



NPTEL ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental health & Clinical Psychiatry
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Lecture 31 : Child Psychiatry I

CONCEPTS COVERED

- Introduction to Child & adolescent psychiatry
- Intellectual disability
- Autism
- Childhood disintegrative disorder
- Retts Syndrome
- Asperger Syndrome
- Communication disorders & Language disorders
- Selective mutism
- Eneuresis , encopresis , pica

Introduction to Child & Adolescent Psychiatry

- ✓ Child and Adolescent Mental Health is an important public health issue across the world and especially in developing countries like India.
- ✓ Children and adolescents constitute approximately 40% of our national population, which is approximately 300 million.
- ✓ **Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years.**
- ✓ Epidemiological and community-based studies in India have reported a **prevalence ranging from 6– 12%.**
- ✓ The recent National Mental Health Survey reported a prevalence of 7.3% in children and adolescents aged 13-17 years.
- ✓ **Overall 8-13% of children are in need of mental health services.**

- ✓ **As early experiences shape the architecture of the developing brain, they also lay the foundations of sound mental health.** Disruptions to this developmental process can impair a child's capacities for learning and relating to others with lifelong implications.
- ✓ **The interaction of genes and experience affects childhood mental health.** The interaction between genetic predispositions and sustained, stress-inducing experiences early in life can lay an unstable foundation for mental health that endures well into the adult years.
- ✓ **Toxic stress can damage brain architecture and increase the likelihood that significant mental health problems will emerge either quickly or years later.** Because of its enduring effects on brain development and other organ systems, toxic stress can impair school readiness, academic achievement, and both physical and mental health throughout the lifespan. Circumstances associated with family ..
- ✓ **Significant mental health problems can and do occur in young children.** Children can show clear characteristics of anxiety disorders, attention-deficit/hyperactivity disorder, conduct disorder, depression, posttraumatic stress disorder, and neurodevelopmental disabilities, such as autism, at a very early age.

Risk Factors for development of mental health issues in children

a) **Biological factors:**

Pre and perinatal exposures to illness/insult, prenatal exposure to substances/ toxins like Nicotine, Alcohol etc, family history of psychiatric and developmental disorders,.

b) **Child characteristics and related factors:**

sex, age, ethnicity, intelligence, thinking, coping and relational patterns/styles.

c) **Environmental factors:**

Influence of family environment, parenting style, neighborhood, school, peers, bullying, high parental expectations, Child abuse and neglect and broader community factors.

Child abuse and neglect may result in a wide range of emotional and behavioral problems in children and adolescents.

The common child and adolescent mental health issues may be broadly classified into three groups:

a) Neuro-developmental disorders:

Intellectual Developmental Disorder, Speech and language-related disorders, Autism spectrum Disorder (ASD), Specific Learning Disorder.

b) Emotional disorders:

Depression, Anxiety spectrum disorders (generalised anxiety disorder, separation disorder, phobias), somatoform disorders and conversion disorder.

c) Behavioural disorders:

Attention deficit hyperactivity Disorder, Oppositional disorders, and conduct disorders.

Comorbidity is a rule rather than an exception in child and adolescent psychiatric disorders.

Intellectual Disability

Formerly known as Mental Retardation

American Association on Intellectual Developmental Disability (AAIDD)

Defines intellectual Disability as disability characterised by significant limitations in both .

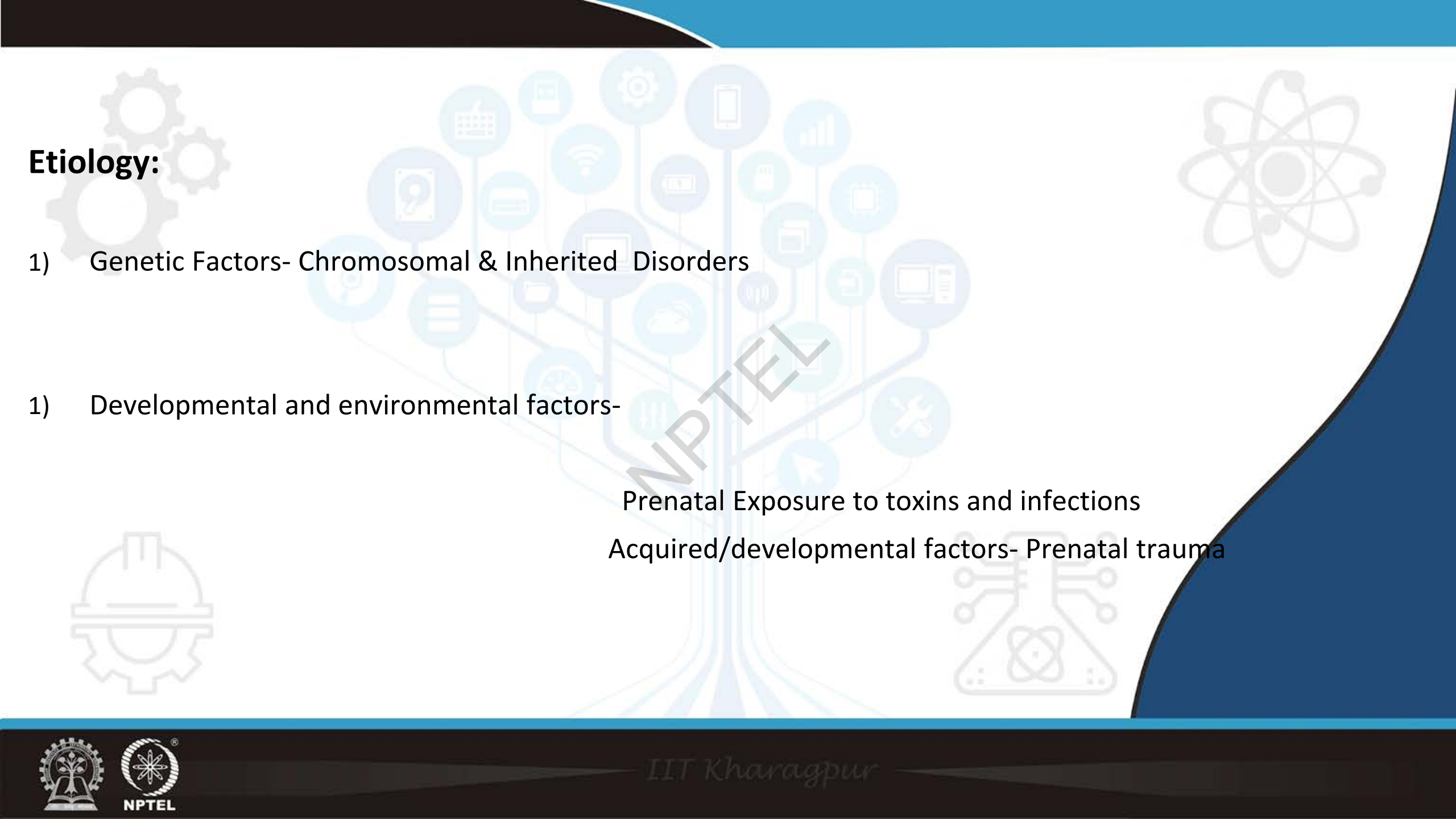


- i) Intellectual functioning (reasoning , learning, problem solving)
- ii) Adaptive behaviour (Conceptual ,social , Practical skills)

The disability should emerge before 18 years.

Assessment of social adaption and intellectual quotient (IQ) should be done to determine the level of Intellectual Disability.

Adaptive functioning is assessed by “Vineland adaptive behaviour Scale”



Etiology:

1) Genetic Factors- Chromosomal & Inherited Disorders

1) Developmental and environmental factors-

Prenatal Exposure to toxins and infections

Acquired/developmental factors- Prenatal trauma

Mild Intellectual Disability-

Includes 85% of persons with intellectual disability.

Can acquire academic skills upto 6 th class.

Can live independently with appropriate support and raise their own families.

IQ ranges from 50-70.

Moderate Intellectual Disability

Includes 10% of persons with intellectual disability.

Challenged academically and can reach upto 2nd - 3rd class.

Socialization difficulties set these persons apart and great deal of social and vocational support is beneficial.

Able to perform semiskilled work under appropriate supervision.

IQ ranges from 35-50.

Severe Intellectual Disability

Includes 4% with Intellectual Disability.

Cause for the disability is more likely to be identified.

Develop communications skills in childhood and often can learn to count and as well as recognize words

May adapt well to supervised living situations and may be able to perform work related tasks under supervision.

IQ ranges from 20 -35

Profound Intellectual Disability

1-2 % with Intellectual Disability

Have identifiable causes for their condition

Self care skills and communication of their needs can be taught with appropriate training

IQ less than 20

Assessment:

Weschler

>= 130- very superior
120-129- Superior
110-119- High average
90-109 - Average
80-89 - Low average
70-79 - borderline
<=69 - Extremely low

Stanford – Binet

145-160 – very Superior
130-144 - Gifted
120-129 - Superior
110-119 - higher average
90 -109 - Average
80- 89 - Low Average
70 -79 - Borderline
55-69 - mildly impaired
40- 55 - moderately impaired

Pervasive Development Disorders

☐ **Pervasive developmental disorders** include several that are characterized by impaired reciprocal social interactions, communication difficulties, aberrant language development, and restricted behavioural repertoire.

Triad of deficits Of

i) Social skills ii) Communication/language iii) Behaviour

☐ They typically emerge in young children before the age of 3 years.

According to **DSM 5** Autism Spectrum Disorder is a new description that will now include

i) Autism ii) Asperger's iii) Childhood Disintegrative Disorder and Pervasive Developmental Disorder (not otherwise specified) in a single category.

ASD is characterized by

1) Deficits in social communication and social interaction and 2) Restricted & repetitive behaviors, interests, and activities (RRBs).

Childhood autism / Kanner's disorder)

3 symptom domains:

- Qualitative impairment in social interaction
- Impairment in communication [language delay is most common cause for initial referral]
- Restricted repetitive and stereotyped patterns of behaviour or interests.

Onset before 3 years

F: M - 4:1

Autism

Biological Factors

- ✓ *Approximately 80% of people with childhood autism have learning disability.*
- ✓ *1/3 rd cases have seizures*

Etiology

1. Genetic Factors

Autistic spectrum disorders are subject to a significant degree of heritability (overall 90% heritability) that multiple genes are involved in the development of autism and linkage analyses have demonstrated that regions of chromosomes 2, 4, 7, 13, 15, 16, 17, 19 are likely to contribute to the genetic basis of autism.

1-4 percent of children with autistic disorder also have **fragile X syndrome**.

Up to 2 percent of children with autistic disorder may also have **tuberous sclerosis**.

The failure of those with autism to understand others situations or feelings is often referred to as a lack of theory of mind.

3. Prenatal & post natal

Associations between autistic spectrum disorder and congenital rubella infection during pregnancy specifically during first trimester. No involvement of obstetric factors

Radioimaging

MRI findings include larger brain volumes and early acceleration in brain growth

Increase in the size of the lateral and 4th ventricles frontal lobe and cerebellar abnormalities (hypoplasia of cerebellar vermal lobules VI and VII).

Increased volume due to three different possible mechanisms:

1) Increased neurogenesis ii) Decreased neuronal death iii) Increased production of nonneuronal brain tissue, such as glial cells or blood vessels



Course

Autism is a neurodevelopmental disorder that persists lifelong. Communication, reading and spelling were impaired in most.

Stereotypies and restricted interests remained for most . A significant proportion of people with autism (at least 60%) will be unable to lead an independent life, and some will require long term residential care



Treatment

There is no cure or treatment for autism.

Early and effective management is desirable for a better outcome, and involves a comprehensive assessment of the child and family's needs.

Pharmacotherapy

SSRIs have become the most widely prescribed medications to treat restricted repetitive behaviours in paediatric ASD populations. However the evidence supporting the effectiveness of SSRIs in ameliorating these symptoms remains limited.

When using SSRIs to treat repetitive behaviour in ASD patients, it has been found that lower doses are required than the therapeutic antidepressant dose.

Second generation antipsychotics are the first line pharmacological treatment for children and adolescents with ASD and associated irritability.

Second generation antipsychotics preferentially Risperidone 0.5 – 1 mg and Aripiprazole 5-10mg is considered. It is indicated for the treatment of autism with aggressive behaviour in children and adolescents. Weight gain, somnolence and hyperglycemia require monitoring.

Psychotherapy

Psychotherapy with the individual may be in the form of specific CBT techniques for those with verbal skills, and behaviour management programmes.

Two specific intervention programmes

1. Applied Behavioural Analysis program:

An intense program [40 hours a week for 3 years] based on operant conditioning, imitation and reinforcement.

2. TEACCH –

Treatment and Education for Autistic and related Communication Handicapped

Children program is based on the belief that children are motivated to learn language.

Successful in reducing self injurious behaviour, and enhancing life skills.

Childhood disintegrative disorder (CDD)

Childhood disintegrative disorder (CDD) aka Heller's disease and disintegrative psychosis is characterized by marked regression in several areas of functioning after at least 2 years of apparently normal development.

- ✓ There is normal development for 2-3 years, followed by a loss of acquired motor, language, and social skills between ages 3 and 4 years.

Stereotypies and compulsions are common

Diagnosis- A child must exhibit loss of skills in two of the following areas: language, social or adaptive behaviour; bowel or bladder control; play; and motor skills.

- ✓ Abnormalities must be present in at least two of the following categories:

Reciprocal social interaction, communication skills, and stereotyped or restricted behaviour.

The main neurological associated feature is seizure disorder.

Male > Females Cause is unknown and prognosis is poor.

Most patients are left with atleast moderate mental retardation

Treatment-

Mood stabilizers
Antipsychotics
Benzodiazepines

Rett's syndrome

Rett's syndrome is a rare X linked dominant disorder of arrested neurodevelopment associated with mutations in the MeCP2 gene.

It almost exclusively affects females.

Characteristics features

- ✓ Head circumference normal at birth and developmental milestones are unremarkable in early life.
- ✓ Between 6 and 18 months, head growth begins to decelerate and produces microcephaly.
- ✓ There is loss of purposeful hand movements, which are replaced by stereotypic motions, such as hand wringing, the loss of previously acquired speech; psychomotor retardation; and ataxia.
- ✓ Other stereotypical hand movements may occur, such as licking or biting the fingers and tapping or slapping.
- ✓ Language skills are lost, and both receptive and expressive communicative and social skills seem to plateau at developmental levels between 6 months and 1 year.

- ✓ Poor muscle coordination and an apraxia gait with an unsteady and stiff quality develop.
- ✓ Seizures in up to 75 percent of affected children and disorganized EEGs with some epileptiform discharges in almost all young children with Rett's disorder, even in the absence of clinical seizures.
- ✓ Irregular respiration, with episodes of hyperventilation, apnoea, and breath holding.
- ✓ The disorganized breathing occurs in most patients while they are awake; during sleep, the breathing usually normalizes.
- ✓ Many patients with Rett's disorder also have scoliosis and spasticity.

Asperger's syndrome

Asperger's syndrome have same type of qualitative abnormalities:

Reciprocal social interaction that typify autism with a restricted, stereotyped and repetitive, repertoire of behaviour/interests.

IQ and language are unusually within normal limits.

No significant delays occur in relation to language development., cognitive development, and/or age---appropriate self-help skills.

Mild motor clumsiness and a family history of autism may be present, as is the case for other autism spectrum disorders.

Epidemiology:

Estimated to be about a third as common as autism with a prevalence of about 6 in 10,000

Factors associated with a **good prognosis** are

- i) Normal IQ and high---level social skills.*
- ii) Psychiatric comorbidity is high with depression most common.*
- iii) BPAD and schizophrenia are more common than in the general population.*

Learning Disorders

Learning disorders are problems that make educational achievement difficult.

Specific learning difficulties can lead to underachievement in :

Reading, Written expression, or Mathematics in comparison with the overall intellectual ability of the child.

Four Diagnostic categories of learning disorders:

- i) Reading disorder
- ii) Mathematics disorder
- iii) Disorder of written expression
- iv) Learning disorder not otherwise specified

Etiology

- i) Genetic predisposition ii) Perinatal injury iii) Neurological and other medical conditions

Learning disorders affect at least 5% of school- age children.

Learning Disorders are associated with :

Attention deficit/hyperactivity disorder (ADHD), communication disorders, conduct disorders, and depressive disorders.

Reading Disorder

- ✓ Reading disorder is characterized by an impaired ability to recognize words, slow and inaccurate reading, and poor comprehension.

Reading disorder starts by the age of 7 years.

- ✓ Reading comprehension skill, reading word recognition, oral reading skill, and performance of task requiring reading may all be affected.
- ✓ Errors are characterized by omissions, additions, and distortions of words.
- ✓ Children have difficulty in distinguishing between printed letter characters and sizes, especially those that differ only in spatial orientation and length of line.
- ✓ The child's reading speed is slow, often with minimal comprehension. Difficulty with reading, in most cases involving a deficit in phonological processing skills.

Male > Female- [4:1].

- ✓ Reading disorders are present in approximately 75% of children and adolescents with learning disorders.

Disorder Of Written Skills

- ✓ Characterized by writing skills that are significantly below the expected level for a child's age and intellectual capacity and impair the child's academic performance and writing in everyday life.
- ✓ Common features of the disorder are spelling errors, grammatical errors, punctuation errors, poor paragraph organization, and poor handwriting.
- ✓ Often coexists with dyslexia and manifests as difficulties with spelling, syntax, grammar, and composition.

Occurs in 2-8% of school age children

M>F- 3:1

- ✓ ADHD occurs with greater frequency in children with writing disorders than in the general population.

Treatment

- ✓ Direct practice in spelling and sentence writing as well as a review of grammatical rules.
- ✓ Intensive and continuous administration of individually tailored, one-on-one expressive and creative writing therapy appears to effect favourable outcome.

Disorders with Mathematics

Common features of mathematics disorder include :

Difficulty with various components of mathematics, such as

- i) Learning number names
 - ii) Remembering the signs for addition and subtraction
 - iii) Learning multiplication tables
 - iv) Translating word problems into computations , and doing calculations at the expected pace.
- ✓ A Child with mathematics disorder generally has significant problems with concepts, such as counting and adding even one digit numbers, compared with classmates of the same age.

Up to 6 percent of school age children.

Females > Males

Often associated with visuo spatial deficits and attributed to right parietal dysfunction.

Treatment

- ✓ Combine teaching mathematics concepts with continuous practice in solving math problems.
- ✓ Flash cards, workbooks, and computer games.

Learning Disorder Not Otherwise Specified:

Learning disorder not otherwise specified does not meet the criteria for any specific learning disorder, but causes impairment and reflects learning abilities below those expected for a person's intelligence, education, and age.

Communication Disorders

Communication disorders are among the most common disorders in childhood.

They include disorders such as

- i) Expressive and mixed receptive expressive language disorder
- ii) Speech disorders such as phonological disorder
- iii) Stuttering
- iv) Social Communication disorder

Expressive Disorder

Expressive language disorder is diagnosed when a child demonstrates a selective deficit in expressive language development relative to receptive language skills and nonverbal intelligence.

A child with expressive language disorder is likely to function below the expected levels of acquired

i) Vocabulary ii) Correct tense usage iii) Complex sentence constructions iv) Word Recall.

A child with an expressive language disorder exhibits the following features:

i) Limited vocabulary ii) Simple grammar, and variable articulation.

Language understanding (decoding) skills remain relatively intact.

Prevalence: 3---5% of children with learning disorder

M:F- 3:1

Co-morbid disorders were attention deficit hyperactivity disorder (ADHD), anxiety disorders, oppositional defiant disorder, and conduct disorder.

Management includes

Special education & Speech therapy

Mixed receptive – expressive disorder

The essential clinical feature of the disorder is significant impairment in both language comprehension & language expression.

Children with both receptive & expressive language impairments may have impaired ability in sound discrimination deficits in auditory processing or poor memory for sound sequences.

