North West
School of Psychiatry

General Adult Module Handbook

MRCPsych Course

2020-2022

A Psychiatry Medical Education Collaborative between Mental Health Trusts and Health Education North West

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Contents

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Brief guidelines for case conference presentation

The objectives of case conference are:

1) To provide a forum to discuss complex/interesting cases in a learning atmosphere.
2) To develop your ability to present cases in a concise and logical manner.
3) To develop your presentation skills.

Guidelines for presenters:

1. Please use PowerPoint for the presentation (or if you are using other tools make sure that they are compatible with your local IT facilities).

2. You have to present a case that is relevant to the theme of the day on which you are presenting.

3. Please meet with your educational/clinical supervisor at least 4-6 weeks prior to the presentation to identify an appropriate case to present. If there is no suitable case in the team that you work in, you may have to approach other teams/consultants to identify a case.

4. Cases can be chosen for their atypical presentation, diagnosis, complexity or for exploring management options.

5. It would be helpful if you can identify specific clinical questions that would you would like to be discussed/answered at the end of the presentation.

6. We would recommend the following structure for the presentation:

- Introduction (include reasons for choosing the case)
- Circumstances leading to admission (if appropriate)
- History of presenting complaint
- Past Psychiatric history
- Medical History/ current medication
- Personal/family History
- Alcohol/Illicit drugs history
- Forensic history
- Premorbid personality
- Social circumstances
- Mental state examination
- Investigations
- Progress since admission (if appropriate)
- A slide with questions that you would you like to be discussed
- Discussion on differential diagnosis including reasons for and against them.
- Management / treatment

7. The structure of the presentation can vary as long it is logical and concise. Please build into the presentation some natural points to stop and discuss the case.

8. Important: Please ask a senior member of your team who knows the case to attend on the day you are presenting.

Brief guidelines for journal club presentation

The objectives of journal club presentation are:

1) To learn to perform a structured critical appraisal of a study.
2) To learn to make appropriate use of evidence in making decisions about the care of your patients.
3) To prepare for the MRCPsych exams.
4) To develop your presentation skills.

Guidelines for presenters:

1. Please use PowerPoint for the presentation (or if you are using other tools make sure that they are compatible with your local IT facilities).

2. Please select one of the 3 papers listed for the week from the School of Psychiatry handbook to present.

3. Email the paper to your local co-ordinator at least a week before the presentation so that it can be circulated in time.

4. As the presenter you are expected to both present the paper and critically review it.

5. We would recommend the following structure for the presentation: Background to study, methods, analysis, results, conclusions, critical appraisal of the study and implications for clinical practice

6. The most important part of the presentation is the critical appraisal. This should include aspects such as:
    - Purpose of the study
    - Type of study
    - Subject selection and any bias
    - Power calculation (could the study ever answer the question posed)
    - Appropriateness of statistical tests used
    - Use of relevant outcomes

- Implications of findings
- Applications of findings/conclusions in your area
- Directions for further research

7. Use standardized critical appraisal tools.

8. Please discuss the paper and the presentation with your educational/clinical supervisor prior to the presentation.

Syllabus Links

Syllabus for MRCPsych

Syllabus for MRCPsych critical review

MRCPsych Paper A -The Scientific and theoretical basis of Psychiatry

MRCPsych Paper B - Critical review and the clinical topics in Psychiatry

MRCPsych CASC

Curriculum Mapping				
Section	**Topic**	**Covered by**		
		LEP	**AP**	**LR**
7.1	Disorders in adulthood			
7.1.1	Unipolar depression	✓		✓
7.1.2	Bipolar depression	✓		✓
7.1.3	Schizophrenia	✓		✓
7.1.4	Anxiety disorders	✓		✓
7.1.5	OCD	✓		✓
7.1.6	Hypochondriasis		✓	✓
7.1.7	Somatization disorder		✓	✓
7.1.8	Dissociative disorders		✓	✓
7.1.9	Personality disorders	✓		✓
7.1.10	Organic psychoses	✓		✓
7.1.11	Other psychiatric disorders	✓		✓
7.2	Perinatal Psychiatry		✓	✓
7.3	General Hospital Psychiatry		✓	✓
7.4	Emergency Psychiatry*		✓	✓
7.5	Eating Disorders			
7.5.1	Anorexia nervosa		✓	✓
7.5.2	Bulimia nervosa		✓	✓
7.6	Psycho-sexual disorders			
7.6.1	Non-organic sexual dysfunction, etc.		✓	✓
7.6.2	Gender Identity Disorders		✓	✓
-	Mental Health Act 1983	✓		✓

Key- LEP – Local Education Programme;

AP- Academic Programme

LR – Learning Resources

Links to Critical Appraisal Checklists	
Study	**Checklists**
Randomized Controlled Trial	1. CONSORT Checklist 2. SIGN Checklist 3. CASP Checklist
Case-control Study	1. SIGN Checklist 2. CASP Checklist
Cohort Study	1. SIGN Checklist 2. CASP Checklist
Meta-analysis & Systematic Review	1. PRISMA statement 2. SIGN Checklist 3. CASP Checklist
Qualitative study	1. CASP Checklist
Economic study	1. SIGN Checklist 2. CASP Checklist
Diagnostic study	1. SIGN Checklist 2. CASP Checklist

Semester 1

Session 1: Psychosis-1
Journal theme: Randomised Controlled trials on Psychosis

Learning Objectives

- To develop an understanding of the clinical presentation of psychotic illnesses.
- To develop an understanding of aetiological theories and epidemiology of Schizophrenia.
- To develop an understanding of possible complications of antipsychotic medication.
- To develop an understanding of Randomised Controlled trials and develop skills for critically appraising RCTs.

Expert Led Session

- Schizophrenia-aetiological theories and epidemiology

Case Presentation

- A case of Schizophrenia (any subtype) /Schizoaffective disorder / Delusional disorder / Acute and transient psychotic disorder / First-episode psychosis/ Schizotypal disorder.

Journal Club Presentation

- Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins, DO, Keefe RS, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK (2005) Clinical Antipsychotic Trials of Intervention Effectiveness Investigators Effectiveness (CATIE) of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med. 353(12):1209-1223.
- Haddock G, Barrowclough C, Shaw JJ, Dunn G, Novaco RW, Tarrier N (2009) Cognitive–behavioural therapy v. social activity therapy for people with psychosis and a history of violence: randomised controlled trial. BJPsych 194:152-157.
- Jones PB, Barnes TRE, Davies L, Dunn G, Lloyd H, Hayhurst KP, et al. (2006) A randomized controlled trial of effect on quality of life of second generation versus first generation antipsychotic drugs in schizophrenia. Arch Gen Psychiatry 63:1079–1087.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Neuroleptic malignant syndrome
- Management of hyperprolactinaemia for patients on antipsychotics
- Management of QTc prolongation for patients on antipsychotics

Statistics '555' Topic

- CONSORT Checklist for RCT's

MCQs

1. A long duration of untreated psychosis is strongly associated with which of the following:

A. Ethnicity

B. Insidious onset

C. Level of Education

D. Living alone

E. Rural residence

2. What is the most likely long-term effect of delirium:

A. Accelerated decline in cognition and function

B. Better physical outcomes in future

C. Increased chance of late-onset psychosis

D. Increased hospital readmission rates

E. Increased likelihood of future episodes of delirium

3. Which of the following depot antipsychotics has a mandatory requirement of observing the patient for at least 3 hours after administration in a hospital setting:

A. Fluphenazine decanoate

B. Olanzapine embonate

C. Paliperidone palmitate

D. Pipothiazine palmitate

E. Aripiprazole maintena

4. Which of the following statements is FALSE about ICD-10 criteria of Schizophrenia:

A. A. Symptoms must be present for at least 6 months

B. Neologism is included in the symptoms

C. Organic brain disorder, alcohol and drug related intoxication, dependence or withdrawal are exclusion criteria

D. One of the criteria is: persistent hallucinations in any modality, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.

5. Which of the following antipsychotic has least effect on QTc interval:

A. Aripiprazole

B. Quetiapine

C. Risperidone

D. Sulpiride

E. Olanzapine

Session 2: Depression-1
Journal theme: Meta-analysis and Systematic review on Depression

Learning Objectives

- To develop an understanding of the clinical presentation of Depression.
- To develop an understanding of aetiological theories and epidemiology of Depression.
- To develop an understanding of possible complications of antidepressant medications.
- To develop an understanding of Meta-analysis and Systematic review and develop skills for critically appraising Meta-analysis and Systematic review.

Expert Led Session

- Depression - aetiological theories and epidemiology

Case Presentation

- A case of major depressive disorder / severe depression with psychotic symptoms / dysthymia / recurrent depressive disorder

Journal Club Presentation

Please select one of the following papers:

- Geddes, JR, Carney, SM, Davies, C, Furukawa, TA, Kupfer, DJ, Frank, E, Goodwin, GM. (2003) Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. Lancet 361: 653–661.
- Turner P, Kantaria R, Young AH (2014). A systematic review and meta-analysis of the evidence base for add-on treatment for patients with major depressive disorder who have not responded to antidepressant treatment: a European perspective. J Psychopharmacol. 28(2):85-98.
- UK ECT Review group (2003). Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis, Lancet 361:799-808.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Agitated, retarded and atypical depression – brief summary
- Antidepressant discontinuation symptoms
- Antidepressants and sexual dysfunction

Statistics '555' Topic

Systematic review, meta-analysis and forest plot

MCQs

1. Which of the following is not a well-recognised symptom of depressive illness:

A. Ruminations of guilt

B. Thought broadcast

C. Irritability

D. Thoughts of worthlessness

E. Hypersomnia

2. David has chronic back pain and depression that is not responding to SSRI antidepressants. Which one of the following is the best antidepressant of choice in this situation?

