

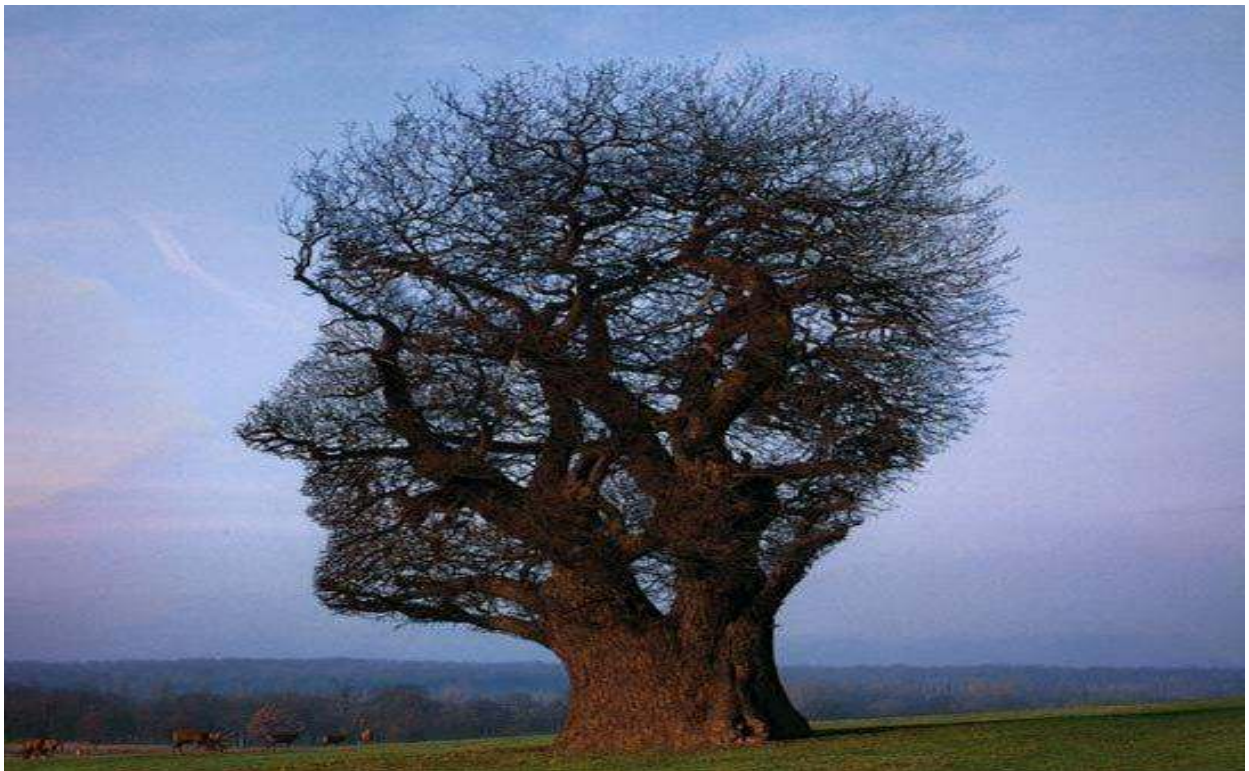
FUNDAMENTALS

of

PSYCHIATRY

(An Undergraduate Text)

SECOND EDITION



MUIDEEN O. BAKARE, M.B.B.S, FMCPsych, MNIM

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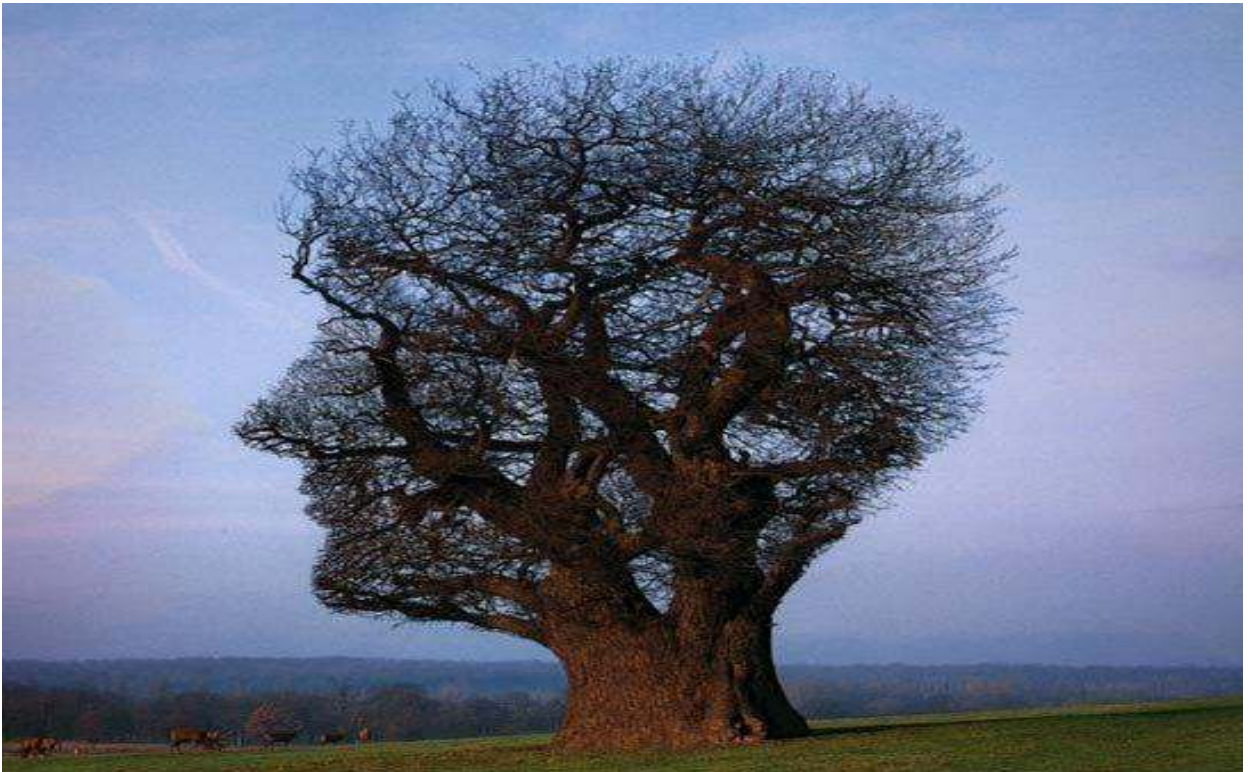
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DEDICATION

To

**Future Development of Psychiatry Sub-specialty in Nigeria and
other African Countries**

PREFACE TO THE FIRST EDITION

Undergraduate psychiatry courses have not been given adequate attention in most medical and paramedical schools in Nigeria and other African countries. In addition, there is no clearly defined curriculum for undergraduate psychiatry courses as at present. Most of the newly qualified medical practitioners after their undergraduate training may not be exposed again to postgraduate training in psychiatry throughout the period of their medical practice.

In this regard, undergraduate medical and paramedical students need to be provided with enough information and clinical exposure to equip them with the necessary skills for recognizing psychiatric disorders early enough and take the appropriate step of treatment or referral.

The need to fulfil the above objective gave birth to this book. Fundamentals of Psychiatry does not lay claim to exhaustive discussion of various aspects of psychiatric disorders. It is rather an introductory text written for undergraduate students. However, the author believes the book will be useful to medical practitioners in other sub-specialities of medicine who are interested in catching a glimpse into the sub-specialty of psychiatry.

Muideen O. Bakare, 2011

PREFACE TO THE SECOND EDITION

With the ongoing revisions of World Health Organization (WHO) International Classification of Diseases, Tenth Edition (ICD - 10) and American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), there is need to update knowledge of undergraduate medical students on the proposed changes and how these would impact the practice of psychiatry in the future.

The DSM-V is proposed to be released officially in May, 2013, while the ICD-11 is proposed for official release in 2015 tentatively. Most chapters of the second edition had witnessed minor to major text revisions with some additional information.

Fundamentals of Psychiatry, being a book conceived primarily for undergraduate Nigerian and African medical students, a brief history of psychiatry in Nigeria has been introduced in chapter 2 of the second edition. It is believed that this will help the students to gain a background of the journey so far regarding psychiatry practice in Nigeria as a prototype for other African countries.

The Second Edition of Fundamentals of Psychiatry retains the introductory nature and the primary objectives of the First Edition.

Muideen O. Bakare, 2013.

Table of Contents

Preface

Chapter 1: Introduction to Psychiatry

Chapter 2: Brief History of Psychiatry in Nigeria

Chapter 3: Classification in Psychiatry and Culture-Bond Syndromes

Chapter 4: Signs and Symptoms of Mental Illness

Chapter 5: History Taking in Psychiatry

Chapter 6: Normal Sleep and Sleep Disorders

Chapter 7: Cognitive Disorders

Chapter 8: Mood Disorders

Chapter 9: Anxiety Disorders, Obsessive Compulsive Disorder and Reaction to Stressful Experiences

Chapter 10: Theories of Personality Development and Personality Disorders

Chapter 11: Psychiatry and Other Medical Specialties

Chapter 12: Schizophrenia and Related Disorders

Chapter 13: Psychoactive Substance Use Disorders

Chapter 14: Human Sexuality and Associated Disorders

Chapter 15: Childhood Psychiatric Disorders

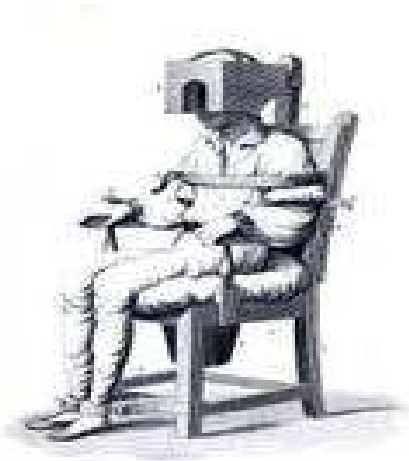
Chapter 16: Treatment Methods in Psychiatry

Chapter 17: Suicide and Deliberate Self Harm

Chapter 18: Forensic Psychiatry

Chapter 1

Introduction to Psychiatry



Definition

Psychiatry is the medical specialty concerned with the study and treatment of mental disorders which includes various affective, behavioural, cognitive and perceptual disorders.

The term was first coined by the German physician Jonathan Christian Reil in 1808. It literally means the “medical treatment of the mind” (psych-mind, -iatry: medical treatment).