Prevalence : Approximately 3 percent of school age children

M:F – 2:1

Children with receptive language difficulties may be experiencing additional deficits in basic auditory processing skills such as discriminating between sounds & symbols.

Treatment : Comprehensive Speech & Language evaluation
Expressive component to be rectified before receptive component

They develop language more slowly than their peers.

Markedly below expected- level of comprehension of verbal or sign language with intact age-appropriate nonverbal intellectual capacity.

Phonologic Disorder

Child's delay or failure to produce developmentally expected speech sounds , especially consonants- , resulting in sound omissions , substitutions , distortions of Phonemes

Their inability to produce clear speech is not due to physical problems as may be seen in dysarthria/dyspraxia

The disorder is first recognized at about 3 years of age and self corrected by 7 years of age.

Males : Females- 3:1

Associated comorbidly with language disorder , reading disorder , developmental coordination disorder

With omissions, the phonemes are absent entirely for example **ca** for **car**, or **whaa?** for **what's that?**

With substitutions, difficult phonemes are replaced with incorrect ones for example, **wabbit** for **rabbit**.

With distortions, the correct phoneme is approximated **but is articulated incorrectly**.

Etiology

- i) Maturational delay in the developmental brain process
 - ii) Neuronal Cause
 - iii) Genetic Factors- Monozygotic Twins have higher chance
 - iv) Developmental coordination disorder
-
- ✓ Children with speech sound disorder are delayed in , or incapable of producing accurate speech sounds that are expected for their age , intelligence and dialect.
 - ✓ Children with speech sound disorder may have various concomitant social ,emotional , behavioral problems.

Treatment

- a)Phonological approach b) Traditional Approach

Stuttering

It is a condition in which the normal flow of speech is disrupted by involuntary speech motor events

Stuttering can include a variety of specific disruptions of fluency

It includes

- a) Sound or syllable repetitions
- b) Sound prolongations
- c) Dysrhythmic phonation and complete blocking or unusual pauses between sounds and syllables of words

Male : Female – 3:1

prevalence 1% in the general population.

Stuttering tends to be most common in young children and has often resolved spontaneously by the time the child is older.

Etiology:

- i) Genetic
 - ii) Incomplete cerebral dominance
 - iii) Hyperdopaminergic state
-
- ✓ The typical age of onset is 2 to 7 years of age with a peak at age 5 years.
 - ✓ Preschoolers and school age children who stutter exhibit an increased incidence of social anxiety, school refusal, and other anxiety symptoms.
 - ✓ Stuttering is also associated with a variety of abnormal motor movements, upper body tics, and facial grimaces. Other disorders that coexist with stuttering include phonological disorder, expressive language disorder, mixed receptive expressive language disorder, and ADHD.

Management: speech therapy.

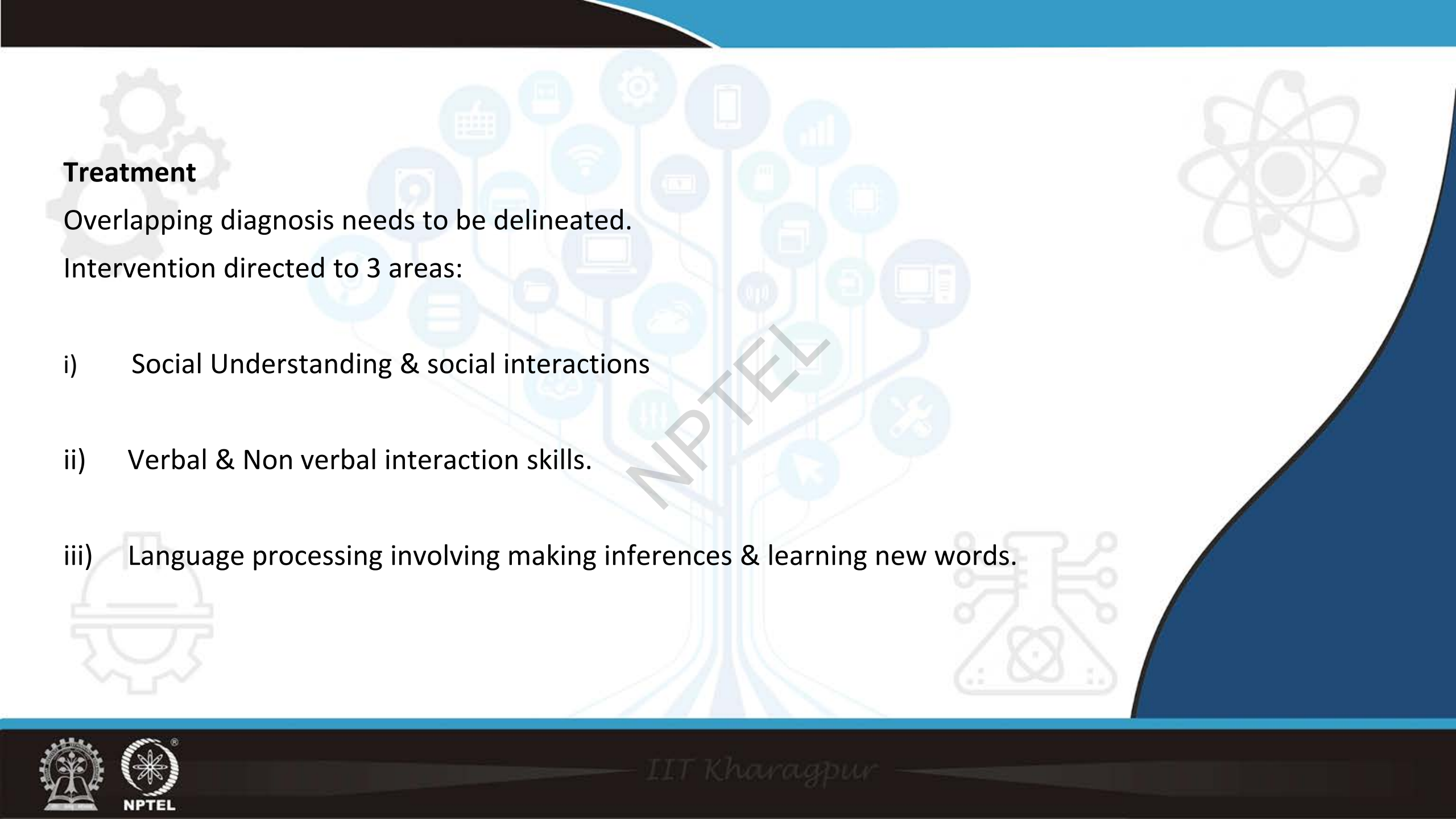
Social Pragmatic Disorder

Characterized by impaired ability to effectively use verbal & nonverbal communication for social purposes and occurs in the absence of restricted and repetitive interests and behaviours.

Following must be met:

- i) Deficits in using appropriate communication such as greeting , sharing information in social context
- ii) Inability to modulate the vocabulary used in social communication.
- iii) Impaired ability to follow rules of conversation such as taking turns or rephrasing conversations.
- iv) Difficulty in understanding things that are not explicitly stated.

These deficits lead to impairments in social situations , in developing relationships and in family & academic settings.



Treatment

Overlapping diagnosis needs to be delineated.

Intervention directed to 3 areas:

- i) Social Understanding & social interactions
- ii) Verbal & Non verbal interaction skills.
- iii) Language processing involving making inferences & learning new words.

Emotional Disorders



Selective mutism

Characterized by a persistent failure to speak in specific settings, such as school where there is an expectation to speak, despite full use of language at home or with family.

A child with selective mutism may remain completely silent or near silent, in some cases whispering instead of speaking out loud.

Girls > boys

Normally begins between ages of 4-8 years, after normal speech has been acquired.

Associated psychiatric illness:

social phobia , communication disorders , language disorders, separation anxiety disorder

Child speaks exclusively at home within the nuclear family, sometimes not even at school & can have academic difficulties or even failure due to lack of participation.

Children with selective Mutism are shy , anxious & increased risk for depression

Etiology

i) **Genetic Factors-** 90 % meet diagnostic criteria for social phobias

Maternal depression , anxiety & dependence common in families .

ii) **Parental Interactions –**

Maternal over protection and anxiety in parents, Emotional or physical trauma

iii) **Speech & Language disorders-**

Expressive & disturbance in auditory processing with comprehension problems

Pharmacological interventions:

SSRIs are first line agents. **Evidence for fluoxetine , fluvoxamine**

Selective serotonin reuptake inhibitors (SSRIs) to treat childhood social phobia, separation anxiety disorder

Non Pharmacological Interventions

- ✓ Psychoeducation and parent training
- ✓ Cognitive Behavioural Therapy (CBT)
- ✓ CBT technique focuses on relaxation training and cognitive restructuring.
- ✓ Individual CBT & Group CBT interventions have been shown to be effective for the treatment of socially phobic children and adolescents.

Enuresis

It is the repeated voiding of urine into a child's clothes or bed, it may be involuntary or intentional.

The behaviour must occur twice weekly for a period of at least 3 months or must cause distress and impairment in functioning to meet the diagnostic criteria.

Enuresis is the repeated voiding of urine into a child's clothes or bed; the voiding may be involuntary or intentional

For the diagnosis to be made, a child must exhibit a developmental or chronological age of at least 5 years.

Prevalence: 2-5% among school aged children.

M:F- 2:1

Types: Primary or secondary, nocturnal or diurnal or mixed.

Nocturnal enuresis: Most important predictor of primary nocturnal enuresis is a family history of enuresis.

70% of children with nocturnal enuresis have a parent or sibling who was late in becoming dry.

Secondary enuresis is predicted by delay in control over bedwetting, and experiencing a high rate of adverse life events.

- ✓ Enuresis is often self-limited, and a child with enuresis may have a spontaneous remission without psychological sequelae.
- ✓ The significant emotional and social difficulties of these children usually include poor self-image, decreased self-esteem, social embarrassment and restriction, and intrafamilial conflict.
- ✓ Children with enuresis are at higher risk for ADHD compared with the general population.

Treatment

Rule out organic causes of urinary dysfunction –e.g.: UTI may lead to obstruction. The first step in any treatment plan is to review appropriate toilet training.

- i) **Psychoeducation:** Child with nocturnal enuresis is not being lazy. Avoid punishments.
- ii) **Behavioural interventions** are the first line of treatment for bed-wetting.

Classic conditioning with the bell and pad apparatus is generally the most effective treatment for nocturnal enuresis, with dryness resulting in more than 60 percent of cases. A star chart may be particularly helpful.

iii) Medications:

- a) Imipramine is efficacious and has been approved for use in treating childhood enuresis, primarily on a short-term basis.
- b) Desmopressin, an antidiuretic compound that is available as an intranasal spray, has shown some initial success in reducing enuresis. Adverse effects that can occur with Desmopressin include headache, nasal congestion, epistaxis, and stomachache.
- c) Reboxetine a norepinephrine reuptake inhibitor with a non cardiotoxic side effect profile has recently been investigated as a safer alternative to Imipramine in the treatment of childhood enuresis.

Encopresis

Voluntary or involuntary soiling of normally formed stools in inappropriate places in a child of 4 years (mental age) or older, in the absence of a sufficient organic cause.

Soiling occurs at least once a month for 6 months.

M: F – 6:1.

Approximately 5% children will be soiling over 4 years of age.

Children show evidence of chronic constipation, leading to infrequent defecation, withholding of bowel movements, which then leads to impaction and eventual overflow soiling.

Organic cause such as Hirschprung's disease, anorectal pathology, neurological problems; nutritional disorders and medication side effects should be ruled out before making the diagnosis of Encopresis

Etiology

- i) With significantly greater frequency among children with known sexual abuse compared with a normal sample of children.
- ii) Seen as a possible defense against further abuse, or retention due to pain.
- iii) Associated with measures of maternal hostility, and harsh and punitive parenting.
- iv) Family patterns such as an unhappy child in a family with clear ongoing difficulties (abuse, domestic violence)
- v) Recent acute stress in the family like death, birth of sibling and over tolerant parents

Encopresis, in some children, can be considered secondary, that is, emerging after a period of normal bowel habits.

Treatment

Initial paediatric assessment, including imaging of the gut .

First line of treatment is to evacuate any stool. Laxatives may be used to prevent further retention.

Education of the family and correction of misperceptions that a family may have about soiling must occur before treatment

Psychological treatment:

Behavioural approach – operant training with rewards and positive reinforcement.

Family support/therapy. It is important to reduce the family tensions about the symptom and a nonpunitive atmosphere is established.

In many cases, encopresis is self limiting

Most soiling stops by the age of 16 years.

Pica

This condition is characterized by persistent (>1month) eating of non nutritive substances at a developmentally inappropriate age (>1 year) and it occurs at least twice a week.

It typically occurs during the 2nd and 3rd years of life and common substances are dirt, stones, plastic, paper, hair, faeces , wood etc.

It is common in people with developmental disability.

Consequences may include toxicity, infection, or GIT ulceration/obstruction.

Hypothesized causes include hunger, malnutrition, nutritional deficiencies, psychosocial stressors and brain disorders such as lesions in the hypothalamus.

CONCLUSIONS

- -In this lecture we have discussed regarding concepts of Intellectual disability ,Autism ,Childhood disintegrative disorder ,Retts Syndrome , Asperger Syndrome ,Communication disorders & Language disorders ,Selective mutism ,Enuresis , encopresis , pica along with its management

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**THANK
YOU !**



NPTEL ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental Health & Clinical Psychiatry

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Department Name Psychiatry

TATA MAIN HOSPITAL

Lecture 32 : Child Psychiatry - II

CONCEPTS COVERED

- Reactive Attachment disorder & disinhibited social engagement disorder
- Sibling rivalry
- School refusal
- Academic problem
- Attention Deficit Hyperactivity Disorder, conduct disorder, oppositional defiant disorder
- Childhood depression ,childhood schizophrenia & bipolar disorder
- Tic & Tourette disorder

Reactive Attachment Disorder & Disinhibited Social Engagement disorder

Reactive Attachment Disorder & Disinhibited Social Engagement disorder are clinical disorders characterized by aberrant social behaviour in a young child that reflect grossly negligent parenting & maltreatment that disrupted the development of normal attachment behaviour.

Pathological Caretaking results into-

- i) Reactive Attachment Disorder
- ii) Disinhibited Social Engagement disorder

DSM-V states that

- ✓ **Reactive attachment disorder** is characterized by a consistent pattern of emotionally withdrawn responses toward adult caregivers , limited positive affect , sadness and minimum social responsiveness to others and concomitant neglect , deprivation and lack of appropriate nurturance from caregivers.

It is presumed that reactive attachment disorder is due to grossly pathological caregiving received by the child.

- ✓ **In Disinhibited Social Engagement disorder**, a child actively approaches and interacts with unfamiliar adults in an overly familiar way , either verbally or physically. There is diminished checking with or seeking of a known caregiver and a willingness to go with unfamiliar adults without hesitation.

These behaviours should not be accounted for by impulsivity

Etiology

- i) Disturbance of normal attachment behaviour
- ii) Maltreatment of the child which includes neglect , physical , sexual abuse
- iii) Parental psychiatric illness, parental subnormal intelligence
- iv) Premature parenthood, parental conflict, substance abuse in parents

Characteristics features:

Child is not progressing developmentally, is below the appropriate weight for his/her age .

Muscle tone poor , skin paler and mottled.

Malnourished with marasmic looking body

There is both marked diminution of initiation towards others & reciprocity in response to the caregiveradult

Treatment

- ✓ First consideration is safety of child and adult caregiving.
- ✓ If neglect or emotional , physical ,sexual abuse is suspected then law enforcement & child protective services should be informed so that law should take its course.
- ✓ Hospitalization is mandatory when the condition of the child is severely malnourished

positive Bonds between caregiver-child

- i) Clinician can target caregiver who does not have the repertoire to respond positively.
- ii) Clinician can work as dyad with caregiver & child to advocate for practicing positive reinforcement.
- iii) Working with the child & caregiver together
- iv) Psychosocial support services
- v) Provisions of close monitoring of progression made

Sibling rivalry Disorder

- ✓ Onset is within 6 months of the birth of an immediately younger sibling.
- ✓ Duration of the disorder is at least 4 weeks.
- ✓ Emotional disturbance that is abnormal in degree and/or persistence
- ✓ Emotional disturbance is shown by anxiety, regression, tantrums, and dysphoria; sleep difficulties, oppositional behaviour, or attention seeking behaviour with one or both parents (two or more of these must be present).
- ✓ Behaviour can range from strong reluctance to share and a lack of positive regard to, in severe cases, overt hostility, physical trauma and/or maliciousness towards, and undermining of the sibling

School Refusal-

It describes the disorder of a child who refuses to go to school on a regular basis or has problems staying in the school.

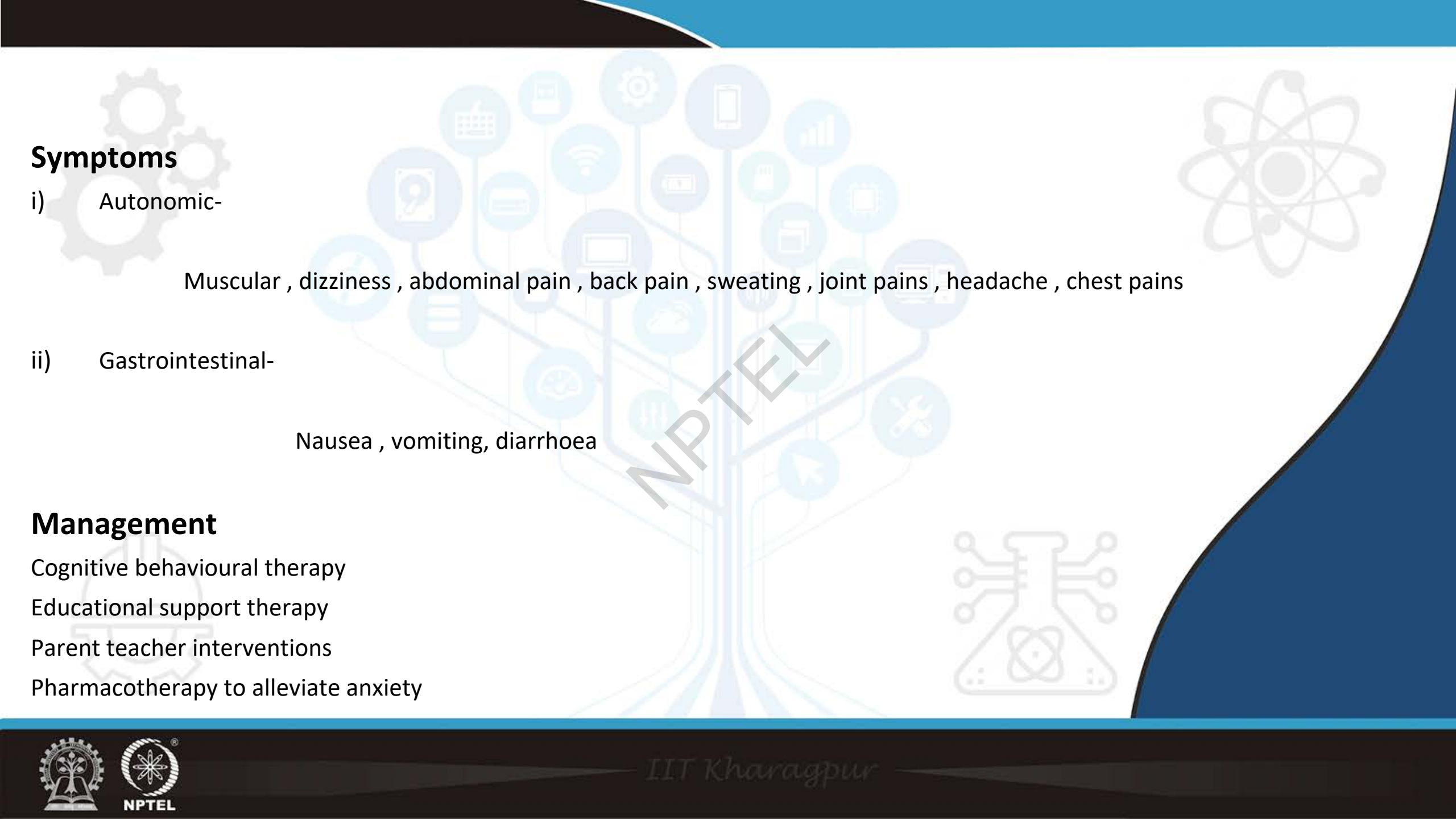
Affects 2-5 % of school going children

common in 5-6 years of age

M=F

Etiology

- i) Entering for the first time in school/transition into new class
- ii) Separation anxiety disorder as a result of separation from parents
- iii) Depressive disorder
- iv) Physical, sexual abuse at school



