PSYCHIATRY ESSAY QUESTIONS AND ANSWERS

SUICIDE

A 14 year old girl in standard 8 was admitted from casualty last night. She had ingested 10 diazepam tablets in an apparent attempt at suicide. She is now stable. You have been asked to take history from her before the major ward round.

a. What factors will you consider when assessing the seriousness of the attempt? (10mrks)

The assessment of suicidal patient should include:-

- *Assessment of suicidal ideation- this should focus on the lethality and availability of the method as well as the likelihood of rescue from the proposed attempt*
- *Assessment of a suicide attempt- Here, the clinician asks questions in order to determine the damage caused by the attempt and the degree to which rescue from that attempt was likely.*
- *The likelihood of rescue would provide one measure of the lethality of any given suicide attempt, as well as data for judgment about continued suicide risk.*
- *General psychiatric evaluation- A careful general history will help in identification of risk factors for suicide as well as problems that might be amenable to change.*

It is important to explore the social situation, occupation, psychiatric history, drug and alcohol history, medical history as well as the mental status examination of the patient

Assessment of suicidal risk *:* ***The Beck Suicidal Intent scale (>5 is significant)***

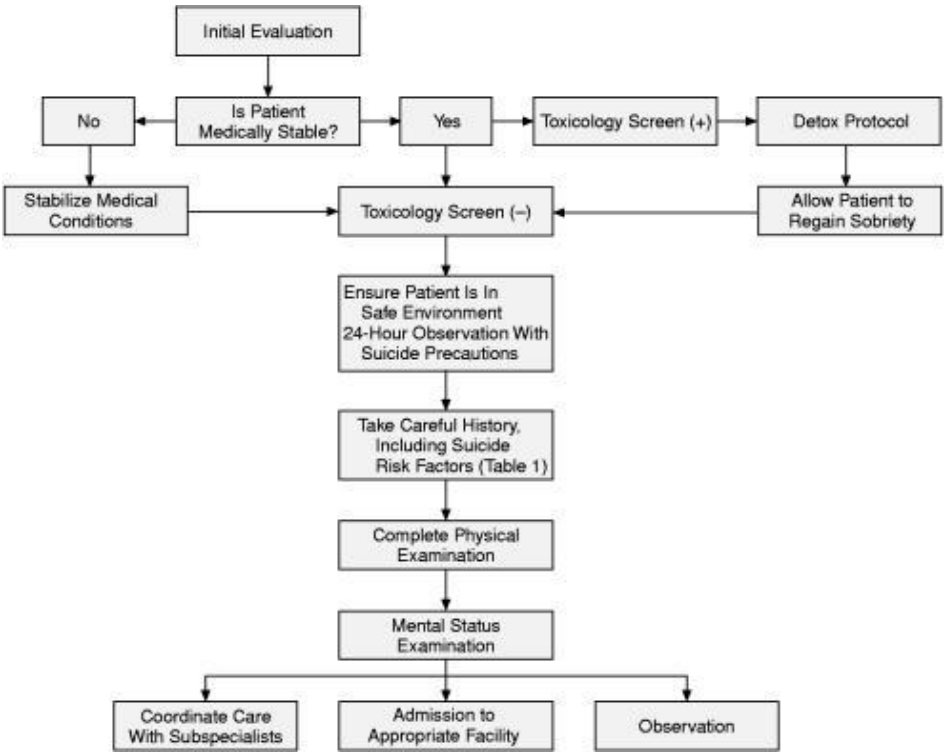
- ***Preparation***
  - *planning in advance*
  - *suicide note*
  - *final acts*
- ***Circumstances***
  - *alone*
  - *intervention unlikely*
  - *precautions against delivery*
- ***After the act***
  - *didn't seek help*
  - *stated wish to die*
  - *believed the act would result in death*
  - *regrets its failure*

The following factors indicate high risk in suicide attempt assessment:

1. *Past suicide attempts*
2. *Seriousness of previous attempts*
3. *Family history of suicide*
4. *Feelings of hopelessness*
5. *Substance abuse*
6. *Social isolation*
7. *Personal or family history of psychiatric disorders e.g. major depression, bipolar disorder*
8. *Burden of physical health problems*
9. *History of loss*
10. *Preoccupation with death*

b. How would you manage her? (10mrks)

Following is the algorithm of management of a patient who recently attempted suicide



Management would include :

- *The clinician should use his judgement about continued risk and available resources to arrive at a plan of action. This is done with the help of the patient, the family, friends and any ongoing caregivers who are available to collaborate in the process.*
- *Three treatment options exist-*
  - *Outpatient care*
  - *Voluntary admission*
  - *Forced hospitalization*

Suicide prevention

- *Effectively treating mental illnesses e.g depression*
- *Improving the coping strategies of people who would seriously consider suicide e.g social support*
- *Reducing the risk factors for suicide e.g firearms*
- *Giving people hope for a better life after current problems are resolved.*

c. What is the prognosis? (5mrks)

A significant number of people who attempt suicide and survive eventually die by their own hands, many within a year of the index attempt. A history of multiple past attempts further increases risk of eventual suicide. That most attempters do not later die by suicide is a statistical fact that should not distract psychiatrists and other mental health professionals from the substantial increase in risk associated with a suicide attempt. Short-term intensive treatment, often with psychiatric hospitalization, reduces immediate risk, but the standard of care often requires more than just a few days of generic inpatient care.

