Management Assessment

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CRISP Framework

C

Clarify Understanding (ICE)

Start by exploring patient's Ideas, Concerns, and Expectations before diving into management

> *"Before we talk about next steps, help me understand what you're thinking about all this?"*

R

Risk Assessment & Formulation

Systematically identify and integrate all relevant risks into your clinical reasoning

> *"As we think about treatment options, I want to make sure we consider what could happen with each approach"*

I

Integrated Management Plan

Present comprehensive options (bio, psycho, social) with clear risks and benefits

> *"We have several ways we can help with this. Each option has some benefits and some things to watch out for"*

S

Safety Netting & Follow-up

Clear follow-up arrangements that reflect condition's natural course and associated risks

> *"Let's talk about when we should next meet and what warning signs to watch for"*

P

Partnership & Shared Decision-Making

Involve patient throughout, ensuring they understand implications and can make informed choices

> *"What are your thoughts about these options? Which one feels right for you?"*

History Taking in Management Stations

"Relevant for Management" - The Golden Rule

Key Principle

Only take history that **directly informs your management decisions**

DO ASK ABOUT

Factors that change treatment choice, contraindications, severity indicators, support systems

Previous Treatment Response:

"Have you tried any treatments before? How did they work for you?"

Medical Contraindications:

"Any physical health problems I should know about before we discuss options?"

Support Systems:

"How much support do you have at home? This helps me think about the best way forward"

DON'T ASK ABOUT

Comprehensive psychiatric history unless it directly affects management choices

Irrelevant Details:

"Tell me about your childhood" (unless trauma-informed treatment)

Academic History:

"How did you do at school?" (unless cognitive assessment needed)

Detailed Timeline:

"When exactly did this start?" (unless acute vs chronic changes management)

Rapport Then Purpose

On "Setting The Scene

1

Build Rapport FIRST

Connect with their emotional experience and validate their feelings

"How are you feeling about everything that's been happening?"

"This must be a lot to take in"

→

2

State Purpose NATURALLY

Link directly to their experience and explain why you're there

"That's exactly why I'm here - to help us work out what's causing these symptoms and what we can do to help you feel better"

Other things to keep in mind:

No Jargons

No jumping topics/ Sudden switch (Complete an area before exploring another)

Sign Posting

No stigmatising language eg Craving/ Addiction etc

Chunk and check

- Would you like me to go over that again?
- Am a clear?
- How does that sound?

Other things to keep in mind:

- Additional areas to incorporate:
- **Systematic Approach – Set the scene/ "Now we have covered this, lets talk about ..." Use Appropriate Question Techniques – Open/ Closed Question Variability (Open-**
- **Close-Close)**
- **No compounded questions! (eg do you do A and B?)**
- **No repeating stock phrases (eg I am sorry for your…)**
- **Range and depth – Chief complaint (5 points) + Comorbids (3 points)**
- **Tonality, Prosody, Rate of speech, Emphasising Key Point**
- **Show you have a range of affect eg Mirroring in the beginning proportionate to the patient's affect then calm in the middle and end.**
- REMEMBER WHEN YOU SPEAK, THE EXAMINER IS DOING AN MSE ON YOU!

Management Stations

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Perinatal - Valproate

- All about valproate
  - Pre-counselling
  - 7th week
  - 20 over week
  - Breastfeeding

⚠ Valproate in Pregnancy - CASC Scenario Guide

Evidence-Based Responses for MRCPsych CASC Stations (2024-2025 Guidelines)

Key Risk Statistics to Remember

- **11% (1 in 9)** - Major birth defects (vs 2-3% background)
- **30-40%** - Neurodevelopmental disorders (vs 6-7% background)
- **7-10%** - Autism spectrum disorders (vs 1% background)
- **Dose-related** - Higher doses = higher risk

Clinical Scenario	If She WANTS TO CONTINUE Valproate	If She WANTS TO STOP/CHANGE Valproate
1. Pre-conception Planning **Woman on valproate planning pregnancy**	**NEVER INITIATE** - Must have TWO specialists sign-off (MHRA requirement) **Document thoroughly:** Must record reasons if no alternatives exist **Maintain contraception:** Until safe switch completed	**Support this choice** - Arrange specialist within days **Slow cross-titration:** Gradual switch to safer option (lamotrigine/lithium) **High-dose folic acid:** 5mg daily (start immediately) **Continue contraception:** Until safe switch completed
2. Early Pregnancy **Already pregnant (1st trimester), been taking valproate**	**DO NOT STOP ABRUPTLY!** - Risk of seizures/SUDEP/mood crisis **Only if no alternatives:** Full informed consent required MDT involvement **Enhanced monitoring:** Detailed USS, fetal cardiology, neonatal planning *"This can only continue with your full understanding and team support"*	**NEVER STOP ABRUPTLY!** - Risk of maternal seizures/death **Specialist-supervised withdrawal:** Slow dose reduction with close monitoring **Dual monitoring:** Both maternal mental health/seizures AND fetal wellbeing *"We'll do this safely - your health is vital for baby's wellbeing too"*
3. Week 7 Pregnancy **Just discovered pregnancy, taking valproate**	**CRITICAL WINDOW** - Neural tube closure happening now **Unlicensed use:** "Valproate is not licensed for bipolar disorder in pregnancy" **Senior consultation:** Clinical Director ethics consultation if continuing *"This is the critical organ formation period - but we must prioritize your safety first"*	**Urgent but careful:** **May prevent major defects** **Maternal safety priority:** Slow withdrawal with intensive monitoring **Fetal anomaly scan:** Detailed scanning at 20 weeks essential **Realistic hope:** "Acting now may prevent some of the more serious concerns"
4. Mid-Pregnancy **20 weeks, been on valproate throughout**	**"Very exceptional" scenario:** Clinical Director ethics consultation required **Lowest possible dose:** fetal growth scans neonatal planning **Prepare for outcomes:** Counseling about potential needs of baby *"Structural changes are set, but brain development continues"*	**Still beneficial:** **May reduce neurodevelopmental risks** **Risk-benefit reassessment:** Withdrawing later carries risk to mother **Slow specialist-guided taper:** With ongoing maternal/fetal support *"It's not too late to help baby's brain development"*
5. Postpartum/Breastfeeding **Has taken valproate in pregnancy, considering breastfeeding**	**Generally compatible** - Continue with monitoring **Monitor baby for:** Bleeding/bruising, jaundice, drowsiness, poor feeding **Continue PPP:** Pregnancy Prevention Programme still applies *"Breastfeeding is usually safe with valproate - we'll monitor baby closely"*	**Support choice:** Alternative feeding is perfectly acceptable **Medication review:** Postpartum is good time to reassess all treatments **No guilt:** Mother's wellbeing is priority for baby's care **Alternative options:** May consider safer mood stabilizers postpartum

🔑 Essential Clinical Principles for CASC Success

Never stop abruptly: Risk of seizures/SUDEP/mood crisis is significant. **MDT involvement:** Always ensure multidisciplinary team (psych/neuro/obstetric/paediatric) involvement. **Documentation:** All decisions must be thoroughly documented for governance. **Bipolar vs Epilepsy:** Only epilepsy is valid indication for continuation; bipolar use essentially contraindicated. **Two-specialist rule:** MHRA requires two specialists to sign off for any valproate initiation under 55 years.

-MHRA Valproate guidance (2024 update)
-NICE CG185 (2023)
-Royal College of Psychiatrists (RCPsych) patient & professional guidelines

Perinatal- Valproate

Terms to know and about breastfeeding

MHRA = Medicines and Healthcare products Regulatory Agency- UK's FDA (drug regulator)

SUDEP = Sudden death in epilepsy patients (why can't stop valproate abruptly)

PPP = Pregnancy Prevention Programme (mandatory contraception + counseling for women on valproate)

MDT in this station = (psychiatrist + neurologist + obstetrician + pediatrician working together)

Two-specialist rule = Need 2 doctors to agree before starting valproate in anyone under 55

Annual Risk Form = Yearly form patient must sign showing they understand pregnancy risks

Fetal anomaly scan = 20-week ultrasound to check baby's development

Breastfeeding

"Sodium valproate/valproic acid passes into breast milk in very small amounts and does not usually cause any side effects in breastfed babies. If your baby is healthy, you may be able to take sodium valproate/valproic acid while breastfeeding. Your doctor may still recommend it if it's the only medicine that works for you." - https://www.nhs.uk/medicines/valproic-acid/pregnancy-breastfeeding-and-fertility-while-taking-valproic-acid/

Perinatal- Valproate

Language to use - Initial rapport

"Thank you for coming to see me today. I can imagine this situation might feel quite overwhelming, so **I want you to know that we'll work through this together and make sure you have all the support you need."**

"First, let me understand what you already know about valproate and pregnancy.....
and what concerns you might have." - *ICE*

[Listen to her response]

Setting the scene:
"Regarding valproate **during pregnancy and while breastfeeding**... if this is something you would like to consider? Some of this might be concerning to hear, but I want to **reassure you we'll find the safest path forward** for both you and your baby ." – *Remember you must tell risks of valproate on pregnancy! So set the scene via Sandwhich approach (say something + then - then +)*

Perinatal- Valproate

Language to use - Side effects and risks

✅ **USE Simple Terms:**

"Birth differences" or "birth problems" instead of "congenital malformations"

"Learning and development challenges" instead of "neurodevelopmental disorders"

"Spine problem" instead of "neural tube defect" (only if specifically asked for details)

"Heart problem" instead of "cardiac anomaly”

❌ **AVOID Medical Jargon:**

Teratogenic, embryotoxic, fetal valproate syndrome

Malformations, anomalies

Cognitive impairment, autism spectrum disorder (initially)

Perinatal- Valproate

Common reasons for failure

❌ Don't overwhelm with medical details initially

❌ Don't lead with percentages - start with understanding her situation

❌ Don't create unnecessary panic about timing

❌ **Don't make decisions for her**

❌ **Don't forget to address her emotional response**

Perinatal- Valproate

Language to use – Talking about number

Risk Communication to persuade her to STOP:

”If I have to put it in numbers: In the general population with women not taking valproate **- about 2 to 3 babies out of every 100 are born with some kind of birth problem**. This is the **risk that exists for everyone.**

For women taking valproate during pregnancy, this risk increases to about 11 babies out of every 100 who might have a birth problem.

Learning and development: In the general population, **about 3 children out of every 100 might have learning difficulties.** For **children whose mothers took valproate, this increases to about 30 to 40** out of every 100.”

Perinatal- Valproate

Language to use – Talking about number

Risk Communication if SHE IS WORRIED:

If 100 women taking valproate - about 11 of their babies might have a birth problem, and **89 would not have these problems.**

So while the risk is there, it's important to remember that most babies - **about 9 out of 10 - don't have these problems even with valproate."**

Perinatal- Valproate

7 weeks pregnant – Women Who Wants to Change

If she is upset that she didn't know about these side effects:

"**I can see you're upset** about not knowing about these risks earlier, and that**'s completely understandable**. *Many women haven't been given this information in the past, and that's not your fault.*"

"**The most important thing now is that we act quickly** to make things as safe as possible for you and your baby."

