MENTAL ILLNESS

BELMATT
HEALTHCARE TRAINING

PRE-COURSE WORKBOOK

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Dr Balu Pitchiah qualified as a Medical Doctor from the Prestigious Stanley Medical College in Chennai, India before completing his Basic Psychiatric Training in Sheffield. During his training in Sheffield, he was inspired by the works of Dr Steve Peters, a leading Mind Management expert and research at the Sheffield Cognition and Neuro-imaging laboratory. After completing his basic mental health training, Dr Balu decided to pursue a career in management and took up an assignment with the Priory Group. He was involved in setting up and management of an inpatient facility which focused on the rehabilitation and empowerment of people with severe and enduring mental health problems.

Dr Balu Pitchiah works as a NHS – Psychiatrist at South Kensington. He works closely with a multidisciplinary team which manages common mental disorders including anxiety disorders, depression, OCD,PTSD and Bipolar affective disorder under his expert supervision. He has expertise in working with high achievers and people with Type A personalities helping them achieve their full potential while minimising the impact of their emotional problems on their work and family life. Dr Balu routinely consults people with multiple co-morbidities and physical health problems including cancer. His treatment approach is holistic, tailored to individual needs working in collaboration with his clients who he believes are the experts in their own condition. In addition to prescribing medicines and recommending psychological treatment, he works with a wide range of professionals offering life coaching, Neurotherapy and magnetic treatment.

MENTAL HEALTH

AIMS

This session aims to discuss common mental illness presentations in primary care.

OBJECTIVES

- Develop an understanding of common mental health problems that present in primary care.
- Identify treatment strategies suitable for individual patients
- Explore current evidence and treatment guidelines.
- Understand the importance of using varying strategies according to care plan agreed for patients/clients to improve concordance.

RECOMMENDED READING

Mood Disorders : https://www.osmosis.org/learn/Clinical_Reasoning:_Mood_disorders?section=Psychiatry&playlist=clinicalreasoning

Psychotic disorders

https://www.osmosis.org/learn/Clinical_Reasoning:_Psychotic_disorders?playlist=clinicalreasoning

Anxiety Disorders

https://www.osmosis.org/learn/Clinical_Reasoning:_Anxiety_disorders?playlist=clinicalreasoning

Personality Disorders

https://www.osmosis.org/learn/Clinical_Reasoning:_Personality_disorders?playlist=clinicalreasoning

Depression: https://geekymedics.com/unipolar-depression/

HISTORY TAKING

Take a basic psychiatric history.

OVERVIEW OF THE HISTORY

- Presenting Complaint(s)
- History of the Presenting Complaint(s)
- Past Psychiatric History
- Past Medical History
- Current and Recent Medication
- Social History - alcohol & drug use; smoking; social circumstances; main relationships/supports/carers
- Family History of Psychiatric Illness
- Personal History
    - Developmental milestones
        - Has the illness always been present e.g. learning difficulties
    - Schooling/Education
        - Gives you an idea about the onset of the illness
    - Occupational history
    - Relationships
    - Pre-morbid Personality

PRESENTING COMPLAINT

- Record the presenting complaint in the patients on words i.e. quote exactly what they are saying, including swear words.

HISTORY OF PRESENTING COMPLAINT

- Clarify each complaint in turn
- Onset, precipitants, course, severity
- Associated symptoms, effects on daily living
- Is it getting worse or better?
- Has it responded to any treatment?

ASKING ABOUT RELATED SYMPTOMS

- After patient has finished volunteering symptoms
- “What other changes have your partner/ family/ friends noticed in you?”
- Ask about specific symptoms - may be closed questions
- Systematic enquiry to screen for other symptoms e.g. depression, obsessions, anxiety, psychosis

EXPLORING PSYCHOTIC SYMPTOMS – PERCEPTS

This is when a patient perceives something that isn't there.

- "Have you seen or heard anything that other people have not been aware of?"
- "Have you heard any people talking when there was nobody around?"
- What do they think is causing them?
- Does it seem possible?
- Beware commands

MEDICATION: Checks medication history including prescribed, over the counter, street, herbal and 'other drugs'. Checks immunization history.