ALCOHOL DEPENDENCE

Mr O.S., 35 year old male, salesman from Isiolo, with recent, healing forearm fracture, with wife requesting for a referral to an alcohol rehabilitation unit

a) Assessment

History and physical examination:

- Age at which alcohol consumption was started
- The type of alcohol(s) consumed
- Quantity and Frequency of alcohol consumption to calculate the number of units
- consumed per week
- CAGE questionnaire.
- Alcohol use disorder identification test (AUDIT)
- Availability of alcohol:
  - Occupation: Bartenders, Brewers, Sailors, High executive
  - Legislative controls: Permitted age for use, Prices,
- Outlets(supermarkets) Genetics: Family history of alcohol consumption
- Childhood environment:
  - Alcoholic parents
  - Alcoholic siblings
  - Identification process
  - Non cohesive home environments
  - Abusive parent
  - Neglectful parents
- Culture
  - Religious controls
  - Social guidelines
  - Social approvals
  - Rituals

Existing psychiatric disorder

- Clinical features of withdrawal
  - Sweating
  - Fever
  - Irritability
  - Agitation
  - Difficulty concentrating
  - Insomnia
  - Abdominal pain
  - Nausea, vomiting, Diarrhea
  - Tachycardia
  - Tachypnea
  - Hypertension
  - Hyperreflexia
  - Tremulousne
  - Worsening of symptoms
  - Seizures
  - Hallucinations: visual or auditory
  - Delirium tremens

- Medical complications:
    - Short term: Hypoglycemia, Dehydration, Delirium, Gastritis, Ulcers
    - Long term: Cirrhosis, Pancreatitis, Alcoholic cardiomyopathy, Neuropathy, Myopathy, Malnutrition
- Social complications:
    - Home: othello syndrome, neglectful parents, separations, divorces
    - Work/education: absentesim, poor productivity, loss of job/school opportunity, poor economy, accidents, thefts, vandalism, insecurity, assaults
- Wernicke-Korsakoff syndrome

Delirium tremens:

Poor memory
Poor attention
Poor concentration
Illusions
Tremors

b) DSM IV criteria for alcohol dependence:

Maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following seven, occurring at anytime in the same 12-month period:

a) Tolerance:
    a. Need for markedly increased amounts of alcohol to achieve intoxication or desired effect
    b. Markedly diminished effect with continued use of the same amount of alcohol
b) Withdrawal:
    a. Characteristic withdrawal syndrome
    b. Alcohol (or a closely related)is taken to relieve or avoid withdrawal symptoms
c) Use in larger amounts or for longer periods than intended
d) Persistent desire or unsuccessful efforts to cut down on alcohol use
e) Time is spent obtaining alcohol or recovering from effects
f) Social, occupational and recreational pursuits are given up or reduced because of alcohol use
g) Use is continued despite knowledge of alcohol-related harm (physical or psychological)[

DEPRESSION

Mr. Kamau, a 50 year old school teacher comes to the clinic with symptoms suggestive of depression and forgetfulness. His wife died 9 months ago.

a. List the clinical features of depression (5mks)

Key symptoms include: depressed mood, anhedonia and fatigue/lack of energy

Ancillary symptoms include:

- Weight and appetite change
- Sleep disturbance
- Low self-esteem/confidence
- Self-reproach/guilt
- Impaired thinking/concentration
- Subjective or objective agitation/retardation

b. What are the possible differential diagnosis (5mks)

- Adjustment disorder/acute stress reaction
- Dysthymia
- Physical illness (hypothyroidism, Addison's disease)
- Anxiety disorder
- Chronic fatigue syndrome
- Organic disorder – substance misuse, dementia

c. How would you differentiate abnormal grief reaction from depression? (5mks)

The DSM-IV is very clear that normal grief reaction can, however, worsen and become an abnormal reaction, and this would be diagnosed under the following conditions:

* Guilt about things other than action taken or not taken by the survivor at the time of death.
* Thoughts of death other than the survivor feeling that he/she would be better off dead or should have died with the deceased person.
* Morbid preoccupation with worthlessness.
* Marked psychomotor retardation.
* Prolonged and marked functional impairment.
* Hallucinatory experiences other than thinking that he/she hears the voice or transiently sees the image of the deceased person.