Timing:

"You're 7 weeks pregnant, which means **some of the very early development has already happened, but there's still a lot of important development to come. Making changes now can still make a real difference**."

"**The baby's spine forms very early - in the first few weeks - and while that time has passed, other important development continues throughout pregnancy**. **So reducing your exposure to valproate now is still very beneficial."**

Perinatal- Valproate

7 weeks pregnant – Women Who Wants to Change

So what is oing to happen:

"Here's what we need to do to keep you both safe:

First, **we cannot stop your medication suddenly** - this could cause seizures or make your mood very unstable, which would be dangerous for both of you.

Instead, **we'll work with a team to gradually reduce your valproate while starting you on a safer medication**. This usually takes a few weeks.

I'll also start you on a **high-dose vitamin called folic acid** today - this helps protect against some of the risks.

We'll **arrange extra scans during your pregnancy (18-20 weeks)** to check how your baby is developing."

Perinatal- Valproate

7 weeks pregnant – Women Who DON'T Want to Change

Acknowledging Her Perspective:

"I understand your concerns about changing a medication that's been working well for you. *(Validate!)* **Your mental health is important, and I want you to feel confident in whatever decision we make together."**

"**Let's talk through what continuing would mean**, and **what support we could put in place**."

Balanced Risk Discussion::

"If we continue with valproate, the risks I mentioned would still be present (Explain the risks first!). **However, we could take steps to make things as safe as possible:**

- Use the lowest dose that keeps you well
- Take high-dose folic acid
- Have extra detailed scans to monitor your baby's development
- Work closely with the obstetric team/ notify paediatrics and neurologist

Perinatal- Valproate

7 weeks pregnant – Women Who DON’T Want to Change

Timing:

"At this stage of pregnancy - around [X] weeks - **the time when major birth problems develop has mostly passed**. The **main concerns now are about learning and development, which we can still influence."**

"**Any changes we make now need to be very gradual to keep you stable**, but even **small reductions in your valproate dose could be helpful."**

Perinatal- Valproate
Required techniques

Chunk and Check:

"I've given you a lot of information. What questions do you have so far?"

"How are you feeling about what we've discussed?"

"Is there anything you'd like me to explain differently?”

Collaborative Language:

"We'll work together to..."

"Let's think about what would work best for you..."

"What matters most to you in this decision?"

"How can I best support you through this?

"What does your partner think about all this?"

"Would it help if we involved your partner or a family member in these discussions?” *–if she is distress*

Perinatal- Valproate

End- Summarise key points and next steps

"Let me summarise what we've discussed and our plan:

The most important things to remember are:

- **You're not alone in this** - we have a whole team to support you
- **We'll move at a pace** that feels manageable for you
- **Most babies do well, even in these situations**
- **We'll monitor everything closely**

Do you have any other questions for me today?

I'll give you a written summary of what we've discussed, and my contact details if you need to reach me before your next appointment. (*Instead of leaflets leaflets leaflets)* "

Quetiapine – Gestational Diabetes

- Quetiapine in Pregnancy **Task:** Discuss the **risks of Quetiapine in pregnancy** and agree on a **management** plan.

Quetiapine – Gestational Diabetes

Rapport

"Hello [Name], thank you for coming in today. I understand you're 12 weeks pregnant and have some concerns about continuing quetiapine. **Can you tell me what's been worrying you?"**

[Listen to her diabetes concerns]

"I can see why reading about diabetes risks online would be concerning, especially during pregnancy. **That's exactly the kind of thing we will discuss today properly.** *(Set the scene here)***"**

"You mentioned this is your second pregnancy and you were on quetiapine before. **How did that pregnancy go? Were there any issues or concerns?"**

Quetiapine – Gestational Diabetes
Risks-Plus-Monitoring

"It's actually really good that you've been thinking about this and doing some research**. The internet can sometimes be overwhelming though - there's a lot of information that needs to be put in proper context.**"

"What specifically did you read about quetiapine and diabetes that worried you most?"

About Gestational Diabetes- NEGATIVE INFO:

"You're absolutely right that there is some increased risk of gestational diabetes with quetiapine. Let me explain what the research shows:

The normal risk of gestational diabetes in pregnancy is about 5-6 women out of every 100.

For women taking quetiapine, some studies suggest this might increase to about 8-10 women out of every 100.

So while there is an increase, it's important to understand that most women - **about 90 out of 100 - who take quetiapine during pregnancy do NOT develop gestational diabetes**."

Quetiapine – Gestational Diabetes

About Gestational Diabetes – PLUS INFO:

"The good news is that **quetiapine is generally considered one of the safer antipsychotic medications in pregnancy**:

- It doesn't increase the risk of birth defects (the rate stays at the normal 3-5 out of 100 babies)
- Most women who take it have healthy pregnancies and healthy babies
- It's well-studied compared to some other psychiatric medications"

Quetiapine – Gestational Diabetes

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To Baby:

- Some babies might have temporary withdrawal symptoms after birth - things like being a bit jittery or having feeding difficulties for a few days
- We might monitor your baby's growth a bit more closely, as some studies suggest babies might grow slightly larger
- **Both of these are manageable and temporary if they occur"**

Quetiapine – Gestational Diabetes
Women Who DON’T Want to Change

"If you **decide to continue with quetiapine,** here's how we'd manage things to keep both you and your baby as safe as possible:

Diabetes Monitoring:

- We'd test your blood sugar more frequently than usual
- You'd have a glucose tolerance test earlier than the standard 24-28 weeks, probably around 16-20 weeks
- If gestational diabetes did develop, it's very manageable with diet changes and sometimes medication

Medication Management:

- We'd use the lowest dose that keeps you well - what dose are you currently on?
- Regular check-ins to make sure your mental health remains stable
- We might need to adjust the dose as pregnancy progresses, as your body processes medication differently

Quetiapine – Gestational Diabetes
Women Who DON'T Want to Change

Baby Monitoring:

- Extra growth scans to check baby's size
- Hospital delivery so baby can be monitored after birth
- Pediatric team aware in case baby needs extra support initially"

Benefit vs Risk Discussion:

"The important thing to remember **is that keeping your mental health stable is crucial for both you and your baby**. Untreated mental health conditions can also carry risks:

- Increased stress hormones can affect baby's development
- Poor self-care, sleep, and nutrition
- Risk of postpartum mental health problems

For many women, the benefits of staying mentally well outweigh the small increased diabetes risk."

Quetiapine – Gestational Diabetes
Women Who Want to Change

Alternatives

"**If you're concerned about the diabetes ri**sk, there are other options we could consider:

Aripiprazole - This might be a good alternative because:

- Lower risk of gestational diabetes
- Good safety data in pregnancy
- Effective for similar conditions to quetiapine

Other options- depending on your specific condition might include:

- Haloperidol (older medication, very well-studied in pregnancy)
- Olanzapine (though this also carries diabetes risk) – DON'T Mention if she doesn't want to increase risk!

Quetiapine – Gestational Diabetes
Women Who Want to Change

Switching Process and Risks:

"If you wanted to switch medications, here's what that would involve:

The Process:

- Gradual reduction of quetiapine over 1-2 weeks
- Starting the new medication at the same time
- Close monitoring during the transition

Potential Risks of Switching:

- Temporary worsening of your mental health symptoms
- Sleep disturbance during the change
- Small risk that the new medication might not work as well for you
- Some adjustment time while we find the right dose

Timeline:

- The switch would take 2-4 weeks to complete
- You'd need very close monitoring during this time
- *May need input from your partner or family for support"- Support*

Quetiapine – Gestational Diabetes

End – Just pick whats relevant…don’t say everything

"Based on what we've discussed, here's what I suggest we do:

Immediate Actions:

- Start more frequent blood sugar monitoring
- Book early glucose tolerance test for around 18-20 weeks
- Continue your current dose of quetiapine for now
- Schedule review appointment in 2 weeks

Ongoing Plan:

- Monthly mental health reviews
- Extra obstetric scans at 28, 32, and 36 weeks
- Plan hospital delivery with pediatric support
- Review our plan if your mental health changes or if you develop diabetes

Decision Timeline:

- You don't have to decide about switching today
- If you want to change medications, sooner is better than later
- We can always reassess if circumstances change"

Psychotherapeutic Interventions

- **Remember, you are being assessed on HOW you speak rather than WHAT you speak!**
- **Create rapport the first 2 minutes.**
- **Personalise your explanation as best you can**
- **“Sell” the therapy (“*therapeutic optimism*”)**

What Examiners Are Looking For

General Principles Across Psychotherapy Stations

Clear & Detailed Explanation

Explain therapy in an **understandable way** using **simple language** and avoiding jargon. Describe **actual interventions** the therapist would use.

Structured Approach

Explanation should be **structured and logical**, avoiding disjointed or rushed delivery.

Patient-Centered Communication

Demonstrate **active listening skills**, respond to verbal and non-verbal cues. **Elicit and address ICE** regarding therapy.

Holistic Management Plan

Plan should be **comprehensive**, reflecting **current best practice**. Include **all relevant options** with **risks and benefits**.

Shared Decision-Making

Involve the patient in discussions and decision-making. Ensure they understand implications and are aware of relative risks and benefits.

Key Advice for Psychotherapy Stations

[redacted]

Explain "Why" and "How"

Don't just explain *what* the steps are, but **why each technique is useful**.

> *e.g., Explain physiological incompatibility for relaxation techniques in Systematic Desensitisation*

Break Down Complex Concepts

For CBT, cover **both cognitive and behavioural components**. Provide **sufficient detail on actual interventions** rather than vague generalities.

Structure Your Explanations

Use **"chunk, check, and pause"** method. Prevent overwhelming the patient and ensure understanding.

Tailor Explanations

Personalise examples based on patient's experiences. Link therapy directly to their lifestyle.

> *e.g., Reducing smoking as a coping mechanism in CBT*

Be Specific About Logistics

Clarify **number of sessions** (e.g., 12-16), **frequency** (e.g., weekly), and **duration** (e.g., 50-60 minutes).

Show, Don't Just Tell

Consider using **visual aids**, such as hierarchy diagrams for graded exposure, to enhance understanding.

Address Patient Commitment

Explore **commitment to engage** and any "homework" or attendance requirements.

Time Management

Be concise in summaries to **allocate sufficient time for management plan** discussion.

Maintain Professionalism

Be **empathetic and polite**, avoid paternalistic language. **Inspire confidence** when discussing anxiety-provoking therapies.

⚠ Biggest Mistakes Identified

Common Errors That Hinder Performance in Psychotherapy Stations

Therapy Explanation Issues

Vague or Insufficient Detail

Fail to provide enough detail on actual interventions a therapist would use. Often only cover basic information or describe treatment vaguely.

Skipping Key Components

Not discussing **both cognitive and behavioural components** for CBT, or not explaining *why* certain techniques are used.

