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Programme : Master of Social Work

Course Title : Mental Health
Course Code : CC-12b

Unit -IV

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Syllabus

Symptoms, Etiology, diagnosis, prognosis and management of

a) Psycho somatic disorder,

b) Personality disorder, Alcoholism, Substance Abuse, Anti social behaviour, Sexual disorder, deviations,

c) Psychiatric problems among children and adolescents

d) epilepsy,

e) Mental retardation.

- Multi-Disciplinary Team Approach in the treatment of psychiatric illness, social workers in mental health settings, roles and functions (day care centers, halfway homes, after care center, rehabilitation center, de-addiction center), Community Psychiatry, Application of Social Work Methods in Mental Health Settings

Paranoid Personality Disorder (PPD)

PERSONALITY DISORDER

- Personality is the **way of thinking, feeling and behaving** that makes a person different from other people.

- An individual's personality is **influenced by experiences, environment (surroundings, life situations) and inherited characteristics**. A person's personality typically stays the same **over time.**
- Personality disorders are different from psychological disorders. Characteristically, the person does not experience them as problems. To the person, they are "Just the way I am."

- Personality disorders are **extreme** personality variations associated with the failure to achieve the universal tasks of establishing a personal identity, forming attachment to others, experiencing intimacy with them, and seeking affiliation.

Types of Personality disorder

There are 10 specific types of personality disorders in the DSM-5-TR. Personality disorders are long-term patterns of behaviour and inner experiences that differ significantly from what is expected.

They affect at least two of these areas:

- Way of thinking about oneself and others
- Way of responding emotionally
- Way of relating to other people
- Way of controlling one’s behaviour

Cluster A: Personality Disorders

People with these disorders often **exhibit odd or eccentric behaviour**

1. Paranoid Personality Disorder
2. Schizoid Personality Disorder
3. Schizotypal Personality Disorder

I. Paranoid Personality Disorder: <u>Mistrust and suspicion</u>

i. A **personality disorder** in which individuals feel that others are out to get them and **cannot be trusted**. Individuals with this disorder show an almost total **disregard** for the rights and well-being of others.

ii. Paranoid personality disorder can be distinguished from Delusional Disorder (persecutory type), Schizophrenia and a depressive disorder or bipolar disorder with psychotic features because, in these disorders, episodes of psychotic symptoms (e.g.**, delusions, hallucinations) are prominent.**

Symptoms of PPD

- Individuals with paranoid personality disorder **are suspicious and distrustful** of others. They think that others do things just to annoy or hurt them, and they read hidden threats or put-downs in the comments of others.
- They **worry** that friends or coworkers are not really **loyal or trustworthy**, and they are reluctant to confide in others because they believe that there is a price to pay when something personal is shared.

- Paranoid people have problems with **anger.** They are easily slighted and **hold grudges**. They find that people say things to attack their character or ruin their reputation, even though it does not seem that way to others.
- Individuals with paranoid personality disorder **read too much into things**, take offense at things that were not meant to be critical, and often try to get back at the person **they believe is attacking them**.

- When involved in a relationship, they often worry that their partner is unfaithful.
- A pattern of being suspicious of others and seeing them as mean or spiteful.
- Often assume people will harm or deceive them and don’t confide in others or become close to them.
- Rules and regulations not for them, and have **Anti-social behaviors**

Etiology

- Research suggests that genetics, abuse and other factors contribute to the development of paranoid personality disorders.
- In the past, some believed that people with personality disorders were just lazy or even evil. But new research has begun to explore such potential causes as genetics, parenting and peer influences.
  - **Genetics:** Researchers are exploring genetic links to aggression, anxiety and fear — traits that can play a role in personality disorders.

Diagnosis of PPD

Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) criteria. A patient must have **a persistent distrust and suspiciousness of others.** This distrust and suspicion are shown by the **presence of ≥ 4 of the following**:

- Unjustified suspicion that other people are exploiting, injuring, or deceiving them
- Preoccupation with unjustified doubts about the reliability of their friends and coworkers
- Reluctance to confide in others lest the information be used against them

- Misinterpretation of benign remarks or events as having hidden belittling, hostile, or threatening meaning
- Holding of grudges for insults, injuries, or slights
- Readiness to think that their character or reputation has been attacked and quickness to react angrily or to counterattack
- Recurrent, unjustified suspicions that their spouse or partner is unfaithful
- Also, symptoms must have begun by early adulthood.

Prognosis of PPD

- PPD is a chronic condition that usually lasts a **person's entire life**.

Treatments- PPD

- PPD is one of the strongest predictors of **aggressive behavior** in a hospital setting.
- **No cure**; treatment can help **manage symptoms** and improve quality of life
- **A combination of psychotherapy, and medication** will help to manage the patients with PPD

II. **Schizoid Personality Disorder (ScPD): Disinterest in others**

1. A personality disorder in which individuals become almost totally detached from the social world(i.e **total isolation**)
2. Schizoid personality disorder is characterized by a **pervasive pattern of detachment** from and **general disinterest** in social relationships and a **limited range of emotions** in interpersonal relationships.
3. Patients with schizoid personality disorder lack interest in other people; they may **not be motivated to change**

Etiology of Schizoid Personality Disorder

Having **caregivers who were emotionally cold, neglectful, and detached** during childhood fueled the **child's feeling that interpersonal relationships are not satisfying.**

Symptoms of Schizoid Personality Disorder

- Patients with SPD seem to have **no desire** for close relationships with other people, including relatives, friends or confidants. They rarely date and often do not marry.
- They prefer **being by themselves**, choosing activities and hobbies that do not require interaction with others (eg, computer games). Sexual activity with others is of little, if any, interest to them. They also seem to experience less enjoyment from sensory and bodily experiences (eg, walking on the beach).

- These patients do **not seem bothered by what others think of them**—whether good or bad. Because they do not notice normal clues of social interaction, they may seem socially inept, aloof, or self-absorbed. They rarely react (eg, by smiling or nodding) or show emotion in social situations.
- They **have difficulty expressing anger**, even when they are provoked. They **do not react appropriately to important life events** and may seem **passive in response to changes** in circumstances. As a result, they may seem to have **no direction to their life.**
- Rarely, when these patients feel comfortable revealing themselves, they admit that they feel pain, especially in social interactions.
- Also, symptoms must **have begun by early adulthood.**

Diagnosis of Schizoid Personality Disorder

Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) criteria, patients must have **a persistent pattern of**

1. **Detachment** from and general disinterest in social relationships
2. **Limited expression** of emotions in interpersonal interactions

This pattern is shown by the **presence of ≥ 4** of the following:

- **No desire for or enjoyment** of close relationships, including those with family members
- **Strong preference** for solitary activities

- Little, if any, interest in sexual activity with another person
- Enjoyment of few, if any, activities
- Lack of close friends or confidants, except possibly 1st-degree relatives
- Apparent indifference to the praise or criticism of others
- Emotional coldness, detachment, or flattened affect

Prognosis of Schizoid Personality Disorder

- Usually doesn't improve over time

Treatment

1. Psychotherapies : CBT
2. Pharmacotherapy
3. Both (1) and (2)

III. Schizotypal Personality Disorder

- Schizotypal personality disorder is characterized by a pervasive pattern of **intense discomfort** with and reduced capacity for **close relationships**, by **distorted cognition and perceptions, and by eccentric behavior**.
- A major thought disorder have more **severe manifestations** and are accompanied by **delusions and hallucinations.**

Diagnosis

- Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) criteria, patients must have

1. A persistent pattern **of intense discomfort** with and decreased capacity for close relationships
2. Cognitive or perceptual distortions and **eccentricities of behavior**

- This pattern is shown by the **presence of ≥ 5** of the following:

1. Ideas of reference (notions that everyday occurrences have special meaning or significance personally intended for or directed to themselves) but not delusions of reference (which are similar but held with greater conviction)
2. Odd beliefs or magical thinking (eg, believing in clairvoyance, telepathy, or a sixth sense; being preoccupied with paranormal phenomena)

1. Unusual perceptional experiences (eg, hearing a voice whispering their name)
2. Odd thought and speech (eg, that is vague, metaphorical, excessively elaborate, or stereotyped)
3. Suspicions or paranoid thoughts
4. Incongruous or limited affect
5. Odd, eccentric, or peculiar behavior and/or appearance
6. Lack of close friends or confidants, except for 1st-degree relatives
7. Excessive social anxiety that does not lessen with familiarity and is related mainly to paranoid fears
8. Also, symptoms must have begun by early adulthood.

Prognosis

- Usually doesn't improve over time

Treatment

- Medications (eg, antipsychotics, antidepressants),
- Cognitive-behavioral therapy, and sometimes supportive psychotherapy.
- Or both

Cluster B: people with these disorders often, exhibit dramatic, emotional , erratic behaviour

1. Anti-Social Personality Disorder
2. Borderline personality disorder
3. Histrionic Personality Disorder
4. Narcissistic Personality Disorder

Anti-Social Personality Disorder

- A personality disorder involving a lack of conscience and sense of responsibility, impulsive behaviour, irritability, and aggressiveness.
- Antisocial personality disorder is characterized by a pervasive pattern of disregard for consequences and for the rights of others.

