressors were present for over a year. Females accounted for 2/3 of the adult group; 35% of the adults were married.

3.3: Adolescents were seen mainly for conduct while adults were more often seen for depressive symptoms (87%)

3.4: In adolescents, the precipitants were school problems, parental rejection, drug problems, parental divorce or separation.

3.5: For the adults, marital problems, separation or divorce, a recent move, financial problems were the major adjustment disorders.

4. ETIOLOGY

4.0: THE PREMORBID PERSONALITY

Determines ones, ability to respond to specific challenges or noxious insults. Some withdraw others lash-out, some respond with humor others with dismay some will be anxious others will have motor retardation. Hence the stressors may vary but the individual's likely strategy or style of contending with it is usually predictable.

4.1: THE STRESSOR

The stressor itself and how it affects an individual is also important. If the magnitude of the stressor is sufficiently pronounced, it will inevitably result into behavioural decompensation. The only issue is for how long can one forestall the decompensation.

For instance while faced with torture or being held as a hostage, behavioural and cognitive dysfunction (post traumatic stress disorder) are all too predictable no matter one's genetic inheritance.

4.2: PREVIOUS EXPERIENCE:

Previous experience with same or other stressors may determine one's response to the current stress. Hence one's deemed ability to respond to a stressor will very much determine one's handling of the available stressor. Dismay, despair or anxiety may lead to decompression. A supportive non threatening setting which minimizes additional challenges or stressors may facilitate coping.

5: CLINICAL SIGNS AND SYMPTOMS

There are nine clinical subtypes distinguished by the predominant features of the maladaptive responses.

5.0: ADJUSTMENT DISORDER WITH DEPRESSED MOODS

The commonest clinical subtype. It is manifested by depressive symptomatology less pronounced than that encountered in major depression and resulting in response to a psychosocial stressor. The category is psychogenic rather than biologically based. Depressive mood disturbance exceeds what is an expected response to the stressors at hand. The disorder may progress to a major depression.

5.1: Adjustment Disorder With Anxious Mood

This is characterized by a reaction of nervousness, worry and jitteriness as a response to a psychosocial stressor. The anxiety may take the form of panic or generalized anxiety.

5.2: Adjustment Disorder With Mixed Emotional Features

This mainly designates a clinical subtype of adjustment disorder with clinical symptomatology of depression and anxiety. It is most noted in adolescents undergoing adjustment difficulties when emerging into adults.

5.3: Adjustment Disorder With Disturbance of Conduct.

This is marked by conduct in which there is violation of the rights of others or of major age-appropriate societal norms and rules. Truancy, vandalism, reckless driving, fighting defaulting on legal responsibilities are some of the conduct disturbances. The differential diagnosis is conduct disorder and antisocial personality disorder.

5.4: Adjustment Disorder With Mixed Disturbance of Emotions and Conduct

- Anxiety }
- Depression }
- Conduct disturbance } Are the major forms of psychopathology noted

5.5: Adjustment Disorder With Work (Academic) Inhibition

Occurs in individuals who were performing quite capably but who suddenly are unable to carry out their usual tasks in response to identifiable stressor, e.g inability to study , write papers or reports.

5.6: Adjustment With Physical Complaints

These are individuals who respond to psycho social stressors by developing somatic symptoms of single or multiple organ origin.

5.7: Adjustment Disorder with Withdrawal

These individuals socially withdraw in response to psychosocial stressors, they do not manifest emotional or conduct complications.

5.8: Adjustment Disorder Not Otherwise Specified

- Emotional disturbance
- Conduct disturbance
- Somatic disturbance
- Work (academic) inhibition

6: TREATMENT

- 6.0: These disorders are expected to remit after the stressor ceases
- 6.1: Supportive psychotherapy has been most often used effectively
- 6.2: Psychotropics may help in cases where they are indicated

SUICIDE AND PARASUICIDE

AIM:

To enable the trainee to assess suicidality effectively and initiate appropriate intervention.

DEFINITION:

Suicide refers to the act of killing of one's self.

Parasuicide - refers to any act undertaken deliberately by a person who mimics the act of suicide but does not result in death.

SUICIDE

- ranks the 10th cause of death in the Western world.
- men use more violent methods
- 75% of those who commit suicide have seen a doctor or told someone of their wish.

Etiology

Social factors

3 types of suicide described:

- i Anomic suicide
 - most frequent
 - occurs after a break up of important social relationships
- ii Altruistic
 - less common
 - committed for the good of others
- iii Egoistic
 - occurs when the individual feels he is not part of the society and has no norms to guide him/her in times of stress

Biological factors

- low levels of certain neurotransmitters in the brain

Psychological factors

Persons with particular psychological traits are more likely to attempt suicide.

- i impulsive
- ii dependent dissatisfied
- iii unrealistic expectations

Family history

- suicide tends to run in families

Risk factors

i. long term

- a. mental illness
 - i Depression
 - ii Alcoholism
 - iii schizophrenia
 - iv neurosis
 - v personality disorders

- up to 90% people committing suicide have mental disorder

b Medical status

- i chronic pain
- ii recent surgery
- iii terminally ill
- iv disfigurement

c Previous suicide attempt

- 20-50% of successful suicides have attempted suicide before

d Demographic factors

- i age - suicide increases with age
- ii sex - males commit suicide more than females.
- iii marital status - the widowed, single, separated are at higher risk
- iv occupation:
 - rates higher in the unemployed
 - among the employed the risk is higher among doctors, police officers and unskilled workers

ii. Acute factors:

- dissolution of a love relationship or other significant loss
- change in medical condition
- drug intoxication
- starting or stopping psychotropic medication
- communication of suicide intent to others
- sudden improvement in depressed mood

PARASUICIDE:

Is commoner among the following groups

- adolescents
- normal people under stress
- those with personality disorders
- single, those living alone, divorced
- retired
- females attempt suicide more often than men

Motives in parasuicide

- "cry for help"

- attempt to get relief from an intolerable situation
- to induce guilt feeling in others
- patient having a death wish

Evaluation of Suicidality

- i Does the patient have a psychological/physical problem?
- ii Is the patient abusing drugs or alcohol?
- iii Has the patient suffered recent loss?
- iv Does the patient have a social support system and a confidant?
- v Any previous suicide attempts?
- vi Does the patient have realistic plans for the future?
- vii Are there any demographic factors indicating a risk of suicide?
- viii Has the patient recently put his affairs in order or given away his belongings?
- ix Does the patient have continuing suicidal ideas or plans and to what degree does he intend to carry them out?
 - assess risk individually depending circumstances

Management

1. Hospitalization if risk high
2. Specific therapy for psychological/physical problems

Out patient management:

- establish therapeutic alliance with patient
- inclusion of supportive family members
- supportive psychotherapy
- prescriptions to be kept at a minimum and supervised by supportive family members

General preventive measures for suicide and parasuicide

1. Improving the living conditions of people, (jobs, housing etc)
2. Health education on mental hygiene, and early recognition of mental disorder
3. Counselling services

FACTITIOUS DISORDERS

Objective - To acquire basic knowledge on factitious disorders.

Definition :

Factitious means not real or genuine. Factitious disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned.

The patient simulates physical or mental illness with the sole objective of assuming the role of a patient. These disorders are distinguished from malingering, in which symptoms are also under voluntary control but the goal is "obviously recognizable with the knowledge of the environmental circumstances" eg feigning illness to avoid trial in court.

EPIDEMIOLOGY

The prevalence of factitious disorders is unknown. They appear to occur most frequently in men and among health care workers.

AETIOLOGY

These patients have a personal history of early deprivation or serious illness from which they recovered from and in which health care workers were loving and caring. In contrast, to a family with a rejecting mother or absent father. The illness is used to recreate the desired positive parent-child bond. The disorder is a form of repetition compulsion - repeating the basic conflict of needing and seeking acceptance and love while expecting rejection. The patient transforms the health care workers into rejecting parents. Significant defense mechanisms are regression, identification with the aggression, repression and symbolization.

CLINICAL FEATURES

- 1) Factitious disorder with Physical symptoms
- 2) Factitious disorder with Psychological symptoms

FACTITIOUS DISORDER WITH PHYSICAL SYMPTOMS

(Munchausen, syndrome, hospital addiction, Polysurgical addiction)

The essential feature of patients with this disorder is their ability to present physical symptoms so well that they are admitted to hospital.

They are familiar with the diagnoses of most disorders requiring hospital admission and give excellent histories capable of deceiving the most experienced doctor.

Common symptoms include acute abdomen, haematemesis and haemoptysis.

Once in hospital they are demanding and difficult.

The symptoms appear to have been produced deliberately and there is evidence that the patient is trying to deceive the doctors e.g account of previous hospital admission, even name and address are often incorrect

FACTITIOUS DISORDER WITH PSYCHOLOGICAL SYMPTOMS

These patients present with psychiatric symptoms that are judged to be feigned. Feigned symptoms often include depression, hallucinations, dissociative and conversion symptoms and bizarre behaviour. Because there is no response to routine therapeutic measures, these patients may receive large doses of psychoactive drugs. Often these patients have a concurrent diagnosis of borderline personality disorder.

Course and Prognosis

The disorder usually begins in early adult life onset may follow a real illness, loss or rejection or abandonment.

Factitious disorder is extremely incapacitating to the patient, often producing severe trauma or reactions related treatment.

Chronic hospitalization is incompatible with meaningful vocational work and sustained interpersonal relationships.

DIAGNOSIS

The psychiatric examination should emphasize securing information from a friend, relative or other informant to reveal the false nature of patients illness.

Differential Diagnosis

Any disorder in which physical symptoms are prominent should be considered in the differential diagnosis.

- 1) Somatoform Disorders
- 2) Personality Disorders
- 3) Schizophrenia
- 4) Malingering
- 5) Drug Abuse
- 6) Ganser's syndrome

GANSERS SYNDROME

This is a condition most typically seen in prison inmates and is characterized by the use of approximate answers or talking past the point (e.g. when asked to multiply 4x5 the patient answers 21). Ganser's syndrome may be a variant of malingering, in that patients avoid punishment or responsibility for their actions. It is classified as an atypical dissociative disorder in DSM III-R.

Treatment - no specific Psychiatric therapy is effective in the treating these patients.

HUMAN SEXUAL DISORDER

OBJECTIVES

DISCUSS:

1. NORMAL SEXUAL BEHAVIOUR
2. SEXUAL DYSFUNCTIONS
3. MANAGEMENT OF SEXUAL DYSFUNCTIONS
4. SEXUAL DEVIATIONS
5. MANAGEMENT OF SEXUAL DEVIATIONS

1: NORMAL SEX BEHAVIOUR

1.0: Epidemiology

1.0.1: Kinsey et al (1948, 1953) Observed that;

- 93% of all men studied and 28% of all women studied masturbated by age 20 yrs.
- 37% of the men had experienced homosexual orgasms (usually at adolescence)
- 4% of the men had experienced only homosexual orgasm
- Men show peak sexual activity at adolescence.
- Women show peak sexual activity in early 30s.
- 75% of the men achieve orgasm within 2 minutes of penetration

Erectile Impotence

- 0.1% under 20 yrs
- 6.7% 40-50 yrs
- 75% over 70 yrs
- 75% of women achieve orgasm in 1st year of marriage.

1.0.2: Schofield (1968) Observed that:

- 11% of boys } had intercourse by 16 yrs
- 6% of girls } had intercourse by 16 yrs
- 30% of boys } had intercourse by 18 yrs
- 16% of girls } had intercourse by 18 yrs

1.0.3: Frank et al (1987) Found that:

- 40% of married men report some degree of impotence
- 60% of married women report some orgasmic dysfunction
- Any disruptive effect of the dysfunction relates to quality of the sexual relationships

2: PHYSIOLOGY

2.0: Masters and Johnson (1966) Kaplan (1978) explained normal human physiology as per the normal sexual script.

2.0.1: The sexual script consist of:

2.0.1.0: Idea } Affected by personal, social cultural hypothalamic and hormonal factors.

2.0.1.1: Desires }

2.0.1.2: Arousal - Excitement, parasympathetic, vasodilatation , penile/vaginal pooling of blood, erection in man, lubrication in women.

2.0.1.3: Orgasm - Emission in man
- Ejaculation in man
- Ejaculation equivalent in women

2.0.1.4: Resolution - longer refractory period in the male (24 hrs if > 60 yrs)
- shorter refractory period in female
- Multiple orgasms possible in female

3: SEXUAL STYLES

- Man on top
- Woman on top
- Side by side
- Sitting
- Kneeling
- Standing

4: RELATIONSHIP BEHAVIOUR

Main determinant of quality of sexual activity

- Consider:
 - Communication - within relationship

- Commitment to relationship
- Conflict within relationship
- Contrast of the sexual encounter e.g culture, personal, attributes and the surroundings.

5: SEXUAL DYSFUNCTIONS

5.0: These are conditions in which there are normal sexual outlets but the abnormal sexual functions are abnormal.

5.1: MALE SEXUAL DYSFUNCTIONS

- 5.1.0: Erectile Impotence
- 5.1.1: Ejaculatory Impotence
- 5.1.2: Premature ejaculation
- 5.1.3: Dyspareunia
- 5.1.4: Low libido
- 5.1.5: Sex phobia

5.2: FEMALE SEXUAL DYSFUNCTIONS

- 5.2.0: Anorgasmia
- 5.2.1: Vaginismus
- 5.2.2: Dyspareunia
- 5.2.3: Low libido
- 5.2.4: Sex phobia

6: CLASSIFICATION

- 6.0: Primary. No history of normal sex function
- 6.1: Secondary. Onset in latter life after normal function
- 6.2: Symptomatic - due to organic cause
- 6.3: Functional - Psychological in origin
- 6.4: Acute onset
- 6.5: Insidious onset

- 6.6: Total dysfunction
- 6.7: Partial dysfunction
- 6.8: Global - any time and in any event
- 6.9: Situational - event related
- 6.10: According to stage affected

6.10.0: <u>Initiation</u>	<u>Male</u>	<u>Female</u>
	<ul style="list-style-type: none"> - Avoidance - Low drive 	<ul style="list-style-type: none"> - Avoidance - Low drive
6.10.0.1: <u>Arousal</u>	<ul style="list-style-type: none"> - Premature ejaculation - Erectile impotence 	<ul style="list-style-type: none"> - Lubricative failure
6.10.0.2: Penetration	<ul style="list-style-type: none"> - Lack of urge to penetrate 	<ul style="list-style-type: none"> - Vaginismus
6.10.0.3: Orgasm	<ul style="list-style-type: none"> - Ejaculatory impotence 	<ul style="list-style-type: none"> - Anorgasmia

7: PROGRAMME OF ASSESMENT

- 7.0: History - Nature of complaint
- Possible etiology and prognostic signs
 - Personal and family history, quality of relationships
 - Sexual marital history
 - Knowledge of and attitude to sex
 - Past sexual experiences
 - Contraception
 - Attitude to pregnancy and Children
 - Drug & alcohol use/abuse

7.1: EXAMINATION

- Physical exam (genital exam)

- Mental state assessment
 - Anxiety } common psychopathology affecting human sexuality.
 - Depression }

7.2: INVESTIGATIONS

- Urinalysis - (sugar)
- LFTs
- Testosterone level
- Nocturnal Penile tumescence strain gauge.

7.3: PARTNER

- Always see and assess sexual partner
- See couple together thereafter if possible

8: POSSIBLE AETIOLOGICAL FACTORS

8.0: PREVIOUS EXPERIENCES:

- Restrictive upbringing (intrapsychic conflict)
- Traumatic early sex encounters
- Abnormal family relationships

8.1: CURRENT CIRCUMSTANCES

- Sexual stresses
- Concerning contraception/pregnancy
- Non - sexual stresses
- Lack of privacy
- Recent child birth
- Relationship difficulties
- Partner rejection
- Sexual sabotage
- Ignorance or guilt resulting in failure to engage in effective sexual behaviour

- Psychiatric disorder
 - Depression
 - Schizophrenia
 - Sexual delusion

- Performance anxiety
- Fear

8.2: SPECTATORING

- Observe ones behaviour in sexual encounter and not allowing spontaneous behaviour to result.

8.3: ORGANIC FACTORS AS SUGGESTED BY :

- Penis never fully turgid
- No associated significant life event
- Previous uninterrupted period of normal sexual function
- Sexual interest being maintained.

8.4: GENERAL ILLNESS

- Hepatic disease
- Endocrine disease (Diabetes Mellitus)
- Cardiac disease
- Renal disease

8.5 DRUGS

1. Benzhexol } Erectile Impotence
2. Probanthine } Erectile Impotence
3. T.C.A. } Erectile Impotence

Anti - adrenergics

1. Phentolamine } Ejaculatory
2. Quanethidine } impotence
3. Methyldopa }

Alcohol, barbiturates, heroin

Anti- androgens (e.g oestrogen, Cyproterone, spironolactone)

8.6: AGE

Increased refractory period between erections with increase in age

Important if no sexual activity exercised for some years

8.7: NEUROLOGICAL DISORDER

Peripheral/spinal nerve damage

e.g. in:

- Tabes
- Multiple sclerosis
- Siringomyelia
- Surgery
- Tumor

8.8: DAMAGE TO HIGHER CENTRES

- Temporal lobe]
- Frontal lobe] syndromes

8.9: VASCULAR DISORDER

- Damage to local blood vessels
- Leukaemia

8.10: LOCAL DISORDER

- urethritis
- Balanitis
- Genital trauma
- Castration - Chemical
 - Surgical

9. TREATMENT

Attend to organic cause first. Thereafter behaviour therapy is essential for specific problems.

9.0.1: Erectile Impotence

- Gradual penetration (assisted) with woman on superior or side position. Male relaxes and enjoys sensation. No thrusting.
- "Get out of your head & into your body" i.e. stop rationalizations
- Intracorporal injections
- Penile prosthesis

9.0.2: Ejaculatory Impotence

- Masturbation to ejaculation point then introduction into vagina

9.0.3: Premature ejaculation

- Seman's Technique - female squeezes base of penis

9.0.4: Vaginismus

- Relaxation training
- Gradual approach to coitus as per the management of erectile impotence
- Vaginal dilators

9.0.5: ANORGASMIA

- Masturbation to orgasm
- Use of vibrators for orgasmic stimulation
- Gradual progress to coitus with manual clitoral stimulation

9.1: DRUG THERAPY

- Mild anxiolytics occasionally help
- Testosterone replacement (where necessary)

9.2: PSYCHOTHERAPY

- sex/marital therapy
- individual psychotherapy (minimal effect)

10: VI PROGNOSIS

10.0: Good if:

- Dysfunction is of acute onset and short duration
- High motivation
- Involved and Motivated partner
- Absence of other psychological problems
- Marked improvement in first few therapy sessions

10.1. Cure Rates. (Masters and Johnsons)

- Primary Impotence - 50%
- Secondary Impotence 70-80%
- Premature ejaculation - 100%
- Female dysfunction - 80%

SEXUAL DEVIATION AND VARIATIONS

In these conditions, the sexual function is normal but the sexual outlet is abnormal.

1: EXHIBITIONISM

1.0: DEFINITION

Deliberate exposure of genitalia by adult male in presence of unwilling female and not as a prelude to intercourse.

- "Indecent exposures" is the criminal offence

1.2: CLASSIFICATION

Type I - 80% of cases - inhibited young men, emotionally immature struggle against impulse, usually expose flaccid penis, feel guilty afterwards; good prognosis.

Type II 20% of cases - sociopathic personality, exposes erect penis. Often masturbate while exposing. Little if any guilt; may take sadistic pleasure, worse prognosis.

1.3 EPIDEMIOLOGY

- Commonest single sexual offence
- 3,000 convictions per year in England and Wales
- Peak age of onset 15 yrs
- Incidence in persons under 25 yrs has doubled since 1945
- 75% under 40 yrs
- 5% subnormal or psychotic

1.4: ETIOLOGY FACTORS

- Personality factors - immature, passive, obsessional if type I
- Enjoyment of risk taking
- Dissociate behaviour in response to stress or depression
- Witness responses (fear or disgust) may reinforce behaviour
- Often poor sexual performance with impotence or premature ejaculation and increased masturbation.
- Possibly close ambivalence relationship with mother and poor distant relationship with father

1.5: VICTIM

- Usually unknown persons
- Especially pubertal girls
- Exposure is often regarded by victim as a nuisance rather than a danger
- Reaction of family is often worse than victims own reaction and may lead to greater disturbance in victim
- No personality difference found between those exposed to and those not exposed to..

1.5: MANAGEMENT

- First court appearance is often sufficient to stop this behaviour
- Psychiatric management suggested if more than one offense of exhibition occurs
- Aversive behavioural techniques and covert sensitization
- Group therapy with other exhibitionists may be helpful
- Cyproterone acetate (chemical castration) may aid impulse control

1.6: PROGNOSIS

- 80% only offend once
- 20% repeat offenders

1.6.0: POOR PROGNOSTIC INDICATORS

- Type 2 offenders
- Exposure to children under 10 yrs
- Previous convictions for other offenses
- Attempts to contact victim physically
- Late onset associated with psychosis or brain damage

1.6.1: GOOD PROGNOSTIC INDICATORS

- Type I offenders
- Stable Personality
- Regular work record
- Heterosexual relationship
- Sympathetic wife

2: PAEDOPHILIA

2.0: DEFINITION

- Erotic attraction to young children

2.1: CLASSIFICATION

- Heterosexual - usually to girls of 6 - 11 yrs
- Homosexual - usually to boys of 12 - 15 yrs.
- Indiscriminate - usually to children of 6 -11 yrs (of both sexes)

2.2: EPIDEMIOLOGY

- 50 % are relatives or friends
- 70% of children participate actively
- 4 related sexual murders of children occur/year in the U.K
- Characteristically three groups of offenders noted:
 - Immature adolescents
 - Middle aged, men with marital difficulties
 - Elderly, socially isolated men

3: INCEST

3.0: DEFINITION

Erotic attraction to blood relative

3.0.1: TYPES

Father - daughter

Mother - son

Brother - sister

3.1: CHARACTERISTICS OF INCESTROUS FATHER

3.1.0: Endogamic

- Confirming all his sexual and social activities to his family. Often yearning for a sexually inaccessible person.

3.1.1: Paedophilic - Attracted to daughters

3.1.2: Promiscuous - Ignores sexual taboos; part of general hedonism

4: TRANSVESTISM

4.0 DEFINITION

- Disturbance of general role behaviour i.e cross-dressing
- Not a disorder of core gender identity
- Not itself an offence though may be charged with behaviour likely to cause a breach of the peace or with theft of women's underwear

4.1: Epidemiology

U.K aprox 30, 000 in number

- 50 % married
- 35% of men are homosexuals
- 15% are permanent cross dressers
- Common in social class II & III

4.2: Clinical features

- Evident before age of 10yrs
- Female interests in normal life
- Female clothing for fetish masturbation
- Club members - in clubs where female life styles are acceptable

5: TRANSEXUALISM

5.1: DEFINITION

Usually a male trapped in a female body

5.2: CLINICAL FEATURES

- Many are fetishistic testislastic transvesties at first
- Convinced they are of wrong sex before 8 yrs of age
- Low sex drive
- Poor social relationships
- Poor work records

5.3: MANAGEMENT

- Usually intractable
- Hormonal therapy and surgery for sex conversion may improve adjustment.
- Live as opposite sex person for more than 2 yrs prior to surgical sex conversion..

6: ZOOPHILIA

6.0: Sexual contact with animals has been a topic of interest for human beings for hundreds of years, In Greek & Roman mythology, females have been portrayed having sexual relations with bears, apes, bulls goats, horses, wolves snakes and even crocodiles (Godow 1982). In actuality, Zoophilia is very rarely practised. In the Kinsey study (1948) out of 6,000 females studies, only 3 reported experience of sexual intercourse with animals.

The Hunt Study (1974) reported a 1.9% female Zoophilia experience. The animals were all domestic dogs and cats and the type of sexual experiences were general body contacts and cunilingus performed by the animals to the females. Compared with the female animal contacts, male sexual contact with animals are more common. The Kinsey study reported 8% while the Hunt Study reported a 4.9% prevalence rates. Coitus was the most commonly reported male animal sexual activity usually with calves, sheep and cows. Those who practice Zoophilia tend to range from adolescents to adults with organic brain disorder.

7: VOYEURISM

7.0: A person who attains sexual gratification by observing others' sexual organs or sexual acts is called a Voyeur. Peeping toms or peepers are the legal terms used to label these people. They tend to be young and unmarried persons and peep on women who are not available as sex partners. The victims tend to be strangers and unwilling participants. Most peepers are mentally healthy but some suffer from alcohol and drug abuse. They may masturbate as they look but in most cases they only peep. They have strong inferiority feelings. Some peepers do so as a compulsion and these are the ones who are careless and apt to get in trouble with the law.

8. FETISHISM

8.0: This describes a situation where sexual arousal is intimately linked with an inanimate object, sound, taste or smell. In extreme cases, the inanimate object becomes a sexual object desired for itself alone and sexual expression is centered around the fetish to the exclusion of a sexual partner e.g high heeled leather shoes.

9: FROTTEURISM

9.0: Recurrent preoccupation with intense sexual urges or fantasies of at least 6 months duration involving touching or rubbing a nonconsenting person for erotic purposes. Usually occurs in crowded conditions such as buses and other public transport vehicles during rush hour. Frequently he touches his victim's buttocks with his erect penis through his clothes resulting in quick ejaculation. In addition to frontage, many frotteurs have been involved in exhibitionism, paedophilia, sadism, rape or voyeurism.

10: **SEXUAL MASOCHISM**

10.0: Having to suffer humiliation, being bound, beaten, or being intentionally involved in activities where one is physically harmed or one's life is threatened in order to produce sexual excitement. The duration of this behaviour must be six months. A large number of masochists are also sadists.

11: **SEXUAL SADISM**

11.0: Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

11.1: The person has acted on these urges or is markedly distressed by them.

12: **PARAPHILIA NOT OTHERWISE SPECIFIED**

12.0: Necrophilia: Use of corpses for erotic purposes

12.1: Partialism : Exclusive focusing on a part of the body for sexual purposes

12.2: Klismaphilia: Erotic arousal by administration of enemas

12.3: Urophilia: Sexual arousal by being urinated on

12.4: Coprophilia: Sexual arousal by the use of faeces

12.5: Telephone Scatologia (Lewdness). Use of rather graphic sexual descriptions over the telephone with strangers for sexual purposes.

EATING DISORDERS: ANOREXIA NERVOSA AND BULIMIA

OBJECTIVES

To acquire knowledge and skills in recognizing and managing anorexia nervosa and bulimia.

She was only 10 inches high, and her face brightened up at the thought that she was now the right size for going through the little door into the lovely garden. First, however, she waited a few minutes to see if she was going to shrink any further, she felt a little nervous about this, "for it might end, you know", said Alice "in my going out altogether, like a candle. I wonder what I should be like them?" Alice in Wonderland.

'Jane' an adolescent girls 14 years old, has like Alice in Wonderland experienced progressive diminution in size. She has been an active cheerful girl, top of her class in academic activities. At the age of 10 yrs, her ability to exercise was restricted after hospitalization for a physical illness. She gained mass. Shortly thereafter she became preoccupied with dieting and the energy content of foods. It was also noted that she was withdrawn and compliant except when it came to issues concerning food and eating. In these instances there would be marked conflict between Jane and her mother. Her dieting became increasingly stringent, resulting in such severe loss of mass over 6 months period that she eventually required hospitalization. In societies where influence is increasing, under nutrition is rare and the average mass of women is increasing, it is paradoxical that medical practitioners are faced with an ever-increasing number of young women like Jane with eating disorders. It is less puzzling that those young women who, like Alice, are shrinking show so little of the anxiety felt by Alice with respect to their diminution in size. A few indeed, do end by going out altogether, like a candle. This highlights both the puzzling nature of these conditions and their seriousness. The clinical entities that will be discussed below are diagnosed in the DSM-III-R as anorexia nervosa and bulimia nervosa.

Diagnosis of anorexia nervosa

It is important to note at the outset that anorexia nervosa is a misnomer. Anorexia means lack of appetite. In anorexia nervosa there is not a decrease in appetite but rather pursuit of a decreased mass due to other reason which will be discussed below. Tab I gives a list of diagnostic criteria for anorexia nervosa as set out in the DSM III R. The essential features of this disorder is the pursuit of thinness accompanied by a intense fear of becoming fat. Distorted body image is certainly present clinically but is difficult to define. If other psychiatric illness are present they should be currently diagnosed on Axis I or if a personality disorder exists it should be diagnosed on Axis II in accordance with the multiple axial system of the DSM III R.

TABLE 1 DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA

A. Refusal to maintain body weight over a minimal normal weight for age and height e.g weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below the expected.

B Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body . weight, size , or shape is experienced, e.g the person claims to 'feel fat' even when emaciated, and believes that one part of the body is 'too fat' even when obviously underweight.

D. In girls, absence of at least three consecutive menstrual cycles otherwise expected to occur (primary or secondary amenorheas). (A woman is considered to have amonorrhea if her period occur only following hormone administration e.g oestrogen)

Diagnosis of Bulimia Nervosa

The name 'Bulimia' come from the Greek words, 'bous' (ox) and 'limos' (hunger) i.e ox appetite. The cardinal feature of this disorder is binge eating which has terminated usually by vomiting, but other methods may be used. In this condition, too, there is a persistent over-concern with body shape and mass.

The DSM-III-R criteria for bulimia nervosa are listed in table II

TABLE II. DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA

- A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time)
- B. A feeling of lack of control over eating behaviour during the eating binges.
- C. The person regularly engages in self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
- D. A minimum average of two binge-eating episodes a week for at least 3 months.
- E. Persistent over concern with body shape and weight.

The question of the relationship between two disorders has not been clearly answered. Clinical experience indicates that they are two distinct entities with different etiologies, epidemiology, associated features and response to treatment. The boundaries become blurred in those patients fulfilling the criteria of anorexia nervosa who go on to exhibit bulimic features as well. the American Psychiatric Association has offered some clarity by dividing anorexia nervosa into 2 subgroups as outlined in Table III.

TABLE III. COMPARISON OF ANOREXIA AND BULIMIA NERVOSA

	<u>Anorexia</u>	<u>Nervosa</u>	Bulimia Nervosa
Cardinal Feature	Restrictor sub group	Bulimic subgroup	
Body Mass	Present Absent	low Present	Normal or overweight
Amenorrhoea (in women)	Usually absent	Present Present	Variable Present
Binge eating			Present
Vomiting/ purging			

Phenomenology

Anorexia Nervosa

In this section I will condense the experience as experienced by many patients and describe the typical features as they occur in 'Jane'. Jane gave history that prior to the weight loss she felt fat, chubby and plump. She resolved to limit her carbohydrates intake and started confining herself to proteins, salads and 'health foods'. She was a cheerful outgoing girl, a high achiever academically and on the sports field.

After a period of some weeks on this diet she felt that she was still eating too much and restricted her intake even further. At the same time she started increasing the amount of exercise. During exercising (jogging, aerobics, swimming) she felt a sense of elation and a sense of tirelessness.

When confronted by her parents or friends she claimed that there was nothing wrong, she merely had a diminished appetite or she was just eating a healthy diet. Over time the concern of her mother escalated into increasing conflict about food, eating and her weight loss. This pre-occupation became the central theme of communication in her family. Her mother fluctuated in her attempt to deal with the situation. She attempted to ignore Jane's lack of eating but found that this was an impossible task. She then became extremely hurt and angry and found that she was completely over involved in her daughter's life. She invoked the help of the father who attempted to take control of the situation but this did not last long and he soon reverted to being emotionally absent. It was impossible for the mother to stand by. Outburst of rage occurred as she perceived that Jane was deceitful and manipulative in ingenious ways by maintaining a low intake of food. She was especially hurt since Jane had always been so honest in the past. Meanwhile Jane herself found she was working harder and harder at her school. It was crucial for her to be first in her class or her sport. This reinforced her sense of superiority which was further fueled by her sense of control of her body. Further her perception that she was thinner than her friends gave her a great sense of satisfaction, yet this was short-lived. She was driven to reach new limits of control and of thinness. Fatness took on frightening implications to her as illustrated by a college entitled 'What fat means to me'.

Another phenomenon which was noticed by friends and family was her interest in preparing food for, and feeding, others. She pored over cookbooks spent hours shopping for food and examining the energy value and content of the various food stuffs. This behaviour soon alienated her peers. They became annoyed at her attempts to make them eat more than they wished, and also became 'bored' with her persistent pre-occupation with food. she gradually lost touch with her peers and their normal teenage activities. This alienation became even more high-lighted as her peers showed an increasing interest in boys. To her this was most undesirable and threatening.

She then started showing starvation effects. Her periods stopped for a number of months. Her hair was thinning and soft downy hairs were growing on her back. She was increasingly intolerant of cold. Her concentration and hence her school work deteriorated. She was no longer able to maintain a facade of cheerfulness. She became sad miserable and depressed. The fun seemed to go out of her life.