Communication Problems

- × **Using medical/psychological jargon** without explanation
- × **Rushing through explanations** without checking understanding
- × **Formulaic interview style** - questions sound rehearsed
- × Failing to actively listen or respond to patient cues

Task Focus & Management Issues

Inaccurate Information

Providing **incorrect details** about therapy structure (e.g., number of sessions).

Lack of Task Focus

Deviating from primary objective - spending too much time on **general MSE when task is therapy explanation**.

Poor Time Management

Rushing through explanations or failing to cover essential aspects due to inefficient time use.

Inadequate Management Plan

Not discussing **range of treatment options** or failing to outline risks and benefits.

Missing Patient Perspective

Not exploring patient's **commitment to therapy** or their views and expectations.

Paternalistic Language

Implying patient's decision is **"irrational"** even when capacity is present.

ERP/ SD

1. Engagement and Perspective Understanding
2. Explanation of CBT and ERP/SD Principles
3. Addressing Natural Fears & Building Realistic Expectations
4. Collaborative Approach
5. Addressing Concerns

ERP / SD

- ***ERP***

Information to get in first 2 min: Nature of OCD + least case scenario and worst case scenario

= "We'll slowly expose you to situations that make you anxious, and together we'll prevent the actions you feel forced to do, helping you feel less anxious over time."

- ***SD***

Information to get in first 2 min: Nature of agoraphobia + least case scenario and worst case scenario + COPE (Talk when discussing breathing technique)

= "We'll help you face your fears step by step, starting with the least scary, and teach you how to relax at each stage."

ERP/ SD

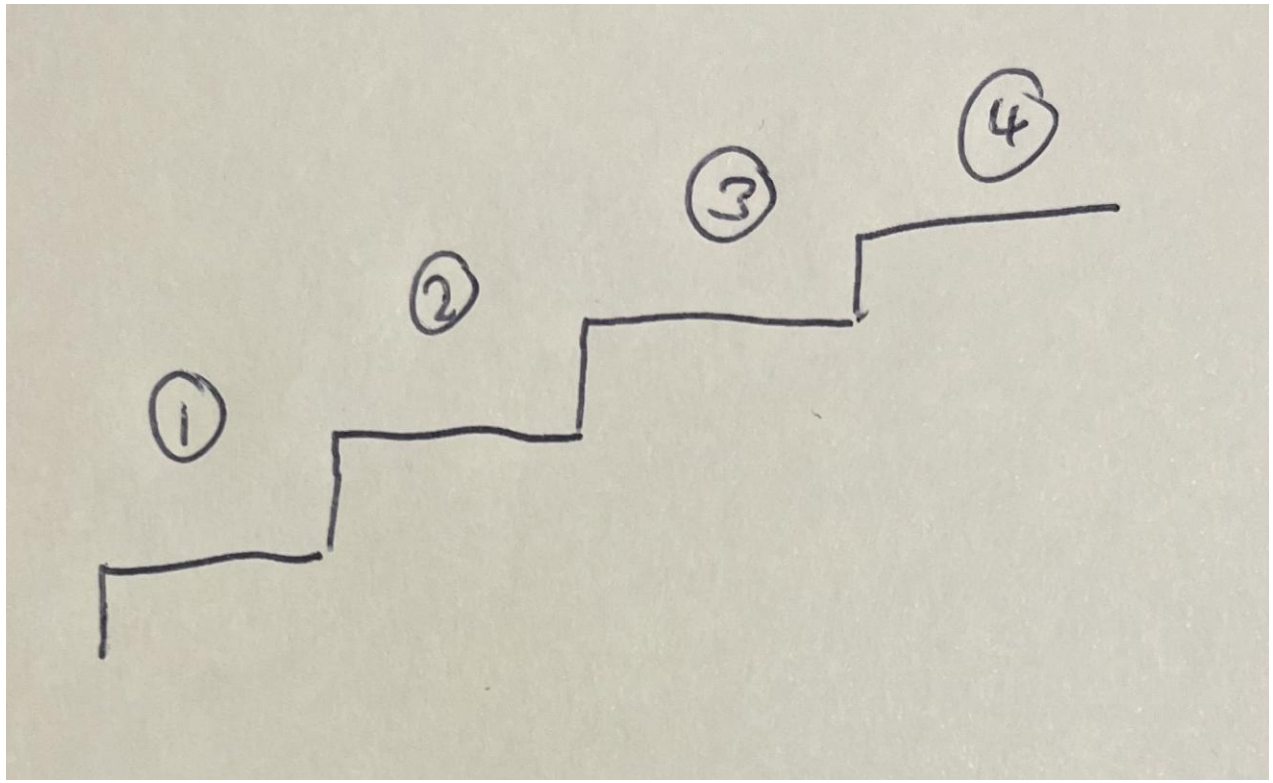
Acknowledging His Fears:

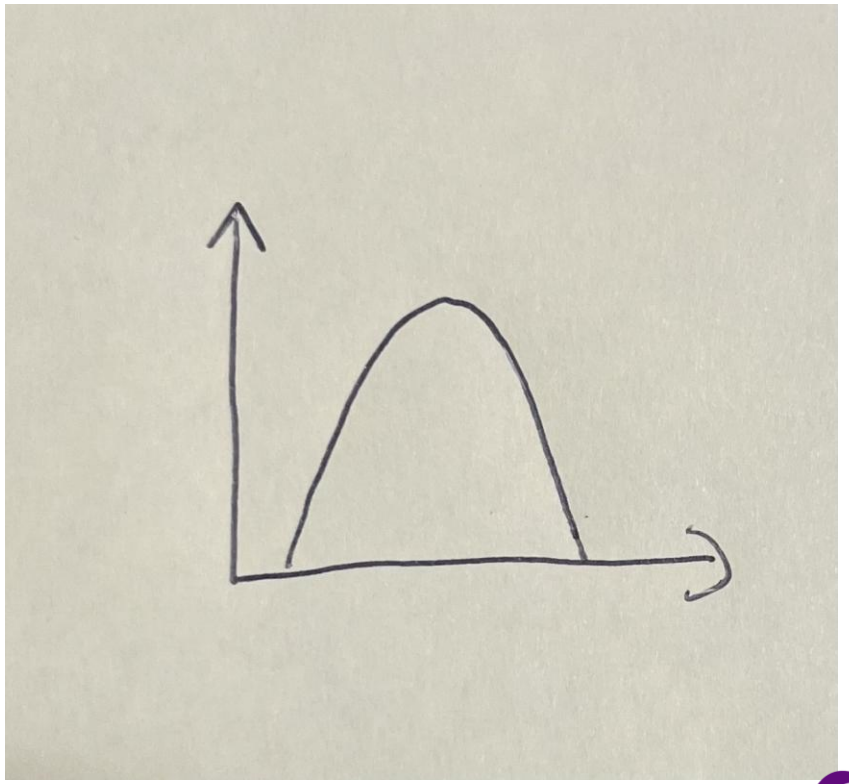
"I imagine this might sound quite scary - the idea of touching things and not washing your hands probably feels overwhelming right now."

"That's a completely normal reaction. Most people with OCD feel anxious when they first hear about ERP."

"The important thing to understand is that this is done very gradually, at a pace you can manage."

ERP / SD





ERP/ SD
Cognitive part!

General:
"Let's talk about the 'cognitive' part first - that's about the thoughts and beliefs that drive your behaviour."

"The cognitive part of CBT **helps you recognise these thought patterns and learn to think about them differently**."

"Your therapist will help you identify your specific thoughts **and examine the evidence for and against them."**

"For example,
-OCD: if you think 'If I don't wash my hands, I'll definitely make someone sick,' you'd look at the actual evidence - how many times has not washing immediately actually led to someone getting sick?"
-SD: identify and change the worried thoughts - like 'If I go out, I'll have a panic attack and won't be able to cope' - and replace them with more realistic thoughts."

Thought Record:
"You might keep what's called a **'thought record'** - writing down your OCD thoughts and **examining how realistic they are."**

"This helps you **step back and look at your thoughts more objectively**, rather than being caught up in them."

Uncertainty Training:
learning to tolerate uncertainty.

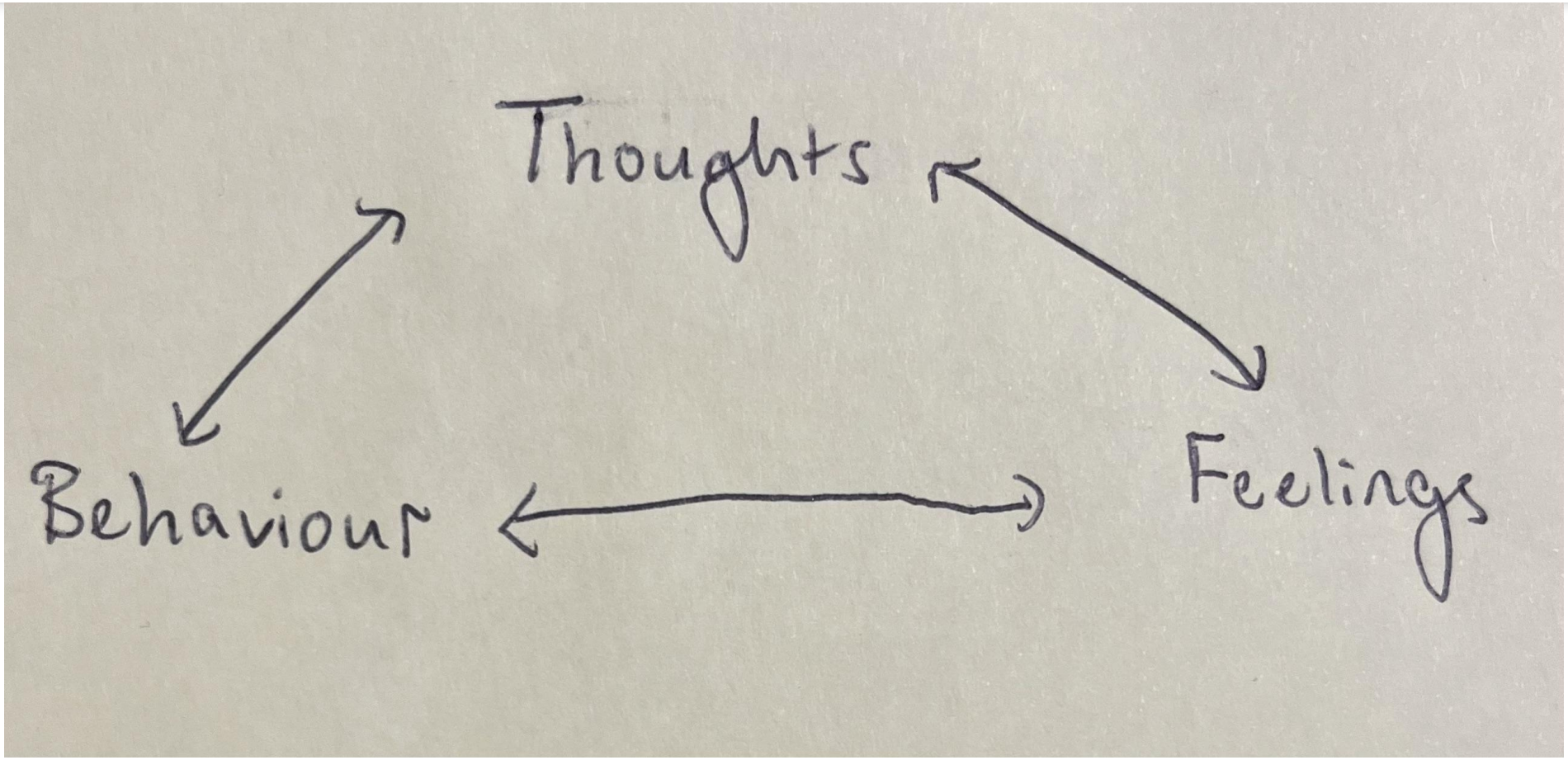
CBT - Depression

Information to get in first 2 min: Nature of depression + Thoughts + Behaviour/ Action