A medical doctor specializing in psychiatry is a Psychiatrist.

Concept of mental illness

World Health Organization (WHO) – defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Mental illness is difficult to define. However, it can be defined as: Illness that involves disturbances of thought, experience, and emotion serious enough to cause functional impairment in people, making it more difficult for them to sustain interpersonal relationships and carry on their jobs and sometimes leading to self-destructive behaviour and sometimes suicide. It is a function of specific socio-cultural environment.

Historical Development of Modern Psychiatry

- **Ancient Time:** Dated back to 5th century BC – mental disorders, especially those with psychotic traits, were considered supernatural in origin or cause by demons and usual treatment were exorcisms, physical restraint, music therapy among others. Examples of these could be found in documented account of the Bible as follows:

“Next day an evil spirit of God seized upon Saul; he fell into frenzy in the house, and David played the harp to him as he had before” – I Samuel 18:10.

“Some Jews who went around driving out evil spirits tried to invoke the name of the Lord Jesus over those who were demon-possessed. They would say, "In the name of Jesus, whom Paul preaches, I command you to come out." [One day] the evil spirit answered them, "Jesus I know, and I know about Paul, but who are you?". Then the man who had the evil spirit jumped on them and overpowered them all.” - Act 14: 14 – 16.

- **Middle Ages:** Mental disorder was still seen as a spiritual disorder or curse that need spiritual interventions.
- **Modern Psychiatry:** Only came onto being in the 19th and 20th century with advances of science and evidence based medical practice. The practice of psychiatry was revolutionalized by the discovery of the first antipsychotic medication (chlorpromazine) in 1950 by Jean Delay and Pierre Deniker. Since then, many other antipsychotics have been discovered which include the conventional (typical) and newer (atypical) antipsychotics. There are still various ongoing trials on newer potential antipsychotic medications.

Chapter 2

Brief History of Psychiatry in Nigeria



Prof. T.A. Lambo (1923 – 2004)
First African and Nigerian Indigenous Psychiatrist

Asylums and Psychiatry Facilities in Nigeria

During the Colonial era, Asylums were the modern psychiatry facilities built by the British before independence in Nigeria. The first Asylum in Nigeria was built in Calabar in 1903. This facility later becomes the Federal Neuropsychiatric Hospital, Calabar located in Cross River State. The second Asylum built in Nigeria was in 1907 and located in Lagos. The facility is now the Federal Neuropsychiatric Hospital, Yaba, Lagos. Thereafter, some other ones were built with the intention of caring mainly for vagrant psychotic patients.

Evolution of Modern Psychiatry Practice in Nigeria

Evolution of modern psychiatry practice in Nigeria had been said to undergo three phases:

Traditional Phrase – This was before and during the period of British colonization when mental illnesses were treated in different Nigerian cultures by traditional healers. For examples, “Babalawo” among the Yorubas and “Dibia” among the Igbos in southern Nigeria. It had also been noted that similar practices existed in different parts of Africa within this time frame.

Transitional Phase – This is characterized by advent of syncretised healing methods that incorporates the traditional healing practices with the modern religion methods, mainly Christianity and Islam. The Islamic practitioners (Alufas) treat patients who are mentally ill through the use of Surahs of the Quran. The Priests or Prophets of the Christian faith employ mixtures of prayer fasting, holy water, exorcism among others in treating mentally ill patients. The transitional phase presently co-exists simultaneously with the latest and modern phase which is the therapeutic phase in most parts of Nigeria and other African countries.

Therapeutic Phase – In Nigeria, the year 1954 heralded the period of therapeutic phase with the arrival from United Kingdom of the first African and Nigerian trained Psychiatrist in person of Professor Thomas Adeoye Lambo (1923 – 2004). On his arrival, Prof. T.A. Lambo a UK trained psychiatrist took over the direction of the Neuropsychiatric Hospital in Aro, Abeokuta in Ogun State. This therapeutic phase coincided with the discovery of Chlorpromazine, the first antipsychotic in 1950. Professor T.A. Lambo later worked with World Health Organization (WHO) between 1971 and 1988 and attained the level of Deputy Director of WHO.

Association of Psychiatrists in Nigeria (APN)

In July 1969, ten psychiatrists founded at the University College Hospital in Ibadan; “Association of Psychiatrists in Nigeria (APN)”. Since then, the association has held its annual general and scientific meetings in different regions of the country till date.

Drs. Alexander Boroffka and Raymond Prince are among the non-indigenous Psychiatrists that have contributed immensely to the development of psychiatry sub-specialty practice in Nigeria. Alexander Boroffka is noted for his detail documentation of history of psychiatry in Nigeria and Raymond Prince for his description of “Brain Fog Syndrome” among Nigerian students.

Chapter 3

Classification in Psychiatry and Culture-Bond Syndromes



Classification in psychiatry is grouping of mental disorders into different diagnostic categories based on similar clinical features (symptoms and signs).

Definition of Concepts

Disease – Refers to objective pathology

Illness – Subjective awareness of distress

Sickness – Refers to a loss of capacity to fill normal social roles

Impairment – is comparable to disease, referring to a pathological defect

Disability – Persistent limitation of physical or psychological function which results from impairment and individual psychological reaction to it.

Handicap – Is comparable to sickness, referring to continuing social dysfunction, arising from inability to fill individual or social expectations.

Why Classification?

First purpose – This is to ensure reliability of diagnosis. This is to enable clinicians to communicate with one another about their patients' symptoms, treatment and prognosis.

Second purpose – This is for the purpose of research and natural history. It enables research and follow-up to be conducted among comparable groups of patients.

Brief History of Classification in Psychiatry

Earlier Concepts

There are two popular concepts that were introduced during the earlier development of psychiatry discipline.

Neurosis - William Cullen in 1772 introduced the term; "**Neurosis**" to denote diseases of the nervous system.



William Cullen (1710 -1790)

Psychosis - Ernst von Feuchtersleben in 1845 introduced the term; "**Psychosis**". He proposed the term to mean severe mental disorders. He also accepted the term "Neurosis" for mental disorders as a whole. So he wrote; "Every psychosis is at the same time a neurosis, but not every neurosis is a psychosis".



Ernst von Feuchtersleben (1806 - 1849)

Modern Concepts

Over time the concept of neurosis was narrowed down and psychoses ceased to be a sub-group of neuroses and were regarded as independent conditions.

Psychosis - In modern usage, the term, "**Psychosis**" refers to severe forms of mental disorders such as organic mental disorders, schizophrenia and affective disorders. Psychosis is often defined as a state of patient's inability to distinguish between subjective experience and reality as evidenced by hallucinations and delusions.

Neurosis - The term "**Neurosis**" refers to mental disorders that are generally less severe than psychosis and characterized by symptoms closer to normal experience (e.g Anxiety disorders).

While the term "Psychosis" is still widely used in today's psychiatry practice, the use of the term "Neurosis" is fizzling out.

Different Types of Classifications

1. Categorical Classification - Classify concepts into definitive categories.
2. Dimensional Classification - Put into consideration different dimensions and do not box concept into definitive categories. This is often used in classifying personality disorders.
3. Multi-axial Classification - Classification that makes use of Axis as contained in making diagnosis according to ICD-10 and DSM-IV-TR.

Evolution of Modern Day Classification

The two most popular modern day classification of mental disorders are: International Classification of Diseases (ICD) produced by consensus of experts from different countries of the world under the World Health Organization (WHO) and Diagnostic and Statistical Manual of Mental Disorders (DSM) produced by experts' consensus and published by American Psychiatric Association (APA).

International Classification of Diseases (ICD)

ICD is a form of classification that included all known diseases worldwide. The Chapter V of latest edition of ICD contained classification of mental disorders. Mental disorders were not included in the ICD until its sixth edition (ICD-6) produced by WHO in 1948. Since then, various other editions of ICD have been produced over the years by update revision and amendment of the previous versions which included ICD-7, ICD-8, ICD-9, and presently ICD-10. There is an ongoing revision towards the making of ICD-11 projected to be released in due course, tentatively in 2015. The present edition being used (ICD-10) was produced and published by WHO in 1992.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

DSM is solely for classification of mental disorders unlike ICD that contained all known diseases of the world. So, DSM-IV-TR is equivalent to the Chapter Five (V) of ICD-10. First edition (DSM-I) was produced by APA in 1952 which was an alternative to ICD-6. DSM-II was produced in 1968 and was an alternative to ICD-8. DSM-III was published in 1980 and was an alternative to ICD-9. DSM-IV was produced in 1994 and was an alternative to ICD-10. The present version of DSM is DSM-IV-TR (Text Revision) which was produced in year 2000 and also an alternative to ICD-10. Work is completed regarding the production of DSM-V which is proposed for official release in May 2013. It will be an equivalence to the proposed ICD-11.

Main Categories of Classification of Mental Disorders in ICD-10 (Chapter V)

F0: Organic, including symptomatic, mental disorders.

F1: Mental and behavior disorders due to psychoactive substance use.

F2: Schizophrenia, schizotypal, and delusional disorders.

F3: Mood (Affective) disorders

F4: Neurotic, stress-related, and somatoform disorders

F5: Behavioural syndromes associated with physiological disturbances and physical factors.

F6: Disorders of adult personality and behavior

F7: Mental Retardation/Intellectual Disability

F8: Disorders of psychological development

F9: Behavioural and emotional disorders with onset usually occurring in childhood or adolescence.

Culture-Bond Syndromes

Culture-bond syndromes are group of psychiatric disorders that present with mixture of psychological and physical symptoms and are peculiar to certain cultures and do not often occur globally. Examples of culture bound syndromes peculiar to African sub-culture are listed below:

Brain Fag Syndrome - This was first described by Dr. Raymond Prince among Nigerian students. Brain Fag Syndrome can be defined as individual's reaction to the demanding tasks of school or the exhaustion of the brain. It is seen predominantly in male students, with symptoms such as depression, difficulty concentrating, remembering things, and thinking. Additional symptoms include pain and pressure around the head and neck, and blurring of vision.

Koro - A culture-bond syndrome characterized by an individual having an overpowering belief that his or her genitals (e.g., penis or female nipples) are retracting and will disappear, despite the lack of any true longstanding changes to the genitals. Koro is also known as shrinking penis.

Chapter 4

Signs and Symptoms of Mental Illness



This is also known as 'descriptive psychopathology'. It describes the appearance and mental state of the patient.

