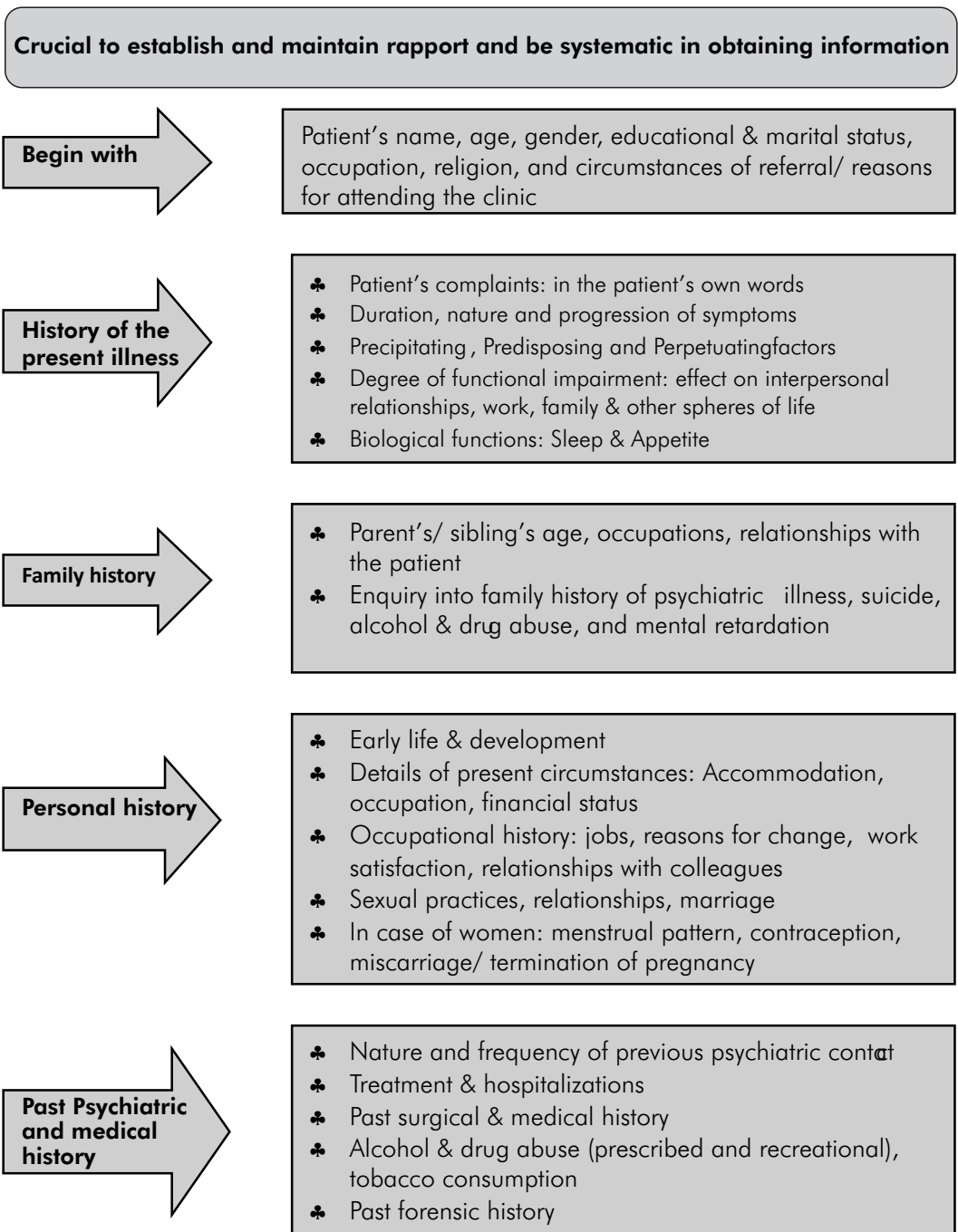


It has been demonstrated that a short-term training of General Medical Practitioners/Medical Officers can result in improvement in their skills to identify, manage and refer the psychiatric patients visiting them. The main role of GPs/MOs include: Identification, Management, Referral & Rehabilitation and follow up care of psychiatric patients.