= *"We'll help you change the way you think and react to difficult situations, so you feel less overwhelmed and can cope better."*

- Show Drawing – Here and now - Homeworks

CBT - Depression



IPT - Depression

Information to get in first half: Nature of depression due to stressors (Role Transition/ Interpersonal Sensitivity/ Dispute/ Grief)

= *"We'll work on improving your relationships with people around you, helping you cope better with changes and conflicts in your life."*

-12- 16 sessions

- **How?:** Role play- Reflection- "Inventory of people around you"

Transference

1. ABC of therapy-“What brought you to therapy?”

2. Logistics of going to therapy and did the therapist say or do anything out of step?

3. Transition into past relationships then childhood

4. **=** *“Sometimes, without realising it, we start feeling the same way about our therapist or doctor as we do about important people in our life, like your parent or partner. It’s natural and can help us understand those feelings better during therapy.”*

5. Invite into therapy again: “Look into this with your therapist to break the cycle for future relationships?”

Transference- What if she wants to leave after months of therapy?

Link to the therapy relationship and her history of abandonment (You want to show you've made the connection with her father)

"After seeing someone every week for nine months, it's very normal to feel attached to them in some way, even if sessions are sometimes difficult."
"You've also told me your dad left when you were young. I'm wondering whether your therapist going away might have touched some of those old feelings of being left or not important. Does that ring true for you?"

If she responds:
"So it feels a bit like, 'people go away just when I start to rely on them.' That would make it very hard to want to go back."

Explore avoidance, control and fear of needing someone -not "lecturing."
"Sometimes, when old feelings of being abandoned get stirred up, it can feel safer to end the relationship yourself rather than risk being hurt again."
"I'm wondering if deciding to stop therapy now might also be a way of staying in control: 'I'll leave before she has the chance to leave me again.' How does that idea sit with you?"

CBT Psychosis

- **Scenario:** John is a 19-year-old man who is currently under the local Early Intervention Service after developing first episode psychosis 6 months ago. His symptoms are currently controlled on Risperidone although he continues to smoke cannabis at times. He is being considered for CBT for psychosis.

- **Task:** Please **explore historical and recent vulnerability factors for psychosis,** establish a **preliminary formulation** to understand his previous presentation and **assess his suitability for CBT for psychosis.**

CBT Psychosis

1. Engagement and Rapport
2. Historical Vulnerabilities
3. Recent Psychotic Experience
4. CBT for Psychosis

CBT Psychosis
CBT for Psychosis Suitability Criteria

✅ **Good Candidates:**

Reasonable cognitive function and attention span

Ability to engage in collaborative relationship

Some motivation for change

Symptom stability (not in acute phase)

Capacity to attend regular sessions

Some insight (doesn't require full insight)

❌ **Poor Candidates:**

Severe cognitive impairment

Active substance misuse *significantly impairing function*

Acute psychotic symptoms with severe agitation

Complete lack of engagement with services

High suicide risk requiring intensive management

Severe depression requiring priority treatment

CBT Psychosis
Engagement and Rapport

"Hello ..., I'm Dr X. I understand you've been working with the Early Intervention team for about 6 months now since you experienced psychosis. *How are things going for you at the moment?"*

"I'd like to spend some time understanding more about your experiences and what might have made you to become unwell, *so we can think about what help might be most helpful going forward*."

"*Is that alright with you? Do you have any questions before we start?"*

CBT Psychosis
Historical Vulnerabilities - Predisposing

Family History:

- Has anyone in your family experienced mental health problems, particularly hearing voices or having unusual beliefs?
- Any family history of schizophrenia, bipolar disorder, or severe depression?

Early Development:

- Any difficulties during your mother's pregnancy or your birth that you know of?
- How was your development as a child - walking, talking, social interaction?
- Any childhood trauma, abuse, or significant losses?

Childhood/Adolescence (You may find stress here!)**:**

- How did you get on at school - academically and socially?
- Any bullying, social isolation, or feeling different from others?
- When did you first start noticing any unusual experiences or thoughts?"

CBT Psychosis
Historical Vulnerabilities - Recent

"Now let's think about what was happening in the months leading up to when you became unwell:

Life Stressors:

- What was going on in your life around that time - work, relationships, living situation?

- Any major changes, losses, or stressful events?

- How were you **coping** (cannabis) with the transition to adulthood?

Substance Use (Frame it as coping – stress and sleep issues):

- When did you start using cannabis, and how much were you using before you became unwell?

- Any other substances - alcohol, stimulants, recreational drugs?

- Did you notice any connection between cannabis use and unusual experiences?

Sleep and Lifestyle:

- How was your sleep pattern in the weeks before becoming unwell? - *Mania*

- Felt withdrawn from friends and family?"

CBT Psychosis
Recent Psychotic Experience

"Can you help me understand what the psychotic experiences were like for you?

Onset and Development:

- When did you first notice something wasn't quite right?
- How did things develop - gradually or quite quickly?
- What did you notice first - unusual thoughts, experiences, or changes in how you felt?

Specific Symptoms:

- Did you hear voices or sounds that others couldn't hear?
- Did you have any unusual beliefs or thoughts that others found hard to understand?
- How did these experiences affect your day-to-day life?
- What was most distressing or frightening about what you experienced?”

CBT Psychosis
Recent Psychotic Experience

Current State Assessment:

"How are things now compared to 6 months ago?

- Are you still having any of these experiences?

- How is the Risperidone helping?

- What's your understanding of what happened to you?

- How do you feel about the diagnosis of psychosis?

- What's been most helpful in your recovery so far?"

CBT Psychosis
Formulation

"Based on what you've told me, let me share my understanding of what might have made you unwell, and see if this makes sense to you:

Vulnerability Factors:

- You had some background vulnerability, possibly including [*family history/early experiences/developmental factors*]

- This meant you were at slightly higher risk of developing psychosis than someone without these factors

Triggering Factors:

- Around the time you became unwell, you were dealing with [*specific stressors*]

- The cannabis use may have contributed - we know it can increase psychosis risk, especially in people who are already vulnerable

The Psychotic Episode:

- When these stresses combined with your background vulnerability, **your brain's way of processing information became disrupted**

- This led to the experiences of [*specific symptoms*], *which understandably were very frightening*

CBT Psychosis
Formulation

Maintaining Factors:

- *What might be keeping you at risk now* includes ongoing cannabis use
- *Stress about the diagnosis itself and its impact on your future*
- [*Any ongoing social or psychological factors*]”

"How do you see the role of cannabis in what happened to you?”- Reflective- checks insight

CBT Psychosis
CBT for Psychosis

Insight and Motivation:

- *What are your goals for your recovery?*

- How motivated do you feel to work on understanding and managing your experiences?

- *What would you like to change or improve in your life right now?"*

Engagement:

- Would you be able to commit to weekly sessions over several months?

- How do you feel about the idea of 'homework' or tasks between sessions?

Substance Use Impact *(If not asked earlier)**:***

- You mentioned you still smoke cannabis sometimes - how much and how often?

- Have you noticed it affects your symptoms or mental state?

- How motivated are you to reduce or stop cannabis use?"

CBT Psychosis
CBT for Psychosis

"Based on our conversation, I think CBT for psychosis could be helpful for you. Let me explain what this involves:

- It helps you develop ways of under*standing and coping* with any ongoing unusual experiences
- We work on strategies *to reduce distress*
- We also look at *stress management / relapse prevention*

"From what you've told me, I think you could benefit from this approach because:

- - You're able to *talk about your experiences openly*
- - You *seem motivated to work on your recovery*
- - Your *symptoms are reasonably stable on medication*

Couple of things we'd need to work on:

- The ongoing cannabis *(**as coping mechanism**)* use could interfere with therapy progress
- We'd need to make sure your symptoms stay stable enough to engage with the sessions

NMS Explanation

- **Task**: Talk to the **father** of this patient to **explain the**
- **cause of this presentation** and **devise a management plan**. Address his **concerns, ideas and expectations**. Do not take history.

NMS – How to talk about the investigations

Vital Signs:

Temperature: 41°C, Pulse rate: 104 bpm, Blood pressure: 140/90 mmHg, Respiration: 22 per minute

Blood Investigations:

WCC: 14,000, CK: 1024 IU/L (38-174 IU/L), AST: 44 U/L (14-20 U/L), ALT: 82 U/L (10-40 U/L)

Other blood parameters are normal. Urinalysis is normal. On examination, there is also some muscle stiffness.

NMS

ICE First

What it is:
-Explain based on the results to disprove his misconception and point towards NMS diagnosis

Outline Treatment Approach

Medical Support:
ICU – Stop antipsychotic/ Mortality rate.

Family Involvement

Address Mr....Concerns

Breaking Bad News

- **Scenario:** Mr. John is a 78-year-old gentleman admitted to the psychiatric unit 3 days ago with a history of acute confusional state. He was living independently until 3 months ago when he began experiencing episodes of confusion and rapidly worsening cognitive problems. A CT brain scan was taken and showed a large tumour mass with central necrosis in the left temporal region and secondaries in the right parietal region. Blood tests and chest X-ray were fine.

- **Task:** Discuss the CT results with his daughter, Mrs. John, and address her concerns.

Breaking Bad News

ICE

"I wanted to meet with you to discuss the results of your father's CT brain scan. Before we talk about that, how has he seemed to you over the past few months? What changes have you noticed?"

[Listen to her account]

"What's your understanding of why we did the brain scan? What were you expecting it might show?"

"Before I explain what we found, what questions do you have about your father's condition?"

"What have you been most worried about regarding his confusion and memory problems?"

"Have you had any thoughts about what might be causing these rapid changes in his thinking?"

"When you think about the changes in your father - the confusion, memory problems - what comes to mind as possible causes?"

Breaking Bad News
Breaking the news

Tell positive findings first THEN negative

Level 1: "Growth" or "Abnormality"

"Mrs Green, the CT scan shows an abnormal growth in your father's brain. This growth is what's been causing his confusion and memory problems."