A. Vortioxetine

B. Trazodone

C. Venlafaxine

D. Bupropion

E. Amitriptyline

3. Which of the following factors is NOT associated with risk of repetition of attempted suicide?

A. No previous psychiatric treatment

B. Alcohol or drug abuse

C. Previous attempts at self-harm

D. Personality disorder

E. Criminal record

4. Which of the following medications has RCT evidence for reduction of suicide rate?

A. Citalopram

B. Imipramine

C. Aripiprazole

D. Bupropion

E. Lithium carbonate

5. Which ONE of the antidepressants below is safest to use in an individual who becomes depressed following a myocardial infarction, as concluded from the SADHART trial?

A. Fluoxetine

B. Mirtazapine

C. Amitriptyline

D. Sertraline

E. Citalopram

Session 3: Bipolar Disorder-1
Journal theme: Case-control studies on Bipolar

Learning Objectives

- To develop an understanding of the clinical presentation of Bipolar disorder.
- To develop an understanding of aetiological theories and epidemiology of Bipolar disorder.
- To develop an understanding of possible complications of mood-stabilizer medications.
- To develop an understanding of case-control studies and develop skills for critically appraising case-control studies.

Expert Led Session

- Bipolar affective disorder- aetiological theories and epidemiology

Case Presentation

- A case of type I bipolar disorder / type II bipolar disorder / cyclothymia / bipolar disorder with psychotic symptoms / rapid cycling bipolar disorder/ unipolar mania.

Journal Club Presentation

Please select one of the following papers:

- Guo JJ, Keck PE Jr, Corey-Lisle PK, Li H, Jiang D, Jang R, L'Italien GJ (2006) Risk of diabetes mellitus associated with atypical antipsychotic use among patients with bipolar disorder: A retrospective, population-based, case-control study. The Journal of Clinical Psychiatry 67(7):1055-1061.
- Cavanagh JTO, Van Beck M, Muir W, Blackwood DHR. (2002) Case—control study of neurocognitive function in euthymic patients with bipolar disorder: an association with mania. BJPsych 180:320-326.
- Alberta U, Coria D, Agugliaa A, Barbaroa F, Lanfrancob F et al. (2013). Lithium-associated hyperparathyroidism and hypercalcaemia: A case-control cross-sectional study; 151 (2); 786–79. doi:10.1016/j.jad.2013.06.046

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Mixed Affective states, Rapid cycling disorder – brief overview
- Atypical antipsychotics as mood stabilizers – a rough guide
- Pharmacological prophylaxis in Bipolar Disorder

Statistics '555' Topic

- Cohort studies and case control studies

MCQs

1. The following statements about bipolar disorder are true except :

A. The lifetime risk of bipolar disorder lies between 0.3% and 1.5%.

B. The prevalence in men and woman is the same.

C. Majority of bipolar patients, particularly women, begin with a manic episode.

D. The age of onset is earlier in bipolar disorder than in major depressive disorder.

E. An onset over the age of 60 is more likely to be associated with organic brain disease.

2. Which of the following most closely reflects the risk of Bipolar Disorder in a first degree relative of an affected proband?

A. 0.3-1.0%

B. 1-2%

C. 5-10%.

D. 15%

E. 20%

3. 48 year old woman is stable stabilised on Lithium Carbonate. She has developed hypertension. Which of the following antihypertensive has the least potential for interaction with Lithium?

A. Losartan

B. Frusemide

C. Ramipril

D. Atenolol

E. Bendroflumethazide

4. Factors associated with a change of polarity from unipolar to bipolar include all except:

A. Hypersomnia and psychomotor retardation.

B. Absence of psychotic features.

C. Younger age of onset.

D. Family history of bipolar disorder.

E. Antidepressant induced hypomania

5. Select one incorrect statement regarding bipolar depression in comparison with unipolar depression.

A. Slower in onset

B. More frequent

C. More severe and shorter.

D. Cause greater socio-economic burden

E. More likely to be associated with psychotic symptoms

Session 4: Mental Health Act
Journal theme: Studies on MHA - Any method

Learning Objectives

- To develop an understanding of the aspects of the Mental Health Act relevant to general adult psychiatry (especially Sections 2, 3, 4, 5(2), 5(4), 136 and Supervised Community Treatment).

Expert Led Session

- Salient points – Sections 2,3,4, 5(2), 5(4), 135, 136

Case Presentation

- A case focusing on aspects of MHA including Section 5(2), Section 136, Section 2 & 3 and Supervised Community Treatment (CTO).

Journal Club Presentation

Please select one of the following topics:

- Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K et al. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet; 381 (9878), 1627–1633. doi:10.1016/S0140-6736(13)60107-5
- Owen GS, Szmukler G, Richardson G, David AS, Raymont V, Freyenhagen F, Martin W, Hotopf M (2013) Decision-making capacity and medical in-patients: cross-sectional, comparative study. BJPsych, 2013 (6) 461-467.
- Brown PF, Tulloch AD, Mackenzie C, Owen GS, Szmukler G, Hotopf M. (2013). Assessments of mental capacity in psychiatric inpatients: a retrospective cohort study. BMC Psychiatry; 13:115. **DOI:** 10.1186/1471-244X-13-115. http://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-115

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Independent Mental Health Advocates (IMHAs) – Duties and Powers
- Nearest relatives – meaning, identification, powers and displacement
- Consent to treatment – T2,T3,T4,T6, CTO11 and CTO12

Statistics '555' Topic

- Formulating research questions (PECO) and common literature search databases with what they include (e.g EMBASE, CINAHL, Psychinfo, Pubmed)

MCQs

1. To prevent deprivation of liberty occurring:

A. There is no requirement to consider what restrictions are placed before entry into a care home

B. Involvement of advocacy services should be avoided

C. It is vital to consider all aspects of the care plan

D. There is no need to involve carers or relatives in planning care

2. The deprivation of liberty safeguards:

A. Were introduced to prevent deprivation of liberty in a person's own home

B. Facilitate protection of people other than the relevant person from harm

C. A primary care trust may be responsible for providing the appropriate standard authorisation

D. The supervisory body issues an urgent deprivation of liberty authorisation.

3. The 2007 amendments to the Mental Health Act abolished the following classifications:

A. Mental illness

B. Psychopathic disorder

C. Mental impairment

D. Severe mental impairment

E. All of the above.

4. Under the amended Act, a patient can be detained if the following conditions for treatment are met:

A. Treatment is legal

B. Treatment is offered by a psychiatrist

C. Treatment is available and appropriate

D. Treatment has an effect on risk

E. Treatment will cure the mental disorder

5. The provision in the amended Act that helps to uphold the human rights of a patient with personality disorder is:

A. Ease of discharge

B. Provision of statutory advocacy service

C. Right to refuse treatment if the patient possesses capacity

D. Regular contact with 'nearest relative'

E. More frequent tribunal hearings

Session 5: Self Harm and Suicide
Journal theme: Survey on Suicide and Self-harm

Learning Objectives

- To develop an understanding of various facets of self-harm and suicide (aetiology, epidemiology, neurobiology, genetics, clinical presentation, risk assessment) and their management (pharmacological, psychological, social).
- To develop an understanding of surveys and develop skills for critically appraising surveys.

Expert Led Session

- Suicide and self-harm - aetiological theories and epidemiology

Case Presentation

- A case of presentation of overdose to A&E / repeated self-harm / suicide attempt

Journal Club Presentation

Please select one of the following topics:

- Bebbington PE, Minota S, Cooper C, Dennis M, Meltzer H, Jenkins, R, Brugha T (2010). Suicidal ideation, self-harm and attempted suicide: Results from the British psychiatric morbidity survey 2000. European Psychiatry 25(7):427-431
- Bertolote JM, Fleischmann A, De Leo D, Bolhari J, Botega N, De Silva D, Tran Thi Thanh H, Phillips M, Schlebusch L, Värnik A, Vijayakumar L, Wasserman D. (2005). Suicide attempts, plans, and ideation in culturally diverse sites: the WHO SUPRE-MISS community survey. Psychol Med. 35(10):1457-65.
- Zalsman G et al(2016). Suicide prevention strategies revisted: 10 year Systematic review. The Lancet Psychiatry. Vol 3. Issue 7. July 2016 Pages 646-6590

'555' Topics (5 slides on each topic with no more than 5 bullet points)

- Factors associated with suicide risk and rates of suicides in Schizophrenia, Bipolar disorder and depressive disorder.
- Substance misuse and suicide risk
- Emotionally unstable personality disorder and risk of suicide

Statistics '555' Topic

. Types of data (qualitative, quantitative etc)

MCQs

1. What is the single strongest predictor of completed suicide?

A. Mental illness

B. Previous self-harm

C. Recent bereavement

D. Having a neurodegenerative physical illness

E. Family history of suicide

2. A patient is refusing life-saving treatment for severe blood loss after cutting her wrists. Under the law in England and Wales, whose responsibility is it to assess capacity to make a decision to refuse treatment?

