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# PURPOSE

The purpose of this course is to provide health care professionals; LPN, RN, ARNP, Therapists, Professional Guardians, other professionals and Certified Nursing Assistants (CNA), Home Health Aides (HHA), Students, other individuals with the opportunity to review Psychiatric aspects; Psychiatry, the difference between the Psychiatrist and the Psychologist, discuss various diagnosis and some of the criteria that are established in APA's Diagnostic and Statistical Manual of Mental Disorders *(*DSM-5*)*, which has the descriptions, symptoms and other criteria for diagnosing the mental disorders, review various treatments depending on the needs of the patients; including psychosocial interventions, different forms of psychotherapy, medications and other treatments for example electroconvulsive therapy (ECT), review class of Medications such as Antidepressants; used to treat depression, panic disorder, Post-Traumatic Stress Disorder (PTSD), anxiety, obsessive-compulsive disorder, borderline personality disorder and eating disorders. Review of Antipsychotic medications; used to treat psychotic symptoms (delusions, hallucinations), bipolar disorder, and schizophrenia. Review class of Medications such as Sedatives and Anxiolytics; used to treat insomnia and anxiety, review of Stimulants; used to treat Attention-deficit/hyperactivity disorder (ADHD).

# OBJECTIVES

After completion of this course the participants will be able to:

1. Define psychiatry and the difference between the Psychiatrist and the Psychologist

2. Describe Psychotherapy and the various forms of treatment

3. Discuss the goals of Psychotherapy

4. Define Electroconvulsive therapy (ECT) and the reasons for use

5. Discuss Class of Medications such as Antidepressants; used to treat depression, panic disorder, Post-Traumatic Stress Disorder (PTSD), anxiety, obsessive-compulsive disorder, borderline personality disorder and eating disorders.

6. Discuss Antipsychotic medications; used to treat psychotic symptoms (delusions, hallucinations), bipolar disorder, and schizophrenia.

7. Discuss class of Medications such as Sedatives and Anxiolytics; used to treat insomnia and anxiety.

8. Discuss Hypnotics; used to induce sleep and/ or maintain sleep.

9. Discuss Mood stabilizers; used to treat bipolar disorder.

10. Discuss Stimulants; used to treat Attention-deficit/hyperactivity disorder (ADHD).

# INTRODUCTION

## MENTAL DISTRESS OR MENTAL ILLNESS

Caring for individuals of all age groups, who are experiencing mental distress or mental illness such as depression, schizophrenia, psychosis, bipolar disorder or dementia requires knowledge to be able to effectively meet the needs of the individual.

## PSYCHIATRY

Psychiatry is the branch of medicine that is focused on diagnosing, treating and the prevention of emotional, mental, and various behavioral disorders.

There are several reasons why people often seek psychiatric help; sometimes the problems are sudden, for example, a panic attack, thought of suicide, hallucinations or hearing voices. At other times the problem might be long-term, for example experiencing sadness, feeling very anxious and or hopelessness that does not go away. Some individuals may develop problems and are unable to function as it seems like their life is out of control or full of chaos.

# DIAGNOSIS

Diagnoses are based on the criteria established in APA's Diagnostic and Statistical Manual of Mental Disorders *(*DSM-5*)*, which has the descriptions, symptoms and other criteria for diagnosing the mental disorders.

## DIFFERENCE BETWEEN THE PSYCHIATRIST AND THE PSYCHOLOGIST

Patients may be seen by a psychiatrist and /or a psychologist.

## PSYCHIATRIST

A psychiatrist is a medical doctor; has completed medical school and residency and has special training in psychiatry. Therefore the psychiatrist can;

- Conduct psychotherapy
- Prescribe medications as well as other medical treatments.

**PSYCHOLOGIST**

Psychologists usually have an advanced degree, most often in clinical psychology. The Psychologist also often has extensive training in clinical practice or research. Psychologists can treat mental disorders with psychotherapy and /or specialize in psychological testing and evaluations.

# TREATMENTS

The Psychiatrist uses various treatments depending on the needs of the patients; may include psychosocial interventions, different forms of psychotherapy, medications and other treatments for example electroconvulsive therapy (ECT).

Psychotherapy (talk therapy) treatment involves a conversation (talking relationship) between the therapist and the patient.

Psychotherapy is used to treat a wide variety of emotional difficulties and mental disorders. The therapist may meet with:

- Only the individual or
- as a couple,
- with a family or
- In a group.

## Goal of Psychotherapy

The goal of psychotherapy is to help the patient function more effectively by;

- Removing or controlling disabling symptoms
- Removing or controlling the troubling symptoms.

## DURATION OF TREATMENT

Treatment can take just a few sessions over 1 week or 2 weeks or may take multiple sessions over a period of years, depending on the extent of the problem.

## Forms of Psychotherapy

There are several forms of psychotherapy;

- Psychotherapies that help the patient change his/ her behaviors or change the thought patterns,
- Psychotherapies that help the patient to explore the effect of past experiences and relationships on present behaviors, and
- Psychotherapies that are specially designed to help solve other issues in specific ways.

## Cognitive behavioral therapy (CBT)

Cognitive behavioral therapy (CBT) is a goal-oriented therapy which focuses on problem solving; exploring relationships among the individuals' feelings, thoughts and behaviors. During Cognitive behavioral therapy the therapist will work with the individual to uncover patterns of thought that are not healthy and how it may be causing self destructive beliefs and behaviors.

## Interpersonal Therapy

Interpersonal therapy involves focusing on the relationships the individuals have with others. With this type of psychotherapy, the goal is to improve the individuals' interpersonal skills. The therapist helps the individual evaluate his/ her social interactions and identify negative patterns, such as aggression or social isolation and eventually helps the individual learn strategies for effectively interacting with and understanding others.

## Dialectical Behavior Therapy (DBT)

Originally, Dialectical behavior therapy (DBT) was developed to treat chronically suicidal individuals with borderline personality disorder (BPD). Over time, Dialectical behavior therapy (DBT) has been adapted to treat individuals with many different mental illnesses, but most individuals who are treated with Dialectical behavior therapy (DBT) have borderline personality disorder as the primary diagnosis. Dialectical behavior therapy (DBT) emphasizes validation and/ or accepting the uncomfortable feelings, thoughts and behaviors instead of the person struggling with them. When the individuals

come to terms with their troubling emotions, thoughts and /or behaviors that they are struggling with, there is hope for change and the individuals can now work with their therapists to create a plan for recovery.

# Exposure Therapy

Exposure therapy; a type of cognitive behavioral therapy which is most often used to treat posttraumatic stress disorder, obsessive-compulsive disorder and phobias. During treatment, the individuals work with a therapist to identify what triggers the anxiety and the individuals learn techniques to avoid becoming anxious when they are exposed to the triggers. The individual then confronts the triggers in a controlled environment (safe) where he/ she can practice implementing the strategies.

## Eye Movement Desensitization and Reprocessing Therapy (EMDR)

Eye movement desensitization and reprocessing therapy is a form of treatment initially used for individuals who are experiencing Post-traumatic stress disorder (PTSD), is now being used in different therapeutic situations. Some studies have shown it can decrease the emotional distress that comes from traumatic memories.

Eye movement desensitization and reprocessing therapy replaces the negative emotional reactions to difficult memories. Performing a series of repetitive eye movements (back and forth) for 20 seconds to 30 seconds can help individuals change the emotional reactions.

# Mentalization based Therapy

Mentalization is the ability to understand both feelings and behaviors and how they are associated with specific mental states, in us as well as others. According to randomized clinical trials, mentalization based therapy (MBT) can bring improvement (long-term) to

individuals with Borderline personality disorder (BPD). Mentalization-based therapy (MBT) is a kind of psychotherapy that engages and exercises mentalizing skill. When an individual consciously perceive and understand his/ her own inner feelings and thoughts, it is mentalizing.

# Psychodynamic Psychotherapy

Psychodynamic therapy known as insight oriented therapy, often uses open-ended questions and free association so that the individual have the opportunity to talk about whatever is on his/ her mind.

The therapist then works with the individual to sort through the thoughts and identify the unconscious patterns of negative behaviors and /or feelings and how they have been influenced by experiences of the past and unresolved feelings. By bringing these associations to the individuals' attention they can learn to overcome the negative feelings and behaviors which they caused.

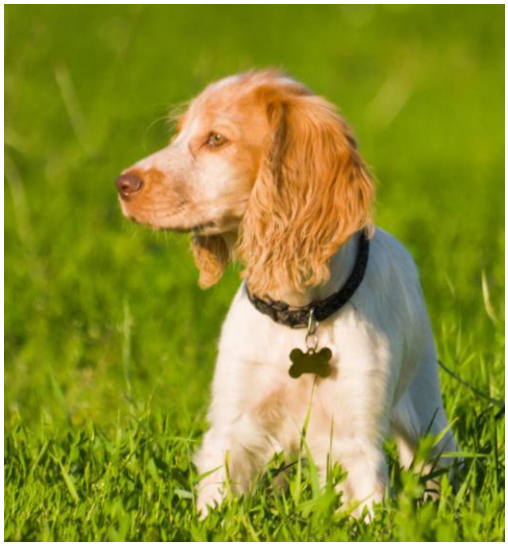
The goal of psychodynamic psychotherapy is to identify negative patterns of behavior and/ or feelings that are related to past experiences and to resolve them.

# Therapy Pets

It has been noted that many individuals who spend time with domestic animals can reduce symptoms of;

- anxiety,
- depression,
- fatigue and
- pain.

Some hospitals, long term care facilities /nursing homes and other healthcare facilities sometimes offer therapy animals; structured animal-assisted therapy or simply visit individuals to provide comfort.



# MEDICATIONS

After completing thorough evaluations, the Psychiatrists can prescribe medications to help to treat mental disorders. Psychiatric medications can help to correct the imbalances in brain chemistry that are thought to play a role in some mental disorders. Patients who are on long-term medication treatment will need to meet periodically, with the psychiatrist to monitor the medication's effectiveness and /or any actual or potential side effects.

# Class of Medications

- Antipsychotic medications; used to treat psychotic symptoms (delusions, hallucinations), bipolar disorder, and schizophrenia.

- Antidepressants; used to treat depression, panic disorder, Post-Traumatic Stress Disorder (PTSD), anxiety, obsessive-compulsive disorder, borderline personality disorder and eating disorders.

- Hypnotics; used to induce sleep and/ or maintain sleep.

- Sedatives and Anxiolytics; used to treat insomnia and anxiety.

- Stimulants; used to treat Attention-deficit/hyperactivity disorder (ADHD).

- Mood stabilizers; used to treat bipolar disorder.

The Psychiatrists frequently prescribe medications in combination with psychotherapy. Other treatments may also be used such as Electroconvulsive therapy (ECT).

## Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) is a medical treatment which involves the application of electrical currents to the brain. It is used most often to treat severe depression that has not being responding to other treatments.

The procedure is done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses.

ECT is generally safe, however risks and side effects may include:

**Confusion -** Immediately after treatment, the patient may experience confusion, which can last from a few minutes to several hours. Confusion is generally more noticeable in the older individuals.

**Memory loss-** Some patients have trouble remembering events that occurred right before treatment or in the weeks or months before treatment. The patient may also experience trouble remembering events that occurred during the weeks of the

treatment. For most individuals, these memory problems usually improve within a couple of months after the treatment ends.

**Physical side effects-** On the days of the ECT treatment, some patients may experience headache, nausea, jaw pain and /or muscle ache. These generally can be treated with medications.

**Medical complications –** the procedure involves using anesthesia, therefore the nurse/ healthcare practitioner needs to watch for respiratory problems and other medical complications. During Electroconvulsive therapy, heart rate and blood pressure increase, and in some cases, that can lead to serious heart problems.

Some newer therapies being used to treat some mental disorders include, but not limited to:

- Deep brain stimulation (DBS),
- Vagus nerve stimulation (VNS), and
- Transcranial magnetic stimulation (TMS)
- Light therapy is used to treat seasonal depression.

# MENTAL ILLNESS

Mental illness refers collectively to all diagnosable mental disorders. Effects of the illness include sustained abnormal alterations in mood, thinking, or behavior associated with impaired functioning and distress.

The effects of mental illnesses frequently involve:

- Disruptions of daily function;
- Incapacitating social, personal, and occupational impairment,

- Premature death.

The most common mental illnesses in adults are anxiety and mood disorders. According to the Centers for Disease Control and Prevention (CDC), mental Illness is reflected as follows:

## Depression:

According to the World Health Organization, unipolar depression was the 3rd most important cause of disease burden worldwide in 2004. Unipolar depression was in 8th place in low-income countries, but at 1st place in middle and high income countries.

In a nationally representative face-to-face household survey;

- 6.7% of adults in the U.S. experienced a major depressive episode in the past 12 months.

Significantly greater percentages of lifetime major depression have been reported;

- among women (11.7%) than men (5.6%).

Examining ethnic differences reveals lifetime percentages of depression of;

- 6.52% among whites and
- 4.57% among blacks and
- 5.17% among Hispanics.

# Anxiety:

Anxiety disorders include;

- panic disorder,
- generalized anxiety disorder,

- post-traumatic stress disorder,
- phobias, and
- separation anxiety disorder,

Anxiety are the most common class of mental disorders present in the general population.

The estimated lifetime prevalence of any anxiety disorder is;

- over 15%,
- while the 12-month prevalence is more than 10%.

Prevalence estimates of anxiety disorders are generally higher in the developed countries than in the developing countries.

Most anxiety disorders are also more prevalent in women than in men.

According to the Centers for Disease Control and Prevention (CDC), one study estimated the yearly cost of anxiety disorders in the U.S. to be approximately $42.3 billion in the 1990s, a majority of which was due to non-psychiatric medical treatment costs. The estimate focused on the short-term effects and did not include the effect of outcomes such as the increased risk of other disorders.

# Bipolar Disorder:

The National Co-morbidity Study reported a lifetime prevalence of nearly 4% for bipolar disorder. Bipolar disorder is more common in women than men, with a ratio of approximately 3:2.

The median age of onset for bipolar disorder is 25 years, with men having an earlier age of onset than women.

In an insured population;

- 7.5% of all claimants with behavioral health care coverage filed a claim, of which 3.0% had bipolar disorder.

Annual insurance payments were greater for medical services for individuals with bipolar disorder than for the patients with other behavioral healthcare diagnoses.

The patient hospitalization rate of bipolar patients (39.1%) was greater than the 4.5% characterizing all the other patients with behavioral health care diagnoses.

Bipolar disorder has been deemed the most expensive behavioral health care diagnosis, costing more than twice as much as depression per affected individual.

For every dollar that was allocated to outpatient care for individuals with bipolar disorder;

- $1.80 is spent on inpatient care, suggesting early intervention and improved prevention management could decrease the financial impact of this illness.

# Schizophrenia:

Worldwide prevalence estimates range between 0.5% and 1%. Age of first episode is typically younger among men (about 21 years of age) than women (27 years). Individuals with schizophrenia pose a high risk for suicide.

The economic burden of schizophrenia is particularly great during the first year following the index episode, relative to the 3rd year onwards. This finding suggests the need for improved monitoring of persons with schizophrenia upon initial diagnosis (CDC 2011).

