Psychiatry Teaching

Introduction

In clinical practice, a psychiatric disorder is considered to exist if the resulting behaviour is a problem. Broadly speaking, there are four categories – organic disorders, psychoses, neuroses, and personality disorders.

Assessment comprises psychiatric history, mental state assessment, physical examination, and medical, physical, and social investigation.

Cognition

Mini-Mental State Examination (MMSE, /30):

Orientation	*Year, season, month, date, day of week*	5
	Country, county, town, building, floor	5
Registration	*Repeat three common objects (e.g. orange, key, ball), record number of attempts to get right*	3, #attempts
Attention & Calculation	*Serial 7s or spell 'world' backwards*	5
Recall	*Three objects from registration*	3
Naming	*Common objects (e.g. pen, watch)*	2
Repeating	*Say 'No ifs, ands, or buts'*	1
Three stage command	*'Take this piece of paper in your right hand, fold it in half, and put in on the floor'*	3
Reading	*Read and obey '**Close your eyes**'*	1
Writing	*Write a short sentence*	1
Construction	*Copy intersecting pentagons*	1

Abbreviated Mental Test (AMT, /10)

Date
Time of day
Age
Date of birth
Current location
Memorise '42 West Street'
WWII date (start or end)
Recognise two people ('doctor', 'nurse')
Current Monarch
Recall address
Count 20 down

Sections of Mental Health Act

2 Admission for up to 28 days for assessment
3 Admission for treatment
4 Emergency admission for up to 72 hours for assessment (single doctor)
5 Detention of in-patient for up to 72 hours (doctor) or 6 hours (nurse) for assessment
136 Removal from public place to place of safety by police officer, for up to 72 hours

Suicide

Suicide – intentional self harm with death the intent.
DSH – intentional self harm where the intent is unclear.

England and Wales, main methods are car exhaust (30%), hanging (28%), overdose (15% - 50% in women). Global average is 16/100 000, with steady increase in males over 50 years, constant in women. Rates vary with country, season, and socioeconomic conditions. M:F 3:1, with high rates in the elderly, unmarried, unemployed, prisoners, certain professions.

Risk factors: open statement of intent, oblique hints, sense of hopelessness, financial/social problems, mental illness, age, sex, previous attempts, chronic painful physical problems, neurological disorders.

DSH - >90% overdose (non-opiate analgesics, minor tranquilisers, antidepressants) or self laceration. Three main patterns – single episode; one or more repeats during limited period; repeat habitually. 1-2% eventually suicide. Currently 3/1000 in UK, increasing. More common in 15-25, M=F, lower social classes, high in divorced.

Assess:
- Degree of intent (planning, precautions, seeking help, method, final acts)
- Current intentions (pleased to be alive/regret, remorse, indifferent)
- Current problems (multiple/single; acute/chronic; relationships, losses, financial, social, medical)
- Psychiatric disorder (Depression, schizophrenia, personality disorder, alcoholism, OCD)
- Resources (capacity to deal with problems, material resources, support network)

Multiple Murderers

Multiple defined as 3+ killings. Divides as:

Mass – all at once/short period
Spree – over longer period (~24 hours)
Serial – over long period of time, usually with long gaps. Most calculated type.

Symptoms associated with dangerousness:

- Personalised delusions (fixed on an individual)
- Command hallucinations to kill
- Persecutory delusions
- Delusions about 'being on a mission'
- Delusions of entitlement
- Depressed mother with suicidal ideation – may take children with her

Obsessive-Compulsive Disorder

Prevalence 0.5%, M=F, early-mid adulthood. No clear familial association.

Features:

- Obsessional thoughts
    - Repeatedly come into consciousness against will of subject
    - Usually unpleasant, often abhorrent
    - Always recognised as own thoughts
    - Not accepted as inevitable
- Obsessional acts or rituals (compulsions)
    - Repetitive actions based on thoughts
    - Not pleasurable, but may relieve anxiety
    - e.g. Checking; cleaning; hand-washing; counting
- Obsessional slowness
    - 3-4% referred cases
    - Not repetitive
    - Probably obsessional thoughts

May be acute or insidious, no clear precipitant in 30%. Continuous not episodic. May be complicated by depression, suicide uncommon. 40% have single episode, 5-10% deteriorate. Poor outcome more often seen in men.

DD includes normal rituals and superstitions (no distress), depression (30% severe cases have obsessional symptoms), phobias, organic (Tourettes, Sydenhams chorea).

Treatment - psychological or drug (clomipramine, SSRIs)

Liaison Psychiatry

Management of psychiatric morbidity in the general hospital.