TABLE 2.1 Differences Between Depression and Grief

Trait	Depression	Grief
Trigger	Specific trigger not necessary	Trigger usually loss or multiple losses
Active/passive	Passive behavior tends to keep them "stuck" in sadness	Actively feel their emotional pain and emptiness
Emotions	Generalized feeling of helplessness, hopelessness	Experience a range of emotions that are usually intense
Ability to laugh	Likely to be humorless and incapable of being happy or even temporarily cheered up; likely to resist support	Sometimes will be able to laugh and enjoy humor, more likely to accept support
Activities	Lack of interest in previously enjoyed activities	Can be persuaded to participate in activities, especially as they begin to heal
Self-esteem	Low self-esteem, low self-confidence; feels like a failure	Self-esteem usually remains intact; does not feel like a failure unless it relates directly to the loss
Feeling of the failure	May dwell on past failures, catastrophize	Any self-blame or guilt relates directly to loss; feelings resolve as they progress toward healing

Depression involved feelings of hopelessness and helplessness, being endless and was associated with a lack of control, having an internal self-focus impacting on self-esteem, being more severe and stressful, being marked by physical symptoms and often lacking a justifiable cause.

d. How would you manage this patient? Assume he is suffering a major depressive illness (10mks)

Establish the diagnosis and gather information by:

* Full psychiatric history and examination
* Using the rating scales e.g. Hamilton Depression Rating Scale to score the severity of the major depressive illness
* Investigations to rule out underlying causes of depression:
  Routine: Full haemogram, ESR, Glusose, U/E/C, Calcium, TFTs, LFTs, Drug screen, ECG, Creatinine clearance
  Others: Urinary copper (Wilson's disease), ANF (SLE), Infection screen (VDRL, HIV), CT/MRI scan
* Risk assessment:
  - Self-harm/suicide attempts: identify context, frequency, outcome
  - Physical neglect
  - Lack of compliance with treatment
  - Violence to others thoughts and actions
  - Abnormal ideas about specified people
  - Any suggestions of harm to children either physical or sexual

Pharmacotherapy indicated: Antidepressive medication:

i. SSRIs: Citalopram, fluvoxamine, Paroxetine and Sertraline
   a. Continue for ≥ 6 months after remission
   b. Continue for 2 years if ≥ 2 episodes in recent past
ii. MAOIs: Moclobemide
iii. TCAs

Psychological therapies:

* Behavioral therapy, cognitive therapy, supportive psychotherapy, dynamic psychotherapy, and family therapy
* Electroconvulsive therapies

PATHOLOGICAL ANXIETY

Irene Masumbuko, a 24 year old college student is referred to the psychiatric clinic from the medical outpatient clinic with complaints of palpitations and fear. A physician has ruled out medical condition and thinks that she could benefit from psychological help. At psychiatric clinic the psychiatrist on duty has asked to assess the patient and will be discussing the case with you later.

PATHOLOGICAL ANXIETY: An inappropriate response to a given stimulus by virtue of either its intensity or its duration

a. What other symptoms and signs would help you to confirm diagnosis of anxiety disorder? (5mrks)
   - Cognitive components:
     - Subjective feelings of apprehension
     - Restlessness
     - Sense of impending danger
     - Feeling of inability to cope
   - Physiological responses:
     - Headache
     - Perspiration
     - Stomach discomfort
     - Diarrhoea
     - Nausea
     - Polyuria
     - Chest tightness
     - Palpitations
     - Tachycardia
     - Tachypnea
     - Increased BP
     - Dry mouth
     - Muscle tension
   - Behavioural responses:
     - Avoidance of certain situations
     - Impaired task performance
     -
b. What other different types of anxiety disorders would you be seeking to rule out? (5mrks)

The physician has already ruled out Anxiety disorder due to a general medical condition which is one type of anxiety disorder

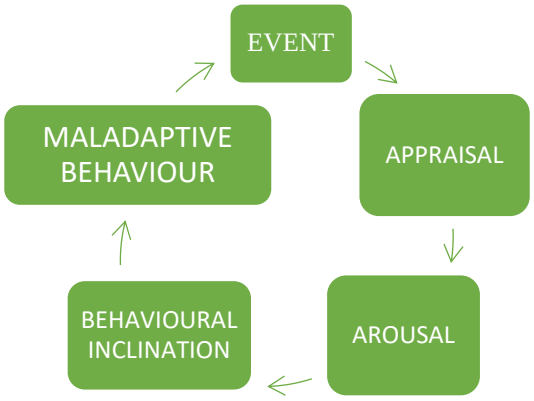
Other types of anxiety disorders according to the DSM IV classification include:

i. Panic disorder (with or without agoraphobia)
ii. Agoraphobia without history of panic disorders
iii. Specific and social phobias
iv. Acute stress disorder
v. Obsessive-compulsive disorder (OCD)
vi. Post-traumatic stress disorder (PTSD)
vii. Generalized anxiety disorder (GAD)
viii. Substance induced anxiety disorder
ix. Anxiety not otherwise specified; including mixed anxiety-depressive disorder

c. What psychosocial problems would you wish to enquire about in this case? (5mrks)
   - Cognitive behaviour theory: patient is responding incorrectly or inaccurately to perceived dangers:
     i. Selective attention to negative details in the environment
     ii. Distortions in information processing
     iii. Overly negative view
   - Psychoanalytic theory: anxiety is a symptom of unresolved unconscious conflict

d. From your discussion with a psychiatrist she determines that the patient is suffering from generalized anxiety disorder. She would like to treat the patient using cognitive behavioural therapy.
She would like you to explain this therapy to the patient since she has been called for another emergency. What would you tell the patient? (10mrks)

- It is a state-of-the-art form of psychotherapy for treatment of some psychiatric disorders
- It attempts to reduce dysfunctional/distorted emotions and behaviour (arising from biological and psychological influences) by modifying the thinking, beliefs and maladaptive behaviours



Cognitive Behavioural Therapy is
- Empirically-based
- Structured and focused
- Problem-based
- Collaborative

• Homework is an essential feature.
• It has an educational factor.
• Cognitive and behavioural interventions are integrated.