# Alzheimer's Disease:

Alzheimer's is defined as a type of dementia that causes the individual to experience problems with memory, thinking and behavior. The symptoms usually develop slowly and they become worse over time. The symptom become so severe that they interfere with the individual's daily tasks.

Alzheimer's is not a normal part of aging**,** although the greatest known risk factor is increasing age, and the majority of people with Alzheimer's are 65 and older.

But Alzheimer's disease is not just a disease of old age. According to the Alzheimer's association, up to 5 percent of individuals with the disease have early onset Alzheimer's which is also known as younger-onset, which often appears when the individual is in their 40s or 50s.

Alzheimer's disease is the most common form of dementia**,** which is a general term for memory loss and other intellectual abilities serious enough to cause an interference with daily life. Alzheimer's disease accounts for 60 to 80 percent of dementia cases.

## Alzheimer's Progression

Alzheimer's is a progressive disease, and the dementia symptoms gradually become worse over a number of years. In the early stages, memory loss is mild, but within the late-stage Alzheimer's, the individual lose his / her ability to carry on a conversation and respond to the environment.

Alzheimer's disease is the sixth leading cause of death in the United States of America. Individuals with Alzheimer's disease live an average of eight years after the symptoms become noticeable to others, but survival can range from four to twenty years, depending on their age and other health conditions.

There is no cure for Alzheimer's, but treatments for symptoms are available and research continues. Although the current Alzheimer's treatments cannot stop the Alzheimer's disease from progressing, they can temporarily slow the worsening of dementia symptoms and improve the quality of life for the individuals with Alzheimer's

and their family and / or caregivers. Currently, scientist / research are in progress to find better ways to treat the disease, delay its onset, and prevent it from developing.

## Symptoms of Alzheimer's

People in general eventually notice some slowed thinking and occasional experiences problems with remembering certain things. However, serious memory loss, confusion and other major changes in the way the mind works may be a sign that the brain cells are failing.

The most common early symptom of Alzheimer's disease is difficulty remembering newly learned information because Alzheimer's changes typically begin in the part of the brain that affects learning.

As Alzheimer's disease advances through the brain it leads to severe symptoms, which includes:

- Disorientation,
- the individual experiences mood and behavior changes
- increasing confusion about events, time and place
- unfounded suspicions about family, friends and professional caregivers.

More serious memory loss and behavior changes may include:

- Difficulty speaking,
- Difficulty swallowing and
- Difficulty with ambulation.

Individuals with memory loss or other possible signs of Alzheimer’s may find it hard to recognize that they have a problem. Signs of dementia may be more obvious to family members or friends. Whenever anyone is experiencing symptoms of dementia they should be seen by a physician as soon as possible.

### The Global Deterioration Scale for Assessment of Primary Degenerative Dementia

Dr. Barry Reisberg developed the Global Deterioration Scale (GDS), which provides caregivers an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's disease. The GDS is broken down into 7 different stages.

Stages 1-3 (pre-dementia stages).

Stages 4-7 (the dementia stages).

Beginning in stage 5, an individual can no longer survive without assistance.

With the GDS caregivers can get an idea of where the individual is at in the disease process by observing behavioral characteristics and comparing them to the Global Deterioration Scale. For more specific assessments, the Brief Cognitive Rating Scale (BCRS) and Functional Assessment Staging (FAST) measures are also utilized.

Remember that not everyone will progress in the same manner or exhibits the same symptoms.

**Stage 1: Normal Behavior** (No impairment/pre-clinical)

When the individual is in this early phase, he /she will not have any symptoms that you can observe. No impairment is evident. The individual is able to function normally and the cognitive functions appear to be intact. Slight changes may begin to develop within the brain 20 years or more before diagnosis. Tangles and plaques may begin to form in the areas of the brain that involves memory, thinking, learning, and planning. A Positron Emission Tomography (PET) scan can reveal whether he / she has Alzheimer's. A PET scan is an imaging test of the brain. It uses a radioactive substance called a tracer to look for disease or injury in the brain.

**Stage 2: Very Mild Changes**

At this stage family and friends may still not notice anything amiss in the individual's behavior. The physician may not notice any changes on the medical examination. The individual is able to function within the normal limits, but may experience mild cognitive decline which may include forgetting a word or misplacing objects. At this stage, the subtle symptoms of Alzheimer's do not interfere with the individual's ability to work or live independently.

Also remember that these symptoms may be Alzheimer's disease, or just normal changes from aging.

**Stage 3: Mild Decline (Mild cognitive decline - early –stage)**

It is at this stage, that family and friends start to notice changes in the individual's thinking and reasoning. This is usually the first stage at which a diagnosis can be made. The areas of the brain that is involved in thinking, memory and planning develop increase numbers of plaques and tangles.

Some changes in the individual's thinking and reasoning may include:

- Forgetting something he /she just read
- Cannot remember names when meeting new people
- Asking the same question over and over
- Has increase trouble organizing or making plans

The family can help the individual by assisting him / her by making sure that he/she pays bills and gets to appointments on time. You can also suggest he ease stress by retiring from work and putting his legal and financial affairs in order.

**Stage 4: Moderate Decline** (Moderate cognitive decline)

During this stage, the problems in reasoning and thinking that were observed in stage 3 become more obvious and new issues appear. Clinical testing more easily identifies the dementia. The individual is usually able to attend to personal care and the activities of daily living and is able to manage most of the simple personal affairs. The period of mild to moderate decline may continue for 2-10 years.

The individual may exhibit signs such as:

- Start forgetting details about himself / herself
- Decreased knowledge regarding current events
- Forgets what month it is
- Forgets what season it is
- Experience difficulty completing complex tasks or multi-tasking
- Experience difficulty putting the right amount on a check and the right date
- Have trouble cooking meals
- Have trouble ordering from a menu

Family and friends can assist with everyday chores and ensuring that the individual is safe. Take steps to make sure that he/ she is not driving anymore. Assist with the individual finances and make sure that no one is trying to take advantage of the individual financially.

**Stage 5: Moderately Severe Decline (Moderately-severe cognitive decline - Moderate/midstage)**

At this stage intervention is often needed. The individual may start to show obvious signs of cognitive impairment and confusion and assistance with daily activities is needed to insure that the individual will eat properly, maintain good hygiene, and are safe. The person may lose track of where he/she is and may lose track of what time it is, may have problems remembering his / her address, phone number, or where he/she attend school. The individual could become confused about what kind of clothing or appropriate clothing to wear for the season or for the day. Family and friends can help by laying out clothing in the morning. This can help the individual to dress by himself / herself and maintain a sense of independence. If the individual repeats the same question, respond a reassuring voice. The brain structures have begun to change with shrinkage of the cerebral cortex and the hippocampus and enlargement of the ventricles. Plaques and tangles within the brain increase in the areas controlling speech and spatial perception.

Other signs may include:

- Increase difficulty using and understanding speech
- Disorientation to date, place and time
- Forgets to eat or just eating a poor diet
- Increase difficulty with simple mental mathematics, for example counting backward from 20 by 2s.
- Losing perception of body in relation to objects

**Stage 6: Severe Decline (Severe cognitive decline - Moderately severe, midstage)**

As Alzheimer's disease progresses, profound changes often occur during this stage. The individual may recognize faces but forget names. He / she may also mistake a person for someone else, for example, thinking his mother is his sister. The individual often goes through personality changes, acting in ways that are different than their normal character. Delusions might set in, such as thinking he /she is going to drive, even though he / she no longer drives or have a car or thinking he / she needs to go to work even though he/ she no longer has a job. He /she may experience personality and behavioral changes, sometimes with paranoia, delusions, and hallucinations. They may feel persecuted. The individuals experience obvious confusion and not able to care for themselves.

The individual may exhibit other signs such as:

- Not remembering most recent experiences
- Recognizing familiar faces but forgetting names or the relationship
- lacking awareness of surrounding
- Wander away and gets lost
- Experience disruption of waking-sleeping cycles and sundowner's syndrome
- Dressing inappropriately, for example, putting shoes on wrong feet or underwear over pants
- Pacing back and forth
- Doing compulsive, repetitive actions, for example, hand-wringing, tearing paper.
- Experience difficulties with toileting and experiences episodes of urinary and bowel incontinence.
- Recall their name but forget many aspects of their personal history
- Confusing reality and fiction for example, thinking what happening on the television is real

This stage can be very prolonged, before the final stage and be difficult for caregivers, often family members, who may be often stressed, and desperate for some help. Others need to assist with all activities of daily living. At this point, brain has shrunk as neurons have continued to die. The last two stages (6 and 7) may last for 1-5 years. It might be hard to talk to the individual but family and friends can still connect with him /her through the senses. Many individuals with Alzheimer's disease love to hear music, looking over old pictures and love to be read to.

**Stage 7: Very Severe Decline (Very severe cognitive decline -Severe of late-stage)**

This is the stage in which the individuals are completely dependent upon others to care for them. Many of their basic abilities such as walking, eating, and sitting up, fade during this stage and they are often wheelchair bound or bedridden. Therefore the individual needs assistance with all activities of daily living and frequently must be fed. Family and friends can involved by feeding the individual with soft foods; food that are easy-to-swallow because of increasing dysphagia. Also assist by helping him to use a spoon, and making sure he / she is drinking. This is very important because many individuals at this stage can no longer tell when they are thirsty.

The individual may exhibit other signs such as:

- Increase muscle weakness and muscle rigidity
- Bladder and bowel incontinence
- Lose most of the ability to speak but may say some words or phrases
- Choking easily
- Lose the ability to stand, walk or sit without support

**Warning signs and symptoms**

There are 10 warning signs and symptoms. Each individual may experience one or more of these signs and symptoms in different degrees. Always follow up with a physician if you observed any of these signs:

1. Memory loss is one of the most common signs of Alzheimer's disease, especially forgetting information that was recently learned, frequently asking for the same information over and over again; requiring assistance from memory aids or family and friends for the things he /she would normally handle on their own.

2. Some individuals may experience changes in the ability to work with numbers or develop or follow a plan. He/ she may experience difficulty concentrating and take much longer time to do the things that they did before.

3. Have problems completing familiar tasks at work, home, or at leisure. It becomes difficult to complete daily tasks; for example may have difficulty remembering the rules of their favorite game.

4. Experience confusion regarding time or place. The individual may lose track of seasons, dates, and time. They may forget where they are. They may also forget how they got there.

5. May experience problems understanding visual images and spatial relationships. Some individuals may experience difficulty with reading, determining color and judging the distance.

6. Develop new problems with words in speaking and /or writing. He /she may experience problems following conversation. For example, may repeat conversation or stop in the middle of a conversation. They may also struggle with vocabulary such as, calling items the wrong name.

7. Misplacing items and lose the ability to retrace steps to find them. Sometimes, the individual with Alzheimer's may accuse other persons of stealing because they cannot find the items that they have misplaced.

8. Experience decrease or poor judgment. Individuals with Alzheimer's may experience changes in decision making or judgment. They may use poor judgment when spending money; may give away to telemarketers. They may pay less attention to grooming themselves or keeping themselves clean.

9. Withdrawal from social activities or from work. The individual with Alzheimer's disease may start to remove himself/ herself from hobbies, social activities, work, or sports, may experience trouble keeping up with his /her favorite sports team.

10. Experience changes in their personality and mood. They may become suspicious, depressed, fearful, confused, anxious or easily upset.

# SPECIALIST

The physician will evaluate the individuals overall health and identify any conditions that could affect how well the mind is working. The physician may refer the individual to a specialist such as a:

- **Neurologist** – specializes in diseases of the brain and nervous system
- **Psychiatrist** – specializes in disorders that affect mood or the way the mind works
- **Psychologist** – has special training in testing memory and other mental functions
- **Geriatrician –** specializes in the care of older adults and Alzheimer's disease

## The Brain and Alzheimer's disease

Alzheimer's is not the only cause of memory loss. Many individuals have problems with memory; this does not mean that they have Alzheimer's disease. There are many different causes of memory loss. If you or your love ones are experiencing symptoms of dementia consult with the physician to find out the cause.

According to the Alzheimer's Association, microscopic changes in the brain begin long before the first signs of memory loss. The brain has 100 billion nerve cells referred to as neurons. Each neuron connects with many others to form the communication networks. Groups of nerve cells have special functions / jobs. Some are involved in learning, thinking, and remembering. Others help us to hear see and smell (Alz.org 2014).

Scientists believe that Alzheimer's disease prevents parts of a cell's factory from working well. They are not sure where the trouble starts. But just like a real factory, backups and breakdowns in one system cause problems in other areas. As damage spreads, cells lose their ability to do their jobs and, eventually die, causing irreversible changes in the brain (Alz.org 2014).

**The role of plaques and tangles**

Two abnormal structures called plaques and tangles are prime suspects in damaging and killing nerve cells.

1. **Plaques** are deposits of a protein fragment called beta-amyloid that builds up in the spaces between nerve cells.
2. **Tangles** are twisted fibers of another protein called tau that builds up inside cells.

Though most people develop some plaques and tangles as they age, those with Alzheimer's disease tend to develop more. They also tend to develop them in a predictable pattern, beginning in areas that are important for memory before spreading to other regions.

Scientists do not know exactly what role plaques and tangles play in Alzheimer's disease. Most experts believe they somehow play a critical role in blocking communication among nerve cells and disrupting processes that cells need to survive. It is the destruction and death of nerve cells that causes memory failure, personality changes, problems carrying out daily activities and other symptoms of Alzheimer's disease.

**Research and progress**

Currently, Alzheimer's disease is at the forefront of biomedical research. Researchers are working to uncover as many aspects of Alzheimer's disease and related dementias as possible. Ninety percent (90 %) of what we know about Alzheimer's disease has been discovered in the last 15 years. Some of the most remarkable progress has shed light on how Alzheimer's affects the brain. The hope is that better understanding will lead to new ways to treat the individuals who are affected by the Alzheimer's disease. Worldwide, there are many potential approaches that are currently under investigation.

**Dementia**

Dementia is a general term for a decline in mental ability severe enough to interfere with daily life for example memory loss. Alzheimer's disease is the most common type of dementia. Dementia is not a specific disease. It is an overall term that describes a wide range of symptoms that are associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease accounts for 60 to 80 percent of cases.

**Vascular dementia** occurs after a stroke, and it is the second most common dementia type. However, there are many other conditions that can cause symptoms of dementia, including some that are reversible, such as those with thyroid problems and vitamin deficiencies.

Dementia is often inaccurately referred to as senile dementia or senility which reflects the formerly widespread belief that serious mental decline is a normal part of aging, which is not accurate.

**Memory loss and other symptoms of dementia**

While symptoms of dementia can vary greatly, **at least two** of the following core mental functions must be significantly impaired to be considered dementia:

- Memory
- Communication and language
- Ability to focus and pay attention
- Visual perception
- Reasoning and judgment

Individuals with dementia may have problems with short-term memory, keeping track of a purse or wallet, paying bills, planning and preparing meals, remembering appointments or traveling out of the neighborhood.

Many dementias are progressive, meaning that the symptoms start out slowly and gradually becomes worse. Professional evaluation by a physician may detect a treatable condition. However, if the symptoms suggest dementia, early diagnosis will allow the individual to get the maximum benefit from the available treatments. This will also provide an opportunity to volunteer for clinical studies or trials.