A. A consultant psychiatrist

B. A clinical psychologist

C. Any psychiatrist who is approved under Section 12(2) of the Mental Health Act

D. The clinician proposing the treatment

E. The duty AMHP (Approved Mental Health Professional)

3. Which of the following are the TWO periods of highest risk of suicide? (please pick two)

A. As an inpatient, during the first week of admission

B. At home, during the first week following discharge

C. During the last week of admission when discharge is imminent

D. At home, after the first week following discharge has passed and there is less support

E. In the emergency department, while waiting for an inpatient bed

4. There is RCT evidence for reduction in suicide risk with which of the following medications? (please pick two)

A. Aripiprazole

B. Sodium valproate

C. Clozapine

D. Topiramate

E. Lithium.

5. What is the most current estimate of lifetime risk of suicide for individuals with schizophrenia?

A. 1%

B. 2%

C. 5%

D. 10%

E. 15%

Session 6: Anxiety Disorders-1
Journal theme: Cohort studies on Anxiety Disorders

Learning Objectives

- To develop an understanding of anxiety disorders* (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and its management (pharmacological, psychological, social). [* Other than OCD and PTSD]
- To develop an understanding of cohort studies and develop skills for critically appraising cohort studies.

Expert Led Session

- GAD and panic disorder - aetiological theories and epidemiology

Case Presentation

- A case of generalised anxiety disorder/ panic attacks/ panic disorder/ agoraphobia/ social phobia/ specific phobias

Journal Club Presentation

Please select one of the following papers:

- Moffitt TE, Harrington H, Caspi A, Kim-Cohen J, Goldberg, D, Gregory AM, Poulton, R (2007) Depression and generalized anxiety disorder: cumulative and sequential comorbidity in a birth cohort followed prospectively to age 32 years. Arch Gen Psychiatry 64(6):651-660.
- Vogelzangs N, Beekman ATF, Jonge P, Penninx B (2013) Anxiety disorders and inflammation in a large adult cohort. Transl Psychiatry. 2013 Apr; 3(4): e249. doi: 10.1038/tp.2013.27
- Watkins LL, Koch GG, Sherwood A, Blumenthal JA, Davidson JRT, et al. (2013). Association of Anxiety and Depression with All-Cause Mortality in Individuals with Coronary Heart Disease. J Am Heart Assoc; 2: e000068. Doi: 10.1161/JAHA.112.000068.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Dissociative disorders – brief overview
- Acute stress reaction and Adjustment disorders
- Pharmacological treatment of Insomnia

Statistics '555' Topic

- Recruitment methods

MCQs

1. Which one of below is not true of body dysmorphic disorder (BDD):

A. First described by Morselli

B. DSM-IV classifies BDD as a somatoform disorder

C. ICD-10 classifies BDD under hypochondriacal disorder

D. Severe BDD is usually treated with SSRI and CBT as first line

E. Commonly associated with morbid jealousy.

2. All of the following anxiety disorders are more common in females, except:

A. Agoraphobia

B. Social phobia

C. Panic disorder

D. Generalised anxiety disorder

E. None of the above

3. All of the below are poor prognostic factors for OCD, except:

A. Early onset

B. Male

C. No compulsions

D. Family history of OCD

E. Longer duration

4. Which of the following is recommended by NICE as first line treatment for PTSD?

A. SSRI antidepressants

B. Counselling

C. Eye Movement Desensitization and Reprocessing

D. Combination of CBT and SSRI antidepressant

E. Quetiapine

5. Which of the following statement is FALSE?

A. Quetiapine has clear RCT evidence for efficacy in Generalised anxiety disorder.

B. Escitalopram is licenced for treatment of OCD

C. Treatment duration of at least 3 months is usually recommended for treatment of OCD

D. Antipsychotics should not routine be combined with antidepressants for treatment of anxiety disorders

E. Paroxetine, Escitalopram and Citalopram are all licenced for treatment of panic disorder

Semester 2

Session 7: Personality Disorders
Journal theme: Any method

Learning Objectives

- To develop an understanding of personality disorders (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and their management (pharmacological, psychological, social).

Expert Led Session

- Personality disorders – an overview

Case Presentation

- A case focusing on any personality disorder or where it is differential diagnosis.

Journal Club Presentation

Please select one of the following papers:

- Nose M, Cipriani A, Biancosino B, Grassi L, Barbui C (2006) Efficacy of pharmacotherapy against core traits of borderline personality disorder: Meta-analysis of randomized controlled trials. Int Clin Psychopharmacol 21: 345–353.
- Clarke S, Thomas P, James K (2013) Cognitive analytic therapy for personality disorder: randomised controlled trial. BJPsych 202:129-134.
- Lieb, K., Völlm, B., Rücker, G., Timmer, A., & Stoffers, J. M. (2010). Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. The British Journal of Psychiatry, 196(1), 4-12.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Schizoid personality disorder vs Schizotypal Disorder
- Dissocial personality disorder - diagnostic criteria
- Co-morbidities in people with personality disorders

Statistics '555' Topic

Standardised mortality rate, Kaplan-meier survival curve interpretation and survival statistics

MCQs

1. Which of the following is NOT a personality disorder in ICD-10?

A. Schizoid personality
B. Paranoid personality
C. Emotionally unstable personality
D. Schizotypal personality
E. Anankastic personality

2. What is the estimated prevalence of personality disorders in the prison population?

A. 5-20%
B. 20-40%
C. 40-60%
D. 60-80%
E. 80-95%

3. A 36 year old man is visited at home by his GP. There is very little furniture, no television, no ornaments or pictures on the wall. He is indifferent to these observations, stating he has no need of those things. He has limited contact with his family and does not have any friends. He is clear he does not feel lonely or depressed. Which of the following personality disorders could he have?

A. Histrionic
B. Antisocial
C. Paranoid
D. Schizotypal
E. Schizoid

4. Which of the following is recommended in the management of emotionally unstable personality disorder?

A. Selective Serotonin Reuptake Inhibitors
B. Minimum inpatient stay of one month
C. Eye movement desensitisation and reprogramming
D. Structured clinical management
E. Polypharmacy

Session 8: Psychosis-2
Journal theme: Economic studies on psychosis

Learning Objectives

- To develop an understanding of the psychopathology and diagnosis in schizophrenia
- To develop an understanding of possible complications of antipsychotic medication
- To develop an understanding of Economic studies and develop skills for critically appraising them.

Expert Led Session

- Schizophrenia: psychopathology and diagnosis

Case Presentation

- A case of Schizophrenia (any subtype) /Schizoaffective disorder / Delusional disorder / Acute and transient psychotic disorder / First-episode psychosis

Journal Club Presentation (Select 1 paper)

- Jones PB, Barnes TR, Davies L, Dunn G, Lloyd H, Hayhurst KP, Murray RM, Markwick A, Lewis SW (2006) Randomized controlled trial of the effect on Quality of Life of second- vs first-generation antipsychotic drugs in schizophrenia: Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1). Arch Gen Psychiatry. 63(10):1079-87.
- Knapp M1, Windmeijer F, Brown J, Kontodimas S, Tzivelekis S, Haro JM, Ratcliffe M, Hong J, Novick D; SOHO Study Group (2008) Cost-utility analysis of treatment with olanzapine compared with other antipsychotic treatments in patients with schizophrenia in the pan-European SOHO study. Pharmacoeconomics, 26(4):341-58.
- Achilla E, & McCrone P. (2013). The Cost Effectiveness of Long-Acting/Extended-Release Antipsychotics for the Treatment of Schizophrenia: A Systematic Review of Economic Evaluations. Applied Health Economics and Health Policy; 11 (2), 95-106. http://link.springer.com/article/10.1007/s40258-013-0016-2.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

Please select one topic:

- Prodromal symptoms in first episode psychosis
- Clozapine- common and uncommon side effects
- Evidence base for High Dose Antipsychotic Therapy

Statistics '555' Topic

- Types of economic evaluation, QALY and DALY

MCQs

1. Which of the following subtype of schizophrenia is classified in DSM but not in ICD 10:

A. Hebephrenic
B. Post schizophrenic depression
C. Catatonic
D. Disorganised
E. Undifferentiated

2. The followings are risk factors for developing tardive dyskinesia except:

A. Old age
B. Male sex
C. Affective disorder
D. History of EPSEs
E. Prolonged use of antipsychotics

3. A 35 years old female patient with Schizophrenia describes, that her husband has been replaced by his "Double" who is identical in appearance but is not the same person. What is this phenomenon called?

A. Capgras Syndrome
B. Couvade Syndrome
C. Fregoli Syndrome
D. Othello Syndrome
E. De Clerambault

4. A young man presents with confusion, agitation and auditory hallucinations. His reflexes are brisk and symmetrical. He is not tremulous. His CT head scan is normal. His CSF shows raised proteins, normal glucose concentration and a small number of lymphocytes. What is the most likely diagnosis:

A. Acute relapse of schizophrenia
B. Alcohol intoxication
C. Catatonic stupor
D. Herpes simplex virus encephalitis
E. Neurosyphilis

5. When assessing a patient in a prison, which of the following would suggest a Ganser state?

A. Confabulation
B. Disorientation to time, place and person
C. Self mutilation
D. Sudden outbursts of violence
E. Visual pseudo hallucinations

Session 9: Depression-2
Journal theme: RCT on depression

Learning Objectives

- To develop an understanding of the psychopathology and diagnosis in Depression.
- To develop an understanding of possible complications of antidepressant medications.
- To develop an understanding of Randomized Controlled Trials and develop skills for critically appraising them.

