UniSHAMS

POSTING GUIDE BOOK YEAR 4

PSYCHIATRY

Name:
Student No.:
Mobile Number:
Session/Semester:
Group:
Posting date
Begin: **End:**

GUIDE BOOK YEAR 4 MAJOR POSTING

Psychiatry I

Lecturer(s) in charge:

1 INTRODUCTION

Welcome to psychiatric posting!

In this posting students will be exposed to proper psychiatric interview, case clerking, clinical presentation and theoretical understanding of psychiatric disorders.

Many students found this posting interesting simply because it has a difference. First and foremost, psychiatry is a branch of medicine that seems to focus on the understanding of the process of thinking, emotion and behaviour. Second, psychiatry if not treated like any other subject in medicine would appear to be loose and abstract. It is suggested that the beginner sticks to methodology used in clinical medicine. As one said, insanity is a disease that affect the brain. Therefore it has to be studied in a similar manner one studied medicine. The difference is on the holistic approach and the authoritative and negotiative style in managing cases. Remember that in psychiatry, systematic history taking and mental status examination must be supplemented with empathic understanding and good doctor-patient relationship. Only then one would be able to produce good diagnosis and treatment modality.

To excel in psychiatric study, group discussion is encouraged on top of individual study alone. This is because in understanding psychiatric terms and phenomena, there will always be different interpretations on similar phenomena. Similarly, different books say differently as well as different classification systems classify the disorder differently. The beginners would be confused if they do not get proper guidance from their teachers or well-informed peers.

Last but not least, it is my hope that this posting would be a memorable one that students would remember throughout their entire medical career.

Coordinator.

NOTES

8 READING LIST

1. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5 5th Edition. American Psychiatric Association. 2013.
2. Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry. By Benjamin J. Sadock and Virginia A. Sadock. 2014.
3. Shorter Oxford Textbook of Psychiatry. Philip Cowen. 2012.
4. Oxford Handbook of Psychiatry (Oxford Medical Handbooks). David Semple. 2013
5. Basic Child Psychiatry, 7th Edition. Philip Barker. 2004.

2 UNDERGRADUATE PSYCHIATRIC PROGRAMME

The objectives of the Year 4 Psychiatry are as follows:

1. Provide the basic core knowledge in psychiatry
2. Provide the students with the clinical skills of history taking and physical examination.
3. Correlate the clinical findings in formulating provisional and differential diagnoses.
4. Introduce the basic investigations including interpretation of the results and principles of management.
5. Expose the students to the basic psychiatric procedures.
6. Inculcate professionalism.
7. Incorporate Islamic values and ethics in the management patients

At the end of the course, students must be able to:

1. correlate knowledge of abnormal states with diseases.
2. communicate effectively.
3. obtain a comprehensive history and perform a thorough mental states examination.
4. formulate diagnosis, differential diagnosis and order appropriate investigations.
5. recognize or diagnose acute/chronic mental problems.
6. propose appropriate plan of management.
7. establish good interpersonal relationship with the health-care professionals at various levels.
8. Perform/observe basic procedures done in psychiatry

3 GUIDELINES FOR PSYCHIATRIC ASSESSMENT

HISTORY

1. Preliminary Identification

- Name, age, marital status; sex; occupation; language if other than English; race, nationality, and religion insofar as they are pertinent; previous admissions to a hospital for the same or a different condition; with whom the patient's lives. There should also be comment on the sources of information and the reliability of history.

2. Chief complaint (s)

- exactly why the patient come to the psychiatrist, preferably in the patient's own words; if information does not come from the patient, note who suppliedit. Note that one important function of the chief complaint is to provide possible differential diagnosis based on your description.

3. History of presenting illness

- This should be started with a very brief description about the patient's past psychiatric illness (if applicable) and time of the last discharge, followed by the time when the patient has become ill this time. This is important in order to put your history in context especially for patients with chronic relapsing illnesses like Schizophrenia or Bipolar Disorder.