**Causes**

Dementia is caused by damage to the brain cells. The different types of dementia are associated with particular types of brain cell damage in particular regions of the brain. Such as, in Alzheimer's disease, high levels of certain proteins inside and outside brain cells make it hard for brain cells to stay healthy and to communicate with each other. Within the brain region called the hippocampus - the center of learning and memory in the brain, the brain cells in this region are often the first to be damaged. That is why memory loss is often one of the earliest symptoms of Alzheimer's.

While most of the changes in the brain that cause dementia are permanent and worsen over time, thinking and memory difficulty or problems caused by the following conditions may improve when the condition is treated or resolved:

- Side effects of Medications
- Excessive use of alcohol
- Depression
- Problems with the Thyroid
- Vitamin deficiencies

**Diagnosing dementia**

There is no one test to determine if an individual has dementia. The physician diagnose Alzheimer's disease and other types of dementia based on:

- Thorough medical history,
- Physical examination,
- laboratory tests, and
- The characteristic changes in thinking,
- day-to-day function and
- Behaviors associated with each type.

Physicians can determine that an individual has dementia with a high level of certainty. But it is much more difficult to determine the exact type of dementia because the brain changes and symptoms of the different dementias can overlap. In some cases, the physician may diagnose dementia and not specify a type. If this occurs it may be necessary to follow up with a specialist such as a neurologist or gero-psychologist.

**Dementia treatment and care**

Treatment of dementia will depend on its cause. In most progressive dementias, including Alzheimer's disease, there is no cure and no treatment that slows or stops its progression. But there are drug treatments that may temporarily improve symptoms. The same medications used to treat Alzheimer's disease are among the drugs sometimes prescribed to help with the symptoms of other types of dementias. Non-drug therapies can also alleviate some symptoms of dementia.

Ultimately, the path to effective new treatments for dementia is through increased research funding and increased participation in clinical studies. Currently, volunteers are needed to participate in more than 180+ actively enrolling clinical trials and studies about Alzheimer’s and related dementias.

**Dementia risk and prevention**

Some risk factors for dementia cannot be changed, such as age and genetics. But research continues to explore the impact of other risk factors on the brain health and prevention of dementia. Some of the most active areas of research in risk reduction and prevention include:

- Cardiovascular factors,
- Physical fitness, and
- Diet.

**Cardiovascular risk factors**

The brain is nourished by one of the body's richest networks of blood vessels. Anything that damages blood vessels anywhere in the body can damage the blood vessels in the brain, and deprive the brain cells of vital oxygen and food. Blood vessel changes within the brain are linked to vascular dementia. They are often present along with changes caused by other types of dementia, including Alzheimer's disease and dementia with Lewy bodies. These changes may interact to cause faster decline or make impairments more severe. You can help protect the brain with some of the same strategies that protect the heart, such as:

- Take steps to keep your blood pressure within recommended range
- Take action to keep your cholesterol within recommended range
- Take measures to keep your blood sugar within recommended limits; and
- Maintain a healthy weight
- Do not smoke

**Physical exercise**

Regular physical exercise may help to lower the risk of some types of dementia. Evidence suggests exercise may directly benefit brain cells by increasing the blood flow and oxygen flow to the brain. Also along with blood flow, nutrients are also involved.

**Diet**

What you eat may have an effect on the brain health. The best current evidence suggests that heart-healthy eating patterns also may help to protect the brain. Recommendations have been made to include healthy diet which has little red meat and

places emphasis on whole grains, fruits vegetables, fish, shellfish, nuts, olive oil and other healthy fats.

**Dementia help and support are available**

If someone has been diagnosed with dementia, the Alzheimer's Association is one of the most trusted resources for information, education, referral and support.
Call the 24/7 Helpline: 800.272.3900
Visit the online Alzheimer's and Dementia Caregiver Center or locate a support group in your community and you can also visit the Alzheimer's Association virtual library at http://www.alz.org/library/index.asp

**Some care giving tips which will assist the caregiver include:**

- Educate yourself about the disease. Read literature /books, consult with the healthcare professional and attend workshops. You can also subscribe to AFA's free caregiver magazine, AFA Care Quarterly.
- Learn how to avoid caregiver burnout by making time for you and join caregiver support groups.
- Discuss the situation with family and friends. Support systems are very important
- Pursue interests beyond the care giving role, such as hobbies, exercise, and journaling.
- Do cognitive stimulation activities with him /her. For example, memory games, listening to music and word puzzles.
- Employ positive thinking. Focus on the individual's remaining strengths and enjoy the relationship while you still can.
- Smile and show kindness, humor and creativity are very important aspects of care giving. Hugs, Smiles, hand massage and other gentle physical contact will help your loved one feel connected and loved.
- Take care of the financial, legal and long-term care planning issues. Try to involve the individual in decision-making, if he /she is still able of providing input, and include his/ her wishes related to any future care and / or end-of-life issues.
- Learn care giving techniques. The main areas include safety concerns, communication skills, managing behavioral changes /challenges and assisting with activities of daily living.
- Understanding the experience, be kind and patient with your loved one.
- Maintain your own mental and physical health. Get involved in activities to reduce stress such as: Exercise, respite and hobbies.
- Ensure communication with the physicians. Become involved in the individual's medical care. Ask any questions you have regarding the progression of the

disease, talk about the concerns and discuss available treatment options.

Reach out for care. Call the Alzheimer's Foundation of America at 866.232.8484, for information, counseling, and referrals to local resources nationwide.

**For More Information**

To learn more about support groups, services, research centers, research studies, and publications about Alzheimer's disease, contact the following resources:

**Alzheimer's Disease Education and Referral (ADEAR) Center**
P.O. Box 8250
Silver Spring, MD 20907-8250
1-800-438-4380 (toll-free)
*www.nia.nih.gov/Alzheimers*
The National Institute on Aging's ADEAR Center offers information and publications for professionals, families, and caregivers on diagnosis, treatment, patient care, caregiver needs, long-term care, education and training, and research related to Alzheimer's disease. The staff answers telephone, email, and written requests and make referrals to local and national resources. The ADEAR website provides free, online publications in English and Spanish; email alert and online *Connections* newsletter subscriptions; an Alzheimer's disease clinical trials database; the Alzheimer's Disease Library database; and more.

**Alzheimer's Association**
225 N. Michigan Avenue, Floor 17
Chicago, IL 60601-7633
1-800-272-3900 (toll-free)
1-866-403-3073 (TDD/toll-free)
*www.alz.org*

**Alzheimer's Foundation of America**
322 Eighth Avenue, 7th Floor
New York, NY 10001
1-866-AFA-8484 (1-866-232-8484; toll-free)
*www.alzfdn.org*

**Eldercare Locator**
1-800-677-1116 (toll-free)
*www.eldercare.gov*

**Family Caregiver Alliance**
180 Montgomery Street, Suite 1100
San Francisco, CA 94104
1-800-445-8106 (toll-free)
*www.caregiver.org*

**NIHSeniorHealth**
*www.nihseniorhealth.gov/alzheimersdisease/toc.html*

# OBSESSIVE-COMPLUSIVE DISORDERS (OCD)

Obsessive-compulsive disorder (OCD) is characterized by unreasonable thoughts and fears (obsessions) that lead the individual to do repetitive behaviors (compulsions). It is also possible to have only obsessions or only compulsions and still have OCD.

With Obsessive-compulsive disorder, the individual may or may not realize that the obsessions are not reasonable, and may try to ignore them or stop them. But that only increases the distress and anxiety. Ultimately, the individuals feel driven to perform compulsive acts in an effort to ease the stressful feelings.

Obsessive-compulsive disorder often focuses around themes, such as a fear of getting contaminated by bacteria or germs. Regardless of efforts to ignore or get rid of bothersome thoughts, the thoughts or urges keep coming back. This leads to more ritualistic behavior and a vicious cycle (repeat over and over) which is characteristic of Obsessive-compulsive disorder.

## Symptoms

Individuals with Obsessive-compulsive disorder may have symptoms of obsessions, compulsions, or both. Obsessive-compulsive disorder symptoms usually include both obsessions and compulsions. But it is also possible to have only obsession symptoms or only compulsion symptoms. About 1/3 rd of individuals with Obsessive-compulsive disorder also have a disorder that includes brief, sudden, sounds or intermittent movements. These symptoms can interfere with the individual's life, such as school, work, and personal relationships.

## Obsessions

Obsessions are the repeated urges, thoughts or mental images that cause anxiety.

Some common symptoms include:

- Fear of contamination or germs
- Aggressive thoughts towards self or others
- Unwanted forbidden or taboo thoughts that involves sex, harm, and religion

- Having things in a perfect order (symmetrical)

## Compulsions

Compulsions are repetitive behaviors that the individual with Obsessive-compulsive disorder feels the urge to do in response to an obsessive thought. Common compulsions include:

- Excessive hand washing
- Excessive cleaning
- Arranging and ordering things in a particular( precise way)
- Compulsive counting
- checking on things repeatedly, such as frequently checking to see if he/she has locked the door.

Not all habits or rituals are compulsions. Sometimes other individuals may double checks things.

But an individual with Obsessive-compulsive disorder generally:

- Cannot control his or her behaviors or thoughts, even when the thoughts and /or the behaviors are recognized as excessive
- Does not get pleasure when performing the rituals or behaviors, but may feel brief relief from the anxiety the thoughts cause
- Experiences significant problems in their daily life due to the thoughts and/or the behaviors
- Spends at least one hour each day on these thoughts and/or the behaviors

Some individuals with Obsessive-compulsive disorder also have a tic disorder. Motor tics are brief, sudden, repetitive movements, for example facial grimacing, eye blinking as well as other eye movements, shoulder shrugging, and shoulder or head jerking. Some common vocal tics include repetitive sniffing, throat-clearing sounds or grunting.

Symptoms may;

- come and go,
- Ease over time or

- Worsen.

Individuals with Obsessive-compulsive disorder may try to help themselves by avoiding situations that trigger the obsessions, or they may use alcohol or drugs to calm themselves.

Although most adults with Obsessive-compulsive disorder recognize that what they are doing does not make sense, some adults and most children may not realize that their behavior is out of the ordinary. Parents or teachers typically recognize Obsessive-compulsive disorder symptoms in children.

## CAUSES OF OBSESSIVE-COMPULSIVE DISORDER

The causes of with Obsessive-compulsive disorder are not known, but some risk factors include:

### Brain Structure /Functioning

Differences have been seen on imaging studies;

- Differences in the frontal cortex and subcortical structures of the brain in individuals with Obsessive-compulsive disorder.

There appears to be a connection between the Obsessive-compulsive disorder symptoms with abnormalities in certain areas of the brain, but the connection is not yet clear. Research is still in progress.

### Genetics

Family and Twin studies have shown that individuals with first-degree relatives for example a child, parent, or a sibling, who have Obsessive-compulsive disorder, are at a higher risk for developing Obsessive-compulsive disorder themselves. The risk is higher if the first-degree relative developed OCD during their childhood or as a teen. Research continues to investigate the connection between Obsessive-compulsive disorder genetics and OCD and may help improve OCD diagnosis and treatment.

## The Environment

Individuals who have been abused (such as sexual and or physical abuse) during their childhood or have experienced other types of trauma are at increased risk for developing Obsessive-compulsive disorder. After a streptococcal infection, a child may develop Obsessive-compulsive disorder or symptoms; this is referred to as Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).

# Treatments / Therapies

Obsessive-compulsive disorder is usually treated with:

- Medication
- psychotherapy or
- a combination of both medication and psychotherapy.

Most patients respond to treatment; however some patients may continue to experience symptoms.

The individuals who have OCD may also have other mental disorders, for example, depression, anxiety, and body dysmorphic disorder (obsessions about their appearance that may last for hours or up days; believes that a part of their body is not normal. When making decisions about treatment, it is very important to consider these other disorders.

## Medications

The goal of treatment with medications for the patient with Obsessive-compulsive disorder is to effectively control the signs and symptoms at the lowest dose possible.

Selective serotonin reuptake inhibitors (SSRIs) and Serotonin reuptake inhibitors (SRIs) are often prescribed to help reduce Obsessive-compulsive disorder symptoms. Examples of medications that have been proven effective in both adults and children with OCD include Anafranil™ (clomipramine hydrochloride) Capsules USP is an antiobsessional drug; the class (dibenzazepine) tricyclic antidepressants, also other selective serotonin reuptake inhibitors (SSRIs), such as:

**Fluoxetine**

Fluoxetine affects chemicals in the brain that may be unbalanced in individuals with anxiety, panic, depression, or obsessive-compulsive symptoms.

**Sertraline**

Sertraline is an antidepressant; selective serotonin reuptake inhibitors (SSRIs). Sertraline affects chemicals within the brain that may be unbalanced in individuals with obsessive-compulsive symptoms, anxiety, depression, or panic.

**Fluvoxamine**

Fluvoxamine is a selective serotonin reuptake inhibitor (SSRI). This medication works by helping to restore the balance of serotonin in the brain.

Serotonin reuptake inhibitors (SRIs) often require higher daily doses in the treatment of Obsessive-compulsive disorder symptoms than of depression, and it may take as long as 8 to 12 weeks to start working, however some patients may experience faster results/ improvement.

When symptoms do not improve with these types of medications, research has shown that some individuals may respond well when given an antipsychotic medication.

# Psychotherapy

Psychotherapy can be an effective treatment for individuals (adults and children) with Obsessive-compulsive disorder. Research has shown that some types of psychotherapy, such as cognitive behavior therapy (CBT) and other related therapies can be as effective as medications for many individuals. Research has also shown that a type of CBT; Exposure and Response Prevention (EX/RP) is effective in decreasing compulsive behaviors in Obsessive-compulsive disorder, even in individuals who did not respond well to SRI medication. Exposure and Response Prevention (EX/RP) is often the add-on treatment of choice when SSRI or SRIs medication does not effectively treat Obsessive-compulsive disorder symptoms.

Some psychiatric medications can help control the obsessions and compulsions of Obsessive-compulsive disorder. Most frequently the antidepressants are tried first. Some antidepressants that have been approved by the Food and Drug Administration (FDA) to treat Obsessive-compulsive disorder include:

- Fluvoxamine (Luvox CR)
- Clomipramine (Anafranil)
- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil/ Pexeva)

## Possible Side effects and risks of Medications

Psychiatric medications have potential side effects such as:

- Stomach upset,
- sleep disturbance,
- sweating
- Decreased interest in sexual activity.

### INSTRUCT / TEACH PATIENTS

Educate the patients to talk with the healthcare practitioner / physician about the possible side effects and about any health monitoring needed while taking psychiatric medications.

**Suicide risk**

Most antidepressants are usually safe, however the Food and Drug Administration (FDA) requires that they display the strictest warnings for prescriptions. There are some cases in which children, teenagers and young adults under 25 years old, may have an increase in suicidal thoughts or behavior when they are taking antidepressants, especially in the first few weeks after starting the medication or when the dose is changed.

### INSTRUCT PATIENTS

Educate the patients and encourage them to update the physician immediately If they experience suicidal thoughts when they are taking an antidepressant. However antidepressants are likely to reduce suicide risk in the long run by improving mood.

- **Interactions with other substances.**

Some medications can have dangerous interactions with other medications, foods, alcohol or other substances. Teach the patients to talk with the physician about all medications and over-the-counter substances they are taking, including vitamins, minerals and even herbal supplements.