Expert Led Session

- Topic: Depression- psychopathology and diagnosis

Case Presentation

- A case of major depressive disorder / severe depression with psychotic symptoms / dysthymia / recurrent depressive disorder

Journal Club Presentation (Select 1 paper)

- Hypericum Depression Trial Study Group (2002) Effect of *Hypericum perforatum* (St John's Wort) in Major Depressive Disorder- a randomized controlled trial. JAMA 287:14, 1807.
- John Z, Schatzberg A, Stahl S, Shah A, Caputo A, Post A (2010) Efficacy and Safety of Agomelatine in the Treatment of Major Depressive Disorder: A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial. Journal of Clinical Psychopharmacology 30:2, 135-144.
- Lincoln NB, Flannaghan T (2003) Cognitive Behavioral Psychotherapy for Depression Following Stroke- a Randomized Controlled Trial. Stroke 34, 111-115.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

Please select one topic:

- Augmentation of antidepressant drug treatment – overview
- Association of depression and physical health problems (e.g. stroke, diabetes, obesity, pain)
- Antidepressants induced hyponatraemia

Statistics '555' Topic

- Concealment and Randomization

MCQs

1. Glucocorticoid receptor hypothesis is associated with which of the following (choose one answer):

A. Depression

B. Generalised anxiety disorder

C. Dementia

D. Mania

E. Schizophrenia

2. What is the approximate male: female ratio of completed suicide in England, Scotland and Wales?

A. 7:1

B. 3:1

C. 5:1

D. 1:1

E. 2:1

3. Which of the following statements about unipolar depression is TRUE?

A. Unipolar depression is three times more likely in females than in males.

B. Relatives of patients with unipolar depression do not have increased rates of bipolar disorder or schizoaffective disorder.

C. In twin studies, concordance rate for unipolar disorder but not bipolar disorder is higher in monozygotic than dizygotic twins.

D. The familial segregation of mood disorders fits a simple Mendelian pattern.

E. There is no evidence to suggest that depressive disorder in later life is associated with parental separation, especially divorce

4. Which of the following abnormalities in monoamine neurotransmission is not found in depression?

A. Decreased plasma tryptophan

B. Increased brain 5-HT reuptake sites

C. Increased D2 receptor binding

D. Clinical relapse after tryptophan depletion

E. Decreased brain 5-HT1A receptor binding

5. Which of the following antidepressants is associated with increased risk of cardiovascular defects in foetus, when used in the 1st trimester?

A. Duloxetine

B. Sertraline

C. Mirtazapine

D. Venlafaxine

A. E. Paroxetine

Session 10: Bipolar Disorder-2
Journal theme: Qualitative studies on bipolar disorder

Learning Objectives

- To develop an understanding of the psychopathology and diagnosis in Bipolar disorder.
- To develop an understanding of possible complications of mood-stabilizer medications.
- To develop an understanding of Qualitative studies and develop skills for critically appraising them.

Expert Led Session

- Bipolar disorder- psychopathology and diagnosis

Case Presentation

- A case of type I bipolar disorder / type II bipolar disorder / cyclothymia / bipolar disorder with psychotic symptoms / rapid cycling bipolar disorder/ unipolar mania.

Journal Club Presentation

- Clatworthy J, Bowskill R, Rank T, Parham R, Horne R (2007) Adherence to medication in bipolar disorder, a qualitative study exploring the role of patients' beliefs about the condition and its treatment. Bipolar Disorders, 9(6), 656-664.
- Healey C, Peters S, Kinderman P, McCracken C, Morriss R (2009) Reasons for substance use in dual diagnosis bipolar disorder and substance use disorders: A qualitative study. Journal of Affective Disorders, 113(1-2), 118-126.
- Michalak EE, Yatham LN, Kolesar S, Lam RW (2006) Bipolar Disorder and Quality of Life: A patient-centred perspective. Quality of Life Research, 15(1), 25-37.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Pharmacological treatment in Bipolar Depression and Rapid cycling Bipolar Disorder
- Lithium side- effects and toxicity
- Risk of bipolar disorder in families of affected individuals

Statistics '555' Topic

- Types of sampling (including sample size and power)

MCQs

1. The experience of two years of hypomania symptoms that do not meet the criteria for a manic episode is known as:

A. Dysthymic disorder
B. Cyclothymic disorder
C. Rapid Cycling disorder
D. Personality disorder
E. Bipolar disorder NOS

2. The Cognitive deficits associated with Bipolar Disorder includes:

A. Executive functioning deficits
B. Verbal learning and memory
C. Difficulties in sequencing of motor acts
D. Processing and psychomotor skills including fine motor skills
E. All of the above

3. Which of the following statements is FALSE- Compared to Bipolar 1 disorder, Bipolar 2 disorder patients experience:

A. More chronic symptoms with more major depressive episodes
B. More episodes with shorter inter-episodic intervals
C. Slightly less substance abuse
D. More anxiety especially social phobia
E. Tend to recover to their pre-morbid levels of psycho-social functioning between episodes.

4. Which of the following statements is FALSE about Rapid Cycling bipolar disorder:

A. History of antidepressant induced hypomania is a risk factor
B. Evidence of low thyroxin levels is found even when not under treatment
C. Lasts less than 2 years in 50% of cases
D. Patients cycle between hypomania and depression each week
E. Is not genetically inherited in families with bipolar disorder

5. Which of the following statements is TRUE regarding Cyclothymia:

A. Is more common in males
B. Prevalence around 5%
C. Usual age of onset is between 35-40 years
D. Results in a diagnosis of bipolar disorder in a third of patients
E. Mood stabilisers are usually ineffective

Session 11: Mental Capacity Act
Journal theme: Any method

Learning Objectives

- To develop an understanding of the aspects of the Mental Capacity Act (including Deprivation of Liberty Safeguards) relevant to general adult psychiatry.

Expert Led Session

- Topic: General principles of MCA 2005 & Deprivation of Liberty

Case Presentation

- A case focusing on aspects of MCA or MCA/MHA interaction or DOLS.

Journal Club Presentation

- Brown P, Tulloch A, Mackinzie C, Owen G, Szmukler G, Hotopf M (2013) Assessments of mental capacity in psychiatric inpatients: a retrospective cohort study. BMC Psychiatry 13:115
- Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M (2007) Mental capacity in psychiatric patients- Systematic review. BJPsych 191: 291-297.
- Cairns R, Brown P, Grant-Peterkin H, Khondoker M, Owen G, Richardson G, Szmukler G, Hotopf M (2011) Judgements about deprivation of liberty made by various professionals: comparison study. The Psychiatrist, 35, 344-349.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- MCA and the Bournewood case
- Advance decisions to refuse treatment and advanced statement - salient points
- Liberty Protection Safeguards – changes in DOLS

Statistics '555' Topic

Hierarchy of evidence (case report through to meta analysis

MCQs

1. Which of the following statements about the MCA 2005 is FALSE:

A. A person must be assumed not to have capacity unless it is established that he has capacity.

B. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

C. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
D. An act done, or decision made, under this Act for on behalf of a person who lacks capacity must be done, or made, in his best interests.
E. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

2. The Court of Protection has powers to:
A. Decide whether a person has capacity to make a particular decision for themselves.
B. Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
C. Appoint deputies to make decisions for people lacking capacity to make those decisions
D. Remove deputies or attorneys who fail to carry out their duties.
E. All of the above.

3. Section 2(1) of the MCA, 2005 defines 'lack of capacity' as:
A. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
B. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain, except alcohol or drug use.
C. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind.
D. For the purpose of this Act, a person lacks capacity in relation to any decision if at the material time he is unable to make a decision for himself because of any psychiatric disorder.
E. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the brain.

4. A person is unable to make a decision if they cannot**:**
A. Understand the 'relevant' information about the decision to be made
B. Retain that information in their mind
C. Use or weigh that information as part of the decision-making process
D. Communicate their decision (by talking, using sign language or any other means)
E. All of the above conditions must be met.

5. Which of the following statements is FALSE: It might be necessary to consider using the MHA rather than the MCA if:

A. It is not possible to give the person the care or treatment they need without carrying out an action that might deprive them of their liberty.

B. The person may need to be restrained in a way that is not allowed under MCA.

C. It is not possible to assess or treat the person safely or effectively without treatment being compulsory.

D. If the person has a known chronic psychiatric illness.

E. The person needs treatment that cannot be given under MCA.

Session 12: Post-traumatic Stress Disorder
Journal theme: Meta-analysis/Systematic Review on PTSD

Learning Objectives

- To develop an understanding of PTSD (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and its management (pharmacological, psychological, social).
- To develop an understanding of Randomised control trials

Expert Led Session

- Topic: Post-Traumatic stress disorder

Case Presentation

- A case of PTSD or a case where PTSD is a differential diagnosis.