Symptoms

i) Autonomic-

Muscular , dizziness , abdominal pain , back pain , sweating , joint pains , headache , chest pains

ii) Gastrointestinal-

Nausea , vomiting, diarrhoea

Management

Cognitive behavioural therapy

Educational support therapy

Parent teacher interventions

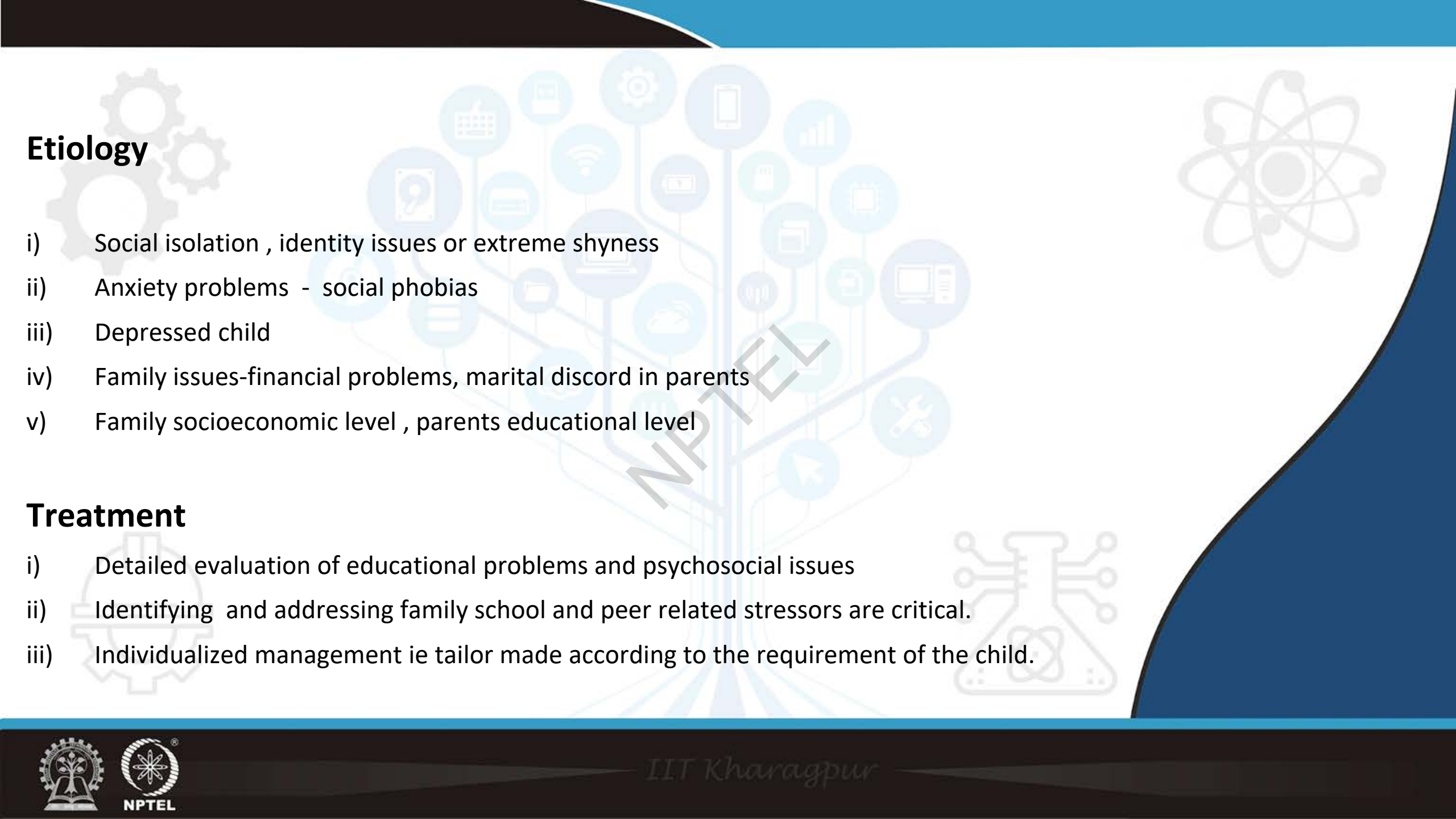
Pharmacotherapy to alleviate anxiety

Academic Problem

When an academic or educational problem is the focus of clinical attention or has an impact on the individual's diagnosis, treatment or prognosis.

It includes

- i) illiteracy or low level literacy
- ii) Lack of access to schooling
- iii) Problems with academic performances or under achievement
- iv) Discord with teachers/school staffs or other students.
- v) Problems related to education.



Etiology

- i) Social isolation , identity issues or extreme shyness
- ii) Anxiety problems - social phobias
- iii) Depressed child
- iv) Family issues-financial problems, marital discord in parents
- v) Family socioeconomic level , parents educational level

Treatment

- i) Detailed evaluation of educational problems and psychosocial issues
- ii) Identifying and addressing family school and peer related stressors are critical.
- iii) Individualized management ie tailor made according to the requirement of the child.

Behavioural Disorders

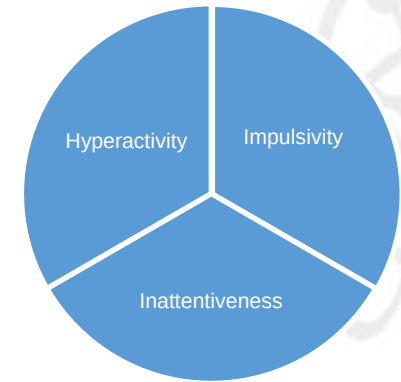


Attention Deficit Hyperactivity Disorder(ADHD)

The cardinal features of ADHD are excessive and impairing levels of

They are pervasive over time.

These features must be evident in more than one setting, cause serious impairment and be excessive in relation to the person's mental age and development, and must not be due to other causes such as anxiety, schizophrenia or autism.



Diagnostic criteria: The hyperkinetic disorder is the ADHD equivalent in ICD 10.

Minimum age – 12 years

Prevalence – 1-2 %

M:F – 3:1

To confirm a diagnosis of ADHD, impairment from inattention and/or hyperactivity-impulsivity must

be observable in at least 2 settings and interfere with developmentally appropriate functioning socially, academically, or in extracurricular activities and should persist for at least six months.

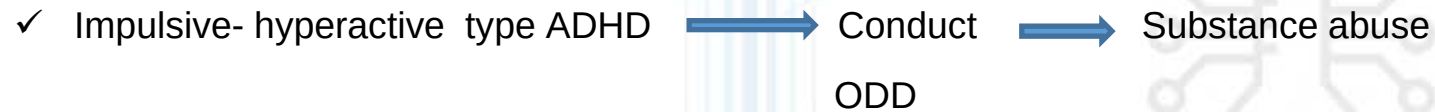
Hyperactivity-impulsivity symptoms include: fidgeting, being 'always on the go', talking excessively; unable to play quietly; continually interrupting.

Inattention symptoms include: being easily distracted, being unable to sustain attention, difficulties completing tasks, difficulties organizing, avoiding tasks requiring mental effort; appearing not to listen, being forgetful, and losing things.

Hyperactivity is more impairing and more noticeable in **pre-school children**.

In school inattention is more noticeable.

Inattention and Impulsivity is noticeable in both adolescent and adult populations, especially in social situations.



Assessment:

Connors questionnaire Vanderbilt Questionnaire

Both will assess parent and Teachers observation regarding child's overall behaviour.

Treatment

General management principles are:

Educational/remedial interventions

Parent training programme for child management skills– based on social learning theory and behavioural interventions

Individual/family/group therapies

CBT methods, especially behavioural , are often effective

Social skills training

Stimulants –

Release noradrenaline, dopamine and also serotonin, increasing extracellular dopamine and thus 'inhibit' impulses, helping persistence in motor and cognitive functions.

They are rapidly absorbed following oral administration.

Hyperactivity is
first symptom
to remit
and
distractibility last

Etiology

- i) Genetic Factor-increased risk for child having ADHD if parents or sibling has ADHD
- ii) Neurochemical factors- Dopamine , noradrenaline
- iii) Developmental Factors-Premature child , Maternal infection during pregnancy ,Perinatal insult
- iv) Psychosocial Factors- Chronic abuse , maltreatment , neglect

Neuroanatomical localization- Decreased activity & volume of prefrontal regions , anterior cingulum , basal ganglia , thalamus

Methylphenidate

Specifically treat ADHD core symptoms hyperactivity >> inattention

Largest and most rapid effect on ADHD of any drug by increasing Dopamine.

Calms comorbid aggression and oppositional defiant behaviour.

Adverse effects

- a) Sleep disturbance (if taken late in day)
 - b) Cramps (first few weeks)
 - c) Evening crash
 - d) **Mild growth slowing first 2 years- “Concept of Drug Holiday” (rationale)**
- ✓ Weekend holidays during Methylphenidate (MPH) administration reduce the side effects of insomnia and appetite suppression

Reduces the effects on BMI, weight, height, pubertal growth spurt.

Atomoxetine

Noradrenaline reuptake inhibitor

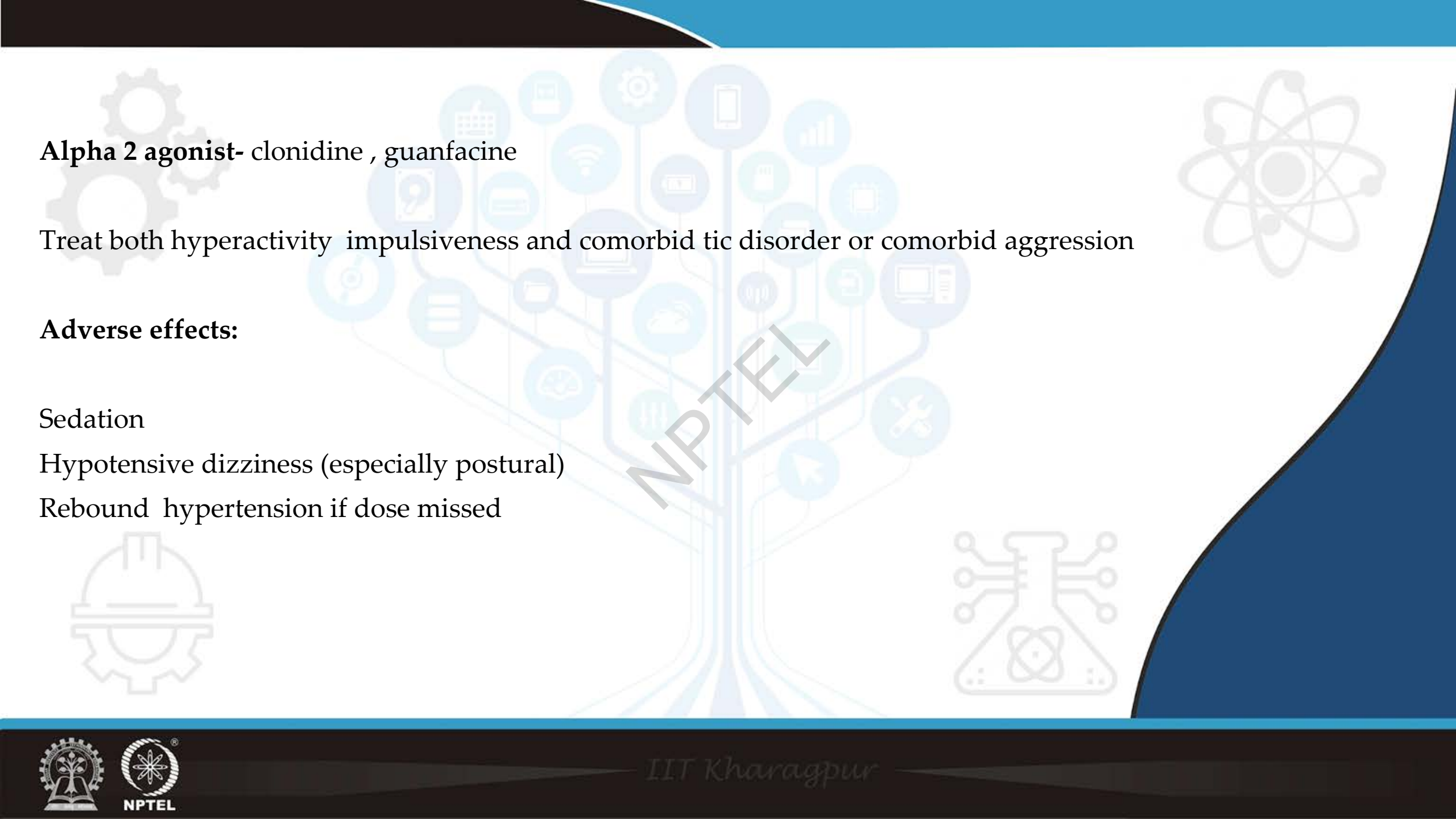
Indicated for use in hyperkinetic disorders.

It increases noradrenaline in the synaptic cleft.

It doesn't affect dopamine levels, and hence doesn't cause more tics.

Adverse effects

- a) Appetite, weight loss
- b) Gastrointestinal (nausea, vomiting, diarrhoea, constipation)
- c) Fatigue, dizziness
- d) Hepatotoxic in higher doses



Alpha 2 agonist- clonidine , guanfacine

Treat both hyperactivity impulsiveness and comorbid tic disorder or comorbid aggression

Adverse effects:

Sedation

Hypotensive dizziness (especially postural)

Rebound hypertension if dose missed

Disorders of Childhood Conduct

Disorders of childhood conduct comprise of (a) Conduct Disorder and (b) Oppositional Defiant Disorder.

- ✓ **Conduct disorder** (CD) is characterized by a severe and persistent pattern of antisocial, aggressive or defiant behaviours that defy age-appropriate societal norms.
- ✓ **Oppositional Defiant Disorder** (ODD) also involves a persistent pattern of defiant behaviour , however, it does not defy age-appropriate societal norms to the same extent as in Conduct disorder.

According to ICD 10, oppositional defiant disorder is a subtype of conduct disorder.

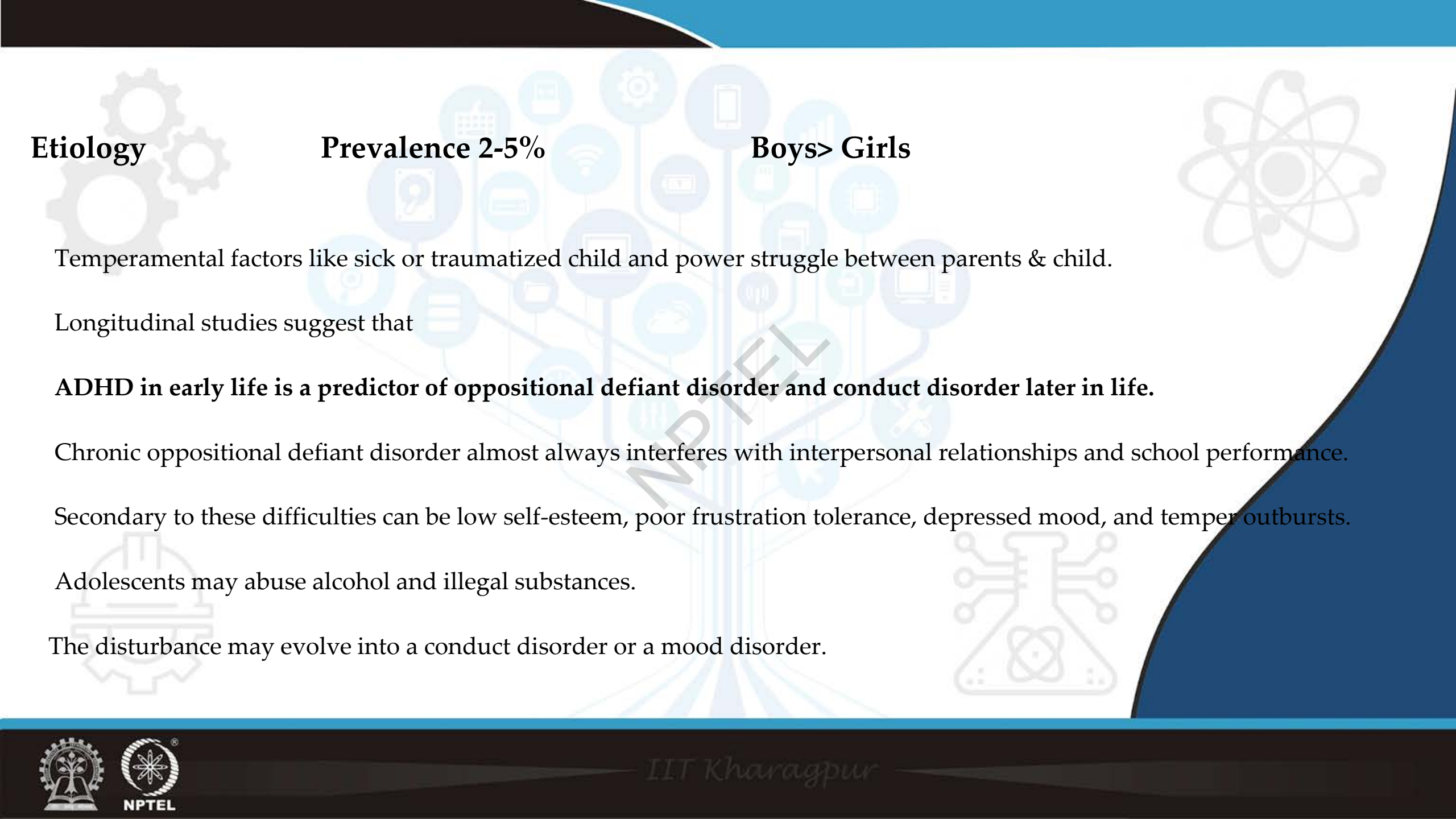
DSM-5 excludes oppositional disorder if a conduct disorder is present.

ODD is characterized by an enduring pattern of negative, hostile, disobedient and defiant behaviour, without serious violations of societal norms or the rights of others.

Symptoms must be persistent and evident for at least 6 months.

Age of onset of ODD is generally earlier than that for CD.

1. The child's temper outbursts, active refusal to comply with rules, tendency to blame others, spiteful and annoying behaviours exceed expectations for these behaviours for children of the same age.
2. Manifestations of the disorder are almost invariably present in the home, but they may not be present at school or with other adults or peers.
3. Features of the disorder from the beginning of the disturbance are displayed outside the home; in other cases, the behaviour starts in the home, but is later displayed outside.
4. Typically, symptoms of the disorder are most evident in interactions with adults or peers whom the child knows well.
5. ODD can begin as early as 3 years of age, it typically is noted by 8 years of age and usually not later than adolescence.



Etiology

Prevalence 2-5%

Boys > Girls

Temperamental factors like sick or traumatized child and power struggle between parents & child.

Longitudinal studies suggest that

ADHD in early life is a predictor of oppositional defiant disorder and conduct disorder later in life.

