

## Course Name : MENTAL HEALTH DISORDERS

Course Description: Mental Health is not merely the absence of mental illness. To the contrary, in order for a person to be mentally healthy, he must portray or clusters some psychological traits. He must be able to harmonize his desires, ambitions, capacities, ideals, attitudes, and conscience in order to meet the demands of life without losing his stability or his touch with reality. Being tolerant and relaxed attitude toward themselves and accept their own shortcomings. Being capable of dealing with most situations that confront them.

Course Objective: Upon completion, the student will use the word concept of mental illness. A term used to define or describe and explain abnormal behavior; related term emotional disorder or personality disorder. Being able to enumerate the two main groups of the mental illness Psychoses and Neuroses. A third group of mental illness, known as behavior disorders has also been classified.

# MENTAL HEALTH

## ANXIETY DISORDERS

Anxiety is defined as a vague, uneasy feeling, the source of which is often nonspecific or unknown to the individual.

### Kinds of Anxiety

- Generalized or "free" floating anxiety
- Separation Anxiety
- Panic Anxiety
- Situational Anxiety

### Defining Characteristics

The defining characteristics of anxiety may be subjective or objective. Subjective characteristics include: increased tension, apprehension, persistent increased helplessness, and feelings of uncertainty,

inadequacy, fear, over-excitability, distress, worry, and impending doom.

Objective characteristics include increased heart rate, dilated pupils, restlessness, insomnia, glancing about, poor eye contact, trembling, facial tension, quivering voice, self-focus, increased perspiration, and expressed concern regarding life events.

#### Related Factors

Related factors include an unconscious conflict regarding essential values or goals of life; threat to self-concept; threat of death; threat to or change in health status, the environment, or interaction patterns; situational or maturational crisis; interpersonal transmission of contagion, and unmet needs.

The most disturbing and difficult condition among the anxiety disorder is "panic disorder." The epidemiology of panic disorder is unclear. It appears that females have it more than males. Distinct periods of intense anxiety last less than an hour. The frequency is twice a week.

In panic disorder, shortness of breath sensations, dizziness, unsteady feeling or faintness (remember, when you are anxious, very often you felt lightheaded), palpitations or tachycardia, trembling or shaking, sweating, choking, nausea or abdominal distress, fear or dying and fear of going crazy.

In the emergency room, you see a young person coming in and claiming that he or she has a heart attack. Fifty percent of all patients with panic disorder you find mitral valve prolapse.

In general, people think that there is an increased sympathetic tone, and of the things that you can test panic disorder with is the infusion of sodium lactate. Seventy percent of people that have panic disorder will get a panic attack on the bed.

People really feel terrible and incapacitated, afraid to go out, and many of them develop a second aspect of panic attack or a good companion of panic attack is agoraphobia. People are afraid to go and be in a place where escape is difficult. They cannot go to bridges, tunnels, public transportation, stand in line; very often they end up being confined to the house. The fear they have very often is to have a panic attack. You treat the panic attack, the agoraphobia goes away.

## How Do You Treat a Panic Attack and Agoraphobia?

Xanax has a strong propensity to develop dependency and severe withdrawal, after you start the treatment with Xanax, put the patient on a tricyclic antidepressant.

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### Social Phobia

Social Phobia: is the feeling of being humiliated when people have attention on you; like performance anxiety. For instance, you and your colleagues give a lecture and you get anxiety. Usually, the anticipatory anxiety is the key here.

Inderal is an excellent medication, it is helpful. You give 20-30 milligrams one hour before the event, that should cover all the social phobia. Generalized anxiety also responds very well to tricyclics.

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### Post Traumatic Stress Disorder

This is the experience of an event that is outside the range of normal human experience. People who get it again like in anxiety disorder, have a higher sympathetic tone.

They have:

Recurrent inclusive recollection of the event (flashbacks).

Recurrent nightmares

Intense distress in situations that symbolizes the event (like an anniversary, people who visit the Vietnam War Monument, in Washington and get flashbacks)

Apathetic

Feelings of detachment or estrangement from others

A global sense of no future

When you see a patient, most of them show up or present all those symptoms.

Irritability and outburst of anger

Difficulty concentrating

Hypervigilance

Exaggerated startle reflex (sometime with the backfiring exhaust of a car, these people can jump to the curve, especially people that were in combat).

The duration has to be at least one month (and as you know most of the people really have it forever). Fifty percent recover spontaneously, but most don't.

The treatment, again as in every anxiety disorder and mood disorder is tricyclics (although some doctors propose MAO Inhibitors).