COURSE OF TREATMENT (CBT)

i. Assessment
ii. A rationale will be provided
iii. Self-monitoring training
iv. Behavioral strategies:
    a. Monitor relationship between situation/action and mood.
    b. Applying new coping strategies to larger issues.
v. Identifying beliefs and biases
vi. Evaluating and changing beliefs
vii. Core beliefs and assumptions
viii. Relapse prevention and termination

INTERVENTIONS IN CBT:

BEHAVIORAL INTERVENTIONS	**COGNITIVE INTERVENTIONS**
Breathing retraining	Monitor automatic thoughts
Relaxation	Teach imagery techniques
Behavioral activation	Promote cognitive restructuring
Interpersonal effectiveness training	Examine alternative evidence
Problem-solving skills	Modify core beliefs
Exposure and response prevention	Generate rational alternatives
Social skills training	Monitor automatic thoughts
Graded task assignment	

DEMENTIA

Amadi has brought his 70 year old mother to the outpatient medical clinic. Previously a neat woman she has been noticed to be unconcerned about her appearance of late. She also made rude comments embarrassing everyone at a wedding party last Saturday. When she stated that she did not think highly of the bridegroom. You think that she could be suffering from dementia.

a) What psychosocial history would you like to ask? (5mrks)
   i. BIODATA: Marital status, Occupation, Residence, Language and Ethnic background, Level of education, Income, Number of children
   ii. HPI:
      - Memory loss (difficulty in learning and forgetting)
      - Difficulty performing daily activities (bathing, shopping, cooking, dressing)
      - Poor insight
      - Paranoid delusions
      - Hallucinations (esp. visual)
      - Anxiety, depression and sleep disturbance
   iii. PAST PSYCHIATRIC Hx
   iv. PAST MEDICAL Hx: Alzheimer's dx, HIV, Parkinson's dx, Huntington's dx, Pick's dx, Brain tumor, head trauma, Epilepsy, MS, CHF, Subacute bacterial endocarditis, SLE, Hypothyroidism, Hyperparathyroidism, DM
   v. FAMILY Hx: Hx of dementia in family
   vi. PERSONAL Hx: Education
   vii. OCCUPATIONAL Hx
   viii. SEXUAL Hx
   ix. MARITAL Hx
   x. SOCIAL Hx: Substance abuse

b) What are two differential diagnosis? (5mrks)
   i. Delirium:
      - Delirious patients have an altered level of consciousness, demented patients are alert
      - Demented patients may develop superimposed delirium
   ii. Amnestic disorder: isolate memory disturbance without cognitive disturbances (dementia has both)
   iii. Major depressive disorder:
      - Depression: mood disturbances precede cognitive deficits
      - Dementia: cognitive deficits precede mood disturbances
      - Demented patients can develop depression
   iv. Age-related cognitive decline
   v. Stroke
   vi. Trauma/head injury
   vii. Schizophrenia
   viii. Substance abuse
   ix. Mentally handicapped
   x. Acute confusional state
   xi. Factitious disorder

c) What investigations would you like to do? (5mrks)
   i. FHG: Leucocytosis (infection)
   ii. LFTs: Hepatic encephalopathy
   iii. U/E/Cs: uremia
   iv. TFTs: hypothyroidism
   v. Urinalysis
   vi. Triple serology; HIV
   vii. Septic screen; urine m/c/s, blood m/c/s, CSF m/c/s
   viii. Serological studies; VDRL and MHA-TP

ix. RBS: DM
x. BGA: Metabolic disturbances
xi. Vitamin B-12 and folate levels
xii. Heavy metal screening: for aluminium levels
xiii. Serum levels of drugs: Alcohol
xiv. EEG: Epilepsy
xv. CT-head; a PET can be done; Alzheimers
xvi. MRI-head
xvii. ECG; HF, Subacute bacterial endocarditis
xviii. Chest radiograph: HF

d) Briefly describe the causes and management of dementia. (10mrks)

i. Alzheimer's type dementia: commonest cause/form of dementia
ii. Vascular dementia: multiple brain infarcts (CVAs)
iii. Dementia due to General medical condition
- Neurological causes: Parkinson's dx, Huntington's dx, Pick's dx, Normal pressure hydrocephalus, Brain tumor, head trauma, Epilepsy, MS, cerebral hypoxia and anoxia
- Vascular: CHF, Subacute bacterial endocarditis, SLE
- Toxicity: Alcohol, radiation, heavy metals (aluminium),
- Infections: HIV, Neurosyphilis, Cryptococcal meningitis, encephalitis, Sarcoid, Creutzfeldt -Jakob dx
- Nutritional: folate deficiency, vitamin B012 dficiency, Thiamine deficiency, Pellagra
- Endocrine: Hypothyroidism, Hyperparathyroidism, DM, pituitary insufficiency
- Metabolic: Uremia, porphyria, hepatic encephalopathy, Wilson's dx

iv. Substance induced persisting dementia
v. Dementia due to multiple etiologies
vi. Dementia not otherwise specified