Disorders of Appearance and Behaviour

Appearance (state of health, posture, cleanliness, clothing and self-care) is an important indicator of other mental functions. For example, mood may be expressed in the form of appearance (facial expression, posture).

Disorders of Expressive Behaviour

These include tearfulness, unhappy facial expression, paucity of movements, downcast appearance in depression; laughing, expansive gesturing and over-activity in hypomania.

Disorders of Motor Activity

The degree and quality of motor activity are important in mental disorders.

Mannerism - Mannerism is described as abnormal repetitive goal directed movements, E.g. A Salute.

Stereotypic Movement - Stereotypic movement is described as abnormal repetitive non-purposeful movements. The movement is not goal directed.

Waxy Flexibility - This is a rigid wax-like condition of posture; E.g. Psychological Pillow.

Disorders of Perception

Sensory distortion - Changes in the quality, intensity or spatial form of a perception, e.g. Hyperacusis, Micropsia.

Sensory deception - A deception of sensory stimulus.

- **Illusions** - Are distortions in perception of real objects, e.g, mistaking a rope for snake and tree stump for a human.
- **Hallucinations** - Are perceptions which arise in the absence of any external stimulus, e.g. visual, auditory and tactile hallucinations.

Disorders of Self-Awareness - This is a form of disorders of perception:

- **Depersonalization** - A situation in which the sense of awareness of existence as a person is altered or lost.
- **Derealization** - Loss of the sense of reality of the surroundings.

Disorders of Thought Process

Disorders related to thinking process. They are as follows:

Disorders of Thought Content

- **Delusions** - A fixed false idea held in the face of evidence to the contrary and out of keeping with the patient's socio-cultural environment. It can be primary delusion, secondary delusion or systematized delusion.
- **Obsessional Thought / Obsessional Phenomenon** - Persistent intrusion into consciousness of unwanted thoughts, feelings or impulses, despite the individual's recognition of their senseless nature and resistance to them.
- **Thoughts Insertion and Withdrawal** - The experience of thoughts being put into or taken out of the mind by some external agency or force.
- **Thought Broadcast** - The experience that others can read or hear the individual's thoughts as they are 'broadcast' from him or her. Hearing one's thoughts spoken aloud.

- **Passivity Phenomena / Made Actions** – Passivity phenomena is a disintegration of boundaries between self and surrounding world. Made actions can be described as either simple motor actions or more complex patterns of behaviour that are experienced as being caused by an outside agents.

Disorders of Form of Thought

These are symptoms and signs reflecting problems in **formation** of ideas from thoughts. These include:

Accelerated Tempo, which can result in:

- Pressure of speech – This can be found in Mania
- Flight of Ideas – This also can be found in Mania
- Loosening of Association – Usually found in Schizophrenia
- Word Salads – Extreme of loosening of association, often found in Schizophrenia

Decreased Tempo, which can result in:

- Poverty of Speech – Often found in depression
- Perseveration – Can be found in depression, delirium and some other mental disorders

Others –

- Derailment – Patient derails from subject being discussed
- Thought Blocking – Sudden stoppage of speech in the middle of conversation, may result from thought withdrawal
- Neologism – Formation of new words

Thoughts, Speech and Writing

Speech and Writing are the windows for assessment of thought process. Disorders of thought process are often reflected through patient's speech or writing. For example, the level of derailment, loosening of association, neologism will decide whether the patient's speech will be coherent or incoherent. A patient with pressure of speech and flight of ideas will have copious speech. A patient with poverty of speech may be mute or give monosyllabic answers.

Disorders of Emotion

Mood – The emotional tone prevailing at any given time. This is usually the patient’s assessment of self.

Affect – Synonymous with prevailing emotion. This is usually the clinician’s assessment of patient’s mood.

The Affect can be low, high, cycling and blunt (blunt affect). There may be need for a clinician to determine whether a patient’s Affect is congruent or incongruent with the Mood as expressed by the patient. Incongruent Affect in relation to the expressed Mood is often characteristic of Schizophrenia.

Disorders of Cognitive (Intellectual) Functioning

Consciousness and Alertness – There are different grades of level of consciousness ranging from being fully conscious and alert to being in coma. The different grades are as follows:

- Clouding of consciousness
- Drowsiness
- Stupor
- Coma

A patient with delirium may have impairment in level of consciousness and alertness.

Attention and Concentration – Attention is defined as the ability to focus and Concentration is defined as the ability to sustain the focus. These may be impaired in patient with mental illness and are usually tested with serial 3 or serial 7 for educated patients. These can also be assessed and detected during the process of conversation with the patient while clinical history is being taken.

Disorders of Memory - Impairment in any of the following types of memory may occur in a patient with mental illness, especially cognitive disorders:

- Immediate Memory / Registration of Information
- Short Term Memory / Recent Memory
- Long Term Memory / Remote Memory

Judgment

Judgement of a patient with mental illness may be impaired or intact. Assessment is made whether a patient's decision or line of action in a particular circumstance is appropriate.

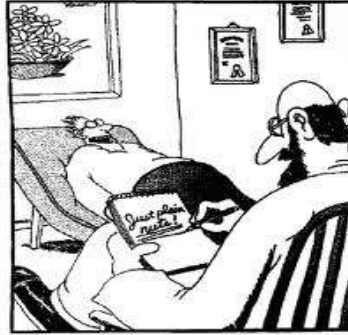
Insight

It is described as a correct attitude to morbid change in oneself. It includes;

- Recognition of Illness
- Attribution of Illness (to mental disorder or other phenomena)
- Awareness of Treatment Benefit and Compliance with treatment
- Awareness of Social Consequences of Illness e.g. disability, handicap, response and concern of relatives.

Chapter 5

History Taking in Psychiatry



History taking in psychiatry is like taking history in other sub-speciality of medical practice, but there are subtle areas of differences. History from patients with psychiatric disorders often needs to be supplemented by information from relatives or any other person who knows the patient quite well. This is because patients with psychiatric disorders are often not aware of the extent of their symptoms.

Format for History Taking

Demographic Data: Data like name, age, sex, marital status, present occupation, address, religious affiliation, ethnic background of the patient are important and relevant to patient's management.

Informant(s): Take note of the informant(s), whether patient himself/herself, relatives, friends, police among other people.

Presenting Complaints: Document the presenting complaints

History of Presenting Complaints: Document in details the chronology of development of different symptoms. Rule in and rule out all other possible diagnoses.

Past Psychiatric History: This is important and contributes to arriving at diagnoses. There might have been previous episodes of the illness. It is important to establish whether the current episode is a relapse or recurrence of previous episodes.

Past Medical History: It helps to identify possible physical co-morbidity and contribute to the management planning.

Family History: This helps to elucidate family functioning and to know if there is any family history of similar illness. Establish whether relatives are mentally stable, functioning and well adjusted.

Personal History: It seeks information about patient's growing up, educational attainment, and relationship with family and friends during the various stages of growing up; it also includes patient's sexual history and orientation.

Pre-morbid Personality/History: Here, you want to establish quality of relationships, predominant mood, character and attitudes of the patient prior to the onset of illness.

Drug History: Any active use of psychoactive substances and other medications. Use of psychoactive substance, if you think contributes to current illness should be documented in details under presenting complaints and history of presenting complaints.

Forensic History: It seeks to establish whether patient has had any arrest, conviction, imprisonment, offences and contact with law enforcement agents.

Gynaecological History: Past menstrual period, Parity, Pregnancy histories are important here. Illness may be associated with pregnancy and post-partum period.

Mental State Examination

While taking the clinical history, it is important to observe the patient and make a documentation of the mental state following these steps:

Appearance and Behaviour: Kempt or Unkempt in terms of dressing and personal hygiene. Are there gesticulations and motor activity?

Speech: The speech may be comprehensible or incomprehensible. Observe the volume of speech and form of speech. The speech could be copious and pressured as may be found in mania. There may be poverty of speech as found in depression. There could also be derailment, flight of ideas and loosening of association.

Mood: Patient's assessment of his/her prevailing emotional state. The mood may be happy, sad, anxious, agitated and so on.

Affect: Clinician's assessment of the patient's prevailing emotional state. It is important to establish whether the affect is congruent or not congruent with the mood.

Disorders of Perception: Hallucinatory experiences which could be through the five senses (auditory, visual, somatic, etc). Illusions can also occur (visual, auditory, etc). Patient may experience disorders of self awareness in relation to the environment, such as derealisation and depersonalization.

Disorders of Thought Process:

- Thought Content - Delusions
- Obsessional Thought Phenomenon - Intruding unwanted thoughts
- Thought Form - Loosening of association, Word salad, Flight of Ideas, etc. Usually reflected through patient's speech.
- Passivity Phenomena - Patient is made passive in his/her experiences and is not in total control of his thoughts and sometimes actions. The phenomena include; Thought Insertion, Thought Withdrawal, Thought Broadcast and Made Actions.

Cognitive Functions:

- Consciousness and Alertness
- Intellect - Reflected in the general reserve of knowledge
- Orientation - Orientation in Time, Place and Person
- Attention and Concentration - Attention is defined as the ability to focus, while concentration is defined as the ability to sustain the focus. Usually tested with serial 3 or serial 7 in educated patients.
- Memory - Consist of Immediate (Registration), Short Term (Recent Memory) and Long Term Memory (Remote Memory).

Judgment: Judgment determines whether a patient's decision or line of action is appropriate for a particular circumstance.

Insight: Patient's awareness of his/her own illness, the need for intervention and medications and awareness of social consequences.

Physical Examination

These consist of general physical examination and systemic examination consisting of Central Nervous System, Cardio-vascular System, Respiratory System, Gastro-Intestinal System, Renal System etc. Physical examination is essential to rule out co-morbid physical problems or to detect an association between physical and mental illness.

Diagnostic Formulation

Diagnostic formulation is a succinct assessment of the case. It addresses possible diagnoses, aetiology, treatment and possible prognosis.