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#### Obsessive-Compulsive Disorder

Lifetime prevalence is 2% Males equal females in this disorder. Mean age most is 20 years old. Etiology is unknown. They found out that there are lesions or underdevelopment of the caudate nucleus in the basal ganglia. They find the same thing in the retriever dogs (you throw something and they bring it back). They found out that when they give the dogs' "chloripramine" (the treatment of choice for OCD) they stopped retrieving.

What obsessions are:

Just to be brief, obsessions are recurrent and persistent ideas. The patients with OCD know that this is senseless but they cannot stop thinking about it. People think that the caudate nucleus is the brake of the brain, the area of the brain that helps us stop thinking about something and move to another area. It is very interesting, but they lose this and they keep thinking about senseless issues again and again.

Compulsions are repetitive, purposeful, and intentional behaviors that are found in response to obsessions. The most common are "obsessions of contamination" followed by checking.

The treatment of choice is a serotonine enhancer such as prozac, fluoxetine or anaframil (anaframil is better).

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## Psychotic Disorders

In general what is Psychosis:

Psychosis is the "misperception of reality" and it is hallmarked by two separate mechanisms: one, which we call delusions, which are the misinterpretations of the environmental stimuli.

Example: All of you know this is a diet coke a Psychotic Patient may think that this is a special message from somewhere the other aspect is hallucinations which are perceptual phenomena that are not in the environment, in other words, the patient sounds, vision, smell, tactile, taste and hallucinations.

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## Schizophrenia

Although a relatively rare disorder with a prevalence in the general population estimated at about 1%.

Schizophrenia takes a tragic toll because of its chronicity and the severe disability it entails in personal, vocational, and social functioning.

It is a disease of young people, the age of onset is commonly between 18 and 35, many of its victims are unable to establish independent lives, and responsibility for their care commonly falls to public and community institutions that are increasingly unable to provide adequate resources for their care.

## Historical Backgrounds

Partly because of the elusive nature of the Pathophysiology of the disorder, observations made early in this century continue to exert a strong influence on our current views. Emil Kraepelin described Dementia Praecox as an illness of young people that led in most cases to deterioration in intellectual and social function.

Bleulers Monograph the group of Schizophrenia's provided an extensive description of these patients, and incidentally suggested the name for the disorder that is more commonly used today. As indicated in his title, Bleuler was careful to emphasize that the term Schizophrenia included not one but several illnesses. Bleuler thought that Schizophrenia Psychopathology reflected weakening of associated bonds and that loosening of associating could be detected in-patients if one looked

hard enough. He theorized that the other symptoms could be understood in terms of this primary defect.

### Bleuler's Theory

#### Four A's:

- associational loosening
- affective flattening
- ambivalence
- autism: (preoccupation with fantasy over reality)

The German psychiatrist Kurt Schneider described particular symptoms that he felt was of diagnostic importance in schizophrenia when they occurred in sufficient number.

Among these symptoms were delusions of influence and particular hallucinatory experiences such as hearing voices, arguing among themselves or commenting on the patient.

When these symptoms are elicited from patients it is for examiners to agree on their presence (that is, they are reliable).

### Signs and Symptoms of schizophrenia

They are no pathognomonic signs or symptoms of schizophrenia neither laboratory studies nor imaging procedures can establish the diagnosis. At different times in its course, especially at the outset, its symptoms may mimic almost any other psychiatric illness, including drug induced psychoses.

The symptomatology of schizophrenia therefore consists of a varying admixture of two symptom clusters:

One related to the occurrence of episodic psychoses and the other to deterioration in the patient's psychosocial functioning.

Transient and remitting psychoses may arise from a large number of sources, including complications of substance abuse reactions to stress in patients with borderline disorders and intensive care psychoses and may closely resemble a true schizophrenia psychotic episode; however, in these instances, symptoms are rarely sustained for six months, the duration criterion for schizophrenic disorder.

## The Active Phase of the Disease:

In the active phase of the psychosis, the schizophrenic patient usually complains of hallucinations or exhibits delusions. In some cases, when the patient is incoherent or displays disorganized or stuporous behavior, it may be difficult to elicit these symptoms. What is important, is that the symptoms must occur as part of an illness that is sustained for a period of at least six months.