Management of dementia:
- No known definitive tx
- Treat any underlying cause
- Stop CNS depressants and anticholinergics
- Patients should avoid highly stimulating environments
- Psychological support for family and/or caretakers
- NON PHARMACOLOGICAL:
  - Psychotherapy: behavior modification, Environment manipulation
  - Psychosocial management: Repetition, Reassurance, Redirection
  - Family therapy
- PHARMACOLOGICAL TREATMENT
  - Tx of Alzheimer's Dementia: Reversible ACE inhibitor (Donepizel (drug of choice), Rivastigmine, Galantamine, Tacrine) or NMDA receptor antagonist (Memantine)
  - Tx of vascular dementia: Control HTN, Aspirin
  - Tx psychosis: Neuroleptics (Riseperidone, Olanzapine, Haloperidol, fluphenazine)
  - Tx Depression: SSRIs(Vanlafaxine, Buproprion, Trazodone, Nefazodone, Mirtazapine)- AVOID TCAs
  - Tx of aggression and agitation:
    - Anxiolytics: Buspirone, Benzodiazepines (Lorazepam)
    - Neuroleptics: Riseperidone, Olanzapine, Haloperidol

PSYCHOTIC DISORDER

A 21 year old woman, Wanjiru who gave birth to a healthy baby boy 2 weeks ago was brought to the hospital emergency department by her husband because when he came home from work he found her crying and she had laid the baby on the kitchen floor and had several knives nearby. She was mumbling something about "sacrifice". Wanjiru had been examined by the medical registrar and she appeared dehydrated and exhausted but otherwise declared to have no obvious medical illness. The psychiatrist on call has been alertedand shehas asked you to assess Wanjiru before she arrives.

a. What are the possible psychiatric diagnoses you would like to rule out. State which is the most likely diagnosis. Give reasons for your choice. (10mrks)

1) Post Partum Psychosis

The peak onset of psychotic symptoms is 10-14 days after parturition, but the risk remains high for months after delivery.

Women with postpartum psychosis have an inability to discern reality from that which is unreal & usually will have difficulty in caring for their infant, and may have delusions leading to thoughts of self-harm or harm of the infant. They may also have an underlying depressive, manic, schizophrenic, or schizoaffective disorder.

They have stretches of lucidity alternating with psychosis. Also frequently noted are symptoms of confusion and disorientation that are often seen in toxic states or delirium.

Characteristically patients begin to complain of:

- Fatigue
- Insomnia
- Restless has episodes of fearfulness
- Emotional lability
- Cognitive deficits/impairement
- Motility disturbances
- Mood abnormalities

Clinical features include:

- The patient may develops frank psychosis and grossly disorganized behavior that represent a complete change from previous functioning.
- Suspiciousness
- Confusion
- Incoherence
- Obsessive concern about baby's health &welfare.
- Irrational statements
- Delusion present in 50% of patient (many involve death of baby or being defective)
- Hallucination " 25% "(voices telling her to kill the baby)
- Inability to move stand or walk is common.
- Feeling of not wanting to care for the baby
- Not loving the baby
- Wanting to harm baby or self or both
- Denial of birth
- Thought of being unmarried persecution

2) Psychotic disorder

3) Brief psychotic Disorder with postpartum onset (if onset within 4 weeks of postpartum)

4) OCD

5) Schizoaffective disorder
6) Schizophrenia
7) Bipolar Mood disorder I
8) General medical condition e.g. hypothyroidism Cushing syndrome leading to depression
9) Substance induced psychosis
10) Infections, toxaemia
11) Neoplasm

b. What additional information would you like to get from the husband? (5mrks)

- Primiparity
- Family history of psychiatric illness
- History of a psychotic illness - Brief intervals between an earlier psychiatric episode and parturition increase the likelihood of relapse. Among the various types of psychiatric disorders that predict postpartum psychosis, bipolar disorder and schizoaffective disorder are the strongest.
- Psychosocial factors - marital disharmony, relevant stressful events

c. Discuss with the psychiatrist your management plan. (10mrks)

- Treatment is dictated by the underlying diagnosis, bipolar disorder, and guided by:
  - The symptom profile
  - Patient's response to past treatments
  - Drug tolerability
  - Breastfeeding preference.

-The somatic therapies include

- Antimanic agents
- Atypical antipsychotic medications
- ECT.
- Estrogen prophylaxis remains purely investigational.

-Do not breastfeed when on medication that affects the baby
-Suicidal caution may be necessary to transfer to psychiatric unit.
-Maintain mother to baby contact but supervise
-Psychotherapy indicated after period of acute psychosis address various conflicts in patient life including:

- Acceptance of mothering role.
- Changes in environmental factors may be indicated.
- Increased husband and other person support to patient to reduce stress.

