REVISION OF WHO's PRIMARY CARE CLASSIFICATION OF MENTAL DISORDERS, THE ICD11-PHC
October 2011

1. INTELLECTUAL DEVELOPMENT DISORDER

Presenting problems:
There is a wide range of presentations depending on the severity of the underlying disorder and disability.

At birth or infancy:
- Identified by family or health worker as looking 'unusual'.
- Characteristic appearance, e.g., Down's syndrome.
- Failure to thrive. Poor feeding or motor tone.
- Delay in usual development for appropriate age and stage.

In children:
- Delay in usual development (walking, speaking, toilet training)
- Difficulties with school work, as well as with other children, because of learning disabilities
- Problems of behaviour. e.g. eating non organic material, not playing with toys, repetitive non constructive activity, self harm, ignoring other children, failing to respond to commands, oppositional
- Child may be socially isolated, an outcast or target of bullying or stigma

In adolescents:
- Difficulties with peers
- Inappropriate sexual behaviour.
- Difficulties in transition to adult life.
- As victims of social, employment and sexual exploitation

In adults:
- Impairments in everyday functioning (e.g., cooking, cleaning)
- Problems with normal social development, (e.g., finding work, relationships, child-rearing).
- Behavioural problems (eg aggressive behaviour, withdrawal, antisocial behaviour)

NB: Malnutrition or extreme social hardship may cause developmental delay.

Clinical Description:
Slow or incomplete mental development resulting in impairment of skills contributing to overall intellectual ability. i.e cognitive, language, motor and social abilities. Usually associated with significant learning difficulties and social adjustment problems.

The disability classified as severe when the child's mental age has not reached half his or her chronological age ie that the child is not doing what a child half his age might be expected to. Mild or moderate disability when he or she has not reached a mental age three quarters of chronological age.

Severe cases usually identified before age 2; require help with daily tasks and capable of only simple speech.
Moderate cases usually identified by age 3-5, needs guidance or supervision in daily activities.
Mild or borderline learning disability; may be limited in school achievement, but able to live alone and work at simple jobs.

Associated symptoms:

May have symptoms of underlying condition e.g facial characteristics of foetal alcohol or Down's Syndrome.
Associated with increased prevalence of physical symptoms and illness, and other mental disorder.

Medical conditions:
Epilepsy
Hearing impairment
Visual impairment
May be difficulties of bowel and urinary incontinence.
Hypothyroidism lead poisoning and some inborn errors of metabolism (e.g., phenylketonuria).
Cardiac abnormalities (particularly in Down's syndrome)

Mental and Behavioural disorders:
Increased prevalence of associated other disorder e.g.: dysphoric disorders
Dependence, social withdrawal, periodic excitability, aggressive or antisocial behaviour

Differential diagnosis includes:
Specific learning difficulties
Attention deficit disorder
Motor disorders (e.g., cerebral palsy)
Sensory problems (e.g., deafness)
Autistic Spectrum Disorder

2. AUTISM SPECTRUM DISORDER

Presenting problems:

- Parental concern that their infant/child is 'different' and 'lives in their own world'.
- Delay in language and social development e.g Not speaking by 16 months,
- Unresponsive to others - poor eye contact.
- Physical clumsiness. Concern over restricted range of interests.

Clinical description:

A spectrum of neuro-developmental disorder characterised by impairments in social interaction; impairments in communication; and restricted interests and repetitive behavior. Symptoms usually develop before the age of two years. May not be reported until later if symptoms mild.

Required Symptoms:

Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years.

1. *Impairment in social interaction*, (at least two of the following)

- Marked impairment in the use of multiple nonverbal behaviors, to regulate social interaction
- Failure to develop peer relationships appropriate to developmental level
- Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people
- Lack of social or emotional reciprocity

2. *Impairment in communication*, (at least one of the following)

- Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- Impairment in the ability to initiate or sustain a conversation with others
- Stereotyped and repetitive use of language, or idiosyncratic language
- Lack of varied, spontaneous make-believe, or social imitative play appropriate to developmental level

3. *Restrictive repetitive and stereotypic patterns of behaviour*, interests, and activities, (at least one of the following)

- Preoccupation with one or more stereotyped and restricted patterns of interest .
- Apparently inflexible adherence to specific routines or rituals
- Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping)
- Persistent preoccupation with objects or parts of objects.

Associated Symptoms:
Intellectual development disorder may also be present.
This is a spectrum disorder. Mild cases show low levels of disability in any or all of the above areas. Individuals with preservation of high level intellectual function were previously classified as Asperger's Syndrome.

Severe cases may show extreme withdrawal from social interaction and marked delay in e.g. language development (some remain mute throughout their lives). May also have difficulty regulating emotions and appear immature in behaviour. Cases may also show disruptive and physically aggressive behaviour. The "give and take" of normal conversation is hard and there is often literal interpretation of phrases of speech. Frequently displays rigidity of thinking and behaviour. Abnormal Sensory problems – hyper or hypo-sensitivity to sensory stimuli (heat, cold, pain). Many have a degree of intellectual disability. Seizures / Epilepsy is common (20-30%)

Cases may also show symptoms of anxiety or depression.

Differential diagnosis
- Attention Deficit Hyperactivity Disorder
- Specific developmental disorder of language or learning
- Conditions that may require specialist referral include tuberous sclerosis, Retts syndrome, and Fragile X syndrome

3. SPECIFIC LEARNING DISABILITY

Presenting problems.
Parental or teacher concern about difficulties in learning in a specific area of academic achievement. The child will have trouble performing specific types of tasks or skills in that area. The most common learning disability is with reading.

Clinical description.
There are significant difficulties in the acquisition and use of reading, writing, reasoning or mathematical ability. Not indicative of intelligence level, or global developmental delay.
Usually categorised by the function impaired and/ or whether disorder due to difficulties in the input, integration, storage or output of information.

Required symptoms.
Disability and difficulty caused in one or more of the following areas, beyond that considered educationally appropriate for age and local access to educational resources.

Multiple sources of information used to assess learning.

Reading disorder (dyslexia) – 70-80% of those with learning disability. Relates to any part of reading (word recognition, decoding, reading rate, comprehension).

Writing disorder (dysgraphia) impairments in handwriting, spelling, organization of ideas, and composition.

Mathematical disability. (Dyscalculia) Difficulties in learning concepts (such as quantity, place value, and time), memorizing math facts, organizing numbers, and understanding how problems are organized.

Associated symptoms. In many countries disability in these skills is reflected in poor academic performance and employment opportunities. Stress related to the disorder can make the coping process difficult, with resultant anxiety symptoms.

Differential diagnosis:

The difficulty in learning is due to known factors such as poor eyesight or poor hearing
Intellectual disability
Attention Deficit Hyperactivity Disorder.
Learning disorder due to poor teaching or non-attendance at school

4. ATTENTION DEFICIT / HYPERACTIVITY DISORDER
(ADHD)

Presenting symptoms:
Concern raised about child behaviour usually by family or teachers depending on age. Child reported as easily distracted, having trouble concentrating and struggling to follow instructions. Family exhausted by child constant activity and impulsive behaviour.