ASSESSMENT OF PSYCHIATRIC PATIENTS:

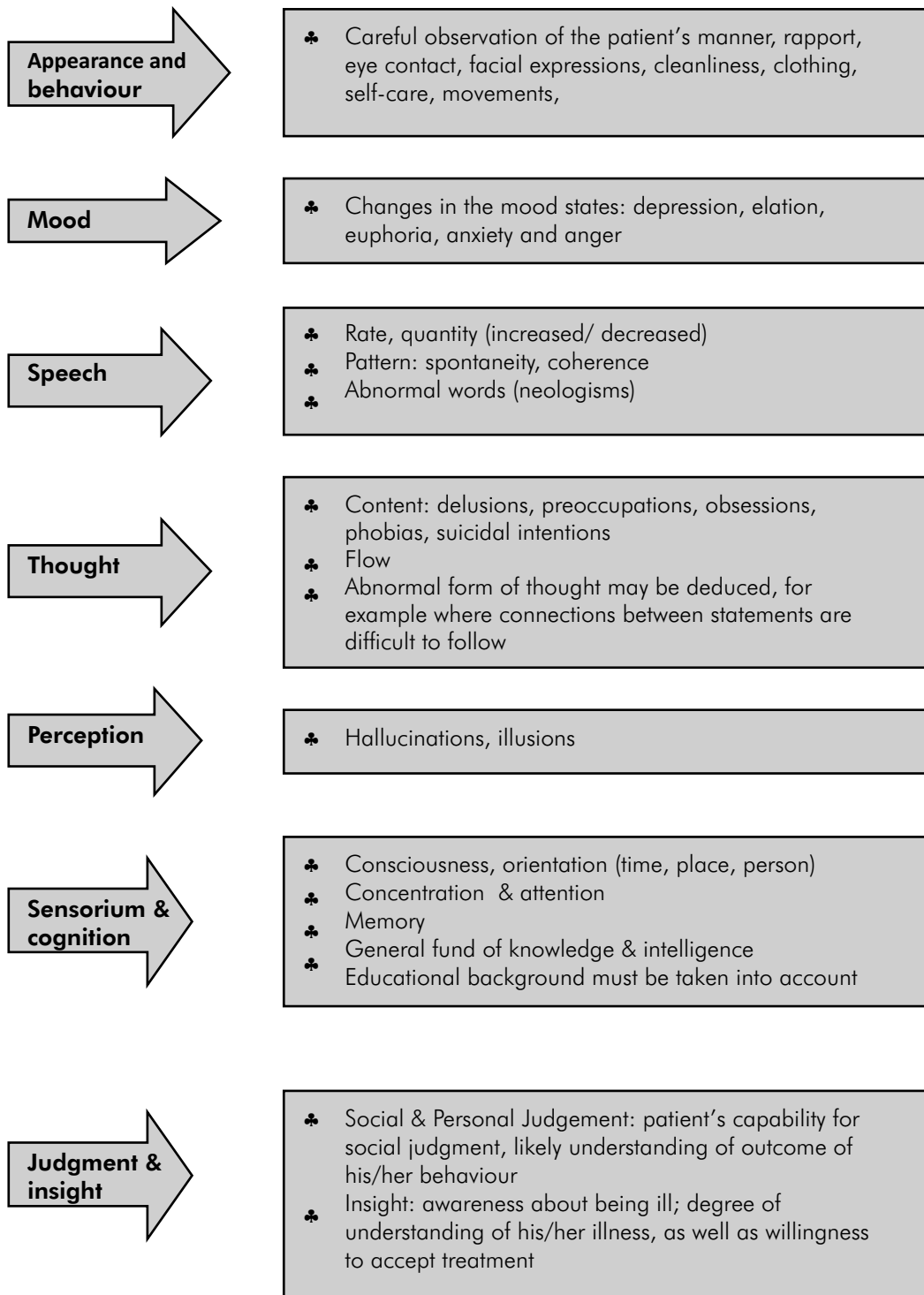
THE HISTORY TAKING

The history taking includes details of family and personal life and patient's personality assessment.



Mental State Examination in Psychiatric assessment of a person is as important as Physical Examination in a general medical condition.

MENTAL STATE EXAMINATION



SYMPTOMS OF PSYCHIATRIC ILLNESSES

The patients may present with psychological symptoms. The possible diagnoses are as follows:

Delirium, Dementia: Alterations in consciousness, orientation, concentration or memory difficulties etc.

Drug Abuse or Dependence: Craving for or abnormal behavior to acquire addictive substances like tobacco, alcohol, opioids, cannabis, etc.