## Other treatments

At times medications and psychotherapy are not effective enough to control Obsessive-compulsive disorder symptoms.

Research continues on the potential effectiveness of deep brain stimulation (DBS) for treating Obsessive-compulsive disorder that does not respond to traditional treatment approaches.

## Prozac (fluoxetine)

Prozac (fluoxetine) is a selective serotonin reuptake inhibitors (SSRI) antidepressant. Prozac affects chemicals in the brain that may be unbalanced in individuals with depression, panic, anxiety, or obsessive-compulsive symptoms. Prozac is used to treat major depressive disorder, bulimia nervosa (eating disorder) obsessive-compulsive disorder, and panic disorder.

### PATIENT TEACHING

Educate patients not to take Prozac if they have taken an MAO inhibitor in the past 14 days. A dangerous drug interaction could occur.

MAO inhibitors include isocarboxazid, linezolid, phenelzine, rasagiline, selegiline, and tranylcypromine. They must wait at least 14 days after stopping an MAO inhibitor before able to take Prozac.

Patient must wait 5 weeks after stopping Prozac before he can take thioridazine or an MAOI.

# ANOREXIA NERVOSA

Anorexia nervosa is a very serious and potentially life-threatening eating disorder which is characterized by self-starvation and excessive weight loss.

Individuals with anorexia nervosa may see themselves as overweight, even when they are dangerously underweight. These individuals will:

- Weigh themselves repeatedly,
- Severely restrict the amount of meals /food they eat, and
- Eat very small amount of only certain foods.

Anorexia nervosa has the highest mortality rate of any mental disorder.

FACTS

- Many young women and men with anorexia nervosa die from the complications that is associated with starvation,
- Some die from suicide.
- In women, suicide is much more common in those with anorexia than with most other mental disorders.

Symptoms include:

- Extremely restricted food intake (restricted eating)
- Extreme emaciation, thinness
- Very afraid " fear" of gaining weight
- Pursuit of thinness, unwilling to maintain normal or healthy body weight
- Distorted body image,
- self-esteem that is greatly influenced by perceptions of body shape and weight
- Denial of the extreme thinness or the seriousness of low body weight

Other symptoms may develop over time, such as:

- Osteopenia or osteoporosis - thinning of the bones
- Anemia
- Muscle wasting
- Muscle weakness
- Brittle hair
- Brittle nails
- Dry skin
- Yellowish skin
- Severe constipation
- Hypotension - Low blood pressure,
- slowed breathing and pulse
- Damage to structure /function of the heart
- Growth of fine hair all over the body - lanugo
- Brain damage
- Multi-organ failure
- Drop in internal body temperature, causing a individual to feel cold all the time
- Infertility

- Lethargy,
- sluggishness,
- Feeling tired all the time

**MONITOR**

It may be difficult to notice signs and symptoms of anorexia because individuals with anorexia often disguise their thinness, eating habits or physical problems.

Watch for these possible behaviors:

- Skipping meals
- Making excuses for not eating
- Eating only a few certain safe foods, usually those low in fat and calories
- Repeated weighing or measuring of themselves
- Adopting rigid meal or eating rituals, (spitting out food after chewing)
- Cooking elaborate meals for others and refusing to eat
- Frequent checking in the mirror for flaws
- Complains of  about being fat
- Covering up in layers of clothing
- Do not want to eat in public
- if inducing vomiting, calluses on the knuckles and eroded teeth

## Causes

The exact cause of anorexia nervosa is not known. However, a combination of factors such as biological, psychological and environmental may play a role.

**Biological –**

Although it is not yet clear which genes are involved, there may be genetic changes that make some individuals more vulnerable to developing anorexia.

- Some individuals may have a genetic tendency toward perfectionism, sensitivity and /or perseverance (traits associated with anorexia).

**Psychological –**

Some emotional characteristics sometimes contribute to anorexia. Young women may have obsessive-compulsive personality traits that make it easier to stick to strict diets and avoid food even when they are hungry.

- They may have an extreme drive for perfectionism, which causes them to think they are never thin enough. And they may have high levels of anxiety and engage in restrictive eating to reduce it.

**Environmental –**

Within the modern Western culture a great emphasis is placed on being thin. Success and worth are often equated with being thin. Peer pressure may also help to increase the desire to be thin, especially among the young girls.

**Risk factors**

Some risk factors increase the risk of anorexia nervosa, including:

**Being female**

Anorexia is more common in girls and women. Boys and men have been increasingly developing eating disorders, may be due to the growing social pressures.

**Young age**

Anorexia is more common among teenagers. However, individuals of any age can develop this eating disorder, although it is rare in those over 40 years old. Teens may be more susceptible because of all the changes their bodies go through during puberty. They also may face increased peer pressure and be more sensitive to criticism or even casual comments about weight or body shape.

**Genetics**

Changes in certain genes may make individuals more susceptible to anorexia.

**Family history**

Those with a first-degree relative (a parent, sibling or child) who had the disease have a much higher risk of anorexia.

**Weight changes**

When individuals lose or gain weight, intentionally or unintentionally, those changes may be reinforced by positive comments from people if weight was lost or by negative comments if there was weight gain.

Such comments and changes may cause someone to start dieting to an extreme. Also starvation and weight loss may change the way the brain works in vulnerable individuals, which may increase the restrictive eating behaviors and make it difficult to return to normal eating habits.

**Transitions**

Changes may occur in the person's life such as a death in family, a new school, new home or new job; a relationship breakup, or illness of a loved one. Any change can bring emotional stress and increase the risk of anorexia.

**Sports / artistic activities**

It is often noted that athletes, actors, dancers and models are at higher risk of anorexia. Coaches and parents may inadvertently raise the risk by suggesting that young athletes lose weight.

**Media and society**

The media, for example the television, and fashion magazines, frequently feature very thin models and actors. These images may seem to equate thinness with success and popularity.

# TESTS

Several examinations and tests are completed to help to diagnose, rule out medical causes for the weight loss, and check for any related complications.

These examinations and tests generally include:

**Physical examination**

Physical examination may include:

- Measuring the height and weight;
- Checking the vital signs ( heart rate, blood pressure and temperature); checking the skin and nails for problems;
- listening to the heart and lungs; and
- examining the abdomen.

**Lab tests**

Laboratory tests may include a complete blood count (CBC) and more specialized blood tests to check electrolytes and protein as well as functioning of the liver, kidney and thyroid. A urinalysis may also be completed.

**Psychological evaluation**

The physician or mental health provider will likely ask about the person thoughts, feelings and eating habits. The individual may also be asked to complete psychological self-assessment questionnaires.

**Other studies**

X-rays may be taken to check;

- the bone density,
- check for stress fractures or broken bones, or
- check for pneumonia or heart problems.

**Electrocardiograms**

Electrocardiograms may be completed to check for heart irregularities.

Testing may also be done to determine how much energy the body uses, which can help in planning the nutritional requirements.

**Diagnostic criteria for anorexia**

- To be diagnosed with anorexia nervosa, the individual generally 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 and by insurance companies to reimburse for treatment.

**DSM-5 diagnostic criteria for anorexia include:**

- **Restricting food intake;** eating less than needed to maintain a body weight that is at or above the minimum normal weight for age and height

- **Fear of gaining weight;** intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, such as vomiting or using laxatives, even though the individual is underweight
- **Problems with body image;** denying the seriousness of having a low body weight, connecting the weight to self-worth, or having a distorted image of appearance or shape

## TREATMENTS AND MEDICATIONS

Treatment is usually done using a team approach that includes medical providers, mental health providers and dietitians, all with experience in eating disorders.

Ongoing therapy and nutrition education are highly required to continued recovery.

**Hospitalization and other programs**

If the individual's life is in immediate danger, he/ she may need treatment in a hospital emergency room for issues such as dehydration, a heart rhythm disturbance, electrolyte imbalances and /or psychiatric problems.

Hospitalization may be required for;

- medical complications,
- psychiatric emergencies,
- severe malnutrition or
- continued refusal to eat.

Hospitalization may be on a medical or psychiatric unit.

Some clinics specialize in treating individuals with eating disorders. Some may offer day programs or residential programs instead of full hospitalization. Specialized eating disorder programs may also offer more intensive treatment over longer periods of time.

**Medical care**

Because of the numerous potential complications from anorexia, the individual may need frequent monitoring of vital signs, hydration level and electrolytes, and also related physical conditions.

In some severe cases, patients with anorexia may initially require feeding through a feeding tube (nasogastric tube).

The primary care physician may be the one who coordinates the care with the other health care professionals involved. Sometimes, the mental health provider will coordinate the care.

# RESTORING A HEALTHY WEIGHT

The first goal of treatment is to get back to a healthy weight.

The individual cannot recover from an eating disorder without first restoring an appropriate body weight and learning proper nutrition.

A psychologist or other mental health professional can work with the individuals to develop behavioral strategies to help them return to a healthy body weight.

A dietitian will offer guidance getting back to regular patterns of eating; including providing specific meal plans and calorie requirements that help the individuals meet their weight goals. The family will also likely be involved in helping the individual maintain normal eating habits.

## Psychotherapy

The following types of therapy may be beneficial:

**Family-based therapy**

This is the only evidence-based treatment for teenagers with anorexia. Because the teenager with anorexia is not able to make good choices about eating and health while in this serious condition, this therapy utilizes parents to help their children with re-feeding and weight restoration until the child can make good choices about health.

**Individual therapy**

For adults, cognitive behavioral therapy (CBT) specifically enhanced cognitive behavioral therapy; has been shown to be effective. The main goal is to normalize behaviors and eating patterns and support weight gain. The other goal is to help change distorted beliefs and thoughts that maintain the restrictive eating. This type of therapy is generally completed once per week or in a day treatment program, but in some cases, it may be part of treatment in a psychiatric hospital.

**Medications**

No medications are approved to treat anorexia because none has been found to work very well. However, antidepressants or other psychiatric medications can help treat other mental disorders the individuals may be experiencing, such as depression or anxiety.

**Treatment challenges in anorexia**

One of the biggest challenges in treating anorexia is that the individual may not want the treatment. Barriers to treatment may include:

- Thinking they do not need treatment
- Fear of weight gain
- Do not see anorexia as an illness but rather seen as a lifestyle choice

Individuals with eating disorders can recover. However, they are at increased risk of relapse during triggering situations or during periods of high stress. Ongoing therapy or periodic appointments during times of stress may help the individuals stay healthy.

**Alternative medicine**

Alternative medications have not been well-studied as a treatment for individuals with eating disorders, but complementary treatments may help reduce anxiety. Such treatments may help individuals with eating disorders by increasing a sense of well-being and promoting relaxation.

Examples of anxiety-reducing complementary treatments include:

- Massage
- Yoga
- Acupuncture
- Meditation

# Bulimia nervosa

Bulimia nervosa is commonly called bulimia. It is a serious, potentially life-threatening eating disorder. Individuals with bulimia may binge (eating large amounts of food) and then purge, to try to get rid of the extra calories in an unhealthy way. The person with bulimia may force vomiting or engage in excessive exercise. The individual may sometimes purge even after eating only a small snack or a normal-size meal.

Bulimia can be categorized in 2 ways:

**Purging bulimia**

The individual regularly self-induce vomiting or misuse laxatives, diuretics or enemas after binging.

**Nonpurging bulimia**

The individuals use other methods to remove calories and prevent weight gain, for example fasting, strict dieting and/ or excessive exercise.
These behaviors often overlap, and the attempt to rid self of extra calories is usually referred to as purging regardless of the method used.

Individuals with bulimia nervosa have recurrent, frequent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes.

The binge-eating is often followed by behaviors that compensate for the overeating for example:

- forced vomiting,
- excessive use of diuretics,
- excessive use of laxatives,
- fasting,
- excessive exercise, or
- a combination of these behaviors.

Individuals with bulimia nervosa usually maintain a healthy body weight or relatively normal weight, unlike anorexia nervosa.

Symptoms include:

- Chronically inflamed throat
- Sore throat
- Swollen salivary glands in the neck and the jaw
- Acid reflux disorder and other gastrointestinal (GI) problems
- Electrolyte imbalance (too low or too high levels of calcium, sodium, potassium and other minerals) which can lead to stroke or heart attack
- Tooth enamel that is worn and increasingly sensitive
- Decaying teeth due to exposure to stomach acid
- Intestinal distress and irritation from abusing laxative
- Severe dehydration from purging of fluids

## PATIENT TEACHING

Encourage the individuals to seek medical help as soon as possible because if it is not treated, bulimia can severely impact their health status.

Because most individuals with bulimia are normal weight or slightly overweight, it may not be apparent to others that something is wrong.

MONITOR INDIVIDUALS - may notice:

- Constantly worrying or complaining about being fat
- Having a distorted, excessively negative body image
- Repeatedly eating unusually large quantities of food in one sitting, especially foods the individual would normally avoid
- Not wanting to eat in public or in front of others
- Going to the bathroom right after eating or during meals
- Exercising too much
- Having sores, scars or calluses on the knuckles or hands
- Having damaged teeth and gums

## Causes

The exact cause of bulimia is unknown. There are many factors that could play a role in the development of eating disorders, including:

- Biology,
- Emotional health,
- societal expectations and other issues.

## Risk factors

Factors that increase your risk of bulimia may include:

**Being female**

Girls and women are more likely to have bulimia than boys and men are.

**Age**

Bulimia often begins in the late teens or early adulthood.

**Biology**

Individuals with first-degree relatives (siblings, parents or children) with an eating disorder may be more likely to develop an eating disorder, suggesting a possible genetic link. It is also possible that a deficiency in the brain chemical serotonin may play a role. Also being overweight as a child or teen may increase the risk.

**Psychological and emotional issues**

Psychological and emotional issues /problems, for example anxiety disorder or low self-esteem, can contribute to eating disorders. Individuals with bulimia may have negative feelings about themselves.

Triggers for binging can include:

- stress,
- poor body self-image,
- food,
- boredom
- restrictive dieting,
- traumatic events
- environmental stress.

**Media and societal pressure**

Once again, media influence, for example the television and the fashion magazines, frequently reveal the very thin actors and models. These images seem to equate being thin with popularity and success.

**Sports/ work pressures**

Actors, athletes, models and dancers are at a higher risk of eating disorders. Sometimes the parent or coach may inadvertently increase the risk by encouraging the young athlete to maintain a low weight, lose more weight and to restrict eating for much better performance.

## Complications

Bulimia may cause several serious and even life-threatening complications. Possible complications include:

- Dehydration, which can lead to major severe medical problems, for example kidney failure
- Heart problems, for example an irregular heartbeat or heart failure
- Severe gum disease and tooth decay
- Absent periods in females
- Irregular periods in females
- Gastrointestinal (GI) /digestive problems, possible dependence on laxatives to have bowel movements
- Anxiety
- Depression
- Misuse of drugs
- Misuse of alcohol
- Suicide

## Tests and diagnosis

Will typically perform:

- A complete physical exam
- Blood and urine tests
- A psychological evaluation, including a discussion of eating habits and attitude toward food

## Criteria for diagnosis

For a diagnosis of bulimia, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, lists these points:

- Recurrently having episodes of eating an abnormally large amount of food ; more than most people would eat in a similar amount of time and under similar circumstances, for example, in a 2 hour time period

- The individuals feel a lack of control during binging, such as how much they are eating and whether they can stop eating
- The individuals get rid of the extra calories from binging to avoid weight gain by vomiting, fasting excessively, excessive exercise, misuse of laxatives, diuretics and /or other medications
- Binging and purging at least once a week for at least three months
- Body shape and weight influence feelings of self-worth too much
- Does not have anorexia, an eating disorder with extremely restrictive eating behaviors

The severity of bulimia is determined by the number of times per week that the patients purge.