- Next, elaborate the chronological background and development of the symptoms of behavioural changes that culminated in the patient's seeking assistance; patient's life circumstances at the time of onset; personality when well: how illness has affected life activities and personal relations – changes in personality, interests, mood, attitudes towards others, dress, habits, level of tenseness,

7 ASSESSMENT

Exam will be held at the end of the posting. Students will be examined by KUIN lecturer. The last week is always been allocated for clinical assessment.

There will be one long case for an hour clerking. Students have to present to an examiner for half an hour. Long case would carry 100%.

The theory will consists of 15-question OBA (15%), 15-questions EMI (15%), MEQ/Short Notes (20%) and viva exam (50%).

Theory would carry a total of 100 marks.

60% from the total of theory and clinical would be added to 40% of the continuous assessment to give rise to the final result.

Continuous assessment would include a satisfactory pass on all aspects of intangible and tangible assessments including punctuality, logbook, seminar presentation, case presentation, professionalism, ward work and 2 case write-ups.

6 GUIDELINES FOR PREPARING CASE WRITE-UP

1. Title. The first page should have the Insaniah logo, dept and student particular like name, Matrix No, IC, year, group, topic and course coordinator. Title would be your provisional diagnosis.
2. Abstract. In about 200 words summarize the: (1) Presenting symptoms (chief complaint) of the patient, (2) HOPI and other relevant history, (3) MSE (4) Provisional and Differential Diagnoses, (5) Investigation and Management of the case.
3. Chief Complaint. Patient's presenting concerns along with key historical data and the specific duration of illness.
4. History of Presenting Illness. Construct history based on the presenting complaints and elaborate according to symptoms and chronology.
5. Systemic Review.
6. Past Psychiatric History.
7. Past Medical and Surgical History.
8. Drug History.
9. Family History.
10. Past Personal History.
11. Social History.
12. Premorbid Personality.
13. Mental States Examination.
14. Physical Examination
15. Case Summary
16. Provisional Diagnosis
17. Differential Diagnosis
18. Final Diagnosis
19. Investigation (Lab & Psychosocial). Result should be included together with an interpretation.
20. Management (Bio-psychosocial)
21. Discussion.
22. Reference.

irritability, activity, attention, concentration, memory, speech.

- Elicit psychophysiological symptoms - nature and details of dysfunction, location, intensity, fluctuation; whether anxieties are generalized and nonspecific (free floating) or specifically related to particular situations, activities, or objects, or object; how anxieties are handled – repeated avoidance of feared situation, use of drugs or other activities for distraction.
- This should then be followed by a section highlighting important negatives and ruling out of the other differential diagnosis presumed from the chief complaint.

4. Previous illnesses

- Past psychiatric history

- Emotional or mental disturbance – extent of incapacity, admissions and type of treatment, names of hospitals, length of illness, effect of treatment.

- If there has been several admissions, try to summarize the main events / presentations. There is no need to give a too detailed account of past episodes.

Past medical or surgical history- Elaborate when relevant.

5. Systemic Review

Keep a brief review of various systems to ensure that you have not missed out any possible organic cause for the patient's presentation.

6. Family history

- Family tree
- Elicited from patient and from reliable informants, since quite different description may be given of the same people and events: ethnic, national, and religious traditions
- Other people in the home, descriptions of them – personality and intelligence – and what has become of them since patient's childhood.

• Description of different household lived in; present relationships between patient and those who were in family;

7. Past Personal History

- History (anamnesis) of the patient's life from infancy to the present to the extent it can be recalled, including age of onset, duration, and impact of significant medical illness on patient; gaps in history as spontaneously related by the patient; emotions associated with those life periods – painful, stressful, conflicting etc.
- Components:

1. Prenatal history – nature of mother's pregnancy and delivery: length of pregnancy, spontaneity and normality of delivery, birth trauma, whether patient was planned and wanted, birth defects.