Psychosis: Odd behavior like wandering aimlessly, aggression, violence, unexplained anger, muttering to self, smiling inappropriately, illogical speech, delusions or hallucinations etc.

Depression: Sadness of mood, hopelessness, helplessness, worthlessness, inability to derive pleasure, easy fatigability etc.

Mania, Bipolar Disorder: Elevated mood, hyperactivity, big talks or big spending etc.

Anxiety Disorders: Obsessions, compulsions, 'ghabrahat', fears, restlessness, agitation etc.

Sex Related Disorders: Sexual problems related to gender identity, sexual orientation, desire, erections, orgasms or perverse sexual behavior etc.

Others: Attention deficit/hyperactivity, impulsivity, difficulty in learning Maths & other subjects, academic decline, stuttering, bed-wetting, lying, stealing, running from school, problems with relationships, school refusal, Malingering, Compulsive behaviours like shopping, gambling, stealing or hair pulling, prolonged grief reactions, personality problems beginning in adolescence, stress, repeated attempts at self-harm, mood symptoms before periods, etc.

The patients with psychiatric illnesses may present with somatic symptoms. The possible diagnoses are as follows:

Depression or Anxiety Disorder: Weakness, low energy, vague aches and pains especially headaches, Panic, strange sensations, "ghabrahat", irritability, tearfulness, etc

Conversion Disorders ("Hysteria"): Pseudo-seizures, motor or sensory deficits, patchy memory lapses, etc

Somatoform Disorders: Multiple pain symptoms, vomiting, diarrhea, genitor-urinary or menstrual disturbances, etc.

Eating Disorders: Eating too little, or excessively with induced vomiting, etc.

Sleep Disorders: Sleeping more, or less, sleepwalking, nightmares, etc

MANAGEMENT OF PATIENTS WITH PSYCHIATRIC ILLNESSES:

- Determine the goals of treatment for the affected persons and create a management plan that respects their preferences for care (also those of their carer, if appropriate).
- Devise a plan for treatment, continuation and follow-up, in consultation with the person.
- Inform the person of the expected duration of treatment, potential side-effects of the intervention, any alternative treatment options, the importance of adherence to the treatment plan, and of the likely prognosis.
- Address the person's questions and concerns about treatment, and communicate realistic hope for better functioning and recovery.
- Continually monitor for treatment effects and outcomes, drug interactions (including with alcohol, over the-counter medication and complementary/traditional medicines), and adverse effects from treatment, and adjust dosages accordingly.
- Facilitate referral to specialists, where available and as required.
- Make efforts to link the person to community support.

- At follow-up, reassess the person's expectations of treatment, clinical status, understanding of treatment and adherence to the treatment and correct any misconceptions.
- Be sensitive to social challenges that the person may face, and note how these may influence the physical and mental health and well-being.
- Where appropriate, involve the carer or family member in the person's care.
Encourage involvement in self-help and family support groups, where available.
- Identify and mobilize possible sources of social and community support in the local area, including educational, housing and vocational supports.
- For children and adolescents, coordinate with schools to mobilize educational and social support, where possible.
- Pay special attention to national and international human rights standards

COMMON PSYCHIATRIC ILLNESSES

DEPRESSION

Depression is a mood disorder characterized by persistent sadness. It may be recurrent or chronic in few cases. It causes significant impairment in overall functioning and disability.

Causes: It is a biopsychosocial illness, currently understood as a neurochemical disturbance in the brain neurotransmitters (serotonin, norepinephrine and dopamine). Life stressors or drug abuse may precipitate or worsen the illness. Those with positive family history for depression have higher chances of getting the disorder.

Clinical features & Diagnosis: persistent low mood, decreased interest in previously pleasurable activities & easy fatigability are cardinal features of depression. There may also be feelings of guilt and unworthiness, hopelessness, poor concentration and death wishes or a suicidal risk in the patient. Sleep and appetite are usually decreased but may be increased in few atypical cases. Symptoms should be present for at least 2 weeks to warrant diagnosis. Illness may be of mild to severe grade. Patient may have suicidal behavior or psychotic symptoms or retardation of psychomotor activity in severe illness. The overall socio-occupational functioning is affected in depression. In some cases depression may be recurrent and in others may be followed by episodes of mania/ hypomania, the latter case is then diagnosed as Bipolar illness.