People with antisocial personality disorder commit unlawful, deceitful, exploitative, reckless acts for personal profit or pleasure and without remorse; they may do the following:

- Justify or rationalize their behavior (e.g.s, thinking losers deserve to lose, looking out for number one)
- Blame the victim for being foolish or helpless
- Be indifferent to the exploitative and harmful effects of their actions on others

- Anti-social personality disorder is more common among **males** than among females
- Anti-social personality disorder has strong **heritable** component.
- Prevalence may decrease with age, suggesting that patients can learn **over time** to change their maladaptive behavior.
- Comorbidities are common.
- Most patients also have **a substance use disorder**, often also have an impulse control disorder, mood disorders, anxiety disorders, gambling disorder, attention-deficit/hyperactivity disorder, or borderline personality disorder.

Etiology of Anti-social Personality Disorder

- Both genetic and environmental factors (eg, abuse during childhood) contribute to the development of antisocial personality
- Disregarding the pain of others during early childhood has been linked to antisocial behaviour during late adolescence.
- The risk of developing this disorder is increased in both adopted and biological children of parents with the disorder.

- If conduct disorder accompanied by attention-deficit/hyperactivity disorder develops before age 10 years, risk of developing antisocial personality disorder during adulthood is increased
- Risk of conduct disorder evolving into antisocial personality disorder may be increased when parents abuse or neglect the child or are inconsistent in discipline or in parenting style.

Symptoms and Signs of Antisocial Personality Disorder

- Patients with antisocial personality disorder may express their **disregard for others** and for the law by destroying property, harassing others, or stealing. They may deceive, exploit, con, or manipulate people to get what they want (eg, money, power, sex). They may use an alias.
- These patients are impulsive; they do not plan ahead or consider the consequences for or the safety of self or others. As a result, they may suddenly change jobs, homes, or relationships. They may speed and drive while intoxicated, sometimes leading to crashes. They may consume excessive amounts of alcohol or take illicit drugs.

- Patients with antisocial personality disorder are **socially and financially irresponsible.** They may change **jobs with no plan for getting another.** They may **not seek employment** when opportunities are available. They may n**ot pay their bills, default on loans, or not pay child support**.
- These patients are often **easily provoked** and **physically aggressive**; they may **start fights or abuse their spouse or partner**. In sexual relationships, they may be **irresponsible and exploit their partner** and be unable to remain monogamous.

- **Remorse for actions is lacking.** Patients with antisocial personality disorder may rationalize their actions by blaming those they hurt (eg, they deserved it) or the way life is (eg, unfair). They are determined not to be pushed around and to do what they think is best for themselves at any cost.
- These patients **lack empathy** for others and may be contemptuous of or indifferent to the feelings, rights, and suffering of others.
- Patients with antisocial personality disorder may be very **opinionated, self-assured, or arrogant**. They may be **charming, voluble, and verbally facile** in their efforts to get what they want.

- These patients are often **easily provoked and physically aggressive**; they may **start fights, abuse, exploit, and irresponsible** to their spouse or partner.
- **Remorse** (feeling of guilt) for actions **is lacking.**
- Patients with anti-social personality disorder may **rationalize** their actions by blaming those they hurt (eg, they deserved it) or the way life is (eg, unfair).

- These patients **lack empathy** for others and may be contemptuous of or indifferent to the feelings, rights, and suffering of others.
- Patients with antisocial personality disorder may be very opinionated, self-assured, or arrogant. They may be **charming, voluble, and verbally facile** in their efforts to get what they want.

Diagnosis of Antisocial Personality Disorder

- Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision, (DSM-5-TR) criteria, patients must have a **persistent disregard for the rights** of others and this disregard is shown by the **presence of ≥ 3** of the following:
  1. **Disregarding the law**, indicated by repeatedly committing acts that are grounds for arrest
  2. **Being deceitful**, indicated by lying repeatedly, using aliases, or conning others for personal gain or pleasure
  3. **Acting impulsively** or not planning ahead

- **Being easily provoked or aggressive**, indicated by constantly getting into physical fights or assaulting others
- **Recklessly disregarding their safety** or the safety of others
- **Consistently acting irresponsibly**, indicated by quitting a job with no plans for another one or not paying bills
- **Not feeling remorse**, indicated by indifference to or rationalization of hurting or mistreating others
- Also, patients must have evidence that **a conduct disorder** has been present **before age 15 years**. (Anti-social personality disorder is diagnosed only in people ≥ 18 years.)

Differential diagnosis

Antisocial personality disorder should be distinguished from the following:

- Substance use disorder: Determining whether impulsivity and irresponsibility result from substance use disorder or from antisocial personality disorder can **be difficult**. Based on a review of the patient's history, including early history, to check for **periods of sobriety**.
- Sometimes antisocial personality disorder can be diagnosed **more easily after a coexisting substance use disorder is treate**d, but antisocial personality disorders can be **diagnosed even when substance use disorder is present**.

- Conduct disorder: Conduct disorder has a similar pervasive pattern of violating social norms and laws, but **conduct disorder must be present before age 15.**
- Narcissistic personality disorder: Patients are similarly exploitative and lacking in empathy, but **they tend not to be aggressive and deceitful** as occurs in antisocial personality disorder.
- Borderline personality disorder: Patients are similarly manipulative but do so to be **nurtured rather than to get what they want** (eg, money, power) as occurs in antisocial personality disorder.

Treatment of Antisocial Personality Disorder

1. Contingency management: Giving or withholding what patients want depending on their behaviour may be of limited benefit
2. Medications in selected cases: selective serotonin reuptake inhibitors

- There is no evidence that any particular treatment leads to long-term improvement

Borderline Personality Disorder (BPD)

- Borderline personality disorder is characterized by a pervasive pattern of **instability and hypersensitivity** in interpersonal relationships, instability in self-image, extreme mood fluctuations, and impulsivity.
- Patients with BPD have an **intolerance** of being alone; they make frantic efforts **to avoid abandonment** and generate crises, such as making **suicidal gestures** in a way that invites rescue and caregiving by others.

Etiology of Borderline Personality Disorder

- A childhood history of **physical and sexual abuse, neglect, separation from caregivers, and/or loss of a parent** is common among patients with borderline personality disorder.
- Certain people may have a **genetic tendency** to have pathologic responses to environmental life stresses, and borderline personality disorder clearly appears to have a heritable component.

Symptoms of Borderline Personality Disorder

- When patients with orderline personality disorder feel that they are being **abandoned or neglected, they feel intense fear or anger.** They think that this abandonment means that they are bad. They fear abandonment partly because they do not want to be alone.
- These patients tend to **change their view of others abruptly and dramatically**. They may idealize a potential caregiver or lover early in the relationship, demand to spend a lot of time together, and share everything. Suddenly, they may feel that the person does not care enough, and they become disillusioned; then they may belittle or become angry with the person.

- Patients with borderline personality disorder can **empathize with and care for a person** but only if they feel that **another person will be there for them whenever needed.**
- Patients with this disorder have **difficulty controlling their anger** and often **become inappropriate and intensely angry**. After the outburst, they often **feel ashamed and guilt**y, reinforcing their feeling of being bad.

- Patients with borderline personality disorder may also **abruptly and dramatically change their self-image**, shown by **suddenly changing their goals**, **values, opinions, careers, or friends**.. They often feel **empty inside.**
- The changes in mood (eg, intense dysphoria, irritability, anxiety) usually last **only a few hours** and **rarely last more than a few days; they may reflect extreme sensitivity to interpersonal stresses.**
- Patients with borderline personality disorder often **sabotage themselves when they are about to reach a goal**. For example, they may drop out of school just before graduation, or they may ruin a promising relationship.

- **Impulsivity leading to self-harm is common**. These patients may **gamble**, engage in **unsafe sex, binge eat, drive recklessly, abuse substances, or overspend**. **Suicidal behaviors, gestures, and threats and self-mutilation** (eg, cutting, burning) are very common. These self-destructive acts are usually **triggered by rejection by, possible abandonment by, or disappointment in a caregiver or lover.** Patients may **self-mutilate to compensate for their being bad, to reaffirm their ability to feel during a dissociative episode, or to distract from painful emotions**.

- Dissociative episodes, paranoid thoughts, and sometimes psychotic-like symptoms (eg, hallucinations, ideas of reference) may be **triggered by extreme stress, usually fear of abandonment, whether real or imagined**. These symptoms are **temporary and usually not severe enough** to be considered a separate disorder. In most patients, **dissociative symptoms lessen over time**, and **the relapse rate is low.** However, functional status does not usually improve as much as the symptoms.

Diagnosis of Borderline Personality Disorder

- Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) criteria patients must have **a persistent pattern of unstable relationships, self-image, and emotions (ie, emotional dysregulation)** and pronounced impulsivity and this persistent pattern is shown **by ≥ 5** of the following:
- Desperate efforts to avoid abandonment (actual or imagined)
- Unstable, intense relationships that alternate between idealizing and devaluing the other person
- An unstable self-image or sense of self

- Impulsivity in ≥ 2 areas that could harm themselves (eg, unsafe sex, binge eating, reckless driving)
- Repeated suicidal behaviour and/or gestures or threats or self-mutilation
- Rapid changes in mood, usually lasting only a few hours and rarely more than a few days
- Persistent feelings of emptiness

- Inappropriately intense anger or problems controlling anger
- Temporary paranoid thoughts or severe dissociative symptoms triggered by stress
- Also, symptoms must have begun by early adulthood but can occur during adolescence.