In spite of the episodes of conflict and emotional flare-ups in her family she described her family in only positive terms. This perception was reinforced by her parents who pointed out that they never showed open hostility or conflict but were always 'nice' to one another.

Eventually Jane's physical condition, her academic capacity and her mood state deteriorated so much, and her family's despair was so great, that they ignored her denial of problems and sought professional help.

Bulimia Nervosa

In this section I will describe the experiences of 'Mary', a fictitious condensation character who typifies many of the features as described by most young women suffering from bulimia nervosa.

Mary was a few years older than Jane when her problems started. She also felt fat and started dieting. After a while, which may have included an episode of anorexia nervosa, she started experiencing intense hunger along with a craving for high-carbohydrate ('junk') food. The temptation to eat became over-wheeling.

After the first bite she had a feeling of abandon, or of liberation, and she gave herself over to the binge. This lasted from a few minutes to 2 hours. The frequency increased and would at times recur several times a day. This was especially the case over weekends or when she knew she would not be disturbed. Ultimately the binge was terminated by a feeling of intolerable fullness or a sense of guilt. Mary may have consumed several thousand kilo joules during a binge. The fear of fatness and the guilt over loss of control led to self-induced vomiting or she may have taken a large amount of laxatives or diuretics to dispose of the kilo joules consumed. Once the episode was over Mary resolved to 'start over' and followed a rigid diet until the onset of the next binge.

She admitted that before the fullness and guilt set in, the binge was pleasurable, comforting and soothing. These feelings were reinforced by a sense of abandon or of oblivion

Mary was thus caught between two opposing drives: on the one hand, a wish to be free of all constraints, to indulge in as much food as she wanted, and on the other hand, a desire to be thin and to maintain rigid control. Mary's rigid dieting throughout the day satisfied the latter drive and her episodes of binging in the evenings or over the weekends fulfilled the former desire.

Initially the vomiting or laxative abuse was the price she had to pay for controlling her weight but in time it became a habitual way of coping with stressful life situations. The problem was that she had become indiscriminate in the emotional use of this mechanism. It served as an escape whether she was feeling angry, hurt, frustrated, tense, anxious or depressed or even as a means of celebration when happy. She may have used it as a means of punishing or manipulating significant others.

Surprisingly, Mary was able to function reasonably well in her work situation. However, it may be noted that she was oversensitive when it came to interpersonal relationships at work. Indeed it was in this sphere that she experienced considerable difficulty not only at work but also with friends (of both sexes) and with her close relatives (parents and siblings).

When asked she admitted to being unhappy, having marked mood swings and to difficulty tolerating any form of pressure. She frequently experienced suicidal ideation.

Once the condition had been present for a number of years, Mary (as is the case in 50% of one sample of bulimics) fulfilled the DMS-III-R criteria for major depression. Evidence of other impulse control disorders e.g alcohol and other substance abuse, may be present. The impulse control disorder may take the form of kleptomania.

Approximately 10% of bulimic patients may go on to fulfill the DMS-III-R criteria for a borderline personality disorder. If we look at Mary's family we find that there are far more overt family problems. There is a family history of both alcoholism and of affective illness (this often takes the form of a major depressive disorder).

There has frequently been open marital conflict between her parents with one of both parents walking out and threatening divorce. The result is that Mary experienced a disturbed and chaotic childhood. In some cases it emerges that there had been sexual molestation in the bulimic's childhood.

EPIDEMIOLOGY

The prevalence of eating disorders depends on what population group is being studied. In North America and Britain the female - to - male ratio is said to be 10:1. In south Africa it would seem that the preponderance of women is even greater.

In this country these disorders occur primarily in the white middle class population. It is rare in the so-called colored population and extremely rare in the black population. These figures may change as socio-cultural forces do.

The actual prevalence in young white middle class women is difficult to assess accurately. This is especially true of bulimia nervosa because the binges are often kept secret for many years.

The number of young women presenting to practitioners is increasing. This may be due to a true increase in incidence or to a higher detection rate. Among university and college students bulimia is currently commoner than anorexia.

As alluded to above anorexia nervosa typically has its onset during adolescence. It rarely occurs before puberty. Bulimia nervosa manifests at a slightly later age. Increasingly, clinical experience reveals that the binge cycles start around the age of 15 years but remains undetected until the later or early twenties.

The relationship between eating disorders and other psychiatric disorders.

As has been mentioned above patients with eating disorders often become depressed. This has raised the question of whether these disorders are a manifestation of a primary affective disorder. The qualitative characteristics of the depression, as well as the response to treatment for depression support the current balance of opinion that the depression is secondary to the eating disorder, i.e. eating disorders are not a variant of affective illness. It is important to bear in mind the association with personality traits. Many anorexic girls have compulsive personality features such as perfectionism, rigidity and inhibition of emotional expression. They are still too young to warrant a diagnosis of personality disorder.

The association of bulimia nervosa with borderline personality features, as well as impulsive control disorders has already been mentioned.

A number of metabolic and endocrine disturbances arise as a result of the eating disorder, especially with anorexia nervosa.

AETIOLOGY

The eating disorders are a good example of the need to adopt a biopsychosocialcultural view in psychiatric and psychological disturbances. Both in aetiology and treatment some or all of these factors will need to be considered. A very brief overview of some of the aetiological theories will be presented.

The social - cultural theory

The fact that these disorders occur in a very specific group (white middle class young women) has led Swartz to postulate that anorexia nervosa can be viewed as a culture-bound syndrome.

The cultures in which they occur are characterized by:

- (i) Relative affluence
- (ii) An emphasis on slimness as being attractive
- (iii) Contradictory social roles for women

The family pathology theory

Familial factors are important in the pathogenesis of these disorder

In **anorexia** the family theme that emerge are:

- a facade of happiness and denial of any conflicts;
- an overinvolvement, overprotectiveness and enmeshment between the index patient and a parent, usually the mother; and
- difficulty in accepting the changing developmental needs of their growing daughter by the parents. It is not always easy to know if these changes are primary or secondary to the marked familial disturbance caused by the anorexia behaviour.

In this case of **bulimic** patients' families the findings indicate a much higher prevalence of more marked and open contributory factors such as:

- a family history of affective disorder amongst first-degree relatives;
- alcoholism and other impulse control disorder in first-degree relatives; and
- family break-up, violence or sexual abuse.

Biological theories

Thus far there have been no identifiable biological causes found although various hypothalamic and endocrine functions have been investigated.

Therapeutic approaches

Experience has shown that approaches incorporating biopscho-social strategies in combinations which vary; depending on the specific clinical circumstances, are the most effective.

For example, a study comparing different treatment modalities showed that for an adolescent girl of less than 18 years who has had anorexia nervosa for less than 3 years the most effective treatment was family therapy. If the girl was able to relate to an individual therapist, adjunctive individual therapy proved to be helpful.

On the other hand the young woman whose onset of anorexia nervosa occurred after the age 19 years benefited most from individual psychotherapy.

Treatment of anorexia nervosa

Individual therapy:

Individual psychotherapy usually progresses through a number of stages. It begins with a focus on issues of dieting, body mass and body perception. The therapy then moves on to an understanding of the patient's emotional life, of her experiences and perceptions. This enables the patient to realize that her world is one that is a far richer one than just food, dieting and body mass.

The third related aspect is that of interpersonal relationships. Here the therapist helps the patient to look both at her relationships in the 'there and now' i.e outside of the patient-therapist relationship, as well as the 'here and now' relationship, as well as the i.e the relationship to the therapist.

Family therapy

The form of family therapy varies considerably from therapist to therapist. A useful model is one which sees the therapist as having three tasks:

- To gain the family's co-operation in working towards a goal that can be agreed upon by therapists and family;
- To assess the family's functioning and organization in such areas as alliances (especially the marital relationship), control techniques and rules; and
- To help the family change to a more adaptive style of communication.

The family therapy usually follows three phases both within each session and throughout the course of the treatment.

Phase 1. A focus on the eating disorder itself and the effect on , the family

Phase 2. A focus on normal family concerns and tasks.

Phase 3. A focus on the index patient's increasing autonomy and changing developmental needs, i.e age appropriate expectations.

Group therapy

Experience has shown that an eating-disorder outpatient group which meets on a weekly basis provides support and decreases the sense of alienation both for the index patient and her family.

Treatment of bulimia nervosa

The treatment of bulimia nervosa usually involves an individual cognitive behavioural approach. Studies indicate that family therapy is not particularly helpful.

Behavioral interventions include;

- Diet and weight management, keeping a diary.
- Strategies to tackle the urge to binge. This may occur within the therapy session .
- Social skills training and interpersonal problem solving as well as individual psychotherapy.

Hospitalization

As with all psychiatric problems occurring in adolescence and young adulthood admission to a psychiatric ward should only be considered if really necessary. In anorexia nervosa hospitalization becomes necessary in those cases where the marked mass loss and starvation pose a serious threat to life. The first priority is physical well-being and gain of mass. Various behavioural systems of reward are known to be very effective in this sphere.

For the bulimic hospital admission is less frequently necessary. The indications may be a serious danger of suicide or complete loss of control of food intake and vomiting or purging. In the latter case a fairly brief period of hospitalization may help re-establish some control over eating behaviour. Sometimes a useful strategy is partial hospitalization in a day hospital therapeutic milieu programme. This avoids many of the unwanted effects of psychiatric admission.

Outcome

Various studies show differing outcomes depending on the assessment used and the period of time before follow-up. In general, approximately half of the patients show a good outcome. Of the other half some have an intermediate outcome in that their eating behaviour persists although to a lesser extent or, if their eating behaviour has improved, their interpersonal relationships and their degree of independence is impaired.

There is a subgroup who do poorly both in terms of their eating behaviour and their functioning: Of these, some, like Alice feared, 'go out altogether', and others go through the door not into a 'lovely garden' but into permanent psychiatric patient status.

SLEEP DISORDERS

OBJECTIVES:

To enable trainees to recognize and manage sleep disorder.

Sleep serves a restorative, homeostatic function, sleep is crucial for normal themoregulation and energy conservation.

Sleep Disorders can be divided into

- 1) Dyssomnias
- 2) Parasomnias

Dysomnias include:

- 1) Insomnia
- 2) Hypersomnia

INSOMNIA

Definition:

Insomnia is a disorder of initiating or of maintains sleep, (DIMS). it is the most common sleep complaints

DIAGNOSTIC CRITERIA FOR INSOMNIA DISORDERS

- A. A Predominant compliant of difficulty in initiating or maintaining sleep or of non restorative sleep.
- B. This disturbance occurs at least three times a week for at least one month and is sufficiently severe to result in daytime fatigue, or impaired social or occupational functioning.

Causes of Insomnia

1. Primary - not due to any known physical or mental conditions.
2. Painful physical conditions.
3. Structural and metabolic disorders affecting CNS
4. Abuse of Alcohol and caffeine and other CNS structural drugs.
5. Psychiatric disorders such as anxiety, depression, manic, grief dues to loss, any environmental changes, life changes etc.

ASSESSMENT

Insomnia may be due to a number of medical and psychiatric disturbances.

It is important to undertake a thorough diagnostic assessment,

Evaluate the sleep history - review patients usual sleeping habits.

- get a description of the disturbance in sleep

Review the current use of drugs - prescription and non- prescription and alcohol.

EEG recording sometimes is useful.

MANAGEMENT

If insomnia is secondary to another condition the latter should be treated

When no cause can be found, encourage no specific measures to induce sleep.

NON SPECIFIC MEASURE TO INDUCE SLEEP (sleep hygiene)

1. Arise the same time daily
2. Limit daily in-bed time to usual amount of present prior to sleep disturbance
3. Discontinue CNS acting drugs (caffeine, nicotine alcohol , stimulants)
4. Avoid day time naps
5. Establish physical fitness by means of graded program of vigorous exercise early in the day
6. Avoid evening stimulation substitute radio or relaxed reading for TV
7. Try very hot, 20 minute body temperature raising bath soaks near bed time.
8. Eat at regular times daily, avoid large meals near bedtime.

9. Practice evening relaxation routines, such as progressive muscle relaxation or meditation.
10. Maintain comfortable sleeping conditions

Hypnotic drug use

Although it may sometimes be justifiable to give a hypnotic for a few nights demands for prolonged medication should be restricted because withdrawal of hypnotics may lead to insomnia as distressing as the original sleep disturbance continuation of hypnotics may be associated with impeded performance during the day, tolerance to the sedative effects and dependency.

THE HYPERSOMNIAS

NARCOLEPSY is an uncommon syndrome characterized by excessive day time sleepiness (sleep attacks - irresistible) and abnormal manifestation of sleep such as hypnogogic hallucinations and sleep paralysis. The most common symptoms is sleep attacks where by the patient cannot avoid falling asleep.

Cataplexy - a sudden loss of muscle tension such as jaw drop, head drop, weakness of the knees, or paralysis of all skeletal muscles with collapse.

Hypnogogic hallucinations - vivid perceptual experiences either auditor, or visual, occurring at sleep onset or on awakening. The Patient is often momentarily frightened but within a minute or two returns to an entirely normal frame of mind and is quite aware that nothing was actually there.

Sleep paralysis - during this episode the patient is apparently awake and conscious but unable to move a muscle.

Onset is at age but frequently adolescence or young adulthood before 30 yrs. Can be dangerous because it can lead to road traffic accidents or industrial accidents.

EEG helpful in diagnosis.

MANAGEMENT

A regimen of forced naps at regular time of day can help and in some case it can almost cure patient without medication.

Drugs. (a) Stimulants e.g amphetamine

(Methylphenidate) ritalin

(b) sometimes stimulants are combined with anti depressants e.g protriptyline when cataplexy is prominent.

Non organic hypersomnia - hypersomnia associated with mental disorder occur especially with mood disorders. Excess daytime sleeping may occur with depression, uncomplicated grief, and anxiety disorders.

Organic hypersomnia - narcolepsy

- Medications - tolerance or withdrawal from CNS stimulants e.g amphetamines, cocaine, caffeine and related drugs. Sustained use of CNS depressants such as alcohol.

- Respiratory disorders, sleep apnoea syndrome and others.

PARASOMNIAS

Parasomnias are a group of clinical conditions consisting of undesirable phenomena that appear suddenly during sleep. They include:

- 1) sleep walking disorder
- 2) sleeping talking disorder
- 3) sleep terror disorder
- 4) Dream anxiety disorder (nightmare)

Sleep Walking Disorder (Somnambulism)

Definition:

Sleep walking disorder is characterized by repeated episodes of arising from bed during sleep and walking about, usually occurring during the first third of the major sleep period.

Diagnostic Criteria for Sleep Walking Disorder

- A. Repeated episodes of arising from bed during sleep and walking about, usually occurring during the first third of the major sleeping period.
- B. While sleep walking, the person has a blank staring face, is relatively unresponsive to the efforts of others to influence the sleep walking or awakened only with great difficulty.

- C. On awakening (either from the sleep walking episodes or the next morning) the person has amnesia for the episode
- D. Within several minutes after awakening from the sleep walking episodes, there is no impairment of mental activity or behaviour (although there may initially be a short period of confusion or disorientation)
- E. It cannot be established that an organic factor initiated and maintained the disturbance (e.g epilepsy)

CLINICAL FEATURES

The Patient sits up sometimes performs preservative motor acts, such as walking, dressing, going to the bathroom, talking, screaming and even driving. This is occasionally dangerous because of the possibility of accidental injury.

This behaviour occasionally terminates in an awakening with several minutes of confusion but more often, the person returns to sleep and has no recollection of the sleep walking event.

Sleep walking usually begins between ages 6 and 12 years but it can still be seen in adolescents and young adults. It tends to run in families.

EPIDEMIOLOGY

The disorder is more common in males than females, and about 15% of children have an occasional episode.

AETIOLOGY

A minor neurological abnormality probably underlies this condition.

The episodes should not be considered purely psychogenic, although stressful periods are associated with an increase in sleepwalking in affected persons.

Extreme tiredness or prior sleep deprivation exacerbates attacks.

Various organic factors can act as precipitants (in predisposed persons) such as febrile illness, CNS drugs including anticonvulsants, antidepressants, strong analgesics, lithium and phenothiazines. Management, will be discussed with that of sleep terror.

REAM ANXIETY DISORDER (Nightmare)

Definition:

The nightmare is an anxiety dream in which something threatens to harm the sleepers. A dream anxiety disorder (nightmare) is characterized by a long, frightening dream from which one awakens frightened. They usually occur late in the night.

DIAGNOSTIC CRITERIA

- A. Repeated awakening from major sleep period or naps with detailed recall of extended and extremely frightened dreams, usually involving threats to survival, security or self esteem. The awakening occurs during the second half of the sleep period.
- B. On awakening from the frightening dreams, the person rapidly becomes oriented and alert (in contrast to the confusion disorientation seen in sleep terror and epilepsy)
- C. The dream experience or sleep disturbance resulting from the awakening causes significant stress.
- D. It cannot be established that an organic factor initiated and maintained the disturbance (e.g certain medications)

EPIDEMIOLOGY

50% general population suffer from nightmares at some time in their lives, commonest 8-10 yrs .

AETIOLOGY

Associated with stress, anxiety, depression, alcohol abuse, etc.

Occurs also in normal people.

Night terrors are quite different from night mares which occur late in the night during paradoxical sleep.

Night terrors simply awaking in terror there is no dream recall and occurs in the early night also not phenomenon paradoxical sleep.

Management:

- Investigate any stressor
- Reassurance and support
- Advice on alcohol/drug if necessary

SLEEP TALKING

Sleep talking is quite common in children and adults.

It occurs in all stages of sleep.

The talking usually involves a few words that are difficult to distinguish /

Episodes of sleep talking sometimes accompany night terrors and sleep walking.

Sleep talking alone requires no treatment.

SLEEP TERROR DISORDER (Pavour Nocturnus)

The night terror is a most fearful human experience Yet it is transient and leaves little or no lasting memory. Typically expression, scream loudly, and sometimes awaken immediately with a sense of intense terror.

Frequently a night terror episodes after the initial screams develops into a sleep and walking episodes.

The two conditions are closely related if sleep walking arise from a night terror, it is more frantic in kids with child booting out of bed, running about .

DIAGNOSTIC CRITERIA FOR SLEEP TERROR DISORDER

- A. A predominant disturbance of recurrent episodes of abrupt awakening (lasting 1 to 10mins)from sleep, usually occurring during the first third of the major sleep period and beginning with a panicky scream
- B. Intense anxiety and signs of autonomic arousal during each episode, such as tachycardia rapid breathing and sweating but no detailed dream is recalled.
- C. Relative unresponsiveness to efforts of others to comfort the person during the episodes and almost invariably at least several minutes of confusion, disorientation and preservative motor movements (e.g Picking at pillow)
- D. It cannot be established that an organic factor initiated and maintained the disturbance (eg brain tumor.)

EPIDEMIOLOGY

Night terrors, occur frequently in children about 1 to 4 % of children have the disorder. The disorder is commoner in males than females and tends to run in families.

AETIOLOGY

- genetic predisposition

- In a predisposed child of a predisposed family more attacks because of daytime anxiety such as stay in hospital, separation, new school, marital crisis.

In adults, a recent road traffic accident in which the patient may have run over and killed a child or war time combat may act as precipitants.

Management:

- 1) Reassurance and support and help in tackling the source of day time anxiety are needed.
- 2) A high proportion of sleep walkers injure themselves nastily. Precautions to avoid objects over which they may trip over, precautions to prevent them falling are needed.
- 3) In rare cases medication required
Diazepam in small doses at bedtime improves the condition and sometimes completely eliminates the attacks

PERSONALITY DISORDERS

OBJECTIVES

DISCUSS:

- 1. THE DEFINITION OF PERSONALITY DISORDER**
- 2. CLASSIFICATION AND MEASUREMENT**
- 3. DIAGNOSIS**
- 4. MANAGEMENT**

1. DEFINITION:

- i) This group of disorders comprises of a number of unrelated disorders which are categorized together purely on none clinical similarities. The best explanation for the existence of this class of psychiatric disorders is purely a social one; that others regard personality disorder as the assignment of a sick role to those whom society finds troublesome.

- ii) However, as per D.S.M - III - R the diagnostic criteria for personality disorders refer to behaviours that are characteristic of the person's recent (past year) and long-term functioning (generally since adolescence or early adulthood). The constellation of behaviour or traits causes either significant impairment in social or occupational functioning or subjective distress. Behaviours or traits limited to episodes of illness are not considered in making a diagnosis of personality disorder.

2. CLASSIFICATION AND MEASUREMENT

a) Measurement

Personality has a set of dimensions along each of which individuals will vary. These individual variations along the many personality dimensions will describe the complex make-up of the individual personality. These variant dimensions are referred to as trait i.e tendencies to feel, think behave in a particular way. There are particular standardized methods of measuring these given tendencies such as:

- (i) Catell sixteen personality factor test (16P.F). Has 16 source traits which are measured against 181 variables.
- (ii) The Minnesota Multiphasic Personality Inventory (MMPI)
- (iii) Eysenck Personality Inventory (EPI)
Neuroticism/Psychoticism
Introversion/Extroversion

b) Categorical (Typological) Classification

Personality types are recognizable as consistent grouping of characteristics.

- (i) Hippocrates - Choleric, Melancholic, Phlegmatic, Sanguine

- (ii) Kretschmer (1921) - related personality types to morphological types (Leptosomic/schizoid, pyknic/Cychothymic, athletic)
- (iii) Schneider (1923) described 10 types of "psychopathic personality"
- (iv) Henderson (1927) - described the inadequate, creative and aggressive psychopathic personalities

A. D.S.M III - R Classification

This type of classification recognizes 3 major clusters of personality disorders. These are listed below:

1. Cluster A: Based on odd behaviour
 - i. Paranoid
 - ii. Schizoid
 - iii. Schizotypal

2. Cluster B; Based on emotional/dramatic behaviour:
 - i. Antisocial
 - ii. Borderline
 - iii. Histrionic
 - iv. Narcistic

3. Cluster C: Based on anxious/fearful behaviour:
 - i. Avoidant
 - ii. Dependent
 - iii. Obsessive/compulsive
 - iv. Passive - Aggressive
 - v. Personality disorder N.O.S
 - e.g a) Mixed personality disorder
 - b) Impulsive personality disorder
 - c) Immature personality disorder
 - d) Self defeating personality disorder
 - e) Sadistic personality disorder

3. DIAGNOSIS

What follows is a detailed diagnostic approach to the various D.S.M - III - R personality disorders.

CLUSTER A

1. PARANOID PERSONALITY DISORDER

A. Starts at early adulthood; persistent tendency to interpret others actions as demeaning, threatening as indicated by 4 of the following:

- i) Expects, without sufficient basis, to be exploited or harmed by others
- ii) Questions, without justification, the loyalty or trustworthiness of friends or associates
- iii) Reads hidden demeaning or threatening meanings into being, remarks or events e.g believes that his neighbour parks his car in front of his door to annoy him
- iv) Bears grudges as is unforgiving of insults or slights
- v) Is reluctant to confide in others because of unwarranted fear that the information will be used against him or her
- vi) Is slighted and quick to react with anger or to counter attack
- viii) Questions without justification fidelity of spouse or sexual partner

B. Occurrence not exclusively during the course of schizophrenia or delusion disorder.

C. Associated Axis Disorder

As a complication of PTSD clients with paranoid disorder can manifest the following psychiatric disorders:

(i) Anxiety Disorder

Generalized anxiety is first experienced as a form of diffuse apprehension of the unknown. Poor concentration, inability to enjoy previously enjoyed activities ending in preoccupation with the hyperarousal symptoms may follow.

Finally this pre-occupation becomes obsessional which culminates in panic attack disorders as the last remnants of self-control are exhausted.

(ii) Affective Disorder

Manic disorder with its features of elevated expansive or irritable mood may occur. (see chapter on Mood Disorders).

(iii) Paranoid Disorders

Delusional beliefs and dramatic impulsive ventilations of these long repressed sentiments may occur. However it is the predominant nature of these people to remain secretive, withdrawing, irritable and persistently suspicious.

(iv) Schizophrenic Disorder

Clients with paranoid disorders do decompensate into excited catatonic schizophrenia or catatonic stupor as a result of experiencing unmanageable environmental events.

2. SCHIZOID PERSONALITY DISORDER

A. Indifference to social relationships, restricted range of emotional experience and expression starting in early adulthood indicated by at least 4 of the following:

- (i) Neither desires nor enjoys close relationships including being part of a family
- (ii) Almost always chooses solitary activity
- (iii) Rarely, if ever, claims or appears to experience strong emotions e.g. anger and joy
- (iv) Indicates little if any desire to have sexual experience with another person (age being taken into account)
- (v) Is indifferent to the praise and criticism of others
- (vi) Has no close friends or confidants (or only one) other than first degree relatives
- (vii) Displays constricted affect e.g. aloof, cold, rarely reciprocates gestures or facial expressions e.g. smiles or nods

B. Occurrence not exclusively during the course of schizophrenia or delusional disorder

C. Associated Axis I Disorders

(i) Affective Disorders

- a) Manic excitations do occur as a result of the avoidant's attempts to break out of his characteristic states of stagnation and interpersonal bareness.
- b) Depressive symptoms may emerge as a result of these individuals' realization of the socially isolated and empty existence they actually lead.

(ii) Dissociative Disorders

Empty or devoid of a part, deficit in psychic cohesion, insensitive to external prompting; they are subject to disintegration and that inclines them to dissociative states.

(iii) Schizophrenic Disorders

- a. Disorganised schizophrenia is the commonest type of schizophrenic decompensation associated with schizoid personality.
- b. Catatonic schizophrenia does occur

(iv) Others

Schizophreniform disorder and brief reactive psychosis also do occur

3. SCHIZOTYPAL PERSONALITY DISORDER

A. Defecate in personality relatedness and peculiarities of ideation, appearance and behaviour starting in early adulthood as indicated by 5 of the following:

- (i) Ideas of reference
- (ii) Excessive social anxiety (especially with strangers)
- (iii) Odd believes of magic thinking not in keeping with culture (e.g. superstition, clairvoyance, telepathy, 6th sense, bizarre fantasies or pre-occupation)
- (iv) Unusual perceptual experiences e.g. illusions, sensing presence of the dead
- (v) No close friends or confidants (or only one) other than first degree relatives
- (vi) Odd or eccentric behaviour or appearance e.g. unkempt, unusual mannerisms, talks to self

- (vii) Odd speech (no loosening associations or incoherence) impoverished, digressive, vague, inappropriately abstract
- (viii) Inappropriate or constricted affect e.g. silly, aloof, rarely reciprocates gestures, or facial expressions e.g. smiles or nods
- (ix) Suspicious or paranoid ideation

B. Occurrence not exclusively during the course of Schizophrenia or pervasive developmental disorders.

C. Associated Axis I Disorder

- i. SCHIZOTYPAL personalities are likely to decompensate into anxiety disorders, somatoform disorders, and dissociative disorders.
- ii. Under extreme environmental pressure or strain, the SCHIZOTYPAL personalities will decompensate into schizophrenic disorders of various types.

CLUSTER B

I. ANTISOCIAL PERSONALITY DISORDER

A. Current age at least 18yrs,

B. Evidence of conduct disorders with onset before age 15 as indicted by a history of three of the following:

- (i) Was often truant
- (ii) Ran away from home overnight at least twice while living in parental or parental surrogate home (or once without returning)
- (iii) Often initiated physical fights
- (iv) Used weapons in more than one fight
- (v) Forced someone in sexual activity with him or her
- (vi) Was physically cruel to animals
- (vii) Was physically cruel to other people
- (viii) Deliberately destroyed others property (not by fire)

- (ix) Deliberately engaged in fire setting
 - (x) Often lied
 - (xi) Has stolen without confrontation of a victim or more than one occasion (even forgery)
 - (xii) Has stolen with confrontation of a victim (e.g mugging, snatching, extortion, armed robbery)
- C. A pattern of irresponsible and antisocial behaviour since the age of 15, as indicated by at least 4 of the following:
- (i) Inability to sustain consistent work behaviour as indicated by (including study work if patient is a student).
 - a. Significant unemployment for 6/12 or more within five years when expected to work and work was available.
 - b. Repeated absence from work unexplained by illness in self or family
 - c. Abandonment of several jobs without realistic plans for others
 - (ii) Fails to conform to social norms with respect to lawful behaviour as indicated by repeatedly performing antisocial acts that are grounds for arrest (whether arrested or not) e.g destroying property, harassing others, stealing, pursuing an illegal occupation.
 - (iii) Is irritable and aggressive as indicated by repeated physical fights or assaults (not required by one's job or to defend someone or oneself) including spouse or child-beating.
 - (iv) Repeatedly fails to honor financial obligations as indicated by defaulting on debts or failing to provide child support or support for other dependents on a regular basis.
 - (v) Fails to plan ahead, or is impulsive as indicated by one or both of the following:
 - a) A prearranged job or clear goal for the period of travel or clear idea about when travel will terminate
 - b) Lack of a fixed address for a month or more

- (vi) Has no regard for the truth as indicated by repeated lying, use of aliases or "conning " others for personal profit or pleasure
- (vii) Is reckless regarding his or her own or others personal safety as indicated by driving while intoxicated or recurrent speeding
- (viii) If a parent or guardian, lacks ability to function as a responsible parent as indicated by one or more of the following:
 - a) Malnutrition of child
 - b) Child's illness resulting from lack of minimal hygiene
 - c) Failure to obtain medical cure for a seriously ill child
 - d) Child's dependence on neighbours or nonresidents relatives for food or shelter
 - e) Failure to arrange for a caretaker for young child when patients is away from home
 - f) Repeated squandering, of money, or personal items, required for household necessities
- (ix) Has never sustained a totally monogamous relationship for more than a year.
- (x) Lacks remorse (feels justified in having hurt, mistreated or stolen from another.)

E. ANTISOCIAL PERSONALITY DISORDER ASSOCIATED AXIS I DISORDER

The antisocial personality disorder is characterised by tendency to impulsively discharge psychological discomfort. As a result, decompensations into associated Axis I disorders is not that prevalent. The two major disorders are anxiety and paranoia.

(i) Anxiety is usually experienced for brief periods prior to their discharging or acting out behaviour. Usually the major cause of this anxiety is the fear of loss of control or being controlled. Hence free floating anxiety is rare. The anxiety is tied to a person, place or thing. Tension and hostility are naturally discharged and the clients act assertively or in domineering manner to avoid accumulation of anxiety.

(ii) Paranoia persecutory delusions or delusional jealousy do occur under stress. These can have single or complex themes. This may lead to verbal or physical abusiveness to others. As a part of PTSD, these paranoid decompensations can be wild, violent and delusional rages.

2. BORDERLINE PERSONALITY DISORDER

A. A pervasive pattern of instability of mood , interpersonal relationships, and self image beginning by early adulthood and present in a variety of contents as indicated by at least 5 of the following:

- (i) A pattern of unstable and intense personal relationships characterized by alternating between extremes of over idealization and devaluation .
- (ii) Impulsiveness in at least two areas that are potentially self-damaging e.g. spending, sex, substance abuse, shoplifting, reckless driving, binge eating.
- (iii) Affective instability: marked shifts from baseline mood to depression, irritability or anxiety usually lasting a few hours and only rarely more than a few days.
- (iv) Inappropriate intense anger or lack of control of anger e.g. frequent displays of temper, constant anger, recurrent physical fights.
- (v) Recurrent suicidal threats, gestures or behaviour, or self -mutilating behaviour.
- (vi) Marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-time goals or career choice, type of friends desired, preferred values.
- (vii) Chronic feelings of emptiness or boredom
- (viii) Frantic efforts to avoid real or imagined abandonment

B. Associated Axis I Disorder

These include anxiety, dissociative, affective disorders as well as schizoaffective states.

(i) Anxiety Disorders

Due to affective instability the borderline personalities are prone to decompensate into generalised anxiety under pressure. If the stress is more, panic disorder is noted. In extreme cases, they disintegrate and develop brief psychotic episodes.

(ii) Dissociative Disorders

The dissociative disorders tend to be psychogenic fugue states. These occur when the clients are overwhelmed, confused or generally out of control.

(iii) Depression

Depression episodes and hypochondriacal disorders are a major way of controlling hostilities in these clients. Other than having to express impulsive anger and frustrations by brief hostile outbursts, a feature common in these clients; these effective decompensations tend to elicit aid from others. Usually this elicited support is resisted by the clients.

(iv) Schizoaffective Disorders

Appear to be a result of the failure to elicit the nurturance required by the borderline disordered client with an affective disorder. They appear in a a bizarre manner often showing regressive tendencies. Yet their desire for approval and nurturance is still significant even at this psychotic stage.