Management:

1) Psychotherapy: trying to address the patients depressive cognitions and restructure them by CBT (cognitive behavior therapy) or addressing interpersonal stresses in IPT (interpersonal therapy), or supportive psychotherapy. In mild cases many times it is treatment of choice.

2) Antidepressant medication: these correct the neurochemical disturbance said to be causative of depression. They may be given in all grades of depression and improve features of depression in 4-6 weeks. Many classes of antidepressants are available but SSRIs (Specific Serotonin Reuptake inhibitors) are most commonly prescribed as first line treatment. Drugs like Fluoxetine and Escitalopram are included in this group. Other drugs include SNRIs (Serotonin Norepinephrine Reuptake Inhibitor), Bupropion and Mirtazapine. TCAs (Tricyclic Antidepressant) are used less frequently now due the availability of other drugs with less side effects. Antidepressants are given for a period of at least 6 months to 1 year to prevent relapse and for longer periods in recurrent or more severe cases.

3) Electroconvulsive Therapy (ECT) may be required in very severe, treatment resistant or high risk suicidal cases.

Relevance to public health: Depressive disorders have a very high prevalence in the community (20-25%). They are considered to have the highest rank in global burden of diseases (higher than cardiovascular disease or infections). There is a significant loss of productive life years in patients suffering from depression along with a risk of suicide and self harm. Around 15% of depressed patients attempt suicide. All these reasons make its treatment important and necessary.

ANXIETY DISORDER

This is a group of disorders namely Phobias, Panic disorder, Obsessive Compulsive Disorder (OCD), Generalized Anxiety Disorder & Post-Traumatic Stress Disorder (PTSD) etc. All these disorders have distinct clinical features but pathological anxiety is common in all.

Clinical Features & Diagnosis:

1. Phobias are characterized by excessive fear and avoidance of any particular object or situation, e.g. Claustrophobia- fear of closed spaces, Agoraphobia- fear of going away from home and being unable to find help, Social phobia- fear of social situations & excessive scrutiny by others.
2. Panic disorder are characterized by recurrent acute attacks of disabling anxiety coupled with autonomic symptoms like breathlessness, palpitations, sweating & an impending sense of doom. These attacks are not situation specific.
3. In Generalized anxiety disorder the patient has free floating anxiety triggered by everyday benign life situations and experiences constant muscular tension and worry.
4. OCD includes obsessions which are recurrent, intrusive thoughts or images that are found inappropriate & difficult to resist by the patient and are often accompanied by Compulsions which are behaviors that the patient feels he must do to decrease his anxiety . Symptoms should last for at least 2 weeks to make diagnosis of OCD.
5. PTSD occurs after a severely traumatic life event in which there has usually been a threat to life like a natural disaster, rape or war. Symptoms may occur anywhere between a few weeks to years after the event and include recurrent flashbacks and nightmares of the event with avoidance of talking about the event, emotional numbing, autonomic symptoms and depressive features.

Cause: Changes in serotonin and norepinephrine (neurotransmitters) transmission in the brain are currently understood to cause anxiety disorders. These changes may be triggered by life events in some cases.

Management:

1. Psychotherapy – cognitive behavior therapy is found to be as useful as drugs in milder cases. Other forms of psychotherapy, relaxation therapy, Yoga and meditation are found useful in addition to pharmacotherapy.
2. Pharmacotherapy: SSRIs are first line treatment in most anxiety disorders e.g. paroxetine, sertraline etc. SNRIs like venlafaxine are also effective. Benzodiazepines like diazepam, clonazepam and alprazolam are effective short term treatment. In OCD a combination of psychotherapy and pharmacotherapy is beneficial.

Relevance to public health: Anxiety disorders are one of the most common psychiatric disorders. They have a very high prevalence in the society. They cause significant distress and dysfunction to the patient and affect healthy, productive community living. They are commonly comorbid with alcoholism and depression. Lifestyle modifications go a long way in prevention and management of anxiety disorders.

PSYCHOSIS

Psychosis is a major psychiatric illness. Psychosis is a disorder of thought and perception. It includes two categories:-

- 1) Organic psychosis, which occurs due to brain disease or is a result of abuse of substances like alcohol or cannabis.
- 2) Functional psychosis, which is a primary psychiatric disorder and includes Schizophrenia, affective psychosis (bipolar disorder) and acute psychosis.