Clinical Description
The co-existence of symptoms of attention deficit, restlessness, being impulsive and hyperactivity with each behaviour occurring infrequently alone, and symptoms starting often before seven years of age. Child cannot sit still, and will not wait for others or listen to what others say.

Required symptoms:
Typical symptoms of inattention, hyperactivity and impulsive behaviour occurring in all situations (home, school, play):

- severe difficulty in maintaining attention (short attention span, frequent changes of activity)
- abnormal physical restlessness, cannot sit still for more than a few minutes (most evident in classroom or at mealtimes), unmodified by social context.
- impulsiveness (the patient cannot wait his or her turn, or acts without thinking).

Associated Symptoms
Sometimes there may be discipline problems, underachievement in school, and proneness to accidents. ADHD may be a long term condition with 30-50% having symptoms persisting into adult life. Associated symptoms and comorbid conditions include conduct disorders and symptoms deriving from those conditions. Undiagnosed or undermanaged ADHD in adolescence may be characterised by chaotic lifestyle and over reliance on recreational drugs and alcohol.

Exclusions:
Exclude children with high but normal levels of activity. Exclude also those where it is clear overactivity is due to lack of parental control. Some children show higher levels of attention deficit when they are anxious

Differential diagnosis.
Medical conditions:

- Epilepsy
- Foetal alcohol syndrome
- Thyroid disease

- Anaemia
- Insufficient or poor quality sleep

All these physical conditions may be co-morbid with hyperactivity but, in addition, epilepsy may be mistaken for it.

Psychological disorders:

When patients fulfil criteria for other psychological disorders these should be managed first. The following may also be co-morbid with ADHD

- Dysphoric disorders (patients exhibits anxiety depression), Specific anxiety disorders particularly chronic separation anxiety disorder.
- Autism Spectrum Disorder (social/ language impairment and stereotyped behaviours are present)
- Conduct disorder (patients exhibits disruptice behaviour without inattentiveness)
- Intellectual disability or specific learning disability.

5. CONDUCT DISORDER

(including oppositional-defiant disorder)

Presenting problems

Concern about the child's disruptive behaviour by parents, family, neighbours or teachers.
In *younger children*: marked tantrums, defiance, fighting, and bullying.
In *older children and adolescents*: significant antisocial behaviour such as stealing, damage to property and assault. The child may be excluded from school, and there is usually persistent conflict with other adults and children.

The behaviour is often seen in all areas of life but may be confined only to school or only to home.

(*Note: all children are 'badly behaved ' at times and adolescents often display opposition to adult rules and wishes at some point. Diagnosis is dependent on duration and severity of behaviour).*

Clinical description.

A disorder characterized by repetitive, persistent and excessive antisocial (destruction of property, theft, fire-setting), aggressive (violent acts, bullying) or defiant behaviour lasting six months or more.

Required symptoms.

Behaviour must be out of keeping with the child's development level, norms of peer group behaviour, and cultural context.

Behaviour across more than one of the following areas:

- Verbal or physical aggression towards people and animals. Examples include bullying, physical verbal or emotional cruelty and forcing others into antisocial activities.
- Damage to property. Deliberate destruction to buildings and other property.
- Deceitfulness or theft. May be overt stealing or lying in order to obtain things from others or to cover up misdemeanours.
- Violation of rules and regulations. Running away from home or school

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

Associated symptoms.

In younger children (up to eight years), the behaviours are characteristically *oppositional-defiant* in type: angry outbursts, loss of temper, refusal to

obey commands and rules, destructiveness or hitting. There is a spectrum of severity. In mild cases there is only minor harm to others (e.g truancy) while in severe cases considerable harm to others results(e.g stealing while confronting a victim, use of a weapon)

Frequently co-morbid diagnoses:

- Attention deficit hyperactivity disorder
- Specific Language Disorder
- Intellectual Development Disorder
- Autism spectrum disorder
- Adjustment reaction to specific trauma (e.g parental separation, abuse)
- Depression in adolescent presentations

Differential diagnosis.

- Organic disease or injury (e.g occult infection / tumour/ traumatic brain injury)
- Epilepsy
- Depression in adolescent presentations
- Consider uncommon presentations such as bipolar disorder in late adolescence

6. PROBLEMS OF BLADDER AND BOWEL CONTROL

Presenting symptoms
The child is usually brought to primary care because of concern about repeated passage of urine or faeces into clothes or bed. Presentation occurs beyond the age of anticipated control of bladder or bowel function.

Enuresis

Clinical Description
Delay in ability to control urination. Either nocturnal , diurnal or both. Usually involuntary, though occasionally intentional. May be continuous from birth (Primary) , or may follow a period or continence (Secondary).
Primary nocturnal enuresis (PNE) - the most common form. Child continues to average at least two wet nights a week with no long periods of dryness or to not sleep dry without being taken to the toilet by another person. Symptoms present for more than three months. More common in boys than girls.

Associated Symptoms

In cases of secondary enuresis patients may also show other emotional or behavioural disorder symptoms, and symptoms may begin after stressful or traumatic event e.g serious event such as physical or sexual abuse, or more minor trauma such as sleeping in a strange bed. Enuresis is more common in some other disorders such as Attention Deficit Hyperactivity (ADHD)

Note: wetting at night is normal until the mental age of 5 years. Most girls can stay dry by age six and most boys stay dry by age seven.

Differential diagnosis

Most enuresis is usually an isolated developmental delay—not an emotional problem or physical illness. Only a small percentage (5% to 10%) of bedwetting cases are caused by other specific conditions.

Medical disorders

- Structural physical abnormalities e.g smaller bladder capacity
- Recurrent urinary tract infection associated with relux nephropathy
- Insufficient anti-diuretic hormone (ADH) production
- Constipation
- Sleep apnea

Psychological disorders
When enuresis is caused by a psychological or neuropsychological disorder it should be considered a symptom of the primary disorder.

- Childhood Distress Disorder. - Stress established as a cause of returning to bedwetting e.g house or school moves, parental conflict or divorce, loss of a loved one or pet.
- Intellectual disability
- Attention deficit hyperactivity disorder (ADHD)

Encopresis

Presenting Symptoms

Child is brought to health worker because of concerns about bowel movements or faecal soiling in inappropriate places.

Clinical Description

Repeated voluntary or involuntary passage of formed faeces into places inappropriate to the individual's own socio-cultural setting (e.g. clothing, floor , bedding).