Chronic oppositional defiant disorder almost always interferes with interpersonal relationships and school performance.

Secondary to these difficulties can be low self-esteem, poor frustration tolerance, depressed mood, and temper outbursts.

Adolescents may abuse alcohol and illegal substances.

The disturbance may evolve into a conduct disorder or a mood disorder.

Poor prognosis is associated with early onset of symptoms, longer duration of symptoms, co-morbid anxiety, impulse control & substance misuse disorders and development of conduct disorder.

Treatment

- ✓ The primary treatment of ODD is family intervention using both direct training of the parents in child management skills and careful assessment of family interactions.
- ✓ **Collaborative problem solving skills** is indicated for the child.
- ✓ **Behaviour therapists emphasize** teaching parents how to alter their behaviour to discourage the child's oppositional behaviour and encourage appropriate behaviour.
- ✓ **Behaviour therapy** focuses on selectively reinforcing and praising appropriate behaviour and ignoring or not reinforcing undesired behaviour.
- ✓ **Individual Psychotherapy**- there is role play and practice adaptive responses.

Conduct Disorder

Diagnostic criteria:

Children with conduct disorder are likely to demonstrate behaviours in the following four categories

- Physical aggression or threats of harm to people, cruelty to people and animals
- Destruction of their own property or that of others
- Theft or acts of deceit
- Frequent and serious violation of age appropriate rules like truancy or running away

ICD-10 requires at least one behaviour to be present for at least six months.

Prevalence - 5-7 %

M:F - 4:1

DSM-5 criteria, **at least 3 out of a list of 15 behaviours should begin before the age of 13, for a period of 12 months.**

Conduct disorder occurs with greater frequency in the children of parents with antisocial personality disorder and alcohol dependence than in the general population.

Etiology

Risk Factors

Low socioeconomic status, [Low family income] Criminality of father, Overcrowding, Maternal neurosis, Institutional care , Chronic marital discord.

Biological risk factors:

Genetic: Heritable trait of being more susceptible to externalizing disorders in general (CD, ODD and and ADHD)

Brain injury

Neurochemical: Low CSF serotonin, deficient serotonergic activity is seen in those with early onset and more aggressive behaviour.

Neuroimaging: Prefrontal brain regions may have reduced volumes

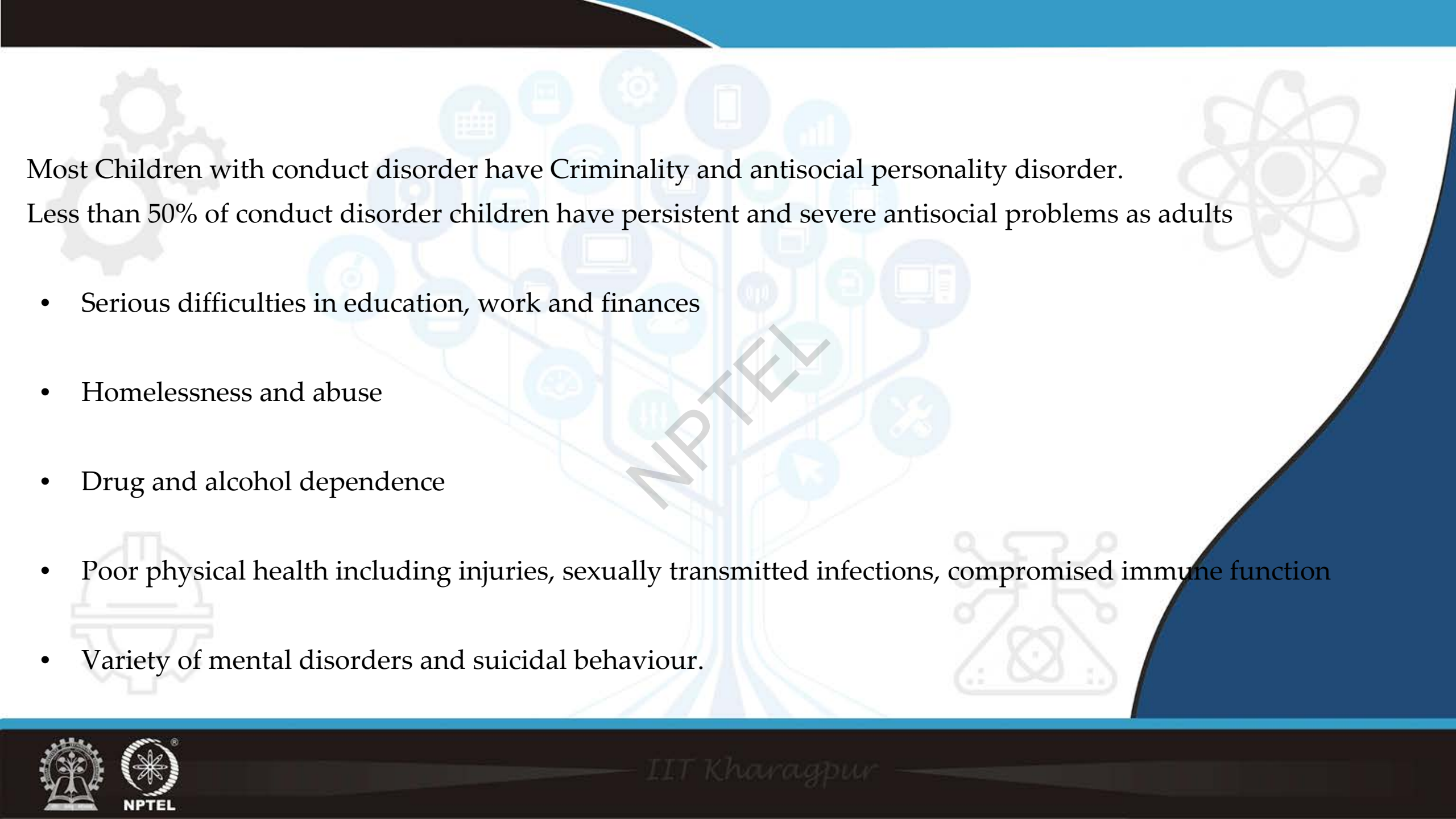
Psychosocial risk factors:

Maternal smoking during pregnancy Parental criminality and substance abuse Harsh and inconsistent parenting

Lack of a warm parental relationship and cold/rejecting family relationships

Domestic violence in the family and child abuse , Large family size , Low socio-economic status / Low family income and social disadvantage

Early loss and deprivation , School failure and poor school achievement , Social isolation;



Most Children with conduct disorder have Criminality and antisocial personality disorder.
Less than 50% of conduct disorder children have persistent and severe antisocial problems as adults

- Serious difficulties in education, work and finances
- Homelessness and abuse
- Drug and alcohol dependence
- Poor physical health including injuries, sexually transmitted infections, compromised immune function
- Variety of mental disorders and suicidal behaviour.

Assessment

A structured diagnostic schedule can be applied.

- 1) Diagnostic interview schedule for children by age (DISC-IV).
- 2) Diagnostic interview for children and adolescents (DICA).
- 3) The schedule for affective disorders and schizophrenia for School-age Children (K-SADS).
- 4) Child and adolescent psychiatric assessment (CAPA).

DISC-IV and DICA are structured interview and do not require trained professionals to be administered while K-SADS and CAPA should be administered by trained professionals.

- **The Achenbach's child behavior checklist had an Indian adapted version and known as childhood psychopathology measurement schedule (CPMS). It is a semi-structured interview schedule having 75 symptoms and has a designated section on CD symptoms**

Treatment

Parent Management Training based on the principles of social learning theory has been very successful in altering the course of conduct disorders.

- ✓ The major objective of parent management training (PMT) is to teach parents the skill of developing and implementing a systematic contingency management plan in home setting.
- ✓ This aims to improve the interaction between parent and child at home and to change the antecedents to behavior to increase the possibility that the child will show prosocial behavior.
- ✓ It also helps parents to improve their capability to keep an eye on their children and teaches them more efficient discipline strategies.

Cognitive behavioural therapy:

CBT for conduct problems in children and adolescents typically includes

- i) Social skills training ii) Anger management.

The most common targets are aggressive behaviour, social interactions, self evaluation and emotional dysregulation.

Contingency management programs

- (1) Setting behavioral goals that slowly shape a child's behavior in specific areas of interest.
- (2) To monitor systematically whether the child is achieving these goals
- (3) Positive reinforcement in taking steps in the direction of reaching these goals,
- (4) Penalty for undesired behavior



Multisystemic therapy:

- i) It is one of the best developed treatments of conduct disorder. The clinicians take on only four to six cases at a time and the team is available 24 hours a day. Treatment is usually given for three months and then stopped.
- ii) Multisystemic therapy, the young person's and family's needs are assessed in their own context at home and in their relationships with other systems such as school and peers.
- iii) The therapist is responsible for ensuring appointments are kept and for making change happen in families cannot be blamed for failing to attend or 'not being ready' to change.
- iv) Regular written feedback on progress towards goals from multiple sources is gathered by the therapist and acted upon and the parents and teenagers fill in weekly questionnaires on whether they have been receiving therapy as planned.
- v) There is close attention to 'quality control' by offering weekly supervisions and the supervisor checks adherence weekly

Childhood Depression

According to DSM-5

- i) Irritable or depressed mood
- ii) Loss of interest or pleasure
- iii) Failure to make expected weight gains
- iv) Daily insomnia or Hypersomnia
- v) Psychomotor agitation or retardation
- vi) Fatigue or loss of energy
- vii) Feeling of worthlessness
- viii) Inappropriate guilt
- ix) Recurrent thoughts of death

Atleast 5 symptoms for a period for 2 weeks

These symptoms must produce social or academic impairment

These symptoms cannot be due to substances or general medical condition

Characteristic features

Feelings of restlessness , irritability ,aggression, reluctance to cooperate in family ventures

Withdrawal from social activities & isolation from peers

Children likely to have complications in the form of substance abuse, antisocial behaviour

Course & Prognosis depends on

- i) Severity of illness
- ii) Rapidity of interventions
- iii) Degree of response to interventions.

Age of Onset , Episode severity & presence of comorbid disorders also have an effect.

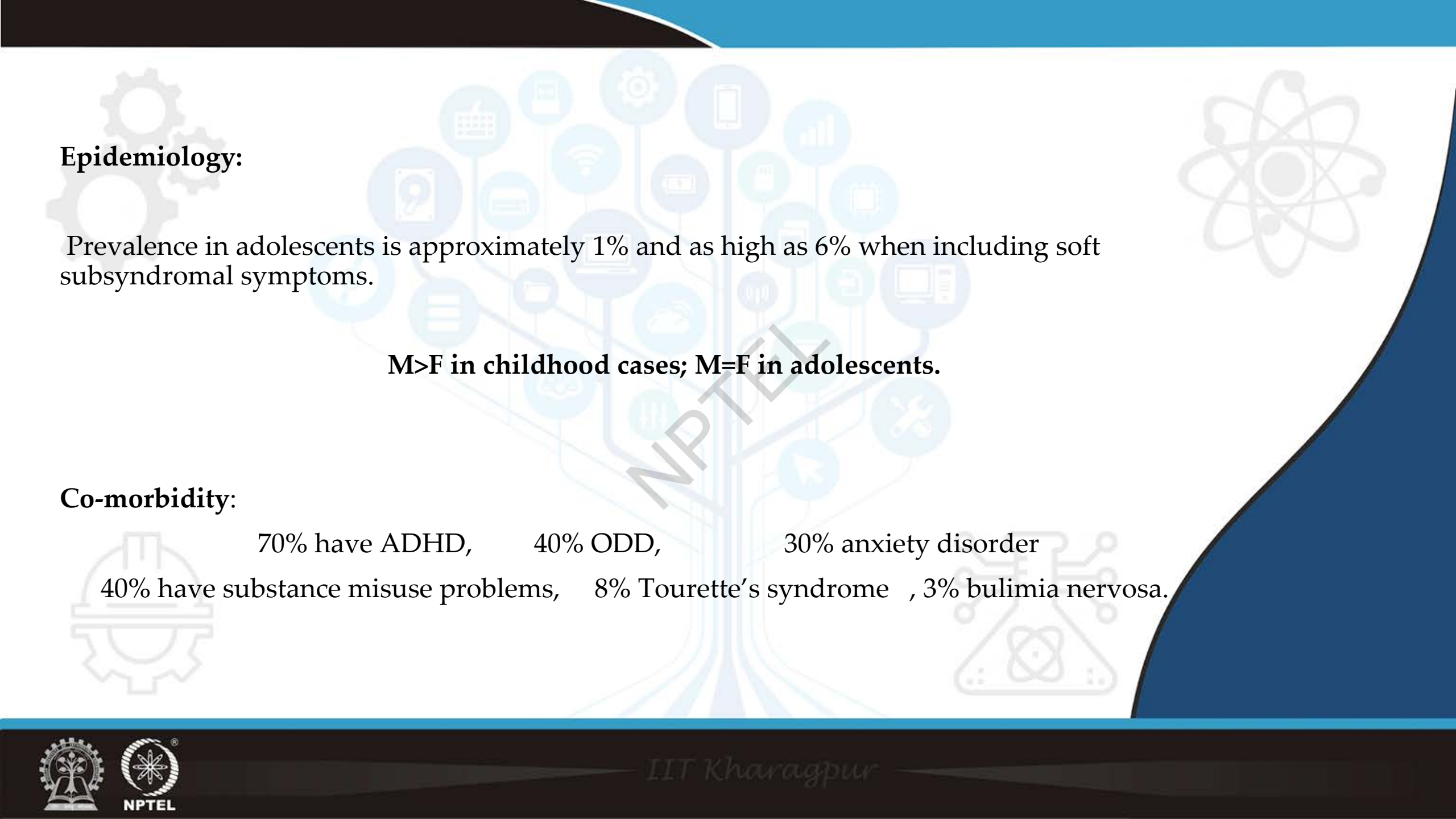
Youth with Major Depression Disorder are at higher risk for future bipolar Disorder

Treatment

- ✓ Psychoeducation
- ✓ Supportive Therapy
- ✓ Cognitive Behaviour Therapy
- ✓ Relaxation Techniques
- ✓ Parent –child interaction Therapy
- ✓ Selective Serotonin Reuptake Inhibitor + Cognitive Behaviour Therapy

Bipolar disorder

- ✓ The **symptoms of mania** commonly reported in children include:
- ✓ Increased energy , distractibility, pressured speech, irritability, grandiosity, racing thoughts, decreased need for sleep, euphoria/elation, flight of ideas and poor judgement.
- ✓ Children experiencing a manic episode typically present with atypical or mixed features characterized by Irritability, labile mood and behavioural problems.
- ✓ Mood lability is a common and impairing presentation in youth, which may not always be a sign of mood disorder.
- ✓ **Elated/euphoric mood and irritability are the two symptoms with the most variability in rates across studies.**



Epidemiology:

Prevalence in adolescents is approximately 1% and as high as 6% when including soft subsyndromal symptoms.

M>F in childhood cases; M=F in adolescents.

Co-morbidity:

70% have ADHD, 40% ODD, 30% anxiety disorder
40% have substance misuse problems, 8% Tourette's syndrome, 3% bulimia nervosa.

Outcome:

The course is often chronic and less responsive to treatment, with atypical and rapid cycling features especially difficult to treat.

Some studies suggest that approximately 20% of adolescents who have an episode of major depression experience a subsequent manic episode by adulthood.

In depressed children and adolescents, development of mania Rapid onset depressive episode with psychomotor features are seen.

Depressive episode with psychotic features

- Family history of mood disorder, especially mania
- History of hypomania or mania following treatment with antidepressant medications
- Suicide risk is high with rates of completed suicide approximately 10%.

Treatment:

Atypical antipsychotics (Olanzapine, Risperidone) are preferred first line for acute mania followed by valproate/lithium.

For maintenance the same choice of medication that controlled manic symptoms is preferred.

Childhood Onset Schizophrenia

Childhood onset schizophrenia (COS) is a rare and severe form of schizophrenia characterized by an onset of psychotic symptoms by age 12 years.

Early onset schizophrenia is used for onset before age 18.

Very early onset schizophrenia (VEOS) refers to onset before 13 yrs

M > F

- ✓ Childhood onset schizophrenia is characterized by more negative symptoms, disorganized behaviour, greater disorganization both of thought and sense of self and fewer systematized or persecutory delusions.
- ✓ It also runs a more chronic course with less chance of a full recovery.
- ✓ Early Onset Schizophrenia have **increased delays in language, reading, bladder control, and social functioning** than adult onset cases.
- ✓ Marked neuropsychological deficits in attention, working memory, and premorbid IQ among children who develop schizophrenia and its spectrum disorders.

Characteristics Features :

1. Children who eventually meet the criteria often are socially rejected and clingy and have limited social skills.
2. They may have histories of delayed motor and verbal milestones and do poorly in school, despite normal intelligence.
3. They often have an insidious onset.
4. Delusions and hallucinations are prominent especially in those who present to services.
5. Children with schizophrenia may giggle inappropriately or cry without being able to explain why.
6. Formal thought disorders, including loosening of associations and thought blocking, are common features among children with schizophrenia.
7. Illogical thinking and poverty of thought are also often present.
8. These clinical symptoms are associated with poor premorbid function with developmental delays.

- **Important predictors of the course and outcome of early-onset schizophrenia**

- i) The child's level of functioning before the onset of schizophrenia,
- ii) The age of onset,
- iii) IQ
- iv) Duration of first episode
- v) Duration of untreated psychosis
- vi) Presence of negative symptoms
- vii) Response to pharmacological interventions
- viii) How much functioning the child regained after the first episode
- ix) The amount of support available from the family.

Treatment

Treatment modalities remains same for an adult and child with some differences.

- ✓ Metabolic side effects are more common in this age group and more intensive monitoring is required.
- ✓ **Atypical antipsychotics favoured over typical ones because dystonia is more common.**

Olanzapine and Risperidone are effective, with advantages over Haloperidol.

- ✓ Clozapine seems to be effective in treatment resistant psychosis in adolescents although this population may be more prone to neutropenia and seizures than adults.
- ✓ Avoid depot and sedating antipsychotics

Psychosocial treatments

Psychoeducation, social skills, and problem-solving strategies and CBT

Tics

Transient Tic Disorder

Transient tic disorder is characterized by single or multiple motor and/or vocal tics (sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations) affecting usually face, nose, throat are involved (grimaces, blinks, frowns, grunts, throat clearing, sniffs).

The tics occur many times a day, nearly every day for at least 4 weeks, but for no longer than 12 consecutive months

Onset is before 18 years.

Criteria should have never been met for Tourette's Disorder or Chronic Motor or Vocal Tic Disorder.

Transient tics occur in 5 - 20% of children. 80% of children with tics will have outgrown them by adult life.

Chronic Tic disorder:

Persists > 1 year and often shows relapses and remissions throughout childhood.

May be one or several tics are simultaneously present.

Motor or vocal tics but not both (so it is a form of partial Tourette syndrome).

Over time, one form fades to be replaced by another.

Tourette Syndrome

- ✓ Characterized by multiple motor and one or more vocal tics, present for at least a year, causing distress and impaired function.
- ✓ The tics occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic free period of more than 3 Consecutive months.

The onset is before age 18 years

Males > Females- 3:1

Prevalence – 1%

Comorbidity:

OCD [1/3rd to 2/3rd of children and adolescents exhibit OCD symptoms) and ADHD [upto 50%] common; depression, anxiety, impulse and conduct disorders and other behavioural problems.

1/3rd of adults with Tourette have persistent OCD into adulthood.

Etiology

Genetic factors:

Autosomal dominant and polygenic common (with increase in Monozygotic twins and first degree relatives).

Neurotransmitter abnormalities thought to underlie tic disorders. Functional excess of dopamine system is a popular speculation as antipsychotics reduce symptoms.

Neuroimaging studies implicate circuits involving the basal ganglia, premotor and motor cortex.