List of Identified Problems

- Psychiatric Diagnosis - Identify predisposing, precipitating and possible perpetuating factors.
- Co-morbid Physical Diagnosis
- Social/Family Problems
- Occupational Problems
- Forensic Problems

Multi-Axial Diagnoses Based on ICD-10

- **Axis I** - Psychiatric Diagnosis
- **Axis II** - Level of Disability
- **Axis III** - Contextual Factors

Multi-Axial Diagnoses Based on DSM-IV-TR

- **Axis I** - Psychiatric Diagnosis
- **Axis II** - Personality Disorder
- **Axis III** - Co-morbid Physical Illness
- **Axis IV** - Psychosocial Functioning (Occupational/Social Problems)
- **Axis V** - Global Assessment of Functioning

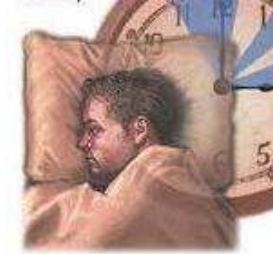
Diagnoses could either be made using ICD-10 or DSM-IV-TR Multi-Axial method or classification.

Management Plan

This should be individualized and directed towards solving identified problems. It often involves multi-disciplinary approach in which a number of professionals including Psychiatrist, Psychologist, Occupational Therapists, Social Workers among others participate in patient's management. Management approach has to be based on Bio-Psycho-Social dimensions to provide holistic care for the patient.

Chapter 6

Normal Sleep and Sleep Disorders



Sleep is essential for physical and psychological well being. Many psychiatric disorders present with sleep problem. For example, a patient with symptoms of mania do not see need for sleep and pre-occupied with excessive activity when he or she is suppose to be sleeping. A patient with depression often does not sleep enough too and will usually ruminate about many ideas while not asleep. Sleep problem also apply to schizophrenia and other psychotic disorders.

Normal Sleep

There are two broad physiological stages of normal sleep: Non-Rapid Eye Movement (NREM) sleep and Rapid Eye Movement (REM) sleep.

Non Rapid Eye Movement (NREM) sleep is further divided into four different stages based Elecro-Encephalography (EEG) tracing:

Stage I - Characterized by low voltage, desynchronized activity on EEG tracing

Stage II - Frequent spindle-shaped and high-voltage K complexes on EEG tracing

Stage III - High voltage delta waves are seen on EEG tracing.

Stage IV - Delta waves consisted of over 60% of the waves on EEG tracing.

Rapid Eye Movement (REM) sleep is comparable to wakeful state and often characterized by increased muscle tone.

Sleep Disorders

Sleep disorders is divided into three broad categories: Dyssomnia; Parasomnia; and Other Sleep Disorders.

Dyssomnia

Primary Insomnia - Primary lack of sleep in the absence of underlying general medical condition.

Primary Hypersomnia - Excessive sleep (Somnolence) in the absence of underlying medical condition.

Narcolepsy - Excessive daytime sleepiness with abnormal manifestation of REM sleep.

Parasomnia

Nightmare Disorder - Nightmares are long frightening dreams from which people awaken frightened. Usually occur during the stage of REM sleep. It is characterized by increased motor activities while asleep. Patient often remembers the content of the dream.

Night Terror Disorder - A sleep terror is an arousal in the night, often heralded by scream and associated with behavioural manifestations of intense anxiety and panic symptoms. Usually patient cannot remember the details of the dream that lead to night terror. Usually occur during the NREM sleep.

Sleepwalking Disorder - This is also known as somnambulism. It is characterized by symptoms of leaving bed and walking about during sleep. Usually occur during NREM sleep. Usually patient does not remember the events that transpire during somnambulism.

Sleep Paralysis - Sleep paralysis is characterized by a sudden inability to execute voluntary motor activity either just at the onset of sleep or on awakening during the night or in the morning.

Other Sleep Disorders

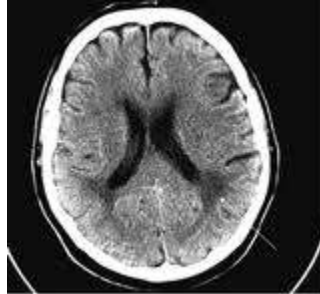
Sleep disorders due to other psychiatric disorders

Sleep disorders due to general medical conditions

Substance Induced sleep disorders.

Chapter 7

Cognitive Disorders



Cognitive disorders are disease conditions characterized by impairment in cognitive functions. This could involve impairment of memory, perception, thinking process or mood. It can also present in form of personality change.

Delirium, dementia and amnesic disorder are the most common form of cognitive disorders that usually present in psychiatry practice.

Delirium

Delirium refers to acute generalized cognitive impairment which often presents with features of impairment in level of consciousness. Delirium is a common presentation in medical wards.

Clinical Features

The key factor is that the presentation is acute. The presentation may vary from one patient to another and from time to time. Common symptoms include;

- Slowness
- Poor Attention and Concentration
- Impairment of Memory
- Disorientation in Time, Place and Person
- Illusions
- Hallucinations, usually visual hallucination.
- Overactivity

- Irritability
- Noisiness
- Reduced Speech and Perseveration
- Anxiety
- Depression
- Labile Mood
- Agitation

Aetiology

Trauma - e.g. Head injury

Metabolic Factors - e.g. Drug intoxication, Organ failure like renal failure, hepatic failure, hypoglycaemia complicating diabetes mellitus.

Infection - This could be Intracranial Infection or Systemic Infection.

Epilepsy/Seizure Disorder

Intracranial space occupying lesion or intracranial haemorrhage

Nutritional and Vitamin Deficiency - e.g. Thiamine, Vitamin B₁₂

Management

Management is usually based on primary cause. So, primary cause has to be established through history taking, physical and mental state examination alongside clinical investigations.

Dementia

Dementia refers to chronic generalized cognitive impairment. It is usually not associated with impairment in consciousness unless complicated by delirium.

Clinical Features

- The development of symptoms is insidious and chronic.
- Memory Impairment: This could include immediate, short term and long term memory. Usually there is problem with recent learning (Registration and short-term memory).

- Confabulation: This is making up story to cover up for deficiency resulting from memory loss.
- Personality Change
- Hallucinations
- Delusion
- Labile Mood
- Depression – Dementia may be complicated with depression.
- Anxiety – Dementia may also be complicated with anxiety.
- Disorientation: This is usually for time first and later for place and person
- Language Problem
- Irritability
- Disinhibition
- Sudden burst of emotion of anger (Catastrophic reaction)

Aetiology

Degenerative Conditions – Alzheimer, Pick’s disease, Parkinson disease, etc

Metabolic Problems – e.g. chronic renal failure

Infection – e.g. chronic encephalitis, HIV, Neurosyphilis

Vascular – Vascular dementia, usually due to chronic vascular occlusions

Toxic – From chronic intake of alcohol, heavy metal poisoning like Lead

Lack of Vitamin – Sustained lack of Vitamin B₁₂, Folic acid

Hypoxia/ Anoxia – Sustained deprivation of oxygen

Trauma – Head injury, punch drunk syndrome in retired boxers

Management

This is often palliative and directed at the aetiological factor

Amnestic Disorder

Amnestic disorder or amnestic syndrome is characterized by disorder of recent memory and that of time sense in the absence of generalized cognitive impairment. That is, isolated problems of recent memory and time sense.

Clinical Features

- Impairment of recent memory
- New learning is difficult
- Remote memory or long-term memory is often relatively preserved
- Disorientation in time sense
- Confabulation can occur to cover up for deficiency arising from recent memory problem
- Other cognitive functions are usually well preserved: Patient is conscious and alert, able to hold conversation, but will forget the events few minutes thereafter.
- Emotional Blunting

Aetiology

- Alcohol Abuse: Most frequent cause
- Dietary deficiency of Vitamin-B Complex
- Direct effect on the brain through vascular lesion, carbon monoxide poisoning, encephalitis, tumours and iatrogenic from surgery, head injury and so on.

Management

This is usually palliative and directed at the aetiological factor.

Cognitive Disorders as Classified in DSM-IV-TR

Dementia

Dementia of the Alzheimer's type with early onset

Dementia of the Alzheimer's type with late onset

Vascular dementia

Dementia due to HIV disease

Dementia due to Head Trauma

Dementia due to Parkinson's disease

Dementia due to Huntington's disease

Dementia due to Pick's disease

Dementia due to Creutzfeldt-Jakob's disease

Delirium

Delirium due to a general medical condition

Substance induced delirium

Delirium due to multiple aetiologies

Amnesic Disorders

Amnesic disorder due to general medical condition

Substance induced persisting amnesic disorder

Investigations in Cognitive Disorders

Neuroimaging - which could include X-ray, CT-Scan and MRI are important investigations alongside other investigations in making a diagnosis of cognitive disorder.

Chapter 8

Mood Disorders



Mood disorders are disorders of depression and elation of the mood.

Depressive Disorders

Depressive disorders occur in about 15 to 25 percent of the general population. It is commoner in women than men with a ratio of about 2:1.

Clinical Features

Depressive mood

Pessimistic Thinking (Depressive Cognition) - This include overgeneralization, selective abstraction etc.

Lack of interest and enjoyment in previously enjoyed activities

Reduced Energy - Affecting daily responsibilities and activities

Psychomotor Retardation - Slowing of motor activities

Slowed Thinking Process - Resulting in poverty of speech, mutism and sometimes perseveration

Lack of Appetite

Impairment in Attention and Concentration

Delusion of guilt - Admitting to being guilty of an act not committed

Perceptual disturbances, e.g. Hallucinations may occur; it could be auditory in form of derogatory comments about the patient. Visual hallucinations may occur about scenes of death and destruction etc.

Nihilistic delusion (Cotard Syndrome) – Delusion of non-existent

Sleep difficulty (Insomnia), usually characterized by early morning awakening.

Aetiology

Genetic Factor

Parental Deprivation

Defective relationship with parents

Recent Life Events – e.g. Frustration in achieving a goal, problem with relationship, loss of love object”, loss by separation or death

Poor social support – Lack of intimacy and confidants

Depression complicating general medical conditions, e.g. most chronic illnesses

Psychological theories of aetiology:

- Learned Helplessness
- Cognitive Theories – arbitrary inference, selective abstraction, overgeneralization and personalization

Biochemical Theories: Deficiency of monoamine neurotransmitters like serotonin, noradrenalin and dopamine

Endocrine pathology, e.g. Addison’s disease, hypothyroidism, hyperparathyroidism

Management

This starts with assessment (history taking, mental state examination, physical examination).

Treatment is better individualized.

Pharmacotherapy

Antidepressants

Tricyclic Antidepressants (TCA) – e.g. Imipramine, Amitryptiline

Monoamine Oxidase Inhibitors (MAOIs) – e.g. Meclobemide

Selective Serotonin Reuptake Inhibitors (SSRI) – e.g. Sertraline, Fluoxetine

Serotonin Norepinephrine Reuptake Inhibitors (SNRI) – e.g. Venlafaxine

Mood Stabilizer

These are usually not first line of treatment for unipolar depression, but can be used as adjunct therapy. They include; Antiepileptics, e.g. Carbamazepine, Sodium Valproate and Lithium Salt.