Differential diagnosis

Borderline personality disorder is most commonly **misdiagnosed as o**ther personality disorders share similar manifestations. This disorder is also characterized by **wide fluctuations in mood and behavior**. However, in borderline personality disorder, mood and behavior change rapidly in response to stressors, especially interpersonal ones, whereas in bipolar disorder, moods are more sustained and less reactive and people often have significant changes in energy and activity.

- **Histrionic personality disorder or narcissistic personality disorder**: Patients with either of these disorders can be **attention-seeking and manipulative,** but patients with borderline personality disorder also see themselves as **bad and feel empty**.

1. **Depressive disorders and anxiety disorders:** These disorders can be distinguished from borderline personality disorder based on the **negative self-image, insecure attachments, and sensitivity to rejection** that are **prominent features** of borderline personality disorder and are **usually absent in patients with a mood or anxiety disorder**.
2. **Substance use disorders:** It may be difficult to determine **whether impulsivity and marked mood changes are due to substance use** disorder or borderline personality disorder.
3. **Posttraumatic stress disorder:** Although many patients with BPD have a history of **trauma,** patients with PTSD have **recurrent symptoms** associated with **reexperiencing the traumatic event as well as increased arousal**, which are not features of borderline personality disorder.

Treatment of Borderline Personality Disorder

- Psychotherapy: Several different psychotherapeutic interventions are effective in reducing suicidal behaviors, ameliorating depression, and improving function in patients with this disorder (1).
- Cognitive-behavioral therapy focuses on emotional dysregulation and lack of social skills. It includes the following:
- Dialectical behavioral therapy (a combination of individual and group sessions with therapists acting as behavior coaches and available on call around the clock)

Systems training for emotional predictability and problem solving (STEPPS):

- STEPPS involves weekly group sessions for 20 weeks. Patients are taught skills to manage their emotions, to challenge their negative expectations, and to better care for themselves. They learn to set goals; avoid illicit substances; and improve their eating, sleeping, and exercise habits. Patients are asked to identify a support team of friends, family members, and clinicians who are willing to coach them when they are in crisis.

Mentalization Effect:

1. Mentalization refers to people's ability to reflect on and understand their own state of mind and the state of mind of others. Mentalization is thought to be learned through a secure attachment to the caregiver. Mentalization-based treatment helps patients do the following:
   - Effectively regulate their emotions (eg, calm down when upset)
   - Understand how they contribute to their problems and difficulties with others
   - Reflect on and understand the minds of others
   - It thus helps them relate to others with empathy and compassion

Transference-focused psychotherapy centers on the interaction between patient and therapist. The therapist asks questions and helps patients think about their reactions so that they can examine their exaggerated, distorted, and unrealistic images of self during the session. The current moment (eg, how patients are relating to their therapist) is emphasized rather than the past. For example, when a timid, quiet patient suddenly becomes hostile and argumentative, the therapist may ask whether the patient noticed a shift in feelings and then ask the patient to think about how the patient was experiencing the therapist and self when things changed. The purpose is

- To enable patients to develop a more stable and realistic sense of self and others
- To relate to others in a healthier way through transference to the therapist

Schema-focused therapy:

It is an integrative therapy that combines cognitive-behavioral therapy, attachment theory, psychodynamic concepts, and emotion-focused therapies. It focuses on lifelong maladaptive patterns of thinking, feeling, behaving and coping (called schemas), affective change techniques, and the therapeutic relationship, with limited re-parenting. Limited re-parenting involves establishing a secure attachment between patient and therapist (within professional limits), enabling the therapist to help the patient experience what the patient missed during childhood that led to maladaptive behavior. The purpose of schema-focused therapy is to help patients change their schemas. Therapy has 3 stages:

- Assessment: Identifying the schemas
- Awareness: Recognizing the schemas when they are operating in daily life
- Behavioral change: Replacing negative thoughts, feelings, and behaviors with healthier ones

- While most types of psychotherapy for borderline personality disorder require **specialized training and supervision**, **"good psychiatric management"** is an approach to patients with borderline personality disorder that is designed for the general clinician. It involves a set of principles and practices that include **individual therapy** once a week; **psychoeducation** about borderline personality disorder, treatment goals, and expectations; and sometimes medications. It focuses on the patient’s reactions to interpersonal stressors in everyday life.
- **Supportive psychotherapy** is also useful. The goal is to establish an **emotional, encouraging, supportive relationship** with the patient and thus help the patient develop healthy defense mechanisms, especially in interpersonal relationships.

- **Medications**: When used, selective serotonin reuptake inhibitors (SSRIs) are usually well-tolerated; risk of a lethal overdose is minimal. However, SSRIs are only marginally effective for depression and anxiety in patients with borderline personality disorder. Other medications that may be used to treat comorbid psychiatric conditions include

1. **Mood stabilizers:** For depression, anxiety, mood lability, and impulsivity
2. **Antipsychotics**: For anxiety, anger, mood lability, and cognitive symptoms, including transient stress-related cognitive distortions (eg, paranoid thoughts, black-and-white thinking, severe cognitive disorganization)

❖**Black-and-white thinking** is a thought pattern that involves viewing situations, people, or concepts in extreme terms, without considering nuances or complexities. Eg: "I am either always right or the world's biggest failure

Histrionic Personality Disorder (HPD)

- Histrionic personality disorder is characterized **by a pervasive pattern of excessive emotionality and attention seeking.**
- Patients with histrionic personality disorder **use their physical appearance, acting in inappropriately seductive or provocative ways, to gain the attention of others.** They lack a sense of self-direction and are highly suggestible, often acting submissively to retain the attention of others.
- Estimated prevalence **is < 2% of the general population**
  - The prevalence in females and males is similar.
  - Comorbidities are common, particularly other personality disorders (antisocial, borderline, narcissistic)
  - Major depressive disorder, persistent depressive disorder, and conversion disorder may also coexist.

Symptoms and Signs of Histrionic Personality Disorder

- Patients with histrionic personality disorder continually demand to be **the center of attention and often become depressed when they are not**. They are **often lively, dramatic, enthusiastic, and flirtatious and sometimes charm new acquaintances.**
- These patients often **dress and act in inappropriately seductive and provocative ways**, not just with **potential romantic interests, but in many contexts** (eg, work, school). Because of their desire to impress others with their appearance, they are often preoccupied with how they look.

- Expression of emotion may be shallow (turned off and on too quickly) and exaggerated. They speak dramatically, expressing strong opinions, but with few facts or details to support their opinions.
- Patients with histrionic personality disorder are easily influenced by others and by current trends. They tend to be too trusting, especially of authority figures who, they think, may be able to solve all their problems. They often think relationships are closer than they are. They crave novelty and bore easily. Thus, they may change jobs and friends frequently. Delayed gratification is frustrating to them, so their actions are often motivated by obtaining immediate satisfaction.
- Achieving emotional **or sexual intimacy may be difficult**. They may try to control their partner using seductiveness or emotional manipulation while becoming very dependent on the partner.

Diagnosis of Histrionic Personality Disorder

- Diagnostic and Statistical Manual of Mental Disorders, 5th Ed, Text Revision (DSM-5-TR) criteria, patients must have: A persistent pattern of excessive emotionality and attention seeking. This pattern is shown by the presence of ≥ 5 of the following:
- **Discomfort** when they are not the center of attention
- Interaction with others that is inappropriately **sexually seductive or provocative**
- **Rapidly shifting and shallow expression of emotions**

- Consistent use of **physical appearance to call attention** to themselves
- Speech that **is extremely impressionistic and vague**
- **Self-dramatization, theatricality, and exaggerated expression of emotion**
- Suggestibility (easily influenced by others or situations)
- **Interpretation of relationships** as more intimate than they are
- Also, symptoms must have begun by **early adulthood**.

Differential diagnosis of <u>Histrionic personality disorders:</u>

- **Narcissistic personality disorder**: Patients with narcissistic personality disorder also **seek attention**, but they, unlike those with histrionic personality disorder, **want to feel admired or elevated by it**
- **Borderline personality disorder**: Patients with borderline personality disorder consider themselves **bad and experience emotions intensely and deeply**; those with histrionic personality disorder do not see **themselves as bad, even though their dependence on the reaction of others may stem from poor self-esteem.**
- **Dependent personality disorder**: Patients with dependent personality disorder, like those with histrionic personality disorder, try to be near others but are **more anxious, inhibited, and submissive** (because they are worried about rejection); patients with histrionic personality disorder are **less inhibited and more flamboyant**.

Treatment of Histrionic Personality Disorder

Psychodynamic psychotherapy

- A type of therapy that focuses on **how a person's unconscious thoughts, feelings, and beliefs impact their behavior**. It's based on the idea that a person's early experiences can relate to their current feelings and actions.
- Psychodynamic psychotherapy, which **focuses on underlying conflicts.**
- Based on the theories of **Sigmund Freud**, but has evolved from the 19th-century model. Other contributors to the field include **Carl Jung, Melanie Klein, and Anna Freud**
- Psychodynamic psychotherapy uses techniques like **dream analysis** to help patients explore their unconscious minds

Narcissistic Personality Disorder (NPD)

- Narcissistic personality disorder is characterized by a **pervasive pattern of grandiosity(impressive/lavish), need for adulation (praise), and lack of empathy**.
- Patients with narcissistic personality disorder have difficulty regulating self-esteem and thus need praise and affiliations with special people or institutions; they also tend to devalue other people so that they can maintain a sense of superiority.
- It is more common among males than females.