## Types of Schizophrenics:

- Disorganized type: distinguished by frequent episodes of incoherence and blunted, inappropriate, or silly affect.
- The Catatonic type: distinguished by inhibited, stuporous or excited motor behavior.
- The paranoid type: distinguished by persecutory grandiose or jealous delusions (or hallucinations with a similar context)
- The undifferentiated type: the most commonly diagnosed, is distinguished by a mixture of these features.
- Residual Schizophrenia: diagnosed when the patient has a history of schizophrenia but shows chiefly symptoms of the residual phase.

Patients whose illness has lasted six months to two years are called Subchronic, longer than two years is Chronic.

## WEEK 3

### Etiology of Schizophrenia

Researchers attempting to elucidate the pathogenesis of schizophrenia have persuaded a wide variety of approaches. It is hard to think of a discipline that has not been brought to bear on schizophrenia research. Much has been learned about the nature of the disorder, but to date both the cause and the mechanism of the disease remain obscure.

### Research on Genetics

Families are similar in more respects than in sharing a common genetic pool; however, they may share a predisposing psychologic environment.

Twin studies are in theory more specific. Genetic similarities between monozygotic (identical) twins are greater than between dizygotic (fraternal).

#### Biological Factors

##### Neurotransmitters in schizophrenia

The antipsychotic effect of neuroleptics correlates with the ability of these agents to block postsynaptic Dopamine receptors. Inevitably, biology research has focused on the possible role of an increase in dopaminergic activity in the etiology of schizophrenic symptomatology.

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#### TREATMENT OF SCHIZOPHRENIA

The development of techniques for in vitro brain imaging has offered neuroscientists an opportunity to investigate brain structure and function in schizophrenic patients. With CT scans groups of schizophrenics show significantly more lateral and third ventricle enlargement than a group of matched controls. Another common finding is cerebral atrophy.

You have to remember two distinct brain regions: one is the hippocampus and the other one is the frontal lobe.

The hippocampus is involved in what we call the positive symptoms of schizophrenia, which is a cluster of symptoms that is typified by hallucinations and delusions.

#### Treatment of Schizophrenia

##### Medication

- Supportive Psychotherapy
- Milieu Therapy
- Family Therapy
- Social and Vocational Rehabilitation

#### Prognosis and Course

In spite of our best efforts as many as 40% of patients who are fully compliant with medication require hospitalization within two years of their first episode, about 80% of patients who fail to take medication will be rehospitalized in this period. The post hospital setting strongly affects these expectations.

In long-term follow-up studies about 30% of patients' function in the community with mild to moderate impairment and another 30% require institutional or extensive outpatients or institutional support. The remainder falls between these two extremes.

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## DELUSIONAL DISORDERS

The subject that has a delusional disorder has only delusion. The delusion can be one of seven types:

**Erotomaniac**, which is when someone believes that someone influential, is in love with him or her (like in the movie: the Taxi Driver).

**Grandiose delusion**: which again, the person believes that he or she has some special powers or makes a very important discovery.

**Jealous** (used to be called Pathological Jealousy): which again where is the boundary between normal jealousy and pathological jealousy.

**Persecutory delusion or Paranoid delusion**: people who didn't have all the negative symptoms of schizophrenia and just had a paranoid delusion (someone is after me).

**Somatic delusion**: they think that their stomach is rotting inside or their liver has liquefied itself, their blood is turning into water.

Please remember, it starts at around the second, third, or fourth decade of life. It is usually persistent-every time that the tows of this delusion come forward, they become either very anxious or very depressed. There is no good treatment for it, although commonly we treat it with Neuroleptics.

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## **Schizo-Affective Disorder**

Think about it like the name suggests, as a combination between schizophrenia affective disorder and schizophrenia. In other words, these are patients who have had signs and symptoms of schizophrenia, but also have signs and symptoms of affective disorder.

Currently, the thought is that this is more of an affective condition than schizophrenia. It really follows more the genetic basis of affective disorder and more the outcome of affective disorder but it responds to lithium and has really a better outcome than schizophrenia.

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## **Brief Reactive Psychosis**

The brief reactive psychosis has several identifiers. First of all, it always follows a major stressor. The symptoms have to last less than one month and it has an excellent prognosis. It usually responds to neuroleptics. Even in everyday, like when you see people who have had a big trauma and become confused and crazy for a while then goes back to normal life. This example is not at all related to schizophrenia or delusional disorder.

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## **MOOD DISORDERS**

Mood disorder is when you don't know why you are either extremely depressed or extremely happy without any reason- the reason of course is biological.