Even if they do not meet all of these criteria, the patients could still have an eating disorder.

**Treatments and drugs**

When the individuals have bulimia, they may need several types of treatment, although combining psychotherapy with antidepressants may be the most effective for overcoming the disorder.

Treatment generally involves a team approach that includes the individual, the family, the primary care physician or other health care provider, as well as a mental health provider and a dietitian experienced in treating eating disorders.

Bulimia treatment options and considerations:

**Psychotherapy**

Psychotherapy (talk therapy or psychological counseling), involves discussing bulimia and related issues with a mental health provider. Evidence indicates that these types of psychotherapy help improve symptoms of bulimia:

**Cognitive behavioral therapy**

To help the persons identify unhealthy, negative beliefs and behaviors and replace them with healthy, positive ones

**Family-based therapy**

To help parents intervene to stop their teenager's unhealthy eating behaviors, then to help the teen regain control over their own eating, and finally, to help the family deal with problems that bulimia can have on the teen's development and the family

**Interpersonal psychotherapy**

Interpersonal psychotherapy addresses difficulties in the close relationships, helping to improve the person’s communication and problem-solving skills.

**Medications**

Antidepressants may be helpful in reducing the symptoms of bulimia when used along with psychotherapy. The only antidepressant specifically approved by the Food and Drug Administration to treat bulimia is fluoxetine (Prozac), a type of selective serotonin reuptake inhibitor (SSRI), which may help even if they are not depressed.

**Nutrition education**

Dietitians and other health care providers can design an eating plan to help the individuals achieve a healthy weight, normal eating habits and good nutrition.

Medically supervised weight-loss programs are very helpful.

**Hospitalization**

Bulimia can usually be treated outside of the hospital. But if the individuals have a severe form and serious health complications, they may need treatment in a hospital. Some eating disorder programs may offer day treatment rather than the inpatient hospitalization.

## Treatment challenges in bulimia

Although most individuals with bulimia do recover, some find that symptoms do not go away entirely. Periods of binging and purging may come and go throughout the years, depending on life circumstances, such as recurrence during times of high stress.

# PATIENT TEACHING

Follow self-care tips for bulimia such as:

**Follow the treatment plan**

Do not skip therapy sessions and stay with the meal plans, even if they make the individual uncomfortable.

**Learn about bulimia**

Education about the condition can empower the patients and motivate them to stay with the treatment plan.

**Get the right nutrition**

If the individuals are not eating well or they are frequently purging, it is likely the body is not getting all of the appropriate nutrients it needs.

Eating regularly and not restricting the food intake is the first step in overcoming bulimia.

**Staying in touch**

Encourage the individuals to avoid isolating themselves from caring friends and family members who want to see them get healthy; and to understand that they have the best intensions for them. Also the nurturing, caring relationships are healthy for them.

**Be kind to themselves**

Resist the urge to excessively weigh or check self in the mirror. These may increase the drive to maintain unhealthy habits.

**Be cautious with exercise**

Encourage the patients to speak with the health care provider about what kind of physical activity, is appropriate, especially if they exercise excessively to burn off post-binge calories.

# Binge-Eating Disorder

Individuals with binge-eating disorder lose control over his or her eating. Unlike bulimia nervosa, periods of binge-eating are not followed by purging, excessive exercise, or fasting. As a result, people with binge-eating disorder often are overweight or obese. Binge-eating disorder is the most common eating disorder in the U.S.

Symptoms include:

- Eating unusually large amounts of food in a specific amount of time
- Eating very fast during binge episodes
- Eating alone (hiding)
- Eating in secret to avoid embarrassment
- Eating even when not hungry
- Eating until uncomfortably full

- Frequently dieting, possibly without losing weight
- Feeling ashamed about the eating
- Feeling distressed about the eating
- Feeling guilty about the eating

### Risk Factors

Eating disorders most often occurs during the teen years or young adulthood but can also develop during childhood or later in life.

Eating disorders affect both genders, although rates among women are greater (2½ times greater) than among men. Men also have a distorted sense of body image just like the women. Men may have muscle dysmorphia (type of disorder marked by an extreme concern with becoming more muscular).

Researchers find that eating disorders are caused by a complex interaction of:

- genetic,
- biological,
- behavioral,
- psychological, and
- social factors.

Researchers continue to study the human genes. Eating disorders run in families.

**Brain imaging studies**

Brain imaging studies are providing a clearer understanding of eating disorders. For example, researchers have discovered differences in patterns of brain activity in the women with eating disorders in comparison with healthy women. These researches can help to guide the development of new means of diagnosing and treating eating disorders.

# Treatments

The foundation of treatment includes:

- Adequate nutrition,
- reduce excessive exercise, and
- Stop purging behaviors.

Treatment plans are tailored to individual needs and may include one or more of the following:

- Individual, group, and/or family psychotherapy
- Medical care and monitoring
- Nutritional counseling
- Medications

## PSYCHOTHERAPIES

Psychotherapies such as the family-based therapy (Maudsley approach) where parents of adolescents with anorexia nervosa assume the responsibility for feeding their children, appear to be very effective in helping individuals:

- Gain weight
- Improve eating habits and
- Improve moods.

To eliminate or reduce the binge-eating and purging behaviors, individuals may undergo cognitive behavioral therapy (CBT), as mentioned earlier, another type of psychotherapy that helps the individual learn how to identify distorted thinking patterns, recognize and change the inaccurate beliefs.

## Medications

Evidence also suggests that medications such as antidepressants, antipsychotics, or mood stabilizers approved by the U.S. Food and Drug Administration (FDA) may also be helpful for treating eating disorders and other co-occurring illnesses such as anxiety or depression.

# POST TRAUMATIC STRESS DISORDERS (PTSD)

Post-traumatic stress disorder (PTSD) is a mental health condition that is triggered by terrifying events either from experiencing the event or witnessing it. Symptoms may include nightmares, flashbacks and severe anxiety, and also uncontrollable thoughts about the event.

Some individuals who experiences traumatic events have difficulty coping and adjusting for a period of time, but they do not have Post-traumatic stress disorder (PTSD). With good self-care and some time, they usually get better. But if the symptoms become worse or last for months or years and affects daily functioning, the individuals may have Post-traumatic stress disorder (PTSD).

Getting effective treatment after PTSD symptoms develop can be critical to reduce symptoms and improve function.

The fight-or-flight response is the body's response that helps to keep the individuals from harm. Most individuals will experience a range of reactions after a traumatic incident, however most individuals recover from the initial symptoms naturally. The people who continue to experience difficulties /problems may be diagnosed with Post-

traumatic stress disorder (PTSD). People who have Post-traumatic stress disorder (PTSD) may feel frightened when they are not in any danger.

### Post-traumatic stress disorder Symptoms

Post-traumatic stress disorder symptoms may start within 3 months after the individual experienced a frightening or traumatic event, but sometimes the symptoms may not appear until years after the event. The symptoms lead to problems within their social lives, their relationships and /or work settings.

Post-traumatic stress disorder (PTSD) symptoms are generally grouped into 4 types:

- Intrusive memories,
- Avoidance,
- Negative changes in mood and thinking or
- Changes in emotional reactions.

## Intrusive memories

Symptoms of intrusive memories may include:

- Frequent recurrent, distressing memories of the traumatic event
- Flashbacks; in which the individual relive the traumatic event (as if it were happening again)
- Distressful dreams about the traumatic event
- Severe physical reaction or emotional distress due to something that reminds the person of the traumatic event.

## Avoidance

Symptoms of avoidance may include:

- Avoid talking about the traumatic event
- Avoid thinking about the traumatic event
- Avoiding activities, people or places that remind them of the traumatic event

## Negative changes in mood and thinking

Symptoms of negative changes in thinking and mood may include:

- Unable to experience positive emotions
- Negative feelings about themselves or other individuals
- Feeling numb (emotionally)
- Problems maintaining close relationships
- Lack of interest in activities they use to enjoy
- Feelings of hopelessness
- Experience memory problems, such as not remembering important details of the traumatic event.

## Changes in emotional reactions

Changes in emotional reactions (arousal symptoms) may include symptoms such as:

- Irritability,
- aggressive behavior
- angry outbursts
- Often being “on guard” for danger
- Experience overwhelming shame
- Experience overwhelming guilt
- Trouble concentrating
- Self-destructive behavior, such as drinking too much or driving too fast
- Experience problems sleeping
- Trouble sleeping
- Frightened easily

## Intensity of symptoms

Post-traumatic stress disorder (PTSD) symptoms can vary in intensity over time. The individual may have more Post-traumatic stress disorder (PTSD) symptoms when they are stressed, or when the individual is reminded of the traumatic events. The individual may hear the sound from a car backfire and relive the combat experience again.

The individuals should follow up with a physician if they are experiencing disturbing feelings and thoughts about a traumatic event for more than 1 month, that is severe and interfering with everyday life. The individual may feel like everything is out of control. It is best to get treatment as soon as possible to help prevent Post-traumatic stress disorder (PTSD) symptoms from getting worse.

**For individuals having suicidal thoughts**

Help is needed immediately.

Instruct / educate the individuals with Post-traumatic stress disorder (PTSD) symptom if they ever experience suicidal thoughts to:

- Call 911 or their local emergency number immediately if they think they may hurt themselves or attempt suicide.

- Call a suicide hotline number within the United States; call the National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255) to reach a trained counselor. Use that same number and press 1 to reach the Veterans Crisis Line.

- Make an appointment with the physician, mental health provider or other health care professional.

- Other resources such as: contacting a minister, a spiritual leader or someone in their faith community, and family and friend for support.

If the individual with Post-traumatic stress disorder (PTSD) symptom is in danger of committing suicide or has made a suicide attempt, someone has to stay with that person. Call 911 or the local emergency number immediately.

Take the person to the emergency room if it is safe to do so.

## Causes

Researchers and physicians are not sure why some individuals get Post-traumatic stress disorder (PTSD). It is probably caused by a complex mix as with most mental health problems.

Post-traumatic stress disorder (PTSD) is:

- Inherited mental health risks, for example an increased risk of depression and anxiety
- The way the brain regulates the hormones and the chemicals the body releases in response to stress
- Life experiences, such as the amount and severity of trauma the individual has experienced since childhood
- Inherited aspects of his/ her personality

People of all ages can experience post-traumatic stress disorder. However, some factors may make an individual more likely to develop Post-traumatic stress disorder (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 risk of being exposed to traumatic events, for example first responders, and military personnel
- Having other mental health problems, such as anxiety or depression
- Not having a good support system of family and /or friends
- Having biological (blood) relatives with mental health problems.

**Kinds of traumatic events**

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 Post-traumatic stress disorder (PTSD), such as:

- Natural disaster,
- Fire,
- Mugging,
- Torture,
- Robbery,
- Car accident,
- Plane crash,
- kidnapping,
- life-threatening health problems /diagnosis etc.

Having Post-traumatic stress disorder (PTSD) also may increase the risk of other mental health problems, such as:

- Depression
- Anxiety
- Issues with drugs abuse
- Issues with alcohol use
- Eating disorders
- Suicidal thoughts
- Suicidal actions

## Diagnosis

Post-traumatic stress disorder is diagnosed based on signs and symptoms and a thorough psychological evaluation.

The health care provider will ask the individual to describe the signs and symptoms and events that led to them.

A physical exam may also be completed to check for medical problems.

To be diagnosed with Post-traumatic stress disorder (PTSD) the individual has to meet criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association.

Diagnostic and Statistical Manual of Mental Disorders criteria for PTSD

Diagnosis of PTSD requires exposure to an event that involved or held the threat of death, violence or serious injury. The exposure can happen in 1 or more of these ways:

- The individual experienced the traumatic event
- The individual witnessed, in person, the traumatic event
- The individuals learned someone close to them experienced or was threatened by the traumatic event
- The individual is repeatedly exposed to graphic details of traumatic events.

The individual experienced 1 or more of the following signs or symptoms after the traumatic event the individual:

- Relive experiences of the traumatic event, such as experiences distressing images and memories.
- Experiences disturbing/ upsetting dreams about the traumatic event.
- Experiences flashbacks as if experiencing the traumatic event again.
- Experience ongoing or severe emotional distress or physical symptoms if something reminds you of the traumatic event.

In addition, for more than 1 month after the traumatic event the individual may:

- Try to avoid situations or things that remind them of the traumatic event
- Not remember important parts of the traumatic event
- View themselves, or others and the world in a negative way
- Loses interest in activities they used to enjoy
- Feel detached from their family and friends
- Experience emotional numbness,
- Feel irritable or have violent or angry outbursts
- Engage in dangerous or self-destructive behavior
- Feel as if they are constantly on guard or alert for signs of danger
- startle easily
- Have trouble sleeping or
- Have trouble concentrating

The symptoms cause significant distress in their life or interfere with their ability to go about their normal daily tasks.

For children younger than 6 years old, signs and symptoms may include:

- Frightening dreams (that may or may not have aspects of the traumatic event)
- Reenacting the traumatic event through play (or aspects of the traumatic event).

# Treatments

The primary treatment is psychotherapy, and often includes medication. The Combination of psychotherapy and medication treatments can;

- Help improve the symptoms,
- teach skills to address the symptoms,
- help the persons feel better about themselves and also learn ways to cope if any symptoms arise again.

Psychotherapy and medications can also help you if you've developed other problems related to the traumatic experience, such as depression, anxiety, or misuse of alcohol or drugs.

# Psychotherapy

Some types of psychotherapy used in Post-traumatic stress disorder (PTSD) treatment include:

**Cognitive therapy**

This type of talk therapy helps the person recognize the ways of thinking (cognitive patterns) that are keeping them fro moving forward. For Post-traumatic stress disorder (PTSD) cognitive therapy often is used along with exposure therapy.

**Exposure therapy**

This behavioral therapy helps the person safely face what he/ she finds frightening so that you can learn to cope with it effectively. One approach to exposure therapy uses virtual reality programs that allow the individual to re-enter the setting in which he/she experienced the trauma.

**Eye movement desensitization and reprocessing (EMDR)**

Eye movement desensitization and reprocessing (EMDR)**,** combines exposure therapy with a series of guided eye movements that help the individuals process traumatic memories and change how they react to traumatic memories.

The individual may try;

- Individual therapy,
- Group therapy or
- both.

Group therapy is an excellent way to connect and meet with others who are experiencing similar issues.

# MEDICATIONS

Several types of medications can help improve symptoms of PTSD:

**Antidepressants**

These medications can help symptoms of depression and anxiety. They can also help improve sleep problems and concentration.

- The selective serotonin reuptake inhibitor (SSRI) medications sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration (FDA) for PTSD treatment.

**Anti-anxiety medications**

These medications also can improve feelings of anxiety and stress for a short time to relieve severe anxiety and other related problems. Because these medications have the potential for abuse, they are not usually taken for a long period of time.