Post-infectious autoimmune mechanisms:

It is well established that group A beta haemolytic streptococci (GABHS) can trigger immune-mediated disease in genetically predisposed individuals.

(PANDAS)- Paediatric autoimmune neuropsychiatric disorder associated with streptococcus

Motor & Vocal tics are of two types:

a) Simple motor – Repetitive contractions of similar muscle groups
eye-blinking, shoulder shrugging

Simple Vocal – throat clearing ,grunting, snorting

B) Complex motor- More purposeful & ritualistic than simple tics-grooming behaviours , echopraxia

Complex vocal- repeating words or phrases out of context, coprolalia , palilalia.

- ✓ Individual tics may increase or decrease or persist or may be replaced by new ones.
- ✓ When comorbid ADHD , OCD social , academic and occupational problems can complicate the course of the illness

- ✓ Medications can be used if tics are disabling and non-responsive to other therapies.

Medications used to treat Tourette's disorder include Haloperidol, Risperidone, Aripiprazole and Clonidine at low doses.

- ✓ Antipsychotics like Risperidone, Haloperidol and Aripiprazole are effective in alleviating tics but their side effects may outweigh benefits and should not be tried as first line drugs.
- ✓ Clonidine (adrenergic alpha 2 agonists) should be tried first.
 - It helps to reduce the severity and frequency of tics.
 - Main side effects are sedation and postural hypotension.
- ✓ Guanfacine also adrenergic alpha 2 agonists has been shown to lead to a 30% reduction in tic rating scales, are more acceptable in terms of adverse effects.

CONCLUSIONS

- -In this lecture we have discussed regarding concepts Reactive Attachment disorder & disinhibited social engagement disorder ,Sibling rivalry ,School refusal ,Academic problem Attention Deficit Hyperactivity Disorder, conduct disorder, oppositional defiant disorder Childhood depression ,childhood schizophrenia & bipolar disorder, Tic & Tourette disorder along with its management.

REFERENCES

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- 2 Comprehensive Text book Of Psychiatry (Kaplan & Sadock)
- 3 Text book Of psychiatry (Tasman & Leiber mann)
4. Stephan stahl's psychopharmacology



**THANK
YOU !**



NPTEL ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental Health & Clinical Psychiatry

Faculty Name Dr Sumit Kumar

Department Name Psychiatry

TATA MAIN HOSPITAL

Lecture 33 : Psychotherapy-1

CONCEPTS COVERED

- Evolution Of Psychotherapy
- Concept of Psychoanalysis & Psychodynamic Therapy
- Interpersonal Therapy
- Dialectical Behavioral Therapy
- Cognitive Analytical Therapy
- Transactional Analysis
- Mentalization Based Therapy
- Transtheoretical Model & Motivational Interviewing
- Acceptance Commitment Therapy & Family therapy

Psychotherapy-1

Evolution of psychotherapy

Contemporary psychodynamic therapy differentiates itself from its Freudian predecessor in several ways.



However, because the fundamentals of the Psychodynamic therapy are typically presented within the context of the Psychoanalytic Therapy



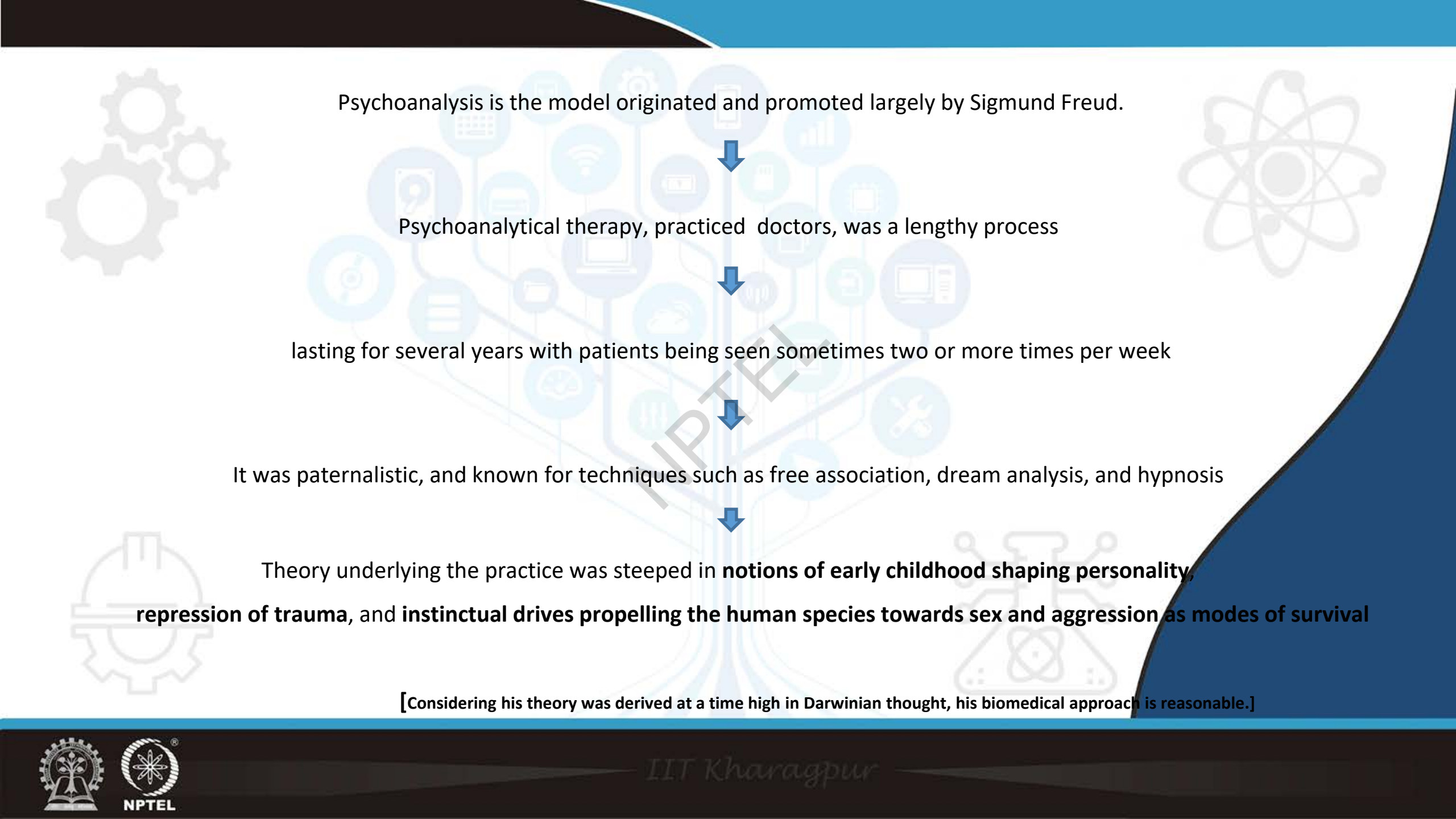
The distinction between old and new is not always easy to discern.



Radical concepts like penis envy and the Oedipus complex seem out-of-date at best, repugnant at worst.



They often turn off students by presenting vestiges of old-school psychoanalysis



Psychoanalysis is the model originated and promoted largely by Sigmund Freud.



Psychoanalytical therapy, practiced doctors, was a lengthy process



lasting for several years with patients being seen sometimes two or more times per week



It was paternalistic, and known for techniques such as free association, dream analysis, and hypnosis



Theory underlying the practice was steeped in **notions of early childhood shaping personality, repression of trauma, and instinctual drives propelling the human species towards sex and aggression as modes of survival**

[Considering his theory was derived at a time high in Darwinian thought, his biomedical approach is reasonable.]

Freud garnered followers that became known as the Neo-Freudians



Many of whom eventually split-off or were ostracized by Freud due to their theoretical departures

[Carl Jung and Alfred Adler , Melanie Klein]

Neo Freudians



The traditional mode of theory and practice is referred to as psychoanalysis.

4 Major Schools of Psychoanalytical theory

i) Freudian ii) ego Psychology iii) Object relations theory iv) Self Psychology

The modern approach that evolved from Freudian origins is termed the psychodynamic system.

As there is no definitive cut-off date distinguishing older psychoanalytic practice from newer psychodynamic practice

Evolutionary Biologist

Richard Dawkins

the change is best conceptualized as an evolutionary process.

In biological evolution, there is **no distinct event that clearly demarcates one species from another.**

Identifying the exact point that your ancestors became Homo sapiens will prove difficult due to evolution being a continual process rather than a series of discrete events

So is the evolution from psychoanalysis to the psychodynamic approach

Psychoanalysis

It is a process involving bringing to the surface repressed memories & feelings.
Unconscious neurotic conflicts are recovered from memory & verbally expressed

Re-experienced in the transference (therapist)

Reconstructed by the therapist

Ultimately resolved through understanding

Recollection

Repetition

Working through

Psychoanalytical setting

Couch
Free association
Evenly suspended Attention
As a mirror
Rule of Abstinence

Goals

Radical reorganization of old developmental patterns based on earlier affects and the entrenched defences built up against them.

Brief Psychodynamic Psychotherapy

Patient Selection Criteria for Psychodynamic Psychotherapy

✓ **Limited time**

A time limit set at the start of therapy imparts a sense of psychological urgency in the patient and therapist to complete a set of goals. Each session would start with, “Including today’s session, we have ‘x’ number of session left together.”

✓ **Limited goals**

Goals, such as coping skills and insight into a few disabling symptoms, can be accomplished in the restricted time frame.

✓ **Maintenance of focus**

The therapist highlights key areas to target the therapeutic effort. This can include a person, event, or feeling, but therapy must be centered around those specific areas.

✓ **High therapist engagement**

This can include the therapist talking more to keep the sessions focused, providing homework or other study material, and providing support for the patient.

✓ **Prompt intervention** The patient must be motivated to be an active participant in the therapy.

Intervention techniques

- ✓ **Interpretation**- This technique is the most insight-enhancing, allowing the unconscious to come into conscious thought.
- ✓ **Confrontation** -Encouraging the patient to face a challenging or unconscious thought.
- ✓ **Clarification** -Requesting that the patient describe a thought or feeling in more detail.
- ✓ **Encouragement**- to elaborate Asking for more information on a topic or statement.
- ✓ **Empathic validation** Commenting about and affirming a patient's feelings in an understanding manner.
- ✓ **Advice and praise**- Giving an evidence-based suggestion on what to do and conveying approval of a patient's thought or behavior.
- ✓ **Affirmation** Giving support to the patient.

Psychodynamic therapy

- ✓ It is an evidence based treatment that focuses on inducing behavioral alterations in patients through gaining insight into the patterns of their past adverse experiences.
- ✓ Psychodynamic Psychotherapy focuses on unconscious process as they are present in clients present behaviour.
- ✓ Brief psychodynamic therapy (BPT) shortens the therapeutic window from years to months, usually involving fewer than 24 sessions.
- ✓ It enables client to examine unresolved conflicts & symptoms that arise from the past dysfunctional relationships and manifest themselves in the need & desire to abuse substances

Goals

- b) Central concept is there should be focus on one major conflict rather than several unconnected issues .

Interpersonal Therapy

- Aims to improve interpersonal functioning and may be offered in conjunction with medication.
- Conducted over 16-20 sessions. 12 to 16, hour-long weekly sessions

Developed in 1970
by
**Klerman &
Weissman**

- Focuses of treatment are the current interpersonal relationships and their relationship to the development of illness.
- **Therapist is nonjudgmental, expresses warmth and positive regard for the patient, and not afraid to make suggestions or provide direct advice when they seem useful.**

Therapy is conducted in 3 phases

First phase – Identification of current interpersonal problems , identification of precipitants leading to the situation (session1-5)

Second phase -strategies are implemented to identify and manage the negative affects associated with problem area (session 6-15)

Lastly - Review progress of the accomplishments and warnings regarding anticipated future difficulty.

Problem areas: **a) Role transitions b) grief & loss c) Interpersonal role disputes d) Interpersonal deficits.**

Indicated in mild and moderate depression and Bulimia Nervosa.

Dialectical behaviour Therapy

- Developed as a treatment for Borderline Personality Disorder.
- Therapy aimed at reducing self harm , behaviours reducing the quality of life

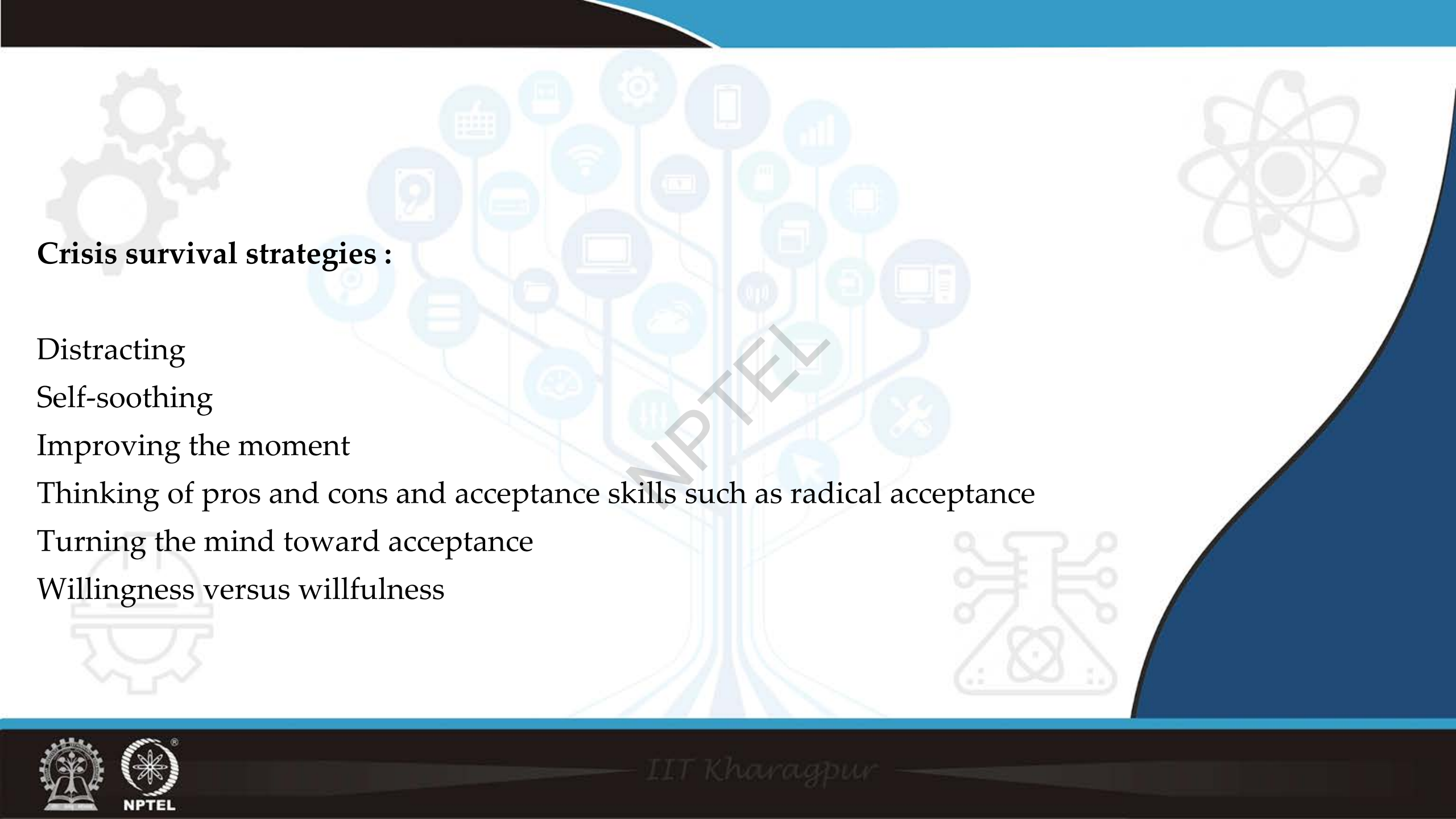
Four **modes** of treatment in DBT are as follows:

(1) group skills training (2) individual therapy (3) phone consultations (4) consultation team.

Techniques utilized:

- Distress tolerance .
- Interpersonal effectiveness- training is very similar to assertiveness and problem-solving training.
- Core mindfulness training - learning to monitor internal mental states.
- Emotion regulation skills form an important part of DBT.
- **DBT also involves social skills training** such as meditation, assertiveness training, etc.

validation - recognizing distress and behaviours as legitimate and understandable but ultimately harmful.



Crisis survival strategies :

Distracting

Self-soothing

Improving the moment

Thinking of pros and cons and acceptance skills such as radical acceptance

Turning the mind toward acceptance

Willingness versus willfulness

Cognitive Analytical Therapy

Therapy started by Anthony ryle.

Conducted for 16-24 sessions in 3 phases

First phase-Exploration of traps , Dilemmas , Snags

Second Phase –Working Through Problem

Third Phases – Both therapist and Patient write good bye together

Two concepts form the basis

1. Procedural Sequence Model
2. Role Repertoires involves behavioural , cognitive & affective components

Procedural Sequence model

- a) Traps: Negative assumptions that produces consequences.
- b) Dilemmas- Either be placid or Explosive
- c) Snags- Appropriate goals are abandoned because others would oppose them.

Procedural Model

Aim Generation

Environmental Evaluation

Plan Formation

Action

Evaluation

Procedural Revision

Transactional Analysis

- Therapy started by Eric berne.
- Examines interaction with people.

3 main Ego-states people consistently use.

- a) Parent : “Criticising” and “Nurturing”
- b) Child : “Strop”
- c) Adult : Behaving in a “rational” /reasonable way’

Mentalisation Based Therapy

- **Given by bateman & Fonagy**
- Derived from Attachment Theory, client – centered , interpersonal , cognitive therapies
- Mentalization is the capacity to perceive others and ones own actions.

Central concepts of therapy is **Understanding of the patient's subjective experience through empathy and validating the patient's experience.**

Person attempts to stay aware of thoughts , feelings , mood & bodily sensations

- Therapy focusses on **De-emphasis of hidden unconscious concerns in favour of conscious concerns**
- Content Less focus on the past as it is represented in the present;
- It is not insight but the recovery of mentalization

Mindfulness

It has its origins in Buddhist philosophy in 19th century to refer to meditative techniques.

Mindfulness applies to self only / Mentalization applies to oneself & others

Novel focus of a Mindfulness approach:

- i) Nonjudgmental awareness of consciousness
- i) Noticing ones own thoughts & feelings in the moment.
- i) Accepting own thoughts without judging or trying to change them.

Transtheoretical Model

Therapy given by Prochaska and Di-clemente.

Identified five common processes of change.

- a) Consciousness raising : helping the patient gather information about self and the problem
- b) Choosing : increasing awareness of healthy individuals
- c) Catharsis : emotional expression of the problem behaviour and the process of change
- d) Conditional stimuli includes stimulus control and counterconditioning

Stimulus control :

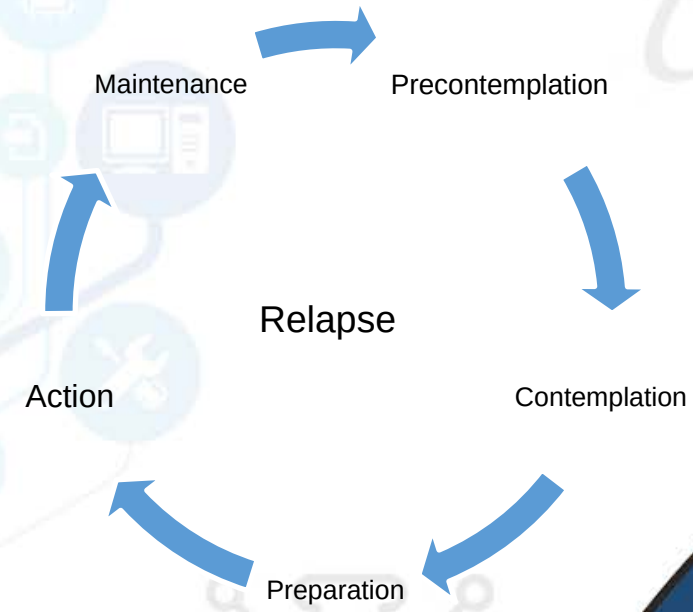
Avoidance of stimuli associated with the problem behaviour and the operant extinction cueing effect of the stimulus on behaviour.