[PAUSE - assess her reaction]

"The growth is quite large and is located in the part of the brain that controls memory and thinking."

Level 2: If She Asks "What Kind of Growth?" → "Tumour"

"The growth appears to be a tumour - that means abnormal cells that have grown into a mass in the brain tissue."

[PAUSE - wait for her response]

"The scan also shows there are some smaller areas of similar abnormal tissue in other parts of his brain."

Level 3: If She Asks "Is it Cancer?" → Then Use "Cancer"

"Yes, I'm afraid it does appear to be cancer. The tumour in his brain seems to have spread from somewhere else in his body."

Breaking Bad News
Management

"I know you're processing a lot right now, but let me outline what happens next:

Further Tests Needed:

- We'll need more detailed scans to understand the extent of the tumours
- Blood tests to look for signs of where the original cancer might have started
- **We'll involve the oncology team who specialize in cancer care**

Your Father's Care:

- We'll continue managing his confusion and keeping him comfortable
- We'll start medications that can help reduce brain swelling
- The team will work together to plan the best approach for his care"

Breaking Bad News
Management

"This is a lot to process, and you don't have to handle it alone:

Support Available:

- I'll arrange for you to meet with our social worker who can help you
- We can connect you with family support services
- There are cancer support groups if you'd find that helpful
- We'll keep you informed of all test results and include you in all care decisions

What You Can Do:

- Spend time with your father - familiar faces and voices can be comforting
- Think about any questions you want to ask at our next meeting
- Consider who else in the family needs to know and how you want to tell them
- Don't feel you have to make any big decisions today"

Breaking Bad News
Likely Questions

"Are you sure it's cancer?"

"I understand this is hard to believe. The scan images are quite clear, but we'll be doing additional tests to confirm all the details. Would it help if I showed you the scan images?"

"Is He Going to Die?":

"I can understand why you need to ask this question. Brain cancer is a serious illness, and yes, it is life-limiting."

"But people can live months or sometimes longer with good quality of life, especially with proper care and treatment."

"We'll know more about timeframes once additional tests is done by the neurology team, and we'll discuss this more fully when we have that information."

When She Asks About Prognosis Directly:

"I understand you want to know about timeframes. We'll know more about what to expect once we hear from the neurological team."

"What I can promise is that we'll focus on your father's comfort and quality of life, whatever the timeline turns out to be."

Hyperprolactinemia

- **Scenario:** Jane Smith, 25, has a 4-year history of schizophrenia and is taking olanzapine 20 mg daily. She has developed milky breast discharge (galactorrhoea). Her GP checked serum prolactin: 2,650 mIU/L. She attends clinic today to discuss the result.

- **Task: Take a focused history, explain the blood results, and devise a holistic management plan with her.**

Hyperprolactinemia
Focused history

A. Clarify her symptoms

“Jane, I understand you’ve noticed some milky discharge from your breasts.

Can you tell me when that started and how often it happens?”

“Any breast pain, lumps, or changes in shape or skin?”

“Any headaches or problems with your eyesight, like blurred or double vision?”

[Warning shot-sensitive questions]- Or you can proceed after asking **impact**. And if she mentioned her relationship being strained

“Any period changes : more irregular, lighter, heavier, or stopped?”

“Any hot flushes, vaginal dryness, drop in sex drive, or difficulty with arousal?”

B. Medication and adherence

“You’re on olanzapine 20 mg … are you taking it every day?”

“Any other tablets, the Pill, herbal remedies?”

“Have you ever missed doses or changed the dose yourself?”

Hyperprolactinemia
Focused history

C. Physical and risk factors

“Any chance you could be pregnant?”

“Any history of thyroid problems in you or the family?”

“How has your weight, sleep, and energy been?”

D. Mental state / psychosis control

“How has your schizophrenia been over the past months – any voices, suspicious thoughts, or relapses?”

“How important has olanzapine been in keeping you well, in your view?”

Hyperprolactinemia
Explain Results

Serum prolactin 2,650 mIU/L = significantly high.

“We did a blood test called prolactin. Prolactin is a hormone made in a gland just under the brain that normally helps with breast milk in pregnancy and breast-feeding.”

“Your level is higher than normal, and that explains the milky discharge from your breasts.”

“One common reason for this is medication like olanzapine. It can ‘block’ the brain chemical dopamine and, as a side effect, the prolactin hormone goes up.”

Reassure :

“This is a known side effect of antipsychotic tablets. High prolactin can have long-term effects if we ignore it, so it’s good we’ve picked it up.”

Hyperprolactinemia
Risks if untreated

“If prolactin stays high for a long time, it can:

Interfere with your periods and fertility.

Affect your bones, making them thinner and more likely to fracture in later life.

Possibly increase the risk of breast and womb problems if left for many years.”

You don’t need to lecture about epidemiology-just show you know:

long-term bone health / fractures

possible breast cancer risk

menstrual / fertility issues.

Hyperprolactinemia
Management

A. Check for other causes

“Although olanzapine is the most likely cause, we should check there isn’t anything else contributing.”

“We’ll repeat the prolactin level in the near future to track it.”

“We should also check your thyroid function and a pregnancy test, because thyroid problems and pregnancy can also raise prolactin.”

“You mentioned headaches – we need the medical/neurology team to review these properly and decide if any brain imaging is needed. Most of the time it’s the medication, but we don’t ignore headaches with high prolactin.”

Hyperprolactinemia
Management

B. Options for managing the antipsychotic (shared decision-making)

Reduce the olanzapine dose

“We could very gradually reduce the olanzapine dose if your mental state allows. Sometimes even a small reduction lowers prolactin.”

Switch to a more prolactin-sparing antipsychotic (e.g. aripiprazole)

“Another option is to slowly switch you from olanzapine to a medicine like aripiprazole, which doesn’t usually raise prolactin and can even bring it down.”

Add low-dose aripiprazole to your current olanzapine

“A third option is to keep you on olanzapine, because it’s working for your schizophrenia, but add a small dose of aripiprazole.

Research shows that adding aripiprazole can lower prolactin and improve symptoms like galactorrhoea, while keeping psychosis under control.”

“This sometimes works quite quickly, over weeks to a few months.”

Hyperprolactinemia
Management

C. Broader physical and psychosocial care

“We’ll:

Involve your GP and possibly the medical team to look at your bone health in the longer term (e.g. considering vitamin D, calcium, maybe a DEXA scan later if indicated).

Offer support or counselling if you wish- eg for relationship issues.”

Hyperprolactinemia

Management – Most important bit throughout- collaboration

“You’ve heard a lot of information. What are your thoughts about the options?”

“How worried are you about the breast discharge and long-term risks compared with your worry about your mental health being stable?”

“Would you lean more towards adjusting the olanzapine dose, adding something like aripiprazole, or planning a gradual switch?”

Then end with a recap and to

Repeat the prolactin.

Angry Mother- Fluoxetine/ Suicidal

- **Scenario:**Mr David is a 16-year-old man who is experiencing a severe depressive episode and has been admitted as an inpatient. He is due to be started on Fluoxetine. His mother, Julie Matthews, has asked to speak to one of the doctors as she is worried about the side-effects of Fluoxetine. You are the registrar on the ward and your consultant has asked you to meet with her.

- **Task: Please elicit her concerns and answer her queries.**

Angry Mother- Fluoxetine/ Suicidal

ICE First!

"Can you tell me what's worrying you most about the fluoxetine? I'd like to understand your concerns properly before we discuss the treatment plan."

[Listen actively, then reflect back]

Lots of Validation:
"It's clear you care deeply about David and want to protect him. Questioning medical treatments shows you're being a responsible parent

"Your instinct to want 'natural' approaches for your son ***comes from a good place***

Angry Mother- Fluoxetine/ Suicidal
Likely Questions

"I read that antidepressants can make teenagers suicidal - why would you give this to someone who's already depressed?"

You're right that there can be a small increased risk of suicidal thoughts in the first few weeks of treatment in teenagers - **about 4 out of every 100 young people might experience this.**

Severe depression itself carries a much higher suicide risk. Without treatment, David's risk of self-harm or suicide is much greater than the small increased risk from the medication.

Mataphor: if someone has a dangerous infection, antibiotics might cause some side effects, but the infection itself is far more dangerous if left untreated.

"But he was admitted because of depression - doesn't that mean the medication isn't safe?"

"Actually, the fact that David needed admission tells us how severe his depression is, which is exactly why medication becomes more important. Severe depression like David's **has about a 15-20% risk of suicide attempts without proper treatment**. The small temporary increase in risk from medication - about 4% - is much smaller than the ongoing risk from untreated severe depression.

We admit young people partly so we can monitor them very closely during those first few weeks when starting medication, ensuring their safety while the treatment starts to work."

Angry Mother- Fluoxetine/ Suicidal
Likely Questions

"How will I know if the medication is making him worse?"

We look for warning signs including:

- Increased agitation or restlessness in the first 2-3 weeks

- New thoughts about self-harm or suicide

- Severe mood swings or increased impulsivity

- Difficulty sleeping or increased energy without mood improvement

This is why we have very close monitoring - daily checks while he's in hospital, then frequent appointments after discharge.

"Why can't he just have talking therapy? Surely that's safer than drugs?"

"Talking therapy is absolutely important, and David will be getting that too. But let me explain why we need both approaches for severe depression:

For mild depression, talking therapy alone is often the first choice. *But David's depression is severe enough to need hospital admission, which puts him in a different category*.

Angry Mother- Fluoxetine/ Suicidal

Likely Questions

"Can't we just wait and see if he gets better naturally?"

"I understand the appeal of waiting - it feels like the safest option. But with severe depression, waiting can actually be the riskiest choice:

- Severe depression can worsen without treatment

- The longer it lasts, the harder it becomes to treat

- It affects his brain development, school, friendships, and self-esteem

- Most importantly, it carries ongoing suicide risk

"I don't want to put chemicals in my child's developing brain. Won't this affect how his brain grows?"

Depression itself affects brain development - it can actually slow normal brain growth and development during these crucial teenage years.

Fluoxetine works by helping the brain's natural chemical messengers (serotonin) work more effectively. It doesn't add foreign chemicals - it helps restore the natural balance that depression has disrupted.

Angry Mother- Fluoxetine/ Suicidal

Likely Questions

"What about long-term effects? Will he be dependent on medication forever?"

"Most teenagers who recover from depression don't need long-term medication. The typical plan is:

- Medication for 6-12 months after David recovers

- Gradually reduce and stop the medication under medical supervision

- Continue with therapy skills for ongoing protection

The goal is always to help David develop his own coping skills and resilience so he can maintain his mental health naturally.

Angry Mother- Clozapine

- **Scenario:** Talk to the angry mother of a male schizophrenic patient, Mr. John, who has been an **inpatient for the last 3 months**. He has **been treated with Clozapine for treatment-resistant schizophrenia**. Prior to admission, he had been **living with his alcoholic brother in squalid circumstances** and was likely exploited financially. He had **deranged liver function tests** at the time of admission, but his **blood tests have been fine for the last 3 months.** She is angry because she **read on the internet that Clozapine suppresses bone marrow**. His response to treatment has been slow, and he **still needs prompting with personal care.** She is not happy about the care he receives and would like to take him home. **She lives 30 miles from the hospital with her husband, who is also an alcoholic.**

- **Task:** Address her concerns.