**Prazosin**

If symptoms include insomnia or recurrent nightmares, a medication called prazosin (Minipress) may help. Although not specifically FDA-approved for Post-traumatic stress disorder (PTSD) treatment, prazosin may reduce or suppress nightmares in many individuals with Post-traumatic stress disorder (PTSD).

Patient may see an improvement in their mood and other symptoms within a few weeks.

**EDUCATE THE PATIENT**

Instruct the patient to contact the physician / health care professional about any side effects or problems with medications. He/ she may need to try more than one or a combination of medications, or the physician/ health care practitioner may need to adjust the dosage or medication schedule before finding the right regimen.

# DEPRESSIVE BEHAVIOR

**TEEN DEPRESSION**

Teen depression is a serious medical problem that leads to a persistent feeling of sadness; the teen has loss of interest in activities. Teen depression affects how the teen behaves, thinks, and feels.

Teen depression can cause:

- Emotional problems
- Functional problems and
- Physical problems.

Mood disorders, for example depression, can occur at any time in life; however the symptoms may be different between teens and adults.

The teens are faced with issues such as:

- Peer pressure,
- Academic expectations

- changing bodies

These issues can bring a lot of ups and downs for the teen. But for some teens, the lows are more than just temporary feelings; they are symptoms of depression. Teen depression can have very serious consequences which require long term treatment.

Frequently teens who are experiencing depression symptoms, show improvement with treatment such as:

- Medication and
- Psychological counseling.

## Teen depression Signs and Symptoms

Teen depression signs and symptoms include changes in the teen's emotions and behavior, for example;

**Emotional changes**

Watch for emotional changes, such as:

- Feelings of sadness, which may include crying spells for no obvious reason
- Irritability,
- Frustration
- Feelings of anger ( over small matters etc)
- Loss of interest in normal activities
- Conflicts with family and/ or friends
- Feelings of worthlessness,
- Feelings of guilt,
- Fixation on past failures
- Exaggerated self-criticism or self-blame
- Extreme sensitivity to failure or rejection
- Need for reassurance (excessive)
- Trouble thinking/ concentrating,
- Trouble making decisions

- Trouble remembering things
- Sense that life and the future are bleak
- Frequent thoughts of death
- Frequent thoughts of dying
- Frequent thoughts of suicide

**Behavioral changes**

Monitor for changes in behavior, for example:

- Tiredness / loss of energy
- Insomnia
- Sleeping too much
- Changes in appetite, such as decreased appetite, weight loss, or increased food intake and weight gain
- Use of alcohol and /or drugs
- Agitation / restlessness  such as pacing, or inability to sit still
- Slow thinking,
- Slow speaking
- Slow body movements
- Frequent complaints of unexplained headaches or body aches
- Poor performance at school
- Frequent absences from school
- Neglected appearance  for example dressed in mismatched clothing or unkempt appearance, messy hair
- Disruptive behavior
- Risky behavior
- Self-harm, for example or excessive piercing, cutting, burning, or excessive tattooing

## Identify Difference

It may be difficult to identify the difference between the regular behaviors (ups and downs) that are just part of being a teenager and the behaviors that reflects teen depression. Talk with the teen.

Try to determine whether the teen seems capable of handling challenging feelings, or if life seems to be overwhelming.

If depression symptoms continue and / or begin to interfere in the teen's life, follow up with the physician or a mental health professional trained to work with adolescents.

## Suicidal thoughts

If the teen is having suicidal thoughts;

Take all talk of suicide seriously.

Call a suicide hotline number (in the United States, call the National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255) to reach a trained counselor).

### TEACH PARENTS / TEENS

Seek help from the physician, a mental health provider or other health care professional.

Reach out to family members,

Reach out to friends

Reach out to spiritual leaders for support and seek treatment.

# ALERT !!

If the teen is in immediate danger of self-harm or attempting suicide:

- Make sure someone stays with the teen.

- Call 911 or the local emergency number immediately.
- Take the teen to the nearest hospital emergency department if this can be done safely.

# Causes of Depression

Researcher / physicians are not sure exactly what causes depression. However several factors may be involved. These factors include:

**Biological chemistry**

Neurotransmitters are naturally occurring chemicals in the brain; they may play a role in depression. When these neurotransmitters are out of balance, it may lead to depression symptoms.

**HORMONES**

Changes in the body's balance of hormones may also be involved in triggering or causing depression.

**Inherited traits**

Depression is more common in individuals whose biological relatives also have the condition.

**Early childhood trauma**

Traumatic events during childhood, for example, physical abuse, emotional abuse, or loss of a parent, may cause changes in the brain that make the individual /teen more susceptible to depression.

**Learned patterns of negative thinking**

Teen depression may be associated with learning to feel helpless rather than learning to feel capable of finding solutions for challenges in life.

## Factors that increase the risk of developing teen depression

Many factors increase the risk of triggering or developing teen depression, such as:

Experiencing issues that negatively impact self-esteem, for example;

- Problems with peers
- Obesity,
- Long term bullying
- Academic problems

Have been the victim of violence; for example physical or sexual abuse.

Have witnessed violence

Being a female; depression occurs more often in females than in males

Have conditions such as learning disabilities, anxiety disorder, anorexia, bulimia, or attention-deficit/hyperactivity disorder (ADHD).

Have a chronic medical problem for example, diabetes, cancer or asthma

Have few friends

Have certain personality traits, for example low self-esteem, being overly dependent, pessimistic or self critical

Abusing nicotine, alcohol or other drugs.

Family history and issues with family or others may also increase the teen's risk of depression:

- Having a parent, grandparent or other biological relative with depression, alcoholism, or bipolar disorder
- Have a dysfunctional family and conflicts
- Have a family member who committed suicide
- Experienced a recent stressful life events, for example the death of a loved one, parental divorce, parent in military service.

## UNTREATED DEPRESSION

Untreated depression can result in emotional, behavioral and health problems that affect every area of the teen's life.

Possible complications related to teen depression may include:

- Low self-esteem
- Alcohol abuse
- Drug abuse
- Problems with school (academic)
- Conflicts with family
- Difficulties with relationships
- Social isolation
- Suicide
- Frequently involved with the juvenile justice system

# TESTS

The healthcare practitioner/ physician will do some exams and tests.

**Physical exam**

The physician may do a physical examination and ask in-depth questions about the teen's health to determine what might be causing the depression. Sometimes, depression may be associated with an underlying medical/ physical health problem.

## Laboratory tests

The teen's physician may order a blood test such as a complete blood count (CBC) or test the teen's thyroid to make sure it is functioning properly.

## Psychological evaluation

This evaluation will include a discussion with the teen about feelings, thoughts, behavior, and may involve a questionnaire. The evaluation tools will help to check for related complications and assist with the diagnosis.

### DIAGNOSTIC CRITERIA FOR DEPRESSION

To be diagnosed with depression, the teen has to meet the symptom criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. This manual is used by the mental health providers to diagnose mental conditions and also by the insurance companies to reimburse for treatment.

Symptoms can be based on the teen's feelings or on someone else observations.

For a diagnosis of major depression the following symptoms must occur ;

- most of the day,
- nearly every day,
- during at least a two-week period,
- and be a change or worsening in the teen's usual behavior and attitude;

## The teen must have <u>at least one</u> of the following:

- Depressed mood, for example feeling sad, tearful, empty or irritable; in the teen, depressed mood can appear as constant irritability,
- Decreased interest or reduced feeling; no pleasure in most or any activities

## The teen must also have <u>four or more</u> of the following:

- Significant weight loss (not dieting),
- Significant weight gain, or increased or decrease in appetite; in teens
- increased desire to sleep or
- Insomnia
- Restlessness behavior that is observed by others
- Slowed behavior that is observed by others
- loss of energy / Fatigue
- Feeling of worthlessness
- Excess guilt
- Inappropriate guilt
- Problems making decisions,
- Problems thinking /or concentrating
- Frequent thoughts of death or suicide (recurrent) , making suicide plans or suicide attempt.

## To be considered major depression:

- Symptoms are not due to a mixed episode; (which is mania along with depression that sometimes occurs as a symptom of bipolar disorder),
- Symptoms must be severe enough to cause noticeable problems in daily activities, such as social, school activities or relationship with other individuals,
- Symptoms are not due to the direct effects of something else; for example drug abuse, having a medical condition for example hypothyroidism, or taking a medication,
- Symptoms are not caused by grieving, for example temporary sadness after the loss of a loved one.

# ANTIDEPRESSANTS

The Food and Drug Administration (FDA) is a federal agency of the United States Department of Health and Human Services. The FDA has approved two antidepressants for the treatment of depression in children and teenagers :

- Fluoxetine (Prozac) for age 8 or older, and
- Escitalopram (Lexapro) for age 12 or older.

The Food and Drug Administration has approved Fluoxetine (Prozac) to treat Obsessive-compulsive disorder (OCD) in children, also the antidepressants sertraline (Zoloft), fluvoxamine (Luvox) and clomipramine (Anafranil).

The physician may use their medical judgment to prescribe other antidepressants for children, for example citalopram (Celexa), referred to as off-label use.

With the antidepressants, a medication guide is included that advises parents, patients and caregivers about the risks and the precautions.

## INSTRUCT PARENT /TEENS, PATIENTS

To carefully read the medication guide and package insert, and discuss any questions with the health care professionals.

## CHILDREN AND ANTIDEPRESSANT

The Food and Drug Administration (FDA) advises that physicians prescribe the smallest amount of pills possible to help to reduce the risk of overdose (deliberate or accidental).

## THE FIRST FEW MONTHS OF TREATMENT

Careful monitoring is required by;

- Parents,
- Caregivers and
- Health care professionals

The first few months of treatment careful monitoring is very important for any child or teen taking an antidepressant for depression and/ or any other conditions.

When taking an antidepressant the highest risk of suicidal behavior and thinking occurs:

- During the first few months of treatment
- When the dosage is increased or decreased

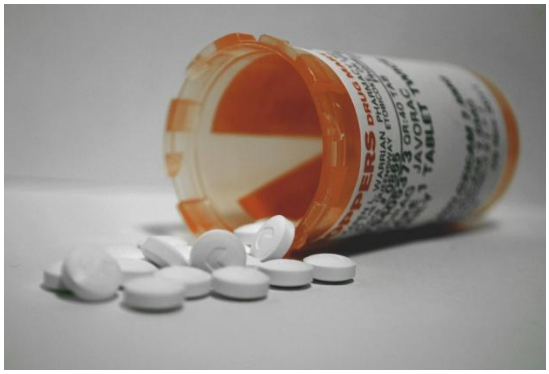
Parents and caregivers need to closely monitor /observe the child daily during these transition periods and watch for troublesome changes for the whole time the child takes the antidepressants.

The Food and Drug Administration (FDA) also recommends that the child receive close monitoring by the health care professional during the first few months of treatment.

Frequency of contact with mental health professionals or the physician depends on the child's needs.

## INSTRUCT PARENT /PATIENT

To keep all child's recommended appointment schedule.



**Warning signs to watch for when the child is taking antidepressants**

The signs and symptoms of suicidal thoughts and/ or self-harm are sometimes very difficult to see. The child may not share his / her thoughts with anyone. The following are some signs that the child's condition may be worsening or that he or she may be at risk of self-harm:

- Conversation regarding dying or suicide
- Suicide attempts
- Increase sadness
- Restlessness
- Self injury
- Agitation
- Panic attacks
- Academic problems at school
- Spending much more time alone
- Social problems
- Excessive talking ( increase ) or activity
- Aggression

- Violence and /or hostility
- Anxiety

## INSTRUCT PARENTS /CAREGIVERS AND PATIENTS

- Do NOT stop the antidepressant treatment without guidance of the child's health care professional.

- Suddenly stopping the antidepressant may cause flu-like symptoms or side effects known as discontinuation syndrome.

## OTHER TREATMENT OPTIONS FOR CHILDREN WITH DEPRESSION

Most of the time, children who take antidepressants show improvement with medication treatment. A combination of medication and psychotherapy (talk therapy) is most likely to be more effective.

Several types of therapy can be helpful, however;

- Cognitive behavioral therapy and interpersonal therapy have proven to be effective in the treatment of depression.

**Cognitive behavioral therapy**

In cognitive behavioral therapy, the mental health provider can help the child improve;

- coping skills,
- communication skills and
- problem solving skills.

The child will also learn about behaviors and ideas that are harmful and learn how to replace them with positive approach, and learn how to regulate emotions. Cognitive behavioral therapy can be effective with children and also teenagers.

### Interpersonal therapy

Interpersonal therapy focuses on relationships. This type of therapy may help the teen adapt to the changes in his/ her current relationships and how to develop new ones.

Talk therapy (interpersonal therapy) alone, may be beneficial for some children with mild symptom.

If antidepressant treatment does not work well, the physician may recommend a blood test (cytochrome P450 - CYP450) to check for the specific genes that are affecting how the body processes the antidepressant. There is a possibility that this may help to identify which antidepressant might be a the best choice. The genetic tests, however, may have some limitations and may not be available in all locations.

## Other types of major depression include:

### Atypical depression

In this type of depression, some signs and symptoms may include:

- Weight gain,
- Increased hunger,

- Excessive sleeping,
- Feeling of heaviness in the arms and Lower extremities
- Difficulty with maintaining relationships.

### Postpartum depression

This type of depression is sometimes seen after the women give birth. It may occur shortly after delivery or may begin several weeks later.

Signs and symptoms may last long and maybe very intense, and eventually affects the ability to care for the baby, or self and handle other activities.

### Psychotic depression

This is when the individual has severe depression that is accompanied by psychotic symptoms, such as delusions or hallucinations.

### Dysthymia

This form of depression is less severe, but more long-term. It is usually not disabling, but dysthymia may prevent the individuals / teens from functioning normally in their day to day routine.

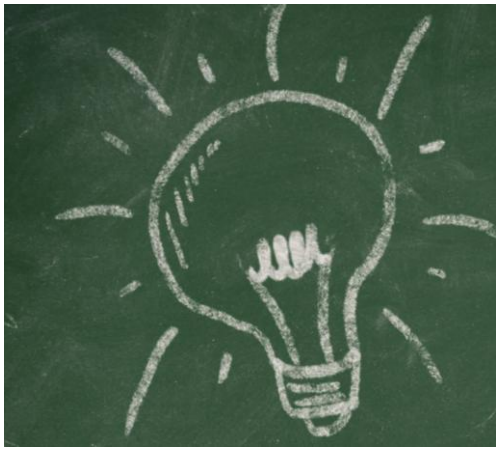
## BORDERLINE PERSONALITY

Borderline personality disorder (BPD) is a serious mental illness marked by unstable moods, behavior, and relationships.

The *Diagnostic and Statistical Manual for Mental Disorders, 3rd Edition* (DSM-III) listed Borderline personality disorder (BPD) as a diagnosable illness for the first time in 1980.

Psychiatrists and other mental health professionals utilize the *Diagnostic and Statistical Manual for Mental Disorders* to diagnose mental illnesses.

Some individuals with severe Borderline personality disorder (BPD) experience brief psychotic episodes, therefore, experts originally thought of BPD as atypical, or borderline, versions of other types of mental disorders.