Clinical features & Diagnosis:

The clinical features of psychosis include:

- 1) Delusions or fixed false beliefs e.g. believing that others are trying to harm one.
- 2) Hallucinations i.e. perceptions without corresponding stimuli for e.g. Hearing voices of someone talking about oneself.

3) Disorganized behavior or speech e.g. laughing without reason or talking incoherently.

4) Violent behavior, poor self care and impaired socio-occupational functioning.

These features would be of short duration in acute psychosis (<1 month) & longer duration in schizophrenia (> 1 month).

Clinical features of bipolar disorder include: episodes of mania or depression. Mania characterized by over activity, over talkativeness, decreased need for sleep and big talks for a period of at least 1 week. Patient may be violent and disruptive.

Cause: Although the etiology is uncertain, it is said to be multi-factorial. Currently the “hypersensitive dopamine (neurotransmitter) system” of the brain is implicated. A positive family history increases risk.

Management:

a) Pharmacotherapy is the mainstay of treatment. In the acute phase of treatment, psychotic symptoms improve with the use of antipsychotics. Older drugs (typical antipsychotics) like haloperidol and newer drugs (atypical antipsychotics) like olanzapine or risperidone may be given orally. Atypical antipsychotics are the treatment of choice due to better tolerability. At times injectable antipsychotics may be required to control agitation.

For management of bipolar disorder mood stabilizers like lithium or sodium valproate are indicated and antipsychotics may be given additionally. Benzodiazepines like clonazepam may be given to control agitation. Following the acute phase of treatment the patient is then maintained on the antipsychotic for longer periods in cases of schizophrenia as compared to acute psychotic disorder. Patients of bipolar disorder are maintained on mood stabilizers. The maintenance drug regimens are primarily aimed at relapse prevention.

b) ECT may be required for treatment resistant or severely suicidal cases.

c) Adjunctive psycho- education and psychotherapy should be done in all cases.

Relevance to Public Health: with a prevalence rate of around 3%-8% percent, psychotic disorders are important as they cause significant psychological and economic burden to the society. Such patients lead less productive lives and are often shunned by others in the community. The society should make an effort to decrease the stigma associated with such patients.

SUBSTANCE USE DISORDERS (DRUG ABUSE)

Introduction

Doctors come across many substance uses related health problems like acid/peptic disease, liver diseases, peripheral neuropathy, accidents and injuries, intoxicated behavior, memory deficits and drug abuse related abnormal behavior.

Why do some people become addicted while others do not? No single factor can predict whether a person will become addicted to drugs. Risk for addiction is influenced by a combination of factors that include individual biology, social environment, and age or stage of development. The more risk factors an individual has, the greater the chance that the person will become dependent. Risk factors include:

- **Genetic.** The genes that people are born with—in combination with environmental influences—account for about half of their addiction vulnerability. Additionally, gender, ethnicity, and the presence of other mental disorders may influence risk for drug abuse and addiction.
- **Environment.** A person's environment includes many different influences, from family and friends to socioeconomic status and quality of life in general. Factors such as peer pressure, physical and sexual abuse, stress, and quality of parenting can greatly influence the occurrence of drug abuse and the escalation to addiction in a person's life.

Genetic and environmental factors interact with critical developmental stages in a person's life to affect addiction vulnerability. Although taking drugs at any age can lead to addiction, the earlier that drug use begins, the more likely it will progress to more serious abuse, which poses a special challenge to adolescents. Because areas in their brains that govern decision making, judgment, and self-control are still developing, adolescents may be especially prone to risk-taking behaviors, including trying drugs of abuse. Tobacco intake in adolescents is the gateway to future drug abuse.

Common substances of abuse in India:

- (1) Cannabis (Bhang, Charas, hashish, Ganja) (2) Alcohol (3) Opioids like Heroin/Smack, spasmoproxyvon capsules, morphine, Codeine containing cough syrups (4) IV drugs like Avil injections, Buprenorphine injections (5) Stimulants (Amphetamines) (6) Hallucinogens (LSD, Ecstasy, Ketamine) (7) Cocaine (8) Tobacco (smoke & smokeless forms).