Angry Mother- Clozapine
Likely Questions

"Why are you giving my son a drug that can damage his bone marrow?"

John has what we call treatment-resistant schizophrenia - his symptoms didn't improve with two other antipsychotic medications we tried. Clozapine is the only medication proven to help people in John's situation.

The bone marrow risk affects about 1 person in every 100 who takes clozapine. That means 99 out of 100 people don't have this problem. That's why he has regular blood tests. If there were any sign of bone marrow problems, we'd detect it immediately and stop the medication. His blood tests have been completely normal for 3 months, which is very reassuring.

"He's been here for 3 months and he's hardly any better! What are you people doing?"

Clozapine is different from other medications - it works more slowly but more effectively. Most people don't see significant improvement until 3-6 months, and full benefits can take up to a year.

John actually IS making progress, though I understand it might not feel like much:
- His blood tests have completely normalized - his liver function is now fine
- He's safer here than he was in his previous living situation

Angry Mother- Clozapine
Likely Questions

"I want to take him home now. He'd be better off with me than in this place!"

- John still needs daily prompting for basic self-care
- He requires weekly blood monitoring for the clozapine to be safe
- His symptoms, while improved, aren't yet stable enough for independent living

"He was fine living with his brother before. Why can't he go back there?"

- His brother's drinking meant John wasn't getting proper support with medication or self-care
- The living conditions weren't suitable for someone recovering from serious mental illness
- John's liver problems suggested his physical health was suffering

We need to find John a living situation where he can be safe, take his medication consistently, and continue to recover. That might be with family if we can put proper supports in place, or it might be supported accommodation.

Angry Mother- Clozapine

Likely Questions

"Are you sure he even has schizophrenia? Maybe you've got it all wrong!"

"I understand why you might hope there's been a mistake - no parent wants their child to have schizophrenia. Let me explain why we're confident about the diagnosis:

John has had:

- Persistent auditory hallucinations (voices)

- Odd beliefs that affected his behavior

- Decline in his ability to care for himself

- Symptoms that have lasted for months, not just days or weeks

When She Threatens to Complain:

"You absolutely have the right to make a complaint if you feel John isn't getting good care. I can give you the details of how to do that.- PALS.

Angry Mother- Schizophrenia

Scenario: Mr. Peter Hill is a 19-year-old university student, who is currently an in-patient on your ward and was admitted few days ago with bizarre behaviour, auditory hallucinations and odd beliefs of lizards taking over the world for **more than 6 weeks**. **Blood and urine tests are normal.** His **mother is angry to know from the nurses that he has been diagnosed as having schizophrenia.** Ms. Linda Hill wants to seek clarification of her son's diagnosis.

- **Task: Address her concerns and allay her anxiety**

Angry Mother- Schizophrenia
Likely Questions

”It was wrong for the nurses to talk about his diagnosis in the hallway!”

Apologise for the experience – You will investigate what happened after their discussion with the nurses and take it from there

"I've read that schizophrenia is caused by bad mothering. Is this my fault? What did I do wrong?”

"Absolutely not. That theory was completely discredited decades ago, but unfortunately it still causes unnecessary pain to families.

What Actually Causes Schizophrenia:

- It's a brain disorder caused by a combination of genetic factors and environmental triggers

- About 1% of people develop schizophrenia regardless of their upbringing

- It affects families from all backgrounds - loving, supportive families like yours

- *Good parenting doesn't cause it, and bad parenting doesn't cause it*

Angry Mother- Schizophrenia

Likely Questions

"How can you be sure it's schizophrenia? He's only been here a few days!"

Peter has been experiencing symptoms for over 6 weeks:

- Hearing voices that others can't hear (auditory hallucinations)

- Unusual beliefs about lizards taking over the world (delusions)

- Bizarre behavior that's very different from his normal self

- These symptoms have significantly affected his ability to function at university

Why We're Confident:

- We've ruled out other causes - his blood tests and urine tests are normal, so it's not drugs or medical conditions

- The pattern and duration of symptoms fit the criteria for schizophrenia

Why Early Diagnosis Matters:

Getting the right diagnosis quickly *means we can start the most effective treatment as soon as possible, which gives Peter the best chance of recovery."*

Angry Mother- Schizophrenia
Likely Questions

"Could it be something else? Maybe he's just stressed from university?"

Stress might cause anxiety, low mood, or sleep problems

- It doesn't typically cause persistent auditory hallucinations or elaborate delusional beliefs

- Peter's symptoms have continued even when removed from the university environment

However:

- Stress can sometimes trigger the onset of schizophrenia in someone who was already vulnerable

"Won't this diagnosis ruin his future? His career prospects? His chance of having a normal life?"

Many people with schizophrenia live full, meaningful lives

- They work, have relationships, get married, have children

- Early treatment, like Peter is getting, significantly improves outcomes

- There are legal protections against discrimination

- Many successful people have schizophrenia and live productive lives

Angry Mother- Schizophrenia
Likely Questions

"Should we keep this diagnosis secret? I'm worried about the stigma."

Unfortunately, stigma around mental illness still exists, but it's decreasing as understanding improves

- Many employers and institutions are much more understanding now
- There are strong legal protections against discrimination

My Suggestion:

- Start with close family and trusted friends who can provide support
- Peter can decide who else to tell as he gets older and more comfortable with his diagnosis

"What will people think of our family?"

- People who matter will be supportive and understanding
- You'll likely find you have more support than you expect
- Some people may surprise you with their kindness and shared experiences
- Peter is still the same person - intelligent, talented, with the same potential
- Your love and support matter more than anyone else's opinion"

Angry Mother- Schizophrenia
Likely Questions

"What does treatment involve? Will he need to be on medication forever?"

- Most people need medication for at least 2-3 years after their first episode

- Some people can eventually reduce or stop medication, but this must be done very carefully with medical supervision

Other Treatments:

- Talking therapies like CBT for psychosis

- Family therapy to help everyone understand and cope

- Occupational therapy to help with practical skills

- Social support and rehabilitation programs

Morbid Jealousy

- **Scenario:** Mr. John, a man in his 40s, has been with his partner for about a year and is convinced she is being unfaithful, believing a neighbor may be her secret lover. He has been checking her personal belongings for evidence but has found none. He is carrying a knife in case he discovers proof of her infidelity. His partner saw him in an agitated state today and persuaded him to attend A&E. Mr. Harris has a history of a similar incident four years ago, leading to hospitalization and treatment with risperidone 2mg.
- **Task: Explain** his **diagnosis** and **further management plan** to his partner and address her concerns.

CBT Psychosis

1. Engagement and Rapport
2. Explore Pattern
3. Reflect back- **Reality Testing**
4. Tell her about Diagnosis - Management

Morbid Jealousy
Rapport and Engagement

"Before I explain what we think is going on with John, I'd really like to understand your perspective. "

"*Can you tell me what's been happening at home* that made you feel he needed to come to the hospital today?"

"What changes have you noticed in John recently?"

"You mentioned he's been stressed - can you describe what that looks like?"

"How has he been with you at home? Any changes in his behavior or mood?"

"What made today different? What happened that made you decide he needed medical help?"

Morbid Jealousy
Rapport and Engagement

Probing About Jealousy:
"Has John been worried about your relationship lately?"

"You mentioned he jokes about you cheating - can you tell me more about that?"

"Has he been asking questions about where you go or who you see?"

"How do you feel when he makes these 'jokes' about infidelity?"

Morbid Jealousy
Explore Pattern

"I understand John had some mental health difficulties a few years ago. What do you know about that?"

[When she mentions his ex] "He told you his ex was unfaithful and it got physical with police involvement. How did John describe what happened?"

"Did John tell you what diagnosis he received back then?"

"You mentioned you encouraged him to stop his medication. What was happening that made you think he didn't need it anymore?"

Current Situation:

"Since he stopped the medication, have you noticed any gradual changes?"

"Has he been checking your phone, social media, or personal belongings?"

"Do you feel like you need to be careful about what you do or say to avoid his suspicions?"

"Has he mentioned any specific people he's worried about - neighbors, colleagues, friends?"

Morbid Jealousy
Reflect back- Reality Testing

"So let me understand what you've told me:

- John has been making 'jokes' about you cheating
- He's been checking your belongings
- He's been agitated enough for you to bring him to A&E
- This follows a pattern from his previous relationship
- He stopped medication against medical advice

Does this sound like someone who's just 'stressed' or does this seem like something more serious?"

"When you think about his previous relationship ending with police involvement, and now similar concerns arising with you, what does that suggest to you?"

Morbid Jealousy
Tell her about diagnosis - Management

"I'm concerned that what you're describing isn't just stress, but a *return of the mental health condition John had before*. This condition *can make people feel very suspicious and sometimes even unsafe*."

"When people have these kinds of intense jealous thoughts, *sometimes they feel they need to 'protect themselves' or 'prepare for confrontation.' Has John mentioned anything like that?"*

"Has John talked about what he might do i*f he 'found evidence' of cheating?"*

"I need to ask - *have you noticed John carrying anything unusual with him recently? Any objects or items that seemed out of place?"*

If She Doesn't Disclose, Then You Must:

"I need to share something concerning that John told me today. He mentioned that he's been carrying a knife because he wants to be 'prepared' if he discovers evidence of your infidelity."

"I can see this is shocking to hear. This is exactly why I wanted to understand your perspective first - because this shows his condition is more serious than just stress or joking."

"Sometimes when we love someone, we can miss warning signs, or we explain away concerning behaviors because we want to believe everything's fine."- *If she is shocked and says she didn't expect this.*

Morbid Jealousy
Tell her about diagnosis - Management

Immediate Management:

"Here's what needs to happen right now:

- John needs to restart medication, probably at a higher dose than before
- He may need hospital admission for his safety and yours
- The knife needs to be removed from your home immediately
- You need a safety plan for the coming days and weeks

Your Role:

- Supporting him to take medication consistently
- Learning to recognise early warning signs
- Having a plan if symptoms return

Morbid Jealousy
Tell her about diagnosis - Management

Long-term Considerations:

"I need to be honest with you about what this diagnosis means for your relationship:

- Morbid jealousy often recurs if medication is stopped
- It can be very difficult to live with someone who constantly suspects infidelity
- *The risk of violence can be high during episodes*
- Treatment works, but requires long-term commitment

Support for You:

- Consider counseling to help you cope with this situation
- Think about what you need to feel safe and supported
- *Remember - you deserve a relationship built on trust, not suspicion*"

Mania Management

- **Scenario:** Mr. … has been brought to A&E by his family, who are concerned he is experiencing a manic relapse. He has expressed grandiose ideas about producing a movie and has spent a large sum of money on it. He has had two previous admissions for mania and was treated with lithium.
- **Task:** Assess Mr. Marcus to **identify the reason for his relapse** and **create a management plan**.