3. HISTRIONIC PERSONALITY DISORDER

A. A pervasive pattern of excessive emotionality and attention - seeking, beginning by early adulthood and present in a variety of contexts as indicated by at least four of the following:

- (i) Constantly seeks or demands reassurances, approval or praise
- (ii) Is inappropriately sexually seductive in appearance or behaviour
- (iii) Is overly concerned with physical attractiveness
- (iv) Expresses emotion with inappropriate exaggeration e.g embraces casual acquaintance with excessive boisterous uncontrollable sobbing on minor sentimental occasions, has temper tantrums
- (v) Is uncomfortable in situations where he or she is not the centre of attention
- (vi) Displays rapidly shifting and shallow expressions of emotions

- (vii) Is self centered, actions being directed towards obtaining immediate satisfaction, has no tolerance for the frustration of delayed gratification
- (viii) Has a style of speech that is excessively impressionistic and lacking in detail e.g. when asked to describe mother, she says "she was a beautiful person"

B. ASSOCIATED AXIS I DISORDER

(i) Anxiety Disorders

When histrionics are alone, they suffer genuine feeling of isolation and emptiness. As a result they learn to fear such periods, hence suffer separation anxiety or over dramatize its effect. They also develop phobias.

(ii) Obsessive Compulsive Disorders

Recurrent persistent thoughts or ideas but without specific focus as those of typical obsessive compulsive disorders.

(iii) Somatoform Disorders

Conversion reactions are the commonest

(iv) Dissociative Disorders

Under strain, histrionics tend to lose what little thoughts organization they possess, they often do go into a fugue state.

(v) Affective Disorder

Dysthymia is the commonest affective disorder in histrionics. Others are bipolar episodes; hypomania and mania.

4. NARCISSISTIC PERSONALITY DISORDER

A. a pervasive pattern of grandiosity (in fantasy or behaviour), lack of empathy and hypersensitivity of the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:

- (i) Reacts to criticism with feelings of rage, shame or humiliation
- (ii) Is interpersonally exploitative, takes advantage of others to achieve his or her own goals
- (iii) Has a grandiose sense of self importance e.g exaggerated achievements and talents expects to be noticed as special without appropriate achievement
- (iv) Believes that his or her problems are unique and can be understood only by other special people
- (v) Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (vi) Has a sense of entitlement, unreasonable expectation of especially favorable treatment e.g assures that he or she does not have to wait in line when others must do so
- (vii) Requires constant attention and admiration e.g. keeps fishing for compliments
- (viii) Lack of empathy: inability to recognize and experience how others feel e.g. annoyance and surprise when a friend who is seriously ill cancels a date
- (ix) Is preoccupied with feelings of envy

B. Associated Axis I Disorder.

1. Dysthymic Affective Disorder

When narcissists are confronted with their inability to live up to their inflated self image, they tend to revert to feelings of self doubts, uncertainty and a general dissatisfaction with themselves. This leads to a depressed state. The depression is usually mild though at times decompenations may lead into major depressive episodes.

2. Acute anxiety Reactions

Proneness to acute anxiety episodes is noted especially when ones inflated image of self is challenged by environmental incompetence.

3. Somatoform Disorder

Preoccupations with concerns for physical illness are the commonest. These tend to be excuse areas to hide behind the narcissists defeats, setbacks or failures.

4. Paranoid Disorders

For they are unable to accept that they can be incompetent, the narcissists tend to run around looking for reasons for failure. In the process, well systematized paranoid delusions do form after major failures. They may act on these delusions.

CLUSTER C

1. AVOIDANT PERSONALITY DISORDER

A. A pervasive pattern of social discomfort, fear of negative evaluation and timidity beginning by early adulthood and present in a variety of contexts, as indicated by at least 4 of the following:

- (i) Is easily hurt by criticism or disapproval
- (ii) Has no close friends or confidants (or only one) other than 1st degree relatives
- (iii) Is unwilling to get involved with people unless certain of being liked
- (iv) Avoids social or occupational activities that involve significant interpersonal contact
e.g refuses a promotion that will increase social demands
- (v) Is reticent in social situations because of a fear of saying something inappropriate or foolish or of being unable to answer a question
- (vi) Fears being embarrassed by blushing, crying or showing signs of anxiety in front of other people

- (vii) Exaggerates the potential difficulties, physical dangers, or risks involved in doing something ordinary but outside his or her usual routine e.g may cancel social plans because she anticipates being exhausted by the effort of getting there

B Associated Axis I Disorders

(i) Anxiety Disorder

These people are always on edge, unable to relax, easily startled, tense worrisome, irritable, pre-occupied with calamities and prone to night mares. They suffer fatigue and many physical ailments. They are always prone to general anxiety under pressure which does erupt into panic attacks especially under pressure.

(ii) Somatoform Disorders

These are mainly hypochondriacal and conversion disorders.

(iii) Dissociative disorder

These may occur especially under pressure

(iv) Affective Disorders

Depression is a common feature in these persons. Other affective disorders may occur.

(v) Schizophrenic Disorders

Disorganized, catatonic and paranoid schizophrenia do occur in these patients.

2. DEPENDENT PERSONALITY DISORDER

A. A pervasive pattern of dependent and submissive behaviour beginning by early adulthood and present in a variety of contents as indicated by at least 5 of the following:

- (i) Is unable to make everyday decisions without an excessive amount of advice or reassurance from others
- (ii) Allows others to make most of his or her important decisions e.g where to live, what job to take
- (iii) Agrees with people even when he or she believes they are wrong because of fear of being rejected
- (iv) Has difficulty initiating projects or doing things on his or her own
- (v) Volunteers to do things that are unpleasant or demeaning in order to get other people to like him or her
- (vi) Feels uncomfortable or helpless when alone or goes to great lengths to avoid being alone
- (vii) Feels devastated or helpless when close relationships end
- (viii) Is frequently pre-occupied with fears of being abandoned
- (ix) Is easily burnt by criticisms or disapproval

B. Associated Axis I Disorders

(i) Anxiety Disorders

Generalized anxiety is the commonest. It may be utilized as a tool to gain support from other.

(ii) Phobic Disorders

Social phobias are the commonest

(iii) Somatoform Disorders

Conversion reactions and somatization disorders are commonly seen. Hypochondriacal symptoms do occur.

(iv) Factitious Disorders

These are physical and psychological symptoms that are produced by the patient but are under voluntary control, yet these symptoms are unreal, not genuine or are unnatural but have no recognizable goal. (cf. Malingering, has a recognizable goal)

(v) Affective Disorders

Dysthymia, major depressive episodes or bipolar affective disorders do occur under pressure

3. OBSESSIVE COMPULSIVE PERSONALITY DISORDER

A. A pervasive pattern of perfectionism and inflexibility beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:

- (i) Perfectionism that interferes with task completion e.g. inability to complete a project because one's own overly strict standards are not met
- (ii) Pre-occupation with details, rules, lists, order, organization or schedules to the extent that the major point of the activity is lost
- (iii) Unreasonable insistence that others submit to exactly his or her way of doing things or unreasonable reluctance to allow others to do things because of the conviction that they will not do them correctly
- (iv) Excessive devotion to work and productivity to the exclusion of leisure activities and friendships
- (v) Indecisiveness; decision making is either avoided, postponed or protracted. e.g the person cannot get assignments done on time because of ruminating about priorities
- (vi) Over conscientiousness, scrupulousness and inflexibility about matters of morality, ethics or values
- (vii) Restricted expression of affection
- (viii) Lack of generosity in giving time, money, or gifts when no personal gain is likely to result
- (ix) Inability to discard worn-out or worthless objects when they have no sentimental value

B. Associated Axis I Disorder

(i) Obsessive Compulsive disorders do occur especially under pressure. These emerge as a defense mechanism in response to a decompensation or failure in the basic personality coping pattern.

(ii) Phobic disorders resulting into fear and avoidance of feared situation also occur. The feared situations tend to be failure, humiliation, being wrong or engaging in socially unacceptable behaviour.

(iii) Anxiety Disorder occur mainly as generalized anxiety and panic attacks especially when overwhelmed by the environment.

(iv) Somatoform Disorder: Somatization and hypochondriacal disorders are sometimes employed by compulsives as a way of rationalizing failures and inadequacies.

(v) Psychosomatic disorders do occur as a result of suppression, repression and the undischarged chronic tension and arousal. The commonest systems affected are G.I.T and C.V.S although any system is at risk. The behaviour of A personality is the most vulnerable.

(vi) Affective Disorders: Dysthymia and major depressive disorders are the two major affective decompensations under stress.

(vi) Brief Reactive Psychoses and Schizophreniform Disorder: When they lose control, compulsives develop brief reactive psychoses and schizophreniform disorders. The former are psychotic symptoms that follow a psychological stressor and last less than 2 weeks; the later are like schizophrenia symptoms but with a duration of more than 2 weeks but less than 6 months.

4. PASSIVE AGGRESSIVE PERSONALITY DISORDER

A. A pervasive pattern of passive resistance to demands for adequate social and occupational performance beginning by early adulthood and present in a variety of contexts as indicated by at least 5 of the following.

- (i) Procrastinates i.e puts off things that need to be done so that deadlines are not met
- (ii) Becomes sulky, irritable or argumentative when asked to do something he or she does not want to do
- (iii) Seems to work deliberately slowly or to do a bad job on task that he or she really does not want to do
- (iv) Protests, without justification, that others make unreasonable demands on him or her
- (v) Avoids obligations by claiming to have "forgotten"

- (vi) Believes that he or she is doing much better job than others think he/she is doing
- (vii) Resents useful suggestions from others concerning how he or she could be more productive
- (viii) Obstructs the efforts of others by failing to do his/her share of work
- (ix) Unreasonably criticizes or scorns people in positions of authority

B. Associated Axis I Disorders

(i) Anxiety Disorders

These people experience prolonged and generalized anxiety disorders.

(ii) Psychosomatic Disorders

These disorders are as a result of people finding themselves in an irresolvable situation. Any physiological system may be affected.

(iii) Affective Disorder

Dysthymia and cyclothymia are the two major disorders of affect which occur in the compromised passive aggressive personalities.

(iv) Somatoform Disorders

Hypochondriacal and somatization disorders are the main forms of symptom profiles depicted.

(v) Personality disorder N.O.S

- Mixed personality disorder
- Impulsive personality disorder
- Immature personality disorder
- Self-defeating personality disorder
- Sadistic personality disorder

MANAGEMENT

1. GENERAL PRINCIPLES

The first and most important issue of management of a personality disorder of any type or form is assessment. The main focus here is to make sure that the perceived personality disorder is not due to an organic disorder. This may be a focal or diffuse brain disorder hence requiring proper history, physical assessment and such investigations as may be indicated. Electroencephalography, skull X-rays, brain C.T. scans and magnetic resonance imaging (M.R.I) may also be indicated as investigative tools. Other metabolic disorders may also be present and cause a personality change. Hence general physical appraisal is necessary. The specific management in these cases depends on the primary organic disorder.

2. PSYCHIATRIC DISORDERS

People with personality disorder do decompensate into specific psychiatric disorders such as anxiety, mood disorders and schizophrenia.

The primary management is that of the presenting psychiatric decompensation.

Subsequent long-term management of the personality disorder shall follow this initial management.

3. PSYCHOPHARMACOLOGY

Psychopharmacology adjunct to psychotherapy as management for personality disorder has been employed. This is especially true in the long term management of such conditions as paranoid or schizotypal personality disorder. Antidepressants, antipsychotics and carbamazepine have all been used where indicated. The benzodiazepines are used with caution as they may release anger in most personality disorders.

4. PSYCHOTHERAPY

a. Individual Psychotherapy either insight oriented or supportive is helpful in mainly dependent, passive personality disorders. In the aggressive and anti-social cases, these therapies tend not to be effective. Hence one has to appraise each case and set clear cut limits of individual therapy. In most cases, confrontation at therapy is more effective than interpretation. The individual therapy tends to be long term and usually not very effective.

b. Group Therapy - used alone or in conjunction with individual therapy tends to be the most effective mode of treatment. Groups are usually between 10 and 20 in number and are well matched for age, sex and personality disorder. Behaviour techniques such as self assertiveness may be included in the group therapy.

5. RESIDENTIAL MANAGEMENT

a. Acute Admissions: This is necessary if crises situations arise e.g. self mutilation, suicidal attempts or alcohol and drug abuse. The in-hospital stay should be short with minimal free time. The emphasis should be expression of emotions and development of relationships with staff and other patients.

b. Long-term Admissions: This is for the severely disabled patients and the focus is on rehabilitation, along social skills development and vocational training. Half-way houses and day care centres may eventually be utilized as part of the resettlement back into the society.

DRUG DEPENDENCE

This chapter aims at:

1. Providing information on drugs of abuse with emphasis on alcohol
2. Introducing the trainees to techniques used in diagnosis of such conditions as drug dependence syndrome
3. Providing the trainees with counseling techniques that can be applied at a primary health care setting

DRUG DEPENDENCY SYNDROME

INTRODUCTION:

Drug dependence is a state arising from repeated administration of a drug on periodic or continuous basis. The characteristics of the drug dependent state vary depending on the drugs involved.

Drug dependence is a worldwide problem and is responsible for so many disabilities in those who get dependent.

There are some drugs which are commonly abused in Kenya and many other African countries. These drugs are alcohol, tobacco, cannabis (bang, marijuana) khat, (miraa) and to a less extent tranquillisers and volatile solvents. Abuse of drugs such as opium, cocaine and heroine are rarely encountered in Kenya although they may pose problems in future as evidenced by isolated cases, mainly diagnosed in immigrants and tourists.

HOW TO IDENTIFY DRUG DEPENDENT PATIENTS

Diagnosis of drug abuse is highly elusive. This is sometimes due to the concealing of any valuable information by the patient. However clinicians are not also always aware of the existence of such a diagnosis.

Suspicious to an existing drug problem are:

1. **From the patient:**

- a) The patient may, though rarely, admit that he or she has been abusing a particular drug.
- b) The patient may give clues such as repeated request for prescriptions for psychoactive drugs or requesting for money in excess of presumed need.

2. **From the significant others (e.g teachers, parents)**

- a) There may be reports that the patient has had pills, syringes found on him.
- b) Disturbed behaviour may have been noted suggesting intoxication. This behaviour may have led into conflict with law, parents, peers etc.
- c) There may be reports that tablets prescribed for others in the family have been disappearing

3. **On Examination:**

- a) The health worker may be able to find injection sites or abscesses on the skin.
- b) Patients might have perceptual disorders e.g hallucinations.
- c) He may also have delusions usually of the paranoid type. Pinpoint pupils are commonly found with opiate dependence.
- d) Withdrawal syndromes may be an indication that the patient has been dependent on a drug. These should be suspected in road-traffic accident victims, or in persons who get unexplained seizures soon after admission.
- e) In extreme cases the health worker may have to confirm the presence of a drug through detection of drug metabolites in the urine or other body fluids. Alcohol dipstick is such one tool which could be used for instant quantification of alcohol in urine or saliva.

ALCOHOL DEPENDENCE

DEFINITION:

World Health Organization defined alcoholics as those excessive drinkers whose dependence on alcohol has attained a degree that they show noticeable mental disturbance or on interference with their bodily health, interpersonal relationship, smooth economic and social functioning or who show prodromal signs of such development.

EPIDEMIOLOGY

Alcohol is a very prevalent drug in the African continent. Several studies done generally indicate that 30-45% of the adults admit to taking alcohol daily or almost daily. The youth aged 15-20 are also known to be consuming alcohol and 10-14% could be classified as abusers, that is those taking alcohol on three or more occasion in a week.

AETIOLOGY

There is no single cause of alcohol dependence. Psychoanalytic theories postulated at the beginning of this century, thought alcoholism was as a result of strong oral influences. It was also regarded as a self destructive drive. Desire to escape responsibility and perpetual sense of inferiority leads to alcoholism. Learning theories suggest that alcohol leads to reduction in fear and conflicts, though temporarily, and this reward is always sought for in consequent drinking sessions.

Physiological theories postulate that genetic factors determine alcoholism. Social organization in a society where the attitudes towards drinking are set propagate or diminish alcoholism in the society. These social factors include:

1. Availability of the alcohol
2. States policy on the production
3. Social attitudes on drinking
4. The social economic status of the people

Thus, development of alcoholism is multifactorial.

ALCOHOL RELATED DISABILITIES AND HOW TO HANDLE THEM

The concept of alcohol related disabilities is more useful in that not every individual who experience impairment or disability related to alcohol consumption is suffering from alcohol dependence and yet such individuals are recognized as experiencing problems. A health worker should consider the importance of the physical, psychological and social disabilities that might result from excessive drinking rather than be overconcerned with dependence syndrome.

DEFINE IF YOUR PATIENT BELONGS TO THE POPULATION AT RISK

These are:

1. General hospital patients especially those with disorders known to be associated with alcoholism e.g pancreatitis, gastritis, tuberculosis cardiomegaly
2. Person with attempted suicide
3. Psychiatric patients
4. Patients attending casualty and emergency services more often
5. Patients attending general practitioner's clinics more often
6. Vagrants
7. Prisoners
8. Those cited for legal offenses connected with drinking (e.g driving while intoxicated)
9. Middle aged males
10. Adolescents
11. Migrant workers
12. Certain occupational groups such as business executives, members of certain professions and seamen

These populations should be screened when they present at health delivery points. If your patient takes alcohol, does he/she have indications of alcohol abuse and alcoholism,

You could find this if you look for the following:

EARLY INDICATIONS OF ALCOHOL ABUSE

1. Heavy drinker often has 4 or more drinks a day (6 grammes of ethanol)
2. Increased tolerance to alcohol
3. Drinks quickly, gulps the first drinks
4. Eats lightly or skips meals
5. Concern or worry about drinking by self and or family
6. Intellectual impairment
7. Tiredness/absenteeism from work due to drinking
8. Most friends are heavy drinkers
9. Most leisure activities involve drinking
10. Frequent use of alcohol to relieve stress, anxiety, depression
11. Has attempted to cut down on drinking with limited success

Classic signs of alcoholism:

1. Very heavy drinker, often has nine or more drinks per day (12 grammes of ethanol)
2. Morning drinker
3. Blackout, memory lapses when drinking
4. Impaired control over alcohol consumption and craving
5. Compulsive drinking style, frequently thinks about drinking
6. Experiences severe alcohol withdrawal reaction
7. Repeated attempts to cut down drinking have failed
8. Gross cognitive deficit e.g. alcoholic dementia
9. Social degeneration - lost job, family problems, legal convictions related to drinking

Several studies have shown that social disabilities, psychiatric problem and physical disabilities are quite common in that order of priority.

SOCIAL DISABILITIES:

1. Marital disharmony is the earliest.

The spouses may deny the existence of the problem but as the problem gets worse marital relations get strained. This is evidenced by several reactions within the family which is undergoing a crisis in terms of personal interactions.

2. Impairment of functioning

The earliest area to suffer is work or school performance. It has been noticed that absenteeism is higher among alcoholics compared with controls. As the drinking problems escalate the person may lose his job, drop from school or fail in his social role as a parent.

3. Socially unacceptable behaviour

With so much drinking going on in most countries on the continent it is now evident that alcohol plays a big role in cases of assault and robberies that are reported.

Alcohol has increasingly been implicated in cases of homicide to an extent of 37-70%. Alcoholism has been associated with child abuse and neglect. This is a serious social evil. As the drinking gets serious there is eventual personality disintegration and one becomes a social litter.

PSYCHIATRIC/EMOTIONAL DISABILITIES

Psychological consequences of alcohol abuse are probably manifested early in the drinking life, but not promptly recognized. They are perhaps the commonest reason for consulting a health worker especially among populations at risk.

ACUTE

1. Intoxication
2. Blackouts
3. Pathological intoxication
4. Mild withdrawal symptoms

INTERMEDIATE

1. Delirium tremens
2. Alcoholic hallucinosis

LONG TERM

1. Wernickes syndrome
2. Alcoholic paranoia
3. Karsakoff's syndrome
4. Depression
5. Suicide

INTOXICATION

Alcohol is a CNS stimulant in moderate quantities but a potent CNS depressant while in excess. Persons who have ingested alcohol present with decreased reaction time, slurred speech, impaired visibility and gait. In severe cases of intoxication coma may ensue.

PATHOLOGICAL INTOXICATION

Are commonly seen in persons with hysterical or epileptoid temperaments and is characterised by a dramatic and sudden consciousness impairment. Other transitory symptoms may include illusions and visual hallucinations. Patients tend to be impulsive and aggressive. Pathological intoxications occurs after consumption of very little quantities of alcohol which would otherwise not cause any intoxication in non-susceptible individuals.

BLACKOUTS (ALCOHOL AMNESIA):

Are characterised by amnesic periods following a drinking episode. The patient may appear to be perfectly normal during this period but has no recollection of the events of the period.

MILD WITHDRAWAL SYMPTOMS:

These are seen after a drinking bout and symptoms include:- nausea, flushing, tremourlessness, palpitation, anxiety, sweating and uneasiness

DELIRIUM TREMENS

These ones follow a prolonged drinking career and are characterised by an acute psychotic episodes, which are commonly seen in people aged 35 years and over and who have been drinking for three to four years. It is a psychiatric emergency and could be precipitated by a prolonged and severe period of drinking.

The signs are impaired consciousness with flirring attention. Perceptual disorders such as illusions and hallucinations are marked. Sleep is disturbed and is accompanied by terrifying dreams. Patients are usually restless and motor activity is marked. When examined, the face and conjunctiva are congested and pupils may appear dilated and react very slowly to light, reflexes are exegerated, speech is incoherent. Coarse tremors and moist skin are noted. Hyperthermia and irregular weak, rapid pulse are present and at times seizures occur.

TREATMENT OF DELIRIUM TREMENS

1. Look for precipitating factors e.g injury, infection, hypoglycaemia, and treat them
2. Detoxify the patient by withdrawing alcohol
3. Correct the electrolyte imbalance and rehydration
4. Reduce agitation by chlordiazepoxide hydrochloride (dose 10-25 mg 6 hrly)
5. Parental diazepam to minimize seizures
6. Nutritional needs of the patient taken care of by giving parental vitamins (thiamine hydrochlorine 200mg daily)
7. High calories diet

PROGNOSIS OF DELIRIUM TREMENS

There is complete recovery within 3-10 days where adequate care is given. However, the mortality rate may range from 10-15% especially if there are concomitant infections and injuries.

ALCOHOLIC HALLUCINOSIS

Alcoholic hallucinosis are characterised by auditory hallucinations occurring in absence of clouding of consciousness, confusion or disorientation and may resemble schizophrenic illness.

Thus the patient has:

- auditory hallucinosis of threatening nature
- ideas of reference
- elaborate delusional system
- patient involves law in his defense against terrifying attacks
- patient is disoriented in time, place, person and fits the hallucination and delusions in real environment
- the mood is apprehensive and fearful and patient may attempt suicide

TREATMENT OF ALCOHOLIC HALLUCINOSIS

Patients should be hospitalised and detoxified. Neuroleptic drugs are given to calm the patient and also to treat the psychosis. Nutritional needs should be met by giving high carbohydrate, high protein and vitamin supplements.

PROGNOSIS OF ALCOHOLIC HALLUCINOSIS

Alcoholic hallucinosis may last for five days to months and by the sixth month the symptoms may disappear completely to reappear if alcohol is ingested.

PHYSICAL DISABILITIES

TRAUMA (INJURIES)

Trauma is usually a very common physical complication of alcohol abuse. It can result from single episode of drinking and could be as a result of several causes e.g road traffic accident, fight or self-inflicted due to a fall. Repeated trauma is a very good indicator that an individual has a drinking problem.

GASTRITIS

Following a bout of drinking alcohol, some individuals develop gastritis with haematemesis.

ALCOHOL FETAL SYNDROME

Alcohol fetal syndrome has been described where newborn babies born to alcoholic mothers were found to have major anomalies, reduced central nervous system performance, retarded growth and characteristic facial appearance. The mortality rate is quite high up to 17% and remaining babies have several other problems.

CENTRAL NERVOUS SYSTEM

The physical injuries done to the central nervous system is seen as Wernike's encephalopathy, Korskoffs syndrome and some forms of neuropathies.

CHROMOSOMAL ABERRATIONS

Studies done on animals have produced some results which suggest that alcohol might be a mutagen and follow up studies too suggested that chromosomes of alcoholic fathers showed significant increase in aberrations.

CIRRHOSIS

It has been estimated that in all cases of cirrhosis in the world at least 50% are linked to alcohol abuse and in some countries this figure rises. All types of alcoholic beverages cause liver disease. Alcohol induced liver injury can express itself in several ways e.g. hypoglycaemia, fatty liver and alcoholic hepatitis.

CARDIOMYOPATHY

Alcoholic cardiomyopathy has been recognised for a long time. The essential evidence concerning aetiology remains the finding that a large number of patients have a long standing history of a very high consumption of alcohol and that improvement may follow its sudden withdrawal.

CANCER OF THE OESOPHAGUS

In Africa, particularly East and Central Africa it is known that there is an association between cancer of the oesophagus and alcohol. This is so especially in areas where alcoholic drinks were made from fermented maize and rare in areas where the alcohol was made from bananas, millet or sorghum.

MANAGEMENT OF ALCOHOL DEPENDENCE SYNDROME

Alcohol dependence is well delineated syndrome with aetiology, clinical manifestations and prognosis.

Assessment of an Alcoholic:

1. Take a comprehensive psychiatric history and particularly note the absence or presence of psychosocial difficulties.
2. Map out the drinking pattern e.g. when the patient started drinking, what beverages, what quantities and frequency are they taken and what areas gives the patient a drinking urge.
3. What resources does the patient have e.g. family, job, social groups, which could be used in management.
4. Plan a management scheme

TREATMENT OF ACUTE COMPLICATIONS

Treatment programs must be designed to fit the needs and resources of the individual patient. Intoxication is treated by hospitalization, chlordiazepoxide 10-25 mg four times daily for one to three days. Rehydration and vitamin supplement should be given parentally, thiamine hydrochloride in 200mg daily doses. Epanutin should be given if convulsions occur.

TREATMENT OF LONG-TERM COMPLICATIONS

The most important treatment ingredient is the relationship between the patient and another person or group. The person could be a physician, psychiatrist, social worker etc. The group could be Alcoholic Anonymous or other supportive groups. Aversion therapy where medicine such as Disulfuram induces vomiting has not been very useful. Disulfurum therapy is dangerous and the compliance is usually poor. These two modes of treatment should be discouraged and psychological treatments preferred.

Primary Prevention:

This is geared towards preventing the problems from occurring. This requires several apparatus and agents. Mass health education directed at the community is an important means of reducing the demand for alcohol thus preventing alcohol problem. Limiting the availability of alcohol by enforcing existing legal and regulatory controls is also useful as a primary prevention measure.

Secondary Prevention:

Early identification of alcohol related problems is a secondary preventive measure. A health worker should be able to identify patients with early drinking problems and offer initial treatment by using simple counselling techniques (see below).

HOW TO HELP PEOPLE WITH ALCOHOL (SUBSTANCE) DEPENDENCE

The following program can be applied in any other drug apart from alcohol:

1. Assess the patient thoroughly. (see assesment of an alcoholic) with emphasis to kinds of alcohol taken, quantities, frequencies and what triggers intake.
2. Plan a management scheme, set goals for short term and long term treatment, counsell on:
 - a. How to avoid alcohol related problems
 - b. How to drink sensibly

AVOIDING ALCOHOL RELATED PROBLEMS

- A. Changing drinking habits: let the patient start by asking
 - i) How do I benefit by changing my drinking habits?
 - ii) How would my life be improved if I changed drinking habits?

Possible benefits on changing drinking habits:

1. May cut down on weight
2. Getting used to smaller amount which still gives enough pleasure
3. Reduce fast aging
5. Minimize risks related to alcohol induced diseases
6. Able to develop better relations
7. Happiness at home will increase
8. Reduce accidents and possible early death
9. Potence will increase for men and women will have healthy pregnancies
 - A. Ask the client to list as many possible reasons why he/she thinks changing his/her drinking behaviour will be beneficial

B. Recognising drinking cues

Ask your patient to list the cues that compel him to seek alcohol

Some people list the following:

1. Being in certain companies where people are drinking
2. Lack of sleep
3. When bothered by personal problems
4. When disappointed.
5. When bored

6. When near a pub or seen one
7. While in parties
8. End of week celebrations

Once the cues have been listed, explore possible ways of avoiding drinking despite the cues.

C. Possible ways of avoiding cues:

1. Distract your mind - by listening to music
 - by talking to friends in the neighbourhood
 - by picking on an activity such as cleaning up
 - by jogging
2. Convince yourself that drinking will not solve your problems
3. Fetch time-occupying activities:
 - i) small business to keep you busy
 - ii) join groups e.g community development committees, self help groups, religious groups etc.
 - iii) develop hobbies - photography, gardening and so on
4. If you find yourself without anything to do try things you may have liked in the past, e.g. visiting animal opharnages, visiting museum, reading old magazines

The client should explore as many other possibilities as possible

At the end ask the client to compile a plan to include his:

1. Reasons for minimizing drinking
2. Possible drinking cues
3. Ways of avoiding these cues and to stick to them

HOW TO DRINK SENSIBLY

Most people drink and have the ability to control their drinking. Others don't and become alcoholics or heavy drinkers. Let the client answer this question: What is good for me?

Cutting down or stopping altogether?

One should stop drinking completely if one:

- Lost his/her job
- Got a separation
- Got into trouble with police
- Considers oneself a heavy drinker
- Has morning shakes
- Health is deteriorating and doctor advises one to do so
- Always loses control over drinking

WHAT IS SENSIBLE DRINKING?

- For men, take four standard drinks five times a week.
- For women, two drinks four times a week

A standard drink is defined

- 1/2 pint of beer
- One tot (measure) of spirits
- One glass of wine with small glass of sherry

Sensible drinking is only suitable to people who:

- i) Don't suffer from withdrawal symptoms such as tremors
- ii) Who have tried it and it worked in the last one year
- iii) Those who really want to be sensible drinkers and meets the above two

TERTIARY PREVENTION

This involves specialized treatment centres and is expensive in itself due to requirement that there should be trained specialized personnel. Rehabilitation programs as well as co-ordination requires resources. It is therefore important that health workers should aim at primary and secondary prevention measures in the management of drug/alcohol management.

PSYCHOLOGICAL ASPECTS OF AIDS AND AIDS COUNSELLING

OBJECTIVES:

- A. The trainee is expected to acquire knowledge on human immunodeficiency virus infections.
1. Historical background
 2. Mode of transmission
 3. Clinical presentation
- B. The trainee should be able to provide counseling services to the patients and their families.

INTRODUCTION

Historical Background:

The first case of Acquired Immune Deficiency Syndrome was reported in 1981 although there are some suspicions that such cases were there much earlier and it was not until 1983 that it was possible to isolate the virus responsible. Since then many cases have been reported world wide.

Human Immuno Deficiency virus causes the illness called Acquired Immuno Deficiency Syndrome (AIDS). The virus stays in the blood before it causes the illness. The acute stage occurs six to twelve weeks after infection and presents with fever, night sweats, headaches, coughs and swollen glands. The asymptomatic stage presents with swollen glands and the individuals appear healthy. AIDS related complex may take many years after infection which brings the stage patients develop many symptoms such as skin problems, generalized weakness, the glands swell and there is marked weight loss. The individuals are HIV carriers and do not have any serious medical problems.

AIDS is the severe end stage of the clinical spectrum of HIV infection. 'A' stands for Acquired which means obtained from others, 'I' stands for Immunodeficiency meaning lack of natural protection against diseases, 'S' stands for syndrome meaning that many different illnesses are seen in the same person at the same time.

EPIDEMIOLOGY

The first epidemic probably began in 1970 and continued up to date. Due to reasons such as under recognition, under diagnosis, and under reporting the actual number of infected people is not clear. It is estimated that 5 - 10 million people are infected world wide and the figure could be even higher. It is estimated that for every AIDS case 25 - 100 people may be infected with HIV. AIDS mainly strikes those in the age group of 20 - 49. However children born of these infected persons are increasingly reported as suffering from AIDS.

MODES OF TRANSMISSION

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In infected persons HIV is present in the blood. The virus infects both lymphatic and neuronal cells in which they replicate and causing cell death. HIV tends to disrupt the normal immunological functions of the body because they infect the helper T4 lymphocytes resulting in decreased stimulation of macrophages, natural killer cells, killer lymphocytes and B lymphocytes. Due to this diminished defense abilities the body is unable to resist infections from opportunistic infections.

HIV has been isolated from many body fluids of infected persons. Such body fluids as semen, vaginal fluids, breast milk, saliva have been implicated in transmission.

Common modes of transmission include the following:

1. Sexual Transmission

This is the most frequent mode of HIV transmission and occurs when one of the sexual partners is infected with the HIV.

Parental Transmission

This mode of transmission was initially responsible for transmitting the HIV but due to improved screening of blood, transfusion of blood is not now a major transmission mode. Others practical means of transmission include use of contaminated equipment such as needles, blades which have not been sterilized.

Perinatal transmission

Perinatal transmission may occur before or shortly after birth. The usual risk of HIV transmission from an HIV infected mother to her infant is about 50% and breast milk has also been responsible in some cases of post natal HIV infection.

