CHILDHOOD PSYCHIATRY

5. Distinguish between:

- School Refusal (M = F)

- This is a condition characterised by reluctance and often outright refusal to go to school in a child who:

i) seeks the comfort and security of home preferring to remain close to parental figures especially during school hours

ii) Displays evidence of emotional upset (or unexplained physical symptoms) when faced with the prospect of having to attend school

iii) manifests no severe antisocial tendencies apart from possible aggressiveness when attempts are made to force school attendance

iv) Does not attempt to conceal the problem from the parents

- It can occur with psychiatric disorders such as: <NB/: It is not a diagnosis but a symptom>
  - Separation Anxiety Disorder
  - Phobic disorder of Childhood
  - Social Anxiety Disorder of Childhood
  - Agoraphobia without panic Disorder
  - Mild Depressive Episode
  - Adjustment Disorder

- Management:

- This child should return to school as quickly as is medically and socially possible and consistently attend school without subjective experiencing of distress

- Cognitive Therapy
  - to restructure the child's thoughts and actions into a more assertive and adaptive framework
  - also included are systematic desensitisation and exposure and operant behavioural techniques to facilitate successful separation of the child from parent
  - modelling, role-playing, relaxation techniques and reward systems for behaviour change are examples of CBT

Psychological Therapy
- psychodynamic approach to delineate the psychological rationale for the symptoms and behaviours
- individual psychodynamic therapy +/- play therapy
- Family therapy

Pharmacologic Therapy (with caution)
- TCAs
- SSRIs (only Fluoxetine in children)
- Anxiolytics
- β adrenergic blocking agents (inhibit physiological symptoms of anxiety)

- School Truancy (M > F)

- Children stay off school and attempt to conceal the fact from their parents. If it persists for > 6 months, according to ICD-10, a conduct disorder exists.

PSYCHIATRY

ANXIETY DISORDERS

#6. 2 months ago, a 20yr old college student witnessed a horrible accident whereby her friend, who she was walking with towards the lecture halls, was badly hurt while crossing the road. She is now quite distressed & uses an alternative route, which takes her an extra 10min, to reach the lecture halls.

a) What is the most likely diagnosis and what additional features would you look for to confirm the diagnosis?

- Diagnosis = Post traumatic stress disorder (PTSD)
- Additional features (In DSM.IV diagnostic criteria):

B = Persistently re-experiencing the event via intrusive recollection or nightmares, flashbacks or intense distress when exposed to reminders of the event

C = Feelings of detachment (emotional numbing), anhedonia, amnesia, restricted affect or active avoidance of thoughts / activities that may be reminders of the trauma

D = General state of increased arousal persisting after the trauma, which is characterized by poor concentration, hypervigilance, exaggerated startle response, insomnia or irritability

(E = Symptoms present for 1 month at least)

F = Symptoms cause significant distress or impaired occupational or social functioning.

b) What are the differential diagnoses?

i) Depression - It's also associated with insomnia, anhedonia, poor concentration & feelings of detachment. A stressful event may also

be associated with the onset of depression.
- However, depression isn't commonly assoc. c̄ nightmares & flashbacks of a traumatic event.

ii) OCD - Assoc. c̄ recurrent intrusive ideas. However, they aren't specific to a traumatic event.

iii) Malingering - PTSD may be an illness for which monetary compensation is given, Pts may fabricate / exaggerate symptoms.

iv) Other anxiety disorders - Can cause symptoms of increased arousal, numbing & avoidance
- However, sx were probably present before the trauma.

v) Borderline Personality Disorder (BPD) - Assoc. c̄ anhedonia, poor concentration, past hx of emotional trauma & dissociative states similar to flashbacks.

- other features of BPD such as avoidance of abandonment, identity disturbance & impulsivity differentiate BPD from PTSD.

c) What are the co-morbid disorders commonly found in this condition? There is risk of:

- ✓ Depression
- ✓ Substance abuse
- ✓ Other anxiety disorders
- ✓ Somatization disorder
- ✓ Suicide

Scanned with CamScanner

d) How would you manage her? Biopsychosocial treatment.

A. 'Bio' = Pharmacological treatment:

- older antidepressants eg. imipramine, amitriptyline & MAO-I are moderately effective esp. for sx of increased arousal, intrusive thoughts & co-existing depression
- Sertraline has also shown efficacy for all the sx clusters of PTSD. Treatment at higher doses than are used for depression may be required.
- Propranolol, lithium, anticonvulsants & buspirone may be effective & should be considered if there's no response to antidepressants

NB: BDZs are only effective in the **acute** phase

B. Psychosocial:

- Psychotherapy eg. Imagination exercises, cognitive restructuring
- Behavior therapy – Anxiety management skills eg. breathing exercises etc
- Education about illness
- Support groups
- Family therapy

Scanned with CamScanner

Psychotherapies:

4) What is behavioural therapy?

