

- **Psychological causes:** These include work-related stress and anxiety more so, performance anxiety, marital or relationship problems, depression, feelings of guilt, and the effects of a past sexual trauma.

Distribution by Sex

Both men and women are affected by sexual problems. Dysfunction can occur in adults of all ages. Among those commonly affected are seniors, which may be related to a decline in health associated with aging.

Men

The most common sexual problems in men are **ejaculation disorders, erectile dysfunction, and inhibited sexual desire.**

Ejaculation Disorders.

There are different types of ejaculation disorders, including:

- **Premature ejaculation** -- This refers to ejaculation that occurs before or very soon after penetration.
- **Inhibited or retarded ejaculation** -- This is when ejaculation is slow to occur.
- **Retrograde ejaculation** -- This occurs when, at orgasm, the ejaculate is forced back into the bladder rather than through the urethra and out the end of the urethra.

Premature ejaculation, the most common form of sexual dysfunction in men, often is due to **nervousness** over how well he will perform during sex. In some cases, premature and **inhibited ejaculation** is caused by a lack of attraction for a partner, past traumatic events, and psychological factors, including a strict religious background that causes the person to view sex as sinful. Certain drugs, including some antidepressants, may affect ejaculation, as can nerve damage to the spinal cord or back injuries.

Retrograde ejaculation is common in males with diabetes who suffer from diabetic neuropathy. This is due to problems with the nerves in the bladder and the bladder neck that allow the ejaculate to flow backward and into the bladder. In other men, retrograde ejaculation occurs after operations on the bladder neck or prostate, or after certain abdominal operations. In addition, certain medications, particularly those used to treat mood disorders, may cause problems with ejaculation. This generally does not require treatment unless it impairs fertility.

Erectile Dysfunction

Also known as impotence or ED, erectile dysfunction is defined as the inability to attain and/or maintain an erection suitable for intercourse.

Causes of erectile dysfunction include diseases affecting blood flow, such as atherosclerosis; nerve disorders; psychological factors, such as stress, depression, and performance anxiety; and injury to the penis. Chronic illness, certain medications, and a condition called Peyronie's disease (The disease arises as a result of development of fibrous scar tissue inside the penis that causes curved, painful erections.) can also cause erectile dysfunction.

- ‘What do you do just before you go to bed? Do you use a computer just before you go to bed?’
- Alcohol/smoking/caffeine before bed? (Caffeine half-life is approx. 6 h).
- Do you have a bed partner? Do they stop you getting to sleep?’

Diagnosis-specific assessments

2 Excessive daytime sleepiness

- Do you fall asleep when you don’t want to?’
- ‘Do you fall asleep when watching TV? During conversations? While driving?’ (Subsequent questions indicate progressively worse sleepiness).

3 Awakening

- At night: Are you having difficulty sleeping through the night? What awakens you? How long are you awake for? What keeps you from falling back asleep?
- Early-morning waking: ‘Are you having any difficulty sleeping until the morning? What is your mood like in the morning?’

4 Regularity and duration

- ‘Do you usually go to sleep at the same time? What time do you typically fall asleep? And what time do you wake? What’s the earliest you go to sleep? And the latest?’
- ‘Do you work odd hours or shifts?’
- ‘Do you give yourself restrictions on how much you let yourself sleep?’

5 Snoring: Have you or anyone else noticed you snore loudly/stop breathing in your sleep?

Other important questions:

- Quantify and discuss their caffeine and alcohol intake. Many patients do not appreciate the extent to which coffee and stimulant drinks can affect sleep quality.
- Prescribed and over-the-counter medications.
- Past psychiatric history and a psychiatric screening assessment.

Post-traumatic stress disorder symptoms may start within **three months** of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social and in relationships.