Counterconditioning- : Training an alternative, healthier response to the cue stimuli.

- e) Contingency control : Positive reinforcement from others and self-appraisal and improving self-efficacy by self-reinforcement.

From these five processes of change, Prochaska and DiClemente identified six stages of change.

- (1) Precontemplation
- (2) Contemplation
- (3) Preparation
- (4) Action
- (5) Maintenance
- (6) Relapse

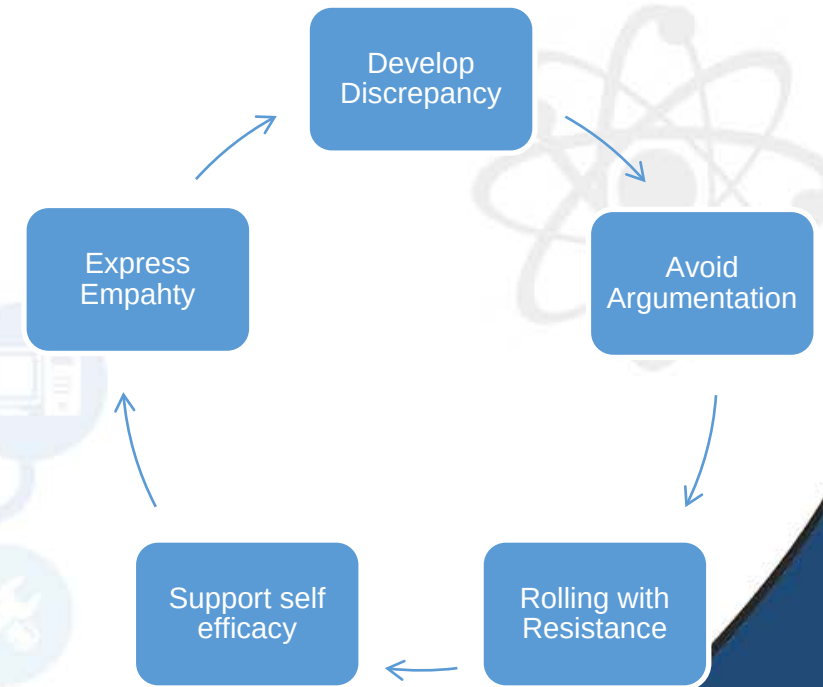


These stages are not linear in sequence but rather cyclical, in that a person can relapse and reenter at a later stage such as preparation

Motivational Interviewing

- **Therapy started by Millner & Rollnick**
- Often used together with Transtheoretical model in substance abuse patients.

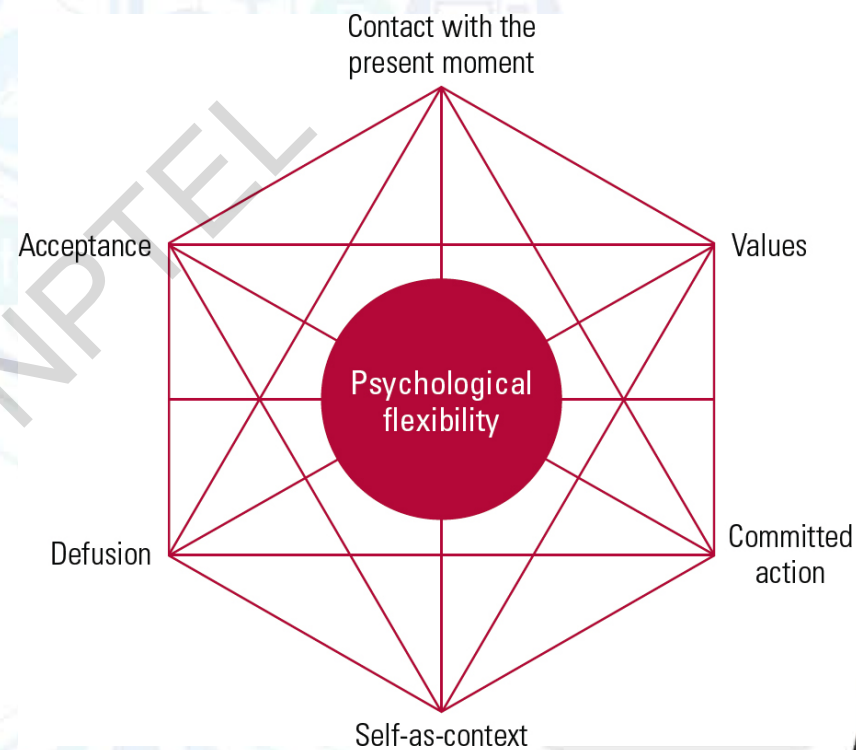
5 Principles----->



- **Therapy is done collaboratively with patients rather than directly challenge them to change their behaviour.**
- **Resolving the ambivalence towards changing can increase intrinsic motivation to change** – this increase in motivation is the main goal of the motivational interview.
- **A change coming from the patient is more powerful than that prescribed by a therapist.**

Acceptance and Commitment Therapy

- **Steven C. Hayes** is Nevada Foundation Professor at the Department of Psychology at the University of Nevada
- Emphasizes working on the way people relate to their thinking and feeling, rather than directly trying to challenge or change.
- Cognitive Fusion and Experiential Avoidance
- **Strategies:**
 - a) Acceptance
 - b) Cognitive Defusion
 - c) Contact with Present moment
 - d) Values
 - e) Committed Action
 - f) Self as context



Experiential Avoidance-

The unwillingness to remain in contact with uncomfortable private events (thoughts, feelings & physiological sensations)by escaping or avoiding these experiences.

Example of family issues at home

Avoidance reduces immediate contact with distressing experience



Short term relief with drinking/smoking



Avoidance leads to greater dysfunction & distress

Psychological Flexibility-

Cultivated by 6 core skills:

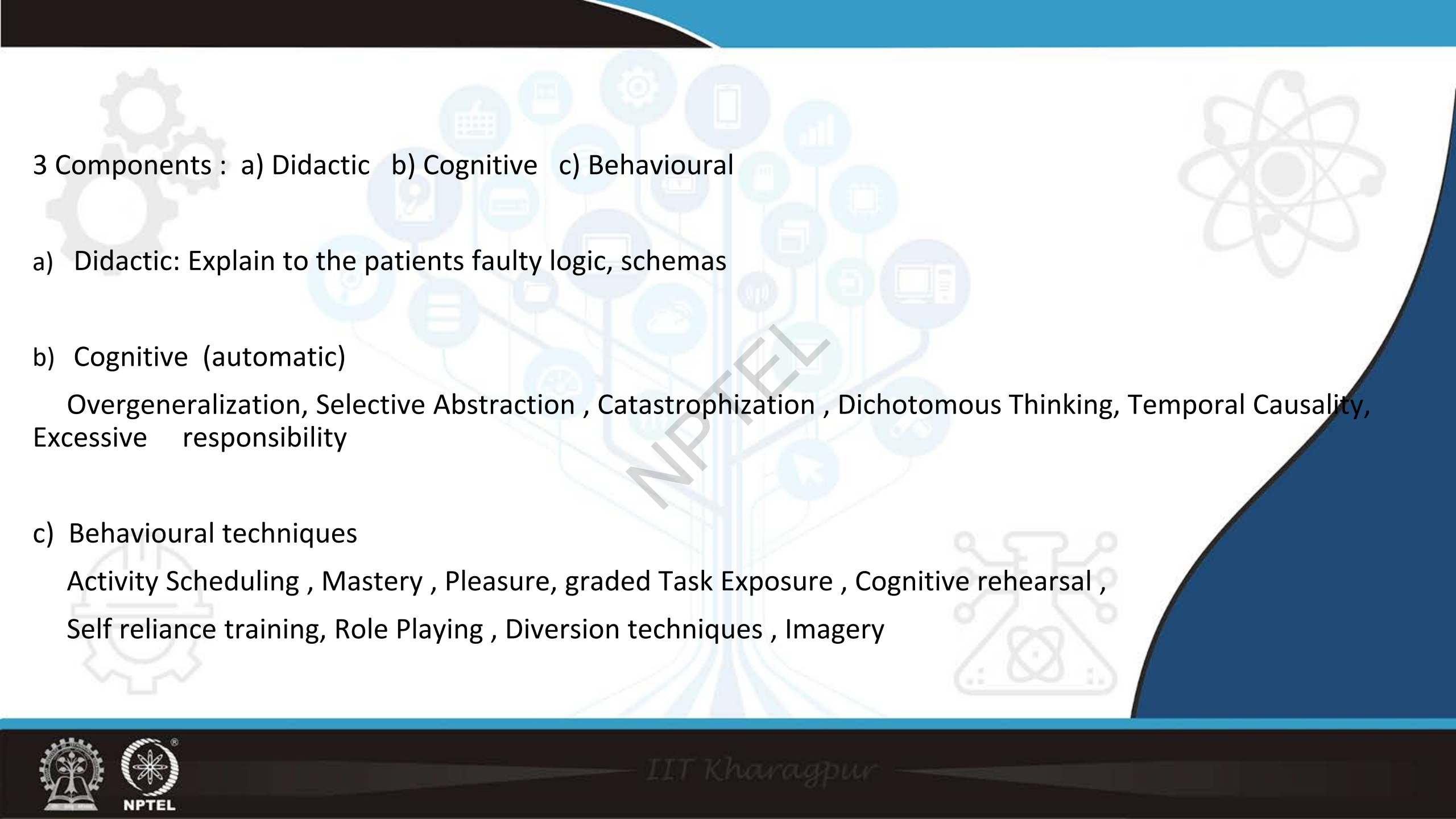
- i) Flexibly & purposefully remaining in the present moment by mindful of thoughts, feelings and bodily sensations
- ii) Keeping Balanced & broad perspective on thinking & feeling.
- iii) Clarifying fundamental hopes, values and goals
- iv) Cultivating commitment in line with hopes, values and goals.
- v) Willingly accepting the unwanted feelings inevitably elicited by taking difficult actions.
- vi) Defusion or stepping back

Cognitive Therapy

Duration: 25 weeks

Central feature of cognitive theory of emotional disorder is Its emphasis on the

- i) Psychological significance of people's belief about themselves (worthlessness)
- ii) Personal world (Helplessness)
- iii) Future (Hopelessness)



3 Components : a) Didactic b) Cognitive c) Behavioural

a) Didactic: Explain to the patients faulty logic, schemas

b) Cognitive (automatic)

Overgeneralization, Selective Abstraction , Catastrophization , Dichotomous Thinking, Temporal Causality, Excessive responsibility

c) Behavioural techniques

Activity Scheduling , Mastery , Pleasure, graded Task Exposure , Cognitive rehearsal ,
Self reliance training, Role Playing , Diversion techniques , Imagery

Family therapy

It is psychotherapeutic technique that focusses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit or its subsystems, and functioning of individual members of the family.

Aka Systemically sensitive therapy

Each session 2hrs /week depending upon the intensity of the situation

Therapist decides regarding the number of sessions required to bring about the change in the family dynamics.

3 Models

- i) Bowen
- ii) Structural
- iii) General System Model

Goals

- a) To resolve or reduce pathological conflict and anxiety within the matrix of interpersonal relationships.
- b) To enhance the perception and fulfilment by family members of one another's emotional needs
- c) To promote appropriate role relationships between the sexes and generalisation.
- d) To strengthen the capacity of individual members and the family as a whole to cope with destructive forces inside and outside the surrounding environment.
- e) Integrate families into the large system of society, extend family and community groups and social systems such as schools, medical facilities and social, recreational and welfare agencies.

CONCLUSIONS

-In this lecture we have discussed regarding evolution of psychotherapy concepts related to psychoanalysis and psychodynamic psychotherapy in brief ,concepts of interpersonal therapy, dialectical behavioural therapy, cognitive analytical therapy, transactional analysis, transtheoretical model, motivational interviewing , Acceptance and commitment therapy.

REFERENCES

- 1 Oxford Test book Of Psychiatry
- 2 Comprehensive Text book Of Psychiatry (Kaplan & Sadock)
- 3 Text book Of psychiatry (Tasman & Leibermann)
- 4 Stephen Stahl's Psychopharmacology
5. Substance Abuse & Mental Health Services Administration, Rockville (MD)
6. Brief Psychodynamic Psychotherapy: JESSICA PORCELAN, MD, and KATHERINE SCRIBNER.



**THANK
YOU !**



NPTEL ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental Health & Clinical Psychiatry
Faculty Name Dr Sumit Kumar
Department Name Psychiatry
TATA MAIN HOSPITAL

Lecture 34 : Psychotherapy-2

CONCEPTS COVERED

- Systemic Desensitization
- Therapeutic Graded Exposure
- Flooding
- Participant Modelling
- Positive Enforcement
- Eye Movement Desensitization Reprocessing (EMDR)
- Couple therapy & Hypnosis/Abreaction
- Supportive Therapy
- Self Help Groups
- Individual Therapy

Behaviour Therapy

Behaviour refers to observable actions and responses.

It involves changing the behaviour of patients to reduce dysfunctions and to improve quality of life.

Father of Behaviourism- John.B.Watson

Utilizes principles of learning Theory

Systemic Desensitization

Joseph Wolpe and his colleagues in Johannesburg , South Africa developed Systemic Desensitization.

Works on the principle of **Counterconditioning**

A person **overcomes maladaptive anxiety elicited by a situation or an object** by approaching the feared situation gradually , in a **psychophysiological state that inhibits anxiety**.

3 steps

Relaxation Training- Edmund Jacobson
(Herbert-Benson named it Relaxation response)

Hierarchy Construction

Desensitization

Works for Phobias , OCD , some Sexual dysfunctions .

Therapeutic Graded Exposure

Relaxation training is not involved.

Treatment is carried out in – vivo.

Individual must be brought in contact with the warning stimulus to learn first hand that no dangerous consequences will ensue.

Exposure is graded according to a hierarchy.

Works in OCD, Phobias

Flooding/Implosion

Implosion (in vitro)

Involves exposing the patient to the feared object in vivo

Works in Phobias

There is no hierarchy.

Works on the premise that escaping from an anxiety provoking experience reinforces the anxiety through conditioning.

Patients are encouraged to confront feared situations directly without a gradual build up as in therapeutic graded exposure .

No relaxation exercises.

Participant Modelling

Patient learns new behaviour by imitation , primarily by observation , without having to perform the behaviour until they feel ready.

Phobic Patients are placed with other patients of their age and sex who approach the feared stimulus or object.

Therapist describes the feared activity in a calm manner

Behaviour Rehearsal – Real life problems are acted out under a therapist observation or direction

Works in Temper tantrums, ADHD,

Positive Enforcement

When a behavioural response is followed by a generally rewarding event , such as food , avoidance of pain or praise, it tends to be strengthened and to occur more frequently than before the reward.

Token Economy in inpatient management

Works in Temper Tantrums, ADHD ,management of inpatients for social skill training

Eye Movement Desensitization and Reprocessing (EMDR)

Saccadic eye movements are rapid oscillations of the eyes that occur when a person tracks an object that is moved back and forth across the line of vision.

Relaxation occurs following the act .

Works in PTSD , Phobias

Couple Therapy/ Marital Therapy

It is a form of psychotherapy designed to psychologically modify the interaction of two persons who are in conflict with each other over one or the other parameters.

- i) Social
- ii) Emotional
- iii) Sexual
- iv) Economic



Marriage counselling
differs in dealing only a
specific problem

Therapist establishes a therapeutic contract with a patient-couple and through definite types of communication attempts

- i) To alleviate disturbance
- ii) Reverse maladaptive pattern of behaviour
- iii) Encourage personality growth and development

4 Types

- a) Individual
- b) Individual Couple Therapy
- c) Conjoint Therapy
- d) Four Way session

Goals

- i) To alleviate emotional distress and disability.
- ii) To promote levels of well being of both partners together and of each as an individual.

Family therapy

It is psychotherapeutic technique that focusses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit or its subsystems, and functioning of individual members of the family.

Aka Systemically sensitive therapy

Each session 2hrs /week depending upon the intensity of the situation

Therapist decides regarding the number of sessions required to bring about the change in the family dynamics.

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- d) To strengthen the capacity of individual members and the family as a whole to cope with destructive forces inside and outside the surrounding environment.
- e) Integrate families into the large system of society, extend family and community groups and social systems such as schools, medical facilities and social, recreational and welfare agencies.

Supportive Psychotherapy

Creates a therapeutic relation as a temporary buttress or bridge for the deficient patient.

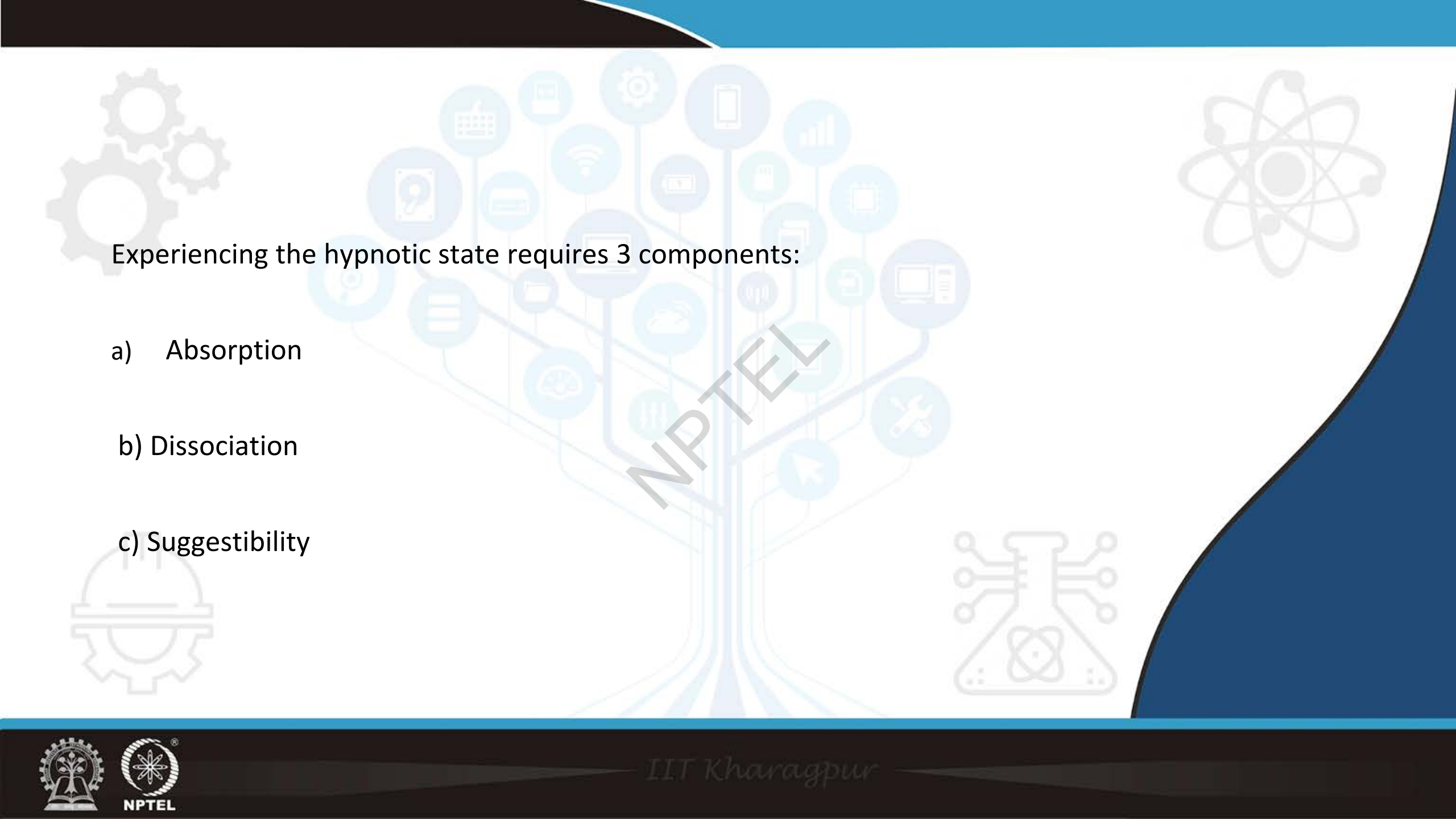
4 areas where the therapy is indicated:

- i) Individual in acute crises or temporary state of disorganization and inability to cope.
- ii) Patients with fragile ego functioning (psychotic , Impulsive disorders)
- iii) Patients whose physical illness and cognitive deficits make them particularly vulnerable.
- iv) Patients who are psychologically unmotivated.