This is a type of psychotherapy that focuses on behaviour itself. The therapist and the patient identifies the unwanted behaviours and determines ways to eliminate them and replace them with new desired behaviours.

5) List 5 specific techniques used in behavioural therapy.

(i) Relaxation training - to cope with stress.
(ii) Systematic Desensitization - for anxiety and avoidance reactions.
(iii) Modelling - observation learning.
(iv) Assertion training - learning to express one's self.
(v) Social Skills Training - learning to correct deficits in interpersonal skills.

6) Which behavioural techniques are used in treating anxiety disorders?

(i) In vivo desensitization.
(ii) Flooding.
(iii) Eye Movement Desensitization and Reprocessing (EMDR).

Scanned with CamScanner

Nicole.

Psychiatry

Dementia

4. List the known causes of Dementia

A) Cortical dementias → present with features of personality change
- Frontotemporal
  - Semantic dementia → hallmark is anomia
  - Normal pressure hydrocephalus (NPH)
  - Progressive non fluent Aphasia (PNFA)
  - Pick's disease
  - Motor neurone disease
- Posterior parietal → memory loss & focal neurological deficits
  - Alhzeimer's disease (4 A's → Agnosia, Apraxia, Aphasia, Amnesia)

B) Subcortical dementias → gross psychomotor slowing, abnormal movements, low mood, mild amnesia, apathetic personality
- Parkinson's disease
- Huntington's disease
- HIV associated dementia
- Binswanger's disease
- Wilson's disease

G) Vascular dementia
- ~~CADASIL~~
- Binswanger's disease

C) Subcortical - cortical dementia
- Lewy- Body dementia → have vivid visual hallucinations

D) Multifocal dementia
- Creutzfeld - Jacob disease

E) Mild cognitive impairment → lack functional impairment

F) Prion disease
- kuru
- creutzfeld Jacob
- Fatal familial insomnia
- Gerstmann Straussler syndrome

Scanned with CamScanner

potentially reversible causes

- Intracranial causes
  - Normal pressure hydrocephalus
  - Subdural hematoma.
  - Cerebral tumors.
  - General paresis of the insane (neurosyphillis)

- Systemic disorders.
  - Alcoholism
  - Anoxia
  - hypoglycemia
  - Myxoedema
  - Vitamin deficiencies eg. vit B12 deficiency
  - Drug & chemical poisoning
  - Pseudodementia
  - Renal & hepatic disease

~~Neuro~~

5. Clinical features of dementia.
   - 4 A's of alhzeimer's → Amnesia, Apraxia, Agnosia, Aphasia
   - Delusions
   - Auditory & visual hallucinations
   - Depression
   - Psychosis
   - Personality change
   - Behavioral change
   - Weight loss
   - weakness
   - stooped posture
   - nonspecific or apraxic abnormalities of gait.
   - Urinary incontinence, decreased mobility & balance problems → mostly in vascular dementias

Scanned with CamScanner

6. Investigations to confirm the diagnosis of dementia

- Full blood count
- Erythrocyte sedimentation rate
- Thyroid function tests
- Blood glucose & lipids.
- LFTs
- UECs
- vit B12 & folate
- Midstream urine sample
- Chest x ray → Risk of Bronchopneumonia
- ECG
- Electroencephalogram (EEG)
- CT scan
- MRI
- SPECT (single-photon emission computed tomography)

Scanned with CamScanner

Psychiatry

5 A 21 year old woman, Wanjiku, who gave birth to a healthy baby boy 2 weeks ago was brought in 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 with several knives nearby.
She was mumbling something about 'sacrifice'. Wanjiru has been examined by the medical registrar and she appeared dehydrated, exhausted, but was otherwise declared to have no obvious medical illness. The psychiatrist on call has been alerted and has asked you to access Wanjiku before she arrives.

a) What are the possible psychiatric diagnosis you would like to rule out

Post partum psychosis
Substance induced psychosis
Psychotic disorders - schizoaffective disorder
- schizophrenia
- schizophreniform.
General medical conditions - cerebrovascular stroke, electrolyte imbalance, brain tumor, thyroid disease, infection, liver disease.
Mood disorder with psychotic features - bipolar, depression
Obsessive compulsive disorder

State which is the most likely diagnosis, giving reasons for your choice.