PTSD symptoms are generally grouped into four types: **intrusive memories, avoidance, negative changes in thinking and mood, or changes in emotional reactions.**

Intrusive memories

Symptoms of intrusive memories may include:

- Recurrent, unwanted distressing memories of the traumatic event
- Reliving the traumatic event as if it were happening again (**flashbacks**)
- Upsetting dreams about the traumatic event
- Severe emotional distress or physical reactions to something that reminds the patient of the event

Avoidance

Symptoms of avoidance may include:

- Trying to avoid thinking or talking about the traumatic event
- Avoiding places, activities or individuals that remind one of the traumatic event

Negative changes in thinking and mood

Symptoms of negative changes in thinking and mood may include:

- Negative feelings about self or other people
- Inability to experience positive emotions
- Feeling emotionally numb
- Lack of interest in activities once enjoyed by the patient
- Hopelessness about the future
- Memory problems, including not remembering important aspects of the traumatic event
- Difficulty maintaining close relationships

Changes in emotional reactions

Symptoms of changes in emotional reactions (also called arousal symptoms) may include:

- Irritability, angry outbursts or aggressive behavior
- Always being on guard for danger
- Overwhelming guilt or shame
- Self-destructive behavior, such as drinking too much or driving too fast
- Trouble concentrating

- Trouble sleeping
- Being easily startled or frightened

Intensity of symptoms

PTSD symptoms can vary in intensity over time. Patients may have more PTSD symptoms when they are stressed in general, or when they run into reminders of what they went through. For example, one may hear a car backfire and relive combat experiences. Or one may see a report on the news about a sexual assault and feel overcome by memories of their own assault.

Causes

One can develop post-traumatic stress disorder when one goes through, see or learn about an event involving actual or threatened death, serious injury or sexual violation.

PTSD is probably caused by a complex mix of:

- Inherited mental health risks, such as an increased risk of anxiety and depression
- Life experiences, including the amount and severity of trauma patients go through since early childhood
- Inherited aspects of one's personality — often called 'temperament'
- The way one's brain regulates the chemicals and hormones one's body releases in response to stress

Predisposing factors

Individuals of all ages can have post-traumatic stress disorder. However, some factors may make one more likely to develop PTSD after a traumatic event, such as:

- Experiencing intense or long-lasting trauma
- Having experienced other trauma earlier in life, including childhood abuse or neglect
- Having a job that increases one's risk of being exposed to traumatic events, such as military personnel and first responders
- Having other mental health problems, such as anxiety or depression
- Lacking a good support system of family and friends
- Having biological (blood) relatives with mental health problems, including PTSD or depression

Traumatic events associated with PTSD

The most common events leading to the development of PTSD include:

- Combat exposure
- Childhood neglect and physical abuse
- Sexual assault
- Physical attack

- Being threatened with a weapon

Many other traumatic events also can lead to PTSD, such as fire, natural disaster, mugging, robbery, car accident, plane crash, torture, kidnapping, life-threatening medical diagnosis, terrorist attack, and other extreme or life-threatening events.

Complications

Post-traumatic stress disorder can disrupt a patient's whole life: job, relationships, health and enjoyment of everyday activities.

Having PTSD also may increase a patient's risk of other mental health problems, such as:

- Depression and anxiety
- Issues with drugs or alcohol use
- Eating disorders
- Suicidal thoughts and actions

Investigations and diagnosis

Post-traumatic stress disorder is diagnosed based on signs and symptoms and a thorough psychological evaluation. A physical exam to check for medical problems is mandatory.

To be diagnosed with PTSD, one must meet criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association. This manual is used by mental health providers to diagnose mental conditions.

DSM criteria for PTSD

Diagnosis of PTSD requires exposure to an event that involved or held the threat of death, violence or serious injury. Patient's exposure can happen in one or more of these ways:

- Experiencing the traumatic event
- Witnessing, in person, the traumatic event
- Learning that someone close experienced or was threatened by the traumatic event
- Repeatedly exposed to graphic details of traumatic events (for example, if a patient is a first responder to the scene of traumatic events)

Experiencing one or more of the following signs or symptoms after the traumatic event:

- Reliving experiences of the traumatic event, such as having distressing images and memories.
- Having upsetting dreams about the traumatic event.
- Experiencing flashbacks as if one were experiencing the traumatic event again.
- Experiencing ongoing or severe emotional distress or physical symptoms if something reminds one of the traumatic events.