ALLERGIES: Obtains a history of allergies including medication, food intolerances, animal or other e.g. latex or plasters

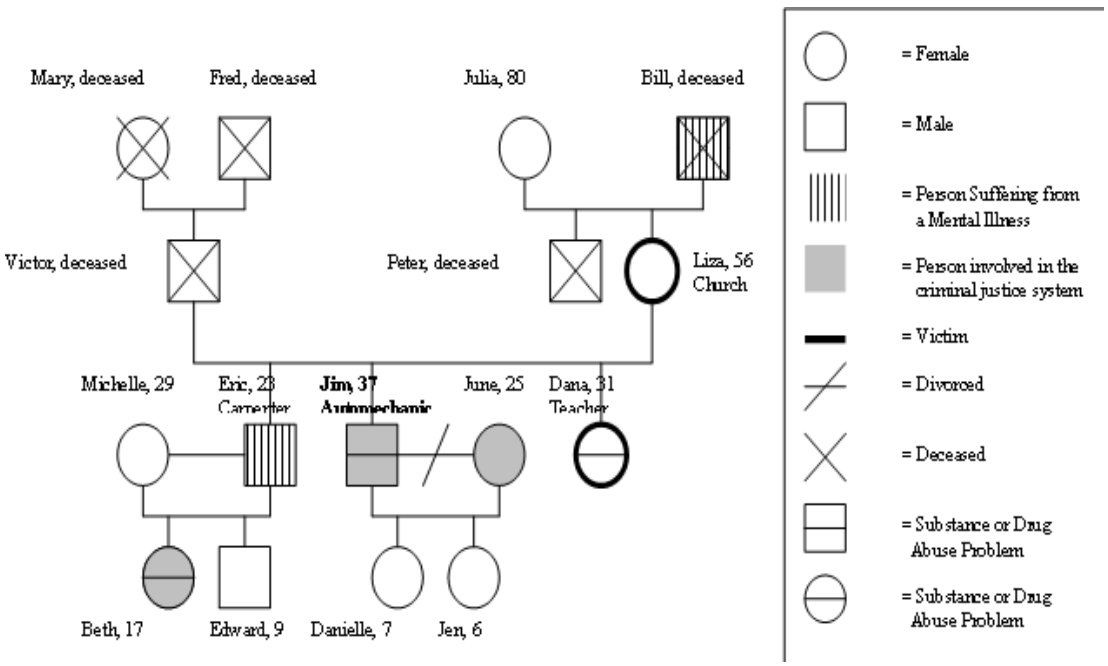
- Past episodes/ diagnoses / contacts
- Previous treatments (psychological, drug and physical)
- Inter-episode functioning
- Previous admissions to hospital
- Attempted suicide/ repeated DSH (deliberate self harm)
- Previous detentions under MHA

FAMILY HISTORY

- Age, employment, circumstances, health problems, quality of relationship

Major mental illness in more distant relatives is important

- Genogram can be helpful
  - Similar to a gene map, parents, grandparents etc



PAST MEDICAL HISTORY

- Developmental problems
- Head injuries
- Endocrine abnormalities
- Liver damage, oesophageal varices, peptic ulcers – alcohol problems or indications for medications
- Vascular risks factors

CURRENT AND RECENT MEDICATION

- Ask about tablets and injections
- Ask about medication recently
- Any drugs discontinued (within past 6 months)
- Ask how long medication has been taken for and at what dose
- Ask about adverse reactions and allergies

SOCIAL HISTORY

- Social circumstances including occupation
- Current financial situation/stressors
- Smoking/Alcohol/illicit drug use
- Current relationship/stressors
- Children – contact

DRUG HISTORY

- Regular or intermittent
  - Amount (know the units)
  - Pattern
  - Depenact on work, relationships, money, police
  - Screening questionnaires eg CAGE
  - Alcohol/Illicit

PERSONAL HISTORY

- Developmental milestones
- Early life
- Schooling
- Occupational
- Relationships (sexual & marital history)
- Financial
- Friendships, hobbies and interests

FORENSIC HISTORY

- “Have you ever been in contact with the police? Charged with any crime?”
- Offences including sentences
- Recidivism
- Particular attention to violent or sexual crimes

PRE-MORBID PERSONALITY

- Rarely comprehensive
- Emphasis on consistent patterns of behaviour, interaction, mood
- Informant account may be essential

“How would your best friend describe you as a person?