CONVERSION DISORDERS

- Hx to dignose conversion disorder
    - Rule out organic causes
        - History and physical exam
        - CT scan
        - UECs
        - LP
        - Pottasium levels - hypokalemic periodic paralysis
    - Rule out feiging
    - Establish psychological mechanims
        - Preceding stressor
    - Is the patient concerned abt their disorder (la belle indifference)
- S/S of conversion disorder
    - Atleeast one neurological symptoms (motor or sensory) - paralysis, autism, blindness, seizures
    - Psychosocial factors e.g stress
    - Symptom is not intentionally produced
    - Cant be explained by medical or drug use
    - Causes significant distress in social or occupational functioning
    - Not limited to pain or sexual symptom
- Differnce from seziures of conversion (PNES) disorder from epilepsy
    - Bitting tip of the tongue and not the whole tongue
    - Lasting > 2 mins
    - Side to side head movements
    - Closing eyes and resisting movement
    - Gradual onset
    - No - incontinence
    - Stop hand from hitting face if dropped over-head
    - Long term video EEG monitoring
- Management
    - Insight oriented psychotherapy
    - Pshysiohterapy
    - Family therapy
    - Group therapy
    - CBT
    - Hyponosis

CHILDHOOD PSYCHIATRY

a. Distinguish between school refusal and school truanting

SCHOOL REFUSAL	*SCHOOL TRUANCY*
Severe emotional distress about attending school; may include anxiety, temper tantrums, depression, or somatic symptoms	*Lack of excessive anxiety or fear about attending school*
Parents are aware of absence; child often tries to persuade parents to allow him/her to stay home	*Child often attempts to conceal absence from parent*
Absence of significant nit-social behaviours such as juvenile delinquency	*Frequent antisocial behaviour, including delinquent and disruptive acts; (e.g. lying, stealing), often in the company of antisocial peers*
During school hours, child usually stays home because it is considered a safe and secure environment	*During school hours, child frequently does not stay home*
Child expresses willingness to do school work and complies with completing work at home	*Lack of interest in schoolwork and unwillingness to conform to academic and behaviour expectations*

b. Give examples of psychiatric disorders that may cause these conditions

Psychiatric conditions that can cause School Refusal include:

- *Mood disorders: depression*
- *Anxiety disorder, Separtion anxiety, Panic disorder*
- *Learning diability*
- *Sleep disorder*
- *The child may want attention from significant people outside of school, such as parents or older acquaintances. (Conversion disorders)*
- *Phobias: social, xenophobia or any other specific phobia*
- *Conduct disorders*

Psychiatric conditions that may lead to truancy:

- *Conduct disorder*
- *Substance abuse*

c. Outline the management of a child who refuses to attend school

Goal is return to fulltime school placement.

A 'rapid return' strategy may be useful if the period of absence is short.

For longer refusal periods a gradual approach used.

Work with parents and teachers and also understand the child's anxiety and concerns.

The following therapies have been used:

i. Cognitive behavioural therapy

ii. Psychodynamic theory

iii. Social therapy

iv. Pharmacology: Only fluoxetine approved for use in <18 yr olds

Useful strategies in some common scenarios:

i. ***Refusing school to avoid difficult situations***
- *Educate regarding anxiety / relaxation training*
- *Learning problem solving skills*
- *Psychological therapy to modify irrational thoughts*
- *Gradual re-exposure to school using a hierarchy*

ii. ***Refusing school to get attention from others***
- *Empowering parents to use brief/clear commands*
- *Help family set a morning routine prior to school*
- *Rewarding children for school attendance*
- *Forced school attendance in special circumstances*

iii. ***Refusing school to get rewards outside of school (e.g. playing videogames)***
- *Rewarding children for school attendance*
- *Not rewarding any non-attendance*

iv. ***Refusing school because of systemic problems (transitions, bullying etc)***
- *Encouraging better parent-teacher collaboration*
- *Anti-bullying measures/• Reducing violence*
- *Increasing positive school climate and making transitions easy for student*

You have been asked to give an educational talk to mothers with disturbed children. They would like to know about the disorders listed below. They would like to have the following questions answered. What is the meaning of the term? What causes it? How is it diagnosed? What help is available for those with the disorder? Write short notes on each of the following to highlight these aspects.

a) Autism spectrum disorder
   i. *Definition – developmental disorder that involves problems with social skills, language, and behaviour.*
   ii. *Cause – there is no exact cause but if the child has genes that predispose him to get autism, pregnancy related conditions such as maternal illness and birth difficulties leading to childs oxygen deprivation can cause autism*
   iii. *Diagnosis – involves 3 major criteria a. problems in social interaction, b.impairment in communication and, c. repetitive, stereotyped patterns of movement*
   iv. *Help available – treatment involves helping improve social skills, not cure disease. Drugs for aggression, hyperactivity and repetitive behaviour and remedial education to assist children achieve expected competencies in core academic skills such as literacy are available.*

b) Conduct disorder
   i. *Definition – repetitive, persistent pattern of behaviour where basic rights of others is violated e.g harm to others or major age appropriate societal norms or rules are violated e.g destruction of property*
   ii. *Cause – multifactorial, involves things like marital conflict at home, association with a negative peer group*

iii. *Diagnosis – prescence of 3 or more of the following criteria in the past 12 months with at least one present in the past 6 months*
    1. *Aggression to people and animals – e.g initiates physical fights*
    2. *Destruction of property – e.g deliberately destroyed property*
    3. *Deceitfulness or theft – e.g broken into others houses*
    4. *Serious violations of rules – e.g truancy from school, beginning before age 13*

iv. *Help available – a multimodal approach is useful. It is important to structure the child's environment with firm rules that are consistently enforced. Individual psychotherapy that focuses on behavior modification and problem solving skills is often useful. Drugs are also available to help some symptoms such as aggression, abnormal electrical activity of the brain etc*

c) Attention deficit hyperactivity disorder (ADHD)