- Don't expect instant results. Working on emotional issues can be painful and may require hard work. It's not uncommon to feel worse during the initial part of therapy as it begins to confront past and current conflicts. One may need several sessions before one begins to see improvement.
- Do homework between sessions. If the therapist asks a patient to document their thoughts in a journal or do other activities outside of the therapy sessions, follow through. These homework assignments can help one apply what one has learned in the therapy sessions to one's life.
- If psychotherapy isn't helping, talk to the therapist. If one doesn't feel that one is benefiting from therapy after several sessions, talk to the therapist about it. A patient and the therapist may decide to make some changes or try a different approach that may be more effective.

Risks

In general, there's little risk in having psychotherapy. But because it can explore painful feelings and experiences, a patient may feel emotionally uncomfortable at times. However, any risks are minimized by working with a skilled therapist who is able to match the type and intensity of therapy with patients' needs. The coping skills one learns can help one manage and conquer negative feelings and fears.

SCHIZOAFFECTIVE DISORDER

Definition

Schizoaffective disorder is a condition in which a patient experiences a combination of schizophrenia symptoms — such as hallucinations or delusions — and mood disorder symptoms, such as mania or depression.

Schizoaffective disorder is not as well understood or well defined as other mental health conditions. This is largely because schizoaffective disorder **is a mix** of mental health conditions — including schizophrenic and mood disorder features — that may run a unique course in each affected patient.

Untreated, patients with schizoaffective disorder may lead lonely lives and have trouble holding down a job or attending school. Or, they may rely heavily on family or live in supported living environments, such as group homes. Treatment can help manage symptoms and improve the quality of life for patients with schizoaffective disorder.

Symptoms

Schizoaffective disorder symptoms vary from patient to patient. Patients who have the condition experience psychotic symptoms — such as hallucinations or delusions — as well as a mood disorder. The

Etiology

Etiological factors in mental retardation can be primarily genetic, developmental, acquired, or a combination. Genetic causes include chromosomal and inherited conditions; developmental factors include prenatal exposure to infections and toxins; and acquired syndromes include perinatal trauma (e.g., prematurity) and sociocultural factors. The severity of the resulting mental retardation is related to the timing and duration of the trauma as well as to the degree of exposure to the central nervous system (CNS). The more severe the mental retardation, the more likely it is that the cause is evident. In about 75% of persons with severe mental retardation, the cause is known, whereas the cause is apparent in only 50% of those with mild mental retardation.

Down syndrome

The description of Down syndrome, first made by the English physician Langdon Down in 1866, was based on the physical characteristics associated with subnormal mental functioning. Since then, Down syndrome has been the most investigated, and most discussed, syndrome in mental retardation. Children with this syndrome were originally called mongoloid because of their physical characteristics of slanted eyes, epicanthal folds, and flat nose. Despite a plethora of theories and hypotheses advanced in the past 100 years, the cause of Down syndrome is still unknown.

The problem of cause is complicated even further by the recent recognition of three types of chromosomal aberrations in Down syndrome:

- Patients with trisomy 21 (three chromosomes 21, instead of the usual two) represent the overwhelming majority; they have 47 chromosomes, with an extra chromosome 21. The mothers' karyotypes are normal. A nondisjunction during meiosis, occurring for unknown reasons, is held responsible for the disorder.
- Nondisjunction occurring after fertilization in any cell division results in mosaicism, a condition in which both normal and trisomic cells are found in various tissues.
- In translocation, a fusion occurs of two chromosomes, usually 21 and 15, resulting in a total of 46 chromosomes, despite the presence of an extra chromosome 21. The disorder, unlike trisomy 21, is usually inherited, and the translocated chromosome may be found in unaffected parents and siblings. The asymptomatic carriers have only 45 chromosomes.