Etiology of Narcissistic Personality Disorder

- Limited data about biologic factors that contribute to narcissistic personality disorder suggest there is a **significant heritable component**. Some theories posit that caregivers may not have treated the child appropriately—for example, by being **overly critical or by excessively praising, admiring, or indulgent** of the child.
- Some patients with this disorder have **special gifts or talents** and become **used to associating their self-image and sense of self with the admiration and esteem of others**.

Symptoms of Narcissistic Personality Disorder

- Patients with narcissistic personality disorder **overestimate their abilities and exaggerate their achievements.** They think they are **superior, unique, or special**.
- These patients are preoccupied with **fantasies of great achievements—**of being admired for their overwhelming intelligence or beauty, of having prestige and influence, or of experiencing a great love. They feel they should **associate only with others as special and talented as themselves, not ordinary people.** This association with extraordinary people is used to **support and enhance their self-esteem**.

- Because patients with narcissistic disorder **need to be admired, their self-esteem depends on the positive regard of others** and is thus usually **very fragile.** People with this disorder are often **watching to see what others think of them and evaluating how well they are doing**. They are **sensitive to and bothered by the criticism of others and by failure, which makes them feel humiliated and defeated.** They may **respond with rage or contempt**, or they may **viciously counterattack**. Or they may withdraw or outwardly accept the situation in an effort to protect their sense of self-importance **(grandiosity**). They may avoid situations in which they can fail.

Diagnosis of Narcissistic Personality Disorder

- Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) criteria, patients must have a **persistent pattern of grandiosity, need for admiration, and lack of empathy.** This pattern is shown by **the presence of ≥ 5** of the following:

1. An exaggerated, unfounded sense of their own importance and talents (grandiosity)
2. Preoccupation with fantasies of unlimited achievements, influence, power, intelligence, beauty, or perfect love
3. Belief that they are special and unique and should associate only with people of the highest caliber
4. A need to be unconditionally admired

5. A sense of entitlement
6. Exploitation of others to achieve their own goals
7. A lack of empathy
8. Envy of others and a belief that others envy them
9. Arrogance and haughtiness
    - Also, symptoms must have begun by **early adulthood**.

Differential diagnosis

- Narcissistic personality disorders can be distinguished from the following disorders:
- Bipolar disorder: Patients with narcissistic personality disorder often present with **depression and, because of their grandiosity (unrealistic sense of superiority)** Also, in narcissistic personality disorder, **changes in mood are triggered by insults to self-esteem.**
- Antisocial personality disorder: **Exploitation of others to promote themselves** is characteristic of both personality disorders. However, **the motives are different.** Patients with antisocial personality disorder exploit others **for material gain**; those with narcissistic personality disorder exploit others **to maintain their self-esteem.**
- Histrionic personality disorder: **Seeking the attention of others** is characteristic of both personality disorders. But patients with narcissistic personality disorder, unlike those with histrionic personality disorder, **disdain doing anything cute and silly to get attention**; they wish to be admired.

Treatments- NPD

- Psychodynamic psychotherapy
- Mentalization-based treatment
- Transference-focused psychotherapy
- Cognitive-behavioral therapy

Cluster C: Personality Disorders

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

Avoidant Personality Disorder (AVPD)

- Avoidant personality disorder is characterized by the **avoidance of social situations or interactions** that involve risk of rejection, criticism, or humiliation.
- People with avoidant personality disorder have **intense feelings of inadequacy** and cope **maladaptively by avoiding** any situations in which they may be evaluated negatively.
- avoidant personality disorder affects females more often than males, though the difference is small

- Comorbidities are common. Patients often also have persistent depressive disorder, obsessive-compulsive disorder, or an anxiety disorder
- They may also have another personality disorder. Patients with social phobia and avoidant personality disorder have more severe symptoms and **disability** than those with either disorder alone.

Etiology of Avoidant Personality Disorder

- **Research suggests that experiences of rejection and marginalization during childhood and innate traits of social anxiety and avoidance may contribute to avoidant personality disorder.**
- **Avoidance in social situations has been detected as early as about age 2 years.**

Symptoms of Avoidant Personality Disorder

- Patients with avoidant personality **disorder avoid social interaction**, including those at work, because they **fear that they will be criticized or rejected** or that people will disapprove of them, as in the following situations:
- They may **refuse a promotion** because they fear coworkers will criticize them.
- They may **avoid meetings**.
- They **avoid making new friends** unless they are sure they will be liked.

- These patients **assume people will be critical and disapproving** until rigorous tests proving the contrary are passed. Thus, before joining a group and forming a close relationship, patients with this disorder require **repeated assurances of support and uncritical acceptance.**
- Patients with APD long for social interaction but fear placing their well-being in the hands of others. Because these patients limit **their interactions with people**, they are **relatively isolated** and **do not have a social network**
- These patients are very **sensitive to anything slightly critical, disapproving, or mocking** because they **constantly think** about being **criticized or rejected** by others. They **are vigilant for any sign of a negative response** to them. Their **tense, anxious appearance m**ay elicit mockery or teasing, thus **seeming to confirm their self-doubts**.

- **Low self-esteem and a sense of inadequacy inhibit** these patients in social situations, especially **new ones**. Interactions with new people are inhibited because patients **think of themselves as socially inept, unappealing, and inferior to others**. They are **typically quiet and timid** and try to disappear because they think that if they say anything, others will say it is wrong. They are **reluctant to talk about themselves lest** they be **mocked or humiliated.** They worry they will **blush or cry when criticized.**
- Patients with AVD are **reluctant to take personal risks** or participate in new activities for similar reasons. In such cases, they often **exaggerate the danger**s and use minimal symptoms or other problems to explain their avoidance. They may prefer a limited lifestyle because of their need for security and certainty.

Diagnosis of avoidant personality disorder

- *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (DSM-5-TR), patients must have a persistent pattern of **avoiding social contact, feeling inadequate, and being hypersensitive to criticism and rejection.** This pattern is shown by **the presence of ≥ 4** of the following:
- Avoidance of job-related activities that involve interpersonal contact because they fear that **they will be criticized or rejected** or that people will disapprove of them
- **Unwillingness t**o get involved with people unless they are sure of being liked

- **Reserve** in close relationships because they fear ridicule or humiliation
- **Preoccupation** with being criticized or rejected in social situations
- **Inhibition** in new social situations because they feel inadequate
- **Self-assessment** as socially incompetent, unappealing, or inferior to others
- **Reluctance** to take personal risks or participate in any new activity because they may be embarrassed

    - Also, symptoms must have begun by **early adulthood.**

Differential diagnosis

- Avoidant personality disorder must be distinguished from the following disorders:
- **Social phobia**: Differences between social phobia and avoidant personality disorder are **subtle and hard to distinguish sometimes**. Avoidant personality disorder involves **more pervasive anxiety and avoidance** than social phobia, which is often specific to situations that may result in public embarrassment (eg, public speaking, performing on stage).
- **Schizoid personality disorder**: Both disorders are characterized by **social isolation**. However, patients with schizoid personality disorder become isolated because they are disinterested in others, whereas those with avoidant personality disorder become isolated because they are hypersensitive to possible rejection or criticism by others.
- **Dependent Personality Disorder** by *a need to be cared for in, A*voidant Personality disorder is a*voidance of rejection and criticism in avoidant personality disorder.*

Treatment of Avoidant Personality Disorder

1. Cognitive-Behavioral Therapy focused on social skills
2. Supportive psychotherapy
3. Psychodynamic psychotherapy which focuses on underlying conflicts, may be helpful
4. Anxiolytics and antidepressants

Dependent Personality Disorder (DPD)

- Dependent personality disorder is characterized by **a pervasive, excessive n**eed to be taken care of, leading to submissiveness and clinging behaviors.
- Patients with dependent personality disorder, the need to be taken care of results in loss of their autonomy and interests. Because they are intensely anxious about taking care of themselves, they become excessively dependent and submissive.

Etiology of Dependent Personality Disorder

- Information about the causes of dependent personality disorder is limited.
- **Cultural factors**, **negative early experiences**, and **biological vulnerabilities** associated with anxiety and depression
- **Genetics**
- **Familial traits** such as submissiveness, insecurity, and self-effacing behavior

Symptoms and Signs of Dependent Personality Disorder

Patients with DPD They use submissiveness to try to get others to take care of them; DPD typically require **much reassurance and advice** when making ordinary decisions. For example, they may depend on their spouse to tell them what to wear, what kind of job to look for, and with whom to associate.

- These patients consider themselves inferior and **tend to belittle their abilities**; they take **any criticism or disapproval** as proof of their incompetence, further undermining their confidence.
- It is difficult for them **to express disagreement** with others because **they fear losing support or approval**. They may **agree to something they know is wrong** rather than risk losing the help of others. Even **when anger is appropriate**, they do not get angry at friends and coworkers for fear of losing their support.