Most individuals who have a diagnosis of Borderline personality disorder (BPD) suffer from:

Problems regulating their thoughts

Problems regulating their emotions

Reckless behavior

Impulsive behavior

Unstable/ difficult relationships with others

Individuals with Borderline personality disorder (BPD) disorder also have high rates of other disorders occurring at the same time such as:

- Anxiety disorders, eating disorders, depression, substance abuse along with self-harm, suicidal behaviors, and completed suicides.

## Causes of Borderline personality disorder (BPD)

Research on the possible causes and risk factors for Borderline personality disorder (BPD) is still in the early stage. Scientists and researchers generally agree that genetic factors and / or environmental factors are likely to be involved.

There have been studies completed on twins with Borderline personality disorder (BPD) that suggest that BPD is strongly inherited. Another study has shown that the individuals can inherit their temperament and other personality trait, such as aggression and impulsiveness.

The scientists are investigating/ studying genes that help to regulate the emotions and impulse control for any possible connections to BPD.

Social factors or cultural factors may increase the risk for Borderline personality disorder (BPD), such as being a part of a culture in which difficulties in the family or unstable family relationships are common; this may increase the individual's risk for the disorder. poor judgment , impulsiveness, hasty poor decisions in lifestyle choices, and other consequences of Borderline personality disorder may lead individuals to dangerous situations. Adults with borderline personality disorder (BPD) are considerably more likely to be the victim of violence.

### Signs & Symptoms

According to the DSM, 4th Edition, Text Revision (DSM-IV-TR), to be diagnosed with borderline personality disorder, an individual must show an enduring pattern of behavior that includes at least 5 of the following symptoms:

- Extreme reactions such as panic, rage, depression or frantic actions; to abandonment, whether perceived or real
- A pattern of stormy and intense relationships with friends, family and loved ones, often veering from extreme closeness and love; idealization, to extreme dislike or anger; devaluation
- Unstable and distorted self-image or sense of self, which may result in sudden changes in opinions, feelings, values, or plans and goals for future for example school or career choices,
- Dangerous and Impulsive behaviors, for example substance abuse, binge eating, spending sprees, unsafe sex and reckless driving,
- Recurring self-harming behavior such as cutting self or frequent suicidal behaviors or threats,

- Intense, highly changeable moods, with each episode may last from a few hours to a few days
- Chronic feelings of boredom and /or emptiness
- Inappropriate, intense anger or
- Problems controlling their anger
- Having stress-related paranoid thoughts or severe dissociative symptoms, for example; feeling cut off from oneself, observing oneself from outside the body, or losing touch with reality.

**Self-harm and Suicide**

As many as 80% of individuals with borderline personality disorder (BPD) have suicidal behaviors, and about 4 to 9 % commit suicide.

Some self-injurious behavior includes:

- suicide attempts
- self-harming behaviors
- Suicide

Some treatments can help reduce suicidal behaviors in people with borderline personality disorder (BPD). For example, one study showed that dialectical behavior therapy (DBT) reduced suicide attempts in women by 1/2 compared with other types of psychotherapy, or talk therapy.

Dialectical behavior therapy reduces the use of emergency room and inpatient services and has retained more participants in therapy, compared to other therapies.

## SELF-HARMING BEHAVIORS

Self harming behaviors do not stem from the desire to die; like suicide attempts, but self-harming behaviors may be life threatening.

Self-harming behaviors linked with borderline personality disorder (BPD) may include:

- cutting,
- burning,
- hitting,
- head banging, hair pulling,
- other harmful acts.

Individuals with borderline personality disorder (BPD) may self-harm ; to help regulate the emotions, to express their pain or , to punish themselves.

According to data from participants in a national survey on mental disorders, about 1.6 % of adults in the United States have borderline personality disorder (BPD) in a given year. Borderline personality disorder (BPD) usually begins during adolescence or early adulthood. Some studies suggest that early symptoms of the illness can occur during childhood.

## Diagnosing Borderline personality disorder (BPD)

Borderline personality disorder (BPD) is often under - diagnosed or misdiagnosed.

A mental health professional who is experienced in diagnosing and treating mental disorders can detect Borderline personality disorder (BPD) based on a thorough interview and a discussion about symptoms; such as a:

- Psychologist,
- Psychiatrist,
- Psychiatric nurse or
- clinical social worker

A thorough and careful medical examination can help to rule out other possible causes of the symptoms.

A mental health professional may ask about;

- The symptoms
- Personal medical history,
- Family medical history,
- Any history of mental illnesses.

This information will help the mental health professional decide on the most appropriate treatment. At times, other mental illnesses that occur at the same time may introduce symptoms that overlap with Borderline personality disorder (BPD). This makes it very difficult to distinguish the borderline personality disorder from other mental illnesses.

## WOMEN AND MEN

According to survey reports women with Borderline personality disorder (BPD) are more likely to have co-occurring disorders for example:

- Major depression,
- Anxiety disorder, and /or
- Eating disorders.

In men, Borderline personality disorder (BPD) is more likely to co-occur with other disorders such as:

- Substance abuse and /or
- Antisocial personality disorder.

According to the largest national study to date of mental disorders in U.S. adults; the NIMH-funded National Co-morbidity Survey Replication, about 85 % of individuals with Borderline personality disorder (BPD) also meet the diagnostic criteria for another mental illness.

Other health disorders /illnesses that often occur with Borderline personality disorder (BPD) include:

- High blood pressure,
- Arthritis,
- Diabetes,
- Chronic back pain, and
- Fibromyalgia.

These illnesses /conditions are often associated with obesity, which is a common side effect of the medications prescribed to treat Borderline personality disorder and other mental disorders.

There is no single test that can diagnose Borderline personality disorder. Scientists who are funded by the National Institute of Mental Health (NIMH) are investigating / seeking ways to improve diagnosis of Borderline personality disorder.

One study found that adults with Borderline personality disorder (BPD) showed excessive emotional reactions when they looked at words with unpleasant meanings, compared with healthy individuals. Individuals with more severe Borderline personality disorder showed more intense emotional response than the people who had less severe Borderline personality disorder.

## Treatments

Borderline personality disorder (BPD) is often viewed as difficult to treat. Research has shown that Borderline personality disorder can be treated effectively, and that many individuals with BPD show improvement over time. Borderline personality disorder (BPD) can be treated with psychotherapy (talk therapy).

Sometimes a mental health professional may also recommend the use of medications to treat some symptoms. When the individual is under the care of more than one professional, it is very important for the professionals to coordinate with one another on the treatment plan.

Some treatment options that may be available to the individual with Borderline personality disorder include:

### PSYCHOTHERAPY

Psychotherapy is often the first treatment for individuals with Borderline personality disorder. Research suggests that psychotherapy can relieve some symptoms, but more studies are needed to understand more about how well / effective the psychotherapy is.

It is important that the individual in therapy trust their therapist. The very nature of Borderline personality disorder can make it very difficult for the individuals with BPD to maintain this type of bond with the therapist.

Types of psychotherapy used to treat Borderline personality disorder include:

## Cognitive behavioral therapy (CBT)

Cognitive behavioral therapy can help individuals with Borderline personality disorder to:

- Identify and help to change behaviors and / or core beliefs that underlie incorrect perceptions of themselves and others and the problems they experience interacting with others.

- Cognitive behavioral therapy may also help to reduce a variety of mood and anxiety symptoms and reduce the amount of suicidal and /or self-harming behaviors.

## Dialectical behavior therapy (DBT)

Dialectical behavior therapy focuses on being aware of (mindfulness) and attentive to the current situation. Dialectical behavior therapy teaches the skills to control intense emotions, reduces self-destructive behaviors, and improves relationships. This therapy differs from Cognitive behavioral therapy in that it seeks a balance between changing and accepting behaviors and beliefs.

## SCHEMA-FOCUSED THERAPY

Schema-Focused Therapy combines elements of Cognitive behavioral therapy with other forms of psychotherapy that focus on reframing schemas, or the ways individuals see (view) themselves.

The approach is based on the idea that Borderline personality disorder stems from a dysfunctional self-image, that was possibly brought on by some negative childhood

experiences, which affects how the individual reacts to his/ her environment, interact with others, and cope with stress or problems.

Therapy can be provided between the therapist and the patient (one-on-one) or in a group setting. Therapist-led group sessions may help teach the individual with Borderline personality disorder how to interact with others and teaches them how to effectively communicate or express themselves.

Systems Training for Emotional Predictability and Problem Solving (STEPPS), one type of group therapy, is designed as a relatively brief treatment consisting of 20 two-hour sessions led by an experienced social worker.

Scientists funded by National Institute of Mental Health (NIMH) reported that STEPPS, when used with other types of treatment such as medications or individual psychotherapy, can help to improve quality of life, reduce symptoms and problem behaviors of Borderline personality disorder, and relieve symptoms of depression.

Some families of individuals with Borderline personality disorder may also benefit from therapy. They are faced with the challenges of interacting with a relative who is ill. The day to day interactions can be stressful, and the family members may not be aware that their actions may also worsen their relative's symptoms.

Some therapies, such as Dialectical behavior therapy Family Skills Training (DBT-FST), include family members in treatment sessions. These programs can help families develop the skills needed to better cope, understand and support the relative with Borderline personality disorder.

Other therapies, for example Family Connections, focus on the needs of the family members. More research is needed to determine the effectiveness of family therapy in Borderline personality disorder. Studies with other mental disorders do suggest that when the family is included this can help in the individual's treatment.

Some symptoms of Borderline personality disorder may come and go, but the core symptoms of intense anger, changes in mood and impulsiveness; these have a tendency to be more persistent.

Individuals whose symptoms improve may continue to face challenges and issues related to co-occurring disorders, for example post-traumatic stress disorder or depression. Research has suggested that relapse, or the recurrence of full-blown symptoms after remission, is not common (very rare). One study revealed that 6 % of individuals with Borderline personality disorder had a relapse after remission.

## MEDICATIONS

No medications have been approved by the U.S. Food and Drug Administration to treat Borderline personality disorder. Only a few studies show that medications are necessary or effective for individuals with BPD.

Many individuals with Borderline personality disorder are also treated with medications in addition to psychotherapy. The medication does not cure Borderline personality disorder, some medications can be helpful in managing specific symptoms. For some individuals, medications can help reduce symptoms such as depression, anxiety, and / or aggression. Most of the time, individuals are treated with several medications at the same time, but there is little evidence that this regimen is necessary or effective.

### OTHER TREATMENTS

Omega-3 fatty acids

One study that was completed on thirty women with Borderline personality disorder showed that omega-3 fatty acids may help reduce symptoms of depression and aggression. The treatment seemed to be as well tolerated as commonly prescribed mood stabilizers and had few side effects. Fewer women who took omega-3 fatty acids dropped out of the study, compared to women who took a sugar pill or placebo.

With proper treatment many individuals experience less severe and fewer symptoms. Many factors may affect the amount of time it takes for the symptoms to improve, therefore it is important for the individuals with Borderline personality disorder to receive the appropriate support during treatment.

# SUSPICOUS BEHAVIOR

Paranoid personality disorder (PPD) is one of a group of conditions called Cluster A personality disorders which involve odd / eccentric ways of thinking.

**Paranoia**

Paranoia refers to the perception or suspicion that others have aggressive or hostile motives in interacting with them, when in fact there is no reason for the suspicions.

Individuals who are experiencing paranoia believe that people are persecuting them and have delusional ideas about themselves as primary figures in scenarios when in reality have little relevance to them.

Minor feelings of paranoia are common, but severe paranoia can lead to significant fear and anxiety and can have a pronounced effect on social functioning.

Feelings of paranoia are often observed with many psychological disorders, such as:

- schizophrenia,
- Many medical diseases, such as Alzheimer's disease, multiple sclerosis that can affect brain function.

**Symptoms of Paranoid Personality Disorder**

Individuals Paranoid Personality Disorder are always on guard. They often believe that others are constantly trying to harm or threaten them. These generally unfounded beliefs, as well as their habits of distrust and blame, might interfere with their ability to form close relationships.

Individuals with Paranoid Personality Disorder:

- Are reluctant to reveal personal information because of fear that the information will be used to hurt them or used against them
- Are often unforgiving
- Hold grudges
- Are hypersensitive
- Take criticism poorly
- Are reluctant to confide in others
- Read hidden meanings in the innocent remarks or casual looks of others
- Have suspicions, without reason, that their spouses are being unfaithful
- Doubt the loyalty, commitment or trustworthiness of others (believes that others are deceiving or using them)
- Hostile

- Stubborn
- Argumentative
- Perceive attacks on their character that are not apparent to others (they generally react with anger and quick to retaliate)
- Cannot see their role in problems or conflicts and believe they are always right
- Have difficulty relaxing
- Cold in their relationships with others,
- Sometimes controlling, jealous in their relationships with others,
- Distant in their relationships with others.

## Causes Paranoid Personality Disorder

The exact cause of Paranoid Personality Disorder is not known, but a combination of psychological and biological factors are most likely to be involved. The fact that Paranoid Personality Disorder is more common in individuals who have close relatives with schizophrenia suggests a genetic link between the 2 disorders. Early childhood experiences, such as physical or emotional trauma, are also suspected to play a role in the development of Paranoid Personality Disorder.

### Diagnosing Paranoid Personality Disorder

If physical symptoms are present, the physician will begin an evaluation by performing a complete medical and psychiatric history and physical exam. Although there are no laboratory tests to specifically diagnose personality disorders, the physician might use various diagnostic tests to rule out physical illness as the cause of the symptoms.

If the physician finds no physical reason for the symptoms, he or she might refer the patient to a psychologist, or psychiatrist, health care professionals who have special training to be able to diagnose and treat mental illnesses. The psychologists and the psychiatrists use specially designed interview and assessment tools to evaluate a individual for a personality disorder.

# TREATMENT

Individuals with Paranoid Personality Disorder often do not seek treatment on their own because they do not think that they have a problem. Psychotherapy is the treatment of choice for Paranoid Personality Disorder.

Treatment will focus on:

- Increasing coping skills,
- Improving social interaction,
- Improving communication, and
- Improving self-esteem.

Trust is an important factor of psychotherapy, therefore treatment is challenging because individuals with Paranoid Personality Disorder do not trust others. Many individuals with Paranoid Personality Disorder will not follow their treatment plan.

Medication generally is not a major focus of treatment for Paranoid Personality Disorder. However, medications, such as anti-anxiety, antidepressant or anti-psychotic drugs, may be prescribed if the patient's symptoms are severe, or if the patient also suffers from an associated psychological problem, for example depression or anxiety.

## Complications Associated With Paranoid Personality Disorder

The thinking and behaviors associated with Paranoid Personality Disorder can interfere with a patient's ability to maintain relationships, as well as their ability to function socially and in work situations. In many cases, patients with Paranoid Personality Disorder become involved in legal battles, suing companies or individuals they believe are after them to cause harm to them (out to get them).

Outlook for the patients with Paranoid Personality Disorder varies. It is a chronic disorder, which means it tends to last throughout the individual's life. Although some individual can function fairly well with Paranoid Personality Disorder and they are able to have careers and marriage, others can be completely disabled by the disorder. Because patients with Paranoid Personality Disorder tend to resist treatment, the outcome often is poor.