Persons with Down syndrome tend to exhibit marked deterioration in language, memory, self-care skills, and problem-solving in their 30s. disorders may share some pathophysiology

Fragile X Syndrome

Fragile X syndrome is the second most common single cause of mental retardation. The syndrome results from a mutation on the X chromosome at what is known as the fragile site (Xq27.3). The fragile site is expressed in only some cells, and it may be absent in asymptomatic males and female carriers. Much variability is present in both genetic and phenotypic expression. Fragile X syndrome is believed to occur in about 1 of every 1,000 males and 1 of every 2,000 females. The typical phenotype includes a large, long head and ears, short stature, hyperextensible joints, and post pubertal macroorchidism. The mental retardation ranges from mild to severe. The behavioral profile of persons with the syndrome includes a high rate of

prematurity and other obstetrical complications. Vaginal hemorrhage, placenta previa, premature separation of the placenta, and prolapse of the cord can damage the fetal brain by causing anoxia. The potential teratogenic effect of pharmacological agents administered during pregnancy was widely publicized after the thalidomide tragedy (the drug produced a high percentage of deformed babies when given to pregnant women). So far, with the exception of metabolites used in cancer chemotherapy, no usual dosages of medications are known to damage the fetus's CNS, but caution and restraint in prescribing drugs to pregnant women are certainly indicated. The use of lithium during pregnancy was recently implicated in some congenital malformations, especially of the cardiovascular system (e.g., Ebstein's anomaly).

Perinatal Period

Some evidence indicates that premature infants and infants with low birth weight are at high risk for neurological and intellectual impairments that appear during their school years. Infants who sustain intracranial hemorrhages or show evidence of cerebral ischemia are especially vulnerable to cognitive abnormalities. The degree of neurodevelopmental impairment generally correlates with the severity of the intracranial hemorrhage. Recent studies have documented that, among children with very low birth weight (less than 1,000 g), 20 percent had significant disabilities, including cerebral palsy, mental retardation, autism, and low intelligence with severe learning problems. Very premature children and those who suffered intrauterine growth retardation were found to be at high risk for developing both social problems and academic difficulties. Socioeconomic deprivation can also affect the adaptive function of these vulnerable infants. Early intervention may improve their cognitive, language, and perceptual abilities.

Acquired Childhood Disorders

Occasionally, a child's developmental status changes dramatically as a result of a specific disease or physical trauma. In retrospect, it is sometimes difficult to ascertain the full picture of the child's developmental progress before the insult, but the adverse effects on the child's development or skills are apparent afterward.

Infection

The most serious infections affecting cerebral integrity are encephalitis and meningitis. Measles encephalitis has been virtually eliminated by the universal use of measles vaccine, and the incidence of other bacterial infections of the CNS has been markedly reduced with antibacterial agents. Most episodes of encephalitis are caused by viruses. Sometimes a clinician must retrospectively consider a probable encephalitic component in a previous obscure illness with high fever. Meningitis that was diagnosed late, even when followed by antibiotic treatment, can seriously affect a child's cognitive development. Thrombotic and purulent intracranial phenomena secondary to septicemia are rarely seen today except in small infants.

Head Trauma

The best-known causes of head injury in children that produces developmental handicaps, including seizures, are motor vehicle accidents, but more head injuries are caused by household accidents, such as falls from tables, from open windows, and on stairways. Child abuse is also a cause of head injury.

Screening for perceptual disturbance is critical for detecting serious mental health problems like psychosis (this is relatively rare in young people, though peak onset is between 19 and 22 years), cases of severe anxiety, and mood disorders. It is also important in trauma or substance abuse. Perceptual disturbances are typically marked and may be disturbing or frightening.

Dissociative symptoms:

- derealisation (feeling that the world or one's surroundings are not real)
- depersonalisation (feeling detached from oneself)

Illusions:

- the person perceives things as different to usual, but accepts that they are not real, or that (*misinterpretation of actual external stimuli*)
- things are perceived differently by others

Hallucinations:

- Hallucinations (*auditory, visual, olfactory [smell], gustatory [taste], tactile*)
 - probably the most widely known form of perceptual disturbance
 - hallucinations are indistinguishable by the sufferer from reality
 - can affect all sensory modalities, although auditory hallucinations are the most common
 - in children it is common to experience self-talk or commentary as an internal "voice" command hallucinations (voices telling the person to do something) should be investigated
 - important to note the degree of fear and/or distress associated with the hallucinations

Insight & Judgement

Insight and judgement is particularly important in triaging psychiatric presentations and making decisions about safety.