Psychotherapy: e.g. Cognitive Behaviour Therapy

Physical Therapy – Electro-Convulsive Therapy (ECT), Exercise, Music therapy, among others.

Sub-Types of Depressive Disorders

Mild depressive disorder

Moderate depressive disorder

Severe depressive disorder

Recurrent depressive disorder

Atypical depression

Unipolar Mania

There is usually elation of mood and opposite of what is observed in depression.

Clinical Features

Elation of mood

Increased activity

Appearance often reveals brightly coloured and ill-assorted clothes. When severe, the patient appearance may become untidy and dishevelled.

Speech is often rapid and copious as there is pressure of speech which results from rapid ideas formation.

Flight of Ideas

Deprivation of sleep, but patient would still be energetic.

There may be increased appetite

Disinhibition and increased sexual desire

Expansive Idea and Grandiose delusions

Hallucinations

Patient may become extravagant and become overly generous without reason

Aetiology

Genetic Factor

Life Events - e.g. Frustration in achieving a goal, failure of an examination, loss and disappointment

Manic symptoms due to general medical conditions

Biochemical Theories - Neurotransmitter abnormality, especially dopamine

Bipolar Disorder

As the name implied, bipolar disorder refers to two poles disorder. Patients who had experience alternating symptoms of depression and mania qualify for a diagnosis of bipolar disorder. Some schools of thought, especially DSM-IV-TR believe that patients who had experienced symptoms of unipolar mania may also qualify for a diagnosis of bipolar disorder. This is based on a premise that on longitudinal follow up, this group of patients will invariably suffer from a depressive episode.

Management

This starts with assessment (History taking, mental state examination and physical examination)

Pharmacotherapy

- Antipsychotics - e.g. Haloperidol, Olanzapine
- Mood Stabilizer - e.g. Carbamazepine, Valproate, Lithium

Psychotherapy - Usually after resolution of acute psychotic symptoms.

Physical Therapy - e.g. Electro-Convulsive Therapy (ECT)

Chapter 9

Anxiety Disorders, Obsessive Compulsive Disorder and Reaction to Stressful Experiences



Anxiety Disorders

Anxiety disorders are group of disorders that present with physical and psychological symptoms of anxiety.

Clinical Features

Psychological Symptoms

- Fear
- Irritability
- Heightened sense of perception
- Restlessness
- Impaired Concentration
- Apprehension
- Insomnia
- Obsessions
- Depersonalization

Physical Symptoms – Mostly features of sympathomimetic activities that could include:

- Dry mouth
- Dysphagia
- Epigastric pain
- Flatulence
- Loose Stool
- Dyspnea
- Chest Constriction
- Hyperventilation
- Palpitation
- Awareness of missed beats
- Frequent Micturition
- Erectile Dysfunction
- Menstrual Discomfort
- Amenorrhea
- Tremor
- Dizziness
- Headache
- Muscle Ache
- Tingling Sensation

Anxiety Disorders as Classified in ICD-10 and DSM-IV-TR

- Agoraphobia without panic disorder
- Agoraphobia with panic disorder
- Social phobia
- Specific phobia

- Panic disorder
- Generalized Anxiety Disorder
- Mixed anxiety and depressive disorder

Aetiology

- Stressful Events
- Genetic Factors
- Personality Types

Management

This begins with Assessment (History taking, mental state examination, and physical examination).

Psychotherapy - Usually the first line of treatment and includes:

- Counselling
- Cognitive Behaviour Therapy
- Relaxation Training
- Anxiety Management Training

Pharmacotherapy - Not usually the first line of treatment and it includes:

- Antidepressants - TCA, SSRI
- Beta-Adrenergic Antagonist - e.g. Propanolol
- Benzodiazepines, e.g. Diazepam, Nitrazepam

Obsessive Compulsive Disorder

Obsessive compulsive disorder is characterized by obsessional thoughts, compulsive behaviour, varying degrees of anxiety and sometimes depression and depersonalization.

Clinical Features

- Obsessional Thoughts – words, ideas, beliefs consider as alien but intruding forcibly into the mind.
- Obsessional Ruminations
- Obsessional Rituals – e.g. repeated hand washing, checking repeatedly if the door is locked.
- Anxiety Symptoms are common in obsessive compulsive disorder

Aetiology

- Genetic Factor
- Evidence of brain disorder e.g. Encephalitis
- Abnormal Serotonergic Function
- Learning Theory and Early Life Experiences

Management

Starts with Assessment (History taking, mental state examination, physical examination)

Psychotherapy:

- Counselling
- Behaviour Therapy

Pharmacotherapy:

Antidepressants - TCA – e.g. Clomipramine; SSRI – e.g. Sertraline, Fluoxetine, etc

Psychosurgery: It is usually a treatment of last resort in severe cases. Procedure may include bimedial leucotomy and cingulotomy.

Reaction to Stressful Experiences

The core feature of the disorders under this category is that there is a stressful event(s). The disorders are characterized by anxiety symptoms mostly. Three types of disorders under this category are listed in ICD-10 and DSM-IV-TR.

Acute Stress Reaction (Acute Stress Disorder)

This is characterized by brief and immediate responses to acute intense stressors in a person who does not have another mental disorder. The clinical features consist of both physical and psychological symptoms of anxiety as highlighted earlier.

Posttraumatic Stress Disorder (PTSD)

This is a prolonged and abnormal response to exceptionally intense stressful events which may include physical assault, rape, natural disaster like storm, earthquake, etc.

Clinical Features of PTSD

- Hyperarousal
- Intrusion or Re-experiencing
- Avoidance
- Other physical and psychological symptoms of anxiety

Adjustment Disorder

This is a more gradual and prolonged response to stressful changes in a person's life. It could be characterized by anxiety symptoms, depressive symptoms and conduct problems.

Reaction to Stressful Experiences as Listed in ICD-10 and DSM-IV-TR

Acute Stress Reaction (Acute Stress Disorder)

Posttraumatic Stress Disorder

Adjustment Disorder

- With depressed mood/symptoms
- With anxiety symptoms

- With mixed anxiety and depressed symptoms
- With disturbance of conduct
- With mixed disturbance of emotion and conduct
- Other unspecified symptoms

Management

Management starts with Assessment - History taking, mental state examination, physical examination.

Psychotherapy - Mainstay of treatment.

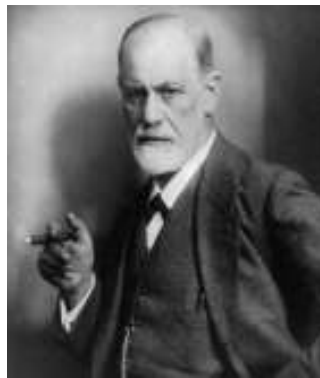
Pharmacotherapy - May be required to treat associated anxiety and depressive symptoms.

Chapter 10

Theories of Personality Development and Personality Disorders



There are many theories of personality development. This chapter will describe the three popular ones as proposed by Sigmund Freud, Erik Erikson and Jean Piaget.



Sigmund Freud (1856 - 1939)

Sigmund Freud - Psychosexual Theory of Personality Development

Oral Stage (0 to 1 year): This stage is characterized by pre-occupation with the mouth and the urge to satisfy personal pleasure first (inability to delay gratification). Failure to successfully pass through this stage leads to “Narcissism” (pre-occupation with self).

Anal Stage (1 to 3 years): This is the period of toilet training and emphasis is placed on cleanliness and orderliness. The child learnt that it is wrong to defecate or urinate anywhere and anytime and will run for his/her defecating pot. Failure to successfully pass through this stage results in obsession with cleanliness, orderliness and so on.

Phallic Stage (3 to 5 years): The child usually plays with the genitals and derives pleasure from doing this. Freud postulated that this is a stage of first awareness for sexual pleasure, the male child sees the mother as a source of sexual pleasure, gain so much attachment to the mother and compete with the father for the attention of the mother (Oedipal Complex). The reverse of this where by a female child gain so much attachment to the father and compete with the mother for attention is referred to as 'Electra Complex'.

Latency Stage (6 to 11 years): This period is characterized by repressed sexual instinct. The boys direct their play interest to fellow boys and keep a company of boys as friends mostly. The same happens to a girl child who during this period derives pleasure from keeping company of fellow girls as friends.

Genital Stage (12 years and above): Sexual instincts gradually re-surface. Sexual interest in the opposite sex developed and boys and girls direct their interest and love to the opposite sex rather than individuals of the same sex. This period heralds the period of sexual maturity.

Closely related theory to the psychosexual stages of personality development is Sigmund Freud's structural model of the mind divided into the concepts of **Id, Ego** and **Super Ego**.

Id - Id is impulsive, works on pleasure principle. It only takes into account what it wants here and now and disregards all consequences. It satisfies gratification without question or second thought.

Ego - Ego maintains the balance between Id and Super Ego. Ego asks the questions; is the place and time appropriate for a particular action? Are there consequences for doing it here and now? Ego delays or postpones gratification.

Super Ego - Super Ego asks the moral question; is the action right at all, even if postponed or delayed? Super Ego overrides or denied gratification.

Interaction among these three components can create conflicts in the mind and can lead to various defence mechanisms for action taken or not taken. Defence mechanisms include **denial**,

rationalization, displacement, etc. Examples are; 'It is not my fault'; 'After all, everybody does it'. Biblical Adam said in the beginning; 'The woman whom thou gavest to be with me, she gave me of the fruit of the tree and I did eat'.

Erik Erikson – Psychosocial Theory of Personality Development



Erik Erikson (1902 - 1994)

Basic Trust Vs Mistrust (0 to 1 year): The child recognized self as different from every other person and his/her environment. This is period of Ego Identity. The child established the reliability of the caregiver.

Autonomy Vs Doubt (2 to 3 years): The child feels in charge and wants to explore. If face with perceived danger or uncertainty, the child will doubt his/her ability.

Initiative Vs Guilt (4 to 6 years): The child want to take initiative at doing something, but when face with failure in the attempt, it leads to guilt.

Industry Vs Inferiority (7 to 13 years): Competitiveness and success result in more hard work, but failure leads to feeling of inferiority.

Identity Vs Role Confusion (14 to 20 years): This a period when questions are asked; Who am I? Why am I here? What role am I suppose to play in life?