You cannot get aids from:

Current knowledge show that the following ways can not transmit HIV. No evidence is available to suggest transmission of HIV through respiratory or enteric routes or by casual person to person contact e.g

- a. shaking hands
- b. crowded buses
- c. playing together with infected person
- d. insect bites
- e. toilets or latrines

Population at risk

1. Multiple sexual partner
2. Those in urban areas
3. Intravenous drug users
4. Heamophilics or patient who have received blood since 1977
5. Sexual partners of people with known HIV exposures

AIDS counselling

Techniques of Aids counselling

Counselling is a process through which one interacts with those in crises and facilitates problem-solving. During counselling those in crises are motivated to make their own decisions about how they are going to change to overcome their crisis. In counselling people should not be told what to do but be helped to decide and manage themselves. While one interacts and listens to each other and accelerates in solution finding them he/she is acting as a counsellor. Counsellors need not be highly trained people.

QUALITIES OF A GOOD COUNSELLOR

1. Be a good listener, nod to show that you understand.
2. Be able to consider the client's feelings, obligations, needs e.g. medical, financial, legal, psychological and appreciate them.
3. Be able to sustain confidentiality: A good mutual trustful relation is very necessary for effective change in your client's knowledge attitude and behaviour.
4. Be accessible: your clients need assurance that your services are available and readily accessible to them when needed.
5. Caring attitudes are very important and counsellor should respect the client's beliefs, culture and be non critical but rather be encouraging.
6. A good counsellor should be consistent and provide factual information to the clients.

Indications for HIV testing:

There are several indications why a person may want HIV test:

1. Patient who belong to high risk aids group (see above)

2. Patient who request testing though they may not admit presence of risk factors.
3. Patients who clinically had AIDS or ARC. Aids related complex which is a term used to describe HIV infected persons, who have not yet developed a major complication of AIDS but have some symptoms of AIDS.
4. women in high risk groups
5. Patients in high risk groups.

COUNSELLING AIMS TO ACHIEVE THE FOLLOWING

- a. To provide pretest counselling
- b. To produce post test counselling
- c. To provide guidance for prevention of HIV transmission from infected to uninfected persons.
- d. To offer social support to patients and their families

PRE-TEST COUNSELLING (Criteria for disease control guidelines)

1. Inform the patient the meaning of a positive result and that it only implies that one is exposed to the Aids virus, the test is not Aids test)
2. Discuss the meaning of negative result (e.g seroconversion requires time, recent high risk behavioural might require follow up.
3. Be available to discuss the extents , fears and concerns (unrealistic fears might require appropriate psychological intervention)
4. Discuss why test is necessary (remember not all patients will admit to high risk behaviour)
5. Explore the patient's reactions to a positive result. (e.g I will kill my self if I am positive) Take appropriate necessary steps to intervene in a potentially catastrophic reactions.
6. Explore past reactions to severe stresses

7. Discuss the confidentiality issues relevant to the testing situation (e.g. is it an anonymous or non anonymous setting? Inform the patient of other possible testing options where the counselling and testing are done completely anonymously (e.g. where the result would not be made permanent part of a hospital card) Discuss who might have access to the test results.
8. Discuss with the patient how being seropositive can eventually affect social status (e.g. health and life insurance coverage employment housing)
9. Explain high risk behaviour and recommend risk reducing interventions.
10. Document discussions on charts
11. Allow the patient to ask questions

At this stage blood will be drawn from the patient. After infection the antibodies to the virus develop in most persons within 6 to 12 weeks.

Antibodies developed by the immune system can be detected by two different tests. Enzyme linked immunosorbent assay (ELISA) and immunoblot. The latter is a confirmatory test while the former is a screening test. Always two ELISA tests are done and if positive a confirming test is done. After obtaining the results a post test HIV counselling is done.

Post HIV test counselling

1. Interpretation of test result. Clarify distortions (e.g. negative test still means you could contract the virus in a future time. It does not mean you are immune from AIDS) Ask questions to the patient about his or her understanding and emotional reaction to test result.
2. Recommendations for prevention of transmission (careful discussion of high risk behaviour and guideline for prevention of transmission).
3. Recommendations on the follow up of sexual partners and or needle contact.

4. If test is positive, recommendation against donating blood, sperms or organs and against sharing razors, tooth brushes or anything else that might have blood on it.

5. Referral for appropriate psychological support

HIV positive individuals often need access to mental health team (assess need for inpatient versus outpatient care; consider individual or group supportive therapy) common themes include shock of diagnosis, fear of death and social consequences, grief over potential losses and dashed hope for good news.

Also look for depression, hopelessness anger, frustration, guilt and obsessional themes.

Activate support available to patients (e.g family, friends, community services)

Adapted from laboratory and diagnostic testing in Psychiatry page 58, American Psychiatric press 1989)

PSYCHOLOGICAL ASPECTS OF HIV INFECTION

1. Worried well Population

Some people despite a negative serum test are worried especially if they belonged to high risk group. The long incubation period worries them even more. They require repeated reassurance by blood tests. They present with symptoms ranging from anxiety, depression to hypochondriasis and this may impair functioning.

2. Responses to a Positive HIV test

Shock:

Patients experience a number of psychological problems but the degree of suffering is related to the counselling done before the testing. Shock on receiving the news is characterized by sensing numb feelings and individual feel that they are not themselves any longer.

Denial and Anger:

A second stage of denial sets in where patient uses all the defense coping mechanisms to handle this stressful situation. However this is only a wishful thinking and patients develop some psychiatric symptoms such as anger. He may feel angry towards himself or others.

Depression:

Depression eventually sets in and may be psychotic in nature. Patients experiences conflict, suicidal desperation and worthless. This may require psychiatric treatment.

Acceptance:

Acceptance of the situation is the first stage of the psychological recovery and is facilitated by counsellor who also prevents the appearance of the stage of revenge where certain individual may want to infect others as a form of revenge.

RAPE

OBJECTIVE:

To enable the trainee to acquire skills and sensitivity in detecting and managing victims of rape. Rape affects the lives of thousands of women each year.

Definition:

Rape is the perpetration of an act of sexual intercourse with a female against her will and consent or when she is below an arbitrary age of consent. The crime of rape requires slight penile penetration of the victim's outer vulva. Rape is an act of violence and humiliation that happens to be expressed through sexual means. Rape is used to express power or anger.

TYPES OF RAPISTS

- Sexual sadists, who are aroused by the pain of their victims.
- Explosive rapists, who use their victims as objects for gratification's in an impulse way.
- Inadequate men, who believe no woman would voluntary sleep with them.

Men for whom rape is a displaced expression of anger and range. The woman is considered the property or vulnerable possession of men and is the rapist instrument for revenge against other men.

VICTIMS OF RAPE

- Victims can be of any age - cases have been reported ranging from fifteen months to 82 years.
- The woman being raped is frequently in a life threatening situation. Rape often is accompanied by other crimes, the victim is threatened, physically harmed and sometimes even killed.
- The rape victim experiences physical and psychological trauma.
- Depersonalization and dissociation may occur during rape. Victims describe leaving their bodies floating, looking down from above at their bodies being raped.

The effects of Rape

- 1) Rape trauma syndrome
- 2) Silent rape reaction

RAPE TRAUMA SYNDROME

Is the acute phase and long-term reorganization process that occurs as a result of rape. This syndrome of behavioural, somatic and psychological reactions is an acute stress reaction to a life threatening situation.

The syndrome is usually a two phase reaction:

- a) The first phase is the acute phase. This is the period in which there is a great deal of disorganization in the woman's life style as a result of rape. Physical symptoms are especially noticeable, and a prominent feeling noted is **fear**.
- b) The second phase begins when the women begins to reorganize her life style. Although the time of onset varies from victim to victim, the second phase often begins about two or three weeks after the attack. Motor activity changes, nightmares and phobias are especially likely during this phase.

1. The Acute Phase: DISORGANIZATION

- Impact Reactions:

In the immediate hours following the rape, the woman may experience a wide range of emotions. There are mainly 2 emotional styles.

The expressed style, in which feelings of fear, anger and anxiety are shown through crying, sobbing, smiling, restlessness and tenseness

The controlled style in which feelings are masked or hidden and a calm, composed or subdued affect is seen. A fairly equal number of women show each style.

Somatic Reactions - occur in the first several weeks after rape. Somatic reactions include:

- a. Physical trauma: this includes general soreness and bruising from the physical attacking various parts of the body such as the throat, neck, breast, thighs, legs and arms.
- b. Skeletal muscle tension - headaches (tension) fatigue, sleep disturbance, nightmares
- c. G.I.T. irritability - bad pain, nausea, anorexia
- d. Genito-urinary disturbance, STDs including AIDS
- e. Pregnancy

Emotional Reactions

Victims express a wide variety of feelings as they deal with the after effects of rape. These feelings include fear, humiliation, embarrassment, anger, revenge and self-blame.

Fear of physical violence and death prominent. Victims state that although a rape was upsetting, they were overwhelmed by the feeling that they would be killed as a result of the assault.

2. The long-term process: Reorganization

- Motor activity - changing residence, telephone number
 - turn for support from family members
- Nightmares - very upsetting
- Taumatophobia - the phobic reaction to a traumatic situation. This phenomenon described especially in war victims, in the rape victims. The phobia develops as a defensive reaction to the circumstances of the rape. The following are common phobic reactions - fear of indoors, fear of outdoors, fear of being alone, fear of crowds and sexual fears.

MANAGEMENT

1. Crisis counselling

- Rape represents a crisis in that the woman's style of life is disrupted.
- Crisis counselling is the treatment of choice in the victim who had been functioning adequately prior to the crisis situation.
- aim of this crisis counselling is to enable the woman to return to her previous level of functioning as quickly as possible.
- Crisis counselling is issue-oriented and previous problems are not a priority for discussion.
- Crisis counselling includes ventilation, reassurance, support of adaptive behaviour and education.

Ventilation

Ventilation consists of facilitating the expression of affect and facilitating communication . The emotional reaction to rape is a major problem and keeps the crisis going until emotions start to subside. Cultural, family or personality factors may inhibit appropriate emotional expression. The counsellor can facilitate the expression of affect by recognizing its existence, and then encouraging its expression and then encouraging or giving permission to the victim to talk about and express these feelings.

Psychotherapy

This is the treatment of choice when the rape victim has a past or current history of psychiatric difficulties or social difficulties along with the rape trauma syndrome. This group noted to have additional symptoms such as depression, psychotic behaviour, psychosomatic disorder associated with alcoholism, drug abuse and sexual activity. These victims with compounded reaction require psychotherapy for the identified psychiatric treatment for the identified psychiatric condition.

SILENT RAPE REACTION

A significant proportion of women do not report rape and clinicians should be alert to a syndrome called the silent reaction to rape. This reaction occurs in the victim who has not told anyone of the rape who has not settled her feelings and reactions on the issue and who is carrying a tremendous psychological burden. A diagnosis of this syndrome should be considered when the clinician observes any of the following symptoms during interview.

1. The patient reports sudden marked irritability or actual avoidance of relationships or marked change in sexual behaviour.
2. History of sudden onset of phobic reactions and fears of being alone, going outside, or being inside alone.
3. Persistent loss of self-confidence and self-esteem an attitude of self-blame paranoid feelings, or dreams of violence and/ or nightmares.

If you suspect that a patient was raped in the past - include question relevant to the woman's sexual behaviour in the interview and ask her directly if anyone has ever attempted to assault her. Such questions may release considerable pent-up material relevant to forced sexual activity.

SEXUAL TORTURE

This is defined as the use of any form of sexual activity with the purpose of manifesting aggression and of causing physical and psychological damage. It is an attempt to deprive the victim of her identity and to terrorize the population.

Sexual torture methods include:

1. Rape
2. Nakedness
3. Threats of rape
4. Electrical & physical trauma to the genitals

Sexual trauma is deeply traumatic

Recounting and living these experiences are connected with strong feelings and shame for the victims. Some develop the Post Traumatic Stress Disorder (PTSD)

Sexual torture differs from usual rape in that sexual torture has cultural and political dimensions. In rape the act is experienced as being without meaning, while sexual torture can be conceived of as being meaningful if reviewed as part of a systematic process of destruction. Victims have a natural resistance against dealing with the traumatic experiences. Confession is painful since it is perceived as a repetition of the torture.

REFRAMING

Experience with traumatized victims shows that a review of the trauma story was not in itself therapeutic often, it stimulates further intrusive thoughts which intensify existing symptoms. It is, therefore, important that the painful events come to be seen in new context, that is are **reframed**. Through reframing the reliving of the trauma is not only a repetition of the pain, it is also experienced and understood in a new and more meaningful manner. It helps the patients to give meaning to their questions " why did this happen to me? How can human beings be so cruel". Therefore, the therapist should not try to break through the resistance to get to " the feelings". A provocation of this kind may lead to an increase of the 'personal' pain at the expense of the ' political pain' and the therapist might be identified with the torturer in the transference situation. Rather it should be communicated to the victim, that many people were also subjected to sexual torture and that the sexual torture was used as a political strategy to terrorize the population as part of a systematic process of destruction. In this way, the victim has the possibility to see her private symptom as part of an attempt at ideological destruction.

The Testimony Method

One important reframing method is the Testimony method. In cooperation with the therapist, the victim bears testimony to the abuse she has been subjected to. The account is written down for purpose of drawing up a document which the victim later can use as evidence - " to let the world know". Besides being a tool for reframing the method has also an offensive quality by testifying against the torture, one also becomes part of the struggle against torture.

The therapist writes the account in detail, while encouraging the expression of emotional aspects. After finishing the testimony, it is read through and edited in cooperation with the victim. By repeatedly working through the trauma story in this way, the trauma story in this way, it can gradually be objectified - the evil is so to say, moved out into the white paper.

SPECIAL CONDITIONS OF WOMEN

OBJECTIVE

To acquire skills and sensitivity in detecting and managing special conditions of women.

These include;

1. Infertility
2. Contraception
3. Pregnancy
4. Pseudocyesis
5. Puerperal Psychosis

INFERTILITY:

A couple is considered infertile if they have had coitus without contraception for a period of one year and pregnancy has not occurred.

It is not one factor or one mate but a combination of several factors that constitute infertility in most cases. However, the blame for the failure to conceive is often placed on the women and feelings of guilt, depression and inadequacy frequently accompany her perception of being barren.

Current practice encourage simultaneous investigation of factors preventing conception in both the man and the woman. However, frequently it is the woman who first presents for herself an infertility work-up.

Management:

A thorough sexual history of the couple

A psychiatric evaluation - marital disharmony, emotional conflicts around intimacy, sexual relations, or parenting roles can directly affect as erection, ejaculation, and ovulation.

However there is no evidence of any simple casual relationship between stress and infertility.

The stress of infertility in a couple who want children can lead to emotional disturbance when a pre-existing conflict gives rise to problems of identity, self-esteem and guilt the disturbance may be severe. It may manifest itself through regression, extreme dependency on the doctor, the mate or apparent diffuse anger, impulse behaviour or depression .

People who have difficulty conceiving experience shock, disbelief and a general sense of helplessness, and they develop an understanding preoccupation with the problem.

- Involvement in the infertility work-up and development of expertise about infertility can be a constructive defense against feelings of inadequacy.
- worries about attractiveness and sexual desirability are common.
- Partners feel ugly, unimportant and experiences of episodic sexual dysfunction and loss of sexual desire are reported.
- In addition they have to deal with a narcissistic blow to their sense of femininity (or masculinity)
- An infertile person fears abandonment or feel the spouse is remaining in the relationship resentfully.

Professional intervention may be necessary to help the infertile couple to ventilate or mourning their lost biological functions and the children they cannot have. Some may decide not to pursue parenthood, while others may opt for adoption.

PSYCHIATRIC ASPECTS OF CONTRACEPTION

Reproduction is one of the important and basic functions of a living being. Any attempts to control or stop this function can generate some fear or apprehension.

- Furthermore sometimes contraception may have some complications (both organic and psychogenic)
- The person may also get conflicts between the age old beliefs and the advantage of a limited family. If contraception is forced on people without preparing them well before hand to accept it, it can lead to problems: These problems include:

A neurotic post sterilization syndrome characterised by:

- hypochondriasis
- vague pains

- loss of libido, sexual unresponsiveness, impulse
- depression
- concerns about femininity or masculinity.

Psychiatric assessment can frequently separate patients seeking sterilization for psychotic or neurotic reasons from those who have made the decision after some time or thought and pre and post counselling is recommended. With oral contraception 8 - 30% women report psychological symptoms such as nausea, dizziness, vomiting, general malaise headache, insomnia, loss of libido, as a result of the effect of the pills.

Proper education removal, of misconceptions, oral and emotional support, good motivation prompt and timely attention to any side effects regular follow-up, encouragement and reassurance is reported helpful.

PREGNANCY

Pregnancy produces marked biological, physiological and psychological changes in women. Most women have a positive attitude to pregnancy. However some experience psychiatric disturbances. Although minor affective symptoms are common in pregnancy serious physical disorders, less common than in non-pregnant women of the same age.

- Psychiatric disorder is more common in the first and third trimesters of pregnancy than in the second. In the first trimester unwanted pregnancies are particularly associated with symptoms of anxiety and depression.
- In the third trimester there may be fears about impending delivery or doubts about normality of the fetus.
- Psychiatric symptoms in pregnancy is common in women with a history of previous psychiatric disorders

PSEUDOCYESIS

This is a rare condition in which a woman believes she is pregnant when she is not, and develops amenorrhoea and abdominal distention.

This distention results in most cases from downward pressure of the diaphragm and lordosis of the lumbar spine.

The condition appears to be akin to hysteria. It usually resolves once the diagnosis has been made.

UNWANTED PREGNANCY

Results in anxiety, depression, guilt and termination of pregnancy (abortion) is often sought. Some women become suicidal if denied abortion.

POST-PARTUM MENTAL DISORDERS

These disorder can be divided into maternity blues, puerperal psychosis and chronic depressive disorders.

MATERNITY BLUES

Among women delivered normal children 50 -75% experience brief episode of irritability and liability of odd and episodes of crying. These symptoms reach their peak on the third or fourth post partum day. Disorder related to readjustments in hormones after delivery. No treatment is required because the condition resolves spontaneously.

PUERPERAL PSYCHOSIS

Incidence 1 in 500 births.

Three types of clinical picture observed.

1. Acute organic syndromes
2. Affective syndromes
3. Schizophrenic syndromes

Occurs after childbirth and is characterized by thoughts of wanting to harm baby or oneself, or delusional beliefs that baby is abnormal or evil.

Patients may be a danger to herself or baby depending on delusion and degree of agitation.

5% kill themselves

4% kill baby

Favorable outcome predicted by absence of family history of depression or schizophrenia supportive family net work and a good social adaptation.

Subsequent pregnancies associated with increased risk of other episodes of puerperal psychosis.

Treatment Generally it is better that baby remains with mother to help maintain emotional 'bonding' between them:

- ECT
- Phenothiazine
- Antidepressant drugs

PUERPERAL DEPRESSION

- Less severe depressive disorders are more common than puerperal psychosis.
- Prevalence rates 10 - 20%
- Onset after two weeks after child birth
- Tiredness, irritability and anxiety often more prominent than depression and there may be phobic symptoms
- Previous psychiatric history and recent stressful events are important aetiological factors.
- Most patients recover after a few months

Treatment

1. Psychosocial treatment
2. Antidepressant drugs

PREMENSTRUAL TENSION

- This term denotes a group of psychological and physical symptoms, starting a few days before the onset, and ending shortly after the onset, of a menstrual period.

Psychological symptoms include anxiety irritability and depression.

Physical symptoms breast tenderness abdominal discomfort, distension

Incidence 30 - 80% women of reproductive age.

Aetiology uncertain probably hormonal or psychological

Treatment

- Progesterone
- Oral contraceptives
- Bromocriptine
- Diuretics
- Psychotropic drugs
- Psychological support and encouragement

THE MENOPAUSE

In addition to the physical symptoms of flushing sweating, and vaginal dryness, menopausal women often complain of headache, dizziness and depression .

Depressive and anxiety related symptoms at the time of the menopause could have several causes.

- Hormonal changes especially deficiency of oestrogen .
- Stress in the woman's role as her children leave home (empty nest syndrome) or as relationships with husband alters or woman's parents die or are ill.

HYSTERECTOMY

Several retrospective studies indicate an increased frequency of depressive disorder after hysterectomy.

DOMESTIC VIOLENCE **SPOUSE ABUSE**

OBJECTIVES

DISCUSS:

- 1. DEFINITION OF SPOUSE ABUSE**
- 2. EPIDEMIOLOGY**
- 3. CAUSES OF SPOUSE ABUSE**
- 4. CHARACTERISTICS OF THE ABUSER**
- 5. CHARACTERISTICS OF THE ABUSED**
- 6. MANAGEMENT OF THE PROBLEM**

1. DEFINITION

Mistreatment or misuse of one spouse by the other. It takes many forms and often results in injury. It can range from shoving, pushing, choking to battering involving broken limbs, broken ribs, internal bleeding and brain damage. Face and breast are the common sites of assaults . In pregnancy the husband often batters the most vulnerable body part, the abdomen.

2: EPIDEMIOLOGY

2.0: U S A - 2 to 12 million homes/year experience domestic violence in the nature of spouse abuse. More than 8% of U.S.A homicide involve the killing of one spouse by another. Wives are more often the victims than husbands. 25% to 30% of all U.S.A women have been beaten at least once during marriage by their spouses. High risk period for spouse battering is during pregnancy. A major predictor for in pregnancy battering is a previous abuse. Wife abuse is the major problem in spouse abuse. However, some beatings of husband are repeated. In these cases the husband is normally culturally or socio-economically compromised, poor physical or mental health and of old age. Another situation associated with husband abuse is the marriage of a robust young wife to an old frail man.

2.1: Wife beating occurs in families of all races, religions and socio economic strata. It is made worse by alcohol and drug abuse. Recent surveys of opinion among adult men and women on wife hitting showed that 20% approved of husband and wife hitting.

3: CAUSES OF SPOUSE ABUSE

3.0: Abusive men are more likely to have come from violent homes where there was wife beating and may be they themselves were beaten.

3.1: The act of wife beating is said to be self reinforcing. Once a man has beaten his wife, he is more likely to do it again.

3.2: Abusive men tend to be immature, dependent, non assertive and suffer from strong feelings of inadequacy.

3.3: The wife abuse is more likely when the man is under stress, feels threatened or frustrated at home, work or by peers.

3.4: The dynamics of wife abuse include:

- a. Identification with an aggressor (father, boss)
- b. Testing behaviour (tolerance of the wife to abuse)
- c. Distorted desires to express manhood
- d. Dehumanization of the woman
- e. The woman is perceived as property and hence can be disposed off as the owner likes.

4. CHARACTERISTICS OF THE ABUSER

4.0: Views wife as property, hates her independence. Hates when she tries to get a job, leave the house/home without his permission or when she threatens to leave the marriage.

4.1: He is most destructive when she is most dependent i.e pregnant, has small children - because he feels neglected and left out.

4.2: He is likely to neglect and abuse his children as well.

4.3: He is extremely jealous, possessive and forces the spouse to feel inept, worthless and incapable of surviving without him.

4.4: He interferes in any friends the wife makes, prevents her from working outside the home or insists she works where he can monitor her while on the job.

4.5: Normally the violence does not start until after marriage.

5: CHARACTERISTICS OF THE ABUSED

- 5.0: 50% of such women grew up in violent homes.
- 5.1: Frequently they married at a young age just to avoid such a violent home.
- 5.2: The women are dependent and perceive themselves as unable to function alone in the world or without a man.
- 5.3: She comes from a background that has supported male/female (aggressive - passive) role models.
- 5.4: She defines her self by her husband and takes the identity from him. Hence this makes it difficult to expose the abusive problem as would in essence mean exposing her self.
- 5.5: Frequently she blames herself for the abuse she receives.
- 5.6: Is a victim of cultural conspiracy to maintain her as property to her husband; as dependent to her husband and the one who calls for violent behaviour at home by misbehaviour.
- 5.7: The wife who comes to therapy is usually found to have
- Depression }
- Passivity } as defenses against her husband's moods and against her suppressed
rage
- 5.8: Therapy is directed towards changing her hopeless state, rebuilding her self esteem, developing her autonomy and enabling her to deal with her own controlled rage. At times this rage is directed to the woman in the form of suicide attempts, or self mutilation, It may also be directed to the children in the form of child abuse. During therapy as the wife becomes less depressive and more assertive, the husband may become more and more abusive making stay together more dangerous.

5.9: The goal of treatment is to resolve the violence in the marriage. This means that both spouses must participate in therapy otherwise they dissolve the marriage. Issues of mutual divorce management and child custody must be addressed.

6: MANAGEMENT

6.0: After a bout of violent behaviour, some men become particularly loving. This encourages the wives to remain at home until the next cycle of violence, which inevitably occurs.

6.1: If the man is convinced that the woman will not tolerate the violent behaviour, change in behaviour on his part will definitely occur. She can do this by leaving for a protracted period and agree to return only after the man has sought definite help. Family therapy can then be effective under such circumstances.

6.2: Neighbour interference and or police action is effective in the less impulsive cases.

CHILD PSYCHIATRY

Child Psychiatry in Africa is still a neglected area, yet we have some of the highest birth rates in the world and in many African countries more than half of the population is under 15 years of age. There are 1.3 billion children under the age of 15 years in the world i.e about a third of the world's total population and approximately, 83% of these children live in developing countries! The wide prevalence of many infections and potentially "killer" diseases in the impoverished African countries has been one of the reasons for mental health receiving less attention. However the African medical scene is changing rapidly and with improved nutrition, vaccinations and other preventive measures; Africans are living longer lives. Moreover, using internationally accepted research a massive corpus of local research indicates that mental disorders are as prevalent here as they are elsewhere in the world. Studies among Kenyan children indicate that at least 20% of them have psychiatric disorders mainly emotional and conduct disorders. Our local press has highlighted child abuse, neglect and mental retardation. The new generation of ambitious, educated parents with high educational aspirations for their children, coupled with reduced educational opportunities, rapidly increasing population, competitive school systems have brought learning difficulties among children to the forefront. The stage is now set for the re-appraisal of child mental health care.

OBJECTIVES

- i) To acquire a basic knowledge of normal psycho social development of children and of factors known to influence it.
- ii) To acquire skills and sensitivity in detecting and managing childhood mental health problems at as early an age as possible.

INTRODUCTION

Child psychiatry practice differs from adult psychiatry in several important ways:

- i) Children are dependent upon social care settings, such as families and school. Children rarely initiate referrals, instead they are brought by adults who think that some aspect of behavior or development is abnormal - whether the child is brought or not depends on the attitudes and tolerance of the adults and how they perceive the child's behaviour.

Psychiatric problems in a child may be a manifestation of disturbance in other members of the child's family. In treatment less use is made of medication, emphasis is laid on reassuring and retraining the child and on environmental manipulation (changing attitudes of adults, coordinating the efforts of those who can help the child).

ii) Children are in varying stages of development, a process which profoundly affects their physical, intellectual, emotional and social characteristics. There fore in deciding what's normal and what's abnormal, attention must be paid to the stage of development of the child. Children generally are less able to express themselves verbally therefore much more reliance is placed on accounts derived from parents, teachers and others, the assessment of these accounts requires skills in taking developmental history, assessing behavior and social assessment.

CHILD DEVELOPMENT

Basic requirements for normal psychosocial development of children (in addition to an intact nervous system) include:-

- A warm, accepting environment with stable parents, who are sensitive to the child's emotional needs and who provide appropriate conversational interchange, opportunities for play and consistent discipline, supervision and support.
- Chance of increasing autonomy and independence
- Adequate interaction with other children and adults at home and outside the home
- Suitable learning opportunities

The first year of life

- A period of rapid development of motor and social functioning
- Wide variation
 - Birth reflex smile/grimace, develops eye/head control
 - 2/12 social smile/smiles at faces
 - 3/12 head/neck control, rolls over
 - 6/12 selective smiling
 - 8/12 fear of strangers, then anxiety on separation from mother
 - 9/12 sits up well, crawls

1 year walks 3-4 words

By the end of the first year the child should have developed a close and secure relationship with the mother. The child also has, by now an ordered pattern of sleeping and feeding,

YEAR TWO

- Child begins to wish to please parents, and is anxious when they disapprove
- Begins to learn to control his behaviour
- Attachment behavior well established
- Temper tantrums if exploratory wishes frustrated
- Simple sentences

PRE-SCHOOL (2 to 5 years)

- Rapid increase in intellectual abilities especially language
- Social development, as child learns to live within the family, temper tantrums continue disappearing before school age. Child very curious and has rich and vivid fantasy life.

MIDDLE CHILDHOOD (5 to 10)

- Should understand his/her identity as a boy or a girl and position in the family
- Has to learn to cope with school, to read, write and acquire numerical concepts

ADOLESCENCE

- The growing up period between childhood and maturity
- physical changes - rapid growth in physique
- secondary sexual characteristics
- intellectual aspects - acquires the capacity of abstract thought, reasoning and verbalization

social aspects emancipation from the family of origin achieving comfort with sexual and working roles and effectively identifying with the status, pleasure and responsibilities of an acceptable adult mastery of sexuality

- questions parents values, separates from family acquires adult identity

PSYCHOLOGY OF ADOLESCENCE

Adolescence refers to the period of transition from childhood to adulthood. During this period the young person develops sexual maturity, establishes an identity as individual apart from the family, and faces the task of deciding how to earn a living. A few generations ago, adolescence as we know it today was non-existent and many teenagers moved from childhood into the responsibilities of adulthood with little for transition. With the current school system, increase in the length of apprenticeship required to enter a profession, the interval between physical maturity and adult status has lengthened. Now young people complete school at later ages and in most countries teens cannot work full-time, sign legal documents, drink alcohol, marry or vote. A gradual transition to adult status has some advantages. It gives the young person a longer period in which to develop skills and prepare for the future, but it also tends to produce a period of conflict between dependence and independence. Adolescence has been described as a prolonged series of crisis (Caplan, 1964). The form of crises can be related to the phase of adolescence which may be sub-divided into 3 major stages:-

1. **PUBERTY**- which refers to children aged approximately 10 to 12 years who are beginning to mature physiologically but cognitively still operating in Piaget's phase of concrete operations and emotionally they are still very dependent on the family of origin and the social structure that reinforces this dependence.
2. **EARLY ADOLESCENCE** - which describes children aged approximately 12 to 15 years, who show external signs of physical maturation, cognitively have advanced into Piaget's phase of formal operations and emotionally are becoming less dependent on the family and have a need to detach themselves, but social pressures tend to maintain them in their former state of dependence.

3. LATE ADOLESCENCE - which covers young people aged approximately 15 to 18 years who are more or less physically and cognitively mature, and who are in active process of emotionally detaching themselves from their families and trying to achieve independent identities. Depending upon a number of factors such as culture, social class, social pressure may be assisting or retarding their detachment but, by and large, society permits them more freedom than the former group.

PSYCHOLOGICAL ASPECTS

Generally the physiological and anatomical changes in puberty are

- i) Rapid growth of general physique so that the individual is larger and stronger
- ii) Special development of reproductive organs with increased size of external and internal genitalia, the development of secondary characteristics and the capacity for reproduction

INTELLECTUAL ASPECTS

Cognitively, the changes of puberty and adolescence are the acquisition of the capacity for abstract thought and reasoning.

PIAGET'S COGNITIVE DEVELOPMENT

- i) The sensory motor stage (birth to two years)
- ii) The stage of animism and precausal logic (two to 7 years)
- iii) The stage of concrete operational thought (8 to 12 years)
- iv) The stage of abstract thought (12 to 15 years)

SOCIAL ASPECTS

Erikson defines eight major life stages in terms of the psycho-social problems or crises that must be resolved.

<u>STAGE</u>	<u>PSYCHOSOCIAL</u>		<u>CRISES</u>
1. First year of life	Trust	vs	Mistrust
2. Second year	Autonomy	vs	Doubt
3. 3rd to 5th year	Initiative	vs	Guilt
4. 6th year to puberty	Industry	vs	Inferiority
5. Adolescence	Identity	vs	Confusion
6. Early adulthood	Intimacy	vs	Isolation
7. Middle adulthood	Generativity	vs	Self-absorption
8. The aging years	Integrity	vs	Despair

Erikson has clearly outlined the social tasks of adolescents - mainly those of:-

- i) Emancipation (separation) from the family of origin

- ii) Achieving comfort with sexual and working roles and effectively identifying with the status pleasures not responsibilities of an acceptable adult, Erikson has delineated the crisis of identity which occurs in the change of self concept from childhood to adult in which certain amount of confusion and uncertainty about "who one is" as unavoidable. A major task confronting the adolescent then is to develop a sense of individual identity - to find answers to the question "whom am I? and " where am I going"? The search for personal identity involves deciding what is important or worth doing and formulating standards of conduct for evaluating one's own behavior as well as the behavior of others. Adolescents' sense of identity develops gradually out of the various identifications of childhood. Young children's values and moral standards are largely those of their parents, their feelings of self-esteem, stem primarily from the parent's view of them. As youngsters move into the wider world of high school the values of the peer group become increasingly important, as do the appraisals of teachers and other adults. Adolescents try to synthesize these values and appraisals into consistent picture. to the extent that parents, teachers and peers project consistent values, the search for identity becomes easier.