Insight:

- acknowledgement of a possible mental health problem
- understanding of possible treatment options and ability to comply with these
- ability to identify potentially pathological events (e.g. hallucinations, suicidal impulses)

medication to prescribe. Doctors will normally also review any other medications the patient may be taking, to ensure the anti-epileptic medications won't interact with them.

The doctor likely will first prescribe a single medication at a relatively low dosage and may increase the dosage gradually until seizures are well-controlled.

Anti-seizure medications may have some side effects. Mild side effects include:

- Fatigue
- Dizziness
- Weight gain
- Loss of bone density
- Skin rashes
- Loss of coordination
- Speech problems
- Memory and thinking problems

More severe but rare side effects include:

- Depression
- Suicidal thoughts and behaviors
- Severe rash
- Inflammation of certain organs, such as the liver

At least half of all patients newly diagnosed with epilepsy will become seizure-free with their first medication.

- **Ketogenic diet.** Some children with epilepsy have been able to reduce their seizures by following a strict diet that's high in fats and low in carbohydrates.

In this diet, called a ketogenic diet, the body breaks down fats instead of carbohydrates for energy. After a few years, some children may be able to stop the ketogenic diet and remain seizure-free.

Side effects of a ketogenic diet may include dehydration, constipation, slowed growth because of nutritional deficiencies (malnutrition) and buildup of uric acid in the blood, which can cause kidney stones. These side effects are uncommon if the diet is properly and medically supervised.

ELECTROCONVULSIVE THERAPY (ECT)

ECT is an effective and safe treatment for severe depression although it can have some negative effects on cognitive function, especially memory. Its bad press reflects understandable fears, misinformation and

- Provide brief advice of the hazards of excess alcohol intake. Tailor advice to the individual, and reinforce with written information.

Advice should be given in a non-judgemental manner.

- Review progress. If problem drinking persists, or is in the harmful range, consider extended brief intervention and/or motivational interviewing.

The **FRAMES** acronym covers the main approach to giving advice about drinking:

- Structured **Feedback** on risk and harm.
- Emphasis on the patient's **Responsibility** for change.
- Clear **Advice** to make a change in drinking.
- Discuss a **Menu** of options for making change.
- Express **Empathy** and be non-judgmental.
- Reinforce the patient's **Self-efficacy**.

Treatment of alcohol dependence

The first requirement is detoxification ('detox', - 'drying out'), which is controlled withdrawal, using a reducing course of a benzodiazepine in place of alcohol. This should always be done as part of a care plan that includes after-care and relapse prevention.

- **Mild dependence** – withdraw at home without drugs or with small doses of benzodiazepines.

Initial screening shows drinking above safe limits

Harmful drinking Possibly dependent, or AUDIT 20

- Extended FRAMES advice

- Motivational interviewing

- Establish dependence severity

- Assess context and needs

Regular monitoring

- Mild dependence/ no complex needs

- Moderate or severe dependence/ complex needs

Detoxification

Relapse prevention and ongoing care options, e.g.

- **Disulfiram** or acamprosate

- CBT and other psychotherapies

- Structured group programmes

- Alcoholics Anonymous

Hazardous drinking

Brief 'FRAMES' advice

Periodic

- **Moderate dependence** – can usually facilitate withdrawal at home with a reducing regimen of chlordiazepoxide over 5 days, especially if the patient has a supportive network and an absence of physical complications or proneness to seizures. Advise the patient to drink plenty of non-alcoholic liquids.

Prescribe vitamins (thiamine 300 mg per day) – deficiencies are common and withdrawal may precipitate Wernicke's syndrome. Consider parenteral thiamine if risk of Wernicke's syndrome is judged to be high as oral thiamine has limited bioavailability.