Post partum psychosis
why?
She has given birth, 2 weeks ago - within the post partum period.
Exhibiting emotional lability - e.g crying
Shows signs of wanting to harm her child or herself.
Delusions and irrational statements e.g 'talking about a 'sacrifice'.
Bizarre behaviour e.g laying child on the ground, with knives.
She is fatigued, dehydrated suggesting she might be experiencing sleep

Scanned with CamScanner

disturbances, poor appetite, not taking care of herself or the baby.

b) What additional information would you like to get from the husband.

~~HPI~~ History of mental illness in the past, history of chronic/medical illness

- Events surrounding this particular incidence, previous incidences similar to this

Has she been behaving abnormally before this, when did change occur

Her pre-pregnancy personality/mood/affect/behavior.

Pregnancy experience - any issues, mood/behaviour etc.

Previous pregnancies? if yes, did she experience the same symptoms.

Use of drugs, alcohol, substance abuse.

How well has she adapted to motherhood, bonding with child, taking care of child.

Family history of psychiatric illness

c) Discuss with the psychiatrist your management plan (10 mks)

Take a thorough history - personal & corroborative history and physical examination of patient

Assess suicidal/homicidal risk (harm to baby) to decide on admission

Carry out investigations to rule out organic cause for behaviour

- TFT, TBC, LFT ....

Definitive treatment

1) pharmacological treatment - (avoid breastfeeding

Antimanic agents e.g lithium

Antipsychotic agents - atypical

~~ECT~~

2) Electroconvulsive therapy - especially for severe disease, suicidal/homicidal ideation

3 Psycho therapy

- to address conflicts in patient's life including

acceptance of mothering role, social support etc

- Social support e.g mother-baby groups, spousal support
coaplard.

Scanned with CamScanner

NEWNEX

1. Describe the clinical features of Alzheimer's Dementia

- Amnesia: loss of recent memory
- Aphasia: changes in speech function
- Apraxia: difficulty in performing simple motor functions
- Agnosia: difficulty in recognizing people & things
- There may be behavioral & psychiatric disturbances such as:
  - ✓ Auditory & visual hallucinations (10-15%)
  - ✓ Mood disorders such as depression (20%)
  - ✓ Psychotic symptoms (may be present; assoc. with a rapid decline)
  - ✓ Thought disorders e.g. delusions (more common than hallucinations)
- Physical symptoms may include:
  - ✓ Weight loss & weakness
  - ✓ Stooped posture & apraxic gait
  - ✓ Urinary incontinence which will be a late feature.

2. List the neuropathological changes seen in Alzheimer's dx (10 mks)

- CT & MRI:
  - ✓ Brain atrophy
  - ✓ Widened sulci
  - ✓ Flattened gyri
  - ✓ Enlarged ventricles (hydrocephalus ex vacuo).
- Microscopic changes include:
  - ✓ Synaptic & neuronal loss
  - ✓ Senile plaques containing amyloid protein
  - ✓ Neurofibrillary tangles containing paired helical filaments @ tau protein
  - ✓ Granulovacuolar degeneration of the neurons
- Neurochemical changes
  - ✓ Neurotransmitter deficiency: Ach, Noradrenaline, 5-HT, somatostatin, corticotropin
- Genetic changes (in 5%)
- Mutations on chromosome 21, 14, & 7

3. Treatment options of Alzheimer's dx

Pharmacological Rx

- Acetylcholinesterase inhibitors: ↑ CNS Ach e.g. Donezepil, Rivastigmine, Galantamine, Memantine
- Antioxidants e.g. Gingko biloba
- Vitamin E supplementation
- Use of SSRIs & Antipsychotics to treat mood/behavioral/psychiatric symptoms

Psychological treatments e.g.

- Cognitive stimulation aids
- Behavior modification
- Memory training
- External memory aids

Other approaches include hormone replacement therapy & aroma therapy.

Additional notes

* Dementia - Decline in cognitive function + global deficits
  - Level of consciousness stable (vs. Delirium)
  - Course: persistent & progressive
  - Commonest cause of Dementia = Alzheimers (65%) & vascular (20%). Other causes: DEMENTIASS (Degenerative dx (e.g. Parkinson, Huntington) Endocrine Metabolic (e.g. Alcohol, B_{12} def, Wilson) Exogenous (e.g. heavy metals) Neoplasia, Trauma (subdural hematoma), Infections (prion), Affective disorder (pseudodementia), Stroke/structure (vascular, ischemia, vasculitis, normal pressure hydrocephalus).