- Because they believe **they cannot do anything on their** own, they have **difficulty starting a new task and working independently**, and they **avoid tasks that require taking responsibility**. They present themselves as **incompetent and as needing constant help and reassurance**. When reassured that a competent person **is supervising and approving of them, these patients tend to function adequately**. However, they do not want to appear too competent lest they be abandoned. As a result**, their career may be harmed**. They prolong their dependency because they avoid learning the skills of independent living.
- These patients go to great lengths to obtain care and support (eg, doing unpleasant tasks, submitting to unreasonable demands, tolerating physical, sexual, or emotional abuse). Being alone makes **them feel extremely uncomfortable or afraid** because they fear they cannot care for themselves.

- Patients with DPD tend to interact **socially with only the few people** they depend on. When a close relationship ends, patients with this disorder **immediately try to find a replacement.** Because of their desperate need to be taken care of, **they are not discriminating in choosing** a replacement.
- These patients **fear abandonment** by those they depend on, even when there is no reason to.

Diagnosis of Dependent Personality Disorder

Clinical criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision [DSM-5-TR]) patients must have a persistent, a excessive need to be taken of, resulting in **submissive and clinging** behavior and fears of separation. This persistent need is shown **by the presence of ≥ 5** of the following:

1. Difficulty making daily decisions without an inordinate amount of advice and reassurance from other people
2. A need to have others be responsible for the most important aspects of their life
3. Difficulty expressing disagreement with others because they fear loss of support or approval

Differential diagnosis

- Several other personality disorders are characterized by hypersensitivity to rejection. However, they can be distinguished from dependent personality disorder based on characteristic features, as follows:
- Borderline personality disorder: Patients with this disorder are too frightened to submit to the same degree of control as patients with dependent personality disorder. Patients with borderline personality disorder, unlike those with dependent personality disorder, vacillate between submissiveness and rageful hostility.

Differential Diagnosis

- Avoidant personality disorder: Patients with this disorder are also too frightened to submit to the same degree of control as patients with dependent personality disorder. Patients with avoidant personality disorder withdraw until they are sure they will be accepted without criticism; in contrast, those with dependent personality disorder seek out and try to maintain relationships with others.
- Histrionic personality disorder: Patients with this disorder seek attention rather than reassurance (as do those with dependent personality disorder), but they are more disinhibited. They are more flamboyant and actively seek attention; those with dependent personality disorder are self-effacing and shy.
- Dependent personality disorder should be distinguished from the dependency that is present in other psychiatric disorders (eg, depressive disorders, panic disorder, agoraphobia).

Treatment of Dependent Personality Disorder

- Cognitive-Behavioral therapy
- Psychodynamic psychotherapy
- Antidepressants

Obsessive-Compulsive Personality Disorder (OCPD)

- OCPD is characterized by **a pervasive obsession with orderliness, perfectionism, and control** (with no room for flexibility) that ultimately **slows or interferes** with completing a task.
- In population-based studies it is equally common in males and females.
- Familial traits of **compulsivity, restricted range of emotion, and perfectionism** are thought to contribute to this disorder.
- Symptoms must have begun by **early adulthood.**

Symptoms and Signs of OCPD

- In patients with obsessive-compulsive personality disorder**, preoccupation with order, perfectionism, and control of themselves and situations interferes with flexibility, effectiveness, and openness**. **Rigid and stubborn in their activities, these patients insist that everything be done in specific ways.**
- To **maintain a sense of control**, patients focus on **rules, minute details, procedures, schedules, and lists**. These patients **repeatedly check** for mistakes and pay extraordinary attention to detail. They do not make good use of their time, often leaving the most important tasks until the end. Their preoccupation with the details and making sure everything is perfect can **endlessly delay completion.** They are **unaware of how their behavior affects their coworkers**.
- Patients with OCPD are **excessively dedicated to work and productivity**; their dedication is not motivated by financial necessity. As a result, leisure activities and relationships are neglected. The goal is perfection.
- Expression of affection is also tightly controlled. These patients may relate to others in a formal, stiff, or serious way. Often, they speak only after they think of the perfect thing to say. They may focus on logic and intellect and be intolerant of emotional or expressive behavior.
- These patients may **be overzealous, picky, and rigid** about issues of morality, ethics, and values. They apply **rigid moral principles** to themselves and to others and are **harshly self-critical**
- Symptoms of obsessive-compulsive personality disorder **may improve** over a time but their persistence over time is less clear.

Diagnosis of OCPD

- Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision (DSM-5-TR) criteria, patients must have a persistent pattern of preoccupation with order; perfectionism; and control of self, others, and situations. This pattern is shown by **the presence of ≥ 4 of the following**:
    1. A striving to do **something perfectly** that interferes with completion of the task
    2. **Excessive devotion to work and productivity** (not due to financial necessity), resulting in neglect of leisure activities and friends
    3. **Excessive conscientiousness, fastidiousness, and inflexibility** regarding ethical and moral issues and values
    4. **Unwillingness to throw out worn-out or worthless objects**, even those with no sentimental value
    5. **Reluctance to delegate or work with other people** unless those people agree to do things exactly as the patient wants
    6. **A miserly approach to spending for themselves** and others because they see money as something to be saved for future disasters
    7. **Rigidity and stubbornness**
    8. Preoccupation with details, rules, schedules, organization, and lists

Treatments for OCD

1. **Cognitive Behavior Therapy (CBT)**
2. **Medication**. Medications can only be prescribed by a licensed medical professional (such as your physician or a psychiatrist), who would ideally work together with your therapist to develop a treatment plan.
3. **Exposure and Response Prevention (ERP)**,

Exposure and Response Prevention (ERP),

1. ERP has the **strongest evidence supporting its use in the treatment of OCD**.
2. The **exposure** component of ERP refers to practicing confronting the thoughts, images, objects, and situations that make you anxious and/or provoke your obsessions.
3. The **response prevention** part of ERP refers to making a choice not to do a compulsive behavior once the anxiety or obsessions have been "triggered."
4. All of this is done under the guidance of a therapist at the beginning.
5. Over time, the treatment will "retrain your brain" to no longer see the object of the obsession as a threat.

Alcohol Use Disorder (AUD)

- AUD is a **medical condition** that is characterized by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), as "**a problematic pattern** of alcohol use leading to clinically significant **impairment or distress**."
- AUD can be
    1. mild
    2. moderate
    3. severe
- It depends on the symptoms a patient has experienced in the previous 12 months.
- As AUD progresses in severity, alcohol-induced changes in the **brain can make it very difficult to cut down or quit**.

Symptoms and Diagnosis

1. **Drinking more alcohol or over a longer period** than originally intended.
2. **Unsuccessfully** trying to cut down or control alcohol use.
3. **Craving, or a strong desire or urge** to use alcohol
4. **Drinking that interferes with responsibilities** at home, at work, or at school.
5. **Continuing** to use alcohol even when it causes problems with family and friends.
6. **Giving up important social, occupational, or recreational activities** because of alcohol use.
7. **Repeatedly** using alcohol in physically hazardous situations.

Health impacts and consequences of alcohol use

- Repeatedly consuming large amounts of alcohol can affect nearly every organ system, especially the **digestive system, cardiovascular system, and central and peripheral nervous systems.**
- **Gastrointestinal effects include** “acid reflux/heartburn,” gastritis, and stomach ulcers. Individuals who drink alcohol heavily, this can lead to liver cirrhosis and/or pancreatitis.
- AUD is associated with a significant increase in the risk of accidents and violence.
- AUD is a contributor **to suicide risk.**
- Heavy drinking can also impact a person’s mood and may make depression harder to treat.

Treatment and Recovery

- Evidence-based treatments including
  - behavioral treatments (therapy/counseling),
  - medication, and
  - mutual support programs can play a major role in treating AUD.

- Recovery is **unique to every individual**. Some may choose to stop drinking altogether, while others may focus on reducing their drinking or limiting it in certain situations.
- Recovery is a process and may involve **periods of remission and relapse**.
- **Support from family and friends** is crucial for a person beginning a recovery journey.
- Forming a treatment plan with your doctor and tracking progress on that plan can greatly increase your chances of successfully recovering.

Symptoms of withdrawal

According to the DSM-5, include:

1. Tremors
2. Sweating
3. Elevated pulse and blood pressure
4. Insomnia
5. Anxiety
6. Nausea or vomiting
7. Seizures
8. Delirium tremens

Substance Use Disorder (SUDs)

- Substance use disorders ina pathologic pattern of behaviors in which patients continue to use a substance despite experiencing significant problems related to its volve use.
- The common terms "addiction," "abuse," and "dependence" have often been used with regard to substance use, but these terms are too loosely and variably defined to be very useful in systematic diagnosis. "Substance use disorder" is more comprehensive and has fewer negative connotations.

These substances all directly activate the brain reward system and produce feelings of pleasure. The activation of these substances also have direct physiologic effects, including

1. Intoxication
2. Withdrawl
3. Substance-induced psychiatric disorders

- **Intoxication**: Refers to the development of a reversible substance-specific syndrome of mental and behavioural changes that may involve altered perception, euphoria, cognitive impairment, impaired judgment, impaired physical and social functioning, mood lability, belligerence, or a combination. Taken to the extreme, intoxication can lead to overdose, significant morbidity, and risk of death.

- **Withdrawal:** Refers to substance-specific physiologic effects, symptoms, and behavioral changes that are caused by stopping or reducing the intake of a substance. To be classified as a substance-withdrawal disorder, the withdrawal syndrome must cause the patient significant distress and/or impair functioning (eg, social, occupational). Most patients with withdrawal recognize that readministering the substance will reduce their symptoms.