Faeces are of normal or near-normal consistency. The child may have failed to gain bowel control (primary) or has gained control but then later again became encopretic. The disorder is not usually diagnosed under the age of four years. It is more common in boys than girls, beyond occasional faecal soiling.
There may be a variety of associated psychiatric symptoms and there may be smearing of faeces.
Exclusions: The symptoms are not exclusively due to a physiological effect of a substance (e.g., laxatives) or a general medical condition, except through a mechanism involving constipation.

Associated symptoms.
May be associated *with* constipation and overflow incontinence, or *without* constipation and overflow incontinence. In cases without constipation faeces may be deposited in prominent locations, and be associated with reluctance, resistance or failure to conform to social norms. May also stem from physiological retention arising from problems over bowel training or stress over bowel evacuation e.g at school.
The child with encopresis may suffer from low self-esteem and peer disapproval related to this problem. If routine bowel habits are not developed, the child may suffer from chronic constipation.

Differential diagnosis

Medical Disorders

- Bowel infection
- Aganglionic megacolon
- Spina Bifida

- Constipation due to medical causes

Psychological Disorders

- Oppositional defiant and conduct disorders
- Intellectual disability
- Phobia of toilet

7. ACUTE PSYCHOTIC DISORDER

Presenting complaints
Patients can present with sudden onset of severe disturbance characterised by strange beliefs and grossly abnormal behaviour. They may be apprehensive, confused or extremely suspicious. Acute psychosis can be very transient in nature lasting for a few hours to a few days or can last for a few weeks. Complete recovery is the norm.

Diagnostic features
Acute psychotic disorder is a diagnostic label given to patients with unusual symptoms of sudden onset, usually with florid disturbance and lasting from a few days to a few weeks. While complete recovery is the norm, a minority of patients can have a relapse with similar presentations.

The unusual experiences, abnormal beliefs and behaviours may include:
Required symptoms:

- Delusions *(*strange beliefs may involve being persecuted or poisoned, of special powers, of one's spouse's infidelity, of being controlled or of being talked about by strangers)
- Hallucinations (hearing voices or seeing visions)

Other common symptoms

- Withdrawal
- Agitation
- Restlessness or disorganised behaviour
- Muddled thinking,
- Incoherent or irrelevant speech
- Labile emotional states

Presentations in childhood
Acute psychosis may present in late adolescence.

Differential diagnosis

- Bipolar disorder – manic phase and psychotic forms of depression may have many similar features, patients may develop symptoms of classical mania and depression or may go on to become chronic mandating a change in diagnosis over time.
- Exacerbations of chronic psychosis, with a total duration of illness of greater than 3 months duration.

Medical conditions like Delirium

- systemic or cerebral infections,
- epilepsy,
- intoxication and withdrawal from drugs and substances

- should be identified and managed when present

8. PERSISTENT PSYCHOTIC DISORDERS

Presenting symptoms and complaints

The presentations include abnormal beliefs, hearing voices or seeing visions and may involve abnormal behaviour. They can also present with lack of energy to do daily chores, the lack of motivation to work, difficulty in concentration, apathy and withdrawal from family, friends and colleagues.

Diagnostic features

The *acute exacerbations* include:

- Delusions (strange beliefs of being persecuted or poisoned, of special powers, of one's spouse's infidelity, of being controlled or of being talked about by strangers)
- Hallucinations (hearing voices and seeing things that others cannot see)
- Restlessness and agitation
- Grossly abnormal behaviour

The *chronic problems* include:

- Lack of energy or motivation to do daily chores and work
- Apathy and social withdrawal
- Strange and abnormal speech
- Poor personal care or neglect

Differential diagnosis

- Bipolar disorder – manic phase may have many similar features
- Psychosis can also be associated with medical illnesses (eg: infections and tumours of the brain, head injury, epilepsy, thyroid disorder)
- Dementia – organic psychoses (eg dementia) can have similar features
- Substance Use - (eg: alcohol, cannabis, opioids, etc).

9. BIPOLAR DISORDER

Presenting complaints:
Patients may present with periods of depression, of mania or, between attacks, with normal mood. Episodes of depression and mania, or mixed states can alternate or one form can predominate.

Diagnostic features

Manic episodes are characterised by:

Required symptoms
Increased energy and activity
Elevated or irritable mood

Other common symptoms
Excessive or rapid speech
Constant changes in activities & plans
Recklessness or loss of inhibition (promiscuity, use of drugs, spending large amounts of money)
Decreased need for sleep
Increased importance of self
Easy distractibility
increased sexual activity/promiscuity
antisocial or criminal behaviour
concurrent illicit drug use

Depressive episodes are characterised by:

Required symptoms
Low or sad mood
Loss of interest or pleasure
Other common symptoms
Disturbed sleep
Guilt or low self-worth
Fatigue or loss of energy
Poor concentration
Subjective complaints of memory loss
Disturbed appetite
Suicidal thoughts or acts

Periods of mania, depression can be recurrent and can alternate with normal mood. Patients may also report delusions and hallucinations during periods of depression and mania.

Differential diagnosis

- Depressive disorder – here there is no history of manic episodes
- Anxious depression – here there is no history of manic episodes
- Acute psychosis can resemble manic episodes
- chronic psychosis

Substance use disorders and dementia may be *concurrent conditions* and should be identified and managed, when present.

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10. ANXIOUS DEPRESSION

Presenting symptoms:
The patients commonly present_with *somatic symptoms*, but will be found to have both anxious and depressive symptoms accompanying these symptoms. A minority may present with depressive symptoms. In primary care settings this clustering of symptoms is often dependent on and influenced by social determinants of health, making it necessary to consider psycho-social issues in both assessment and management of the patient. Patients may also present with physical symptoms such as loss of weight.

Clinical description:
This is a dysphoric disorder in which mixed anxious and depressive symptoms cause significant distress or dysfunction and lead to functional impairment and care-seeking. *"S" indicates a screening question, if both are negative, the others need not be asked*

*Required symptoms***:**
There must be no previous manic episodes, and they must have at least 3 anxious and 3 depressive symptoms from the following list for, at least **two weeks**:

- The "*anxiety symptoms*" are:
- feeling nervous, anxious or on edge (S);
- not been able to control worrying (S);
    - having trouble relaxing;
    - so restless hard to keep still;; and
    - afraid something awful might happen.
- The "*depression symptoms*" are:
- persistent depressed mood (S);
- markedly diminished interest or pleasure (S);
    - feelings of worthlessness or guilt;
    - low self confidence
    - recurrent thoughts of death or suicide.

*Associated symptoms***:**
weight / appetite loss
loss of libido
fatigue / low energy
panic attacks,
obsessional ruminations
excessive concern with their health

Severity:

Mild anxious depression has 6 or 7 symptoms every day for the past 2 weeks. They are distressed by their symptoms, but are managing most activities, but with increased difficulty

Moderate anxious depression has 8 or more symptoms, with marked disability in at least one area. They may also have neuro-vegetative symptoms like changes in appetite and weight, poor sleep, diurnal variation of mood or loss of libido. Patients may also experience panic attacks.