- Many chromosomal loci and genes are implicated, and overlap with those for schizophrenia

Current leading bipolar disorder candidate genes include **the HLA (human leucocyte antigen) complex, ANK3 and CACN1C. There is some evidence for inheritance down the maternal line.**

- No childhood risk factors are known.
- Life events can precipitate the initial episodes; once the disorder is established, its course is increasingly immune to environmental circumstances.
- Most of the neurobiological abnormalities described for depressive disorder are also implicated in bipolar disorder, although there may be differences in the abnormalities in emotional processing.
- Always consider drug-induced mania (an example of organic mood disorder) in young people with no family history of bipolar disorder. In someone first presenting in middle age, exclude cerebrovascular disease, tumours and medication side effects

Management of bipolar disorder

Treatment of mania and mixed episodes

Patients with mild manic symptoms can be successfully treated as out-patients, if the patient has insight that they need treatment. More severe mania, especially if psychotic, usually requires admission, often compulsorily.

- Antipsychotics (e.g. risperidone, olanzapine) or valproate and lithium are effective antimanics. Antipsychotics are probably slightly more effective, but cause more sedation and weight gain. Benzodiazepines are used, as required, for sedation.

The epidemiology of bipolar disorder

Lifetime risk 1%

1-month prevalence 0.4%

Sex ratio (M: F) 1:1

Mean age of onset Early 20s

Risk to first-degree relatives of a patient with bipolar disorder:

- The choice of drug is influenced by the patient's existing medication – they may already be on a mood stabilizer. If they are on an antidepressant e.g. Amitryptilline, stop it. If the patient is on lithium, check the blood level to assess recent adherence.

disorder. The decision is an important one and the patient should be given sufficient information and time to make a properly informed choice.

- Long-term lithium treatment is the standard prophylaxis for bipolar disorder and is supported by the most robust evidence. **Lithium** reduces the risk of both manic and depressive relapse by 40–50%. Long-term lithium treatment should not be initiated unless both patient and doctor intend to continue it for at least 2 years.

Valproate and olanzapine also reduce the risk of manic relapse. Lamotrigine reduces the risk of depressive relapse. Other drugs such as **carbamazepine** may also be used, although the evidence is limited.

- Psychological approaches such as CBT or family therapy may also help in preventing relapses.

AVOLITION DISORDER

Avolition is the decrease in the motivation to initiate and perform self-directed purposeful activities. Such activities that appear to be neglected usually include routine activities, including hobbies, going to work and/or school, and most notably engaging in social activities. A person experiencing avolition may stay at home for long periods of time, rather than seeking out work or peer relations.

Psychopathology

Most often identified as a negative symptom of the psychotic disorder Schizophrenia, Substance Abuse as well as Depression.

Negative symptoms

- Asociality is the decrease in interest and motivation in forming relationships.
- Anhedonia is the absence of experiencing pleasure.
- Blunted affect (sometimes referred to as “flat” or “restricted” affect) is the reduction in outward displays of emotional expression.
- Alogia is the significant decrease or reduction in speech output.

Clinical and Social Implications

Implications of avolition are tied closely to social deficits. It may be difficult to engage an individual experiencing avolition in active participation of any form of therapy. Several first person accounts of mental illness report being physically and mentally unable to eat, drink, sleep, work, initiate nor maintain relationships.

Treatment

Treating negative symptoms is notoriously difficult. Several medications are available; however, as many as 30% of people do not respond favorably to first-generation antipsychotics. First-generation antipsychotics are called such because they came out of the first wave of empirically supported medication treatments. First-generation antipsychotics include Chlopromazine, Thiothixene and Haldol. Unfortunately, these are not effective in treating negative symptoms. Second-generation antipsychotics were produced by a second wave of research. These include Zyprexa (olanzepine) and Risperidol. These drugs are more effective at treating avolition and other negative symptoms, but are also prone to troubling side effects including pancreatitis and weight gain linked to type 2 diabetes. As a result, psychosocial interventions show more promise.

Two of the most promising psychosocial treatments are cognitive-behavioral therapy (CBT) and social skills training. CBT is a type of psychotherapy that helps individuals understand how thoughts and feelings influence behavior. Psychotherapy, sometimes referred to as "talk therapy", can compliment the role of medication, by helping patients, families, and friends work through these emotional challenges.

Social skills treatment focuses on teaching the individual how to successfully manage interpersonal situations. These could include job interviews, discussing medications, interacting with co-workers or friends.

Preview from Notesale.co.uk
Page 86 of 87