- **Substance-induced psychiatric disorders:** Substance-induced psychiatric disorders are psychiatric changes produced by substance use or withdrawal that resemble independent psychiatric disorders (eg, Depression, Psychosis, Anxiety, or neurocognitive disorders).

Diagnostic criteria

Diagnosis of substance use disorder is based on identifying a pathologic pattern of behaviors in which patients continue to use a substance despite experiencing significant problems related to its use. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM5-TR). Individuals meeting **2 or more of these criteria within a 12-month period** are considered to have a substance use disorder.

- **Impaired control over use**
    1. The person takes the substance in larger amounts or for a longer time than originally planned
    2. The person desires to stop or cut down on use of the substance
    3. The person spends substantial time obtaining, using, or recovering from the effects of the substance
    4. The person has an intense desire (craving) to use the substance

- **Social impairment**
  1. The person fails to fulfill major role obligations at work, school, or home
  2. The person continues to use the substance even though it causes (or worsens) social or interpersonal problems
  3. The person gives up or reduces important social, occupational, or recreational activity because of substance use
- **Risky use**
  1. The person uses the substance in physically hazardous situations (eg, when driving or in dangerous social circumstances)
  2. The person continues to use the substance despite knowing it is worsening a medical or psychologic problem

- **Pharmacological symptoms**
  1. Tolerance: The person needs to progressively increase the drug dose to produce intoxication or the desired effect, or the effect of a given dose decreases over time
  2. Withdrawal: Untoward physical effects occur when the drug is stopped or when it is counteracted by a specific antagonist

Treatment

- Alcoholics Anonymous
- psychotherapy
    1. motivational enhancement therapy,
    2. cognitive-behavioral therapy,
    3. relapse prevention
- Medications

Reference

- DSM 5 TR

Somatic Symptoms Disorder (ASPD)

- Somatic symptom disorder is characterized by **disproportionate and excessive thoughts, feelings, and concerns about physical symptoms**. The symptoms are **not intentionally produced or feigned** and may or may not accompany a general medical illness.
- Patients are commonly unaware of their underlying psychiatric issue and believe that they have physical ailments, so they typically continue to pressure clinicians for additional or repeated tests and treatments even after results of a thorough evaluation have been negative.

Symptoms and Signs of Somatic Symptom Disorder

- Recurring physical complaints
- Severe pain.
- Overtly depressed.
- Anxious about their health
- Unusually sensitive

Diagnosis

Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision (DSM-5-TR) criteria

1. Disproportionate and persistent thoughts about the seriousness of the symptoms
2. Persistently high anxiety about health or the symptoms
3. Excessive time and energy spent on the symptoms or health concerns

Treatment

Cognitive-behavioral therapy

- Patients, even those who have a satisfactory relationship with a primary care clinician, are commonly referred to a psychiatrist. Pharmacologic treatment of concurrent psychiatric disorders (eg, depression) may help; however, the primary intervention is psychotherapy, particularly cognitive-behavioral therapy.
- Patients also benefit from having a supportive relationship with a primary care clinician, who coordinates all of their health care, offers symptomatic relief, sees them regularly, and protects them from unnecessary tests and procedures.

Reference

- DSM 5-TR
- https://www.msdmanuals.com/professional/psychiatric-disorders/somatic-symptom-and-related-disorders/somatic-symptom-disorder#Diagnosis_v9115288

Sexual Disorder

- Sexual disorders are a **relatively invisible, highly prevalent set of problems** created by combinations of personality development, individual psychology, interpersonal psychology, biology, and culture.
- They can seriously interfere with courtship, pleasure in living, reproduction, and loving.
- Two major categories of disorders:
    1. the sexual dysfunctions, which include problems with
        a. sexual desire,
        b. arousal,
        c. orgasm,
        d. pain during intimate contact,
    2. sexual identity problems
        1. paraphilias.

Sexual Dysfunction

- **Desire disorders**: Lack of sexual desire or interest in sex. This may mean you have no interest in any type of sexual activity.
- **Arousal disorders**: Inability to become physically aroused or excited during sexual activity. You may feel a desire for sex, but your body doesn't respond. In people with a penis, this could mean you can't get an erection.
- **Orgasm disorders**: Delay or absence of orgasm (climax). You may feel desire and arousal but be unable to orgasm.
- **Pain disorders**: Pain during intercourse makes you not want to have sex.

Gender Dysphoria

- Previously GD is Known as **Gender Identity Disorder.**
- According to the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), is defined as a "marked incongruence between their experienced or expressed gender and the one they were assigned at birth."
- Children or adolescents who **experience this turmoil cannot correlate** to **their gender expression when identifying themselves** within **traditional societal binary male or female roles**, which may cause **cultural stigmatization**.

Gender Dysphoria

- This can further lead to **relationship conflicts with family, peers, and friends** in various aspects of their daily lives and **lead to rejection from society, interpersonal conflicts**, **symptoms of depression and anxiety, substance use disorders, a negative sense of well-being, and poor self-esteem, and increased risk of self-harm and suicidality**.
- The term gender should not be confused with sexual orientation. A transgender man (biological female) may identify himself as heterosexual and still be sexually attracted to women and vice versa

Etiology

- The etiology of gender dysphoria (GD) remains unclear, but it is thought to originate from a complex biopsychosocial link.

Diagnosis *Gender dysphoria in children*

A. A marked incongruence between one's **experienced/expressed gender and assigned gender**, of **at least six months duration**, as manifested but at least six of the following (one of which must be criteria A1)

- A **strong desire to be of the other gender** or an **insistence that they are the other gender** (or some alternative gender different from one's assigned gender)
- In boys (assigned gender), a strong preference **for cross-dressing or simulating female attire** or, in girls (assigned gender), a strong preference **for wearing only typical masculine clothing and strong resistance to wearing typical feminine clothing**
- A strong preference for **cross-gender roles in make-believe play or fantasy play**
- A strong preference for **the toys, games, or activities stereotypically used or engaged** in by the other gender.

- A strong preference **for playmates of the other gender**
- In boys (assigned gender), **a strong rejection of typically masculine toys, games, and activitie**s and a **strong avoidance of rough-and-tumble play or, in girls (assigned gender), a strong rejectio34**
- **n of typically feminine toys, games, and activities.**
- A strong dislike of one's **sexual anatomy**
- A strong desire for the **primary and/or secondary sex characteristics matching one's experienced gender.**

B. The condition is associated with clinically significant **distress or impairment in social, school, or other important areas of functioning.**

Gender dysphoria in adolescents and adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender of at least six months duration, as manifested by at least two of the following:

- A marked **incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics** (or, in young adolescents, the anticipated secondary sex characteristics).
- A strong desire **to be rid of one's primary and/or secondary sex characteristics** because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

- A strong desire for the **primary and/or secondary sex characteristics of the other gender**.
- A strong desire to be of **the other gender** (or some alternative gender different from one's assigned gender).
- A strong desire to be **treated as the other gender** (or some alternative gender different from one's assigned gender).
- A strong conviction that **one has the typical feelings and reactions of the other gender** (or some alternative gender different from one's assigned gender).

B. The condition is associated with **clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

Paraphilias and Paraphilic Disorders:

- Paraphilic disorders are **recurrent, intense, sexually arousing fantasies, urges, or behaviors** that are **distressing or disabling** and that involve **inanimate objects, children or nonconsenting adults, or suffering or humiliation** of the person or a partner, with the potential to cause harm. In most cultures, paraphilias are far more common **among males.** Biologic reasons for the unequal distribution may exist but are **poorly defined.**

- People with a paraphilic disorder may have an **impaired or a nonexistent capacity for affectionate, reciprocal emotional and sexual intimacy** with a consenting partner.
- The pattern of **disturbed erotic arousal** is usually fairly well developed **before puberty**. At least 3 processes may be involved:
    1. **Anxiety or early emotional trauma** interferes with normal psychosexual development.
    2. The standard **pattern of arousal is replaced by another pattern**, sometimes through **early exposure to highly charged sexual experiences** that reinforce the person's unusual experience of sexual pleasure.
    3. The pattern of sexual arousal often acquires symbolic and conditioning elements (eg, a fetish symbolizes the object of arousal but may have been chosen because the **fetish** was accidentally associated **with sexual curiosity, desire, and excitement**).

Treatment / Management

- **Care team**: A comprehensive approach with an endocrinologist and mental health providers should be made available.
- **Expectations:** **T**ransgender hormonal and surgical treatment options will help address the patient's external appearance to be in congruence with their gender identity. **Unrealistic expectations should be addressed adequately**. **A supportive network of peers, friends, and family** is often helpful.

- **Risks and benefits of treatment: B**oth hormonal and surgical therapies accompany significant risks: venous thromboembolism, bone mineral density, and pubertal suppression.
- **Fertility preservation: B**efore initiating hormonal and surgical treatment, the patient might lose the ability to reproduce. So , fertility preservation should be discussed, as it is done by freezing the individual's gametes.
- **Sexual health: The** incidence of sexually transmitted infections and HIV was higher in this population.