Severe anxious depression have all the above, wi.th severe distress and disability affecting most areas (work, family, activities of daily living)
Some of the symptoms severe in intensity, and may also show *motor agitation*

Childhood: Before puberty depression may present with somatic features, irritability and oppositional behaviour, especially in boys - easily mistaken for oppositional defiant disorder. There may also be a decline in school performance

Differential diagnosis:
* Physical Diseases: Hyperthyroidism, Cushing's syndrome
* Side-effects of medication (e.g.: beta-blockers, anti-hypertensives, H_2 blockers, steroid treatment) or substance use

11. DEPRESSIVE DISORDER

Presenting symptoms: Sadness or depressed mood and lack of interest or pleasure are the core symptoms that indicate the presence of a depressive disorder when present for at least two weeks. The number and type of other symptoms involved will indicate severity. Patients may also present with physical symptoms such as loss of weight.

Clinical Description:
This is a dysphoric disorder in which depressive symptoms cause significant distress or dysfunction and lead to functional impairment and care-seeking, without significant anxiety symptoms.

Required symptoms: There must be no previous manic episodes, and they must have **at least three** from a list of 5 depressive symptoms and few anxious symptom, causing significant distress or dysfunction and lead to functional impairment for at least **two weeks**. *"S" indicates a screening question, if both are negative, the others need not be asked*

Required symptoms:

- persistent depressed mood (S);
- markedly diminished interest or pleasure (S);
    - feelings of worthlessness or guilt
    - low self confidence;
    - recurrent thoughts of death or suicide.

They have few anxious symptoms

- feeling nervous, anxious or on edge (S);
- not been able to control worrying (S);
- having trouble relaxing;
- so restless hard to keep still;; and
- afraid something awful might happen.

Associated symptoms: disturbed sleep and appetite, agitation or slowing of movement or speech; fatigue, irritability, diurnal variation of mood, early waking, reduced self-esteem and self-confidence, bleak and pessimist view of the future.

Childhood: Before puberty depression may present with somatic features, irritability and oppositional behaviour, especially in boys - easily mistaken for oppositional defiant disorder. There may also be a decline in school performance.

Severity:

Mild depression has at least 3 symptoms of depression, every day for the past 2 weeks. They are distressed by their symptoms, but are managing most activities, but with increased difficulty

Moderate depression has at least 4 symptoms every day for the past 2 weeks, with marked disability in at least one area.. They may also have neurovegetative symptoms like changes in appetite and weight, poor sleep, diurnal variation of mood or loss of libido.

Severe depression has all the above, with some of the symptoms severe in intensity, and may also show slowing of both speech and action, or psychotic ideas.

Differential diagnosis:

- Physical Diseases: Hypo/Hyperthyroidism, Cushing's syndrome
- Side-effects of medication (e.g.: beta-blockers, anti-hypertensives, H_2 blockers, steroid treatment) or substance use
- Anxious Depression – but these have 3+ anxious symptoms
- Anxiety Disorder - these also have 3+ anxious symptoms
- Bodily distress disorder (BDS) – these do not have 3+ depressive symptoms

12. ANXIETY DISORDER

Presenting symptoms:
Patients may present with somatic manifestations of anxiety, such as palpitations, tremor, dry mouth or tension headache. There may also be a permanent sensation of being 'on edge' and anxious. Tension pains may also be present such as headache or stomach cramps.

Clinical description:
This is a disorder that cause significant distress or dysfunction and lead to functional impairment and care-seeking, in which anxious symptoms predominate, without significant presence of depressive symptoms.

Required symptoms: Patients have at least THREE from the list of 5 anxious symptoms (with no more than one depressive symptom) over the past two weeks:

- The "*anxiety symptoms*" are:
  - feeling nervous, anxious or on edge;
  - not been able to control worrying;
  - having trouble relaxing;
  - so restless hard to keep still; and
  - afraid something awful might happen.

  They have few depressive symptoms

  - persistent depressed mood (S);
  - markedly diminished interest or pleasure (S);
  - feelings of worthlessness or guilt
  - low self confidence;
  - recurrent thoughts of death or suicide.

Associated symptoms: panic attacks, and fear symptoms related to particular situations with avoidance behaviour.

Duration: **At least 2 weeks** of continuous anxious symptoms.

Childhood: usually somatic symptoms, but agitation and repeated worries can be the only symptoms. Difficulties in adapting to school.

Severity:

Mild: 3 anxious symptoms continuously for 2 weeks. They are distressed by their symptoms, but are managing most activities, but with increased difficulty.

Moderate: 4 or 5 anxious symptoms continuously for 2 weeks. with marked disability in at least one area..

Severe: 5 anxious symptoms continuously for 2 weeks, several of great intensity with severe disability. There may also be motor agitation.

Differential diagnosis:

Physical Diseases: Hypo/Hyperthyroidism, Cushing's syndrome
Side-effects of medication (beta agonists, xanthines) or substance use including excessive coffee

13. DYSPHORIC DISORDERS

Presenting symptoms:
A wide variety of non-specific complaints such as fatigue, poor sleep and low energy, and minor symptoms of anxiety & depression. In primary care settings this clustering of symptoms is often dependent on and influenced by social determinants of health or by stressful life events, making it necessary to consider psycho-social issues in both assessment and management of the patient.

Clinical description:
Multiple non-specific symptoms accompanied by symptoms of anxiety and depression that fall short of standard required for the diagnosis of either, but *accompanied by some distress and disability*, (eg not feeling able to go to work or to carry out housework) for at least two weeks. This is a mild disorder, and while it is often transient it may also be a prelude to case diagnosis.

Required symptoms:
There are at least 3 anxious or depressive symptoms from the list of 10, but just falling short of the number required for a case diagnosis of either anxiety or depression. Anxiety symptoms include feeling nervous, anxious, tense or on edge, and restlessness, trouble falling asleep. Depressive symptoms include feeling sad or depressed, trouble staying asleep, and early waking.

Associated symptoms:.

- fatigue & low energy,
- irritability and
- trouble sleeping,
- *Somatic* symptoms may also headache and backache, occurring at times of stress

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Childhood equivalent:
Irritability and unspecified somatic symptoms such as headache or abdominal pain on school days, child normal at week-ends and on physical examination.

<u>Differential diagnosis</u>:

1. Bodily distress disorder (BDS) These patients must have at least three different somatic symptoms with persistent concern about their health, and spngend much time & energy devoted to their health concerns
2. Anxiety disorder: Three or more of the anxiety symptoms, which may or may not be accompanied by a range of somatic symptoms

3. Depressive disorder: Three or more of the depressive symptoms, which may or may not be accompanied by a range of somatic symptoms
4. Anxious depression: satisfying requirements for “2” and “3”

14. POST TRAUMATIC STRESS DISORDER

Presenting Symptoms:
After a trauma, the person experiences episodes of repeated reliving of the trauma (‘*flashbacks*’) that occur against a persisting background of a sense of "*numbness*" with fear and avoidance of cues that remind the sufferer of the original trauma.