Journal Club Presentation

- Seidler GH, Wagner F (2006) Comparing the efficacy of EMDR and trauma-focused cognitive behavioural therapy in the treatment of PTSD: a meta-analytic study. Psychological Medicine, 11, 1515-1522.
- Hoskins M, Pearce J, Bethell A, Dankova L, Barbui C, et al. (2015). Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis. The British Journal of Psychiatry; 206 (2); 93-100; DOI: 10.1192/bjp.bp.114.148551

- Watts BV, Schnurr PP, Mayo L, Young-Xu Y, Weeks WB. (2013). Meta-Analysis of the Efficacy of Treatments for Posttraumatic Stress Disorder. J Clin Psychiatry; 74 (6): e541-e550. DOI:10.4088/JCP.12r08225

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- NICE guidelines for medications in PTSD
- Eye Movement Desensitization and Reprocessing (EMDR)
- PTSD- co-morbidity and suicide risk

Statistics '555' Topic

Confounding factors, bias and methods to control and reduce

MCQs

1. Which of the following psychological intervention can be effective for the treatment of post-traumatic stress symptoms in children and young people who have been sexually abused?

A. Psychodynamic psychotherapy
B. CAT
C. Trauma focused CBT
D. IPT
E. Single episode debrief

2. Which antidepressant is licensed for the treatment of PTSD?

A. Sertraline
B. Mirtazepine
C. Venelafaxine
D. Amitrytalline
E. Meclobamide

3. Which of the following is a DSM IV symptom of PTSD?

A. Pain
B. Substance misuse
C. Palpitations
D. Emotional blunting
E. Agitation
F.

4. Which of these statements is true regarding acute stress reaction and PTSD?

A. Acute stress disorder only occurs in the elderly population and children

B. Acute stress disorder describes symptoms in someone who was not present at an incident, while PTSD takes place only in those who were present

C. PTSD is not diagnosed until after 4 weeks following the traumatic event

D. Acute stress disorder and PTSD can be diagnosed at any time after the stressful event

E. All acute stress disorder patients develop PTSD

5. Which of the following is recommended as first line treatment for PTSD in adults?

A. Mirtazepine

B. EMDR

C. Citalopram

D. Mirtazepine

E. Risperidone

Semester 3

Session 13: Psychosis-3
Journal theme: Meta-analysis / Systematic Review on Psychosis

Learning Objectives

- To develop an understanding of the biopsychosocial management of schizophrenia
- To develop an understanding of evidence-based treatment
- To develop an understanding of the use of antipsychotics in special cases e.g. liver and renal impairment
- To develop an understanding of Meta-analysis / Systematic Review and develop skills for critically appraising them.

Expert Led Session

- Schizophrenia: Biopsychosocial management and evidence based treatment.

Case Presentation

- A case of Schizophrenia (any subtype) /Schizoaffective disorder / Delusional disorder / Acute and transient psychotic disorder / First-episode psychosis

Journal Club Presentation (Select 1 paper)

- Leucht S, Komossa K, Rummel-Kluge C, Corves C, Hunger H, Schmid F, Asenjo Lobos C, Schwarz S, Davis JM (2009). A meta-analysis of head-to-head comparisons of second-generation antipsychotics in the treatment of schizophrenia. Am J Psychiatry, 166(2):152-63. doi: 10.1176/appi.ajp.2008.08030368
- Souza JS, Kayo M, Tassell I, Martins CB, & Elkisa H. (2013). Efficacy of olanzapine in comparison with clozapine for treatment-resistant schizophrenia: evidence from a systematic review and meta-analyses. CNS Spectrums; 18 (2), 82- 89. DOI: http://dx.doi.org/10.1017/S1092852912000806

- Leucht S, Cipriani A, Spineli L, Mavridis D, Örey D. (2013). Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis. The Lancet; 382 (9896), 951–962. DOI: http://dx.doi.org/10.1016/S0140-6736(13)60733-3

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Recommendations for antipsychotics in liver disease
- Recommendations for antipsychotics in renal impairment
- Antipsychotics and sexual side effects

Statistics '555' topic

- t tests, p values and statistical significance

MCQs

1. Which one of the following led a trial that proved Clozapine's effectiveness in treating resistant schizophrenia?
   A. Kretschmer
   B. Cade
   C. Kraepelin
   D. Kane
   E. Bleurer
2. Choose the correct match from the following pairs:
   A. Risperidone: dibenzoxapine
   B. Droperidol: butyrophenones
   C. Aripiprazole: benzisothiazole
   D. Thioridazine: diphenyl butyl piperidine
   E. Flupentixol: dihydroindole
3. Which of the following atypical agents have the shortest half-life?
   A. Quetiapine
   B. Aripiprazole
   C. Olanzapine
   D. Clozapine
   E. Risperidone
4. The patients who are prescribed clozapine or olanzapine should have their serum lipids measured every:
   A. 6 days whilst on treatment
   B. One year whilst on treatment
   C. 3 months for the first year of treatment
   D. 6 weeks for the first year of treatment
   E. 6 months for the first year of treatment
5. What percentage of patients develop Tardive Dyskinesia with every year of typical antipsychotic exposure?
   A. More than 50%
   B. 2-5%
   C. 5-10%
   D. 20-25%
   E. 10-20%

Session 14: Depression-3
Journal theme: Qualitative study on depression

Learning Objectives

- To develop an understanding of the biopsychosocial management of Depression.
- To develop an understanding of evidence based treatment.
- To develop an understanding of the use of antidepressant in special cases e.g. liver and renal impairment.
- To develop an understanding of Qualitative study and develop skills for critically appraising them.

Expert Led Session

- Depression- Biopsychosocial management and evidence-based treatment

Case Presentation

- A case of major depressive disorder / severe depression with psychotic symptoms / dysthymia / recurrent depressive disorder

Journal Club Presentation (Select 1 paper)

- Coupe N, Anderson E, Gask L, Sykes P, Richards DA, et al. (2014). Facilitating professional liaison in collaborative care for depression in UK primary care; a qualitative study utilising normalisation process theory. BMC Family Practice; 15:78. DOI: 10.1186/1471-2296-15-78
- Gask L, Rogers A, Oliver D, May C, Roland M (2003) Qualitative study of patients' perceptions of the quality of care for depression in general practice. Br J Gen Pract., 53(489):278-83.
- Gask L, Dixon C, May C, Dowrick C (2005) Qualitative study of an educational intervention for GPs in the assessment and management of depression. Br J Gen Pract, 55(520):854-9.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- ECT – indications and contraindications
- Depression – important rating scales
- Treatment of refractory depression- first choice (evidence-based)

Statistics '555' topic

- Basic statistics- mean, median, mode, range, standard deviation, standard error

MCQs

1. Which of the following neurotransmitters does Venlafaxine act on?
   A. Serotonin only
   B. Noradrenaline and Serotonin
   C. Dopamine
   D. Noradrenaline, Serotonin and Dopamine
   E. GABA

2. Which of the following statements about Trazodone is FALSE?
   A. It is relatively safe in overdose
   B. It does not have strong antihistamine properties
   C. It is not a MAO-A and MAO- B inhibitor
   D. It does not block 5-HT reuptake
   E. It is a 5HT2 agonist

3. Which of the following are not common side effects of Sertraline?
   A. Tachycardia and arrhythmias
   B. Nausea, vomiting, abdominal pain
   C. Sexual dysfunction
   D. Agitation, anxiety
   E. Insomnia

4. Laura is a depressed 61-year-old woman who has not responded to an SSRI and has urinary incontinence. Which one of the following antidepressants is the best choice in this situation?
   1. Phenelzine
   2. Mirtazapine
   3. Vortioxetine
   4. Trazodone
   5. Duloxetine

5. Hypertension is a common side effect of which of the following antidepressants?
   A. Venlafaxine
   B. Paroxetine
   C. Escitalopram
   D. Trazodone
   E. Mirtazapine

Session 15: Bipolar Disorder-3
Journal theme: RCT on bipolar disorder

Learning Objectives

- To develop an understanding of the biopsychosocial management of Bipolar disorder.
- To develop an understanding of evidence-based treatment.
- To develop an understanding of the use of mood-stabilizers in special cases e.g. liver and renal impairment.
- To develop an understanding of Randomized Controlled trials and develop skills for critically appraising them.

Expert Led Session

- Bipolar disorder- Biopsychosocial management and evidence-based treatment.

Case Presentation

- A case of type I bipolar disorder / type II bipolar disorder / cyclothymia / bipolar disorder with psychotic symptoms / rapid cycling bipolar disorder/ unipolar mania.