Mania Management

1. **Review Current Symptoms and Establish Diagnosis- Detect 4 symptoms (Thoughts/ Sleep reduced/ Heightened irritability/Elated mood)**
2. **Identify the Reason for Relapse**
   - **Medication Non-Compliance**- lithium –**Ask why**
   - **Substance Use**?
3. **Address his question *"Why should I take a medication that will bring my mood down"***
4. **Formulate a Management Plan**
   - **Medication Adjustment**: Possible increase in lithium or addition of antipsychotic (e.g., olanzapine, quetiapine)
   - **Inpatient Care**
   - **Supportive Care**: Crisis outreach team

Genetics of Schizophrenia

- **Task:** Talk to Mrs. … and **address his concerns** about the **risks of her child developing Schizophrenia disease.** Do not perform a mental state examination.

Validation Bridge Technique

Opening Responses Before Delivering Clinical Truth

VALIDATE → BRIDGE → TRUTH

Impossible/Inappropriate Requests

Sterilization, genetic testing, etc.

- *"I can see where you're coming from, **however** ..."*
- *"That would feel more certain, **however** ..."*
- *"I understand why you'd want that, **but** ..."*

Right Question, Anxious Patient

Valid concerns, need reassurance

- *"That's exactly the right question, **so** ..."*
- *"You're absolutely right to ask, **and** ..."*
- *"That shows good thinking, **here's what** ..."*

Partial/Wrong Information

Myths, half-truths, misconceptions

- *"There's some truth there, **but** ..."*
- *"I see why you'd think that, **however** ..."*
- *"That's common to hear, **actually** ..."*

Too Late/Missed Opportunity

Should have been done earlier

- *"That would have been ideal earlier, **however** ..."*
- *"In a perfect world yes, **but now** ..."*
- *"Ideally we would have, **however at this stage** ..."*

💬 Real CASC Examples

Genetic Testing at 12 weeks:

"That would certainly give you peace of mind" ***however*** *"we can't test for schizophrenia genes in pregnancy..."*

Clozapine Life Span Worry:

"That's exactly the right concern to raise" ***and*** *"the evidence shows this mainly affects people who don't monitor their health..."*

Sterilization Request:

"I can see you want to protect him from difficulties" ***however*** *"sterilization isn't something we can consider..."*

Missed Pre-conception Planning:

"That would have been ideal to discuss earlier" ***however*** *"now that you're pregnant, here's what we can do..."*

🎯 Why This Works

Validation prevents defensiveness → Bridge maintains rapport → Truth lands more gently

Genetics of Schizophrenia
Rapport and Engagement

ICE
"When you think about 'passing on the schizophrenia gene,' what is your understanding of how that works?"

"What have you heard or read about the genetics of schizophrenia?"

"How certain do you feel that your child would develop schizophrenia if you continue the pregnancy?"

Genetics of Schizophrenia
Heritability

- Having schizophrenia doesn't mean you carry 'bad genes' that you'll definitely pass on
- Your child might inherit mostly protective genes
- Genetics is just one piece of a complex puzzle”

- **13% if one parent, 45% if both**
  Even with you having schizophrenia, there's about a 87-90% chance your child will NOT develop it

  9 out of 10 children of parents with schizophrenia are completely unaffected

Genetics of Schizophrenia
Environmental Factors & Prevention

Things That Increase Risk:

- Cannabis use, especially in teenagers
- Severe childhood trauma or abuse
- Social isolation and lack of support
- Major life stresses during vulnerable periods
- Urban living and social deprivation

Things That Protect Against Schizophrenia:

- Strong family support (which your child would have)
- Good education and social connections
- Avoiding drugs, especially cannabis
- Managing stress effectively
- Early intervention if any symptoms appear"

Genetics of Schizophrenia
What can you do

During Pregnancy:

- Take good care of your mental health
- Continue your treatment as recommended
- Eat well, avoid alcohol and drugs
- Manage stress and get support

As Your Child Grows:

- Provide a loving, stable home environment
- Be aware of early warning signs (which most parents never see)
- Ensure good education about drug risks, especially cannabis
- Build strong family relationships and social support
- Know that early intervention works very well if ever needed”

- Modern treatment means even if your child developed schizophrenia, their life could still be very fulfilling

Alzheimer Genetics (Similar approach to Schizophrenia Genetics)

- **Task:** Talk to Mr. … and **address his concerns** about the **risks of developing Alzheimer's disease.** Do not perform a mental state examination.

Alzheimer Genetics

- **Opening Statement:** "Hi Mr. …., I understand how worrying it must be to see your grandfather diagnosed with Alzheimer's. ***How is he?*** How do you feel about his diagnosis? It's natural to wonder about your own risk. …Let's talk about the factors that can contribute to Alzheimer's and what you can do to reduce your risk."

Alzheimer Genetics

Discuss Emotional Impact : "It's normal to feel anxious about family history, but having a relative with Alzheimer's doesn't mean it's inevitable"

Clarify Risk Factors for Alzheimer's Disease – Age, Family history, Genetics

- **THEN**

Reassure and Address Risk Factors

Lifestyle Changes

Cognitive Activity: (learning, puzzles, reading) may delay or prevent cognitive decline

Next Steps

Recommend regular check-ups for cognitive health

Negative Sx of Schizophrenia

- Was admitted to rehab- discharged to local residential home
- **Task:** Talk to Mr. … about the **psychosocial Rx options for her negative symptoms.**

Negative Sx of Schizophrenia

Establish Diagnosis

<u>Compare difference then and now.</u>

Psychosocial treatment

-Social Skills Training/ CBT/ Cognitive Remediation Tx/ Peer support group/ Music Tx (Taylor to Hobby!)

Dissociative Stupor

Scenario: Mrs. Graves is a 45-year-old woman whose 18-year-old daughter, Annie, has been admitted to her local hospital after collapsing in the street yesterday afternoon. Annie has been admitted to the acute medical unit for assessment and has been fully investigated but no organic cause has been found. She is presenting as entirely unresponsive and not accepting any food or drink.

Task: Please take a brief history from Mrs. Graves and explain her daughter's likely diagnosis.

Dissociative Stupor

1. Engagement
2. Explore The Event And Stressors
3. Psychosocial Context & Previous Episodes
4. Concerns and Prognosis
5. Management

Dissociative Stupor
Engagement

"Mrs Graves, I'm Dr X. I can only imagine how frightening this must be for you, seeing Annie in this state. **I want to help you understand what might be happening."**

"The medical team has done extensive tests and thankfully found no physical cause for Annie's condition. To help us understand what's going on, I'd like to ask you some questions about what led up to her collapse yesterday."

"**Can you walk me through what happened in the days or weeks before Annie collapsed?"**

Dissociative Stupor
The event and stressors

Time of Collapse:
"What was Annie doing just before she collapsed?"

"Had she seemed upset or stressed about anything recently?"

"Were there any arguments, difficult conversations, or upsetting events in the past few days?"

"How was her mood in the week leading up to this?”

Life Stressors:
"Has anything significant been happening in Annie's life recently - school, relationships, family issues?"

"Any major changes or stresses - exams, university applications, relationship problems?"

"Has she experienced any losses or disappointments lately?"

"Any family conflicts or difficult situations at home?"

Dissociative Stupor
The event and stressors

Baseline Functioning:
"How has Annie been generally over the past few months?"

"Is this completely out of character for her, or have you noticed any changes in her behavior or mood?"

"How does she usually cope with stress or difficult situations?"

"Has she ever had episodes like this before, even milder ones?"

Dissociative Stupor
Psychosocial Context & Previous Episodes

Family and Social History:
"Tell me about Annie as a person - how would you describe her personality?"

"How does she usually handle difficult emotions or stress?"

"Are there any mental health problems in the family?"

"How are things at home generally - any family stresses or conflicts?"

"What's Annie's social situation like - friends, relationships, school?"

Previous Episodes Assessment:

"Has Annie ever 'shut down' or become unresponsive before, even briefly?"

"Any episodes of 'spacing out,' seeming disconnected, or not responding normally?"

"Has she ever had unexplained physical symptoms during stressful times?"

"Any previous contact with mental health services or counselors?"

Dissociative Stupor

Explaining Dissociative Stupor Diagnosis

"Based on Annie's presentation and what you've told me about recent stresses, I believe Annie is experiencing what we call *dissociative stupor.*"

"**Dissociative stupor** **is a psychological response where the mind essentially 'switches off' as a way of protecting itself from overwhelming stress or emotions."**

"Her body is physically fine - that's why all the medical tests were normal. But her mind has temporarily disconnected from her ability to respond to the world around her."

"It's not that she's choosing not to respond - her brain has automatically switched into this protective state without her conscious control."

Why it happens:
Usually happens when someone experiences stress or emotions that feel too overwhelming to process normally."/

"It's actually a sign that Annie's mind is trying to protect her from something that feels too difficult to cope with."/

"Some people are more prone to this kind of response, especially those who are sensitive or have difficulty expressing difficult emotions."

Dissociative Stupor
Concerns & Prognosis

"Is this mental illness?":

What Annie is experiencing is a psychological response to stress, but it's not a permanent mental illness.

"Many healthy, intelligent people can have dissociative episodes during particularly stressful times in their lives."

"This is more like a temporary protective mechanism that her mind has activated."

"Will she get better?":

"The good news is that dissociative stupor typically resolves, often quite quickly once the underlying stress is addressed."

"Most people recover completely with appropriate support and treatment."

"Annie is young and this appears to be her first episode, which are positive factors for recovery."

Dissociative Stupor
Concerns & Prognosis

"How long will this last?":

"It's difficult to predict exactly, but dissociative episodes can last anywhere from hours to days, sometimes weeks."

"Once Annie feels safe and the underlying stress is managed, her mind should allow her to reconnect with her surroundings."

About Not Eating/Drinking:

"I understand you're worried about her not eating or drinking. The medical team will ensure she stays physically safe and hydrated while we work on the underlying cause."

"As her psychological state improves, her ability to eat and drink should return naturally."