Clinical description:
Delayed and/or protracted response to the exposure to one or more of stressful event or situation such as death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, either experiencing the event(s) him/herself or witnessing, in person, the event(s) as they occurred to others

Required Symptoms:
At least one symptom from one of the following four groups:

A: Repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams.
B: Avoidance of circumstances resembling or associated with the stressor.
C: Conspicuous emotional detachment, numbing of feeling, inability to experience positive emotions. Sometimes there is an inability to recall either partially or completely some important aspect of the period of exposure to the stressor
D: Over-arousal with autonomic disturbances, sleep problems, irritability, concentration problems, hypervigilance and exaggerated startle response.

Alterations in arousal began or worsened after the traumatic event, as shown at least 3 (in children, two) of the following:

- Irritable or aggressive behaviour
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration

Associated Symptoms:

Anxiety and/or depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive

use of alcohol or drugs may be a complicating factor. There is usually a state of autonomic over-arousal.

Duration:
A "probable" diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible.

Differential Diagnosis:
Depression and anxiety without PTSD
Dissociative Disorder
Obsessive Compulsive Disorder

15. PANIC ± AGORAPHOBIA

Presenting Complaints

Patients may present with physical symptoms (e.g., chest pain, dizziness, shortness of breath, palpitations) that may include (or not) unexplained attacks of anxiety or fear that begin suddenly, develop rapidly and may last only a few minutes. Questioning may reveal the presence of specific fears that lead to avoidance or restriction of activities such as travelling to the doctor's office, going shopping, visiting others.

Diagnostic Features

Required symptoms:

Panic attacks are unexplained attacks of anxiety or fear that begin suddenly, develop rapidly and may last only a few minutes. The attacks often occur with **physical symptoms** such as palpitation, chest pain, sensations of choking, churning stomach, dizziness; and **psychological symptoms** such as feelings of unreality, or fear of personal disaster (losing control or going mad, heart attack, sudden death). An attack often leads to fear of another attack and *avoidance* of places where attacks have occurred, leading to unreasonably strong fear and avoidance of specific places or events.

Associated symptoms:

Agoraphobia refers to being unable to leave home (unless accompanied) or unable to stay alone because of fear and other symptoms of anxiety, including panic attacks

Exclusions: Panic accompanying anxious depression or depression, where panic attacks were *not* present before depressive symptoms developed,

Differential diagnosis

- Depression may accompany panic agoraphobia, and should be diagnosed if there are 3 or more symptoms
- Many medical conditions may cause symptoms similar to panic attacks (arrhythmia, cerebral ischemia, coronary disease, thyrotoxicosis). History and physical examination should be sufficient to exclude many of these.
- Substance abuse or effects of other medications

Version "A"

16. BODILY DISTRESS SYNDROME (BDS)

Presenting Symptoms/Complaints

The patient presents with multiple somatic symptoms. These symptoms may be influenced by culture and change over time.

Clinical Description

The patient suffers from multiple persistent bodily symptoms, which are present at the same time. In order to diagnose BDS, the symptoms must at some stage present as autonomic arousal symptoms, musculoskeletal tension or general/neurological and cognitive symptoms and result in significant disruption in daily life. Symptoms are distressing and/or result in significant disruption in daily life, as well as persistent concerns about the medical seriousness of the symptoms.

Required symptoms:
The patient must have at least 3 concurrent symptoms from one of the following organ groups, or 4 or more of the characteristic symptoms altogether. Those with 3 or more symptoms from 3 or more groups have severe or multi-organ BDS

- Cardiopulmonary/autonomic arousal (e.g. palpitations, precordial discomfort, breathlessness without exertion, hyperventilation, hot or cold sweats, trembling or shaking, dry mouth, churning in stomach, flushing or blushing)
- Gastrointestinal arousal (e.g. abdominal pains, frequent loose bowel movements, feeling bloated, regurgitations, constipation, diarrhoea, nausea, vomiting, burning sensation in chest or epigastrium)
- Musculoskeletal tension/(locomotor tension or dysfunction?) (e.g. pains in arms or legs, muscular aches or pains, pains in the joints, feelings of paresis or localized weakness, back ache, pain moving from one place to another, unpleasant numbness or tingling sensations)
- General symptoms (e.g. concentration difficulties, impairment of memory, excessive fatigue, headache, dizziness)

Exclusion:
Those with anxiety or depression at case level should not be diagnosed as BDS

Severity:

Patient fulfilling criteria for 3-4 symptom groups have severe or multi-organ bodily distress.

Childhood variations

Bodily distress in children may be mono-symptomatic, and the type of symptoms varies with age, with abdominal pain and headache common in smaller children, whereas the prevalence of fatigue and neurological symptoms seems to increase with age. Bodily distress in children may continue into adult life.

Differential Diagnosis

- Consider *physical disease* with multiple symptoms, e.g. multiple sclerosis, hyperparathyroidism, acute intermittent porphyries, myasthenia gravis, AIDS, systemic lupus erythematosus, Lyme disease, connective tissues disease.
- *Psychiatric disorder* with physical symptom presentation, e.g. dysphoric disorders presenting with physical symptoms, substance use disorders, psychotic disorders.
- *Health preoccupation* if health concerns predominate rather than the symptoms themselves.
- *Conversion disorder* if the symptom picture is dominated of neurological symptoms and the onset of symptoms is related to a severe psychological trauma

Version "B"

16. BODILY DISTRESS SYNDROME (BDS)

Presenting Symptoms/Complaints

The patient may present with any physical symptom and symptoms may be influenced by culture and change over time. However, in order to diagnose BDS the symptoms must at some stage present as a pattern of multiple physical symptoms (such as arousal symptoms, musculoskeletal tension or general/ neurological and cognitive symptoms) combined with disproportionate concerns about these symptoms

Clinical Description

The patient suffers from multiple persistent bodily symptoms, which are present at the same time. Symptoms are distressing and/or result in significant disruption in daily life. If a dysphoric disorder is also present this may be the cause of the physical symptoms*. (Note: a dysphoric disorder" refers to patients with both subthreshold anxious and subthreshold depressive symptoms)*

Required symptoms:

The patient must have at least 3 concurrent physical symptoms for at least 3 months, accompanied by disproportionate and persistent concerns about the medical seriousness of the symptoms. Disproportionate concerns may include excessive time and energy devoted to these symptoms

THE REST OF VERSION "B" IS IDENTICAL TO VERSION "A"

17. HEALTH PREOCCUPATION

Presenting symptoms

The patient may present with any physical symptom and symptoms may change over time. The main problem is not the symptom itself but *the patient's worry about potential health problems*, lasting at least 3 months.