Intimacy Vs Isolation (Young Adult): This is the period when capacity to love and be loved developed. This is the period of commitment of oneself to another.

Generativity Vs Stagnation (Adulthood): There is measurement of accomplishment and desire to achieve more or stagnation at this stage.

Integrity Vs Despair (Old Age): During this period, the questions are asked; Have I run a good race? Do I have any regrets? Individuals either experience sense of accomplishment or despair answering these questions.

Jean Piaget - Theory of Cognitive Development



Jean Piaget (1896 - 1980)

Sensorimotor Stage (0 to 2 years) - The child develop sense of object permanence. He/She knows that when mother goes away, she will eventually come back.

Pre-operational Stage (2 to 7 years) - The child see things in his or her own way, develop egocentrism. The child also develops use of language and symbol.

Concrete Operational Stage (7 to 12 years) - The child develop concept of conservation. This is what Mum and Dad said it is, that is what it is.

Formal Operational Stage (12 years and above) - The child is now capable of abstract thinking. At this stage, the child asks questions, queries dogma and beliefs.

Personality Disorders

Personality disorders are defined as deeply ingrained maladaptive patterns of behaviour recognizable by the time of adolescence or earlier and continuing through most of adult life, although often becoming less obvious in middle or old age. As a result of these maladaptive patterns of behaviour, the individual suffers or others have to suffer and there is an adverse effect on the individual or on the society.

Types of Personality Disorders

Paranoid Personality Disorder - Individual with this type of personality disorder is suspicious, sensitive, mistrustful and self important.

Schizoid Personality Disorder - Individual with this type of personality disorder is emotionally cold, detached, aloof, humourless and introspective.

Schizotypal Personality Disorder - This type of personality disorder is characterized by features found in Schizoid personality disorder, but with additional features of oddities of ideas and experiences, e.g. telepathy, clairvoyance, etc.

Antisocial (Dissocial) Personality Disorder - Individual with this type of personality disorder disregard the feelings of others. He/She is unable to sustain relationship, has low tolerance for frustration, has high tendency to violence, he/she lacks guilt, and there is failure to learn from past experiences.

Impulsive Personality Disorder - Individual with this type of personality disorder is unrestrained, is emotionally labile with outpouring of anger.

Borderline Personality Disorder - This type of personality disorder is characterized by unstable relationships, impulsive behaviour, labile mood, lack of control, recurrent suicidal threats or behaviour, uncertainty about personal identity, chronic feeling of emptiness. These individuals often make efforts to avoid abandonment.

Histrionic Personality Disorder - This type of personality disorder is characterized by being vain, self-centred, short-lived enthusiasms, craving for novelty and excitement and unrestrained emotional display.

Narcissistic Personality Disorder - This type of personality disorder is characterized by grandiose sense of self importance, pre-occupation with fantasies of unlimited success power and intellectual brilliance. Individual with this type of personality disorder is self absorbed.

Obsessive Compulsive (Anankastic) Personality Disorder - This type of personality disorder is characterized by being obstinate, inflexible, paying attention to details. Individual with this type of personality disorder lack emotion or humour, he/she has high standards, judgemental, but law abiding.

Anxious (Avoidant) Personality Disorder - Individual with this type of personality disorder is uncomfortable in company of other people, he/she fears disapproval, criticism and rejection. Such individual has poor self esteem, see self as being inferior to others, unappealing and socially incompetent.

Dependent Personality Disorder - Individuals with this type of personality disorder are characterized by being weak willed and unduly compliant with the wishes of others. They avoid responsibilities and lack self-reliance.

Passive-Aggressive Personality Disorder - Individual with this type of personality disorder responds to situation with some form of passive resistance such as procrastination, stubbornness, pretended forgetfulness. Such individual criticizes people in authority unreasonably.

Dissociative Identity Disorder (Multiple Personality Disorder) - Dissociative identity disorder, formerly known as Multiple Personality Disorder is classified under Dissociative Disorders in DSM-IV-TR. It is characterized by at least two distinct and relatively enduring identities or dissociated personality states that alternately control a person's behaviour and is accompanied by memory impairment for important information not explained by ordinary forgetfulness.

Management of Personality Disorder

This starts with assessment with detail history taking, mental state examination and physical examination.

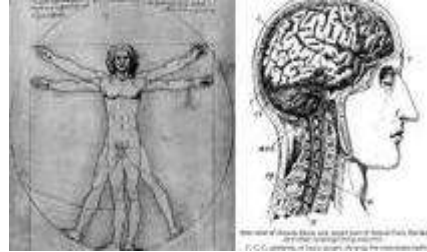
Psychotherapy – Mainstay of treatment.

Pharmacotherapy:

- Antipsychotic – May be useful for antisocial personality disorder
- Anxiolytics – May be useful for anxious (avoidant) personality disorder to mitigate aggressive behaviour.
- Tricyclic Antidepressant – May be useful in anxious and obsessive compulsive personality disorder to relieve anxiety state.
- Antiepileptics – Could be useful in treating burst of violence and aggression.

Chapter 11

Psychiatry and Other Medical Specialties



Psychiatric Disorders that present with physical symptoms

There are a number of psychiatric disorders that present with physical symptoms. Common types of such psychiatric disorders will be discussed in this chapter.

Somatisation Disorder (Briquet's Syndrome) – Somatisation disorder is described as a syndrome of chronic multiple somatic complaints with no identified organic cause. Invariably, detail medical examination and investigation will not reveal any cause. Common presentations are heat in the head, body heat, crawling sensation, etc.

Conversion Disorder – This is also known as dissociative disorder. The old terminology is 'Hysteria' according to ICD-10. The condition is characterized by symptoms presentation without any demonstrable organic findings. There is a strong presumption that the symptoms presentation is linked to unresolved internal conflict or stress. The reaction to this unresolved conflict appears to be at an unconscious level. Presentation is more common among females. Listed below are cardinal features necessary for diagnosis of conversion disorder.

- Primary gain – Achieve the aim of resolving the conflict and resolving anxiety
- Secondary gain – Seeks and get the attention of others
- Symptoms presentation – This is modelled closely on recent experience in self or others, e.g. seizure, motor paralysis e.t.c.
- Manipulation – Manipulation of others and the environment

- Patient may have hysterical personality type or disorder

Conversion disorder is further classified according to symptoms presentation as follows:

- Presentation with Motor symptoms or deficits, e.g. psychogenic paralysis, psychogenic tremor, feeling of lump in the throat, etc.
- Presentation with Sensory symptoms or deficits, e.g. psychogenic deafness, psychogenic blindness etc.
- Presentation with Seizure and Convulsion – psychogenic convulsions

Hypochondriasis – Hypochondriasis is defined as a state of disease conviction and disease phobia. It is a belief of having a serious disease based on the individual's interpretation of feeling of physical signs and symptoms as evidence of physical illness. Example is an individual who believes he has brain tumour because he has been feeling intermittent headache. The patient would have sought repeated medical help and change physicians repeatedly without finding any underlying pathology. Co-morbidity with depression and other disorders is common.

Dysmorphophobia – This is a condition characterized by the conviction that some part(s) of the body is too large, too small or disfigured. However, to other people the appearance is normal. The common complaints are about the nose, ears, mouth, breasts, penis, but any part of the body may be involved.

Munchausen's Syndrome – This is a fraudulent act of assuming a sick role when the individual is not actually ill.

Malingering – This is characterized by fraudulent simulation or exaggeration of symptoms.

Chronic Pains – This is characterized by persistent pain without identifiable aetiological factor.

Psychiatric Consequences of Physical Illnesses

Psychiatric disorders often complicate many physical illnesses. Exhaustive list cannot be made of such co-morbidities, but few examples would be highlighted.

Acute Physical Illnesses

Malaria – Malaria infestation, especially cerebral malaria may be complicated with delirium and psychotic symptoms.

Typhoid Septicaemia – This could be complicated with delirium and psychotic symptoms (Typhoid Psychosis).

Tetanus Infection – May present with delirium.

Stroke or Cerebro-Vascular Accident (CVA) – May be complicated by delirium and depression.

Acute Organ Failure (e.g. Acute Renal Failure) – May be complicated with delirium

Chronic Physical Illnesses

HIV/AIDS – Could be complicated with delirium, dementia, psychosis, depression and even posttraumatic stress disorder.

Diabetes Mellitus – Could be complicated with delirium and depression

Sickle Cell Disease – Depression, anxiety and psychosis have been reported as complications

Hypertension – Could be complicated with anxiety and depression

Cancer – Could be complicated with anxiety and depression

Cardiac Problems – Could be complicated with anxiety, depression

Chronic Organ Failure (e.g. Chronic Renal Failure) – Could be complicated by delirium and depression.

Side Effects of Medications

Side effects of medications used in medical wards can cause symptoms of mental illness.

Example is some antihypertensive and depression.

Eating Disorders

Anorexia Nervosa – Malnourishment leading to radically reduced weight.

Bulimia Nervosa – This is a condition characterized by compulsive food eating which may lead to obesity.

Disorders related to Women and Child Birth

Premenstrual Syndrome – This is often characterized by mild to moderate depressive symptoms and the mood may be labile shortly before each menstrual cycle.

Postpartum Blues – This is characterized by presence of mild to moderate depressive symptoms within few days post child birth and the symptoms are not severe enough to meet diagnostic criteria for major depressive disorder.

Postpartum Depression - This is characterized by presence of depressive symptoms of a level of severity meeting diagnostic criteria for major depressive disorder within one year post child birth.

Puerperal Psychosis – This is characterized by presence of psychotic symptoms within one year post child birth.

Pseudocyesis – This is a false belief about being pregnant. Delusion of pregnancy, it often occurs co-morbidly with other psychiatric disorders but may occur alone. It is characterized by all symptoms of pregnancy, but pregnancy tests and ultrasound scan confirmed that there is no pregnancy.

***Note - Examples of inter-relationship between Psychiatry and other Medical Specialties given in this chapter are by no means exhaustive.**

Chapter 12

Schizophrenia and Related Disorders



Historical Background



Wihelm Greisinger (1817 - 1868)

Wihelm Greisinger, a German Psychiatrist in his paper of 1870 introduced the concept of 'Unitary Psychosis' which holds the notion that psychotic disorders are a continuum with varying degree of severity.