- The most common paraphilic disorders are
  1. Voyeuristic Disorder
  2. Exhibitionistic disorder
  3. Frotteuristic disorder

- Voyeuristic disorder
  - Voyeurism is achievement of **sexual arousal in an adult by observing people who are naked, disrobing, or engaging in sexual activity**. When observations are of unsuspecting people, this sexual behavior often leads to problems with the law and relationships. Voyeuristic disorder involves acting on **voyeuristic urges or fantasies with a nonconsenting person or experiencing significant distress or functional impairment b**ecause of such urges and impulses, in a person who is **at least 18 years of age.**

- Exhibitionistic disorder
  - Exhibitionism is characterized by **achievement of sexual excitement through genital exposure, usually to an unsuspecting stranger.** It may also refer to **a strong desire to be observed by other people during sexual activity**. Exhibitionistic disorder involves acting on these **urges with a nonconsenting person** or experiencing s**ignificant distress or functional impairment** because of such urges and impulses.

Frotteuristic disorder

- Frotteurism is **intense sexual arousal from touching or rubbing against a nonconsenting person**. Frotteuristic disorder is diagnosed when a person experiences, for at **least 6 months**, **recurrent and intense arousal from frotteurism (manifested by fantasies, urges, or behaviors)** and has either acted on these sexual urges or the urges cause **clinically significant distress or impaired functioning.**

- Sexual masochism disorder
  - Sexual masochism is intentional participation in an activity that involves being humiliated, beaten, bound, or otherwise abused to experience sexual excitement. Sexual masochism disorder is diagnosed when a patient experiences recurrent, intense sexual arousal from these activities but also has clinically significant distress or impaired functioning.
- Sexual sadism disorder
  - Sexual sadism is infliction of physical or psychological suffering (eg, humiliation, terror) on another person to stimulate sexual excitement and orgasm. Sexual sadism disorder is sexual sadism that causes clinically significant distress or functional impairment or is acted on with a nonconsenting person
- Pedophilic disorder
  - **Pedophilic disorder is characterized by** recurrent, intense sexually arousing fantasies, urges, or behaviors involving sexual activity with prepubescent children, generally **≤ 13 years;** based on clinical criteria, it is diagnosed only when the **patient is ≥ 16 years** and **≥ 5 years older than the child** who is the target of the fantasies or behaviors

- Transvestic disorder
  - Transvestism involves **recurrent and intense sexual arousal from cross-dressing,** which may manifest as fantasies, urges, or behaviors. Transvestic disorder is transvestism that causes **clinically significant distress or functional impairment** in one or more important areas of life.
  - Fetishism **(sexual arousal by fabrics, materials, or garments**) or autogynephilia (**arousal by thoughts or images of self as a woman**) are present.
  - The condition has been present **for ≥ 6 months**
  - When their partner is cooperative or willing to participate, cross-dressing men may engage in sexual activity in partial or full feminine attire. When their partner is not cooperative, they may **feel anxiety, depression, guilt, and shame because of their desire to cross-dress** and may experience **sexual dysfunction** in their relationship. In response to these feelings, these men **often purge their wardrobe of female clothing.** This purging may be followed by additional cycles of accumulating **female clothes, wigs, and makeup, with more feelings of shame and guilt, followed by more purges.**

Treatment

- Social and support groups
- Various psychotherapies

No medications are reliably effective

Reference

- https://www.ncbi.nlm.nih.gov/books/NBK532313/

Psychiatric Problems among Children

- Childhood and adolescence are times of carefree bliss, as many as 20% of children and adolescents have a diagnosable psychiatric disorder that causes **distress and functional impairment.** With **increasing age**, the **prevalence (occurrence) of psychiatric disorders increases**.
- Studies that follow children from birth to adulthood indicate that most adult mental health disorders begin in early childhood and adolescence Genes associated with psychiatric disorders have been reported to show high expression throughout the lifespan**, beginning in the fetus in the 2nd trimester** and **impacting neurodevelopmental processes**, which may explain the early ages of onset. Most of these disorders may be viewed **as exaggerations or distortions of normal behaviors and emotions.**

- Like adults, children and adolescents vary in t**emperamen**t. Some are **shy and reticent**; others are **socially exuberant**. Some are **methodical and cautious**; others are **impulsive and careless**. Whether a child is behaving like **a typical child or has a psychiatric disorder is determined by the presence of impairment and the degree of distress** related to the symptoms. For example, a 12-year-old girl may be frightened by the prospect of delivering a book report in front of her class. This fear would be viewed as social anxiety disorder only if her fears were severe enough to cause significant distress and avoidance.
- There is much overlap between the symptoms of many disorders and the challenging behaviors and emotions of normal children.
- **Appropriate management** of childhood behavioral issues may **decrease the risk of temperamentally vulnerable children developing a clinical disorder**.
- **Effective treatment** of some disorders (eg, anxiety) during childhood may **decrease the risk of a mood disorder later in life.**

- The **most common psychiatric disorders** of childhood and adolescence fall into the following categories:
- Anxiety disorders
    - Anxiety disorders are characterized by **fear, worry, or dread** that greatly **impairs the ability to function normally** and that is disproportionate to the circumstances at hand. Anxiety may result in physical symptoms. **Diagnosis is clinical**. Treatment is with **behavioural therapy and medications**.
- Stress-related disorders
    - Acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) **are reactions to traumatic events**. The reactions involve **intrusive thoughts or dreams, avoidance of reminders of the event, and negative effects on mood, cognition, arousal, and reactivity**. ASD typically begins immediately **after the trauma and lasts from 3 days to 1 month.** PTSD can be a continuation of ASD or may manifest up to 6 months after the trauma and lasts for >1 month. **Diagnosis is by DSM clinical criteria.** Treatment is with **behavioral therapy and medications.**

- Mood disorders
  - Depressive disorders are characterized **by sadness or irritability** that is severe or persistent enough to interfere with functioning or cause considerable distress. **Diagnosis is by clinical criteria.** Treatment is with **antidepressants, supportive and cognitive-behavioral therapy, or a combination of these modalities**.
- Obsessive-compulsive disorder
  - Obsessive-compulsive disorder is characterized by **obsessions, compulsions, or both**. Obsessions are **irresistible, persistent ideas, images, or impulses to do something**. Compulsions are pathologic **urges to act on an impulse.** The obsessions and compulsions cause great distress and interfere with **academic or social functioning**. **Diagnosis is by clinical criteria**. Treatment is **with behavioral therapy and medications**.

- Disruptive behavioral disorders
  - Attention-deficit/hyperactivity disorder [ADHD]
    - Attention-deficit/hyperactivity disorder (ADHD) is a syndrome of **inattention, hyperactivity, and impulsivity**. The 3 types of ADHD are predominantly **inattentive, predominantly hyperactive/impulsive, and combined**. **Diagnosis is made by clinical criteria**. Treatment usually **includes pharmacotherapy with stimulant or other medication, behavioral therapy, and educational interventions.**
  - conduct disorder
    - Conduct disorder is a **recurrent or persistent pattern of behavior that violates the rights of others or violates major age-appropriate societal norms or rules. Diagnosis is by clinical criteria**. Treatment are psychotherapy and considerable supervision.
  - oppositional defiant disorder
    - Oppositional defiant disorder is a **recurrent or persistent pattern of negative, defiant, or even hostile behavior directed at authority figures.** Diagnosis is by clinical criteria. Treatment is with **individual psychotherapy combined with family or caregiver therapy.** Occasionally, **medications may be used to reduce irritability.**

Neurodevelopmental disorders affect both mental health and overall development in children. Some of these disorders include:

- Autism spectrum disorders
- Rett syndrome
- Fragile X syndrome
- DiGeorge syndrome
- Mitochondrial disorders

Reference

- https://www.msdmanuals.com/professional/pediatrics/inherited-disorders-of-metabolism/mitochondrial-oxidative-phosphorylation-disorders#Leigh-Syndrome_v88761966

Epilepsy

- Epilepsy is sometimes referred to as **a seizure disorder**
- **Epilepsy** is a chronic brain disorder characterized by recurrent (≥ 2) seizures that are unprovoked and that occur > 24 hours apart.
- A single seizure is **not considered an epileptic** seizure.
- Epilepsy is often **idiopathic (no specific cause)**, but various brain disorders, such as malformations, strokes, and tumours, can cause symptomatic epilepsy.

Etiology of Epilepsy/Seizure Disorders

- Common causes of seizures (see table Causes of Seizures) vary by age of onset:
  1. Before age 2: Fever, hereditary or congenital neurologic disorders, birth injuries, and inherited or acquired metabolic disorders
  2. Ages 2 to 14: Idiopathic seizure disorders
  3. Adults: Cerebral trauma, alcohol withdrawal, tumors, strokes, and an unknown cause (in 50%)
  4. Older people: Tumors and strokes

Diagnosing epilepsy and seizures

- Generally, epilepsy is diagnosed after a person has had two or more unprovoked seizures separated by at least 24 hours.
  - **Medical history**
    - Taking a detailed medical history, including symptoms and duration of the seizures, is still one of the best methods available to determine what kind of seizures a person has had and to help determine what type of epilepsy the person has. The medical history should include details about any past illnesses or other symptoms a person may have had, as well as any family history of seizures.
    - Since people who have a seizure often do not remember what happened, accounts from people who have witnessed the seizures are very important. The observers will be asked to provide a detailed description and timeline for the seizure.