History/PE

- Patients with dementia are usually not concerned about their cognitive decline and are often accompanied to the doctor visit by a family member or friend (versus major depressive disorder [MDD]/pseudodementia).
- Characterized by progressive memory impairment that can be classified into the following four stages:
  - **Preclinical:** Slight forgetfulness, fully oriented, and capable of self-care.
  - **Mild:** Moderate memory loss, impaired executive function, impaired function at home, but can maintain most chores. Personal hygiene may need prompting.
  - **Moderate:** Severe memory loss, inability to recognize friends (agnosia), impaired social judgement, requires assistance with dressing and personal hygiene.
  - **Severe:** Severe memory loss, oriented only to person, completely dependent on others for ADLs, and may develop aphasia and become incommunicable.
- Personality, mood, and behavior changes are common (eg, wandering and aggression).

Scanned with CamScanner

1. ANTISOCIAL PERSONALITY DISORDER

3 or more of:

- x Failure to conform to lawful behaviour
- x Impulsivity
- x Irritability or aggressiveness
- x Deceitfulness
- x Lack of remorse
- x Consistent irresponsibility
- x Reckless disregard for safety for self and others.

- Other than substance use disorders, this disorder most linked to adult criminal behaviour.
- Person must be ≥18yrs old. Most displayed patterns b. <15yr (conduct disorder)
- M:F = 4:1
- Often arrested.
- Higher rates of alcoholism / substance use disorders.
- Psychodynamic theorists propose that this disorder begins with an absence of parental love, leading to a lack of basic trust; lack of superego.
- Behaviourists: antisocial symptoms may be learned thru modelling or unintentional reinforcement.
- Cognitive view: people with the disorder hold attitudes that trivialize the importance of other people's needs.
- Biological factors may play a role.

Scanned with CamScanner

lower levels of serotonin - impulsivity & aggression.
Deficient firing of the frontal lobes
Lower levels of anxiety & arousal - risks & thrills.

Scanned with CamScanner

What is the medical relevance of antisocial personality disorder?

ASPD is associated with co-occuring mental health and addictive disorders, including major depressive disorder, bipolar disorder, anxiety disorders, somatic symptom disorders, substance use disorders, gambling disorders and sexual disorders.

Due to their recklessness, irresponsibility and impulsivity, people with ASPD are at risk for traumatic injuries, accidents, suicide attempts, and sexually transmitted infections - hepatitis B, C, HIV etc promiscuity

Alcohol & substance use leading to their related physical health issues.

High mortality rates owing to accidents, suicide and homicide. Premature deaths

Aggression, impulsivity, reckless disregard for safety of self & others -> increased risk of physical injury & accidents which could lead to death

People with ASPD may neglect their medical problems or fail to comply with medical regimens -> premature death and increased morbidity. This is due to consistent irresponsibility and reckless disregard for self.

Scanned with CamScanner

CONDUCT DISORDER

2.

a) What is it?

It is repetitive and persistent antisocial, aggressive and defiant behaviour that violates age appropriate societal norms

b) Diagnosis criteria.

- 3 or more symptoms for more than 12 months but at least one symptom over the last 6 months of:
  1. Aggressive behaviour towards people and, or animals
  2. Destruction of property - with or without fire setting
  3. Deceitfulness / theft
  4. Severe provocative or disobedient behaviour
- These symptoms must be clinically distressing to self and others
- If the child is above 18 years, the symptoms cannot be explained by antisocial personality disorder.

3. Biological and psychosocial risk factors associated with conduct disorder

- Biological

1.) Child factors
- Low IQ
- Neurodevelopmental disorders
- Brain damage
- Epilepsy
- Poorly controlled temperament
- Attachment problems
- Poor interpersonal relationships

} more of psychological

2.) Parental factors
- Parental criminality (genetic predisposition to crime)

Scanned with CamScanner

• Psychosocial factors

1.) Parental factors
- Psychiatric illness
- Substance abuse
- Inconsistent parenting.
- Parental conflict
- Teenage pregnancy.
- Single parenthood.

2) Society factors
- Poverty
- Low social economic status
- homelessness
- Overcrowding
- Social isolation
- Societal high rates of unemployment, deviancy & truancy

4. Evidence based treatments for managing CD
1. Parental management training - group therapy for parents w children with CD. Also support group for such families/parents
2. Functional family Therapy
3. Multi-systemic Therapy - Family + school + community involvement
4 Child interventions - social skills, problem solving, anger management, confidence building
5. Treat co-morbidities - ADHD, substance abuse, anxiety, depression, Autism, Learning disorders.

Scanned with CamScanner