Features of abuse or dependence:

The following features can be identified in those with drug dependence:

1. Craving: irresistible desire to take the substance.
2. Loss of control.
3. Tolerance: A specified amount of alcohol/drug intake fails to give the required effect and the person increases the amount or switches to stronger drugs.
4. Progressive neglect of family, work and social responsibilities.
5. Deterioration of his moral and ethical standards.
6. Neglect of alternative methods of recreation.
7. Physical & Mental health problems.
8. Withdrawal symptoms: On stopping use or delay in intake symptoms like craving, tremors of hands, sleeplessness, aches and pains, restlessness, sweating, are reported.

Management:

1. Identification: Thorough clinical history and mental state examination, family interview and screening methods like AUDIT (Alcohol Used Disorders Identification Test) is useful for alcohol dependence.
2. Motivation: Check for motivation of the person to give up drugs. If the individual is willing for treatment, understands the hazards of drug use and if the withdrawal symptoms are not very severe, or there are no severe physical problems, you can start detoxification on an outpatient basis.
3. For detoxification of alcohol dependence, use the following guidelines for calculating the amount of diazepam or chlordiazepoxide required to control withdrawal symptoms. 30 ml of alcohol used requires either 5mg of diazepam or 10 mg of chlordiazepoxide during detoxification. Therefore, if a person is using, let us say 300 ml of alcohol per day, he will require 50 mg of diazepam or 100 mg of chlordiazepoxide on the first day of detoxification which should be gradually reduced and stopped at the end of 10 days. Give Diazepam (50 mg) or Chlordiazepoxide 100 mg in divided doses. Reduce Diazepam 5mg or Chlordiazepoxide 10 mg a day from day 2. In addition, the person should be given vitamins.

The detoxification phase usually lasts for 2 weeks and is followed by long term maintenance treatment.

Relevance to public health: Substance abuse largely affects the adolescent and young adult population which is the most productive group in society, hence its prevention and treatment is of utmost importance.

DEMENTIA

Introduction:

We all tend to get more forgetful as we get older. But dementia is different and is beyond the usual forgetfulness

associated with aging. It is a brain disease which often starts with memory problems, but goes on to affect many other parts of the brain, producing:

- difficulty in coping with day to day tasks.
- difficulty in communicating.
- Changes in mood, judgment or personality.

It is much more common in older people, but can start as early as 40. About 1 in every 20 persons over-65s has dementia and by the age of 80 about 1 in 5 will have some degree of dementia. The clinical picture consists mainly of progressive deterioration of intellectual functions like memory, intelligence and judgment, changes in the personality (behavior pattern), quick fluctuations in the emotional responses and stereotyped repetition of words or actions. As the illness progresses, patient is unable to take care of his personal needs and hygiene. He may develop symptoms like restlessness, sleeplessness, wandering and suspiciousness. Learning new information becomes harder – patient cannot remember recent events, appointments or phone messages. Patient may forget the names of people or places and may struggle to understand or communicate with others. This can make patient frustrated and depressed. Patient may also have paranoid symptoms like ideas of being followed or criticized.

Patients may also develop neurological symptoms like fits, difficulty in speech and motor movement coordination.

Cause:

1. CNS Degenerative Disorders like Alzheimer's disease, vascular dementia, Parkinson's disease, Huntington's disease etc. Alzheimer's disease is the commonest cause. Damaged tissue builds up in the brain to form deposits called 'plaques' and 'tangles'. These cause the brain cells around them to die.
2. CNS infections like tuberculosis, AIDS and cryptococcal meningitis.
3. Repeated trauma to the brain (e.g. in boxers)
4. Alcoholic dementia.
5. Endocrine and metabolic causes (e.g. hypothyroidism, Vit.B 12 deficiency)
6. CNS space occupying lesions like tumors.

About 10% of all dementia are treatable and reversible. Examples include dementia due to syphilis, tuberculosis of the brain, hypothyroidism, vitamin deficiency states, normal pressure hydrocephalus and brain tumors.

Management:

These patients often need investigations and should be referred to a hospital. Treatable conditions after full investigations should be managed on a priority. Counseling of the family members regarding the nature and course of the condition is very important. Tablets of haloperidol in small doses 1.5 to 5 mg, Risperidone 1-2mg, Quetiapine 25-50 mg or Lorazepam 1-2 mg should be given when behavioral symptoms are present. Any person developing psychosis for the first time after the age of 50 years should be investigated for organic psychosis.

Relevance to public health: With increase in life expectancy, the elderly population in our country is growing. Dementia is one of the most debilitating illnesses in the elderly. Dementia patients require support from the family as well as the society.