Emil Kraepelin (1856 - 1926)

Emil Kraepelin in 1893 after observing a group of patients with psychotic disorders over a period of time noticed that some patients' illness remitted without use of any medication, while others showed chronic illness state without resolution of the symptoms. He then classified these patients into two groups. The first group of patients with spontaneous resolution of their symptoms he referred to as 'Manic-depressive Psychosis', while he referred to the other chronic group without resolution of symptoms as 'Dementia Praecox', a term which means precocious dementia.

In 1911, Eugen Bleuler introduced the concept 'Schizophrenia' to refer to the group of patients Kraepelin classified as having 'Dementia Praecox'. The term 'Schizophrenia' literally means split psyche. Bleuler described schizophrenia as collection of psychotic disorders with fundamental symptoms referred to as, **(Four As)**.



Eugen Bleuler (1857 - 1939)

Eugen Bleuler's Four As

- *Ambivalence* - which may be noticed in motor activities.
- *Affective Incongruity* - when the affect of the patient is incongruent with expressed mood.
- Loosening of *Association* - which can be reflected in patient's speech or writing.
- *Autism*- Literally means being withdrawn to self.

In 1959, Kurt Schneider (1887 - 1967) introduced characterization of schizophrenia as disorders with First Rank symptoms. The First Rank symptoms include:

- Thought broadcast
- Third person auditory hallucinations
- Hallucinations in the form of a commentary
- Somatic passivity
- Thought withdrawal
- Thought insertion
- Made actions – feelings and experience as if under the control of an external force.
- Delusional perception

Epidemiology of Schizophrenia

Schizophrenia occurs in about 1% of the general population.

Clinical Features

The clinical features are as highlighted in Bleuler’s **Four As** and Schneider’s **First Rank** symptoms. There may be associated sleep difficulty and gradual deterioration in social and occupational functioning.

Aetiology

Genetic Factors

Biochemical Factors (Neurotransmitters)

- Dopamine – Dopamine overactivity in mesolimbic pathways
- Serotonin – Serotonin agonist induce psychosis and its antagonists improves symptoms of psychosis
- Noradrenaline – Overactivity can cause psychotic symptoms

Neuroimaging Findings - Structural and functional problems in the brain which include non-specific ventricular enlargement

Life Events – Adverse life events can precipitate symptoms of schizophrenia in a patient already predisposed as a result of high genetic load.

Management

Management starts with assessment which includes history taking, mental state examination and physical examination.

Pharmacotherapy

Typical Antipsychotics – e.g. Chlorpromazine, Haloperidol etc

Atypical Antipsychotics – e.g. Risperidone, Olanzapine

Physical Therapy

Electroconvulsive Therapy

Psychotherapy

Psychotherapy is usually employed after substantial resolution of acute psychotic symptoms.

Psychotherapy methods employed include:

- Supportive psychotherapy
- Cognitive Therapy – Usually for fixed encapsulated delusions

Related Disorders

Schizoaffective Disorder

Schizoaffective disorder describes patients with illness of mixed affective and schizophrenic symptoms. It is characterized by sudden onset after stressor. Individuals with schizoaffective disorder often have good pre-morbid adjustment.

Treatment

This could include use of a combination of antipsychotics and antidepressants.

Delusional Disorders

The hallmark of presentation is encapsulated delusion which is often a non-bizarre delusion. Functioning is often not markedly impaired and behaviour obviously not abnormal, if the subject of delusion is left untouched.

Sub-types of Delusional Disorders

- Persecutory delusional disorder
- Erotomania (De Clerambaut Syndrome) - Delusion of Love
- Othello Syndrome - Delusion of Jealousy
- Somatic delusional disorder
- Grandiose delusional disorder

Management

Require detail assessment. It is usually difficult to treat.

Psychotherapy - usually more of cognitive therapy

Antipsychotics may be useful in some cases.

Chapter 13

Psychoactive Substance Use Disorders



Definition of Terms

Intoxication – This is defined as a transient syndrome due to recent substance ingestion that produces clinically significant psychological and physical impairments. These changes disappear when the substance is eliminated from the body.

Abuse (Harmful Use) – This is maladaptive patterns of repeated substance use that impair the state of health in a broad sense.

Dependence – This refers to a strong desire to repeatedly take a substance and as a result gradually leading to progressive neglect of alternative sources of satisfaction. It is characterized by development of **tolerance**, which is a state where increasing doses of a substance is required to produce the same effect usually produced by a lower dose. A state of dependence often interferes with a patient's social and occupational functioning.

Withdrawal – This characterized by a group of symptoms and signs that occurs when a drug of dependence is reduced in amount or withdrawn. The nature of these symptoms and signs would be related to the particular substance of dependence.

Withdrawal with Delirium – This is a state of withdrawal with additional symptoms of delirium.

Psychotic Disorders induced by Psychoactive Substance – This is characterized by presentation of psychotic symptoms as a direct effect of a psychoactive substance.

Amnestic Disorder induced by Psychoactive Substance – Presentation of symptoms of amnestic disorder as a direct effect of a psychoactive substance.

Mood Disorder induced by Psychoactive Substance – This is presentation of mood symptoms resulting from a direct effect of a psychoactive substance.

Anxiety Disorders induced by Psychoactive Substance – Characterized by presentation of anxiety symptoms resulting directly from direct effect of psychoactive substance.

Sexual Dysfunction due to Psychoactive Substance – This is sexual dysfunction resulting from a direct effect of psychoactive substance.

Sleep Disorders due to Psychoactive Substance – Sleep disorders resulting from a direct effect of psychoactive substance.

Classification of Psychoactive Substances

- Alcohol – This is the most common psychoactive substance used
- Opioids – Examples include Heroin, Morphine, Meperidine, Methadone, Pentazocine.
- Cocaine and Crack-Cocaine
- Amphetamines
- Hallucinogens – Examples include Lysergic Acid Diethylamide (LSD), Mescaline, Psilocybin
- Phenylcyclidine
- Cannabis
- Barbiturates
- Benzodiazepine
- Belladonna Alkaloids – Examples include Homatropine, Atropine, etc.
- Methamphetamine - Ecstasy (MDMA) – 3,4 methylene dioxymethamphetamine.
- Volatile Substances – Examples include Acetone, Benzene, Trichloroethylene, Halogenated hydrocarbons.

Use of any of these psychoactive substances can result in intoxication, harmful use, dependence and other disorders highlighted earlier at the beginning of this chapter.

Chapter 14

Human Sexuality and Associated Disorders



Human sexual behaviour is essential for perpetuation of human race and healthy living condition.

Phases of Normal Human Sexual Response

- Desire
- Arousal
- Plateau – Maintenance of arousal
- Orgasm
- Resolution

Sexual Disorders

Disorders of Sexual Desire

- Hypoactive sexual desire or lack of sexual desire
- Sexual Aversion

Disorders of Sexual Arousal

- Female sexual arousal disorder
- Male erectile disorder/dysfunction

Orgasmic Disorders

- Female orgasmic disorder
- Male orgasmic disorder
- Premature ejaculation

Sexual Pain Disorders – Arising from:

- Vaginismus
- Dyspareunia

Sexual Dysfunction due to General Medical Conditions

This comprises of a range of sexual disorders that are direct effect of underlying general medical conditions, e.g. Hypertension, Diabetes Mellitus, e.t.c.

Substance-induced Sexual Dysfunction

This comprises of a range of sexual disorders that are direct effect of psychoactive substance use, e.g. Alcohol induced sexual dysfunction.

Disorders of Sexual Preferences (Paraphilia)

- Exhibitionism – Deliberate exposure of genitalia by adult male in the presence of unwilling female and not as a prelude to sexual intercourse
- Fetishism – The preferred means of achieving sexual excitement are inanimate objects, e.g. women pants, women bra, stockings etc
- Transvestic Fetishism – This refers to preference for cross-dressing. The term is usually applied to males with preference for wearing articles of female clothing
- Paedophilia – This describes erotic attraction to young children
- Sexual Sadism – This describes a situation where sexual excitement is derived by inflicting pain, humiliation and bondage during sexual intercourse
- Sexual Masochism – This describes a situation where sexual pleasure is derived from experience of pain

- Voyeurism – This is characterized by observing the sexual activities of others repeatedly as a preferred means of deriving sexual pleasure. Such individuals may also spy on naked women undressing or bathing
- Paraphilia Not Otherwise Specified – e.g. Necrophilia (Sexual pleasure derived from having sex with dead body); Zoophilia (Sexual preference for animals like dog, horse etc)

Homosexuality

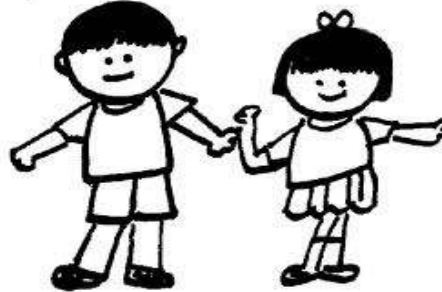
Homosexuality is now classified as a normal variant of sexual preference. It is no more classified as a disorder of sexual preference as it was many years ago. Advocate for legitimate right for same sex marriage is presently prevailing in the United States of America (USA) and other western countries in Europe.

Gender Identity Disorder

Transsexualism – This is a core gender identity problem characterized by a biological male who believed and is convinced that he is suppose to be female and vice-versa. Such individuals would do anything to assume the convinced gender role. They would engage in activities ranging from dressing in opposite sex clothes to seeking cosmetic surgery to change appearance and possibly genitalia.

Chapter 15

Childhood Psychiatric Disorders



Assessment of Children with Psychiatric Disorders

Assessment of children with psychiatric disorders takes special consideration to obtain additional information from parents and teachers about the child concerned. To get complete information, interviewing the child, the parents and the teachers is essential as perspectives of information that originate from different sources often differs.

Internalizing Symptoms - Children and adolescents are better at describing emotional problems they are going through which might not be obvious to the parents or the teachers.

Externalizing Symptoms - Information regarding externalizing symptoms such as attention deficit hyperactivity, conduct problems, which the child might find difficult to give account of is better obtained from the parents and the teachers.

Childhood Psychiatric Disorders in Pre-School Age Children

Reactive attachment disorders

The child either keeps excessively to self or become overly friendly to total strangers. The condition often results from lack of parental bonding. The disorder is commoner among Institutionalized children.