Clinical Description

Health preoccupation is a disorder of the awareness of one's body with a high degree of illness worry. The patient must have obsessive rumination with intrusive thoughts, ideas or fears of harbouring illness that cannot be stopped or can only be stopped with great difficulty.

Required symptoms:
One (or more) of the following 3 symptoms:

- The patient must have obsessive rumination with intrusive thoughts, ideas or fears of harbouring illness that cannot be stopped or can only be stopped with great difficulty.
- Either worrying about or preoccupation with fears of harbouring a severe physical disease or the idea that disease will be contracted one in the future or preoccupation with other health concerns or attention and intense awareness on bodily functions, physical sensations, physiological reactions or minor bodily problems that are misinterpreted as serious disease.
- Suggestibility and auto-suggestibility. If the patient hears or reads about illness (s)he is inclined to fear that (s)he has the same disease.

Associated symptoms:

- Excessive fascination with medical information
- An unrealistic fear of being infected or contaminated by something touched, eaten or a person met.
- Fear of taking prescribed medication

Childhood variations

Children may be subject to parent's health preoccupation.

In young children with health preoccupation the specific cognitive distortions may be difficult to verify directly, but their presence might be based on observations of the child's behaviour such as being hard to calm down or divert when having physical symptoms or a tendency to complain a lot about pain and physical symptoms when there seems not to be much wrong.

Differential Diagnosis

- Anxiety or depression may be at case level
- Consider worries that are caused by a physical disease.
- Consider bodily distress syndrome if the clinical picture is dominated by physical symptoms and bodily distress.
- Consider dysphoric disorders if the patient suffers from worry and/or anxiety other than related to health

18. DISSOCIATIVE DISORDER

Presenting complaints

Patients exhibit unusual or dramatic symptoms, such as seizures, amnesia, trance, loss of sensation, visual disturbances, paralysis, aphonia, identity confusion and 'possession' states.

Clinical Description

One or more symptoms are present that affect voluntary motor or sensory function. Symptoms are distressing and/or result in significant disruption in daily life. Onset is often sudden and must be related to extreme psychological stress/severe psychological trauma or extremely difficult personal circumstances.

Required symptoms:
The symptom, after appropriate medical assessment, is found not to be due to a general medical condition, the direct effects of a substance, or a culturally sanctioned behaviour or experience.

Associated symptoms: In acute cases, symptoms may:

- be dramatic and unusual
- change from time to time
- be related to attention from others

Differential diagnosis

- Consider physical conditions. A full history and physical (including neurological) examination are essential. Early symptoms of neurological disorders (e.g. multiple sclerosis) may resemble conversion symptoms.
- Consider bodily distress syndrome if multiple physical symptoms are present and history shows no psychological trauma.
- Consider anxiety / depression if these symptoms accompany the dissociative symptoms.

19. SEXUAL PROBLEMS (MALE)

Presenting complaints

Patients may be reluctant to discuss sexual matters. They may instead complain of physical symptoms, depressed mood or relationship problems.

Sexual problems are often somatised, expectations may be unrealistic and psychological explanations and therapies may not be readily accepted. In some settings patients may be more likely to regard sexual dysfunction as physical rather than psychological in origin. Whatever the setting, it is important to remember that sexual problems are often the result of both physiological and psychological factors. It is important to recognise that presentation of these problems should take into account individual ethnic, cultural, religious, and social background. Be aware that patients with sexual problems may have a history of sexual abuse/assault (in childhood or later).

Diagnostic features

Sexual dysfunction may cause marked distress and interpersonal difficulty. Common sexual disorders in men are:

- erectile dysfunction
- premature ejaculation
- retarded ejaculation or orgasmic dysfunction (intra-vaginal ejaculation is greatly delayed or absent but can often occur normally during masturbation)
- lack or loss of sexual desire.

Distinguish between lifelong versus acquired, generalized versus situational, and sexual dysfunction caused by psychological versus combined factors.

Differential diagnosis and concurrent conditions

- Physical factors frequently contribute to *erectile dysfunction*, including diabetes, hypertension, alcohol misuse, smoking, medication (eg antidepressants, antipsychotics, diuretics and beta-blockers), multiple sclerosis, vascular disease in particular coronary artery disease and spinal injury. (Important clue: inability to achieve erection at *any* time - nocturnal, morning, masturbation, etc.)
- Specific organic pathology is a rare cause of *orgasmic dysfunction* or *premature ejaculation*.

- Problems in relationships with partners frequently co-exist and may contribute to sexual disorder, especially those of desire. Where there is persistent discord in the relationship, relationship counselling should precede the diagnosis or treatment of sexual dysfunction.
- Erectile dysfunction and low or absent sexual desire may be a consequence of depression, anxious depression or distress disorders.
- Patients may have unreasonable expectations of their own performance.
- Note that more than one sexual dysfunction can co-exist.

20. SEXUAL PROBLEMS (FEMALE)

Presenting complaints

Patients may be reluctant to discuss sexual matters. They may instead complain of physical symptoms, depressed mood or relationship problems. Patients may mention sexual problems during a routine cervical-smear test, well-woman clinic or when discussing contraception, and may also present with infertility.

Sexual problems are often somatised, expectations may be unrealistic and psychological explanations and therapies may not be readily accepted. In some settings patients may be more likely to regard sexual dysfunction as physical rather than psychological in origin. Whatever the setting, it is important to remember that sexual problems are often the result of both physiological and psychological factors. It is important to recognise that presentation of these problems should take into account individual ethnic, cultural, religious, and social background. Be aware that patients with sexual problems may have a history of sexual abuse/assault (in childhood or later).

Diagnostic features

Sexual dysfunction can cause marked distress and interpersonal difficulty. Common sexual disorders presenting in women are:

- lack or loss of sexual desire, sexual aversion
- *sexual arousal disorder* (inability to attain/maintain an adequate physiological response to sexual excitement)
- sexual pain disorders:
  - *vaginismus* (spasmodic contraction of vaginal muscles on attempted penetration accompanied by a fear or phobia of penetration - the phobia can rarely occur without the spasm)
  - *dyspareunia* (pain in the vaginal or pelvic region during sexual intercourse)
- *orgasmic disorder* (delay in, or absence of, orgasm or climax).

Distinguish between lifelong versus acquired, generalized versus situational, psychological versus combined factors.

Differential diagnosis and co-existing conditions

- Low desire or sexual arousal disorder may be a consequence of depression or relationship problems, and may relate to inappropriate or unrealistic demands of partners. Women may regard low desire as a natural response to stress or relationship problems.
- Physical factors frequently contribute including diabetes, hypertension, alcohol abuse, smoking, medication (eg antidepressants, antipsychotics, diuretics and beta-blockers), multiple sclerosis and spinal injury.

21. SLEEP PROBLEMS

Presenting complaints

Patients will often complain directly about sleeping difficulties, or the disabling effects of poor sleep. These can include:

- Falling asleep at inappropriate times during the day.
- accident prone at work (especially drivers).
- educational problems in young people.
- chronic dependence on hypnotic medication and sometimes alcohol as an (ineffective) means of helping to sleep.