- **Imaging and monitoring epilepsy:** There are several scans and imaging techniques that can help diagnose and monitor a person's epilepsy. These include:
  - An **electroencephalogram (EEG)**, a test that measures **electrical activity in the brain**, can look for abnormalities in the person's brain waves and may help to determine if antiseizure drugs would help. **Video monitoring** may be used in conjunction with EEG to determine the nature of a person's seizures and to rule out other disorders that may look like epilepsy.
  - **SEEG (stereoelectoencephalograpy)** is **the surgical implantation of electrodes into the brain** in order to better find where the seizures are located. SEEG can help determine if an individual is a candidate for epilepsy surgery. A magnetoencephalogram (MEG) measures the magnetic signals generated by neurons to help find unusual brain activity.
  - **CT (computerized tomography)** and **MRI (magnetic resonance imaging)** scans reveal **structural abnormalities of the brain** such as tumors and cysts, which may cause seizures. It can be used to localize normal brain activity and detect abnormalities in brain function.
  - **PET (positron emission tomography)** scans take pictures of the brain and show regions of the brain with normal and abnormal chemical activity. PET scans can be used to identify brain regions with lower-than-normal metabolism, which can indicate the focus of the seizure after it has stopped.
  - **Single photon emission computed tomography (SPECT)** is sometimes used **to find the location of focal seizures in the brain**. In a person admitted to the hospital for epilepsy monitoring, the SPECT blood flow tracer is injected within 30 seconds of a seizure. The images of brain blood flow at the time of the seizure are compared with blood flow images taken in between seizures. The seizure onset area shows a high blood flow region on the scan.

- **Blood tests**
  - Blood tests can screen for metabolic or genetic disorders that may contribute to the seizures.
- **Developmental, neurological, and behavioral tests**
  - Tests to measure motor abilities, behavior, and intellectual ability often are used to determine how epilepsy is affecting an individual.

Treatment

- Medications to treat seizures in epilepsy
  - Antiseizure medications are effective for many people with epilepsy. Those individuals do not respond to or are not able to take medications, may be undergone for surgery, dietary changes, or devices to stop their seizures.
- Diet and lifestyle changes in epilepsy
  - A high-fat, high-protein, very low carbohydrate ketogenic diet is sometimes used to treat medication-resistant epilepsies. People with epilepsy should practice **good sleep hygiene**: going to bed and getting up at the same time each day, reducing distractions in the bedroom, and avoiding big meals and exercise within a few hours of bedtime.

Surgery for epilepsy

1. **Surgery to remove a seizure focus** involves **removing the defined area of the brain** where seizures originate. It is the most common type of surgery for epilepsy, which doctors may refer to as **a lobectomy or lesionectomy** and is appropriate only for focal seizures that originate in just one area of the brain.
2. **Multiple subpial transection** may be performed when seizures originate in part of the brain that cannot be removed. It involves making **a series of cuts that are designed to prevent seizures** from spreading into other parts of the brain while leaving the person's normal abilities intact.
3. **Corpus callosotomy** or severing the network of neural connections between the right and left halves (hemispheres) of the brain, is done primarily in children with severe seizures. Corpus callosotomy can end **drop attacks and other generalized seizures**.
4. **Hemispherectomy and Hemispherotomy** involve **removing half of the brain's cortex, or outer layer**. These procedures are used predominantly in children who have seizures that **do not respond to medication**
5. **Thermal ablation for epilepsy**, also known as **laser interstitial thermal therapy**, directs **energy to a specific, targeted brain region** causing the seizures (the seizure focus). The energy, which is **changed to thermal energy**, destroys the brain cells causing the seizures. Laser ablation is less invasive than open brain surgery for treating epilepsy.

Neurostimulation devices

- Vagus nerve stimulation involves surgically implanting a device under the skin of the chest. The device, which is attached by wire to the vagus nerve in the lower neck, delivers short bursts of electrical energy to the brain.
- Responsive stimulation uses an implanted device that analyzes brain activity patterns to detect a forthcoming seizure. Once detected, the device administers an intervention, such as electrical stimulation or a fast-acting drug to prevent the seizure from occurring.
- Deep brain stimulation involves surgically implanting an electrode connected to a pulse generator (similar to a pacemaker) to deliver electrical stimulation to specific areas in the brain to regulate electrical signals in neural circuits

Reference

- https://www.ninds.nih.gov/health-information/disorders/epilepsy-and-seizures#toc-types-of-seizures
- https://www.msdmanuals.com/professional/neurologic-disorders/seizure-disorders/seizure-disorders?query=epilepsy

Intellectual Disability

- Intellectual disability, earlier it is known as **Mental retardation**.
- It is considered **a neurodevelopmental disorder.**
- It appear early in childhood, **typically before school entry**, and **impair development of personal, social, academic, and/or occupational functioning**.
- They typically involve difficulties with the acquisition, retention, or application of specific skills or sets of information.
- Neurodevelopmental disorders may involve dysfunction in one or more of the following: **attention, memory, perception, language, problem-solving, or social interaction.**

Intellectual disability must involve childhood onset of deficits in both of the following:

1. **Intellectual functioning** (eg, in reasoning, planning and problem solving, abstract thinking, learning at school or from experience)
2. **Adaptive functioning** (ie, ability to meet age- and socioculturally appropriate standards for independent functioning in activities of daily life)

- Basing severity on IQ alone:
    1. Mild: 52 to 70 or 75
    2. Moderate: 36 to 51
    3. Severe: 20 to 35
    4. Profound: < 20, is inadequate.

Classification:

1. Intermittent: Occasional support needed
2. Limited: Support such as a day program in a sheltered workshop
3. Extensive: Daily, ongoing support
4. Pervasive: High level of support for all activities of daily living, possibly including extensive nursing care.

Etiology of Intellectual Disability

1. Prenatal Factors
2. Perinatal Factors
3. Postnatal factors

Prenatal factors

1. A number of **chromosomal anomalies** and genetic, metabolic, and neurologic disorders can cause intellectual disability
2. Congenital infections include **rubella** and those due *to cytomegalovirus*, *Toxoplasma gondii*, *Treponema pallidum*, *herpes simplex virus*, *or HIV.* **Prenatal Zika virus infection** may cause congenital microcephaly and associated severe intellectual disability.
3. **Prenatal medication and toxin exposure** can cause intellectual disability.
    1. **Fetal alcohol syndrome** is the most common of these conditions.
    2. **Antiseizure medications** such as phenytoin or valproic acid, chemotherapy drugs, radiation exposure, lead, and methylmercury are also causes.
4. **Severe undernutrition during pregnancy** may affect fetal brain development, resulting in intellectual disability.

Perinatal factors

- Complications related to prematurity bleeding in central nervous system **high forceps delivery, etc.** may increase the risk of intellectual disability.
- The risk is increased in gestataional age in fantsvintellectual impairment and decreased weight share similar causes.
- **Very low- and extremely low-birth-weight** infants have variably increased chances of having intellectual disability, depending on gestational age, perinatal events, and quality of care.

Postnatal factors

- Undernutrition and environmental deprivation (lack of physical, emotional, and cognitive support required for growth, development, and social adaptation) during infancy and early childhood
- Viral and bacterial encephalitides and meningitides, poisoning (eg, lead, mercury), and accidents that causes head injuiry, etc may result in intellectual disability.

Symptoms

1. Slowed acquisition of new knowledge and skills
2. Immature behavior
3. Limited self-care skills
4. Lack of training in socially responsible behavior
5. Inconsistent limit setting
6. Reinforcement of faulty behavior
7. Impaired ability to communicate
8. Discomfort due to coexisting physical problems and mental health disorders such as depression or anxiety

Diagnosis of Intellectual Disability

1. Prenatal testing
2. Intelligence and developmental assessment
3. Imaging of the central nervous system
4. Genetic testing

Treatment of Intellectual Disability

1. Early intervention program
    1. **Folate (folic acid) supplementation** (400 to 800 mcg orally once a day) in females beginning 3 months before conception and continuing through the first trimester reduces the risk of neural tube defects
    2. **Vaccines** have all but eliminated congenital rubella and pneumococcal and *H. influenzae* meningitis as causes of intellectual disability.
    3. Pregnant patients should be advised to **avoid all alcohol intake**.
2. Family support and counseling

1. Multidisciplinary team support
    a) Neurologists or developmental-behavioral pediatricians
    b) Orthopedists
    c) Physical therapists and occupational therapists (who assist in managing comorbidities in children with motor deficits)
    d) Speech pathologists and audiologists (who help with language delays or with suspected hearing loss)
    e) Nutritionists (who help with treatment of undernutrition)
    f) Ophthalmologists or optometrists (who help ensure optimal vision)
    g) Social workers (who help reduce environmental deprivation and identify key resources)
    h) Psychologists (who oversee planning of behavioral interventions)

Prognosis for Intellectual Disability

- Many people with mild to moderate intellectual disability can support themselves, live independently, and be successful at jobs that require basic intellectual skills.
- Life expectancy may be **shortened**, depending on the etiology of the disability. But health care is improving long-term health outcomes for people with all types of developmental disabilities.
- People with severe intellectual disability are more likely to **require life-long support**. The more severe the cognitive disability and the **greater the immobility, the higher the mortality risk.**

Acknowledgement

I wish to place on record, the sincere appreciation and thanks to **Ms. Ambi Joseph**, Doctoral Research Scholar, Department of Social Work, Bharathidasan University, Tiruchirappalli-23, for the able assistance in the preparation of this Course Material for Mental Health.