When the views differ, the possibility of conflict is great and the adolescent may experience what has been called role confusion where the adolescent tries one role after another and has difficulty synthesizing the different roles into a single identity. Role play and experimentation is sometimes necessary before the adolescent finds a self concept with which he can comfortably fit. Ultimately, an identity definition is worked out, with the principal shift made from child to adult.

Social Pressures

The changing physical status of the adolescent and his increasing age bring new social pressures. At first in the puberty phase only expected to be a little more responsible and self sufficient. In the early adolescence, expected to apply himself to his studies, demonstrate some adult attitudes and being to participate in adult activities. In late adolescence he is treated as a man expected to be one, think about work, prepare for profession, look for a job, dating etc.

INTRA PSYCHIC ASPECTS

1. Detachment from family of origin, his primary love upon whom he is still to some extent dependent.
2. Tolerate grief of detachment and fear of isolation
3. Tolerate the grief he observes in his family as he detaches and the fear that they will abandon him.
- 4 Transfer his attachment meets with their forbidden erotic component to a suitable member of the opposite sex, while at the same time continuing to care about his family.

In summary, the essential areas of adolescence intra psychic conflict are;-

- 1) the control of sexuality
- 2) the control of aggression
- 3) the need to separate from parents in order to become
- 4) independent and thus develop adult identity

CLASSIFICATION OF PSYCHIATRIC DISORDERS IN CHILDREN

W.H.O has developed a classification of child psychiatric disorders along a number of independent axes:-

1. The clinical psychiatric syndrome
2. Specific delays in development
3. Intellectual level
4. Medical conditions
5. Abnormal psychosocial situations

FIRST AXIS-CLINICAL PSYCHIATRY SYNDROMES

Psychoses: These include drug induced, transient schizophrenia and affective psychoses as for adults and also infantile autism, disintegrative and other psychoses specific to childhood.

Conduct disorders: These include unsocialised disturbance of conduct, characterized by disobedience, aggression, destructive behavior, stealing, bullying and strained relationships socialized disturbance with whom they steal, truant and wonder.

Neurotic disorders: Include anxiety states hysteria, phobias, obsessive compulsive disorders and neurotic depression as well as disturbance of emotions specific to childhood.

Adjustment reactions: Include depressive reactions, other emotional disturbances of conduct and missed disorders of conduct and emotions.

" Psychosomatic disorder"

Hyperknetic syndrome of childhood

The essential features are shot attention span, distractibility and over activity.

Personality Disorder

Manifestation of mental subnormality only

Other clinical syndromes

These include eating, sleeping, elimination and habit disorders.

2nd axis: Specific Development Delays

Normal variations,
Speech and language disorders
Specific learning disorder,
Abnormal motor coordination

3rd axis Intellectual level

Normal variation
Mild retardation
Moderate retardation
Severe retardation
Profound retardation
Retardation, degree cannot be estimated

4th axis medical conditions

5th Axis Abnormal Psychosocial situations

- Normal psychosocial situation
- Disorder of intra-familial relationships (hostility, rejection, lack of warmth etc.)
- Excess of parental control
- Social or material deprivation (poverty, overcrowding etc.)
- Experimental deprivation (lack of parent-child interaction, deficiency of normal experiences)
- Child living other than with his two biological parents
- Specific trauma events

- Adverse extra familial circumstances
- Other psychosocial disorders

EPIDEMIOLOGY

Prevalence studies among African children in the general population indicate that 6-10% children have psychiatric morbidity. The rate increases to 18-24% among African children attending health care facilities.

AETIOLOGY

In child psychiatry, there are fewer disease entitled and more reactions to environmental factors, notably those in the family, school and neighbourhood.

Furthermore the determinants of childhood disturbances are usually multiple. These include: inheritance, temperament, physical impairment and environmental, family, social and cultural causes.

INHERITANCE: Hereditary factors do not seem to control the disorders directly but rather the predisposition to develop them.

Temperament - certain temperamental factors detectable before the age of 2 years might predispose to later psychiatric disorder. Difficult children (respond to new environmental stimuli by withdrawal, slow adaptation and on intense behavioural response) are more likely to develop psychiatric disturbance than "easy children: (respond to new stimuli with positive approach, rapid adaptation and a mild behavioural response)

PHYSICAL DISEASE

Although serious physical disease of any kind can predispose to psychiatric disorders, brain disorders are the most important. The rate of psychiatric disorder among children with brain damage is related to the severity of the damage.

ENVIRONMENTAL FACTORS

Maternal/parental deprivation

- Prolonged separation from or loss of parents can have a profound effects on psychological development in infancy and childhood
- Poor relationship in the family may have similar effects. An unstimulating environment and lack of encouragement to learn in infancy is as with educational under achievement in later years.
- The family factors strongly associated with psychiatric disorders in the child include discordant relationship, mental illness or personality disorders in parent(s) and a large family size
- Social and cultural factors: Rates of childhood psychiatric disturbance are higher in areas of social disadvantages (lack of play space, inadequate social amenities, overcrowding)

PSYCHIATRY ASSESSMENT OF CHILDREN AND THEIR FAMILIES

Aim of assessment is to obtain a clear account of the problem supposedly present in the child and how this is related to this past and present life in its psychological and social context. It consists of:

1. The history
2. Interviewing the parents
3. Interview the child
4. Physical and mental examination
5. Psychological and social investigations
6. Formulation including treatment plan and prognosis

THE HISTORY

Should cover the following fully:

- Record the source and the circumstances of information
- Reasons for referral and expectations about the referral
- List of present problem and complaints
- Complaints as stated by informant and the child
- Date of onset, frequency, severity, content precipitating factors, consequences, how dealt and obtain and document specific examples

List parents, siblings and document name, age, education, occupation; health (physical and mental), personal circumstances note whether any has history of MI, suicide/threat attempts, alcohol abuse, difficulty in learning to read/speak and seizure.

Establish the quality of parent-child marital and sibling relationship, ask about attitudes, closeness, joint activities and helpfulness

Record the nature of family discipline, rewards and punishment, bedtime, TV and friends regulations; independence and pocket money

Describe family's current material and financial circumstances

PERSONAL HISTORY

Pregnancy/delivery, neonatal problems, milestones, development of attachments, significant separation experiences, childhood illnesses, schooling, temperamental and personality attributes.

- Meeting new people, approach to strangers
- New situations - places, food, toys
- Emotional expressions - how vigorous is expression of feeling happy miserable before problems
- Relationships
- Regularity of functions; sleeping, bowels, appetite
- Sensitivity

PRESENT STATUS OF THE CHILD

1. General health; physical complaints, fits, faints, vegetative functions
2. Interests, activities, hobbies
3. Social relations with sibs, peers and adults
4. Rituals, tics, mannerism
5. Antisocial behaviour
6. Attention, persistence, activity levels
7. Schooling

INTERVIEWING THE PARENTS

Goals of initial interview

Data gathering

Understanding why the referral has been made now

What the parents perception of the child and his problem are

observation of personal interactions between family members

INTERVIEWING THE CHILD

Aims:

1. Obtaining information about the present problem and its context as well as the mental and development status of the child
2. Explaining why the child is being seen and how the assessment is to proceed.

Specific differences from interviewing adults:

- a) The child involved cannot be taken for granted. He has been brought to the clinic by others who themselves may well have been told to come, for example, by the school or social services. Furthermore the child himself may not suffer or complain, any distress as a result of his behaviour or shortcomings being experienced by his family.

- b) Children's language and cognitive functions is generally immature, their communication skills and assumptions comparatively naive.
- c) Children are likely to provide answers they think adults want to hear.

PRELIMINARIES

When meeting the child for the first time, get down to their eye level, (by squatting, kneeling or sitting) and introduce yourself. Ask their name and age. Explain what is going to happen in simple language.

SETTING BASIC REQUIREMENTS

1. Privacy
2. The provision of toys and drawing material is essential
3. A low table and chair for young children to draw and play at

THE ACTUAL INTERVIEW

Age 7- 12 years- Most of the interview can be carried out verbally whilst allowing the child to play if he so wishes.

The first part of the interview should be non-threatening and consist of conversation about the child's school or leisure, activities and interests. It provides the opportunity for assessing the following:

- Language functions in conversational setting
- Affective state
- Quality of relationship with the interviewer
- Observable physical abnormalities or mannerisms

The second phase consists of a flexible but a thorough inquiry into the following areas:

- Friends elicit names, (whether seen out of school)
- peer group activities status in peer group (teasing, picked on etc) quarrels, fights, getting in trouble

- worries, fears, unhappiness, bad dreams, source of irritations or anger
- Relationship with siblings, parents

A positive response in any of these areas require probing to elicit frequency , severity, a recent example and (if appropriate) the response of others.

- Some cognitive tasks should be set (serial 3s from 20, days of the week forwards and backwards) to assess attention span, distractibility and persistence.

The last phase of the interview should provide an opportunity for fantasy; Common techniques include:-

- Ask which 3 magic wishes the child would choose if you could make them come true (explain that you can't)
- Ask him the worst thing and the best that has happened to him (and that could happen)
- Suggest he draw a picture " a house and everyone who lives in it"

Age 6 yrs and younger

The conversational format is less likely to be useful and more reliance placed on play.

Squiggle game. - make a squiggle, get the child turn your squiggle into a picture of anything he likes, follow up by verbal discussion.

Picture analysis

Writing up the interview:

- Description of the child's appearance
- Outline course of interview
- Mental state; anxiety, mood, responsiveness, to specific topics
- Spontaneity of talk and social disinhibition
- Social confidence
- Speech
- Co-operation
- Eye contact
- Activity level, attention span, distractibility, persistence
- Mannerisms
- Quality of play, expressiveness and fantasy

PHYSICAL EXAMINATION

Much information may be gathered during interview purely by observation: facial appearance, drawing skills, hand preference, speech and comprehension.

Twenty basic procedures:

1. Sit child down
2. Inspect hands
3. Ask child to put thumb on each finger of the same hand in turn. Allow practice.
Should complete in 4 seconds by age of 8 yrs. Look for mirror involvement in contra-lateral hand (should disappear by age of 0 yrs). Repeat for the other hand.
4. Demonstrate and ask for finger - nose coordination bilaterally.

5. Examine skill at performing rapidly alternating movements e.g tapping bilaterally. Give a demonstration for the child to copy.
6. Stand child up with feet together, out to stretch out hand and spread fingers, put out, shut eyes 20 seconds. Look for involuntary chore- athetoid movements in tongue and fingers.
7. Sit child down, look at face (abnormal face, asymmetry)
check muscle power and voluntary tongue movements
8. Check visual acuity in each eye
9. Examine ocular movements, nystagmus, pupillary reflexes
10. Inspect eyes for ptosis and strabismus
11. Inspect eyes circumference
12. Test hearing by speaking numbers (66,99,55, etc.) in a soft resonant voice 1 metre distance and out of child's field of vision
13. Ask child to remove shoes /socks and inspect feet
14. Ask the child to stand up
 - a) heel-toe walk
 - b) tip-toe walk
 - c) hopping on each leg
15. Screw up some paper into a ball throw it on the floor and ask child to kick it
16. Check tendon and plantar reflexes

17. Measure weight and height
18. Ask child to put socks and shoes back on - observe how done
19. Examine constructional skills (building towers, copying triangle, diamond and star by drawing)
20. Pubertal status; describe primary and secondary sexual characteristics

ORGANIC INVESTIGATIONS

PSYCHOLOGICAL ASSESSMENT

- Intelligence tests
- Social development assessments: cover general self-help, communication, social isolation, occupational abilities-"social age"
- Personality
- Reading

Neale Analysis of reading difficulty - graded test of reading ability and comprehension

OTHER INFORMATION

The most important additional information are the child's teachers. They can describe his classroom behaviour, educational achievements and relationships with other children.

Social worker can make a home visit; this can provide useful information about material circumstances in the home, their relationship of family members and the pattern of their life together.

REVIEW OF CLINICAL SYNDROMES

1. HYSTERIA IN CHILDHOOD

Unconscious mental conflicts produce anxieties which are converted into physical symptoms. (Freud 1893 - 95 Kennel, 1974, Mechanic, 1962)

Mildred Creak (1938) classified hysteria in childhood into 3 groups

- i. True conversion hysteria - neurological symptoms attributable to conversion of anxiety into somatic manifestations

- ii. Hysterical prolongation of a symptom which was originally part of an organic illness
- iii. Organic disease in which there are associated complicating psychological factors

The diagnosis of hysteria does not depend upon exclusion of organic disease and may be made in the evidence of current or recent physical disorder, especially that which has yielded benefits of the sick role.

Levine 1974 described epidemic/ communicable hysteria which refers to the spread of physical symptoms among closely knit groups of adolescents or young children.

Monosymptomatic hysteria refers to common reactions which consist of disorders of limbs i.e gait or posture; sensory organs - blindness, deafness, aphasia; dissociative reactions such as amnesia and wandering fugue states.

Monosymptomatic hysteria is unlikely under 5 years of age, is commoner in girls than boys and the symptoms arise rapidly and appear related to a recent threatening even in child's life in the lives of people important to the child. The symptoms tend to be static and fluctuate little (little evidence in childhood of 'la belle indifference to the physical complaints).

Other complaints include low self-esteem, lack of confidence and thoughts of being bad.

AETIOLOGY

- Psychoanalytic - conversion
- Learning theory - identified/imitated phenomena from child's environment
- 'sick role' the nature of being physically ill increases a child's anxieties
- Poor verbal communication skills

TREATMENT

- Symptom removal
- i. Simple suggestion abreaction - a psycho therapeutic procedure to help outward expression of troublesome emotions
catharsis/cathartic expression

- i. Suggestion
 - ii Drug assisted abreaction
 - iii Behaviour programme, finally therapy
- attention to the underlying psychopathology

POLYSYMPOMATIC HYSTERIA

Common in older children and young adults.

Children present with recurrent vague abdominal pain, mood disturbances esp. anxiety.

EPIDEMIC HYSTERIA

- typically in adolescents.

Episodes of fainting, headache, hyperventilation, sudden onset mainly in girls which spread to include people in close proximity to the original person or persons and so a large number of people may complain of identical symptoms.

Group anxieties eg, academic stresses, recent illness often present.

MANAGEMENT

- press publicity may be harmful, but publication that the disease is psychological can be helpful.
- school may be closed for a short time to prevent further bouts of contagion.
- Doctors/ school teachers can allay effectively the anxieties of the children with support and reassurance thereby helping control the spread of symptoms.
- main instigators isolated and their personal problems examined.
- sometimes psychiatric intervention may be necessary

PSEUDOEPILEPTIC SEIZURES

Pseudoepileptic seizures are attacks of sudden unconsciousness, usually associated with dramatic motor manifestations, which simulate epileptic attacks to a varying degree.

Pseudoepileptic seizures are a frequent manifestation of hysteria.

- previous episodes of unconsciousness, either experienced personally or observed within the family or work environment, often provide a model for the choice of pseudo epileptic seizures as the hysterical manifestation.
- patients with pseudoepileptic seizures tend to display many other features indicative of psychopathology - family history of mental illness; a past personal history or psychiatric disorder with suicidal attempts; concurrent affective symptoms; unsatisfactory current life situation..

DIFFERENTIAL DIAGNOSIS

- Clinical picture fails to confirm to any recognized type of epilepsy.
Pseudoepileptic grandmal attacks differentiated by random struggling or thrashing movements of the trunk, limbs, or head instead of the classical symmetrical clonic movements. Side to side throwing or rolling of the head or body is common.
Furthermore these movements increase on restraint.
- reflexes and pain perception retained
- onset and termination of pseudoepileptic seizures is usually gradual
- pseudoepileptic seizures often occur in the presence of other people
- unlike true epileptic seizures pseudoepileptic seizures never occur during sleep
- More frequent
- Poor response to anticonvulsant drugs
- Marked emotional display
- Fewer injuries
- EEG

INVESTIGATIONS

- clinical pattern of attacks carefully observed and described
- EEG
- post-ictal serum prolactin levels < 1000-200m units/l
- CT-SCAN to rule out underlying CNS pathology

British Journal of Psychiatry (1986) 149, 28 - 37 G. W.Fenton

Depression

Many children appear miserable in unhappy circumstances e.g, parental illness. death of family member, parental disharmony is associated with tearfulness, loss of interest and poor concentration, eat and sleep disturbance. Children often present with "masked" forms of depression presenting with wide variety of symptoms including somatisation, enuresis, boredom, truancy, running away from home bullying or promiscuity.

TREATMENT:

- reduce unhappy circumstances
- help child to talk about his feelings
- antidepressants

PSYCHOSES IN CHILDHOOD

1. INFANTILE AUTISM
2. SCHIZOPHRENIA
3. MANIC DEPRESSIVE PSYCHOSES
4. DISINTEGRATIVE PSYCHOSES
5. OTHER PSYCHOTIC DISORDERS IN CHILDHOOD

INFANTILE AUTISM (I.A.)

Infantile autism is a clinically (behaviourally) defined syndrome, a disorder present from early infancy in which 3 cardinal features are:

1. A failure in social development
2. A deviant and delayed language development
3. Various ritualistic activities, compulsive phenomena associated with repetitive stereotyped play patterns

Infantile autism begins before 30 months of age. It has two distinct types of clinical onset:

1. First are patients whose development delays and symptoms are observed during the first few weeks and months of life.
2. Second are patients who display normal development until 12 to 14 months of age, after which regression and plateaus in development begin and specific symptoms first appear.

There is a general failure to develop social relationships together with various specific abnormalities in interpersonal functioning. Whereas early authors (Kenner & Eisenberg 1955) have suggested that its autistic aloneness (failure to make warm relationship with people) and failure to form relationship was the central or primary disorder and other symptoms were in a sense derivative, it is now clear (Rutter, 1966) that the autism may improve substantially in later childhood and adolescence while other symptoms remain unchanged. The features which composite autism are:

- No anticipatory social responses (absence/delayed smiling response) and unaffectionate
- Baby does not respond to mother's voice or hold out arms to be lifted
- Difficulty to engage in baby games
- Poor or absent eye to eye contact
- No interest in toys - aloof
- No co-operative play

RITUALISTIC BAHAVIOUR: includes abnormal routines, resistance to change, attachment to odd objects and stereotyped patterns of play, obsessiveness for sameness.

Language

There is usually severe problems in the understanding of spoken language (impaired comprehension). Speech is delayed and if it develops it is characterized by echolalia, reversal of pronouns, immature grammatical structure and inability to use both verbal and gestural language autistic children show less spontaneity in their use of spoken language, they talk less readily and make less use of speech for social communication or chat. It is not just that autistic children use little speech but when their language develops, it is abnormal in many respects.

Verbal IQ = Deficits in language, sequencing and abstraction.

Even on tests which did not involve any use of speech, autistic children performed badly when verbal or sequencing skills were required. The implication is that the problem in autism is not lack of speech as such but rather a serious deficit in cognitive skills involving sequencing and abstraction and other related functions. The speech and language problems involve an incapacity or lack of basic skill. There has been confusion about whether IA (Infantile Autism) is the earliest possible manifestation of schizophrenia or a discrete clinical entity, but the evidence points toward infantile autism & schizophrenia as separate entities.

Infantile autism is not schizophrenia

- 1) The symptomatology of the two conditions are quite different. one (infantile autism) involves a failure of social development, the other (schizophrenia) a loss of reality sense after development is well established. The schizophrenic may retreat from reality into fantasy, but the autistic child does not retreat, rather he fails to develop social relationships. Delusions and hallucinations are characteristic of schizophrenia but are quite rare in infantile autism, this could be the result of symptom modification due to the stage of maturation but delusions and hallucinations are rare even after autistic children reach adulthood (Rutter, 1970).
- 2) The course of the disorder in the two conditions also differs. Marked remissions and relapses are well recognized in schizophrenia but are uncommon in autism where a relatively steady course is much more usual.
- 3) There are also striking intellectual differences between the disorders. Mental Retardation is a common accompaniment of autism but is much less frequently associated with schizophrenia. Furthermore the characteristics pattern of IQ subject scores (high on Verbal-Spatial tasks and low on language skills) found in autism is not a feature of schizophrenia.
- 4) The sex distribution in autism differs sharply from that in schizophrenia. Schizophrenia in adults occurs with about the same frequency in men and women where as autism is three to four times as common in boys as girls.

- 5) Organic factors also differentiate the two disorders; parental complications are commoner in autism and epilepsy is also much commoner. When schizophrenics are epileptic, the epilepsy is usually of temporal lobe type. This is not so in autism.
- 6) The social class of parents of autistic children is most unlike that of the parents of schizophrenics. A high proportion of the parents of autistic children are above average intelligence and of superior social-economic status. In contrast the social background of schizophrenics is the same as that of the general population.
- 7) The age of onset of psychoses in childhood follows a markedly bipolar distribution. there are peaks under three years and over 11 years with a decided trough in between. This strongly suggests a discontinuity between infantile autism and schizophrenia.
- 8) The family history of schizophrenia is rare among the parents and sibs of autistic children whereas schizophrenia occurs in about 10% of the parents of schizophrenics.

If autism is not schizophrenia what is it?

The evidence suggests that autism develops on the bases of a central disorder of cognition which involves the impairment of both the comprehension of language and defects in the utilization of language or conceptual skills in thinking.

EPIDEMIOLOGY

Prevalence

4-5 per 10,000 (0.04 to 0.05%)

sex distribution

Infantile autism is more frequent in boys than girls (3 to 5 times more)

ETIOLOGY

There is some evidence suggesting a genetic component in aetiology. The risk of autism in the sibs of autistic children is 3 to 4 times higher than in general population (Rutter, 1967).

A family history of speech delay in about 25% of their families (Bartak 1975).

Rutter, in 1976, found that 4 out of 11 pairs monozygotic twins were concordant for autism as against none of the 10 pairs of diszygotic twins. An organic cause is suggested by development of seizures in some children when they reach adulthood 4 to 32% get fits.

Demonstration of dilatation of anterior horn of the lateral ventricle (DeLong 1978)

EEG abnormalities 10-83% IA children although no EEG finding is specific to IA there's some indication of failed cerebral lateralization.

- Increased serotonin efflux

- Trauma to developing CNS

- Psychological theories

- Autism frequently occurs in association with other syndromes and developmental disabilities e.g 80%. Infantile autism patients have also MR, epilepsy, fragile and severe allergies are other concurrent syndromes. Infantile autism syndrome that may have more than one cause.

PROGNOSIS

10 - 20 % improve enough to attend ordinary schools and obtain work.

10 - 20% live at home, need special school.

The rest improve a little, need residential care.

DIFFERENTIAL DIAGNOSIS

1. Schizophrenia
2. Developmental language disorder
3. Deafness
4. Mental retardation

TREATMENT

Since exact causes are currently unknown, the most we can offer our patients is symptomatic therapies. They are immediate helping patients maximize their existing potentials and minimize their pathologically induced handicaps. These techniques fall within the realms of psychology and special education and are often augmented by psychotropic medication for behavioural control.

1) Special education - structured educational programmes

2) Symptomatic control with psychotropic medication; often behaviours such as self mutilation, hyperactivity, assaultiveness require chemotherapy. When employed for this purpose, the following guide-lines should be followed before and during therapy:

- a) Target behaviours must be specific in writing and baseline frequency counts obtained.
- b) Dosage should be started at as low level as gradually increased until specific improvement in target behaviour occur or adverse side effects limit increases.
- c) Target behaviour should be constantly monitored.

Neuroleptics are often an important component of a comprehensive treatment program for autistic children.

They are prescribed to diminish a variety of undesirable behaviours (including hyperactivity, withdrawal aggressiveness and stereotypes) and to facilitate learning.

These agents appear to be most beneficial for the hyperactive autistic child.

Currently, Haloperidol is the drug of choice for these children at a dose of 0.5 to 4 mg./day. (reduces behavioural symptoms accelerates learning).

Fenfluramine, an antiserotonergic agent is a promising drug which merits further clinical investigations.

Lithium can be tried for aggressive or self- injurious behaviour. Dopamine agonists, such as methylphenidate are not recommended for autistic children as they are not effective and have side effects irritability, hyperactivity, loss of appetite and weight , worsening of stereotypes and psychosis.

3. Behaviour modification and social support for families

SCHIZOPHRENIA

Schizophrenia as we know it in adults can begin in childhood. It does so most often during the pre-adolescence or adolescent period but the onset may be as early as 7 years and rarely, even before that.

Kelvin, 1971, studied 33 cases of schizophrenia occurring before age of 15 years.

- Onset of often insidious

- Psychosis developed against the background of pre-existing abnormalities of personality or behaviour
- Only difference noted

- a) Boys outnumbered girls by a ratio of 2.5 to 1
- b) transient and mild degrees of delay in speech development in nearly 50% children - a rate higher than in adult schizophrenia

Childhood schizophrenia is no longer then occurred the status of a separate diagnostic category. A diagnosis of schizophrenia is made in childhood if the criteria for the adult disorder is satisfied.

PRECURSORS IN CHILDHOOD OF SCHIZOPHRENIA IN ADULTS

It has often been observed that schizophrenia in which florid symptoms do not appear until late adolescence or early adult life has often been preceded by additives of personality or behaviour which have been evident during childhood. It could well be that schizophrenia occurs in childhood but does so in a form of the adult condition. Evidence on this question has been increasing in virtue of follow up studies, by twin studies and retrospective studies. It is well documented that persons who develop schizophrenia in adult life have frequently shown abnormalities (neurotic, anti-social or both) of a non-specific type in childhood. It seems that schizophrenia is more likely to develop in persons of somewhat below average intelligence who showed oddities of personality and had impaired relationships with peers. Characteristics such as poor motor development also appear to be precursors of schizophrenia. However, although it would be a great advance to identify pre-schizophrenia syndrome, so far this is not possible.

All that one is sure is that among the mixture of children attending child psychiatric clinics, some will have disorders which are a fore runner of schizophrenia in adult life. Unfortunately, we do not know how to tell which children will have such disorders.

DISINTEGRATIVE PSYCHOSIS

Heller (1930) provided the first description under the heading dementia infantilis. In this condition, development appears normal or near normal, on all counts up to the age of three to four years at which time there is profound regression and behavioural disintegration.

Often there is a premonitory period of vague illness and the child becomes restive, irritable, anxious and overactive. Over the course of a few months, there is impoverishment and loss of speech and language.

Comprehension of language deteriorates, and intelligence often declines. There is a loss of social skills, impairment of interpersonal relationship, and the development of stereotypes and mannerisms. Probably, several causes are involved. The condition may follow over brain damage such as measles and encephalitis; but also it may occur in the absence of any known organic disease or damage. Prognosis is poor, the children remaining without speech and severely handicapped in their intellectual development.

TREATMENT IN CHILD PSYCHIATRY

Drug Treatment:

Drugs are of limited value in child psychiatry. the main indications are epilepsy, mood disorders, over activity syndromes and neurosis.

Psychotherapy with the child

Most Psychotherapy with children is brief and aims to help with the current problems. The therapist tries to make a warm and accepting relationship with the child. He uses this to encourage the child to express feelings and to find alternative ways of behaving. Acceptance is important and criticism should be avoided.

Family Therapy

In a family therapy the child's symptoms are considered as an expression of the functioning of the family, which is the focus of treatment.

Behaviour Therapy

These methods have several applications in child psychiatry. They can be used to encourage new behaviour by positive reinforcement and modeling. Behavioural treatment have been devised or specific symptoms such as enuresis, encopresis, phobias, tics, obsession symptoms.

Education and occupational therapy

Special teaching may be needed to remedy backwardness, in writing reading and arithmetic which are common among children with conduct disorders. In occupational therapy, social interaction can be encouraged and practical skills developed.

MENTAL HANDICAP

DEFINITION

A general term for subnormal, mental ability which becomes evident in childhood and interferes with learning and with social and psychological development. Mental handicap, mental deficiency, mental subnormality are alternative terms. Mental handicap then is intellectual impairment starting early in childhood and may be classified as follows.

The classification of mental handicap

Mild MR	IQ	50-70
Moderate MR	IQ	35-49
Severe MR	IQ	20-34
Profound MR	IQ	under 20

It is unsatisfactory to define mental handicap in terms of IQ alone, social criteria must also be included since a distinction must be made between people who can lead a normal or near-normal life and those who cannot i.e. socially incompetent. Therefore the above categories all require the additional specification of the presence of " concurrent deficits or impairments in adaptive behaviour" .

- Educationalist's - criterion of educability

Britain - Educationally subnormal (ESN)

- Severely educationally subnormal [ESN(S)]

USA - Educable MR (EMR)

- Trainable MR (TMR)

- Severely MR (SMR)

- Concept of mental handicap embraces - intelligence

- social competence

- educability criteria

Effects of mental handicap on the family is described by parents themselves as grief. The parents must cope with three crises:

- 1) The first is the initial shock
 - 2) The second is the value crisis which involves a refashioning by the parents of their hopes and expectations for their child.
 - 3) The reality crisis in which the parents have to come to grips with day-to-day practical problems.
- responsibility of caring for MR. is detrimental to health and happiness of the mother, marriage
 - Sibs - fear physical attack
 - resentment of the parents attention to mentally retarded child
 - Ashamed of stigma of mentally retarded child
 - Increased emotional disturbance among sibs

Families are faced with many problems including those of finance, accommodation and opportunities for rest and leisure.

MILD MENTAL RETARDATION (IQ 50-70)

- 80% mental retardation (MR)
- Their appearance usually unremarkable if any sensory/motor deficits are slight
- Develop more or less normal language abilities and social behavior during pre-school years, their MR may not be identified until starting of school.

Adult life: most mentally retarded individuals live independently, though may require help under some unusual stress.

MODERATE MENTAL RETARDATION (IQ 35-49)

- 12% MR

Most can talk/act least learn to communicate

Most can learn to care for themselves abit with some supervision

As adults usually can undertake simple routine work and find their way about

SEVERE MENTAL RETARDATION (IQ 20-30)

70% MR

preschool years their development usually greatly slowed eventually many may be trained to look after themselves under close supervision and to communicate in a simple way.

As adults they can understand simple task and engage in limited social activities

PROFOUND MENTAL RETARDATION (IQ UNDER 20)

- Less 1% MR
- Few of them learn to care for themselves completely
- Some eventually achieve some simple speech and social behaviour

AETIOLOGY OF MENTAL RETARDATION

MR is not a disease but rather a symptom with many causes, inborn or acquired, whereby there is arrested mental development which is apparent from an early age. Even with the current diagnostic sophistication the exact cause of mental impairment is known in only 20-30 % of those cases. It is convenient to present two sets of aetiological factors, the pathological and the social, although they are interdependent. The Pathological factors are harmful biological or physical agents responsible directly for the onset of some encephalopathy or neuronal dysfunction. The social adversity such as poverty, overcrowding malnutrition also enhance the risk of exposure to some pathological agents, may also present the full utilization of curtailed abilities in an individual.

Cause may further be classified under the general headings of prenatal, perinatal, postnatal and social cultural factors.

Prenatal causes:

1. Genetic: Intellectual levels are believed to be inherited. Children of highly intelligent parents tend to be highly intelligent, while children of parents of low intelligence are usually mentally subnormal.
 - a. Autosomal recessive - metabolic disorders such as phenylketonuria, galactosemia, maple syrup urine disease,
 - b. Autosomal dominant - tuberous sclerosis and neurofibromatosis
 - c. Sex Linked recessive Hunter's, Lesch -Nyhan

d Chromosomal abnormalities - these comprise the largest number of known genetic causes trisomies - Down's Syndrome, trisomy 18, 14, Cri-du-chat syndrome -partial deletion of Chromosome 5, etc.

e. Sex chromosomes - Klinefelter's XXY, Turner's XO, multiple X syndromes XXY

2. Infections Rubella, Toxoplasmosis, Syphilis Cytomegalovirus etc.

3. Injury - irradiation

4. Intoxication, drug and maternal alcoholism

5. Metabolic disorders, toxemia, placental dysfunction, hypothyroidism, hypoparathyroidism, kernicterus.

Perinatal causes:

Prenatal brain damage leading into MR may be the result of various adverse factors acting just before, after labour and delivery. These include anoxia, brain haemorrhage, elevated serum bilirubin, hypoglycemia and complications of prematurity:

Postnatal causes:

Infections (encephalitis meningitis)

Injury - accidental as well as child abuse

Cerebral vascular thrombosis

Intoxication - lead, carbon monoxide - poisoning

The assessment of the mentally handicapped

- Team, psychiatrist, psychologist, social worker, teacher, pediatrician

- Continuous process

- Full assessment has several stages

HISTORY

- Family history of MR

- Estimate parent's IQ from school + occupation record

- Pregnancy history delivery to rule out perinatal complication

- Delayed psychomotor development

- Childhood illness or brain injury, convulsions
- Abnormal behaviour such as quiet, screaming, head banging, destructive, peculiar movements
- General backwardness, academic backwardness

PHYSICAL EXAMINATION

- Systematic physical exam including the recording of weight, height and head circumference
- Be alert for physical stigmata of the many specific syndromes
- Neurological exam, particular attention to vision and hearing assess sensory/motor physical handicaps.