Journal Club Presentation (Select 1 paper)

- Jones SH, Smith G, Mulligan LD, Lobban F, Law H, et al. (2010). Recovery-focused cognitive–behavioural therapy for recent-onset bipolar disorder: randomised controlled pilot trial. The British Journal of Psychiatry; 206 (1) 58-66. DOI: 10.1192/bjp.bp.113.141259
- Castle D, White C, Chamberlain J, Berk M, Berk L, Lauder S, Murray G, Schweitzer I, Piterman L, Gilbert M (2010) Group-based psychosocial intervention for bipolar disorder: randomized controlled trial. BJPsych, 196: 383-388.
- Kemp D, Gao K, Fein E, Chan P, Conroy C, Obral S, Ganocy S, Calabrese R (2012) Lamotrigine as add-on treatment to lithium and divalproex: lessons learned from a double-blind, placebo-controlled trial in rapid-cycling bipolar disorder. Bipolar Disord., 14(7):780-789.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Monitoring requirements for mood stabilizers
- Bipolar I Vs Bipolar II – differences in diagnosis and treatment
- Role of Psychotherapy in long term management of Bipolar Disorder

Statistics '555' topic

- Intention-to-treat analysis & Last Observation Carried Forward (LOCF)

MCQs

1. Sodium valproate:

A. Is mostly renally metabolised
B. Commonly causes hypertrichosis
C. Reduces lamotrigine levels
D. Is licensed for prophylaxis of BPAD
E. Is a first line choice in acute mania

2. Which of the following drugs has a high therapeutic index:

A. Lithium
B. Carbamazepine
C. Phenytoin
D. Warfarin
E. Gabapentin

3. The risk of Ebstein's anomaly in babies born to woman taking lithium is:

A. 1:10
B. 1:100
C. 1:500
D. 1:1000
E. 1:10000

4. Which of the following commonly causes hypercalcaemia:

A. Lithium
B. Valproate
C. Risperidone
D. Quetiapine
E. Clozapine

5. Lithium levels in once daily nocte dosing should be taken:

A. 4 hours post dose
B. 12 hours post dose
C. 6 hours post dose
D. Immediately before the next dose
E. 8 hours post dose

6 . Match the following to a drug from the list below:

1. Spina Bifida
2. Tricuspid valve defect
3. Cleft palate
4. Microcephaly

A - Lithium

B - Benzodiazepines

C - Valproate

D - None of the above

7. Match the following mood stabilisers to their chemical structure:

1. Haloperidol D
2. Risperidone A
3. Olanzapine C
4. Quetiapine B

A. Benzizoxazole

B. Dibenzothiazepine

C. Thienobenzodiazepine

D. Butyrophenone

Session 16: Anxiety disorders-2 (GAD, panic disorder, phobic anxiety disorders)
Journal theme: case –control studies on the topic

Learning Objectives

- To develop an understanding of GAD, panic disorder, phobic anxiety disorders (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and their management (pharmacological, psychological, social).

- To develop an understanding of Case-control studies and develop skills for critically appraising them.

Expert Led Session

- Biopsychosocial management of GAD, panic disorder and phobic anxiety disorders.

Case Presentation

- A case where either GAD, panic disorder or phobic disorder is the main diagnosis or a differential diagnosis.

Journal Club Presentation (Select 1 paper)

- Lipka J, Miltner WH, Straube T (2011) Vigilance for threat interacts with amygdala responses to subliminal threat cues in specific phobia. Biol Psychiatry, 70(5):472-8.
- Santos MA, Ceretta LB, Réus GZ, Abelaira HM, Jornada LK, Schwalm MT, Neotti MV, Tomazzi CD, Gulbis KG, Ceretta RA, Quevedo J (2014) Anxiety disorders are associated with quality of life impairment in patients with insulin-dependent type 2 diabetes: a case-control study. Rev Bras Psiquiatr., 36 (4):298-304.
- Kiropoulos L, Klien B, Austin D, Gilson K, Pier C, Mitchell J and Ciechomski L (2008) Is internet-based CBT for panic disorder and agoraphobia as effective as face-to-face CBT? Journal of anxiety disorders 22(8), 1273-1284.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- CBT for agoraphobia- principles
- Principles of use of benzodiazepines for anxiety disorders
- Prognosis in GAD and Panic Disorder

Statistics '555' topic

- Null hypothesis, Type-1 error and type-2 error

MCQs

1. Venlafaxine of not licenced for which of the following indications?
   A. Social anxiety
   B. PTSD
   C. Panic disorder
   D. Depression +/- Anxiety
   E. GAD

2. The following are TRUE of the pharmacokinetics of benzodiazepines:
   A. When long-acting they have long elimination half-life.
   B. When short-acting they have a small distribution volume.
   C. When long-acting they have no active metabolites
   D. When short-acting they have high accumulation
   E. Benzodiazepines with a half-life of 12 hours tend to be used as anxiolytics.

3. Which of the following statements is FALSE about the effects of hypnotics no sleep?

A. Benzodiazepines supress stage IV sleep.
B. With chronic Benzodiazepines use suppression of REM sleep in the early part of the night occurs
C. On withdrawal of Benzodiazepines a rebound increase above the 'normal' amount of REM sleep occurs.
D. It may take up to 6 weeks to see a return to a normal sleep pattern on Benzodiazepine withdrawal.
E. Barbiturates are more likely to suppress REM sleep than are Benzodiazepines.

4. With regards to the NICE guidelines on GAD, which of the following is FALSE?

A. SSRIs (particularly Sertraline) are the first line medications.
B. SNRIs are second line.
C. If the patient cannot tolerate SSRI or SNRI, offer Pregabalin.
D. Antipsychotic should be offered for the treatment of GAD in primary care.
E. Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises

5. With respect to the NICE guidelines on psychological intervention for GAD, which of the following is FALSE?

A. CBT for people with GAD should be based on the treatment manuals used in the clinical trials of CBT for GAD.
B. CBT for GAD usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour.
C. Practitioners providing high-intensity psychological interventions for GAD need not have regular supervision to monitor fidelity to the treatment model.
D. If a person with GAD chooses a high-intensity psychological intervention, offer either CBT or applied relaxation.
E. Consider providing all interventions in the preferred language of the person with GAD if possible.

Session 17: Suicide/self-harm-2
Journal theme: Any study method on the topic

Learning Objectives

- To develop an understanding of various facets of self-harm and suicide (aetiology, epidemiology, neurobiology, genetics, clinical presentation, risk assessment) and their management (pharmacological, psychological, social).

Expert Led Session

- Suicide & self-harm- comprehensive risk assessment

Case Presentation

- Cases related to any type of clinical presentations where suicide and/ or self-harm is the central theme

Journal Club Presentation (Select 1 paper)

- Quinlivan L, Cooper J, Steeg S, Davies L, Hawton K, Gunnell D, Kapur N (2014) Scales for predicting risk following self-harm: an observational study in 32 hospitals in England. BMJ Open, doi: 10.1136/bmjopen-2013-004732.
- Kapur N, Gunnell D, Hawton K, Nadeem S, Khalil S, Longson D, Jordan R, Donaldson I, Emsley R, Cooper J (2013) Messages from Manchester: pilot randomised controlled trial following self-harm. BJPsych 203: 73-74.
- Kapur N, Turnbull P, Hawton K, Simkin S, Sutton L, Mackway-Jones K, Bennewith O, Gunnell D (2005) Self-poisoning suicides in England: a multi-centre study. Q J Med, 98: 589-597.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- National Confidential Inquiry into suicide by people with mental illness – Key findings of the latest annual report
- Purpose of a Coroner's Inquest
- Epidemiological factors associated with suicides

Statistics '555' topic

- Standard error and confidence intervals

MCQs

1. **Which of the following has been shown to be associated with increased rates of suicide?**
   A. Peptic ulcer
   B. Non-delusional body dysmorphia
   C. Huntington's chorea
   D. Epilepsy
   E. All of the above

2. Deliberate self-harm is more common in:
   A. Males
   B. Rural areas
   C. Age over 35 years
   D. Lower socioeconomic status
   E. Married

3. Predictors of repetition of DSH include all except:
   A. Personality disorder
   B. Alcohol misuse
   C. Male gender
   D. Previous DSH
   E. Younger age of onset

4. Which of the following is associated with suicide in patients with schizophrenia?

A. Akathisia
B. Older patient
C. Poor premorbid functioning
D. Short duration of illness
E. Presence of positive symptoms

5. Which of the following physical health problems are associated with increased risk of suicide?

A. AIDS
B. Huntington's disease
C. Cushing's disease
D. Porphyria
E. All of the above

Session 18: Perinatal psychiatry
Journal theme: Study with any method

Learning Objectives

- To understand the impact / risks of major mental disorders on pregnancy and post-partum period. To understand the general principles of prescribing; and the risks & benefits of prescribing psychotropic medications in pregnancy, post-partum period and breast feeding.

Expert Led Session

- Evidence-based recommendations for psychotropic medications in pregnancy [antipsychotics, antidepressants, mood stabilizers and anxiolytics].

Case Presentation

- A case of any mental disorder in pregnancy or post-partum period.