2. Early childhood (through age 3)

a. Feeding habits: breast-fed or bottle-fed, eating problem
b. Maternal deprivation, early development – language development, motor development, signs of unmet needs, sleep pattern, object constancy, stranger anxiety, separation anxiety.
c. Toilet training: age, attitude of parents, and feelings about it.
d. Symptoms of behaviour problems: thumb sucking, temper tantrums, tics, head banging, locking, night-terrors, fears, bed wetting or bed soiling, nail biting, masturbation.
e. Personality as a child: shy, restless, overactive, withdrawn, studious, outgoing, timid, athletic, friendly, patterns of play, reactions to siblings.
f. Early or recurrent dreams or fantasies

3. Middle childhood (ages 3 to 11)

- early school history – feelings about going to school, early adjustment, gender identification, conscience development, punishment.

4. Later childhood (from pre-puberty through adolescence

a. Social relationships: attitudes toward siblings

and playmates, number and closeness of friends, leader or follower, social popularity, participation in group or gang activities, idealized figures; patterns of aggression, passivity, anxiety, antisocial behavior

from patient's point of view on the patient's suffering from mental illness.

14. Log Book

Student must complete the logbook. Marks will be given to the completion of the logbook. It has to be submitted at the last day of the posting. Submission after the due date will not be given mark. **Forge signature will be penalized**.

15. Visit to Hospital Bahagia Ulu Kinta (HBUK)

At the end of the posting, student will have a study tour to HBUK accompanied by a lecturer. Normally, the travel starts at 6.30 am from the main campus. Student will be briefed by a designated staff from HBUK and brought to see the acute admission, long stay, security and farm wards. Students have to observed psychosocial rehabilitation, on how it is being conducted, patient selection and patients' activity. Finally, student will be visited the museum before returning home.

8. Case write up

Students are required to take care of each patient in the ward. The group leader will allocate cases in the ward to students. The student would then clerk, manage and follow-up the case for write up. If students have no case in the ward, they should look for cases in the clinic. No similar cases are allowed for write up. Students are required to pass-up 2 cases (1 neurotic and 1 psychotic) for their write-up. The first case should be submitted by the end of the 3nd week. The 2nd case should be submitted by the end of the 6th week. The case write-up will be given marks and used as continuous assessment. Detail of each write-up must be documented in the log book. It has to be certified by the lecturer or specialists/MOs (from MOH) treating the patient. **Students are strongly reminded to avoid copy other people works through cut & paste method. Serious action will be taken if the students are found guilty of plagiarism.**

9. Case conference (CP)

Weekly student's CPs are held in Insaniah. Please clerk with all the details before presenting in the case conference. Please make sure the spelling, grammar are in order. All presentation will be given marks for continuous assessment. Students must behave like they are presenting in front of the professional audience.

10. Assigment

The assignment will be given depending on the need of the students.

11. Procedures

Students must observed procedures listed in the logbook before they finish the posting. Failing to do so means incomplete posting.

12. Psychosocial Rehabilitation (PSR) Centre visit

Students are encouraged to observe operation of PSR center in the hospital. Student leader would have to contact Occupational Therapist and ask their permission to do so.

13. Film Appreciation (Cinematic Psychiatry)

Selected films will be viewed in order to give proper understanding

b. School history: how far the patient went, adjustment to school, relationships with teachers – teacher's pet or rebellious – favourite subjects of interests, particular abilities or

assets, extracurricular activities, sports, hobbies, relationships of problems or symptoms to any school period

c. Cognitive and motor development: learning to read and other intellectual and motor skills, minimal cerebral dysfunction, learning disabilities – their management and effects on the child

d. Particular adolescent emotional or physical problems: nightmares, phobias, masturbation, bed wetting, running away,

delinquency, smoking, drug or alcohol use, weight problems, feeling of inferiority

e. Psychosexual history

i. Early curiosity, infantile masturbation, sex play.

ii. Acquiring of sexual knowledge, attitude of parents toward sex.

iii. Onset of puberty, feelings about it, kind of preparation, feelings about menstruation, development of secondary sexual

characteristics

iv. Adolescent sexual activity: crushes, parties, dating, petting, masturbation, wet dreams and attitudes toward them

v. Attitudes toward opposite sex: timid, shy, aggressive, need to impress, seductive, sexual conquests, anxiety

vi. Sexual practices: sexual problems, homosexual experiences, paraphilia, promiscuity.