Dissociative Stupor
Management

Creating Safety:

- Ensuring Annie feels physically and emotionally safe
- Reducing any ongoing stressors that might be contributing
- Providing a calm, supportive environment

Gentle Reactivation:

- Gradually encouraging responsiveness without pressuring her
- Using familiar voices and gentle stimulation
- Building on any small signs of awareness or response

Addressing Underlying Issues:

- Once Annie is more responsive, exploring what triggered this episode
- Helping her *develop better coping strategies for stress*
- Family therapy if family stresses contributed to the episode"

Dissociative Stupor
Management

Your Role as Mother:

- Talking to her gently, even though she seems unresponsive
- Sharing positive memories or reassuring messages
- Being patient and not pressuring her to respond
- Taking care of yourself so you can support her

What We'll Do:

- Monitor her physical health and ensure proper nutrition
- Create a calm, supportive environment
- Gradually work on helping her reconnect with her surroundings
- Arrange appropriate psychological support once she's more responsive"

Refeeding syndrome

- **Scenario:** Miss … is a 24-year-old woman with anorexia nervosa. She has been under the care of the community eating disorder service for a month following a relapse. Her **BMI was 13.5 kg/m²** when care began, and she **has recently gained 3 kg** in one week. Her blood pressure has increased from 90/60 mmHg to 100/70 mmHg, and the community nurse has noted concerns about her physical symptoms.
- **Task:** Speak to the **community nurse** regarding Miss …'s physical symptoms, establish **the likely cause**, and **formulate a management plan.**

Refeeding syndrome – talking to a staff

- **Opening Statement:** “Hi, I understand you’ve been monitoring Miss …, and you’re concerned about her recently. Can you give me a handover/ keep me up to speed with whats happening so we can figure out what might be happening.”

- At some point, offer praise to the staff/ involve the staff in the plan.

Refeeding syndrome

-Identify Recent Physical Symptoms – Rapid weight gain/ BP change/ Electrolyte imbalance

-Establish the Likely Cause: Refeeding Syndrome

= "*happens when someone who hasn't eaten enough for a long time starts eating again too quickly. Their body, which has been trying to save energy, suddenly gets more food than it's ready for. This can cause dangerous changes in their body's salts and fluids, leading to serious problems like heart issues, swelling, and trouble breathing."*

-Immediate Investigations – Blood tests and vital signs

-Formulate a Management Plan – diet plan/ electrolyte supplement/ medical check ups

-Psychological Support

Metabolic Syndrome/Olanzapine Side Effects/ Lifestyle changes

- **Task:** Explain results, establish **the likely cause**, and **formulate a management plan including lifestyle change.**

Metabolic Syndrome/Olanzapine Side Effects/ Lifestyle changes

- **Rapport –** Impact of weight/ Benefit of psychotropic.

- **Reveal Results** (Simplify - Remember you are not a GP)
- **Check for affect changes** → **Nonchalant? Surprised? Shocked?** → ***Motivation to change!***

- **Lots of ICE/ Explore insight of bad lifestyle to results! – Commit to each management option!**
- **Diet – Nutritionist**
- **Exercise- Physiotherapist**

Anorexia Explanation

- **Scenario:** Mrs. … is a 40-year-old woman **concerned about her 16-year-old daughter**, who has been diagnosed with anorexia and **admitted with weight loss and mild hypokalaemia.** Mrs. … wants to know more about the signs, symptoms, and treatment of anorexia.

- **Task**: **Address Mrs. … concerns**. **Do not take a history** or perform a **mental state examination**.

Anorexia Explanation

What it is:
"Anorexia is an eating disorder where [person] become ***very focused on her weight and food****, often* ***eating too little and worrying excessively about gaining weight****."*

Reassure AND Explain the Severity

"…'s weight loss and low potassium levels are *concerning*, but the *fact that she's being treated* means *we're keeping a close eye* on her health and addressing these problems."

Outline Treatment Approach

Nutritional Support:
"We'll help her gradually regain weight in a safe way, with a focus on balanced nutrition."

Psychological Therapy:
"She'll also get therapy to help her change how she thinks about food, her body, and herself."

Family Involvement:
"Family-based treatment can help you support her recovery."

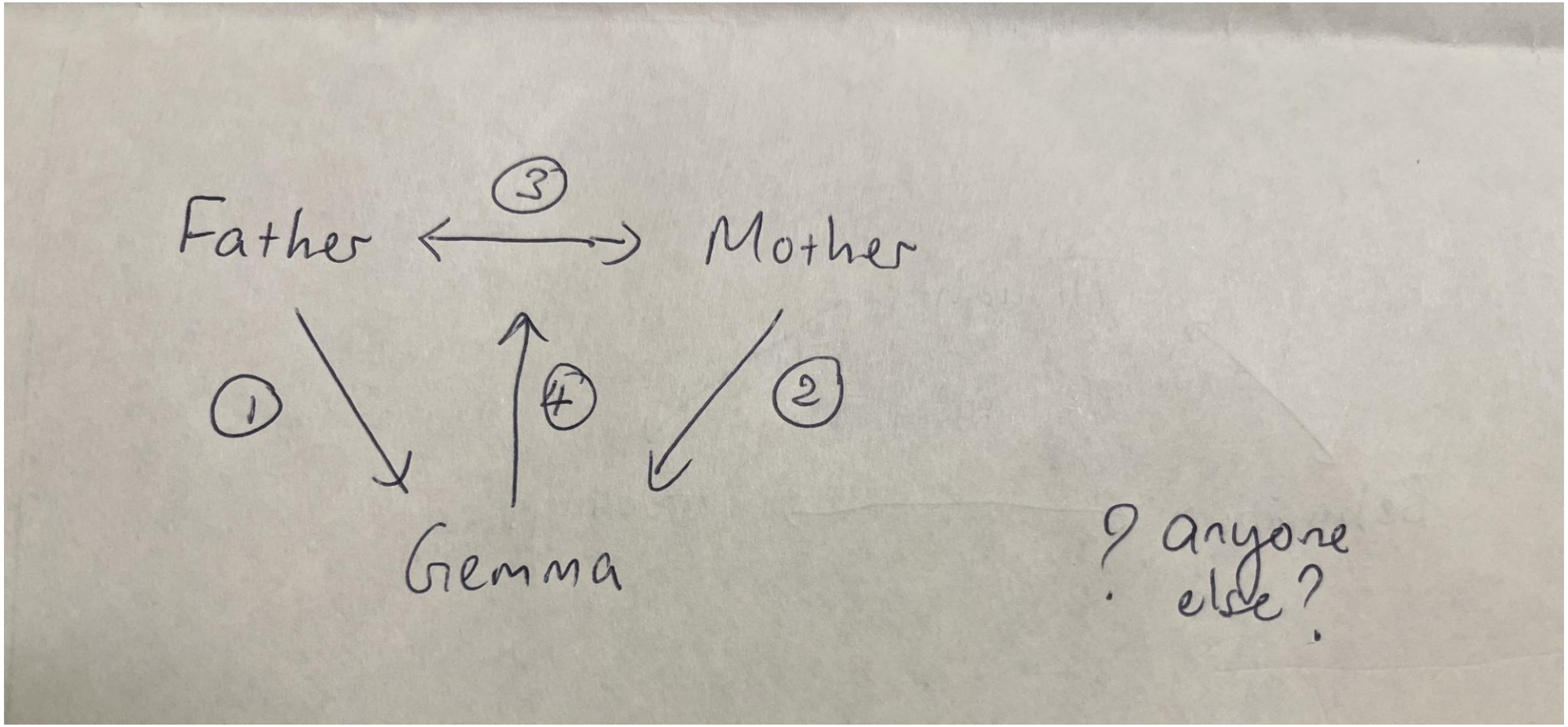
Address Mrs. …'s Concerns

Allay Anxiety:
"It's natural to feel anxious, but the important thing to know is that anorexia is treatable. She will have a team of doctors, therapists, and dietitians working with her."

Family Dynamics

- **Scenario:** Mr. Harding is the father of Gemma Harding, a 15-year-old girl recently diagnosed with a first episode of schizophrenia and now under the care of the Early Intervention Service. Mr. Harding and his wife have frequent arguments about how to best support their daughter. He feels his wife is being "too soft" on Gemma, while he believes that Gemma should be encouraged to resume normal activities, like returning to school and socializing. These differences have caused tension in the family.
- **Task:** Talk to Mr. Harding alone in the clinic to **assess the family dynamics** that **may affect Gemma's progress**. **Do not discuss family therapy.**

Family Dynamics



Family Dynamics

High Expressed Emotions:

"Mr. Harding, ***I understand that you and your wife want the best for*** Gemma, but **sometimes when there are strong emotions at home**—whether it's [quote from what the father said eg. trying to push her to engage more, or even being too protective]—***it can add extra stress for her***. This is what we call **'high expressed emotions.' It's not about blame**, but when there's [quote experiences between him and his wife eg. tension, arguments, or pressure], **it can make it harder for Gemma to manage her schizophrenia.**

What can really help is **finding a middle ground** where she **feels supported but not overwhelmed.**

"Is it my fault she is like this?":
Your intentions were good and you being here to change things is a bright step moving forward. Shows your commitment towards her

Alcohol and Schizophrenia

- Scenario: Mrs. ….is a 38-year-old woman and the sister of Mr. …. . Mr. … has a diagnosis of paranoid **schizophrenia** and has been on **Clozapine for several years**. Unfortunately, **their parents have both died recently**, and Mr. .. is now **living alone** in the family house. Their **parents had been his main carers** until shortly before they died. **Mrs. … lives around a 2-hour drive** from the house and has 2 young children, so she is unable to provide regular care to her brother but has been coming to see him when she can. She has been increasingly worried about him as he has seemed **low in mood and has told her that he is drinking more than before.** She is not sure how much he has been drinking, but she has seen a lot of empty whiskey and beer bottles around the house. He has been talking about people watching him when he is out of the house, which is one of the symptoms he had before, and she has noted that he has more Clozapine around than he should, and he has said that he sometimes forgets to take it.

- Task: Please explain to the sister **a formulation of the case** and explain the potential **adverse effects of alco**hol on her brother's **physical and psychological health.**

Alcohol and Schizophrenia

- **Formulation:**
  Mr. …'s increased alcohol use appears to be his way of coping with the grief of losing his parents . Living alone and feeling isolated may have contributed to his low mood. His on and off use of Clozapine, combined with the alcohol, is likely worsening his schizophrenia symptoms, as he is now experiencing paranoid thoughts again.

Alcohol and Schizophrenia

Physical Health Risks:

Liver Damage: *Heavy alcohol use can lead to liver problems, which can affect how medications like Clozapine are processed.*

Clozapine Interactions: *Alcohol can interact with Clozapine, increasing side effects like sedation and making it harder for him to stay alert.*

Increased Risk of Accidents: *Drinking can impair his coordination and judgment, putting him at risk for falls or other injuries.*

Mental Health Risks:

Worsening of Schizophrenia Symptoms: *Alcohol can exacerbate symptoms like paranoia, hallucinations, and delusions, making it harder to manage his condition.*

Mood Instability: *Alcohol is a depressant and can worsen his low mood, increasing the risk of further depression or suicidal thoughts.*

Big group Session:
Free Zoom session, every Saturday 3-5pm UK time, the link will be shared directly on our WhatsApp community.

Small Groups Sessions:
Limited seats, 6 candidates + 2 observers, playing a total of 96 heigh yield stations total (6 stations per session , 16 session)

CASCers Mocks:
4:1 mock (16 stations)
-played with 2 other role players and feedback contributed by them
2:1 mock (8 stations)
-with detailed feedback from Mohammad and Praveen

Private Sessions:
One to one or two to one sessions (1 or 2 hours per session)

Practice Sessions(Coming Soon):
Where you will be practicing with different candidates the new stations every week

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