Diagnostic features

Common problems include:

- Difficulty falling asleep.
- Restless sleep (frequent waking during the night).
- Unrefreshing sleep.

In many cases common problems are the result of poor sleep hygiene, e.g. sleeping environment not conducive to sleep (including snoring or restless bed partner), excessive intake of caffeine or overuse of nicotine or alcohol, especially at night, or no regular times for going to bed and waking up.

Daytime sleepiness maybe due to obstructive *sleep apnoea*, or to paroxysmal pathological sleep (*narcolepsy*)

Differential diagnosis

- Consider *physical disorders* that may disturb sleep, e.g. painful conditions, respiratory disorders, in particular sleep apnoea, where a partner may describe loud snoring followed by periods where breathing stops.
- Consider narcolepsy where the patient cannot resist periods of deep sleep during the daytime, often for less than an hour.
- Consider *medications* which may cause insomnia, including decongestants, theophylline, some antidepressants, and hypnotics in the withdrawal phase
- *Short term* sleep problems (up to several weeks) may result from acute physical illnesses or stressful life events.
- *Persistent* insomnia (months or years) may indicate other psychiatric disorders e.g. anxiety or depression.

- Sleep problems can be the presenting complaint of *alcohol* or *substance abuse*.

22. EATING DISORDERS

Presenting symptoms:
Patients commonly present with physical problems which are the results of extreme dietary restriction, binge eating, and various forms of extreme weight-control behaviour, such as self-induced vomiting, driven exercising or laxative misuse. The patient may, less commonly, present with weight concern

Patients may also present with:

- gastrointestinal symptoms: abdominal pain, bloatedness, constipation, food allergy/intolerance
- women with menstrual disturbances or amenorrhoea
- non-specific symptoms: cold intolerance, light-headedness, lethargy
- oropharyngeal problems, dental problems, salivary-gland swelling
- hair, nail or skin changes.

The *family* may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhoea. Earlier stages may include levels of dietary restriction or episodes of binge eating that cause alarm within the family.

Diagnostic features
This us a spectrum disorder, ranging from the common binge eating disorder to the much less common anorexia nervosa
Required symptoms:
Common features of all three eating disorders are:

- unreasonable fear of being fat or gaining weight
- extensive efforts to control/reduce weight (eg strict dieting, vomiting, use of purgatives, excessive exercise)

Associated features:

- Physical examination may show pallor, Gaunt face (big eyes), coarse knuckles of the hands, hypothermia, hypotension, peripheral oedema, slow pulse, arrhythmias
- Preoccupation with food

Patients may have **Binge Eating Disorder** when:

- There are recurrent episodes of binge eating (ie discrete episodes of uncontrolled overeating), on average, at least once a week for three months.

- The disorder may lead to increases in body weight
- The binge eating is **not** associated with the recurrent use of inappropriate compensatory behavior (for example, purging or induced vomiting) and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Patients with **bulimia nervosa** typically show:
Required symptoms:

- Body weight may be normal or show rapid fluctuation
- binge-eating (ie eating an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances)
- purging (attempts to eliminate food by self-induced vomiting or misuse of laxatives, diuretics or other medications)

Associated features:

- other compensatory measures such as excessive exercise or short periods of fasting
- self-evaluation is based on body shape and weight.

Patients with **anorexia nervosa** typically show:

- Weight, measured as body mass index (BMI) <17.5 kg/m2. Severe form may show: body mass index <15 kg/m2 and/or rapid weight loss of > 0.5 kg per week.
- Amenorrhoea for three months or longer (unless they are taking an oral contraceptive)
- A proportion of patients binge and purge.
- Altered perception of body image

(*A patient may show both anorexic and bulimic patterns at different times)*

Children: May present with growth problems or delay in secondary sexual development if pre-puberty.

Differential Diagnosis:

Physical illness (eg malabsorption syndrome, chronic inflammatory intestinal diseases, tumours, tuberculosis, vasculitis and diabetes mellitus) may cause weight loss or vomiting, although it is not self-induced.

23. ALCOHOL USE DISORDERS

Presenting symptoms:
Patient may present with

- problems associated with their drinking: depressed mood, nervousness, insomnia; as well as
- physical complications of alcohol use (ulcer, gastritis, liver disease)
- accidents or injuries due to alcohol use, or
- poor memory or concentration

There may also be:

- legal or social problems due to alcohol use (relationship and family problems, domestic violence, absence from work)
- signs of alcohol withdrawal (sweating, tremors, morning sickness, hallucinations)
- Patients may sometimes deny or be *unaware* of alcohol problems.

Family may request help before patient does (eg. because patient is irritable at home or missing work). Presenting symptoms may differ between men and women

Clinical Description:

A disorder characterized by the excessive consumption of alcohol leading to psychological, social and physical harm and dependence. Alcohol use may be steady, or occur is bouts of "binge drinking"

Required symptoms:

Hazardous use of alcohol- drinkers whose consumption poses a considerable risk to own and others' health. Quantity will be defined by local standards e.g. over 21 standard drinks per week for men, over 14 standard drinks per week for women (NB alcohol content of standard drinks varies).

Harmful use of alcohol- drinkers for whom there is clear evidence that alcohol use is responsible for (or substantially contributes to) physical, social or psychological harm, including impaired judgment or dysfunctional behaviour. There is progressive neglect of alternative pleasurable activities.

Dependence syndrome

- Continued alcohol use despite harm
- Difficulty in controlling alcohol use

- Strong desire to use alcohol
- Tolerance (drinks large amounts of alcohol without appearing intoxicated)
- Withdrawal (anxiety, tremors, sweating, delirium, fits)

Drinking during pregnancy may result in the foetal alcohol syndrome, with abnormal brain development, stunted growth, typical face and neurological abnormalities

Childhood
Children may also take alcohol to excess and develop alcohol-related disorders

Differential Diagnosis:
Consider other psychiatric conditions as possible contributors to alcohol problems such as anxiety or depression. They may also emerge after a period of abstinence.
Bipolar disorder is associated with both alcohol and drug use.

24. DRUG USE DISORDERS

Presenting symptoms:
Patients may present with:

- depressed mood, nervousness, or insomnia
- physical complications of drug use
- accidents or injuries due to drug use
- a wide range of other symptoms and signs of either acute drug intoxication or withdrawal

There may also be:

- unexplained change in behaviour, appearance or functioning
- denial of drug use
- complaints of pain or direct request for narcotics or other drugs
- legal or social problems due to drug use (relationship and family problems, domestic violence, absence from work, criminal activity to support cost of use)

Family may request help before patient does (eg. because patient is irritable at home or missing work)

Clinical Description:
A disorder characterized by the excessive consumption of drugs (including illicit drugs (eg opiates, stimulants, cannabis) prescription drugs (eg. Benzodiazepines, synthetic opiates) and other commonly available chemical intoxicants (eg. solvents, lighter fluid) leading to psychological, social and physical harm and dependence.