F. Religious background: strict, liberal, mixed (possible conflicts), relationship of background to current religious practices.

5. Adulthood

a. Occupational history: choice of occupation, training, ambitions, conflicts; relations with authority, peers, and subordinates; number of jobs and duration: changes in job status; current job and feelings about it.

b. Social activity: does patient have friends; is he or she withdrawn or socializing well; kind of social, intellectual, and physical interests; relationships with same sex and opposite sex; depth, duration, and quality

of human relations.

c. Adult sexuality

i. Premarital or extra – marital sexual relationships

ii. Marital history: common-law marriages, legal marriages, description of courtship and role played by each partner, age at marriage, family planning and contraception, names

and ages of children, attitudes toward the raising of children, problems of any family members, housing difficulties if important to the marriage, sexual adjustment, areas agreement and disagreement, management of money, role of in-laws.

iii. Sexual symptoms: anorgasmia, impotence, premature ejaculation etc.

iv. Attitudes toward pregnancy and having children; contraceptive practices and feelings

about them

v. Sexual practices: paraphilias

d. Forensic History: any involvement with the

law or criminal offences.

8. Current social situation:

- Where does patient live - neighborhood and particular residence of the patient; is home crowded; privacy of family members from each other and from other families; sources of family income and difficulties in obtaining it; public assistance, if any, and attitude about it; will patient lose job by remaining in the hospital; who is caring for children.

9. Premorbid Personality

- In this description of the personality prior to the beginning of the mental illness, do not be satisfied with a series of adjectives and epithets, but give illustrative anecdotes and detailed statements. Aim at a picture of an individual, not a type. The following is merely a collection of hints, not a scheme. It will not be possible to cover all the items isted in the course of the first interview, but an attempt should be made, particularly in case of neurosis or affective disorder, to elicit evidence about all aspects of pre-morbid personality in the course of explorations extending over a period. Of

Students will divide themselves into groups. One group will attend community meeting and the rest will be attend clinic. Students are encouraged to present cases to lecturers or medical officers in the clinic. Any new cases should be seen by students first for clerking and present to MO/lecturer in-charge.

5. Briefing on the ward

The group leader would have to arrange briefing with the Ward Manager/Sister-in-charge before students are allowed to enter the respective wards on the first day. Since psychiatric ward is consider secured, students must try to enter in batches. Having said that individual entry is also allowed. Security must be one's own responsibility.

Some do's and don't:

- Do not bring valuable property with you when enter the ward.
- Always suspicious and on the look for possible attacker.
- Distance yourself when talking to patients. Avoid quiet area.
- Do not enter the toilet or pantry unaccompanied with staffs.
- Stop the interview, use excuse tactfully when confronted with irritable patients while doing the interview.
- Request for chaperone when needed.
- Get a company when on call (if necessary).

6. Ward round

Different specialists/MOs (MOH) would have different day when they conduct their ward rounds. Students are encouraged to follow ward round especially when it is done early in the morning before clinical teaching with KUIN lecturers start.

7. Ward Work and On-call

Ward work would officially starts at 8 am. From 2.00 pm till 5 pm, student need to be in the ward clerking cases either for the next day case presentation, case write-up and to follow-up their allocated patient. Those on-call would have to present till 11.00 pm. All students are needed to clerk new admission and present the case either to the doctor on-call or to the lecturer on the next day.

5 INSTRUCTION TO STUDENTS

1. Seminars

Seminars topics are listed in the time-table roster. Students are expected to read on the topic before the session starts. The presenters are expected to read from established textbook so that they could explain to the rest in greater depth. They are also expected to meet the lecturer in-charge of the seminar 7 days earlier so that the material presented is relevant to the topic.