DEVELOPMENT ASSESSMENT

IQ tests Weschler intelligence scale for children (WISC) - a profile of specific verbal and performance ability as well as IQ cannot be used for IQ below 40. Weschler pre-school and primary scale of intelligence (WPPSI) A version of WISC for use for younger children (4-6 1/2 yrs) and with the MR. Griffiths Mental development scale - tests of locomotor social, language, eye-hand performance, practical reasoning.

SUBCULTURAL MENTAL HANDICAP

Studies suggest factors in social environment may account for variations in IQ by as much as 20 points.

- Low IQ related to low social class, poverty, poor housing, unstable family environment

(1) effects of low IQ genetic cause - drift

(2) adverse environs - low IQ

- Attempts to enrich the environment of deprived children in special residential care + to provide special education - higher IQs

HEADACHES

OBJECTIVES:

To recognise and manage various types of headaches.

INTRODUCTION:

Research has shown that headaches result from vasodilatation, skeletal muscle tension or change in intracranial pressure. One or more of these mechanisms can be associated with precipitating factors such as:

- stress
- depression
- hypertension
- infectious disease
- organic disease.

CLASSIFICATION

- A. Vascular headaches
- B. Tension headaches
- C. Traction & Inflammatory headaches
- D. Idiopathic headaches

A. VASCULAR HEADACHES

Caused by abnormal reaction of the cerebral arteries, particularly a tendency toward dilatation.

About 8% of headache patients seen by the general doctor and over 50% of those seen by specialists have vascular headache.

A.1. MIGRAINE

1. Attack: At any time between the ages of 5 and 30 usually during puberty.

2. Sex ratio: Boys and girls are affected about equally, but afterwards the disorder affects more woman than men. In women, migraine may subside after menopause.

3. Family history: Nearly 70% of migraine patients have a family history; the mode of inheritance is not yet clear.

4. Clinical presentation

a. Aura:- Visual disturbances blurred or cloudy vision.

- Photophobia, Vertigo.

- Nervousness abnormal increased hunger.

b. Localization: half of the head by later it may spread to the other side.

c. Accompanied by: nausea, photophobia, vomiting, diarrhoea tremors, excessive perspiration, chills.

d. Trigger factors:

- Stress is the major initiating factor in migraine; although the migraine attack does not begin until the stress is over. In fact occurrence of migraine after resolution of a conflict is one of its distinguishing features.

- Rapid change in hormone level: which accounts for migraine during ovulation or before menstruation in women; and rapid change in blood glucose levels which accounts for migraine after fasting or oversleeping.

- Certain foods with a high content of tyramine or other vaso active substances (alcohol, chocolate, aged cheese).

- Medication

- vasodilateurs

- anti hypertenseurs

NB: oestrogen worsens the headache in 50% of women who have migraine.

5. Pathogenesis: The vascular changes in migraine involve both the intracranial and extra cranial blood vessels

Initial vasoconstriction due to increased serotonin followed by reduction of cerebral blood flow, an aura develops with symptoms corresponding to the part of the brain most affected by the ischemia.

- Vasodilatation: In response to localized anoxia, local arteries dilate to meet metabolic demands of brain tissue.

6. Treatment

Abortive therapy:

- Aspirin: 600 mg every 4 hours p.n. or Acetaminophen
- Ergotamine tartrate
- Dihydroergotamine

Prevention:

- Propranolol
- Cyproheptadine
- Ergotamine tartrate
- Amitriptyline
- Methysergide

A. 2. CLUSTER HEADACHE

- Clinical profile:
- Attacks generally at night duration: several minutes to 1 hour rarely more than 4 hours.
- Frequency: they occur every 24 hours during the cluster period. The clusters usually occur for several weeks or months then disappear for 6 months or a year. In some cases, an attack lasts continuously for years (chronic cluster headache).

Most cluster patients are between 20 and 30 years old, 90% are male.

- Localisation: behind or around one eye and spreading over the affected side.

Presentation: boring pain, likened by some patients to a knife cutting into their head. The pain is of such magnitude that patients have attempted suicide during a series of attacks.

Associated features:

- Temporal artery pulsating
 - Severe headache, pain behind eye
 - Conjunctival injection, tearing, nasal congestion, rhinorrhea, sweating.
 - Unilateral ptosis, swelling and redness of eyelid.
-
- Trigger factors: cluster headaches are most often brought on by consumption of alcoholic beverages.
-
- Pathogenesis: increase in serotonin and histamine levels in blood at the onset.
-
- Treatment (as soon as possible)
 - Ergotamine tartrate
 - Dehydroergotamine
 - Oxygen inhalation by mask
-
- Abortive therapy
 - Ergotamine tartrate
-
- Prevention
 - Methysergide (first choice) which blocks the vasoconstrictor and inflammatory effects of serotonin is effective in 75% of patients.
-
- Lithium carbonate (in chronic cluster headache)
-
- Anti-inflammatory agents
 - Indomethacin.

B. MUSCLE CONTRACTION HEADACHE (TENSION HEADACHE)

- Most common in adulthood when the frustrations of life are larger; infrequent in children.
- The majority of patients with chronic muscle contraction headache are female and about 40% have a family history of headache.
- Association with migraine is very frequent.

B1 CLINICAL PROFILE

- Generalized, non pulsatile headache
- Intermittent, recurrent or constant head pain often in forehead, temples or back of head and neck.
- Frequent descriptions by patients
 - Occipital tension
 - Rigidity of the neck
 - Temporal tightness or pressure
- Not responding to the usual pain relieving drugs.
- Associated features
- Disturbances in falling asleep, they awaken several times during the night if depressed.
Depression headaches are usually worse in the morning than in the evening and tend to occur between 4 and 8 AM and 4-8 PM.
These are periods of silent crisis when the patient anticipates conflicts on the office or home.

B2 PSYCHOGENIC FACTOR

Emotional factors appear to be of prime significance in the genesis of muscle contraction headache. Multiple conflicts, repressed hostility, unresolved needs, psycho sexual conflicts, are usually evident in these patients. Secondary gain from the muscle contraction headache can often be identified.

B3 PATHOGENESIS

- Reduced serotonin level by stressful events.
- Drop in endorphin levels facilitates the transmission of painful impulses and leaves the patient susceptible to chronic pain.

B4 TREATMENT

- Minor conflicts resulting in headache can often be resolved through **discussion and counselling** although **drug treatment** is usually necessary to alleviate an underlying depression.
- **Relaxation training** has been successful in some patients.
- **Anti depressant** if depression present.

B5. TRACTION AND INFLAMMATORY HEADACHE

Organic diseases may cause headache when the pain-sensitive structures of the head become distended, displaced or involved in an inflammatory process. The most important structures registering intracranial pain are vessels (cerebral & dural arteries) large veins, venous sinuses. Haematoma, abscesses, tumour, brain edema cause traction.

Inflammatory processes causing headache include (Meningitis, intracranial or extracranial arteritis, phlebitis).

NB: Pain from sense organs, teeth, neck, jaw may be referred to the head.

HYPERTENSIVE HEADACHE

Usually develops when the hypertension becomes moderate or severe.

Presentation: Headache usually occipital, starts in the morning and then begins to diminish when the patient fully awakens and stands up. When diastolic blood pressure rises to about 130 mm Hg.

Associated features: Episodes of blurred vision, confusion drowsiness which will respond to antihypertensive therapy.

Papilloedema if diastolic above 130.

BRAIN TUMOR

Headache intermittent, deep, aching pressure like. It may be aggravated by coughing, sometimes worse in the erect position than in the recumbent. A slow growing tumor may give rise to recurrent headaches occurring mainly in early morning hours. Neurological signs depending on the localization.

CEREBRAL HAEMORRHAGE

Sudden, bursting headache after an effort such as sexual intercourse, defecation or physical activity.

HEAD TRAUMA HEADACHE

Localized or generalized pain that lasts for a few minutes. Other post-traumatic headaches resemble vascular headaches or muscle contraction headache.

SINUS INFECTIONS

Frontal headache
Secretions in sinuses

TRIGEMINAL NEURALGIA: Pain in the distribution of the nerve. Sudden onset, almost invariably unilateral and occurs on the right side. The pain is brief and severe. It may occur in intervals lasting for approximately 3 minutes.

Trigger points: Upper & lower lip upper, eyelid are easily stimulated by pressure, facial movements or emotional excitement.

Treatment: Carbamazepine or Phenytoin is effective in 90%.

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PSYCHOLOGICAL ASPECTS OF PHYSICAL ILLNESS

INTRODUCTION:

- all illnesses require some psychological adjustment except for the most trivial
- about 20% of patients referred to a psychiatrist suffer from a maladaptive response to physical illness
- there is an excess of stressful life events during the weeks prior to the onset of a number of acute physical illnesses
- there is a higher mortality rate among psychiatric patients compared to the general population

Psycho pathology arises from conflicting impulses namely:-

- i need to avoid the painful effects of the illness
- ii need to understand the reality (meaning) of the illness

Factors modifying the psychological response include:-

- i pre morbid personality
- ii role models
- iii social circumstances
- iv nature of illness
- v nature of treatment required

Psychiatric syndromes commonly associated with physical illness include:-

- i adjustment disorders
- ii secondary mood disorders
- iii symptomatic mood disorders

- iv psychotic reactions
- v hysteria

CANCER

- newly diagnosed patients express shock, disbelief, some denial, anger, depression and even suicidal ideation
- advanced cases have various psychological reactions to pain, weakness, loss bodily function, lack of response to treatment and thoughts of impending death
- neuropsychiatric reactions occur due to metastasis and metabolic disturbance
- 40% patients referred to a psychiatrist have organic brain syndromes
- significant depression occurs in 20-25% of those with advanced cancer
- in pancreatic cancer, 76% of the patients are depressed. Further depression is the presenting feature in 50% of the cases
- treatments given (radiotherapy, chemotherapy, surgery) may lead to affective and cognitive symptoms
- 25% of women develop mood disorders 18 months after mastectomy
- other effects include, social isolation, marital and sexual difficulties

General Principles of Management of Psychological reactions to Physical illness

- i. minimize stress
- ii supportive psychotherapy
- iii help patient to address the prognosis realistically especially in terminal illness
- iv family psycho-education and support

PSYCHO-PHYSIOLOGY AND CONSEQUENT PSYCHOSOMATIC MANIFESTATION OF TRAUMA

OBJECTIVES

1. To consider the physiological changes in the body as a response to trauma.
2. To discuss the consequences of prolonged stress on the health of victims
3. To help the trainee be able to recognize stress - related diseases. (psychosomatic disorders)

INTRODUCTION

This chapter will be divided into two sections. First the physiology of trauma will be considered and part two will consider the effects of stress on health.

PSYCHO PHYSIOLOGY OF TRAUMA

In 1950s and 1960s some historical experiments were carried out by Hans Selye. He subjected animals to various forms of external and internal pressure such as cold, fatigue, poison just enough not to cause death and even prolonged emotional tension. He observed that despite the type of trauma (stress) the animals were subjected to their physiological responses had a similar pattern characterized by three phases. Selye coined the phrase "general adaptation syndrome" to describe what he observed.

PHASE 1 (ALARM PHASE)

During alarm phase the body mobilizes its resources to meet the threat. The Hypothalamus pituitary adrenal axis in particular gets activated and the adrenals are known to pour excess adrenaline into circulation. The physiological changes that follow are:

1. Pituitary gland secretes hormones that activate the adrenal glands to secrete adrenaline and steroids.
2. The hair stands on end
3. Pupils of the eyes dilate
4. Salivary glands activity slows (dry mouth)
5. Lungs expand
5. Heart rate and blood pressure rise
6. Liver releases glucose for energy to muscles
7. Blood vessels near the skin contract
8. Large blood vessels dilate to speed blood flow in the muscles
9. Muscle tension increases
10. Sweat glands get activated and the palms becomes moist

During this phase the animal gets ready either for a fight to defend itself or a flight to escape the danger, "the fight or flight response".

PHASE II (RESISTANCE STAGE)

After a few days Selye's animals tended to adapt to the continued exposure to stress producing conditions. However they were not actually very normal and if further challenges were made to the animals at this stage they tended to die. After prolonged resistance to stress the animals entered the final third phase.

PHASE III (EXHAUSTION STAGE)

This stage is final in that the animals died after prolonged exposure to stress and this was as a result of exhaustion.

What we have described here was experimental, however, in daily life activities the sequence of events is not that sequential. Human beings do experience prolonged stress and this does not necessarily lead to death but however manifests as physical illnesses referred to as psychosomatic disorders.

PSYCHOSOMATIC MANIFESTATIONS OF TRAUMA

Taylor (1956) described four ways through which stress affects health and these include:

- a. Direct route
- b. Interactive route
- c. The health behaviour route
- d. The illness behaviour route

DIRECT ROUTE

Stress if prolonged causes arousal of autonomic nervous systems which may lead to symptoms such as rapid heart beats. Stress is a risk factor in coronary heart disease which is a disease attributed to a build up of fatty plaque on coronary vessels thus reducing blood flow and hence oxygen and nutrient supply to the heart muscles.

This may clinically manifest as left sided chest pain radiating to the arm. When there is complete block the heart muscles get an infarct (dies) and is what people refer to as heart attack. Studies done on people who have high demanding jobs with little control over them tend to experience a lot of stress and are at a higher risk of coronary heart disease. Studies in immunology have shown beyond doubt that chronic stress reduces the body's immune response and hence increase risk of falling sick.

In one experiment individuals were subjected to a virus known to cause "common cold" and they were requested to list stressors in the last one year. In the meantime they were monitored for symptoms of common cold.

It is was observed that those subjects who developed common cold had the highest stress index thus demonstrating that stress reduced resistance to infection.

SCHEME FOR ETIOLOGY OF STRESS RELATED DISEASES

TRAUMA (see examples)

PSYCHOLOGICAL STRESS

Constitutional
makeup

Impact is modified by individual capacity
to cope with stress.

GENETIC
FACTORS

PHYSIOLOGICAL
RESPONSES

ENVIRONMENTAL
FACTORS

organ vulnerability

Inherited defects

STRESS RELATED DISEASES
(see the examples)

disease causing agents
infective agents
chemicals
drugs

Adapted from J.J. Braunotein, R.P. Toister eds. Medical applications of behavioural sciences (page 168).

INTERACTIVE ROUTE

It is common sense that not every body develops an illness despite exposure to germs. The explanation is that, illness occurs when stress and personality interact with each other or when pre-existing biological vulnerability to a disorder is present, and stress only precipitates the illness. This is what is referred to as vulnerability , stress- model (diathesis-stress model).

Diathesis is vulnerability or predisposition to a disorder. Vulnerability makes an individual susceptible to a particular disorder but stress only seems to precipitate the disorder.

This concept applies to many illness where a precipitating factor, be it stress or exposure to virus initiates the disease process. Trauma may be the only experience required for the individual to develop a psychosomatic disorder.

2 HEALTH BEHAVIOUR ROUTE

Stress tends to make individuals neglect their mental and physical health. A widowed individual may result to poor feeding, drinking too much alcohol and thus injuring her health. Health behaviours are varied from individual to individual and indirectly contribute to development of illness.

3. ILLNESS BEHAVIOUR ROUTE

Somatoform disorders tend to be as a result of illness behaviour. Faced with conflicts that cause stress individuals experience unpleasant symptoms such as fatigue, sleep problems, upset stomach and some even develop severe physical illness which have no physical basis e.g hysteria. These individuals tend to seek health services more than those under no stress and they also tend to exaggerate their symptoms. These individuals tend to keep on seeking health services in future rather than use coping skills and actually perpetuate the illness.

HOW DO THE PSYCHOSOMATIC DISORDERS PRESENT?

Psychosomatic disorders are associated with some psychological trauma or stress, common examples of traumas that may result into psychosomatic disorder include:

- Combat experience, commonly seen in soldiers in battle field
- Natural catastrophes such as earthquakes, floods and fires
- Assault, where the individual is maimed or humiliated
- Rape, where one is forcefully made to have sexual intercourse usually by strangers and in life threatening circumstances.

- Serious accidents (road traffic accidents, fires)

Trauma can result into psychological difficulties which may present as a physical disorder. The cardinal feature is that the onset of this disorder can directly be attributed to concurrent stress.

Examples are:

- Peptic ulcers, obesity, anorexia nervosa
- Colitis: where the large intestine gets inflamed
- Essential hypertension where the blood pressure gets elevated
- Migraine, headaches
- Bronchio asthma, hyperventilation syndrome, hay fever - in these conditions the lungs are affected in a way that makes breathing difficult.
- Neurodermatitis where the skin gets infected or develops rash
- Rheumatoid arthritis, low back pain: in these condition the joints swell and become painful
- Hyperthyroidism, diabetes mellitus: these are metabolic disorders which develop after endocrine glands fail to produce their respective hormones
- Premenstrual syndrome, menopausal distress: these conditions tend to affect females and presents with various symptoms such as flushing, low back pain
- Chronic pain
- Cancer
- Immune disorders: these present in various ways such as autoimmune disorders where the body destroys its own tissues or immunosuppression where the immunity is lowered

FEATURES OF POST TRAUMATIC STRESS DISORDER

The cardinal features of PTSD are:

1. Re-experiencing of the trauma through dreams and waking thoughts
2. Emotional numbing to life experiences and relationships
3. Symptoms of autonomic instability, depression and cognitive difficulties such as poor concentration

Due to symptoms of autonomic instability, patients with PTSD are known to manifest with psychosomatic disorders apart from the psychological symptoms.

ADAPTATION STRATEGIES FOR COPING WITH TRAUMA IN THE WAR

OBJECTIVES:

Understand the mechanism used in coping with trauma during and after the war.

INTRODUCTION:

Trauma means incisure, disruption, discontinuity. It carries the connotation of the

- unexpected pain
- inability to cope in a customary manner.

Trauma can be described as: an interaction between an unusual event, an ineffective response, and inner experience of being overwhelmed and helpless.

In a war situation, post-traumatic states can be acute, chronic or delayed either individual or collective. Furthermore, trauma can be cumulative following recurrent exposure or sequential for instance when persecution and banishment is followed by traumatic reentry into a rejecting society. It can also be massive after extreme long lasting pressures.

In man-made disaster (war, genocide ,atrocities, killings) important traumatic factors are:

- The non-anticipated violent loss of people
- The injustice which shakes basic trust in the society
- The helpless witnessing of killings, engendeing guilt.
- Exposure to the unspeakable and unbelievable precluding use of culturally acquired coping and grief reactions.

EXAMPLES OF COPING STRATEGIES USED IN HOLOCAUST SURVIVORS

The Holocaust survivors used a combination of luck, professional skills, physical strength, time and place of incorporation.

Although many survivors attribute their survival to luck or to being in the right place at the right time, most also cite specific behaviors and defenses that they believe enhanced their chances of survival.

(Dimsdale, 1974) described nine ways in which inmates coped with camp life

1. Intellectualization (focusing on the theological and philosophical aspect of death.
2. Using humor (trying to tell jokes)
3. Praying
4. Hoping (this cannot go on forever once the world knows, help will be forthcoming)
5. Trying to gain sympathy from perpetrators
6. Relying on fate or becoming dependent upon others, so that stress was experienced passively.

COPING STRATEGIES

- Coping: The term "coping" suggests that the subject is reacting as adaptively as possible to a difficult situation.

- Strategies for coping with threats involve choices about what to think and about what to do.

A. Changing the mental focus

Talking, reading, talking about other topics will temporarily take their minds off the threatening situation and restore emotional stability.

- B. The achievement of humor
- C. Use of philosophic or religious perspectives during stressful situations.
- D. Habituation , generalization.

ADAPTATION STRATEGIES PROVOKED BY EXTREME STRESS

The brain has a great capacity for adaptation. The victim adapt to the atrocious circumstances with the goal of preserving as much as possible of their personality. By adaptation is understood as the change from a stable structure of personality to another stable organization.

By coping is understood all reactions whose aim is to manage the various situation.

SOCIAL ASPECTS IN WAR RELATED TRAUMA

1. *OBJECTIVES:*

Identify social factors that play a role in coping with traumatic experiences.

2. *INTRODUCTION*

The role of social factors cannot be underscored in the prevention as well as in the healing of traumatic experiences. Weaknesses of social links and support and important contributing factors to vulnerability and war related trauma symptoms.

3. NOTES ON SOCIAL SUPPORT

- Social support is a simple concept that states that "Man can overcome misery when supported by others."
- Support may be given by different people or groups varying from the spouse to the whole society. Support may also come in different ways ranging from encouraging remarks to financial help.

A NATURE OF SOCIAL SUPPORT

The following types of support are distinguished in empirical studies(Flattery 1990).

- a. Cognitive support: Providing information and advice for the traumatic phenomena.
- b. Emotional support: Activities and remarks from others which make the person feel better when he/she is under stress.
- c. Social sanctioning: Approval or disapproval of specific behaviours or events.
- d. Companionship: The support one experiences when doing things together with others
- e. Material help:
 - Providing food, health care, shelter
 - Financial support

Assistance from others prevents the occurrence of symptoms.

Some forms of support are more important than others in a given situation.

A. SOCIAL SUPPORT IN BEREAVEMENT

Support from relatives and friends is effective in facilitating the process of mourning.

The importance or lack of social support after loss emerges clearly from a comparative study of 2 groups of Australian and American widows (by Madison & Walker 1967).

The American group, who had a good social support had nearly recovered 13 months after the loss of their husband whereas the Australian widows were still in bad shape; they were unable to talk about their deceased; the immediate environment had kept them from expressing their emotions, nobody had shown understanding of their feelings.

In fact, the immediate surrounding stimulates the expression of emotion and in that way prevents pathological mourning: Girer(1965) found a poor social support as well as inability to express sadness to influence the pathological grief and make the loss of a loved one dramatic. People who end up alone after the death of a loved one have more problems to contend with.

In a study by Clayton (1975) 27% of the persons who lived on their own after a traumatic event (death of a spouse) , suffered from depression during the first year, compared to 5% of those who did not live alone.

B. SOCIAL SUPPORT AND OTHER TRAUMATIC EVENTS.

Several studies which have been carried out on PTSD (post traumatic stress disorder) show that the lack of social and community support have a deleterious effect on the course of Psycho trauma symptoms .

- Studies on raped women reported the following:
- Fear and other symptoms lessened when a woman spoke about the situation with others(Sutherland & Scherl 1970)

- The women who could not share their experiences with people from their immediate environment were usually the ones with serious complaints and symptoms (Evans 1978).
- The same is true in road traffic accident.
- In wartime or any serious stressful situation, the social support contributes to the appraisal of the circumstances as less powerless, disrupting or discomforting.

The importance of social support in war is proven by the following findings.

- Feeling supported by a group proved to play a positive role in perseverance during combat.(Grinkel and Spregel 1945)
- The lack of support from others caused intense anxiety reactions to soldiers in World War 2.

Many studies on stress and health have found that social support correlated negatively with symptoms, illness and problems.(Mueller 1980 & Sarason 1985).

A study by Berkman and Syme(1979) showed that:

- The degree of support people experience is related to the duration of life.
- Those who were deprived of social and community ties died sooner than those who had intensive ties.

Some studies indicate that social support neutralizes the negative effects of drastic events. Several studies have reported that the absence of social support in stressful situations acts to increase the likelihood of developing post-trauma difficulties (Solomon, Mikulincer 1988).

Murphy (1988) suggests that social support which is developed and maintained over time and exists prior to traumatic stress may protect individuals from the negative effects of trauma.

The perception of spouse love and a stable network support of others predicted stress-related health consequences. While pre-trauma social support appears to moderate the negative effects of trauma, several investigations have studied the role of post-trauma support:

- Combat veterans who had high support after discharge reported significantly less psychological distress than those who reported low social support.(Kadushin, Boulanger & Martin 1981).

Results indicated that positive emotional support from a spouse results in considerably less acute distress than in men with low social support.

Furthermore, nearly half the married men in this study with acute post-trauma symptoms did not develop chronic distress as opposed to 71% of unmarried men who continued to experience chronic distress.

In summary, research with trauma victims suggests that social support may provide important benefits to trauma survivors. Social support can be provided by positive emotional affiliation from the perception of respect and acceptance from the community.

WIDOWHOOD

I. INTRODUCTION:

During Rwanda genocide and massacres (1994), executions were often carried out in front of family members. The corpses would be left in the street. Several family members were killed as well as children.

II. CIRCUMSTANCES OF DEATH

- a. unanticipated
- b. involving several members of the family
- c. people often in front of spouses and children
- d. lack of burial: funeral ceremonies were not possible as the bereaved family was also hiding, threatened to death. People were buried in mass graves by machines, eaten by dogs or thrown in rivers.

Bereaved people may even not know where their relatives were buried. Death was associated to torture and several traumatic events. (e.g. rape and several sexual humiliation).

III. SITUATION OF THE WIDOW

Rwanda government estimates the number of widows to be 250,000 in a population of nearly 4 millions. As stated earlier, the widow not only lost her husband but also some of the children in tragic circumstances. Like others, she went through various traumatic events (polytraumatism) on top of her losses. The loss of a loved one is a complex phenomenon (especially the husband). The death of a partner is a loss on many fronts and also a transition to a new situation. Coping with such a loss is a gradual and complicated process which requires time.

1. Reaction to the loss of the partner

Sometime after the loss, despair and loneliness intensify. The widow realizes that the other is gone from her life for good. She gradually becomes used to the facts that **she is a widow and no longer somebody's wife**. Nearly one year after the loss, the widow begins to take on new roles. In the marriage both partners may have complementary roles. (e.g. the wife usually takes care of the household while the husband earns income for the family).

In Rwanda, there are nearly two categories of couple:

- (a) Upcountry farmers: couples cultivate, all share field duties. The wife, on top of that, remains a housewife: cooking, washing, looking after the children.
- (b) For educated people: either both earn salaries or one of them, mostly the husband. In either case, the wife is more responsible of the household and children education, although there is a strong network.

This is very concretely expressed when certain routines suddenly become meaningless: (she no longer has to set the table for two people). She now must arrange a way in which to earn income, to manage the household and to raise the children. In other words, she must assume a double role: mother and father for children, man and woman for all chores. She is then confronted with a new situation in the society. She must build a new identity and at the same time abandon the old one. **The widow is relabelled as single.**

Psychologically, the attachment remains in several studies (Weiss and Parkers 1974) found that 60% of the widows think of their deceased husband long after the loss. 25% may even forget that the loved one had died. The deceased is present in the dreams of approximately 50% of the widows.

2. Abnormal grief reaction

- a. Unanticipated grief - when the partner's death is sudden, unexpected symptoms of anxiety, tension, depression, social isolation are predominant as well as difficult to cope with. This has been the case in Rwanda war.
- b. Conflicted grief - difficulty in recovering from a loss is more likely to occur after a bad marriage than after a good marriage, although one might expect the opposite to be the case.

NB: Excessive reaction to a death may also be expressed by various medical complaints and certain behaviour (for example, acting and such as increased sexuality)

3. DETERMINANTS OF TRAUMA AND COPING IN WIDOWS

A. Characteristics and circumstances of the event:

Anticipation: Expected deaths, though extremely threatening, create fewer problems for those who remain behind (Parkes 1972).

B. Personal characteristics:

Each person reacts differently to a traumatic situation.

- Biographical characteristics (age)

- Age: The younger a woman is at the time she is widowed, the more intense her grief will be and the more her health will be affected. Young widows visit their general practitioner more often and use more medication. In women under 40 years of age, pathological grief is relatively more frequent. (Parkes and Weiss 1983). Loneliness and anxiety are found to be greater problems for old widows (Sanders 1988).

- Education and social class

The higher the education, the fewer problems were experienced in a Dutch study by Abtains et al 1979. People with a high level of education are said to have more skills and more self-confidence.

The effect of social class is expressed in the following research findings. Women with financial problems did not recover as quickly after trauma as women without those problems.

- Past psychiatric history

Parkers (1972) for instance found a greater number of cases of pathological grief in widows who had psychiatric records.

C. Social support:

The immediate surrounding stimulates the expression of emotion and in that way prevents pathological mourning. Many studies have found that social support correlated negatively with symptoms after loss. In fact, aid from others prevents the occurrence of signs regardless of whether there are any stress factors.

The importance of social support clearly emerges from a comparative study of two groups of Australian and American widows. (Maddison and Walker 1967).

One group of women were still in bad shape 13 months after the loss of the husband while a group of comparable women had nearly recovered. The widows from the first group complained that the immediate environment had kept them from expressing anger and other emotions. They had not been able to talk much about the deceased. The widows of the other group mentioned that someone had shown understanding of their feelings with that person, a friend, family member or doctor. They had been able to talk about the loss and had been able to discuss memories of the deceased. The immediate surroundings stimulated the expression of emotions and in that way, prevented pathological grief.

People who end up alone after the death of a loved one have more problems to contend with. However, the social network does not always exercise a positive influence on the process of coping with the loss of partners when it consists of small children (Parkes 1972, Glick et al 1974). It is difficult for the widow to take care of them.

D. Cultural aspects:

From studies done by Maddison and Walker 1967, not talking out the suffering, not sharing, worsens the symptoms of grief. The lack of cultural customs in mourning is strongly affecting the bereaved. In a study on grief by Parkes and Weiss 1983, it was found that widows who showed no grief, wore no mourning clothes and did not visit their husbands grave suffering from more disturbance than other women.

LOSS; GRIEF, MOURNING, BEREAVEMENT

I. Definitions:

1. Grief: Overall reaction to loss is a biologically founded pattern of physiological and psychological reactions to a loss.
2. Mourning: Refers to the loss-related reactions that have been prescribed by society.
3. Sadness: Emotion, an expression of grief that emerges due to the loss of a person, an object or other important matters.
4. Bereavement: The situation of the loss of a loved one as a result of death.

II. Phases in the coping process after loss

a. Bewilderment (Numbness)

Duration: From several hours to 1 week

Signs: - emotional numbness
- disbelief
- pain

The surviving relative feels numbed by the loss, unable to realize it, is confused and carries out activities almost automatically.

b. Yearning, searching for the deceased

Duration: several months to 1 year

Signs:

- strong desire of the grieving person to search for the other; to protest against the loss.
- the individual experiences pangs of emotions which are accompanied by crying, insomnia.

A widow may be preoccupied with a clear visual memory of her husband, or may experience a comforting sense of his presence nearby.

Anger is also characteristic of this period in the grief process. It may manifest itself in:

- irritability
- bitterness
- anger toward friends, relatives and sometimes doctors.

According to CM.Parkers 1972, Feelings of anger are strongest during the first month after the death.

The following symptoms are the most important characteristics

- restlessness
- preoccupation with thoughts of the deceased
- attention for the aspects of the situation that are related to the deceased and/or which suggest that the other person is still alive.
- actual searching for the lost person in the environment.
- crying, intense yearning for the lost person.
- anger, irritation, accusations and ingratitude towards others.

These symptoms are often short-lived and express the urge to re-establish the bond with the deceased.

c. Disorganization and despair

Sometime after the loss, despair and loneliness intensify. The individual realizes that the other is gone from his life for good. The widow withdraws from social activities, depression prevails, accompanied by apathy and loneliness. She undertakes little, relies heavily upon friends and relatives. There is no sharp boundary between this phase and the preceding one: moments of yearning and despair may exist.

d. Reorganization

Duration: approximately 1 year after the loss

While he feels despair, the bereaved already realizes that certain ideas, expectations and activities are no longer relevant and attempts to deal with the new situation, and takes a new role.

III. An alternative to phases

No individual will go through the successive 4 phases exactly as the model predicts. Some people skip certain phases, other people remain in a phase for a very long time, and again other people oscillate back and forth between phases. Grief is necessary and a person must accomplish grief work.

Mourning is seen as involving 4 basic tasks:

1. to accept the reality of loss
2. to experience the pain of grief
3. to adjust to an environment in which the deceased is missing
4. to withdraw emotional energy from the deceased person and reinvest in another relationship.

IV. Grief as a normal process

Grief is a normal psychological process that takes place over a certain period. It is not a pathological condition rather an adaptive process which requires no intervention. The duration of a normal bereavement reaction cannot be sharply defined. The most intense reactions will surely have disappeared after about 6-12 months but many effects remain for at least 1 or 2 years after the loss. They may also suddenly return years later.

V. Pathological forms of grief

a. Chronic mourning or grief

According to Bowlby 1980, the category is characterized by:

- Intense and prolonged emotional reactions to a loss
- Great deal of self blame
- Anger, anxieties and little sadness
- Depression.