Specific Developmental Disorders – These are disorders that affect specific areas of childhood development. They include:

- Specific developmental disorder of scholastic skills
- Specific developmental disorders of speech and language
- Specific developmental disorder of motor skills

Pervasive Developmental Disorders – In pervasive developmental disorders, the impairments in development pervade almost all aspects of development. These disorders are often characterized by impairments in areas of social interaction, communication and repetitive, stereotypic patterns of behaviour may also be found in these children. According to ICD-10 and DSM-IV-TR these disorders include:

- Childhood Autism
- Childhood Disintegrative Disorder
- Asperger's Syndrome
- Rett's Syndrome

The DSM-V and the forthcoming ICD-11 subscribed to the notion that Autism is a disorder with spectrum severity. Therefore, in the new classifications (DSM-V & ICD-11), the term Autism Spectrum Disorder will replace Childhood Autism, Childhood Disintegrative Disorder and Asperger's Syndrome and these three terms will no longer be in use. In line with these changes, under the broad category of pervasive developmental disorders, there would be Autism Spectrum Disorder (ASD) and Rett's Syndrome.

Childhood Psychiatric Disorders in School Age Children

Attention Deficit Hyperactivity Disorder (ADHD) – This is characterized by hyperactive and inattention symptoms. It is usually diagnosed about the age of 6 years and above.

Conduct Disorder – This is a disorder of conduct in children and it can be likened to antisocial personality disorder in adults. Often occur co-morbidly with Attention Deficit Hyperactivity Disorder (ADHD) and other emotional problems.

Mixed Disorders of Conduct and Emotion – This is a mixture of conduct problems and presence of emotional symptoms.

Emotional Disorders with Onset Specific to Childhood – These include:

- Depressive disorders with onset specific to childhood
- Anxiety disorders with onset specific to childhood
- Obsessional disorder with onset specific to childhood

Psychotic Disorders with Onset Specific to Childhood – These include:

- Schizophrenia-like disorder of childhood onset
- Other psychotic disorders of childhood onset

Elimination Disorders – These include:

- Enuresis – This describes involuntary night time bedwetting in a child who was already continent (usually over 5 years of age) leading to soiling of clothes.
- Encopresis – This is defined as the voluntary or involuntary passage of stools in a child who had been toilet trained (usually over 4 years of age) which result in soiling of clothes.

Tic Disorders – Tic disorders is defined as repetitive, non-rhythmic, stereotyped motor activity. These could be motor tics or vocal tics.

Mental Retardation (Intellectual Disability)

Mental retardation is defined as significantly sub-average general intellectual or cognitive functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self care, home living, social and interpersonal skills

used for community resources, self direction, functional academic skills, work, leisure, health and safety and having an onset before the age of 18 years.

Classification Categories of Intellectual disability

Mild Mental Retardation (IQ 50 - 70)

Moderate Mental Retardation (IQ 35 - 49)

Severe Mental Retardation (IQ 20 - 34)

Profound Mental Retardation (IQ < 20)

Assessment and Diagnosis of Intellectual Disability

Diagnosis of children with Intellectual disability after thorough assessment could be in Multi-Axial forms comprising of three Axes:

Axis I - IQ Score/ Category

Axis II - Associated or underlying Medical Problem, e.g. Cerebral Palsy, Down's Syndrome, e.t.c

Axis III - Level of Disability/ Functioning

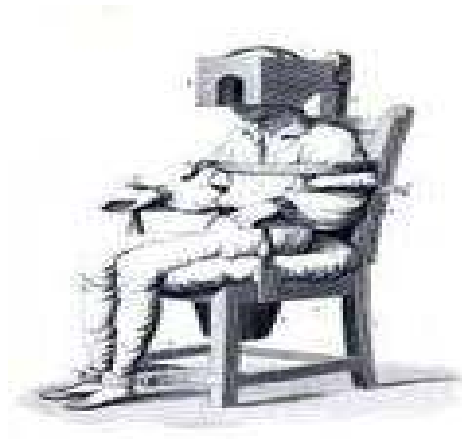
Chapter 16

Treatment Methods in Psychiatry



Physical Restraint

One of the earlier treatment methods in psychiatry before the advent of chemical restraint was physical restraint which can take different forms. Example of physical restraint method used in the olden days is shown in the figure below.



Earlier Physical Restraint Method

Physical restraint as a treatment method is still applicable in some cases in contemporary psychiatry practice, especially in patients with delirium following organic mental disorders which may include metabolic syndrome and organ failure.

Pharmacotherapy

Psychotropic medications used in psychiatric practice as discussed in this chapter is not exhaustive. Readers should consult a standard textbook of pharmacology to get detail information about pharmacokinetics, pharmacodynamics and side effects of these medications.

Psychotropic Medications Used in Psychiatry Practice

Antipsychotics (Neuroleptics)

- Typical (Conventional) Antipsychotics – e.g. Chlorpromazine, Haloperidol
- Atypical Antipsychotics – e.g. Risperidone, Olanzapine, Clozapine

Antidepressants

- Tricyclic Antidepressants (TCAs) – e.g. Imipramine, Amitriptyline
- Monoamine Oxidase Inhibitor – e.g. Phenelzine
- Selective Serotonin Re-uptake Inhibitor (SSRI) – e.g. Sertraline, Fluoxetine
- Serotonin Norepinephrine Re-uptake Inhibitor (SNRI) – e.g. Venlafaxine

Anxiolytics and Sedatives

- Benzodiazepines, e.g. Diazepam, Nitrazepam
- B-blockers – e.g. Propanolol

Anti-Epileptics and Mood Stabilizers

- Carbamazepine
- Sodium Valproate
- Lithium Salt

Stimulants

- Caffeine
- Amphetamine
- Methylphenidate

Physical Therapy

- Electroconvulsive Therapy
- Trans-cranial Magnetic Stimulation
- Psychosurgery
- Bright light Therapy
- Music Therapy
- Physical Exercise

Psychotherapy

- Counselling
- Psychodynamic Psychotherapy
- Cognitive Behaviour Therapy
- Group Therapy
- Family Therapy

Chapter 17

Suicide and Deliberate Self Harm



Assessment of Patient for Suicidal Risk

Assessment of a patient with psychiatric disorder often incorporates aspects of assessing whether the patient is dangerous to self and/or dangerous to others. When a patient is potentially dangerous to self, the probability of inflicting harm on self or engaging in the acts of suicide is high. Suicide often complicates many psychiatric disorders such as depression, bipolar disorder, disorders due to psychoactive substances, schizophrenia and other psychotic disorders.

Suicide assessment is very important in patients with psychiatric disorders. Assessment should focus on three levels of suicidal ideation, suicidal plan and suicidal act. Relevant questions should be asked to clarify whether the patient fit in into any of these three levels.

Suicidal Ideation or Intent - Patient has thought or is thinking about the idea of killing himself/herself. He/She often thinks that life is empty and it does not worth living again.

Suicidal Plan - After the stage of ideation or intent, patient will usually make definitive plan about how and when the suicide is to be carried out. Clinician needs to establish from patient whether there is any definitive plan made to commit suicide once a history of suicidal ideation or intent is established.

Suicidal Act - The final level is the act of suicide itself. At this level, the patient may write a suicide note that is dropped somewhere for relatives and friends to discover. The act of suicide may be complete or incomplete. Complete suicide act is common among males, while incomplete suicide act is common among females. When a suicide act is incomplete, then the diagnosis will be that of deliberate self harm.

Deliberate Self Harm

Deliberate self harm often result from an act of inflicting harm on self to gain sympathy and attention from others, it may also result from an act of incomplete suicide. Deliberate self harm is further divided into deliberate self injury and deliberate self poisoning.

- **Deliberate Self Injury** - This is an act of inflicting bodily injury on self to achieve the objectives of deliberate self harm.
- **Deliberate Self Poisoning** - This is an act of ingesting poisonous materials to achieve the objectives of deliberate self harm.

Suicide

Suicide is described as an act of deliberately taking one's life. Histories of previous suicidal ideation, suicidal plan or suicide attempt are high risk factors for a repeat occurrence of suicidal act.

Chapter 18

Forensic Psychiatry



As highlighted in the previous chapters, a patient with psychiatric disorder may be dangerous to self or dangerous to others. This chapter on forensic psychiatry focussed mainly on the aspect of patient being dangerous to others and also to self.

Patients with psychiatric disorders often at one time or the other have contact with law enforcement agents because of the likelihood of breaching the law. At one time or the other, there might be questions on rationality of decisions made by a patient with psychiatric disorders because of the defect in the state of mind. Such issues are very important and are under the subject of forensic psychiatry.

Issues that can be encountered in relation to law and court proceedings in forensic psychiatry include:

Unfit to Plead – A patient may not be in a best state of mind to take his/her plea in court because of defective mental state.

Not Guilty by Reason of Insanity (Mac Naughten’s Rules) – This law stated as follows; “Labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong”.

Diminished Responsibility – The law stated; “Suffering from such abnormality of mind as substantially to impair his mental responsibility for his acts”. The law is usually used in cases of murder by a patient with psychiatric disorders.

Criminal Responsibility – Criminal responsibility requires prove of intent (**mens rea**) and the unlawful act itself (**actus reus**). A child under the age of 10 years is assumed to be incapable of forming guilt intent (**mens rea**). A child from 14 years and above is presumed to be fully responsible.

Testamentary Capacity – This is defined as capacity of a person to make a will. An individual may make a will if he or she is of “sound disposing mind” and fulfilled the following criteria:

- Knows the nature and extent of his/her properties
- Knows the persons that would be having claim on the properties and the relative strengths of their claims.
- Can express himself or herself clearly without ambiguity.

Competence to Consent to Treatment – This is a big issue in psychiatry practice, especially in a patient with psychotic disorder who lacks awareness or insight into the nature of his/her illness. Informed consent can be verbal or written. Mental health bill is needed in Nigeria to protect the rights of the patients, clinicians and that of any third party.

Negligence against Physicians Treating a Patient with Psychiatric Disorder – In case of negligence, there must be a **duty** to perform, and there should be **dereliction** of duty with **direct damages**. A psychiatrist may be charged with negligence in cases of suicide, injury to third party, direct adverse effect of treatment or medications.

Tarasoff Law/Doctrine – The law stated that “A psychiatrist has the responsibility of informing a third party of a patient’s potential dangerousness towards the third party and also the responsibility to protect the third party from the patient’s dangerousness”.

Child Custody – Issues of child custody in cases of separated parents could also require the opinion of a psychiatrist.



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Fundamentals of Psychiatry made attempt at covering undergraduate curriculum in psychiatry for medical students in Africa.

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