Hypnosis/ Ab Reaction

It is a normal activity of a normal mind through which **attention is more focussed** , critical **judgement is partially suspended**, and **peripheral awareness is diminished**.

Mental health professional/ Psychiatrists/hypnotist in the achievement of the state to facilitate the acceptance of new thoughts and feelings , thereby accelerating therapeutic change.



Experiencing the hypnotic state requires 3 components:

- a) Absorption
- b) Dissociation
- c) Suggestibility

Self Help groups

Comprise persons who are trying to cope with a specific problem or life crisis and are usually organized with a particular task in mind.

Qualities of self help groups:

- a) Members of the group have homogeneity ie have same disorders and share their experiences good / bad , successful/unsuccessful.
- b) Provide mutual support
- c) Emphasizes cohesion.
- d) Needs of the members are met by acceptance
- e) Help in overcoming maladaptive patterns of behaviour.

Group Psychotherapy

It is a modality that **employs a professionally trained leader who selects , composes, organizes and leads a collection of members to work together** the maximal attainment of the goals for each individual in the group and for the group itself.

To determine the suitability for group psychotherapy , therapist requires great deal of information:

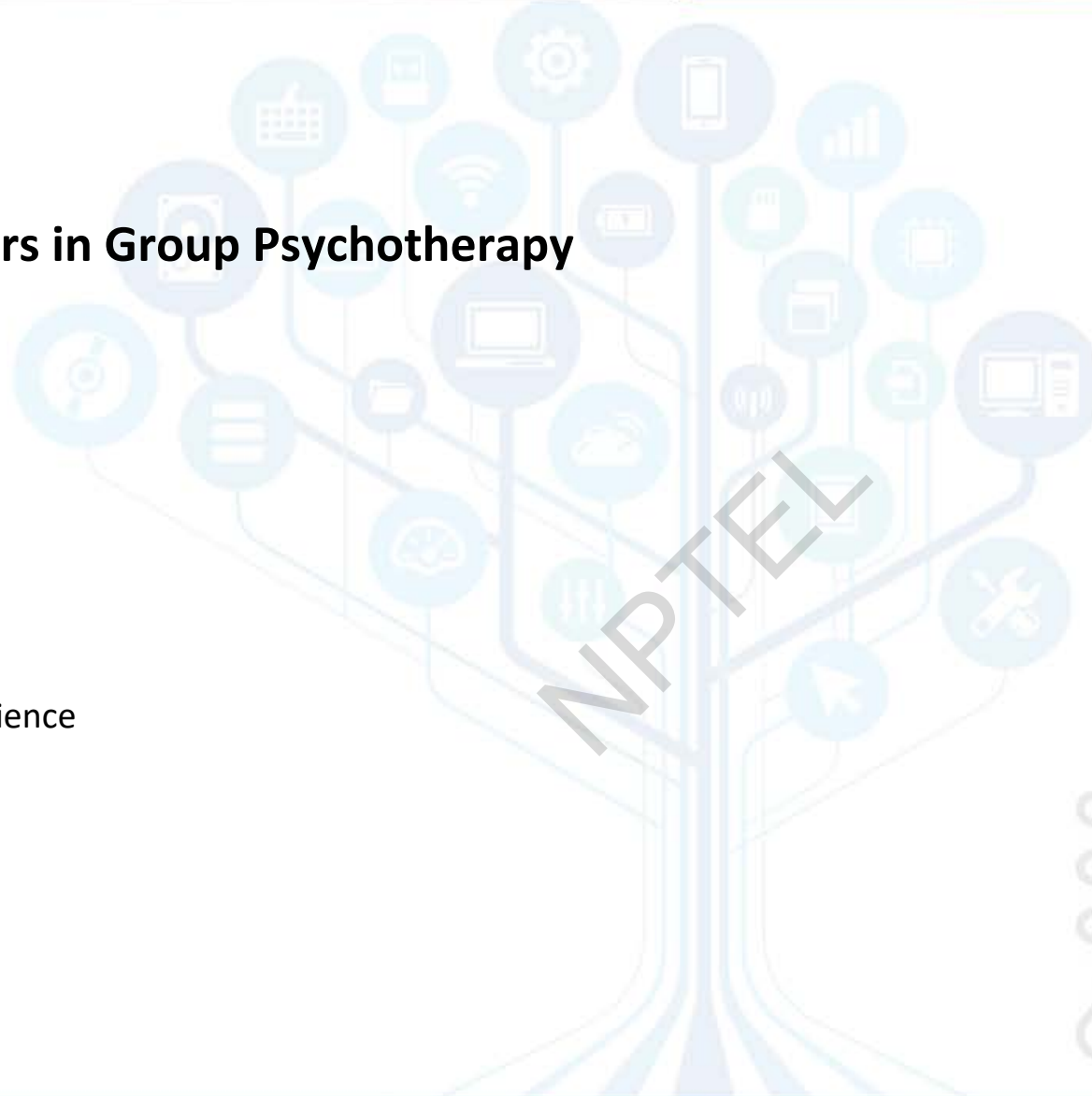
- i) Authority Anxiety
- ii) Peer Anxiety

Therapist's Role in Group therapy:

- a) Size of group
- b) Patient Composition
- c) Confidentiality
- d) Goals
- e) Preparation of patients

Therapeutic factors in Group Psychotherapy

Acceptance
Altruism
Catharsis
Cohesion
Consensual Validation
Contagion
Corrective Familial experience
Empathy
Identification
Imitation/Role modelling
Reality Testing
Ventilation



Individual Psychotherapy

Individual Psychotherapy involves one to one treatment using verbal and play techniques.

The treatment is based on working with the patient in the here and now that is relationship that develops between the patient and the therapist.

Individual Psychotherapy is administered for - 18 months to 21 years.

9 Categories where individual psychotherapy can be given.

- i) Family breakdown & Reconstituted families
- ii) Life Events
- iii) Child or Young person with chronic physical or mental handicap
- iv) Children & young people with acute & chronic conditions
- v) People who have been abused (Physical, sexual, emotional , economical)
- vi) People with psychosomatic conditions
- vii) Developmental delay
- viii) Children in foster / adopted families
- ix) Adolescents with emotional turmoil

Desirable qualities for the therapist:

Compassionate

Resilience

Humour

Courage

Perseverance

Appropriate Professional behaviour



REFERENCES

- 1 Oxford Test book Of Psychiatry
- 2 Comprehensive Text book Of Psychiatry (Kaplan & Sadock)
- 3 Text book Of psychiatry (Tasman & Leiber mann)
- 4 Stephen Stahl's Psychopharmacology

CONCLUSIONS

-In this lecture we have discussed regarding concepts of behavioural therapy like systemic desensitization , therapeutic graded exposure , flooding , participant modelling , positive enforcement , eye movement desensitization & reprocessing , family therapy , self help groups , supportive psychotherapy , individual psychotherapy and its clinical implications in various psychiatric illnessess



**THANK
YOU !**



NPTel ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental Health & Clinical Psychiatry
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Lecture 35 : Psychological Tests

CONCEPTS COVERED

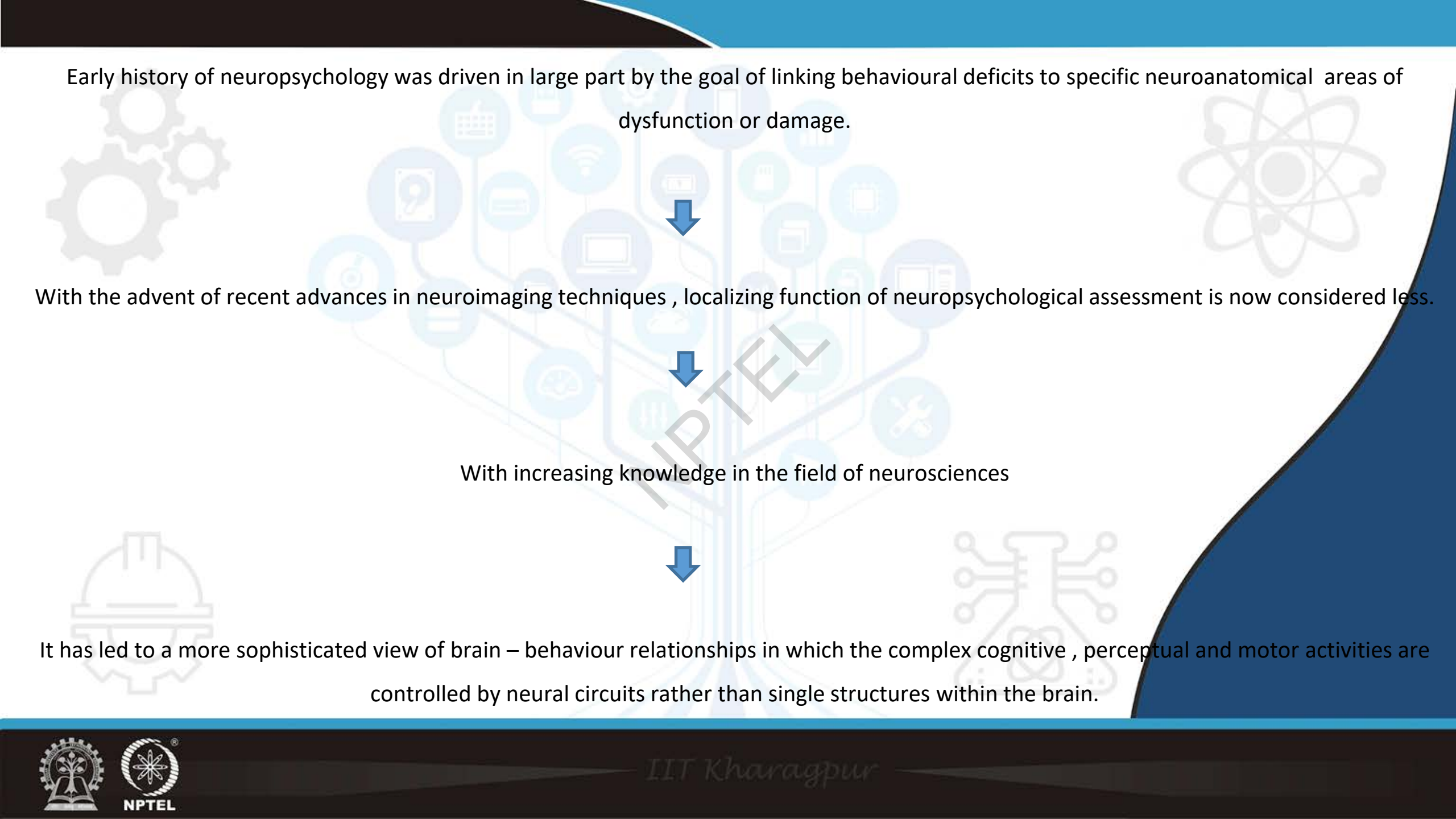
- Evolution of Neuropsychology
- Components Of Neuropsychological Assessment
- Personality Assessment
- Mental Status Examination

Psychological Test



Clinical Neuropsychology

It is a speciality in psychology that examines the relationship between behaviour and brain functioning in the **realms of cognitive , motor , sensory and emotional functioning.**

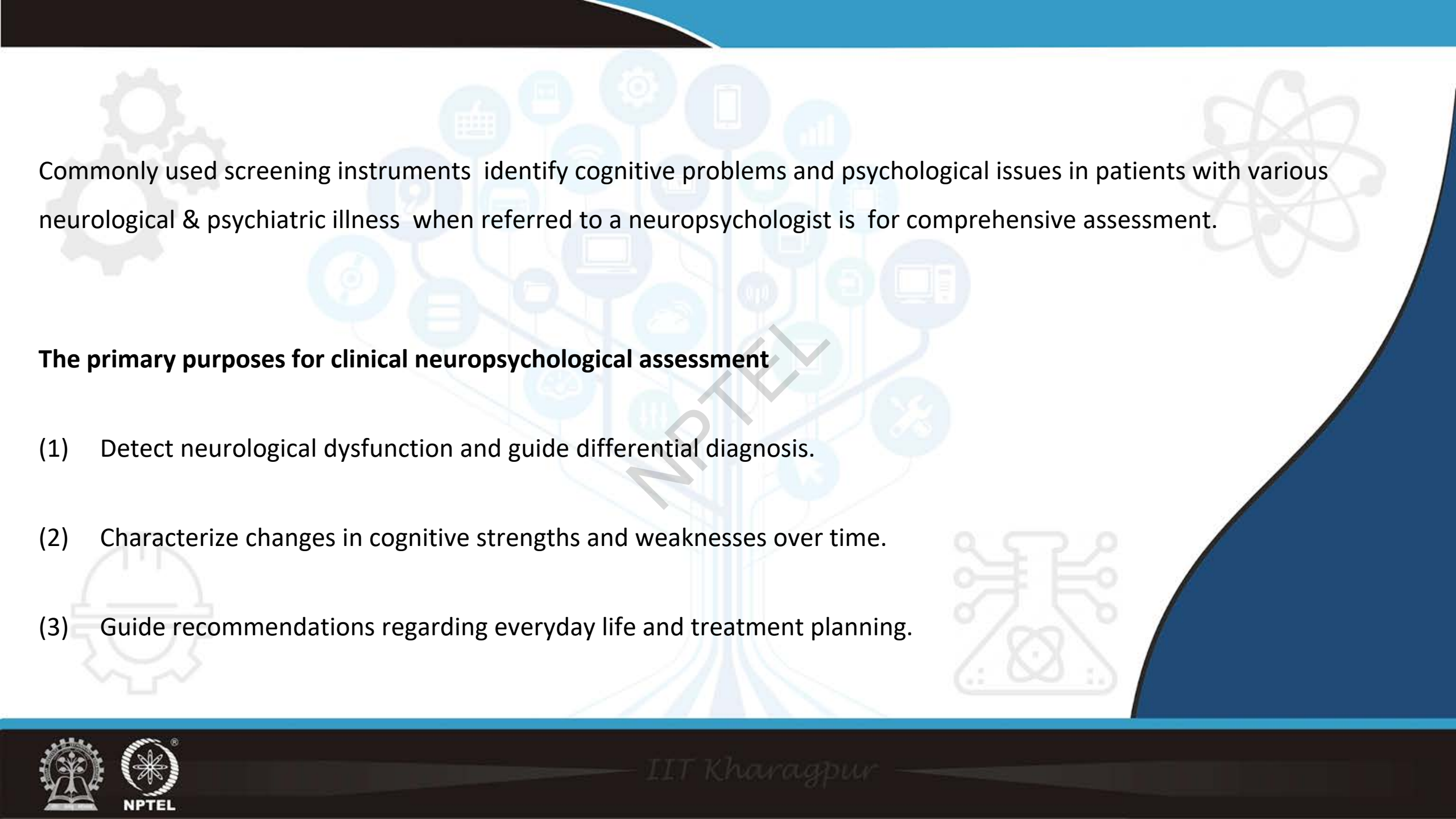


Early history of neuropsychology was driven in large part by the goal of linking behavioural deficits to specific neuroanatomical areas of dysfunction or damage.

With the advent of recent advances in neuroimaging techniques , localizing function of neuropsychological assessment is now considered less.

With increasing knowledge in the field of neurosciences

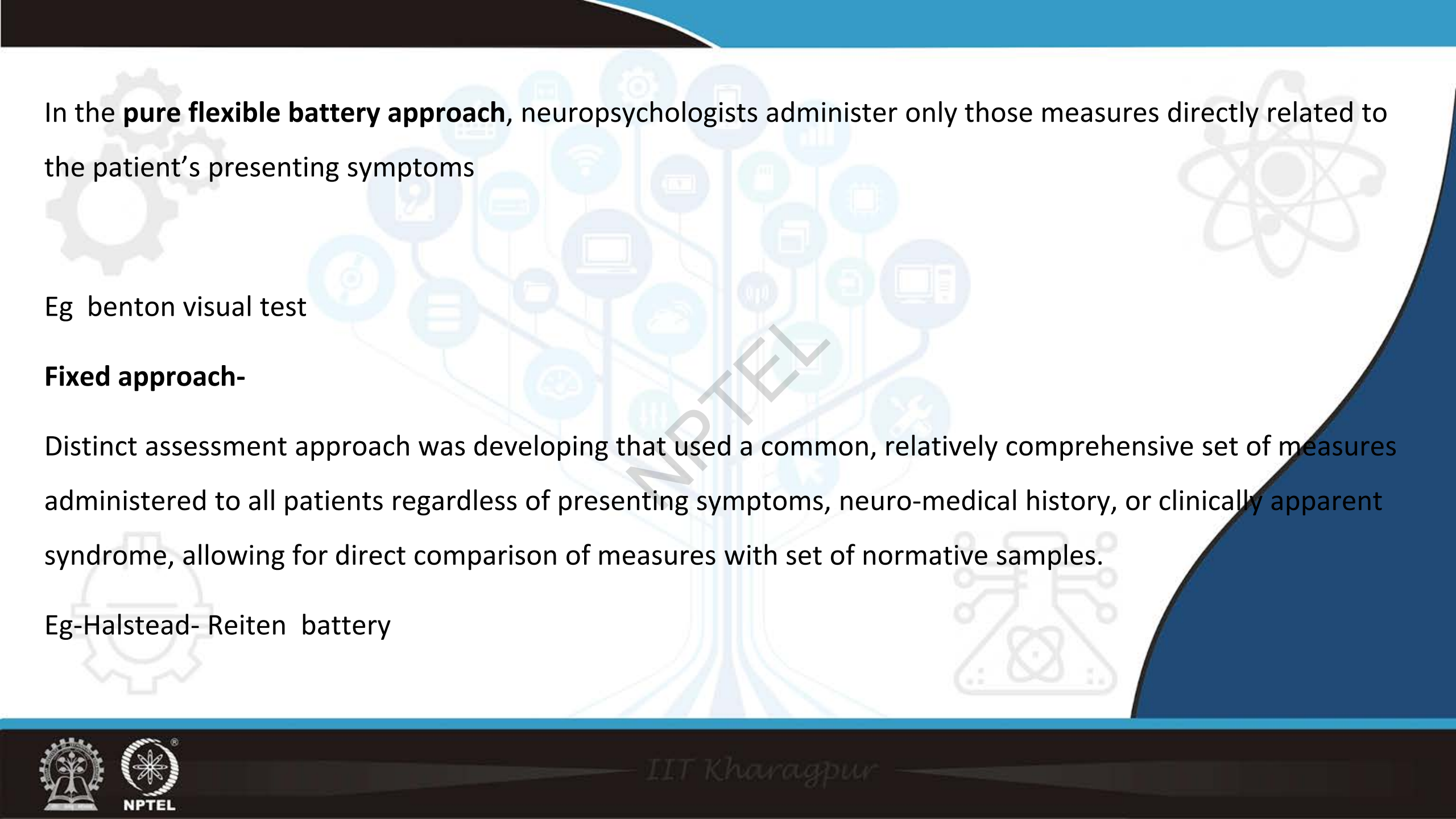
It has led to a more sophisticated view of brain – behaviour relationships in which the complex cognitive , perceptual and motor activities are controlled by neural circuits rather than single structures within the brain.