Required symptoms:

- *Heavy or frequent use*
- Drug use has caused *physical harm* (eg. injuries while intoxicated) psychological harm (eg. psychiatric symptoms due to drug use, psychiatric disorders exacerbated by drug use)

  OR

  has led to harmful *social consequences* (eg. loss of job, serious family and relationship problems, financial and legal problems)

Severe forms may show:
Dependence syndrome

- Continued drug use despite harm
- Difficulty in controlling drug use
- Strong desire to use drugs

Differential Diagnosis:
Consider other psychiatric conditions as possible contributors to alcohol problems such as anxiety or depression. They may also emerge after a period of abstinence.
Bipolar disorder is associated with both alcohol and drug use.

25. TOBACCO USE DISORDERS

Presenting symptoms:
Patient may present with a request for help in stopping smoking.

Patients with **smoking related diseases** such as coughing, sputum or frequent respiratory infections, high blood pressure or heart disease, should be *asked directly* about their smoking habits.

Clinical Description:
A disorder characterized by the consumption of tobacco (by smoking or chewing) leading to dependence and physical harm.

Required symptoms:
Any regular use is potentially harmful and will lead to dependence.

Dependence syndrome
- Continued drug use despite continued harm
- Difficulty in controlling use
- Strong desire to smoke
- Nicotine withdrawal symptoms

Health information:

> Parents of young children who smoke may contribute to respiratory problems in their children
>
> *Smoking during pregnancy causes premature birth, low birth weight and twice the likelihood of cot death*
>
> *Smoking is an important contributory cause of lung cancer, high blood pressure, heart disease and peripheral vascular disease*

Childhood variations:
Children may begin to smoke at an early age and have symptoms of dependence..

Differential Diagnosis:
Commonly co-occurs with other substance use disorders.

26. PERSONALITY DISORDER

Presenting problems:
Patients display a characteristic pattern of problematic behaviour over time in their relationships with other people. This may have a variety of presentations including episodes of threatened or actual self-harm, instability of mood, suspicion of, or repeated complaints about, the behaviour of others or simply an avoidance of people. There may be serious conflict in personal relationships and episodes of aggression and violence.

Required feature:
An enduring pattern of difficult and disturbed relationships with other people.

Associated features:
Difficulty in relating to other people is manifest in aggressive or antagonistic behaviour, suspicion and withdrawal from, or avoidance of, social contact, excessive need for control and order, or in rapidly changing emotions ranging from anger to self-loathing.

In some of them, a liability to become involved in intense and unstable personal relationships causes repeated emotional crises, often marked with episodes of self harm or suicidal threats. Individuals may display excessive anger during periods of crisis, with abrupt shifts to depressive and/or anxious symptoms. There may be other self-damaging behaviours such as alcohol and drug use, shop-lifting, reckless driving and binge eating.

There may also be difficulty in engaging in stable and effective helping relationships with health professionals with a tendency to present in crisis but failure to attend when crisis is resolved or to blame others for their problems.

In **severe cases** there may be:

- Brief periods of psychotic symptoms, not associated with drug use,
- Serious risk to self due to self-harm or personal neglect
- Serious risk to the safety of others due to violence or exploitation.

Differential diagnosis

- bipolar disorder
- depressive disorder

- drug use disorder

:

27. DEMENTIA

Presenting Complaints:
The *patient* may present with forgetfulness or feeling depressed.

The *family* may complain of falling memory, changes in personality or behaviour, poor hygiene or of severe form such as confusion, wandering or incontinence.

Clinical Description:
Dementia is a clinical manifestation of damage to brain tissue, either by a degenerative process, a stroke or metabolic causes.

Required symptoms:
Cognitive changes: The central feature is problems with memory. There is difficulty both in learning new information, with *recalling recent events* in life, and remembering information previously learned (**amnesia**).

Associated symptoms:
Other cognitive symptoms include **aphasia** (either expressive or receptive), **apraxia** (inability to carry out tasks – such as dressing - despite intact sensory and motor systems)and **agnosia** (inability to recognize familiar people and objects).

Behaviour problems include noisiness, restlessness, wandering and getting lost, incontinence, antisocial and inappropriate behaviour due to disinhibition, agitation and being out of the bed or confined to the bed. Daily activities such a cooking, shopping, going out of the house and paying the bills may also be affected.

Psychiatric symptoms include feeling depressed, suspiciousness and paranoid ideas (people are harming them or stealing from them), hallucinations, sleep disturbances, wandering away, apathy and anxiety.

Personality changes include easy frustration, explosive spells of anger. blunting and disinterest, social withdrawal, and inappropriate friendliness.

Common causes of dementia include:
- Alzheimer's Disease (gradual and progressive course)
- Cerebrovascular dementia (with a step-like course, associated with hypertension)
- Parkinson's Disease

Potentially reversible causes include:

- Depression - if low mood is persistent and prominent along with memory and concentration problem.
- Vitamin B_{12} and folate deficiency
- Korsakow's syndrome (severe short term memory problems due to thiamine deficiency, seen in alcoholism)
- Congestive heart failure
- Uraemia may be
- Liver failure – may be reversible
- Urinary infection
- Subdural haematoma
- Cerebral tumour
- Normal pressure hydrocephalus
- HIV infection
- Neurosyphilis
- Prescribed drugs or alcohol

Differential Diagnosis:
Minor cognitive impairment (MCI) memory impairment not interfering with occupational or social functioning

28. DELIRIUM

Presenting Complaints:
The patient may present with confusion, feeling fearful with restlessness and agitation, often uncooperative.

Clinical Description:
The onset is usually acute that develops over a short period of time (hours to days) and tends to fluctuate over the course of day.
Required symptoms:

- Clouding of consciousness with confusion
- Disorientation in time (followed by general disorientation)

Associated symptoms

- Disturbances of memory & registration
- Hallucinations (often visual) & illusions
- Restlessness common, but slowness & apathy can also occur

There is disturbance in consciousness with reduced awareness of surrounding and inattention (reduced ability to focus, sustain and shift attention).There can be disorganized thinking and incoherent rambling speech.

While agitated patients attract medical and nursing attention with their distressing and disruptive behavior, the symptoms of hypoactive delirium are easy to miss, characterized by symptoms such as low mood and fatigue, lethargy, confusion and sluggishness.

Differential Diagnosis:
Delirium is a first stage diagnosis – the task is to find its cause:

- Severe infections
- Alcohol intoxication or withdrawal (delirium tremens)
- Drug intoxication (a wide range of drugs) or withdrawal
- Metabolic changes (e.g. liver disease, dehydration, and hypoglycemia)
- Head injury
- Vascular – heart attack, heart failure anaemia
- Post operative.