I. *Definition – is a long term (chronic) condition that involves persistent inattention, hyperactivity and sometimes impulsivity (begins in child hood and often lasts into adulthood)*

II. *Cause – multifactorial; Genetic factors, prenatal trauma/toxin exposure (e.g fetal alcohol syndrome, lead poisoning), neurochemical factors (dysregulation in brain messengers i.e noradrenergic systems, abnormal electrical activity of brain as evidenced by [EEG] patterns or positron-emission tomography scans), psychosocial factors (emotional deprivation etc.)*

III. *Diagnosis –*

- ***1.*** *At least six symptoms involving inattentiveness, hyperactivity, or both that have persisted for at least 6 months:*

Inattention*—problems listening, concentrating, paying attention to details, organizing tasks; easily distracted, often forgetful.*
Hyperactivity–impulsivity*—blurting out, interrupting, fidgeting, leaving seat, talking excessively, and so on*

2. *Onset before age 7*
3. *Behavior inconsistent with age and development*

IV. *Treatment – multimodal;*

a. *Pharmacotherapy – CNS stimulants (methylphenidate i.e ritalin 1st line therapy), SSRIs/TCAs as adjunctive therapy*
b. *Individual psychotherapy - involves techniques to modify child's behaviour*
c. *Parental counselling – educating parents on the condition and offering skills to aid support of child*
d. *Group therapy- helps improve social skills and self-esteem*.

d) Nocturnal enuresis

a. *Definition - as involuntary (or even intentional) wetting in children 5 years of age or older after organic causes (e.g diabetes) have been ruled out*
b. *Cause – several theories are present; genetics may predispose (70% of children have an affected relative), ADH (helps reabsorb urine) underproduction, bladder problems (small, muscle spasms), sleep problems (deep sleep, cant wake up to urinate)*
c. *Diagnosis –*

Diagnostic criteria for 307.6 Enuresis (DSM 4) – OBSOLETE??

A. *Repeated voiding of urine into bed or clothes (whether involuntary or intentional).*

B. *The behavior is clinically significant as manifested by either a frequency of twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.*

C. *Chronological age is at least 5 years (or equivalent developmental level).*

D. *The behavior is not due exclusively to the direct physiological effect of a substance (e.g a diuretic) or a general medical condition (e.g diabetes, spina bifida, a seizure disorder).*

d. *Treatment - Two main interventions are available: alarm treatment and pharmacotherapy (Desmopressin (ADH analogue) and tricyclic anti depressants)*
   - *Alarm treatment – (both parent and child motivation needed) consists of a pad or a metal sensor, which is connected to a bell by a wire. Once the sensor becomes wet, an electric circuit is closed and the alarm is set of and the child wakes up or is woken up by parent to go and urinate, change clothes, alarm reset.*

1. **A man was attended by the doctor at casualty 2 nights ago and admitted for uncomplicated peptic ulcer. He was found to be smelling of alcohol. On the 3rd night he appears confused and agitated. You are the intern on call and the nurse calls you to attend the patient**

    - List the possible causes of agitation
        - Alcohol withdrawal syndrome
        - Encephalopathy - Hepatic or Wernickes
        - Head injury
        - Delirium
        - Hypoglycemia
    - Outline the physical psychological and lab investigations you would request
        - Physical exam
            - Neurological exam
                - Signs of encephalopathy
                - Signs of head injury - localizing signs
            - Abdominal exam
                - Abdominal tenderness due to peptic ulcer
            - Signs of chronic liver disease
        - Psychological evaluation
            - CAGE
        - Lab investigations
            - FHG
            - LFT'S
            - Blood alcohol levels
            - Abdominal U/S
            - CT head
        - Management
            - Acute management - Detoxification
                - ABC
                - Especially to fluid and electrolyte imbalace (most alcoholics are dehydrated and have low sodium, potassium, magnesium and calcium levels)
                - If hypoglycemic - transfuse 5% dextrose
                - Benzodiazepines
                - Thiamine (B1) - prevent Wernike's encephalopathy
                - Folic acid and other multivitamins - alcoholics are usually nutritionally deficient
                - Naloxone

            - Treating dependence
                - Disulfuram
                - naltrexone
            - Rehabilitation - psychotherapies
                - Group therapy - e.g alcoholic anonymous
                - CBT
            - PUD treatment