It is though the mourner is stuck in the second phase of the grief process.

b. Prolonged absence of conscious mourning

The person often suffers from vague physical and psychological symptoms that he does not relate to the loss (tension, headache, insomnia).

It seems as if the individual has coped well with the event, but then he suddenly becomes depressed. It is as if the person has remained in the first phase of the bereavement process with emotional numbness.

Parkes and Weiss propose a trichotomy of pathological grief:

- a. unexpected grief
- b. conflicted grief (or prolonged absence)
- c. chronic grief

Unanticipated grief:

- great difficulty in acknowledging the death,
- avoidance of the confrontation with the loss,
- self reproach, despair, withdrawal,
- preoccupation with thoughts of the deceased,
- anxiety and depression,
- feelings of guilt

Conflicted grief:

Difficulties in recovering from a loss are more likely to occur after a bad marriage than after a good marriage although one might expect the opposite to be true (Weiss and Parkes).

Chronic grief (see chronic mourning)

VI. Determinants of the grief

The development of a bereavement process is influenced by a diversity of factors:

- a. whether the loss was expected or not

b. personality characteristics:

- introversion (extraversion)

c. social factors:

- support of people during bereavement process
- rules and rituals that exist for mourning in a given society

d. the nature of the relationship with the deceased.

The closer the bond, the harder the loss, however the relationship need not necessarily to be a positive one:

There exist a connection between ambivalence in the attachment between partners and bereavement problems. The reactions to a loss are prolonged when the survivor had been dependent upon the deceased.

c. In conclusion the psychological and social reactions to a loss are determined by:

- the strength of the bond with the deceased
- the security of the bond
- the ambivalence in the relationship
- the dependence on as well as the trust in the deceased for the execution of all kinds of tasks and roles.

The impact of the nature of the relationship with the deceased upon the bereavement reactions is clearly shown by the general findings that the death of one's own child is the most devastating loss (Bowlby 1980, Gorer 1965).

50% of the persons treated for disturbances in the process of coping with a loss were coping with the death of their child (especially sudden death).

VII. Conclusion

Grief is a complex but coherent pattern of psychological, social and physical reactions to a clearly defined event, namely the loss of a loved one. Sadness and Depressions are the emotions more strongly in the foreground after loss; whereas anxiety play an important role in traumatic events. □

DIFFERENT EXPERIENCES OF TRAUMA IN RWANDA WAR

INTRODUCTION:

Survivors of massacres and genocide have been reporting horrible atrocities which they experienced, witnessed or heard about

Known cases of Torture Survivor

A. Physical Torture

People slashed by machetes, sword or knife in order:

- To kill them
- To kill them slowly cutting small pieces of the body (fingers, ears etc.)
- To maim the victim for the rest of the life
- Children, adults amputated arms, legs, hands and left alive deliberately to make them suffer
- People shot on the head or foot
- Some cases of evisceration have been reported (abdomen slashed, opened and intestines left outside)
- Breast of mother breast feeding or ladies cut, victim left alive
- Mr.E. was forced to eat a piece of his own ear which they had cut
- A couple was tied with ropes on a tree one in front of the other
- A case of a mother whose head was cut at the level of the neck while carrying her baby at the back but the baby was killed.

B. Psychological Torture

- (i) Children witnessing the killing (slaughtering or shooting) of their parents or relatives
- (ii) Being wounded and lying for 2-3 days among corpses of relatives or friends
 - 2 well known

- (iii) Being buried alive (one case was documented in April in the East of the country and was rescued on time)
- (iv) Being compelled to witness torture or killing of a wife, a husband, relatives etc. Without any possibility to help them (several cases of couple with different tribes or political parties)
- (v) Being singled out to witness the killing of relatives
 - Mrs.X, 49 years old who already has requested our services (4, children, the husband were slaughtered in front of her.) She requested also to be killed. They told her that she was left alone deliberately as a widow without children
- (vi) Impossibility to bury relatives
- (vii) Several people forced to kill in order not to be killed
 - a known case in Nyamata where a man was forced to kill his brother so that both will not be killed
- (viii) Mixed couple (Hutu & Tutsi) whereby one spouse was forced:
 - to let the spouse be killed
 - to kill her in order to save the life of one spouse and children
- (xi) In a mixed couple,(Hutu & Tutsi) with 4 children, one parent was forced to choose among 4 of the children 2 to be killed (half of the children being considered to be Hutu, the other half tutsi)
- (x) 1 case of religious man forced to dig his own grave
- (xi) Being denied health care
 - a businessman, diabetic on insulin injection
(the insulin was confiscated)
 - wounded not attended to because of their tribes
- (xii) Sham execution (being threatened to be killed and shooting in the air)
- (xiii) Threats, beatings etc.

NB: Among perpetrators some have also been traumatized

- mixed couples whereby one goes to kill (usually the man) and finds the spouse killed
- impossibility to help his relatives/cousins of the opposite tribe in order not to be killed

C. Sexual Torture

- Several cases of rape with threat to several people in public (along the barricade)
- Being raped in front of the husband
- To witness sexual torture or rape of parents or children or spouses
- Being raped and told that the aggressor is HIV sero-positive (2 known cases)

EXPRESSION OF EMOTION AND SUFFERING IN RWANDESE CULTURE

OBJECTIVES:

To enable the trainee recognise the way suffering is expressed by Rwandese in order to manage it.

CULTURAL INFLUENCE ON TRAUMA

Definition:

Culture can be seen as an acquired lens through which an individual perceives and understands the world that he/she inhabits and learns how to live within it (Helman 1990). It supplies him/her with **behavioral patterns, ways of thinking and feelings.**

Culture determines the language on which psychological distress is communicated to others:

Although customs can vary greatly Averil (1979) and Bowlby(1980) stated that feelings of bereavement and the coping process itself are the same in all cultures, only their expression differs: Depressed patients in African or non-Western cultures often complain of varieties of diffuse physical symptoms such as vague pains, headaches, dizziness and general malaise. This somatization becomes a dominant way of coping with unpleasant experiences in African societies. Individuals interpret and articulate their problems, experience and respond to them through the medium of the body because psychological symptoms are not widely understood or accepted.

MANIFESTATION OF PTSD IN RWANDESE WOMEN

Each culture provides its members with ways of shaping their suffering into a recognizable illness entity and explaining its cause and treatment. Being a concept that has been developed in the Western World, it contains many elements of psychological distress, therefore it is likely to be expressed in non-psychological language, in a non-Western setting (Rwanda).

A survey done in November 1994 in Kabarondo and Tare Health Centers (Rwanda) on 100 female patients showed that nearly 70% had signs of PTSD and depression expressed as follows:

- a. **Malaria:** Meaning general weakness due to several days of insomnia and nightmares.
- b. **Worms (Inzoka):** Attributed to any abdominal discomfort, dyspepsia, nausea, anorexia.
- c. **Heart disease:** Meaning anxiety, panic attacks, emotions, palpitation, chest pain.
- d. **Ifumbi:** Vague description of general malaise occurring in depressive states often on menopausal syndrome.

In general there is no direct link between the mind and the body. This is of course to be taken into consideration in setting up therapeutic and rehabilitation programs for Rwandese victims of Psycho-trauma. When a Rwandese patient goes to see a therapist, presenting physical signs; he/she expects a physical treatment (injection or tablets); he/she expects to be physically examined.

The patients in Kabarondo and Tare health centers were treated to their expectations using a physical treatment as a bridge to the psychological problem. Placebo, mild psychotropics were been effective. In fact the direct treatment of psychological problems with drugs in co-ordination with psychotherapy enhances the effects of the latter.

EXPRESSION OF THE SUFFERING IN RWANDESE SETTING

Rwandese are usually introvert, and do not like to talk openly about their inner suffering. A study by Maddison & Walker (1967) showed that not talking out the suffering, or sharing it, worsens symptoms of trauma.

The situation of genocide and massacres was sudden and unexpected. Burial, funeral ceremonies and mourning rituals were not possible. Many people did mourn and the lack of customs in mourning strongly affect the bereaved.

In Rwandese culture wise men are not expected to cry or show out the pain.

- Amalira y'umugabo atemba agwa mu nda. (the tears of a man go inside)

- Intore ishinjagira ishira

Immediately after death ,some relatives close to the deceased may cry (especially women or children). After the burial people try to ignore the suffering by drinking, and making jokes. They try to divert the bereaved from being alone and provide them with social support (usually beer or food sometimes).

Most of the time psychological trauma is repressed, somatized rarely expressed in crying.

PSYCHOLOGICAL REACTIONS TO THE WAR

1. OBJECTIVE:

To enable the participants to detect and manage different psychological aftermaths of the war.

2. INTRODUCTION:

Observing and talking to Rwandese who have survived recent genocide and massacres leaves no doubt about the trauma and loss felt by everyone.

The great number of people affected, the torture and atrocities which they went through makes the situation unique:

- Adults as well as children, in all social classes, all over the country, have been affected. In several instances entire families have been wiped out. Almost every Rwandese fled his or her home, lost a family member or a friend and encountered several traumatic experiences. Hence, large segments of Rwandaise population have been subjected to
- Loss (human and/or property)
- Polytraumatism

3. REACTION TO TRAUMA AND LOSS

A. P T S D (post-traumatic stress disorder)

(Acute, chronic, delayed)

B. Differential Diagnosis

1. Acute stress disorder
2. Adjustment disorder
3. Brief reactive psychosis
4. Abnormal grief reaction
 - Chronic mourning
 - Lack of mourning

5. Other abnormal behaviors

6. Treatment

A. P.T.S.D (Post-traumatic Stress Disorder)

Following exposure to an extremely stressful event most people temporarily develops a set of symptoms which can be acute, delayed or chronic. This should, however, not always be considered as pathological rather as UNDERSTANDABLE RESPONSES TO ABNORMAL SITUATION.

These symptoms are grouped in PTSD.

The extend of PTSD is determined by:

- The nature of the trauma.
- The vulnerability of the victim
- His or her social environment.

1. Epidemiology

-On average 25% of individuals exposed to an overwhelming event develop the full blow PTSD syndrome.

- the prevalence of PTSD ranges from
- 1-2% in the general population
- 3-58% in "at risk" individuals

Some experiences carries more risk than others

- Rape
- Torture

The severity of symptoms and the probability of developing PTSD increase as a function of stressor magnitude.

2. Risk factors

- History of childhood conduct problem
- Parental poverty
- Low level of social support
- Positive history of psychiatric disorder
- Interpretation of the even

SYMPTOMS OF PTSD

1. Intrusive experiences

- intense memories or feelings related to the event in the form of recollections or thought which they cannot control.
- vivid dreams or nightmares
- acting out of the event as if the event is happening again in Flash backs.

2. Avoidance behaviors

Thought; Things which symbolise or remind them of the event may cause physiological discomfort therefore they avoid them (avoidant behaviors, psychogenic amnesia).

3. Emotional numbness

Most people develop feelings of detachment from others and have difficulty in experiencing feelings of affection.

4. Pessimism about the future

5. Increased startle response

There is often a heightened awareness of risk. People expect danger any time; they are easily alarmed, anxious.

6. Other symptoms

- Sleep disturbances (nightmares, insomnia, night terrors)
- Irritability and sudden anger
- Difficult in concentration.

N.B: Many people have the above symptoms from time to time, others are chronically tormented by them; immediately or much later after the occurrence of trauma.

The severity of PTSD is related to :

- The nature of trauma, the way it is interpreted, the individual personality and his previous experiences.

Denition of PTSD in DSM IV.

DSM IV - Diagnostic and statistical manual of mental disorders - Fourth edition

Diagnostic Criteria for 309.81 post-traumatic stress disorder

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

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

2. The person's response involved intense fear, helplessness or horror.

NOTE: In children, this may be expressed instead by disorganized or agitated behaviour.

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

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

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

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). NOTE: In young children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
 5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:
1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.
 2. Efforts to avoid activities, places or people that arouse recollections of the trauma.
 3. Inability to recall an important aspect of the trauma.
 4. Markedly diminished interest or participation in significant activities.
 5. Feeling of detachment or estrangement from others.
 6. Restricted range of affect (e.g. unable to have loving feelings)
 7. Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
1. Difficulty falling or staying asleep
 2. Irritability or outbursts of anger
 3. Difficulty concentrating
 4. Hypervigilance

- 5. Exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B,C. and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

- Acute: if duration of symptoms is less than 3 months
- Chronic: if duration of symptoms is 3 months or more

Specify if:

- with delayed onset: if onset of symptoms is at least 6 months after the stressor.

TREATMENT OF PTSD (Principles).

Naturally, people tend to avoid talking of the trauma, to forget, hoping that feelings would go away by themselves, with time.

a.. Catharsis:

-Sharing experiences with other traumatized people reduce stress. The focus should be on what happened to each person and how he felt at the time. This can be done through groups or testimonies.

-It is preferable to tell the story to someone outside the family, who is trusted. It is also helpful for the whole family to talk of their experiences so that each understands what the other has gone through.

- Other methods
- Writing down the story to someone to read later.
- Dictate the story into a tape

Talking or writing help to overcome the stress, to accept the reality, cope with it and integrate it in the new life.

b. Avoid to be alone engage in physical work, being in a company.

c. Social rehabilitation (self help group, improve social support)

d. Physical treatment if need be

NB: PTSD can be:

- Acute: when the duration of symptoms is less than 3 months.

- Chronic: when the symptoms last 3 months or longer.

- With delayed: if at least 6 months have passed between the traumatic event and the onset of the symptoms

6. DIFFERENTIAL DIAGNOSIS

1. ACUTE STRESS DISORDER

The symptoms pattern must occur within 4 weeks of the traumatic event and resolve within that 4 week period. If the symptoms persist beyond 1 month and meet criteria for PTSD, the diagnosis is changed from Acute Stress Disorder to PTSD.

2. ADJUSTMENT DISORDER

The stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situation in which the response to an extreme stressor does not meet criteria for PTSD or another special mental disorder and for situations in which the symptom pattern of PTSD occurs in response to a stressor that is not extreme (e.g. spouse leaving, being fired).

3. BRIEF REACTIVE PSYCHOSIS (Diagnosis criteria D S M IV)

A. Presence of one(or more)of the following symptoms:

1. Delusions

2. Hallucinations

3. Disorganised speech(e.g frequent derailment or incoherence)

4. Grossly disorgazed or catatonic behavior.

NB: Exclude a symptom if it is culturally sanctioned response pattern.

B. Duration is at least 1 day but less than 1 month with eventual full return to premorbid level of functioning.

C. The disturbance is not better accounted for by a Mood Disorder with Psychotic features, Schizoaffective Disorder or Schizophrenia and is not due to the direct physiological effects of substance (drug, medication or a general medical condition.)

D. Symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost any one in similar circumstances in the person's culture.

4. ABNORMAL GRIEF REACTIONS

-Grief is a complex but coherent pattern of psychological, physical and social reactions to the loss of a loved one. Sadness and Depression are the emotions more strongly in the foreground after loss. Whereas anxiety plays an important role in traumatic events. In case of war related atrocities and killings whereby trauma and loss occur altogether, Anxiety and Depression Coexist very often.

- Lack of mourning

Grief is not only normal and healthy but also a necessary phenomenon. The avoidance of grief results in psychological problems. Many victims were not able to bury or mourn their relatives, friends, loved ones in Rwanda war. People were buried by machines, in mass-graves or thrown into rivers.

Several people have a continuous preoccupation as to the circumstances of death (how, where). In this prolonged absence of conscious mourning, the person often suffers from vague physical and psychological symptoms that he does not relate to the loss (tension, headache, insomnia).

It is as if the person has remained in emotional numbness with disbelief and pain. He has to accept the reality of loss.

- Chronic mourning

According to Bowlby (1980) the category is characterized by:

-Intense and prolonged reactions to a loss

- Great deal of self blame ,
- Anger,anxieties
- Sadness and Depression the psycho-social reactions to a loss are determined by:

The ambivalence in the relationship difficulties in recovering from a loss are more likely to occur after a bad marriage than after a good one although one might expect the opposite to be true. (Weiss & Parkes 1983).

The dependence on as well as the trust in the deceased for the execution of all kinds of tasks and roles. The reactions to a loss are prolonged when the survivor had been dependent upon the deceased.

The strength of the bond with the deceased (the closer the bond ,the harder he loss). The death of one's own child is the most devastating loss (Bowlby 1980, Girer 1965). They found that 50% of the persons treated for disturbances in the process of coping with a loss were coping with the death of their child (especially sudden death).

In view of the above;the following categories of people in Rwanda are prone to abnormal grief reaction:

- People who could not mourn,bury their relatives.
- Those who do not know how they died and where they are buried.
- Those who lost several people,children,spouses.
- Widows who were dependant on husband.
- Old widows who lost their children and cannot remarry to get other children because of the age for instance widow.

5.OTHER ABNORMAL BEHAVIOR

- Mood disorders
- Conversion
- Excessive alcohol intake
- Increased sexuality
- Personality changes
- Anger,Hatred
- Dissociative disorders
 - Psychogenic amnesia

- Depersonalization
- Multiple personality disorder.

There is a tendency to withdraw from emotionally painful or conflicting experiences connected with dramatic circumstances.

6. TREATMENT

Holistic treatment (see Psychotherapy, physical treatment and social rehabilitation).

EFFECTS OF TRAUMA ON THE FAMILY

1. INTRODUCTION

The influence of trauma is not restricted to the victims. Like every case of serious disturbance which afflict individuals, their families (children, spouse, relatives) get mixed up in them. The war-related emotional disorders impart pressure on family relationships and may cause family disintegration or exacerbation of family members' emotional problems (Hoganecamp and Figley 1983)

2. EFFECTS OF TRAUMA ON SURVIVORS' CHILDREN

A. Direct effects

- effects of direct exposure to trauma (P.T.S.D. and other stress syndromes.)
- consequences of loss and detachment.
- presence of several unaccompanied children and orphans.

B. Transgeneration effects

1. Definition

Somebody's behaviour may permanently influence that of other people; that is called **Transmission.**

Actually there exists a double way of transmission in children of war survivors:

- The straight forward message which the parents convey to the child for instance "you must always be successful to revenge our defeat or 'you have to organise your life around us because we have been going through this.'"
- Apart from that, the child is damaged because the capacities for parenting of traumatized parents have been impaired. They are so preoccupied by the reminiscence of the war that they can not be emphatic to the emotional needs of the child.

2. Effects on Second Generation war survivors.

The following P.T.S.D symptoms and other pathological reactions have been observed in war survivors children, (Holocaust).

- a. These children often react with severe pathological responses (i.e anxiety) when exposed to stress because of their heightened vulnerability (**Barocas 1979**)
- b. Survival guilt; The war survivors and their offsprings feel that they do not quite have the right to live when so many others were killed.
- c. Conflicts about the expression of aggression have also been found to be strong in children of survivors, on the other hand, aggression by the children is often encouraged by the parents, who may vent their anger on their offsprings or unconsciously push their children to act out the aggression that they themselves had not been able to express. (Axelrod 1980).
- d. Many children express a need to identify with their parents' suffering in order to feel more intimate to them. Others report difficulty in talking to the parents about the war for fear of causing pain.
- e. Role reversal: children as Rescuers

The intrusions of war experiences and many losses make the parents psychologically venerable and turn to their children for support .

As a result children feel responsible for their parents and for the parents' well being, they see themselves as **guardians** and **protectors**. That is the phenomenon of **parentification**: a reversal of roles in the family which is often mentioned in the literature on Holocaust survivors (Danieli, 1982).

Children believe it is their responsibility to keep people happy and to ensure that nothing goes wrong; if there is trouble at home, they blame themselves or feel guilty.

It has also been stressed that survivor parents expect their children to perform maximally so that they did not survive their ordeal for nothing; this might lead to high intellectual achievements in children (Begemann 1991).

In general a reduced psychological well being is expected in these children in particular feelings of depression guilty and difficulties in expression of emotions (Nadler, Gleitman 1985).

III. *EFFECTS ON THE PARTNER*

During and after war time, the family necessarily undergoes changes; roles may shift to compensate missing or unable family members.

Lumry et al (1970) found that war survivors suffered from severe interpersonal problems, especially in their marital relationships: difficulties survivors have in maintaining intimate relationships with their wives, may often be compounded by sexual problems.

The survivors sexual drive is frequently diminished with a resulting drastic impairment of sexual activity. Partners in return may feel rejected and unloved and may suffer frustration.

The survivors' elevated level of hostility too, can have severe psychological repercussions on the partner. Similarly, anger and the increased susceptibility to acting it out may also result into violent outbursts towards the spouse.

A married survivor who suffers from war related P.T.S.D. is unlikely to engage in affectionate, supportive relationships or to fulfil his/her responsibilities towards the family.

Clinical observations demonstrate that intimacy with a partner, the birth of a child and comforting a crying child may increase stress in war survivors. (Harley 1978).

The survivor's partner feels responsible for his/her well being and sacrifices too many of his or her own needs for the rest of the family. Such strong sacrifices may lead to **frustration and aggressive feelings**.

In case of women clinical evidence suggests that they tend to find it difficult to express their aggression overtly.

The only solution open to them is to displace aggressive feelings from the husband to a less threatening target: her children or her self. In the latter instance the wife's aggression takes the form of **depression** and **guilt** feelings (Bar -Tur 1977).

Wives of Vietnam veterans tend to suffer from guilt, anger, and mistrust (Williams 1980).

IV. *CLINICAL IMPLICATIONS*

It seems quite clear that it is really impossible to properly address the P.T.S.D of war survivors in isolation from their families. To be effective, family intervention should be adapted to the specific nature and needs of each family. It would be inappropriate to prescribe the same treatment mode or sequence for each family.

Despite their real problems several families are reluctant to seek or accept psychological help: The process would start with the survivors feeling ashamed of having P.T.S.D. They consider it as a weakness or cowardice and prefer not to expose their discomfort. Soon the embarrassment affect the partner as well and the family becomes withdrawn to itself.

V. *INTERVENTION STRATEGIES*

A. Planning of clinical intervention for families will take into account both the problems of such families and their attitudes towards

- the illness
- themselves
- social establishment.

B. Attempts to change family attitudes

- provide information about trauma and related problems as well as its effects on the family.

C. Involvement of the natural social network:

- friends
- workmates
- relatives

UNWANTED PREGNANCIES FOLLOWING RAPE

INTRODUCTION:

During genocide and massacres, rape has been very common. It was carried out secretly or openly sometimes by several people and for a long time.

There are even cases of forced cohabitation often with the murderers of their relatives (husband, children) or friends.

.CONSEQUENCES OF RAPE

- Sexual dysfunction

Burge (1988) reports that women who have been raped often have flash backs during sexual activity in which the present partner is perceived as rapist. Victims of sexual torture are also known to have intrusive thoughts about the torture during intercourse (Agger 1967).

Similarly, labour and delivery following unwanted pregnancy remind the woman of rape experience.

- Psychological sequelae

-PTSD

-Hatred toward the opposite sex: a rape victim was saying: **"I cannot stand talking to a man."**

-STD (Sexually Transmitted Disease) like

-infection (gonorrhoea, syphilis),HIV.

Pregnancies

During Rwanda war several rape victims became pregnant (single ladies, widows often pregnant from murders of their husband and children). Over 200 pregnant women attended Kigali maternity.

PSYCHO-SOCIAL IMPACT

A. On victims (mothers)

They mostly suffer from

- PTSD
- Shame following rape as it was often done in public
- Stigma of having been raped or and impregnated.
- Ladies who become single mothers do not marry easily and become a burden for the family (parents).

Victims become ambivalent:

Refusal of pregnancy and the child, fear of stigma. On the other hand, cultural and religious beliefs that push the victims to keep the pregnancy and the child.

B. On the pregnancy

Most of the unwanted pregnancies do not have psychological signs of the first trimester. Pregnancies are often discovered at a late stage (5-6 months). The same phenomenon has been observed after Rwandese war. According to Catherine Bonnet (1993) a mechanism of psychic protection is used: DENIAL.

DENIAL OF PREGNANCIES:

This mechanism explains how some pregnant women could ignore pregnancies for such a long time: Despite menorrhea, change of body shape they could not make a connection with a fecund sexual relationship. Nor did they perceive the presence of the fetus, till denial becomes less efficient; the fantasy of becoming impregnated through sexual intercourse with a man has been erased from their psyches; the pregnancy is UNTHINKABLE. When the pregnancy is discovered, they begin to have fantasies of violence toward the unborn child.

The pregnancy becomes so unbearable that some request termination of pregnancy or try to kill themselves.

- Over 80% of those who attended Kigali Maternity requested abortion or termination of the pregnancy.
- There have also been cases of aseptic abortion.

C. On delivery

In C. Bonnet study the following was noted:

- Labour was anticipated with a great anxiety.
- Women did not seek prenatal care, neglected their pregnancies.
- Two of them experienced denial to such an extreme that they did not even realize that labor had begun pain was there, but was not associated with pregnancy, to the extent that they were actually surprised when the baby emerged from their bodies.
- Some killed the babies immediately or abandoned them in public places, or toilet.
- In several instances, babies have been abandoned in Kigali maternity. Some mothers did not want to see or breastfeed the babies.

Those neglected after delivery are subject to several complications.(infection, bleeding even death.)

D. On the child

After delivery most of known women, abandoned the children in maternity, some for religious or social reasons handed them over to the family (mother or grand mother) or decide to stay with them. "I do not want to give birth to a murderer, a militia." were saying some women. Health professionals have been trying to convince them that babies are innocent.

It has been hypothesized that forcing an interaction between the mother and the child, while ignoring her refusal of the child (often in fantasy) creates the risk of:

- Neglecting the child even infanticide.
- Lack of maternal love.
- Developing or worsening of psychological problems. (the child being a constant reminder of rape experience especially if it resembles the rapist.)

When these children are grown up either in institutions or families, they may have an identity problem: being always labeled fruit of torture, they are likely to carry a shameful stigma of having been born in such circumstances.

E. On the family and community

- Spouses (men) have difficulty in accepting the pregnancy and the child.
- Rape of their wives is very shameful especially if it is done openly and in their presence. They are also secondary victims of STD and HIV infections.
- Children issued from rape are often abandoned if not mistreated; the community is responsible for them as well as for their mothers.

INDIVIDUAL FAMILY AND COMMUNITY CARE APPROACH

- (a) Create awareness in the country on psycho-social impact and available measures to deal with that problem.
- (b) Analyze and possibly review the law on abortion.
- (c) Try secret delivery with of course cultural and religious consideration encourage. [accouchement sous X]
- (d) Adoption by extended families where possible rather than institutionalization.
- (e) Avoid stigma on children.
- (f) Treatment and Rehabilitation of victims, children, family.

TRAUMA DESENSITIZATION(BIOFEED - BACK)

I. OBJECTIVES:

Give to the trainees the theoretical and practical, knowledge of trauma desensitization by use of Biofeed - back (Respicon 1).

II. DEFINITIONS::

- Biofeed back:

As a technique for treatment began in 1968 after the discovery that in animals as well as in humans, physiologic functions thought to be out of voluntary control (e.g. respiration) were modifiable by appropriate monitoring techniques made perceptible to the subject.

- Desensitization:

Wolpe (1958) first designed the method of systematic desensitization as a counter-conditioning technique by which a certain reaction (anxiety) is made impossible by the occurrence of another reaction (relaxation).

III. TRAUMA DESENSITIZATION

Trauma desensitization is a method in which the client reexperiences a traumatic event he/she has gone through. The main aim of the method is to restore the feeling of control, which was shattered by the traumatic event. The following elements are important in trauma desensitization.

A. The treatment schedule i.e how often and how long will the patient be seen; usually according to the mutual agreement of therapist and client: Keeping the treatment relatively brief in general sustains positive expectation of the patient.

B. Instruction to patients about the aim and means of treatment with an emphasis on control and on the ability to confront the traumatic event.

e.g" **In this treatment we want to teach you to achieve control over the tension you experience when you remember unpleasant events that occurred to you. You notice that you tend to become very tense when you think of those events.**

Consequently, you will often try not to think about them. The aim of the treatment is to help you think about it in a relaxed manner. This relaxation will help you to cope with what has happened."

C. Exploration: The aim is to find "themes" (stimulus) and connected feelings (anger, guilt, anxiety.)

D. Relaxation: In case of Trauma patients a relationship has been observed between Post-Traumatic-Stress and Hyperventilation. Because of this relation an important contribution can be made by the training of breathing techniques.

The most important idea behind the method of breathing regulation is that breathing is a very important determining factor in anxiety states: it has a direct influence on other physiological mechanisms and can voluntarily be controlled by the individual.

Introducing a regular breathing pattern is therefore a good method of achieving a condition of physical relaxation.

A breathing regulator (RESPICON 1) exists. This apparatus produces 2 different sounds one increasing infrequency. The four components of the breathing pattern, (Inhalation, exhalation and the pauses in between) may each be separately scheduled in terms of duration.

The effectiveness of this apparatus was proven in a study on the treatment of Hyperventilation

[Swat, Grissman & Defares 1983.]

E. Desensitization: The process of desensitization takes place according to the, following cycle.

1. Relaxation
2. Confrontation
3. Reexperiencing and Termination
4. Evoking a pleasant image

1. Relaxation: The client undergoes relaxation process in a sitting position with or without the therapist's presence.

2. Confrontation : The client is asked to bring up images connected to a specific item (anxiety, anger) it is advisable to work through images connected to one emotion first.) One must, however, be aware that sudden changes occur: when the focus, for example, might be on anxiety, a sudden shift to anger laden images may occur. He can be aided in these by having his attention drawn to details, for example:

- look at the color of
- let the image of this come
- look at...

The patients often need several confrontations before they see a clear image.

3. Reexperiencing and Termination: The client is instructed to relive the feelings that have been evoked. Then relaxation by breathing. The confrontation is concluded with the following instruction:

"When you feel that you really experienced the situation, you can stop the image by saying aloud:

IT IS OVER; I AM LETTING IT GO."

Pressure should be avoided, the client works at his own pace and it is he/she who decides when to cease the imagery by saying the sentence. The way in which the sentence is said can yield important clues for the therapist:

- When spoken quickly and superficially, it often indicates avoidance.

A good and lively experience is generally concluded with an emotionally laden expression. Repeating 2 or 3 times.

d. Evoking a pleasant image: After each confrontation the client is asked to relax and to evoke a pleasant image linked to the item that was just evoked. After themes in which anxiety plays a role, a general image (such as a beautiful beach is evoked). After the confrontation with themes involving guilt, anger, sadness, if they relate to persons with whom a pleasant relationship existed, a memory or image of the pleasant relationship with that person is evoked.

NB: Themes concerning sorrow and grief are not brought up in desensitization. The client is confronted with these themes without relaxation.

During the last sessions, images relating to the future are also evoked, connected to the daily life of the client. In summary, trauma desensitization enables the client to regain control on recurring traumatic events.

BASIC SKILLS IN COUNSELLING

Counselling involves helping a client cope more effectively with his or her current problems of living.

Common Life Problems include:

- i loss problems e.g. bereavement
- ii life change problems e.g. getting married, retirement, being promoted etc
- iii interpersonal problems
- iv environment problems
 - neighbourhood
 - work situation

Objectives of Counselling:

- a setting up of an adult-to-adult relationship with client
- b client encouraged to take responsibility for the problem and its solving
- c establishing a treatment program
- d facilitating expression of harmful emotions to make client think more clearly
- e establish rapport

STAGES IN COUNSELLING

1. Facilitating the release of emotions
 - therapeutic relationship should be trusting
 - therapist should be:
 - a calm
 - b have non judgmental interest
 - c be a good listener
 - d use plenty of eye contact
 - e be empathic
 - client encouraged to outline the problem and his feelings about the situation

2. Reflection, clarification and reassurance
 - therapist to restate the problem in solvable terms
 - reassure client to enhance self-esteem
3. Facilitating the client's understanding of the problem
 - clarify distortions in client's perception of problem
 - examine predisposing and precipitating factors and their meaning to the patient
4. Facilitating problem solving
 - problem solving should be done by the client and not the therapist

Basic steps

- i identify problem
- ii identify alternative methods of coping
- iii examine each alternative and its implication
- iv choose one appropriate alternative
- v define the behavioral steps necessary to carry out the alternative
- vi carry out the steps
- vii check the consequences

Role of the counsellor/therapist

- educating client on the principles of problem solving
- helping the client define the problem appropriately
- suggesting additional methods of coping not considered by the client
- reminding the client of his strength and weaknesses as he chooses the alternatives
- negotiating a behavioral contract to ensure the patient carries out the alternative method of coping as agreed
- helping the patient overcome his inhibitions when solving problems

Client/therapist relationship in counselling

- counsellor uses emphatic listening and awareness of his own feelings to understand the client's experiences and formulate problem solving

- counsellor should not over identify with patient if he has experienced similar problems.
- good listening and patience is essential (silence is just as important)
- patients tend to medicalise their problems if talking to medical personnel.
- therapist should not collude with the patient as it does not prepare him to deal with associated emotions
- counsellors should not take control of the interview
- sessions should not be prolonged unnecessarily as it encourages dependency
- involvement with self-help groups help the patient to see their problems as not purely medical
- counsellors should be free to share their anxieties about counselling with other supportive persons or groups

THE CLIENT - THERAPIST RELATIONSHIP

OBJECTIVES

To equip the trainee with skills to develop good client (patient) - therapist relationship.