Commonly used screening instruments identify cognitive problems and psychological issues in patients with various neurological & psychiatric illness when referred to a neuropsychologist is for comprehensive assessment.

The primary purposes for clinical neuropsychological assessment

- (1) Detect neurological dysfunction and guide differential diagnosis.
- (2) Characterize changes in cognitive strengths and weaknesses over time.
- (3) Guide recommendations regarding everyday life and treatment planning.



In the **pure flexible battery approach**, neuropsychologists administer only those measures directly related to the patient's presenting symptoms

Eg benton visual test

Fixed approach-

Distinct assessment approach was developing that used a common, relatively comprehensive set of measures administered to all patients regardless of presenting symptoms, neuro-medical history, or clinically apparent syndrome, allowing for direct comparison of measures with set of normative samples.

Eg-Halstead- Reiten battery

Neuropsychological Assessment

1. Attention
2. Concentration
3. Memory
4. Language
5. Visuo-spatial functions
6. Sensory & Motor Functions
7. Intellectual functioning
8. Executive Functions

Assessment

Attention –

a) Selective attention b) Sustained Attention c) divided Attention
verbal & visual Short term memory

Memory -

Visual memory tasks- Face & Figures are memorized by right hemisphere
Verbal Memory tasks- by left hemisphere

Problems with encoding & retrieval

Executive functioning - fluency, planning, problem solving

Language- Problems related to expressive & receptive issues (single words , Phrases , complex sentences, pragmatics)

Visuo-perceptual functioning- visuoconstructive /visuoperceptual

Sensory-motor functioning-

- a) Visual field assessment
- b) Auditory perception
- c) Agnosia
- d) Handedness
- e) Demonstrate gait by walking

Intellectual functioning

Weschler Intelligence scale assesses

a) Verbal IQ b) Performance IQ c) Full scale IQ

Verbal and Performance IQ are associated with Left and right hemisphere functioning

Personality Assessment

Personality- Defined as individual's enduring and pervasive motivations , emotions , interpersonal styles , attitudes and traits. It measures concepts as depression, anger , suicide potential , anxiety etc.

Purposes of Psychological Testing:

- i) Assisting in differential Diagnosis.
 - ii) Aiding of Psychotherapy
-
- a) Used in pre-treatment planning
 - b) Assessing
 - c) Evaluating the effectiveness of the therapy
 - d) Objective tests allow patients to compare with objective norms
 - e) Can reveal areas of patients life
 - f) Provide baseline information which can be repeated to assess the change

Psychological Tests

Two Types:

- a) **Projective Personality Tests**
- b) **Objective Personality Tests**

Projective Personality Tests:

1. They are unstructured , indirect.
2. Responses to questions are indefinite.
3. Allows patients fantasies to be expressed.
4. Assess the personality as a whole.
5. Difficult to feign the test.
6. Focusses on unconscious aspect of personality.

Examples of Projective Personality Test

- a) Rorschach Test
- b) Thematic Apperception
- c) Sentence Completion Test
- d) Make a picture story

Rorschach Test

1. Herman Rorschach, Swiss Psychiatrists developed the test in 1910.
2. Ten symmetrical inkblot cards which when presented as ambiguous stimuli results in unlimited number of responses by the patients.
3. Tests acts as a screen on which the patients projects their needs , thoughts , conflicts.
4. After the responses with 10 cards are made enquiry phase begins wherein the patients is asked to give explanations regarding the responses he/she made.

Thematic Apperception Test (TAT)

1. Henry Murray developed TAT in 1943.
2. Reflects the their own needs ,thoughts , feelings stresses ,wishes and desires
3. According to the test patient identifies himself/herself as the hero of the story who happens to be of the as same age group/sex

Objective Personality Tests:-

1. Direct , structured and specific questions.
2. Patient given a set of questions and compared with normative group.
3. The degree to which the patient deviates from the norm is noted and used in the interpretive process.

Examples of Objective Personality Tests

- a) Minnesota Multiphasic Inventory – 2
- b) Million Clinical Multiaxial Inventory I,II
- c) Eysenck Personality Questionnaire (EPQ)
- d) Tennessee self –Concept (TSCS)
- e) Personality Assessment Inventory

Minnesota Multiphasic Personality Inventory (MMPI-2)

1. Easy to administer and takes 1.5 hrs to complete the test.
2. Consists of 567 questions which requires only 8 th grade reading level.
3. Responses of questions are compared with normative data.

Newer version restructured form (MMPI-2 RF) was developed in 2008 which contains 338 questions and allows less time to administer.

Personality assessment Inventory (PAI)

Test consists of 344 items and required 4 th grade reading level.

Takes 45 – 50 mins to complete the test.

No separate forms for male or female

Mental status examination

It is a clinical assessment which includes observation of the patient for evaluation of psychological signs and symptoms analogous to physical examination in medicine.

General Appearance:

The description of the patient should be vivid as possible.

i) Physical appearance

ii) Age Estimate

iii) Body built

iv) Eye contact with examiner

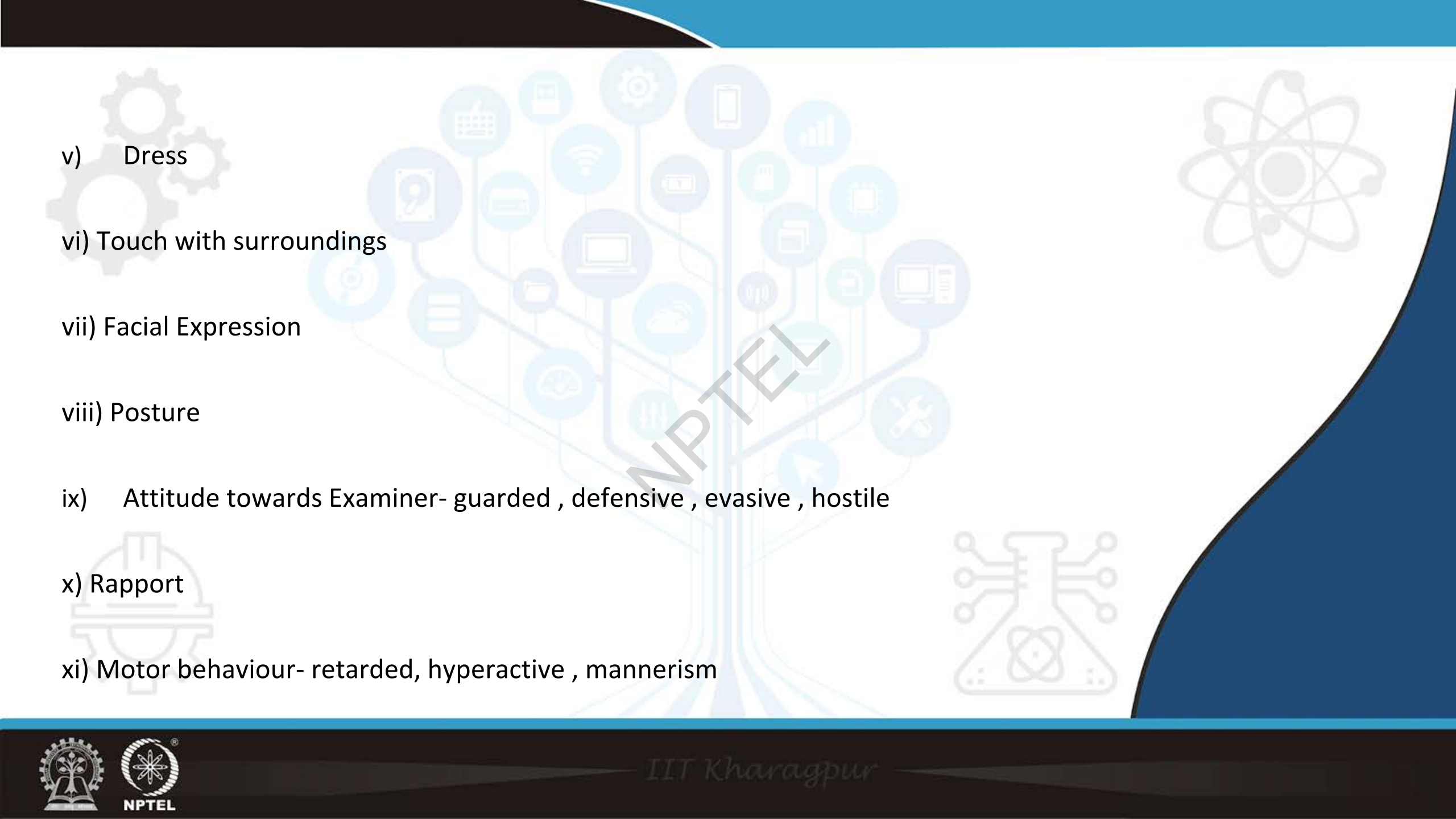
Partial – depression , anxiety

Absent – schizophrenia , Persistent delusional disorder

Ernst Kretschmer- Pyknic, Leptosomes , Athletic

Sheldon – Endomorphs , Ectomorphs, Mesomorphs





v) Dress

vi) Touch with surroundings

vii) Facial Expression

viii) Posture

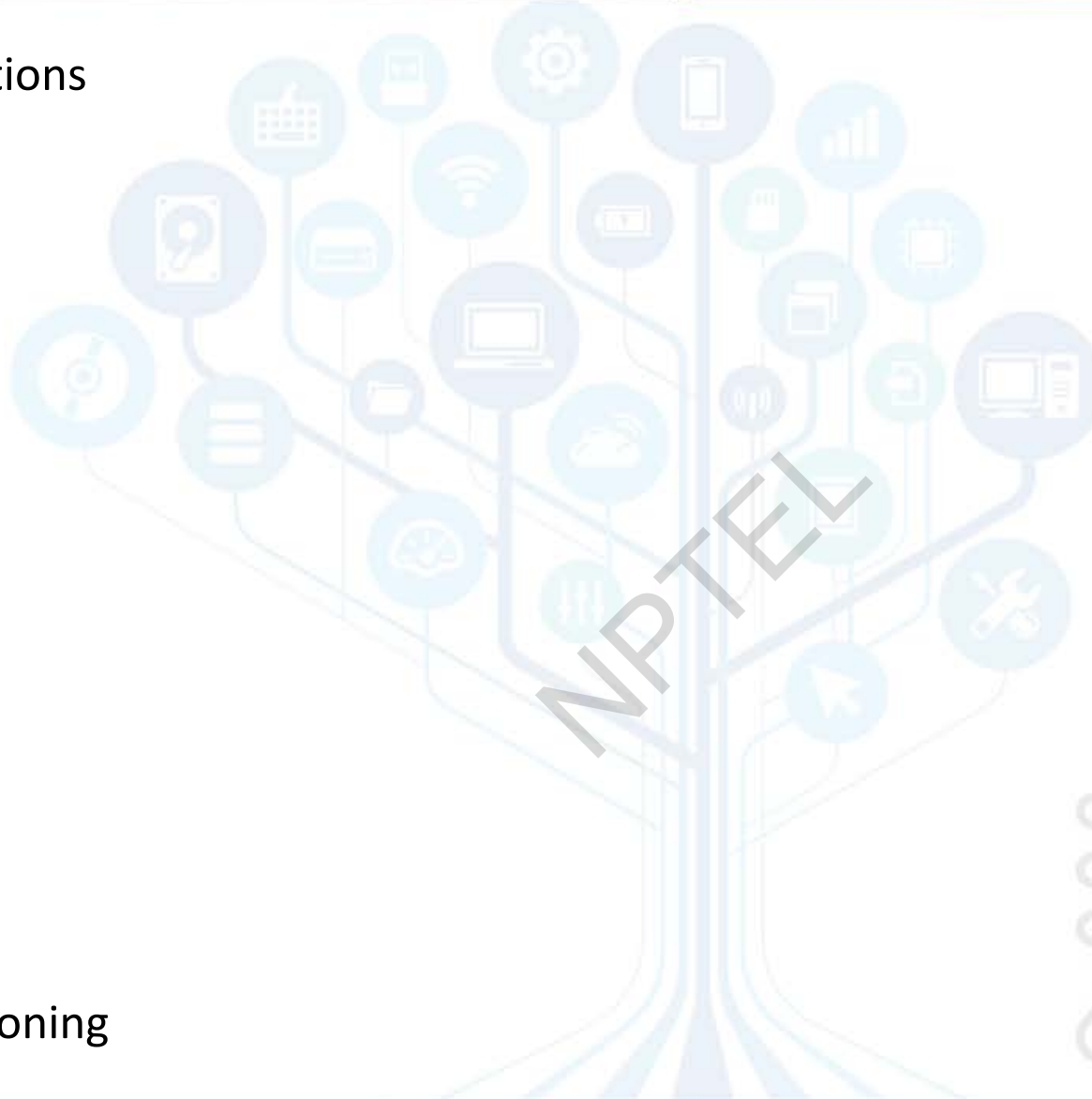
ix) Attitude towards Examiner- guarded , defensive , evasive , hostile

x) Rapport

xi) Motor behaviour- retarded, hyperactive , mannerism

2. Higher Mental Functions

- i. Consciousness
- ii. Attention
- iii. Concentration
- iv. Memory
- v. Abstract Ability
- vi. Intellectual functioning



3. Mood & Affect

Affect - a) **Subjectively**- what the patients respond with b) **Objectively** - what the interviewer sees

Parameters under which affect is assessed.

- a) **Quality**- Dysphoric , anxious , irritable , depressed , euphoric , euthymic
- b) **Intensity**- strength of emotional expression : i) Shallow ii) Blunt iii) Flat
- c) **Mobility**- **Constricted , Mobile , Fixed**
- d) **Range** – restricted , Full
- e) **Reactivity**
- f) **Communicability**
- g) **Appropriateness**
- H) **Diurnal variation**

4. Thought

- i) Form
- ii) Stream
- iii) Possession
- iv) Content

i) Form

Formal thought Disorders

- a) Circumstantiality
- b) Loosening Of Associations/ Derailment
- c) Tangentiality

i) Stream

- a) Flight Of ideas
- b) Prolixity
- c) Thought block
- d) Neologisms

iii) Possession-

- a) Thought withdrawal b) Thought Insertion c) Thought broadcasting

iv) Content

- a) Obsessions b) Compulsions c) Phobias d) Delusions e) Over valued ideas f) Suicidal thoughts**

5. Perceptual Abnormalities

- a) Sensory Distortions b) Hallucinations c) Illusion d) Imagery e) Depersonalization f) Derealization**

6. Judgement

- a) Social**

7. Insight

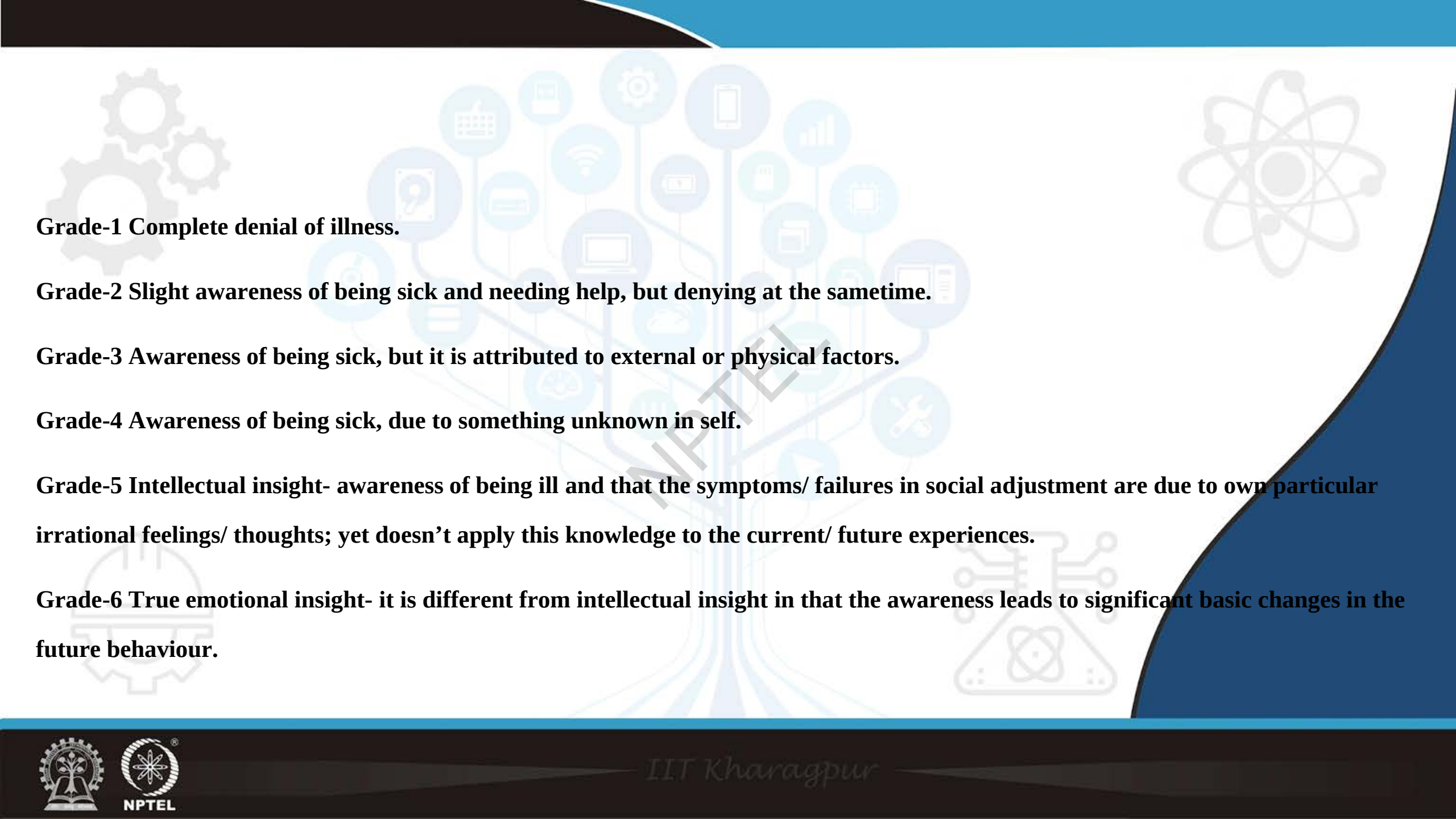
Multi dimensional concept which includes 4 a's:

Awareness of one's own symptoms (absence ---- anautognosia)

Attribution of symptoms to mental disorder appropriately (absence – dysautognosia)

Appraisal or analysis of consequences of such symptoms

Acceptance of treatment



Grade-1 Complete denial of illness.

Grade-2 Slight awareness of being sick and needing help, but denying at the sametime.

Grade-3 Awareness of being sick, but it is attributed to external or physical factors.

Grade-4 Awareness of being sick, due to something unknown in self.

Grade-5 Intellectual insight- awareness of being ill and that the symptoms/ failures in social adjustment are due to own particular irrational feelings/ thoughts; yet doesn't apply this knowledge to the current/ future experiences.

Grade-6 True emotional insight- it is different from intellectual insight in that the awareness leads to significant basic changes in the future behaviour.

REFERENCES

- 1 Oxford Text Book Of Psychiatry
- 2 Comprehensive Text Book Of Psychiatry (Kaplan & Sadock)
- 3 Text Book Of Psychiatry (Tasman & Leibermann)

CONCLUSIONS

-In this lecture we discussed regarding the evolution of neuropsychology , components of neuropsychological assessment ,personality assessment & mental status examination.



**THANK
YOU !**