- Abnormal behaviour can cause physical symptoms (DSH, drug abuse, etc)
- Physical illness/treatment can cause psychiatric symptoms (acute confusional states, steroid psychosis, etc)
- Psychological reaction to physical illness (denial, anxiety, depression, etc)
- Physical presentations of psychiatric disorders (somatisation)

Depression – may be co-incidental; reaction to stress of illness; symptom of medical disorder; iatrogenic effect of treatment. Occurs in 25% of in-patients, higher if elderly, painful/life-threatening illness, chronic/disabling/disfiguring illness, major/unpleasant treatment. Often not detected – best discriminators from medical problem are depressed mood, morning depression, and hopelessness.
Physical illnesses often causing depression – cancer (esp. pancreas); cerebrovascular disease; degenerative neurological disorders (PD, HD); endocrine; metabolic (B_{12} deficiency); viral (EBV, hepatitis, HIV); autoimmune.
Medications – antihypertensives (reserpine, β-blockers); OCP; steroids; benzodiazepines; opiates; H_2 receptor antagonists; chemotherapeutic agents.
Treatment – address medical problems. Treat depression – medication, CBT, supportive, psycho-education, etc.
Antidepressants increase recovery from depression from 30% to 65%, and may have analgesic effect, especially in chronic pain.

Childhood Anxiety Disorders

School refusal – irrational fear of school attendance. May be based on fear of separation, specific fear of features of school ('school phobia'). Not truancy (absence concealed, no anxiety symptoms). Severe cases ~1/1000 at 10-11, more common in mild or acute cases. Gender/socioeconomic class no effect. Peaks at 5, 11, 14-15.

Often starts after absence or change of school, onset usually over weeks but may be acute. May be explicit anxiety or somatic symptoms (headache, stomach ache). May be associated with depression/OCD. Family features may include anxious/depressed/dependant mother; absent/passive/abusive father; youngest or previously ill child. May be bullying or teacher problem, but not usually.

Assessment needs exclusion of physical illness, interview whole family (relationships, dynamics), see child alone (worries), exclude other psychiatric diagnosis, contact school.

Treat – mild cases early school return, agree date with school. Support family to be firm. Brief family therapy may help. Chronic cases – communication essential. Individual psychotherapy/CBT, family therapy. Graded return. Prognosis good for mild/acute/situational cases. 20-30% of severe cases will not return, especially if older. 1/3 will develop adult neurotic disorders.

Normal developmental anxiety:
Early – communicated anxiety, stranger anxiety, separation anxiety, heights, novel stimuli
Middle/late – physical illness, mutilation, death; monsters/dark/animals (3-5); ridicule/shame/social situations (6-11); aggressive/sexual feelings, existential worries, nuclear war (adolescence)

Developmental Disorders

Autism Spectrum Disorders – social reciprocity deficit, communication deficit, and repetitive/stereotyped behaviours. Subtypes – Aloof; Passive; Active but odd.

Kanner Autism	**HFA/Aspergers**	**Pervasive Developmental Disorder NOS**
75% learning disabled	Normal/elevated IQ	Specific learning disabilities
Delayed/absent speech	Verbose/formal language	Subtle language abnormalities
Epilepsy	Obsessions/restricted intense interests	Often socially active but odd
Stereotypies	Clumsiness	Variable eye contact
25% chromosomal abnormalities		

0.7-1% of childhood population, 3-4:1 M:F. About 60% heritability, MZ:DZ 100:20. No social class correlation. 5% known medical cause (congenital rubella, etc)

Language symptoms
- Language delay
- Echolalia
- Stereotyped language
- Overly literal
- Lack of initiation of conversation
- Lack of reciprocity in conversation
- Fixation on certain topics

Social symptoms
- Poor eye contact
- Doesn't seek/offer comfort
- Few/no friends
- Lack of social initiation
- Social avoidance/overly friendly
- Lack of facial expression
- Deficit in reading expression/non-verbal communication

Repetitive behaviours
- Heightened sensory awareness
- Insistence on routines
- Restricted/odd interests
- Focus on small detail
- Lack of imagination
- Repetitive behaviour, e.g. lining up toys

Assessment – can be picked up in second year. No pathognomic symptoms – needs specialist assessment.
Treatment – good/early diagnosis, psychoeducation, behavioural treatment, (medical – co-occurring conditions), family therapy, educational and family support.

Impact on family – denial/rejection; overprotection; isolation; bereavement reaction; transition times; parental/sibling stress.

Child Maltreatment

Physical abuse
- Hitting/shaking/throwing objects
- Burning or scalding
- Drowning, suffocating
- Poisoning

Emotional abuse
- Persistent negative views with excessive punishment/scapegoating
- Inconsistent/unpredictable behaviour towards child
- Causing child to feel frightened/unsafe frequently
- Inappropriate expectations
- Emotionally unavailable/unresponsive

Neglect
- Failing to provide basic needs (clothing, shelter, food)
- Failing to ensure access to medical care/education
- Failing to protect from danger or provide adequate supervision
- Neglecting basic emotional needs

Sexual abuse
- Engaging child in inappropriate sexual activities
- May or may not involve contact (e.g. watching pornography/sexual acts)
- Physical may involve penetrative/non-penetrative acts
- Abusers and victims may be male or female
- Can be carried out by young people

Of 11 million children in the UK, some 4 million are thought to be vulnerable, 3-400000 ‘in need’, and 32000 on the child protection register. 48% for neglect, 27% physical abuse, 18% emotional abuse, 17% sexual abuse. 69% of parents have a mental health problem, misuse of drugs or alcohol, or are involved in domestic violence.

Effects of abuse include attachment problems; emotional disorders; disruptive behaviour; substance misuse; offending behaviour; sexually precocious behaviour; poor parenting as adults; vulnerability to further abuse into adulthood; personality disorders.