2. Quiz and E-learning

Students have to read before attending the quiz and e-learning sessions. Most of the materials have been presented in the lectures. Discussion is well encouraged. Quiz and e-learning will be conducted in the computer lab

3. Clinical teaching

Format of case presentation (history taking & MSE) will be taught in the first week. Students are encouraged to present as many cases as possible. Each student must compete to present cases as that is the only time when student can learn on the proper presentation skills as well as making good provisional and differential diagnosis. The leader would have to allocate patient in the ward for each and individual student. Students have to present the new case and update the progress to the lecturer during clinical round and teaching.

4. Clinic

course, presence of a reliable informant is crucial to get an accurate account of the patient's Premorbid personality.

MENTAL STATUS EXAMINATION

Mental Status: sum total of the examiner's observations and impressions derived from the initial interviews.

1. GENERAL APPEARANCE AND BEHAVIOUR:

- Posture, state of personal hygiene, abnormal involuntary movements, mannerism, hyper / hypoactivity, physical signs of anxiety, like sweating of hands, wide eyes, frequently changing posture and frequent swallowing or depressive signs like stooped posture, vacant look apathy to surrounding.

• Attitude (towards the examiner) - co-operative, communicative, Domineering, with drawn, interfering, evasive, guarded, hostile, rapport.

2. SPEECH :

- Language, relevance
- Amount - Normal / increased / decreased
- Volume - Normal / increased / decreased
- Speed - Normal / increased / decreased; pressure of speech / poverty of speech
- Tone - Normal / monotonous

3. MOOD AND AFFECT

- MOOD

Definition: A pervasive and sustained emotion that colors the person's perception of the world This is a subjective and longitudinal emotional state.

Question : How have you been feeling lately?

- AFFECT

Definition: Emotional expression in response to a given situation. This is an objective and cross-sectional emotional state.

Affect is characterized in several ways

1. By the type of emotion expressed and observed : anger, sadness elation, etc.

2. By the intensity / depth of emotion expressed : normal, blunted or flat. In flat affect, there is no expression of feeling; the face is immobile and the monotonous. In blunted effect, the expression of feeling is severely reduced.

3. By the range of emotion shown : Broad affect describes the normal condition in which a full range of feelings is expressed. Restricted or constricted affect is when it is limited in

expression.

4. By it appropriateness: Inappropriate affect is apparent emotion discordant with accompanying thought or speech (e.g. laughing while telling a story most people would

find horrifying).

5. By consistency or liability of emotion: labile affect shifts rapidly between different emotional states such as crying, laughing, and anger.

4. PERCEPTUAL DISTURBANCE

a. Definition

Hallucination - Sensory perception without an objective external stimuli.

Illusion - Sensory misinterpretation of an objective stimulus.

b. Modalities - Auditory, visual, olfactory, gustatory, tactile.

-Auditory Hallucination

Second person

- When the voice addresses the patient directly as “you” or commands him to do things.

Third person

- When 2 voices converses and refer the patient as third person eg.‘he’, ‘she’ etc.
- When a voice gives a running commentary of the patients activities

d. Description - Continuous / Intermittent

Depersonalization - Sense of unreality pertaining to the self with a quality of “as if”.

w Derealization - Sense of unreality pertaining to the surrounding with a quality of “as if”.

SEMINAR TOPICS

Classification in Psychiatry

Psychopharmacology 1

Psychopharmacology 2

Eating, Sleep and Sexual disorders

Psychological Therapies

Psychiatric Related Neuromedical d/o

Personality disorders

Psychiatric Emergencies + ECT

PTSD, Grief & Bereavement

Defense Mechanism

Community Psychiatry and Rehabilitation

LECTURE TOPICS

History taking and MSE Psychopathology

Schizophrenia (L)

Substance-related disorder

Mood disorder

Anxiety, Somatoform & Dissociative disorders

Cognitive disorders (Delirium & Dementia)

1. Proverb test - Proverbs known to the patient.
2. Test of similarity - 2 to 3 each
3. Test of difference

f. JUDGEMENT

- Social judgment: behaviours harmful to self and others and or against all social norms.
- Test judgment: patient's prediction of what he would do in imaginary situations - what he would do if he found a stamped, addressed letter in the street.
- Personal judgment: future plans after discharge

g. INSIGHT: The awareness of having mental illness and the necessity for the treatment