Journal Club Presentation (Select 1 paper)

- Ennis, Z. and Damkier, P. (2015). Pregnancy Exposure to Olanzapine, Quetiapine, Risperidone, Aripiprazole and Risk of Congenital Malformations. A Systematic Review. *Basic & Clinical Pharmacology & Toxicology*, 116(4), pp.315-320.
- Boden, R., Lundgren, M., Brandt, L., Reutfors, J., Andersen, M. and Kieler, H. (2012). Risks of adverse pregnancy and birth outcomes in women treated or not treated with mood stabilisers for bipolar disorder: population based cohort study. *BMJ*, 345(nov07 6), pp.e7085.
- Uguz, F. (2016). Second-Generation Antipsychotics During the Lactation Period: A Comparative Systematic Review on Infant Safety. *Journal of Clinical Psychopharmacology*, 36(3), pp.244-252.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Post-partum risks of relapse in schizophrenia, bipolar disorder and depression
- Congenital malformations associated with Lithium, Valproate, Carbamazepine, Lamotrigine and Paroxetine- salient points
- Use of SSRIs in pregnancy – salient points

Statistics '555' topic

- Absolute risk reduction, relative risk reduction, Number needed to treat and number needed to harm

MCQs

1. During pregnancy the following physiological changes occur

A. Plasma volume markedly increases and eGFR increases

B. Plasma volume markedly decreases and eGFR increases

C. Plasma volume markedly increases and eGFR decreases

D. Plasma volume markedly decreases and eGFR decreases

E. There is no change in either plasma volume or eGFR

2. Which of the following is NOT associated with exposure to SSRIs in the Perinatal period?

A. Perinatal Death

B. Persistent Pulmonary Hypertension of the Newborn

C. Postpartum haemorrhage

D. Poor neonatal adaptation syndrome

E. Preterm birth

3. Which of the following statements is TRUE regarding NICE guidelines?

A. Benzodiazepines can be offered in pregnancy for medium term treatment of anxiety

B. Consideration of medication dose changes do not have to be made during pregnancy

C. If this is a first pregnancy a women's previous response to medication should not influence the choice of antidepressant (being pregnant dictates the choice)

D. Lithium can be continued if the women is at high risk of relapse and an antipsychotic is unlikely to be effective

E. Measure prolactin levels in women planning pregnancy who are taking a prolactin raising antipsychotic as raised prolactin increases the chances of conception

4. Which of the following statements is TRUE?

A. Valproate is associated with reduced fertility in women and men

B. Taking Folic acid 5mg with Valproate will reduce teratogenicity

C. Valproate monotherapy is not associated with an increased risk of Attention Deficit Hyperactivity Disorder

D. Valproate monotherapy only affects the child in the 1st and 3rd trimester

E. Valproate passes in higher concentrations than Lamotrigine in breastmilk

5. Which of the following is TRUE regarding breastfeeding?

A. Patients with postpartum mental health disorders who require pharmacotherapy should generally be discouraged from breastfeeding

B. All psychotropic medications are transferred to breast milk in varying amounts

C. Psychotropics should be chosen with regard to longer half life and less protein binding

D. Mothers should change their pregnancy medication for breastfeeding

E. Methadone and Nicotine Replacement Therapy are incompatible with breastfeeding

Semester 4

Session 19: Psychosis - 4
Journal theme: Genetic studies in Psychosis

Learning Objectives

- To develop an understanding of the course and prognosis of schizophrenia.
- To develop an understanding of risk factors for poor outcomes.
- To develop an understanding of the relevance of duration of untreated psychosis.
- To develop an understanding of genetic studies and develop skills for critically appraising them

Expert Led Session

- Topic: Schizophrenia- course and prognosis

Case Presentation

- A case of Schizophrenia (any subtype) /Schizoaffective disorder / Delusional disorder / Acute and transient psychotic disorder / First-episode psychosis

Journal Club Presentation (Select 1 paper)

- Nicodemus K, Marenco S, Batten A, Vakkalanka R, Egan M, Straub E, Weinberger D (2008) Serious obstetric complications interact with hypoxia-regulated/vascular-expression genes to influence schizophrenia risk. Molecular Psychiatry 13, 873-877.
- Di Forti M, et al. (2012) Confirmation that the AKT1 (rs 2494732) genotype influences the risk of psychosis in cannabis users. http://dx.doi.org/10.1016/j.biopsych.2012.06.020.
- Cardno A, Rijsdijk F, Murray R, McGuffin P (2002) A twin study of genetic relationships between psychotic symptoms. Am J Psychiatry 159:539-545.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Cost comparison of antipsychotics
- Tardive Dyskinesia
- Clozapine monitoring

Statistics '555' topic

- Correlation co-efficients and regression curve

MCQs

1. The chemical structure of Olanzapine is:
   A. Benzizoxazole
   B. Dibenzothiazepine
   C. Thienobenzodiazepine
   D. Butyrophenone
   E. Benzobutyramide

2. Which of the following genes are thought to be involved in the aetiology of Schizophrenia according to the current evidence?
   A. COMT
   B. DISC-1
   C. DTNBP-1
   D. GABRB-2
   E. All of the above

3. Which of the following is not a predictor of course and outcome in Schizophrenia?
   A. Sociodemographic status
   B. Features of initial clinical state and treatment response
   C. First rank symptoms at baseline
   D. Family history of psychiatric disorders
   E. Premorbid personality and functioning

4. Which of the following scales is the most appropriate for assessment of extra-pyramidal side effects of antipsychotics?
   A. Barnes' scale
   B. Brief Psychiatric Rating Scale
   C. Simpson-Angus Scale
   D. Positive and Negative Symptom Scale
   E. Unified Parkinson's Disease Rating Scale

5. Who established antipsychotic effects of Chlorpromazine?
   A. John Cane and colleagues
   B. Jean Delay and Pierre Deniker
   C. Eugene Bleuler
   D. John Cade
   E. Arvid Carlsson

Session 20: Depression- 4
Journal theme: ROC analysis studies in Depression

Learning Objectives

- To develop an understanding of the course and prognosis of Depression.
- To develop an understanding of risk factors for poor outcomes.
- To develop an understanding and skills for critically appraising Receiver Operating Characteristic Curve studies.

Expert Led Session

- Topic: Depression- course and prognosis

Case Presentation

- A case of major depressive disorder / severe depression with psychotic symptoms / dysthymia / recurrent depressive disorder

Journal Club Presentation (Select 1 paper)

- Leentjens A, Verhey F, Luijckx G-J, Troost J (2001) The validity of the Beck Depression Inventory as a screening and diagnostic instrument for depression in patients with Parkinson's disease. Movement Disorders 15(6), 1221-1224.
- Cameron I, Cardy A, Crawford J, Toit S, Hay S, Mitchell K, Sharma S, Shivaprasad, S, Winning S, Reid I (2011) Measuring depression severity in general practice: discriminatory performance of the PHQ-9, HADS-D and BDI-II. Br J Gen Pract, DOI: 10.3399/bjgp11X583209.

- Karlović D, Serretti A, Jevtović S, Vrkić N, Šerić V, et al. (2013). Diagnostic accuracy of serum brain derived neurotrophic factor concentration in antidepressant naïve patients with first major depression episode. Journal of Psychiatric Research; 47 (2), 162–167. DOI:10.1016/j.jpsychires.2012.09.017

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Risk factors associated with early onset and late onset depression
- Biological markers of recurrent depression
- Role of psychotherapy in long term treatment of depression

Statistics '555' topic

- Sensitivity, Specificity, Positive Predictive Value, Negative Predictive value

MCQs

1. In recurrent depression with a history of significant functional impairment, long term antidepressants should not be withdrawn until what duration since complete remission:

A. 3 months
B. 6 months
C. 1 year
D. 2 years
E. 3 years

2. Many risk factors have been identified in depressive disorder. Which ONE of the following statements regarding risk of developing depression is NOT true?

A. Risk is increased if there is a first degree relative with bipolar affective disorder
B. Risk is more increased in lower social classes than middle social classes following a life event
C. Risk is increased by having poor social support
D. Risk in single women doubles in the presence of poverty
E. Risk is increased in females who are heterosexual compared to males who are homosexual

3. Mrs. Jones is treated for breast cancer with Tamoxifen but is also depressed. Which of the following drugs is contraindicated in her situation?

A. Vortioxetine
B. Roboxetine
C. Fluoxetine
D. Mirtazapine
E. Venlafaxine

4. What is the approximate male : female ratio of completed suicide in England, Scotland and Wales?

A. 7:1
B. 3:1
C. 5:1
D. 1:1
E. 2:1

5. The average duration of an untreated episode of depression:

A. 3 years

B. 1 year

C. 6 months

D. 3 months

E. 1 month

Session 21: Bipolar Disorder - 4
Journal theme: Meta-analysis / systematic review on bipolar disorder

Learning Objectives

- To develop an understanding of the course and prognosis of Bipolar disorder.
- To develop an understanding of risk factors for poor outcomes.
- To develop an understanding of meta-analysis and systematic review and develop skills for critically appraising them.

Expert Led Session

- Topic: Bipolar disorder- course and prognosis

Case Presentation

- A case of type I bipolar disorder / type II bipolar disorder / cyclothymia / bipolar disorder with psychotic symptoms / rapid cycling bipolar disorder/ unipolar mania.

Journal Club Presentation (Select 1 paper)

- Severus E, Taylor MJ, Sauer C, Pfennig A, Ritter P, et al. (2014). Lithium for prevention of mood episodes in bipolar disorders: systematic review and meta-analysis. International Journal of Bipolar Disorders; 2 (15). DOI: 10.1186/s40345-014-0015-8

- Cerullo MA, & Strakowski SM. (2013). A systematic review of the evidence for the treatment of acute depression in bipolar I disorder. CNS Spectrums; 18 (4), 199- 208. DOI: http://dx.doi.org/10.1017/S1092852913000102

- Ogawa Y, Tajika A, Takeshima N, Hayasaka Y, Furukawa TA. (2014). Mood Stabilizers and Antipsychotics for Acute Mania: A Systematic Review and Meta-Analysis of Combination/Augmentation Therapy Versus Monotherapy. CNS Drugs; 28 (11), 989-1003. DOI: 10.1007/s40263-014-0197-8.