There are several mood disorders:

- unipolar depression
- Bipolar affective disorder
- dysthymia
- Mania
- hypomania

The hallmarks of mood disorders are:

- Loss of sense of control
- Loss of mood
- Loss of affect

The epidemiology is very important in mood disorders. Unipolar depression has a lifetime prevalence of 6%, female to male ratio 2-1. Its more prevalent among women.

The biology of depression is related to disturbance of regulation of biogenic amines. Primarily norepinephrine and serotonin.

There are sleep abnormalities in depression; primarily decreased REM latency (so the first REM phase comes earlier after you fall asleep).

The first REM period is increased, and increased density of REM. There is too much REM activity in the brain of a depressive patient. Also, disturbances in the immunological system. People that are depressed tend to get more illnesses and people think that the immunological system is compromised in depression.

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### Symptoms of Depression:

First of all it has to last at least two weeks. Anhedonia-the inability to feel pleasure changes in appetite and weight, psycho-motor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate or indecisiveness. Pseudo dementia happens in depressed patients. Depressed patients very often present the same "I don't know what happened to me," "I cannot think anymore," "I don't remember anything," and so on.

How to differentiate the Pseudodementia depression from real dementia? First of all, the pseudo-dementia corresponds one to one with a depressive episode. The patients who are truly demented go through great length to deny it. They may bump against the walls in their own house and still insist on driving.

People who have Pseudo-dementia are more vocal about it and complain about it all the time ("Doctor, I don't know what's happening to me, I don't feel well, cannot think, I lost my memory").

Ten percent of depressed patients have psychotic depression. In other words, the entire above plus a delusion and hallucinations. And this is best treated with neuroleptics and antidepressants.

The melancholic type is somewhat more severe form of depression.

The three important elements:

- It is worse in the morning
- Significant anorexia and weight loss
- Early morning awakening

### BIOLOGIC THEORIES

-Biogenic Amines

Metabolic products of both noradrenaline (NA) and serotonin (5HIAA) 5 hydroxy indoacetic acid are decreased in the urine in-patients with severe depression.

There is evidence that depressed urinary 5HIAA may be a predictor of suicide potential.

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### **Major Depressive Disorder**

The diagnosis of major depressive disorder requires several factors. The first is a dysphoric mood that is "prominent and persistent."

#### **Symptoms:**

Changes in appetite sleep habits, easy fatigue difficulty in concentration, and feelings of helplessness.

The latter may lead the patient to complain (often with some truth) that he is no longer able to function at home or at work with his usual degree of effectiveness close inquiry may reveal that reduced feelings of interest or pleasure of lowered self-esteem are the cause rather than the result of his impairment. Close inquiry about feelings about suicidality-either suicidal preoccupation's or actual attempts is an essential part of the history in these cases.

This cluster of findings is almost always accessible on interview once a trusting relationship has been established. If a sufficient number of such symptoms are sustained over a significant period of time, it requires that four of these symptoms to be present at least daily over a two-week period; the degree of depression justifies considering the Dx.

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### **Bipolar Affective Disorder**

Tend to occur in the third or fourth decade in some patients, depressed episodes are interspersed with relatively sustained periods of elevated mood. At times, the low mood status may alternate within a single episode so rapidly that they appear admixed.

Although this set of circumstances is relatively rare. It appears in about 3% of depressed patients-it is striking and has captured the public imagination. In the lay mind, all major depressions and many minor mood swings are referred to as manic-depressive.

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## **Mania**

Is the opposite of depression; so you can be manic for half a day (it's okay); you're still considered manic.

## **Characteristics**

Persistent, elevated, expansive or irritable mood. Inflated self-esteem or grandiosity, decreased need for sleep, more talkative or pressured to speak, flight of ideas or racing thought, destructibility, psychomotor agitation, excessive involvement in pleasurable activities (usually with harmful consequences like indiscriminate sex, shopping sprees or writing to your boss and telling him what you really think about him). The mood impairment has to be severe enough to cause either social or occupational impairment or both. If it's not severe enough, then it is called hypomania. And that is the only difference between hypomania and mania.

Unipolar depression, as it says is only depression (recurrent depressive episodes). Bipolar depressions, you have to have a manic episode.

## **Prognosis**

Fifty percent of the people with unipolar depression recover. Bipolar has a poorer prognosis and only 7% recover. Laying in bed waiting to kill yourself and two months in a year you are engaged in indiscriminate sexual behavior, you want to spend all your money is typical.

## **Treatment**

The treatment is very simple. For depression, you gave antidepressants- nothing could be simpler. For the fluctuation in the mood, we usually give lithium.