2. **Schizophrenia**
    - Outline the first rank symptoms of schizophrenia
        - Auditory hallucinations
            - 3rd person e.g hearing 2 people talking
            - Running commentary
        - Thought
            - Thought withdrawal
            - Thought insertion
            - Thought broadcast
        - Control - Delusion of control i.e some one is controlling your actions
        - Delusion of perception - For example, the subject interprets a stop sign as an exhortation from another world to "stop being such a bad person
    - Outline the theories of schizophrenia
        - Neurotransmitter theory
            - Due to ↑dopamine activity in certain tracts of the brain
                Prefrontal cortical - negative symptoms
                Mesolimbic - postive symptoms
            - Evidence :
                antipsychotics that are dopamine antagonists are beneficial to patients
                Cocaine and amphetamines increases dopamine activity and lead to schizophrenia like symptoms
        - Down-ward drift theory
            - Low socioeconomic groups have higher rates of schizophrenia
            - It prostulates that people suffering from schizophrenia are unable to function well in society and hence enter low socioeconomic groups
        - Genetic theory - Twin studies
            - Findings from twin concordance, adoption, and family tree studies suggest a strong genetic contribution independent of environmental or child-
            - Monozygotic twins - 65%
            - Dizygotic - 12%
            - One parent schizo - 5-10%
            - Two parents schizo - 40%
            - 1st degree relative - 12%

        - Family theories
    - Outline the management of 24 yr old man with schizophrenia
        - Investigations
            - FHG, LFT,UEC - can effect drug choice and dosing
            - CT head - to rule out any organic brain damage
        - Medical treatment
            - Antipsychotics
                - Typical
                - Atypical
            - Psychotherapies
        - Prognosis

3.

a) Outline the clinical features of a manic patient. (10)
   1. ***D****istractibility*
   2. ***I****nsomnia*
   3. ***G****randiosity (delusions) and inflated self esteem*
   4. ***F****light of ideas or racing thoughts*
   5. ***A****ctivity – increase in goal directed activity e.g work*
      - *Excessive involvement on pleasurable activities that may later have negative consequences e.g shopping sprees*
   6. ***S****peech - pressured (rapid and uninterruptible)*
   7. ***T****houghtlessness*
   8. *Abnormally, persistently elevated, irritable or expansive mood*
   9. *Hallucinations*

b) Discuss the management of a manic patient (15)
   - *Is a psychiatric emergency*

   1. *Pharmacotherapy*
      - *Lithium – mood stabilizer*
      - *Anti convulsants – sodium valproate and carbamazepine*
      - *Olanzapine – atypical antipsychotic*
      - *Adjuncts - benzodiazepines*
   2. *Seclusion and restraint – as may be harmful to self or others*
   3. *Sleep aids*
   4. *ECT*
      - *Once manic episode controlled*

   1) *Lithium prophylaxis to prevent recurrence*
   2) *Psychotherapy – supportive, family and group therapy*

4.

a. Using specific examples describe the 3 levels of prevention in mental health. (5)
   http://oxfordmedicine.com/view/10.1093/9780195173642.001.0001/med-9780195173642-chapter-4
   1. *Universal mental health prevention interventions - School-based programs offered to all children to teach social and emotional skills or to avoid substance abuse. Programs offered to all parents of sixth graders to provide them with skills to communicate to their children about resisting substance use.*
   2. *Selective mental health prevention interventions - Programs offered to children exposed to risk factors, such as parental divorce, parental mental illness, death of a close relative, or abuse, to reduce risk for adverse mental, emotional, and behavioral outcomes*
   3. *Indicated mental health prevention interventions - Interventions for children with early problems of aggression or elevated symptoms of depression or anxiety*

b. How may depressive illness be prevented? (5)
   - *The evaluated preventive strategies are based primarily on cognitive behavioral and family-educational approaches that seek to reduce risk factors e.g neglect, substance abuse and enhance protective and resiliency factors associated with depression in youth.*
   - *Teaching at-risk individuals to become more resilient—to develop skills and abilities to spring back from or adapt to adversity*
   - *Teaching individuals at risk to enhance and enrich the positive aspects of living by changing cognitive patterns, enhancing social skills, and increasing resiliency*
   - *Some other aspects that may help are; reaching out to family and friends in times of crisis*

c. Describe the course and prognosis of a depressive illness (15)
   1. *Course – patients experience depressive symptoms 2-3 weeks prior to a major depressive episode. An episode lasts about an average of 6-8 months if untreated, weeks to 3 months (treated).*
      - *60% of people with a prior episode eventually experience another episode and 20% progress to chronic depression. Affected individuals experience about 6 episodes in a 20 year period*
      - *Subsyndromal symptoms are present in the vast majority of individuals who recover from an episode of MDD, with or without treatment. The presence of these symptoms suggests that the MDD is still clinically active and unremitted. This leads to a significant increase in risk for early relapse into full criteria MDD and should not be interpreted as an apparent state of wellness by either the clinician or patient. The clinician must continue to treat these symptoms in an effort to bring the patient to an asymptomatic state*
      - *The risk of recurrence after recovery is extremely high (36% after 1 year and about 85% after 15 years)*
      - *Severe anxiety symptoms develop in patients with MDD (probability of about 50%), co-orelating with worse clinical outcomes*
      - *Upto 30% develop an episode of mania about 3 decades after the initial episode, thereby resulting in a bipolar1 disorder. This may develop as a consequence of antidepressant medication*
   2. *Prognosis – relatively poor*
      - *Depression is a chronic disorder that relents periodically, requiring long term treatment.*
      - *Increased risk of suicide is present especially with patients who eventually develop anxiety symptoms*