- To conduct a mental state examination.

MENTAL STATE EXAMINATION

- Appearance
- Behaviour
- Mood
- Speech
- Thoughts
- Beliefs
- Percepts
- Suicide/Homicide
- Cognitive function
- Insight

APPEARANCE

- Height/Build
- Clothing - appropriate/inappropriate, kempt, bizarre
- Personal hygiene - clean/unshaven/malodorous
- Make up, jewellery, accessories

BEHAVIOUR

- Greeting
- Non verbal cues
- Gesturing - normal, expansive, bizarre
- Abnormal movements - tremor, choreioathetoid movements, posturing, akathisia (needing to be in constant motion)
- Cooperative, rapport

MOOD

- Eye contact
- Affect - facial movements/reactivity
- Psychomotor function - retarded, agitated

SPEECH

- Spontaneity
- Volume - loud, quiet, poverty
- Rate - pressured, slowed
- Rhythm - rhyming and punning
- Tone - monotonous, lilting
- Dysarthria
- Dysphasia - expressive/receptive

ABNORMAL THOUGHTS

- Thought broadcast/insertion/withdrawal
- Thought blocking/echo
- Knight's move thinking/derailment
    - A sequence of unrelated or only remotely related ideas
- Flight of ideas
- Close relationship to speech - external manifestation of thoughts
- Obsessions
- Negative thoughts

ABNORMAL BELIEFS

- Preoccupations
- Over valued ideas
- Delusional beliefs - fixed, false belief out of cultural context
    - You can also have a delusion about something that happens to be right but you got there through a series of clues that were delusional

      e.g. wife having an affair

SUICIDE/HOMICIDE

- Must always ask about suicidal thoughts
- Ideation
- Intent
- Plans - vague, detailed, specific, already in motion
- Also homicidal risk – write down that you asked it as well

COGNITIVE FUNCTION

- Orientation - time, place, person
- Attention/concentration - throughout i/v
- Short term memory - 3 objects; name & address

INSIGHT

- Multi faceted
- Not just present/absent
- Varies over time/illness
- Are symptoms due to illness?
- Does medication/treatment help?
- Do they need to be in hospital/see the doctor?

DEFINITIONS

- **Psychopathology** is concerned with abnormal experience, cognition and behaviour.
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- **Descriptive Psychopathology** describes and categorizes the abnormal experience as described by the patient.
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- **Phenomenology** in psychiatry refers to the observation and understanding of the psychological event or phenomenon so that the observer can as far as possible know what the patient's experience feels like.

CASE STUDY

A young man attends the surgery to talk about a women he is in love with since watching a movie about 6months ago. He believes the actress in the movie and him are destined to be together and he begins to stalk her. He states there is a conspiracy to keep them apart, When she ignores his poems and phone calls, he informs you that he will win her love and catch her attention if he assassinates the current president. He insists that there is no chance his plot will fail. He has no visual or auditory hallucinations. He has no friends as he gets anxious in social situations. He appears awkward. He seems obsessed with his plans and wants you to do a full health check on him so that he is in the bets possible health when he gets the actress attention.

1. What is his likely diagnosis?

2. What will you do?

3. Is this sectionable?

A 85-year-old male is brought to your office by his wife. She complains that his memory has been gradually getting worse and that he has difficulty buttoning his shirt. On interviewing him, you find that he has trouble finding words. What is his likely diagnosis?