CONFIDENTIALITY

"WHATEVER in connection with my professional practice, or not in connection with it I see or hear in the life or men which ought not be spoken abroad, I will not divulge, as reckoning that all that should be.....kept secret." - *The Hippocratic Oath*

A long held premise of medical ethics binds the doctor to hold secret all information given by a patient. This obligation is what is meant by confidentiality. Confidentiality is particularly important in psychiatry because information is collected about private and highly sensitive matters. Maintain total confidentiality of the information obtained as part of therapy contacts. At no point should personal details be provided to other persons not included into the patients' problems and treatment. One of the aspects of confidentiality is to keep the records in a safe place and not to discuss illness details in front of others. If a patient's case is to be used for teaching purposes the patients must give prior permission (informed consent) meeting in a private room is important as it implies to the patient that Confidentiality is a top priority. The therapist should also highlight the prominent place of confidentiality and thus enhance the sense of security the patient enjoys.

SEXUALITY

Medical ethics prohibits romantic involvement between therapists and patients. The friendship model of the doctor-patient relationship is dysfunctional and unethical. It involves blurring of boundaries between professionalism and intimacy. An actual romantic relationship between doctor and patients can be destructive especially for the patient.

ESTABLISHING RAPPORT

Establishing a satisfactory therapist/patient relationship is very essential for successful assessment, diagnosis and management of patients with Psychological/mental problems.

A satisfactory therapist/patient relationship achieves the following objectives.

1. The patient's willingness to trust you and disclose why he/she has come and to provide diagnostic information.
2. Relief of physical and psychological distress
3. Willingness to accept treatment plan
4. Patient satisfaction
5. Therapist satisfaction

The establishment of a satisfactory therapist relationship depends on the therapist ability and skill to convey their interest and warmth to their patients as they listen to the patient's problems, thus understanding and trust between the doctor and the patient.

The establishment of rapport also depends on a basic understanding of interpersonal factors such as transference and counter transference.

TRANSFERENCE

Transference is defined as the set of expectations, beliefs and emotional responses that a patients brings into the doctor acts in reality but rather, on experience the patient has had with other important authorities figures throughout life. The Patients attitude to the therapists is often a repetition of the attitude he/she has towards authority figures. This attitude may range from one of a realistic basic with expectation that the doctor has the contemptuous and potentially abusive. Understanding the power and manifestations of transference is necessary for the establishment of any good doctor - patient relationship. How the doctor behaves and interacts affects the emotional and even the physical reactions of the patient e.g one patient repeatedly had high blood pressure when examined by a physician he considered cold, aloof and stern. He had normal blood pressure, however when seen by a doctor he regarded as warm understanding and sympathetic.

COUNTER TRANSFERENCE

Just as the patient brings predetermined attitudes to the doctor-patient relationship, doctors themselves often develop counter transference reactions to their patients.

Counter transference may be

- a) Negative feelings (disruptive to the doctor-patient relationship)
- b) Positive feelings

In short transference refers to the emotional responses to doctor, while counter transference refers to the doctor's emotional response to the patient.

Most patients including the severely disturbed are capable of understanding your reactions and responding to them accordingly. Try to establish a good therapist patient relationship. Patients need to feel that you are genuinely interested concerned about them and that you are willing to listen to their problems attentively and carefully. Ask yourself whether you have a genuine desire to help the patient and whether you are communicating this interest to the patient.

HOW CAN YOUR INTEREST AND CONCERN FOR THE PATIENT BE COMMUNICATED?

Listen carefully to your patient and give him/her an opportunity to express his problems as spontaneously and fully as possible with least interruptions

Maintain eye contact with the patient as much as possible

Acknowledge and respond to what the patient says verbally and/or nonverbally (gesture like nodding.)

Do not convey your constraints of time

Be sensitive to the emotional distress of your patients

Be careful about your own emotional reactions, (counter transference) while you approach a severely disturbed patient. Your reactions likely to be among the following:-

- i) fear and apprehension that the patient may be dangerous
- ii) anger and rejection because the patient is arrogant and annoying

- iii) dislike and disgust because the patient is dirty
- iv) Sympathy and pity as the patient is suffering
- v) distrust and disinterest as the patients is deemed unreliable
- vi) amusement and laughter due to the patient's funny behavior

Try to recognize your reactions and make every effort to moderate them. When you show respect, trust and concern for these very disturbed, they in turn will trust you and follow your instructions. The mentally ill person is a human being with his own feelings thoughts, like dislike and self-respect. Remember that he expects to be treated as a responsible and respectable individual and hence treat his as one who is suffering and is in need of your understanding and help.

Do not do anything to degrade the patient. Do not comment, confront, criticise or laugh at your patient.

Try to understand what the patient has to say and do not deny the reality of the patient's experience. You do not have to concur with all his statements but accept them with a neutral attitude.

By direct verbal reassurance inform the patient of your commitment to his welfare. It is unwise to consider the patient "mad and unreliable" and listen only to his attendants.

Don't ask personal or questions regarding sexual matters infant of others. Obtain such details in privacy and reassure the patient that the details will be kept confidential.

After the patient's description of his problem, talk to his relatives. If there any discrepancies in the information given by the patient and the relatives, do not get alarmed but draw their attention to this and request them to clarify.

OCCUPATIONAL HAZARDS IN THE TREATMENT OF TRAUMA VICTIMS

1. OBJECTIVES:

Create awareness among trainees (future therapists) about risks encountered in the treatment of traumatized individuals.

II. INTRODUCTION:

All workers experience some emotional upheaval when listening to client recount their trauma stories. There are indications that therapists treating patients with PTSD caused by man-made disaster are in danger of negative impacts on themselves (J. Lansen 1993). Disaster workers set high expectations for themselves at this task; consequently failure or inability in helping to reduce the trauma of the situation may lead to feelings of personal failure (Hartsongh & Myers 1985). Although they do not personally experience the physical effects of the disaster, they experience second-hand the losses of others.

SECONDARY TRAUMA is the term that describes the range of psychological and physiological effects seen in therapists working with man-made disaster victims.

Experts have referred to these effects as:-

(a) BURNOUT AND EXHAUSTION

(b) COUNTER-TRANSFERENCE

(c) VICARIOUS TRAUMA

Danieli (1984) found in therapists who worked with Holocaust survivors the following reactions:

- Bystanders: guilt, shame, powerlessness

McCann and Pearlman (1990) described the psychological effect of working with victims from a different point of view whereby the therapist's feelings have not so much to do with the patient's personality as with the patient's history. In this case, TRANSMITTED TRAUMATIZATION would be a better name (J. Lansen 1993). Several other authors have pointed at these phenomena. Van der Veer (1991) describes how working with victims of torture and persecution deeply affects the therapist's life. Munzoe (1990) proved that these effects are distinct from BURNOUT. To prevent and avoid that, there is a general agreement that a form of mental hygiene is mandatory for staff working in trauma field.

III. DEFINITIONS:

A. BURNOUT and EXHAUSTION:

These refer to the general psychological strain of working in overwhelming situations where demand for help is disproportionate to its supply. Helpers trying to provide for the often infinite need of traumatized populations are typically unwilling to relinquish their posts until the point of physical exhaustion.

B. TRANSFERENCE and COUNTER-TRANSFERENCE

Traditionally refer to the reciprocal impact that the client and the therapist have on each other during the course of psychotherapy. It is an interactive process and may stimulate reactions (e.g. emotional states, memories, fantasies) in both the patient and the therapist.

C. VICARIOUS TRAUMA:

Describes a substituted experience of trauma in therapists caused by intimate work with trauma.

IV. FACTORS ASSOCIATED WITH SECONDARY TRAUMA

1. Nature of the stressor and the way it is presented in the story:

- Grotesqueness, death, mutilation, abuse
- Moral dilemmas during event
- Duration, severity of exposure

2. Personal factors in therapist/helper

- Personal beliefs, religion, ideology, preconceptions
- Degree of training and experience with trauma and victimization
- Motivation to work in trauma field

3. Factors in the client:

- Age, race, gender, ethnicity
- Role in traumatic event (perpetrator, victim, witness)
- Personality characteristics
- Defenses and coping styles

4. Institutional/organizational factors relevant to therapeutic powers

- Political context (supportive versus oppositional)
- Support for therapist

NB: Other Contributing Factors

- Communication difficulty (lingual and cultural)
- Conflicted feelings and issues of trust are typical where survivors may be both perpetrators and survivors
- Inadequate resources and equipment

V. THERAPIST REACTION TO TRAUMA

(i) WITHDRAWAL (TYPE II)

- Denial
- Minimization
- Distortion
- Avoidance
- Counter-phobic reactions
- Detachment
- Withdrawal from clients
- Stance towards the client

(ii) DESEQUILIBRIUM (TYPE I) involves in contrast forms of:

- Overidentification
- Overidealization
- Enmeshment
- Excessive advocacy for the client
- Behaviours that elicit guilt reactions

(iii) FREQUENT & SYMPTOMS IN VICARIOUS TRAUMATIZATION:

Withdrawal, denial, distancing from the patient, disbelief, loss of compassion

Overinvolvement and overidentification with the client

Somatic discomfort, feelings of insecurity, uncertainty as to how to deal with the client, hyperarousal, nightmares

Common symptoms for both type may occur:

- fatigue, sadness, depression, sleep disturbances
- somatic problems (headaches, joint pains, abdominal discomfort, diarrhoea)
- feeling of helplessness

NB: Type I reaction is likely to occur in therapists with a personal history of trauma and victimization.

They may unconsciously attempt to rescue traumatized client as an indirect way of dealing with their own unintegrated personal conflicts. There are risks of abandonment.

Although a therapist may experience one reaction pattern more often than another, it is possible to experience any or all of the 2 types during the course of treatment with a traumatized client.

VI. FACTORS INDICATIVE OF VICARIOUS TRAUMATIZATION IN THERAPIST OR HELPER

(i) Physiological and physical reaction:

- Symptoms of increased autonomic nervous system arousal
- Somatic reaction to trauma story
- Sleep disturbances
- Avoidance reactions

(ii) Emotional Reactions:

- Irritability
- Annoyance or disdain toward the client
- Hostility reactions, numbing reactions
- Sadistic/masochistic reactions
- Guilt, shame

(iii) Psychological reactions:

- Detachment reactions based on intellectualization
- Rationalization, denial, minimization
- Overidentification based on projection, introjection

(iv) Behavioural signs conscious or unconscious:

- Forgetting, parapraxes, hostility toward the client
- Relief when client misses appointment or wish that client not now for session

- Denial of feelings and/or denial of need for supervision/consultation
- Narcissistic belief in role of being gifted specialist in PTSD
- Excessive concern/identification with the client

VI. PREVENTION AND TREATMENT

A. Professional support system:

- Professionals can share and work through reactions that are painful and disruptive
- It is important that group members do not pathologize the secondary trauma otherwise both the therapist and client will be serviced poorly
- Peer monitoring system or external supervision by an outsider therapist

B. Psychological Debriefing (weekly experiences are shared). It is a forum for reviewing experience of working with trauma victims and experiencing the conflict feelings of fear; frustration and success that frequently accompany such work.

C. Supportive relationships with family and friends

D. Rotation through different types of work activity

E. Mandatory intermittent work-free periods (days, weeks)

F. Relaxation techniques

- Formal methods such as meditation, deep - breathing exercises

- Informal methods such as listening to music

G. Physical exercise, good nutrition, adequate sleep, avoid excessive use of stimulant such as caffeine

H. Minimize staff burnout through their involvement in project work, enrich their leisure time.

VII. CONCLUSION

Work with patients who have been traumatized involves a risk of therapists or helpers, independent of the professional discipline of the worker. The number of therapists involved in some sort of secondary trauma might be at least 10%. (Johan Lansen 1993). a practical conclusion is that working alone is to be avoided. Therapy should be done preferably in team. Where supervision, psycho-hygiene and caseload should be considered.

The treatment centres might consider other measures such as staff composition, anti-burnout strategies, training and courses.

PSYCHOTHERAPY OF POST TRAUMATIC STRESS DISORDER

OBJECTIVES

DISCUSS:

1. INDIVIDUAL THERAPY
2. GROUP THERAPY

1. INDIVIDUAL THERAPY

1.0: The initial approach to the psychodynamic management of P.T.S.D was psychoanalytic (Freud 1921). However, the results of this approach were not favourable for most of the cases analyzed (Freud 1974). Subsequent research for other methods has resulted in a more eclectic approach to the dynamic management of P.T.S.D victims. The major functions of the psychotherapeutic approach are remembering, working through and putting into perspective the trauma causing event.

1.1: Most trauma victims are found to benefit from that type of individual therapy which allows the expression of ideas, thoughts and suppressed material that is accompanied by emotional responses that produce a state of relief to the victim (catharsis). This allows disclosure of the cognition of the trauma event, the safe expressions of the threatening trauma related feelings while at the same time reestablishing a trusting relationship with the therapist.

1.2: Subsequent to the cathartic process, the previously repressed traumatic material is reexperienced and brought back to consciousness (abreaction). In the process the victim not only recalls but also relives the material which is accompanied by the appropriate emotional response. Insight usually results from this abreaction experience.

1.3: Horowitz (1985) pointed to the need to alternate between support and confrontation during the cathartic/abreaction therapy so that the client could cover up traumatic material when it threatens to become overwhelming and yet not wall off the trauma during emotional constriction. This approach usually has an organizing effect on the patient. Individual therapy has its own short comings. It tends to reinforce dependency on the therapist and may decrease the subjective sense of mastery of one's situation.

1.4: Kobasa and Puretti (1982) confirmed that those trauma victims who had good social support net work and good internal control faired better than those who had only good social support alone. Hence internal support locus is more important in individual psychotherapy than social support network. According to Ann Freud (1974), psychotherapy alone cannot undo damage caused by traumatic experiences even though it may clarify the past and help the client to deal with the consequences of the trauma..

1.5: Time limited psychotherapy has been advocated for acute simple traumatic events. The technique here is mainly cognitive and educative so as to complete the emotional integration of the experience into the patients life. Alternative therapies emphasize the patients inability to tolerate the intense effects and so are aimed at increasing the patients affective expression and tolerance. The prognosis for acute traumatic disorders in healthy individuals is good, and time -limited therapy with emphasis on cognitive or emotional aspects is indicated.

1.6: For those who suffer from chronic P.T.S.D psychotherapy tends to be more complicated. Even compliance with therapy is difficult and a high dropout rate has been reported (Kaplan).

1.7: During therapy - especially dynamic or explorative - victims of chronic trauma are usually a difficult undertaking. Some of the patients rage may be transferred to the therapist who in turn reacts with guilt, dread, horror or displaced rage. Some of these chronic patients can never really integrate their trauma and so their goals must be limited. In this case, a supportive long-term treatment based on recognizing the chronic course of the disorder, setting limited goals, and solving practical problems of living may offer the most realistic relief.

2. GROUP THERAPY

2.0: Group therapy is widely regarded as the treatment of choice for many patients of P.T.S.D. It has been used in victims of incest (Herman, 1984), rape (Yassen, 1984) spouse battering (Rounsaville, 1979), and war trauma. Grinker and Spiegel (1945) found that the group more nearly approximates the state of the human being (Walker 1981) in a natural setting. Placed in a group, most traumatized men were eventually able to express aggression, hate, love, and wishes without much guilt. Working out one's trauma issues in this small group should be able to prepare one for the larger group; the world at large.

2.1: People who come from abusive or neglectful homes are almost always hostile to or suspicious of authority figures. Hence they are often difficult to engage in individual psychotherapy. But such persons have a high inclination to peer group formation. Hence they are easy to form into a therapeutic group.

The temporary illusion of fusion in groups of individuals who share common history of trauma and relative anonymity of the group afford temporary suppression of ambivalent and aggressive feelings (Kolk -1987)

2.2: Short-term groups can be useful in decreasing anxiety and restoring hope, courage and meaning in the life of the victimized.

Usually self-blame is resolved by allowing external attribution. Parson (1984) has explained the need for therapist activity such as modeling, assertiveness training and reading assignment groups.

2.3: Groups of traumatised individuals are characterized by dependency, rather than confrontation. After overcoming the initial mistrust and shame, the group members rapidly establish a high degree of cohesion. Because of this cohesion, the group members are rather defensive. According to Parson (1984), the group is very sensitive to exploration of aggression - dominated symptoms during this initial phase of group development. The group members learn that they are similar in important ways and they respond to one another as aspects of their own selves. (Pines, 1983). At first, they use each other to reflect traumatic memories and feelings, making their past public permits each patient to find personal meaning in the traumatic event (Parson, 1984).

2.4: Trauma victim groups tend to be concerned with action rather than introspection. Group members are prone to use drugs of dependence so as to deal with the emotions generated by the group interactions. However, after the group has formed good alliance, individual differences and attachments slowly emerge allowing members to break through psychological numbing. The victims now are able to start learning the process of communication.

2.5: According to Pines (1983) the process of group communication is identical to therapy. Clients learn to express themselves in language that has to be understood by their fellow group members. Gradually, what were personal problems become located in the group process and become recognizable by all group members. By hearing how others express their emotions verbally, by learning how others manage to deal with the aftermath of trauma through reflection rather than action, many clients become capable of using similar manoeuvres to deal with their own helplessness and pain.

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examination of groups negative transference much easier.

2.10: The Unique therapeutic virtue of the group is the opportunity it provides to experience, explore and work through interpersonal relationships (Pines 1985). The foundation for this is group cohesiveness which is determined by how safe individual members feel with each other (Scheidlinger -1982). The task of the group leader (therapist) is primarily to be a facilitator of group cohesiveness rather than a provider of psychotherapeutic attention to individuals.

He must create an environment where the members can explore their relationship with each other and with the leader. Focus on extra group issues usually promotes intellectualization and idealization inhibits the sharing of affects, promotes regression and leads to competition for the leader's attention. In contrast, a focus on intragroup issues usually promotes cohesiveness.

2.11: Group psychotherapy re-establishes a peer group in which sharing and reliving of common experiences may facilitate entrance into a world of adult relationships where others can be regarded as both subjects and objects. By experiencing the effect of others on themselves and vice versa, clients can learn to modulate their responses to others according to today's requirements rather than the demands of past trauma. This allows them to resume the process of growing to emotional maturity which was arrested by trauma.

2.12: Most therapeutic groups are of a maximum of 20 persons and are better matched for age, sex and psychological trauma types. To avoid scape-goating, other variables such as religion, language and race may be discriminants for group formation.

2.13: Leader - less groups such as the Vietnam veterans "rap" groups have been originated. They tend to be support groups with no specific tasks. Their therapeutic purposes are doubtful.

TESTIMONY METHOD OF POST-TRAUMATIC THERAPY

1. OBJECTIVES:

Familiarize the trainees with the above method used to help victims go through their traumatic experiences.

2. DEFINITION:

Testimony comes from Latin TESTIMONY "TESTIS = WITNESS", "MONY = FORMING". A client is encouraged to describe what he/she witnessed in as much detail as possible as if he/she were making a testimony. The testimony method in post-traumatic therapy was developed in CHILE, as a result of experiences with victims of the military dictatorship there (Cienfluego & Monelli, 1983). It has also been used by some in treating torture survivors (Agger & Jensen, 1990).

3. AIMS:

This method is aimed at helping the victim to assimilate the experience of TRAUMA and to work towards a restoration of self-esteem. Fragmentary experiences become integrated in the life story and the client gets a total picture of what happened to him or her.

- By expressing trauma events and related emotions through the compilation of the testimony, the client breaks the feeling of extreme helplessness often experienced by trauma survivors. According to Monelli (1983) and Cienfluego, this approach is effective because it provides the possibility of channelling aggression in the form of a charge or indictment: As the suffering has been symbolized in a different form {a written testimony for instance} and the importance of that experience has been recognized by the therapist, the need to express that suffering through somatic complaints often disappears or lessens in frequency.

4. METHOD

It is important to begin with birth and go right through the survivor's personal history and that of the person's family. In this way, traumatic experiences are part of an individual's life; they are not the whole story, nor the only story:

- (a) The client's personality and the way in which he or she coped with previous trauma are assessed.
- (b) The client is asked to describe in detail what he/she went through, he or she is also encouraged to express related emotions.
- (c) What the client says is recorded, transcribed by the therapist and the text is discussed with him or her.

NB: The testimony can be directly written by the client or the therapist or not written

5. RESULTS:

The success is largely depending on:-

- The client motivation
- The client coping skills

Good results have been found in:

- a. People who know exactly what they want to talk about and realize that it is important to talk about it.
- b. Those who still experience oppression as a result of their present situation.
- c. People with little education, not accustomed to talk about themselves and their emotions. (**Case of Chile**)

NB: The method has been less useful in case of highly educated people, able to write down their stories themselves (**E. Lira 1986**)

Testimony is said to be best when carried out in family units or social units especially in case of generalized trauma. When done in groups, this may stimulate others who are shy or fear to tell out their suffering.

6. **CONFESSION:**

By confessing, the person expresses what he/she did wrong; acknowledges the fault either in public or to a confessor. This method would be beneficial if used by the perpetrator. Little is known on the therapeutic effect of confession.

Methods similar to testimony have also been proved to be successful in survivors of sexual torture.

7. **OTHER USE:**

Testimony is broadly used in religious institutions whereby a person tells out what he/she went through. It is mainly in what is called "INNER HEALING" when the person expresses the traumatic experiences as well as related emotions to a pastor/priest or to a group of people. Several people claim to be relieved especially when they are asked to forgive.

8. **CONCLUSION:**

Since trauma has been generalized in Rwanda, and taking into consideration the introvert nature of most Rwandese; this method or similar ones are to be encouraged for the following reasons:-

- (a) It is appropriate for people with little education
- (b) It does not require highly trained therapists
- (c) It can be done on self-help groups up-country and would reach many people

PHYSICAL TREATMENT IN P T S D

OBJECTIVES

DISCUSS:

1. **PSYCHOPHARMACOLOGY IN P.T.S.D.**
2. **BENZODIAZEPINE USE**
3. **NORADRENERGIC BLOCKADE**
4. **TRI-CYCLIC ANTIDEPRESSANT USE**
5. **M.A.O.I. USE**
6. **LITHIUM CARBONATE AND CARBAMAZEPINE USE**

PSYCHOPHARMACOLOGY OF P.T.S.D

a. INTRODUCTION: Psychotherapy is rarely helpful as long as the P T S D patient continues to respond to contemporary events and situations with a continuation of physiological emergency reactions as if relieving the trauma. The three functions of psychotherapy - remembering, working through, putting in perspective, can not proceed as long as the patient is unable to tolerate feelings associated with the trauma and continue to experience emotionally stimulating events as an unmodified recurrence of trauma. (Kolb -1987). Therefore psychotherapy often must be supplemented with medications that decrease the anxiety accompanying the recurrent intrusive re-experiencing of affective or cognitive elements of trauma.

b. CLINICAL REPORTS: These have claimed success for every class of psychoactive medication tried in the management of P T S D. Benzodiazepines (Kalk, 1983) tricyclic antidepressants (Burnstein, 1984) monoamine oxidase inhibitors (Kalk 1983, Hogben, 1981, Levenson 1982) Lithium carbonate (Kalk 1983) beta adrenergic blockers (Kolb, 1984) Clonidine (Kolb, 1984) and antipsychotic agents have all been tried.

c) BENZODIAZEPINES reduce anxiety due to their effects on the C.N.S GABAERGIC system which has a central inhibitory effect. They decrease new learning in humans by blocking anxiety in response to aversive stimuli (Carlton 1981). Hence patients maintained on these drugs for a long time are less capable of learning from unpleasant experiences. These drugs also improve sleep, decrease nightmares and may decrease self medication with alcohol. Most traumatized patients prefer Diazepam because of its rapid absorption (peak activity in 20 min after oral administration). However this rapid onset may lead to abuse. Lorazepam and Oxazepam are slower in onset of action and have shorter half lives, hence have less abuse potential. Clonazepam may have special advantages in modulating affective arousal. Benzodiazepines and alcohol have cross tolerance. Hence benzodiazepines are contraindicated in trauma victims with alcohol abuse.

d) CLONIDINE is known to occupy and blockade alpha 2 receptors in the Locus Coeruleus (LC) in the brain where certain cell bodies manufacture most CNS-NA which is in turn transported through neuronal axons to synaptic clefts in the hypothalamus, limbic system and cerebral cortex.

e) THE BETA-BLOCKERS have a selective sympatholytic action on the peripheral nervous system which reduces the physical manifestation of anxiety.

f) Patients who receive either Clonidine or the beta blockers report a decrease in the startle responses, explosiveness, intrusive reexperiencing and nightmares of the P.T.S.D. The clonidine dose ranges between 0.2 - 0.4 mg per day while that of propranolol is 120 - 180mg/day. Doses as high as 640mg of propranolol have been safely used in hyperactive P.T.S.D. patients who had not responded to other drugs.

g) ANTIDEPRESSANTS are widely used for the treatment of PTSD and appear to be effective in the constricted phase. The tricyclic antidepressants are reputed to be effective in post-traumatic nightmares. Monoamine oxidase inhibitors appear to be useful in the constricted phase but worsen PTSD patients who are aggressive and anxious.

h) LITHIUM AND CARBAMAZEPINE are mood stabilizers. Lithium seems to exert control over all the machines that regulate affect and hence its use in mood control. It reduces autonomic hyperarousal as well as alcohol use. Carbamazepine use in P.T.S.D patients has same effects as those of lithium salts. Clinical practice has demonstrated that only those patients who remain in regular individual or group psychotherapy are likely to continue to take their lithium or carbamazepine as prescribed. Many patients prefer the excitement of reliving the trauma to the dull realities of everyday life. Hence the low drug compliance rate in the unmotivated groups.

REHABILITATION

Objective: To enable the trainee to acquire basic knowledge on rehabilitation.

Definition:

Rehabilitation may be defined as re-education or restoration of the person to the fullest physical, mental, social, vocational, and economic usefulness of which the person is capable. It may involve re-education of the person with skills formally acquired but lost, or education with new alternative skills.

PRINCIPLES OF REHABILITATION

Rehabilitation aims to remedy 3 kinds of problems.

- i) Impairments of functions directly due to psychiatric illness e.g persistent hallucinations social withdrawal, underactivity and slowness
- ii) Secondary social disadvantages, such as unemployment, poverty, homelessness , as well as the stigma still attached to psychiatric illness.
- iii) adverse personal reactions, such as low self-esteem, expectations of failure and helplessness.

ASSESSMENT OF PATIENT'S NEEDS

A person with psychological problems evidently has difficulties in various areas of his life.

At the personal level, the person suffers feelings of inadequacy, low self esteem, lack of confidence and feelings of worthlessness.

At the interpersonal level, the patients due to their peculiar behaviour and withdrawal from shared reality suffer social alienation and have difficulties interacting and socializing with other people including those of their own family.

At the work level the patient has lost various skills that are necessary for his effective participation in productive work.

The patient may have lost skills necessary for his chosen occupation or even those of self personal care.

Rehabilitation should not be regarded as the same for all patients but should be tailored to individual needs. It is therefore important to assess each patient in relation to six items.

- i) Persistent symptoms , both positive and negative
- ii) Unusual behaviour especially if likely to be socially disapproved e,g shouting obscenities
- iii) Activities of daily living such as the capacity to wash and dress.
- iv) Occupational skills, or domestic skills such as shopping and cooking.
- v) Personal attitudes and expectations
- vi) the social circumstances to which the patient is likely to return.

After these 6 items have been assessed a rehabilitation plan can be drawn up to suit the individual patient, the plan should specify the following.

- The order in which disabilities will be attended to
- The responsibilities of each member of the clinical team.
- The methods and facilities to be used
- Ways of encouraging the patient to participate, and of rewarding him for doing so.

FACILITIES REQUIRED

Several facilities are required for a rehabilitation programme. They can be divided into

- (a) social
- (b) occupational
- (c) residential

SOCIAL FACILITIES include small and large group psychotherapy, behaviour therapy and social case work with relatives or friends.

OCCUPATIONAL FACILITIES

Include occupational therapy and work rehabilitation in hospital and sheltered workshop, day centres and day hospital in the community.

RESIDENTIAL FACILITIES.

Include hostels, group homes and boarding houses.

OCCUPATIONAL REHABILITATION

Definition:

"Occupation" is defined in the dictionary as calling, employment or engagement.

To "occupy" is defined as to "keep busy or engaged" from the above occupational therapy may be described as "healing through engagement". Classically Occupational Therapy is defined as "A program of selected activities conducted for treatment under medical direction for physical and psychological problems". Occupational Rehabilitation or therapy allows the patient to communicate unconscious psychic reality through the performance of activities. Through activities such as painting, drama, dance and productive work, the patient is able to communicate deep feelings conflicts and turmoils

Apart from offering a channel of self expression, which is cathartic or cleansing, occupational therapy also offers the patient a chance to create something and therefore to raise his/her self esteem and her/his self-confidence. The Patient creates something that can be seen and admired by others and therefore once more feels appreciated, needed and useful.

Through activity the patient also interacts with other people and fall back into the social main stream rather than being isolated and lonely. Occupational rehabilitation also teaches the patient his lost occupational skills, social and self care skills preparing him/her to go back to productive living, which the final goal of rehabilitation.

COMMUNITY PSYCHIATRY

OBJECTIVES

To consider the scope of community psychiatry and discuss how to set up community mental health services.

COMMUNITY PSYCHIATRY

Also called: Community mental health, preventive psychiatry, outreach psychiatry, public Health psychiatry.

This chapter will refer to community mental health.

SCOPE OF COMMUNITY PSYCHIATRY

1. Prevention of mental disorder
2. Treatment of mental disorders at the community level
3. Rehabilitation of people with mental disorder

Community mental health is very important, it is described as the "third psychiatric revolution". The first was the age of enlightenment when people realised that mental illnesses were not caused by witchcraft. The second revolution was as a result of Sigmund Freud who said mental illnesses are linked to the way we were brought up. Now community mental health policies say "mental health services should be decentralized, be accessible and be community run."

WHY COMMUNITY (PSYCHIATRY) MENTAL HEALTH?

Advantages of community mental health include the following:

1. It reduces stigmatization
2. Community participates in the management of mental health programs by providing resources.
3. Is always available, because it is situated near work place, home etc.
4. Due to the proximity, the mental illness are identified early reducing the long term complications of such illnesses.

HOW SHOULD COMMUNITY MENTAL HEALTH BE ORGANIZED?

The community mental health team is comprised of psychiatrists, psychologists, psychiatric social workers, psychiatric nurses and administrative staff. It should have some links with churches, schools etc.

Community mental health team's role is purely to provide expertise; the consultant psychiatrist only provides direct educational activities to the centre and other members of the team provide direct services to the community. The team does community diagnosis through:

- Identifying all mental health needs of the population
- Knowing the available resources
- Involving the local population and prominent figures in planning, decision making.

The community mental health team should respond to all the needs e.g

- Needs of the special groups (elderly and children)
- Emergency
- Rehabilitation after hospitalization
- Surveillance of those discharged into the community

HOW DOES C.M.H. ACHIEVE GOALS (AIMS)

Primary prevention:

By providing ways through which incidences (Onset) of mental disorders are reduced.

(a) eliminating causative agents

- improved nutrition in the community
- prenatal/postnatal counselling to reduce mental retardation
- substance abuse education to youth and parents
- modifying laws e.g. divorce laws so that overall mental hygiene is improved

(b) Reducing risks factors

- genetic counselling for parents
- AIDS awareness

(c) Using social support systems to help people cope

- widow groups
- alcoholic groups
- single mother groups
- preparing people to cope with catastrophies

Secondary Prevention

Being in direct contact with community, early identification of cases is done, early intervention is also done therefore reducing total number of existing cases (prevalence). Experience in the second world war and Korean war showed that treatment of soldiers with combat induced mental disorders resulted in faster recovery if treated in battle field.

Tertiary prevention:

- Involves rehabilitation of patients so that they can achieve their highest level of functioning.

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Tertiary prevention:

- Involves rehabilitation of patients so that they can achieve their highest level of functioning.

- Homelessness is associated with chronically ill patients especially in urban areas, hence need for extensive social support, psychiatric treatment, vocational training
- Should encourage "long term care" to be done by families to avoid institutionalization

KENYAN EXAMPLE

The referral hospital has a community mental health team which does:

1. Domiciliary visits - to provide counselling, treatment and social support to psychiatric patients at their homes.
2. Run in conjunction with city council authorities a centre within a low social economic suburb, where patients have easy access to mental health services.

Participants will be requested to do a community diagnosis and recommend ways of setting up a community mental health service in their respective communities.