5. THINKING

a. Disorders Of Form

- Form refers to the meaningfulness or understandability of the speech. Normally ideas, associations and symbols are connected meaningfully to reach a reality oriented conclusion.
- Fantasy thinking – the connections may be meaningful but the conclusions reached are unrealistic.
- Autism – may be present as thinking is less responsive to external stimuli
- Neologism – presents with highly personalized meaning being attached to newly formed words
- Association disturbance
- Looseness – may be association / incoherence – inability to logically understand the jumps from one topic to another.
- Flight of ideas – it is based on rhyming, punning etc. leading to vague wooly thinking and word salad. Presence of pressure of speech is also necessary (see below).NB: prolixity is flight of ideas without the pressure of speech.
- Conceptual thinking – evidence of abnormal overgeneralization / concretization (mainly through proverbs / similarity / differences tests)
- Circumstantiality / Tangentially

b. Flow

- Productivity and continuity of speech/thought.
- Increased productivity (pressure of speech) may give rise to flights of ideas and circumstantiality.
- Decreased productivity gives rise to thought retardation
- Disturbance of continuity produces either perseveration or thought block

c. Content

If refer to the content of thinking per se. It includes primary delusions, secondary delusions, preoccupations, overvalued ideas and also obsessional or repeated thoughts.

d. Possession

Normally the subject experiences his thinking as his own i.e. he has a sense of possession. Disorder of possession means the subject

thinks that his thoughts are no longer his own or no more under his control eg. thought insertion, broadcasting, withdrawal and obsessions and compulsions. Note that the disorders of thought possession are also delusions. So, you need to attempt at challenging these believes as well.

- Thought Insertion

Q. Do you think other people / force are putting their thoughts in to your mind/head against your wish?

- Thought broad casting

Q. Do you think others can know your thoughts without you telling so?

- Thought withdrawal

Q. Do you think somebody / some force snatches your thoughts away against your wish?

6. COGNITION

a. Orientation

- Time - does patient identify the date correctly; can be approximate date, time of day if he is in a hospital, does he know how long he has been there; does patient behave as if he is oriented to the present?
- Place: does patient know where he is?
- Person: self and others. Does the patient know the identity of himself and the examiner, does he know the roles or names of the persons with whom he is in contact.

b. Attention And Concentration:

- Serial Subtraction Test

i) 100 - 7 (N - 120 sec.)

ii) 40 - 3 (N - 60 sec.)

iii) 20 - 1 (N - 15 sec.)

- Days of the week and months forward and backward.

c. MEMORY:

- Efforts made to cope with impairment - denial, confabulation, catastrophic reaction, circumstantiality; whether the process of registration, retention, or recollection of material is involved.

(i) Immediate memory - Digit span test

- digit forward (DF) & digit backward (DB)
- Instruction to the patient with example.
- Read digits one per sec.
- The following digits may be used

5-7-3

6-3-8-2

1-6-4-9-5

3-8-1-7-9-6

7-2-5-9-4-8-3

4-7-2-9-1-6-8-5

The normal range for DF is 7 ! 2 and DB is 5 ! 2.NB: Avoid using consecutive numbers or numbers with a familiar pattern (e.g. 2,4,6,… or 1,3,5,7,…) in the list. Also, do not use the same set of digits for both DF and DB.

(ii) Recent memory:

- The past few days; what did patient do yesterday, the day before; what did he have for breakfast, lunch, dinner, object recall test - (2 dissimilar objects, one address - name, house number, street, city) after 3 minutes of distraction.

Remote memory: Personal like birthday, dates of graduation, employment, marriage, no. of children, I.C. No. and impersonal like old events like the Independence Day, the May-13 incident, the Agung's installation.

d. INFORMATION AND INTELLIGENCE

(i) Comprehension

(ii) General Knowledge

(iii) Arithmetic

(iv) Vocabulary

e. ABSTRACT THINKING:

- disturbances in concept formation; manner in which the patient conceptualizes or handles his ideas;