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Pt attends the surgery with her mother. Patient is 18years old. Her mother says she cannot deal with her anymore.The patient is reserved and reluctant to answer questions. Her mother says her daughter regularly abuses alcohol and has many sexual partner. The patient says her most recent boyfriend is "the love of her life and would do anything" for her. She does not have a job and is home schooled, due to an inappropriate relationship with a former teacher. Physical examination shows numerous cuts on her forearm. Which of the following is most likely present in this patient

A. Borderline personality disorders

B. Histrionic personality disorder

C. Narcissistic personality disorder

D. Obsessive compulsive personality disorder

E. Schizoid personality disorder?

A 25-year-old female presents to the emergency department for an acute anxiety attack. She also complains of nausea and feels like she "has another urinary tract infection." Her medical history is significant for recurrent UTIs and an "issue with my heart's QT thing." She has no allergies and currently takes no medications. The chart from her previous visit confirms hereditary QT prolongation. A 12-lead ECG reveals a QTc of 600 ms.

Given her presentation and medical history, which of the following drugs is safe to give to this patient? Which of the following drugs is safe to give the patient?

A. Ondansetron

B Fluoxetine

C. Ciprofloxacin

D. Lorazepam

E. Sotalol likely present in this patient

A patient attends the surgery for her blood results. She has a history of schizophrenia and bloods were done when she complained of galactorrhea. She is 45yrs old and blood tests show hyperprolactinemia . You call the psychiatric team who advise switching the patient's current psychiatric neuroleptic agent to another neuroleptic that will adequately treat the patient's psychotic condition but at the same time have no hyperprolactinemic side effect. You prescribe the drug and 3 weeks later, the patient's returns with a family member who complains that she is drooling. Which drug has likely caused the drooling?

A. Chlorpromazine
B. Risperidone
C. Olanzapine
D. Clozapine

Why?

A 56yr old male with a history of chronic fatigue attends the surgery. He states he has difficulty sleeping and finds it hard to concentrate. His medical notes show he has a history of alcohol abuse and he has chronic back pain. He takes tramadol and cocodamol for pain. He claims he feels life is out of control and side effects of his medication. Feel he is losing control. Blood tests were normal at recent visit as you notice he has called 111 a few times and come to the surgery with similar symptoms 3 times in the past month.

Which condition does he likely have

a. Schizophrenia
b. Major Depressive Disorder
c. Generalised anxiety Disorder
d. Depression
e. Obsessive Compulsive Disorder

A 85-year-old male attends a surgery appointment accompanied by his wife. She complains that his memory has been gradually getting worse and that he has difficulty buttoning his shirt. On interviewing him, you find that he has trouble finding words. Which condition does he likely have?

a. Dementia
b. Parkinsons
c. Alzheimers
d. Delirium

A 25year old female attends a routine appointment, somewhat reluctantly with her mother who is concerned as the patient recently dropped out of school to pursue a home business.

In the past month, patient has been very self confident, appears to have racing thoughts, is not sleeping and the mother has noted from a recent credit card statement that she has maxed out her credit cards in one week, spending about £6000.00 During the patient interview, her speech is notably pressured and she is quick to change topics. Which of the following is a possible diagnosis?

a. Schizophrenia
b. Bipolar Disorder
c. Generalised anxiety disorder
d. Borderline Personality Disorder

25yr old male attends with his girlfriend who is concerned about a change in his behaviour in the past 3 months. He has always been the top student in his class but has recently been skipping classes for the past term. The patient states he had a ‘revelation’ and has been chosen for a “special mission” He states that he hears messages from "the deity." Mental status examination shows disorganized thought process. No evidence of drug use. Which of the following is the most likely diagnosis?

a. Delusion Disorder
b. Schizophreniform disorder
c. Bipolar Affective Disorder
d. Borderline Personality Disorder

A 30-year-old woman comes to the clinic because of a progressive decline in social and occupational functioning over the past year, along with a withdrawal from her regular activities. In addition, her family notes that over the past 4 months she has had paranoid delusions, exhibited disorganized speech, and has been hearing voices. She has not had any major depressive or manic episodes. A physical examination reveals a dishevelled female with a flat affect, poor eye contact, and loosely-associated speech. A toxicology screen and basic laboratory analysis are unremarkable. She is not on any medications. Which one of the following is the most likely diagnosis?

A Brief psychotic disorder
B Delirium
C Delusional disorder
D Schizoaffective disorder
E Schizophrenia

What do you think is first line treatment?