Patients/ individuals with dependent personality disorder typically shows:

- Indecisiveness
- Submissive behavior
- Clinging behavior

# SCHIZOPHRENIA

Schizophrenia is a severe brain disorder in which individuals interpret reality abnormally. Schizophrenia may result in some combination of:

- Hallucinations,
- Delusions, and
- Extremely disordered thinking and behavior.

Contrary to popular belief, schizophrenia is NOT a split personality or multiple personality. The word "schizophrenia" does mean "split mind," but it refers to a disruption of the usual balance of emotions and thinking.

Schizophrenia is a chronic condition, requiring lifelong treatment.

**SYMPTOMS**

In men, schizophrenia symptoms typically start in the early to mid-20s. In women, symptoms typically begin in the late 20s. It is uncommon for children to be diagnosed with schizophrenia and rare for those older than 45.

Schizophrenia involves a range of problems with thinking (cognitive), behavior or emotions. Signs and symptoms may vary, but they reflect an impaired ability to function.

Symptoms may include:

## Delusions

These are false beliefs that are not based in reality. For example, the patients are being harmed, harassed, or comments are directed at them. Delusions occur in as many as 4 out of 5 patients with schizophrenia.

## Hallucinations

Hallucinations usually involve seeing or hearing things that do not exist. But for the individuals with schizophrenia, they have the full impact of a normal experience.

Hallucinations may be in any of the senses, but the most common hallucination is hearing voices.

### Disorganized thinking/ speech

Communication can be impaired, and answers to questions may be partially unrelated or completely unrelated. Speech may include putting words together that are meaningless; that cannot be understood (word salad).

### Extremely disorganized / abnormal motor behavior

This may be manifested in several ways; form childlike silliness to agitation. Behavior is not focused on a goal, which makes it hard to perform tasks. Abnormal motor behavior may include:

- Resistance to instructions,
- Inappropriate /bizarre posture,
- Complete lack of response, or
- useless and excessive movement.

**Negative symptoms**

Negative symptoms refer to the lack of ability or decreased ability to function normally. The individual appears to lack emotion, not making eye contact, speaking without inflection (monotone) or not adding hand or head movements that normally provide the emotional emphasis in speech. The individual may have a reduced ability to plan activities or carry out task such as neglecting personal hygiene, or have a loss of interest in day to day activities, lack of ability to experience pleasure or social withdrawal.

**Symptoms in teenagers**

Schizophrenia symptoms in teenagers are similar to the adults, but the condition may be more difficult to recognize in teenagers. Some of the early symptoms of schizophrenia in teenagers are common for typical development during the teen years, for example:

- Withdrawal from friends and family
- Decline in performance at school
- Difficulty sleeping
- Irritability
- Depressed mood
- Decreased or lack of motivation

Compared with schizophrenia symptoms in adults, teens may be:

- Less likely to have delusions
- More likely to have visual hallucinations

Individuals with schizophrenia are often not aware that their difficulties come from a mental illness that also requires some medical attention. Therefore the family or friends are the persons who have to get them some help.

## Suicidal thoughts and behaviors

Suicidal thoughts and behavior are common among individuals with schizophrenia.

Call 911 or the local emergency number immediately if the patient is in danger of committing suicide or has made a suicide attempt. Someone has to stay with that person. Take the patient to the nearest hospital emergency room, if it is safe to do so.

### CAUSES

It is not known what causes schizophrenia, but researchers believe that a

- combination of genetics and environment contributes to development of the disorder.

Problems with certain naturally occurring brain chemicals, such as:

neurotransmitters (dopamine and glutamate), also may contribute to schizophrenia. Neuro imaging studies show differences in the brain structure and central nervous system of individuals with schizophrenia. While researchers are not certain about the significance of these changes, they support evidence that schizophrenia is a brain disease.

## Risk factors

The exact cause of schizophrenia is not known, however certain factors seem to increase the risk of developing or triggering schizophrenia, such as:

- Having a family history of schizophrenia
- Exposure to toxins, viruses or malnutrition while in the womb, especially in the first and second trimesters
- Taking mind-altering (psychoactive or psychotropic) drugs during teen years and young adulthood
- Increased immune system activation, such as from inflammation and / or autoimmune diseases
- Older age of the father

**Complications**

If left untreated schizophrenia can lead to severe emotional, behavioral and health problems, and also legal, and /or financial problems that affect every area of life.

Some complications that schizophrenia may cause or be associated with include:

- Any type of self-injury
- Anxiety
- Phobias
- Depression
- Abuse of alcohol,
- Drug abuse
- prescription medications abuse
- Inability to attend school
- Inability to work
- Poverty
- Conflicts in the family
- Homelessness
- Social isolation
- Health problems, including those associated with antipsychotic medications,
- smoking
- poor lifestyle choices
- Being a victim of aggressive behavior
- Aggressive behavior,
- Suicide

## Tests and diagnosis

When the healthcare practitioners / physicians suspects that someone has schizophrenia, they will ask for medical history, psychiatric history conduct a physical examination, and complete medical and psychological tests, such as:

### TESTS AND SCREENINGS

Laboratory test such as complete blood count (CBC), and other blood tests may help rule out conditions with similar symptoms, and screening for drugs and alcohol. The physician may also request imaging studies, for example such as a CT scan or MRI.

### PSYCHOLOGICAL EVALUATION

The healthcare practitioners / physicians, or mental health provider will check mental status by observing the appearance, about mood, thoughts, delusions, substance abuse, hallucinations, and potential for violence or suicide.

### DIAGNOSTIC CRITERIA FOR SCHIZOPHRENIA

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

Diagnosis of schizophrenia involves ruling out other mental health disorders and determining that symptoms are not due to substance abuse, medication or a medical condition. In addition, the individual must have at least 2 of the following symptoms most of the time during a one-month period, with some level of disturbance being present over 6 months:

- Delusions
- Hallucinations
- Disorganized speech (indicating disorganized thinking)

- Extremely disorganized behavior
- Catatonic behavior, which can ranges from a coma-like daze to bizarre, hyperactive behavior
- Negative symptoms, which relate to reduced ability or lack of ability to function normally

At least one of the symptoms must be;

- Delusions,
- hallucinations or
- disorganized speech.

The patient shows a significant decline in the ability to work, attend school or perform normal day to day tasks most of the time.

**Treatments**

Schizophrenia requires lifelong treatment, even when symptoms have subsided. Treatment with:

- Medications and
- Psychosocial therapy

can help manage the condition.

During times of severe symptoms (crisis periods), hospitalization may be needed to ensure safety, adequate sleep, basic hygiene and proper nutrition.

A psychiatrist who is experienced in treating schizophrenia usually guides treatment. The treatment team may include a psychiatric nurse, psychologist, social worker and a case manager to coordinate care.

# MEDICATIONS

Medications are the cornerstone of schizophrenia treatment. However, because medications for schizophrenia can cause serious but rare side effects, people with schizophrenia may be reluctant to take them.

Antipsychotic medications are the most commonly prescribed drugs to treat schizophrenia. They're thought to control symptoms by affecting the brain neurotransmitters dopamine and serotonin.

Willingness to cooperate with treatment may affect medication choice. Someone who is resistant to taking medication consistently may need to be given injections instead of taking a pill. Someone who is agitated may need to be calmed initially with a benzodiazepine such as lorazepam (Ativan), which may be combined with an antipsychotic.

**Atypical antipsychotics**

These newer, second-generation medications are generally preferred because they pose a lower risk of serious side effects than do conventional medications. They include:

- Aripiprazole (Abilify)

- Asenapine (Saphris)
- Clozapine (Clozaril)
- Iloperidone (Fanapt)
- Lurasidone (Latuda)
- Olanzapine (Zyprexa)
- Paliperidone (Invega)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Ziprasidone (Geodon)

**Conventional, typical, antipsychotics**

These first-generation medications have frequent and potentially significant neurological side effects, including the possibility of developing a movement disorder (tardive dyskinesia) that may or may not be reversible. This group of medications includes:

- Chlorpromazine
- Fluphenazine
- Haloperidol (Haldol)
- Perphenazine

The antipsychotics are often cheaper than the newer counterparts, especially the generic versions, which can be an important consideration when long-term treatment is necessary.

It may take several weeks after first starting the medication to notice an improvement in symptoms.

The goal of treatment with antipsychotic medications is to effectively control the signs and symptoms at the lowest possible dosage. The psychiatrist may try different medications, different dose or combinations over time to achieve the desired effects. Other medications also may help, such as antidepressants or anti-anxiety medications.

## Psychosocial interventions

When psychosis recedes, psychological and social (psychosocial) interventions are important in addition to medication treatment. These may include:

**Individual therapy**

Learning to cope with stress and identify early warning signs of relapse can help individual with schizophrenia manage their illness.

**Social skills training**

Social skills training focus on improving interactions, communication and social interactions.

**Family therapy**

Family therapy provides support and education to families dealing with schizophrenia.

**Vocational rehabilitation and supported employment**

This focuses on helping individuals with schizophrenia to prepare for, find and keep jobs.

# Delusion of Grandeur

Delusion of Grandeur is the fixed, false belief that one possesses superior qualities such as fame, genius, omnipotence, or wealth. It is most often a symptom of schizophrenia, but can also be a symptom found in psychotic or bipolar disorders, and also dementia such as Alzheimer's disease.

Delusion of Grandeur reflects the belief that one is highly famous and important.

## SUBSTANCE USE DISORDER

**OTHER DRUGS** tobacco, cannabis (marijuana), stimulants, hallucinogens, and opioids.

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual.

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

## Alcohol Use Disorder (AUD)

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Data from the National Survey on Drug Use and Health (NSDUH); 2014 (PDF | 3.4 MB) show that in 2014, slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD.

Many Americans begin drinking at an early age. In 2012, about 24% of eighth graders and 64% of twelfth graders used alcohol in the past year.
The definitions for the different levels of drinking include the following:

- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) **of greater than 0.08 g/dL.** This usually occurs after 4 drinks for women and 5 drinks for men over a 2 hour period.
- Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria.

Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms.

The severity of an AUD; mild, moderate, or severe is based on the number of criteria met.

**Medications for Alcohol Use Disorders**

Medications also exist that can assist in the treatment of alcohol use disorder.

- **Acamprosate** is a medication that reduces symptoms of protracted withdrawal and has been shown to help individuals with alcohol use disorders who have achieved abstinence go on to maintain abstinence for several weeks to months.

- **Naltrexone**, a medication used to block the effects of opioids, has also been used to reduce craving in those with alcohol use disorders.

- **Disulfiram** is another medication which changes the way the body metabolizes alcohol, resulting in an unpleasant reaction that includes flushing, nausea, and other unpleasant symptoms if a person takes the medication and then consumes alcohol.

**Tobacco Use Disorder**

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).
In 2014, the prevalence of current use of a tobacco product was 37.8% for American Indians or Alaska Natives, 27.6% for whites, 26.6% for blacks, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians.

**Medications for Tobacco Use Disorders**

There are three medications approved by the Food and Drug Administration (FDA) to treat tobacco use disorders (cigarette smoking).

Nicotine replacement medications assist with reducing nicotine withdrawal symptoms including anger and irritability, depression, anxiety, and decreased concentration. Because nicotine delivered through chewing of gum containing nicotine, via transdermal patch, or in lozenges has a slower onset of action than does the systemic delivery of nicotine through smoked tobacco; these medications have little effect on craving for cigarettes.

These medications are available over-the-counter. However, the nicotine inhaler and nasal spray deliver nicotine more rapidly to the brain and so are available only by prescription.

**Bupropion** is a medication originally developed and approved as an antidepressant that was also found to help people to quit smoking. This medication can be used at the same dose for either cigarette smoking or depression treatment (or both).

**Varenicline** is a nicotine partial agonist that reduces craving for cigarettes and has been helpful in smoking cessation for many.

Bupropion and varenicline are prescription medications.

**Cannabis Use Disorder**

Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data:

- In 2014, about 22.2 million people ages 12 and up reported using marijuana during the past month.
- Also in 2014, there were 2.6 million people in that age range who had used marijuana for the first time within the past 12 months. People between the ages of 12 and 49 report first using the drug at an average age of 18.5.

In the past year, 4.2 million people ages 12 and up met criteria for a substance use disorder based on marijuana use.
Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing

compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

**Cannabis Use Disorder**

The Cannabis Youth Treatment Series is a five-volume resource for substance abuse treatment professionals that provides a unique perspective on treating adolescents for marijuana use.

The Brief Marijuana Dependence Counseling (BMDC) program is an evidence-based program and a 12-week intervention designed to treat adults with a diagnosis of cannabis dependence.

**Stimulant Use Disorder**

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression.

Like other prescription medications, stimulants can be diverted for illegal use.

The most commonly abused stimulants are :

- Amphetamines,
- methamphetamine, and
- cocaine.

Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

In 2014, an estimated 913,000 people ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder as a result of using other stimulants besides methamphetamines. In 2014, almost

569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

**Hallucinogen Use Disorder**

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

**Opioid Use Disorder**

Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration.

Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them.

Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opiates to heroin as a result of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin on the black market, this also increases risk of overdose.

Overdoses with opioid pharmaceuticals led to almost 17,000 deaths in 2011. Since 1999, opiate overdose deaths have increased 265% among men and 400% among women.

In 2014, an estimated 1.9 million people had an opioid use disorder related to prescription pain relievers and an estimated 586,000 had an opioid use disorder related to heroin use.

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

Acute opioid-related disorders that require medical management include:

- Opioid intoxication,
- Opioid overdose, and
- Opioid withdrawal.

Issues pertaining to treatment of chronic opioid abuse include:

- Opioid agonist therapy (OAT), psychotherapy, and treatment of acute pain in patients already on maintenance therapy.

**TREATMENT**

**Opioid intoxication**

General supportive measures for opioid intoxication are as follows:

- Assess patient to clear airway.
- Provide support ventilation, if needed.
- Assess and support cardiac function.
- Provide IV fluids.
- Frequently monitor the vital signs and cardiopulmonary status until the patient has cleared opioids from the system.

- Give IV naloxone if necessary. Naloxone is a specific opiate antagonist with no agonist or euphoriant properties.
    - When Naloxone is administered intravenously or subcutaneously, it rapidly reverses the respiratory depression and sedation caused by heroin intoxication.

NOTE

Clonidine is used as adjunct therapy in opiate withdrawal.

Antidepressants and medications with Dopaminergic activity in the brain for example (fluoxotine) Prozac are used to treat cocaine withdrawal.

## Attention-deficit/hyperactivity disorder (ADHD)

Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder characterized by an ongoing pattern of inattention and/or hyperactivity impulsivity which interferes with functioning and /or development.

## Inattention

Inattention means the individual wanders off task, has difficulty sustaining focus, lacks persistence, is disorganized; and these problems are not due to lack of comprehension.

## Hyperactivity

Hyperactivity means the individual seems to move about constantly (continuously), including situations in which it is not appropriate when it is not appropriate, excessively

fidgets, talks or taps. In adults, it may be extreme restlessness or wearing others out with the activity.

## Impulsivity

Impulsivity means the individual makes impulsive, hasty actions that occur in the moment without first thinking about them and that may have consequences such as high potential for harm; or the individuals have a desire for immediate rewards or inability to delay gratification. The impulsive person may also be socially intrusive and excessively interrupt others or make important decisions without even considering the long-term consequences.

# TAKE EXAM

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