‘555’ Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Distinguishing between mood symptoms of bipolar disorder (type I and II), emotionally unstable personality disorder and cyclothymia
- Nice guidelines – Treatment of acute mania
- Role of depot antipsychotics in bipolar disorder

Statistics ‘555’ topic

Inter rater reliability and test-retest reliability

MCQs

1. Using the broadest definition, prevalence of bipolar spectrum disorders in the general population has been estimated as high as:

A. 0.8%
B. 1.2%
C. 3.9%
D. 8.3%
E. 10.4%

2. Age at onset of bipolar disorder:

A. Has little prognostic relevance
B. Is not a heritable trait
C. Has been observed to be higher in more recent studies
D. Is higher in women than men
E. Has implications for clinical course

3. Individuals with bipolar disorder:

A. Rarely receive a diagnosis of unipolar depression
B. Have longer episodes of mania than depression
C. Commonly have psychiatric co-morbidities
D. Have fewer depressive episodes than those with unipolar depression
E. Show poorer prognosis if they have predominantly manic episodes

4. When compared with bipolar I disorder, bipolar II disorder:

A. Is associated with better inter-episode functioning
B. Is similar and frequently develops into bipolar I disorder
C. Is associated with fewer affective episodes overall
D. Has a less chronic course
E. Has a significantly higher age at onset

5. Regarding the treatment of bipolar disorder:

A. Delays in initiating treatment are rare

B. The vast majority of patients respond to lithium or an anticonvulsant treatment when in a manic phase

C. Quetiapine leads to remission in over 50% of patients in the depressive phase

D. There are a number of well-tolerated treatments that are effective in all phases of the illness

E. The majority of patients are maintained on monotherapies

Session 22: General Hospital Psychiatry
Journal theme: Case report/ case series

Learning Objectives

- To develop an understanding of psychiatric assessment of patients with physical illness, liaising with colleagues in other specialties, psychiatric consequences and aspects of brain pathology; and clinical and theoretical psychiatric aspects of pain and its management.

- To develop an understanding of Case reports/case series studies and develop skills for critically appraising them.

Expert Led Session

- Topic: Overview of psychiatric presentations in general hospital / liaison psychiatry

Case Presentation

- A case of psychiatric presentation in general hospital / liaison psychiatry

Journal Club Presentation (Select 1 paper)

- Amoako AO, Brown C, Riley T (2015) Syndrome of inappropriate antidiuretic hormone secretion: a story of duloxetine-induced hyponatraemia. BMJ Case Rep. 2015 Apr 24.
- Warren R, Burrow J, Conroy D, Lukela J, Kahn DA (2014) "I didn't know cognitive therapy was deep": a case study of sudden and lasting gains in cognitive-supportive therapy of depression. J Psychiatr Pract., Sep; 20(5):379-88.
- Nagoshi Y, Tominaga T, Fukui K. (2014) Effect of aripiprazole augmentation for treatment-resistant somatoform disorder: a case series. J Clin Psychopharmacol., Jun 34(3):397-8.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Pathophysiological theories of chronic somatoform pain disorders.
- Pathophysiological findings in chronic fatigue syndrome
- Evidence based treatments for Chronic Fatigue syndrome

Statistics '555' topic

- Internal and external validity

MCQs

1. Lesions in the following structure have been associated with pathological crying:

A. Temporal pole
B. Pineal gland
C. Caudate nucleus
D. Pons
E. Tegmentum

2. The following theoretical model is commonly applied to somatoform pain disorders:

A. Central demyelination theory
B. Central sensitisation theory
C. Operant sensitisation theory
D. Central operant theory
E. Operant receptive field theory

3. Diagnostic criteria for Chronic fatigue syndrome requires a duration of symptoms for at least

A. 4 weeks
B. 3 months
C. 4 months
D. 6 months
E. 12 months

4. Diagnostic criteria for Fibromyalgia requires a duration of symptoms for at least

A. 4 weeks
B. 3 months
C. 4 months
D. 6 months
E. 12 months

5. The following medication is routinely used for treating Fibromyalgia:

A. Carbamazepine
B. Vigabatrin
C. Pregabalin
D. Mirtazepine
E. Mianserin

Session 23: Organic Psychiatry
Journal theme: Neuroimaging studies

Learning Objectives

- To develop an understanding of organic psychiatric disorders. To develop an understanding of the psychiatric consequences and aspects of brain disease, damage (including stroke) and dysfunction.
- To develop an understanding of brain imaging studies and develop skills for critically appraising them.

Expert Led Session

- Topic: Overview of organic psychiatric disorders in GA psychiatry.

Case Presentation

- Any case with a theme of organic psychiatric disorder or where there are specific organic findings (e.g in brain scans) or where such disorders are a part of differential diagnoses.

Journal Club Presentation (Select 1 paper)

- Mallas EJ, Carletti F, Chaddock CA, Woolley J, Picchioni MM, Shergill SS, Kane F, Allin MP, Barker GJ, Prata DP (2016) Genome-wide discovered psychosis-risk gene ZNF804A impacts on white matter microstructure in health, schizophrenia and bipolar disorder. PeerJ. Feb 25;4:e1570.
- Hamilton J, Etkin A, Furman D, Lemus M, Johnson R, Gotlib I (2012) Functional neuroimaging of major depressive disorder: a meta-analysis and new integration of baseline activation and neural response data. Am J Psychiatry 169:693-703.
- De Wit S, Alonso P, Schweren L, et al. (2014) Multicentre voxel-based morphometry mega-analysis of structural brain scans in obsessive-compulsive disorder. Am J Psychiatry 171:340-349.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Psychosis in medical conditions
- Depression in medical conditions
- Anxiety in medical conditions

Statistics '555' topic

- Types of randomization

MCQs

1. Patients with Phaeochromocytoma may resemble patients experiencing:

A. Depression
B. Mania
C. Psychosis
D. Panic disorder
E. OCD

2. Which of the following commonly features in early Borrelia infection?

A. Erythema nodosum

B. Flu type symptoms

C. Tinnitus

D. Polyuria

E. abdominal pain, especially at night

3. Which of the following is NOT a risk factor for hypothyroidism?

A. Age <40 years

B. Post-partum

C. Neck surgery

D. Radiation exposure

E. Amiodarone

4. Patients with untreated Borrelia infection progressing to neurological symptoms:

A. 5%

B. 10%

C. 15%

D. 18%

E. 20%

5. HSV encephalitis commonly affects the:

A. Frontal lobes

B. Temporal lobes

C. Parietal lobes

D. Brainstem

E. Corpus callosum

Session 24: Obsessive Compulsive Disorder
Journal theme: RCT studies in OCD

Learning Objectives

- To develop an understanding of OCD (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and its management (pharmacological, psychological, social).
- To develop an understanding of Randomized controlled trail and develop skills for critically appraising them.

Expert Led Session

- Topic: OCD- an overview

Case Presentation

- A case of OCD or a case in which it is a differential diagnosis.

Journal Club Presentation (Select 1 paper)

- Foa E, et al. (2005) Randomized, placebo-controlled trial of exposure and ritual prevention, Clomipramine and their combination in the treatment of obsessive-compulsive disorder. Am J Psychiatry 162: 151-161
- Carey P, Vythilingum B, Seedat S, Muller J, Ameringen M, Stein D (2005) Quetiapine augmentation of SRIs in treatment refractory obsessive-compulsive disorder: a double-blind, randomized, placebo-controlled study. BMC Psychiatry 5:5. doi:10.1186/1471-244X-5-5.
- Kamijima K, Murasaki M, Asai M, Higuchi T, Nakajima T, Taga C, Matsunaga H (2004) Paroxetine in the treatment of obsessive-compulsive disorder: randomized, double-blind, placebo-controlled study in Japanese patients. Psychiatry Clin Neurosci 58(4): 427-433

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Neurobiology of OCD
- Summary of NICE guidelines on OCD
- Evidence for psychological therapies in OCD- summary

Statistics '555' topic

- Methods of blinding

MCQs

1. The lifetime risk of OCD is:

A. 2.1%

B. 1 %

C. 0.5 %

D. 5 %

2. Which of the following it TRUE about OCD?

A. There is evidence of increased volume of basal ganglia structures

B. Meta-analyses of brain imaging studies shows consistent findings

C. Studies have found an increase in volume of orbitofrontal cortex

D. Anterior cingulate area volume always remains normal

3. NICE recommends:

A. CBT including exposure and response prevention in OCD with mild functional impairment

B. Choice of monotherapy with an SSRI or intensive CBT alone for OCD with moderate functional impairment
C. Use of combination therapy after inadequate response at 12 weeks
D. All of the above

4. NICE recommends consideration of in-patient treatment in OCD when there is:
A. Risk of suicide
B. Severe self-neglect
C. Reversal of normal night/day patterns making attendance for daytime therapy impossible
D. A, B and C
E. Only A and B
5. All of the following statements about the CBT model for OCD is true EXCEPT:
A. According to the model, intrusive thoughts are universal, with a content indistinguishable from that of clinical obsessions
B. Avoidance is not a part of the definition of OCD
C. Excessive attentional bias on monitoring intrusive thoughts is specific to OCD
D. Rumination covers both the obsession and any accompanying mental compulsion
E. Thought-action fusion is also known as magical thinking

Further Reading

PSYCHOSIS

Guidelines

- NICE Guidance Pathway: Psychosis and Schizophrenia Pathway - : http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia
- Nice guidelines: CG178- Psychosis and schizophrenia in adults: http://guidance.nice.org.uk/CG178
- BAP guidelines: Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association for Psychopharmacology- http://www.bap.org.uk/pdfs/Schizophrenia_Consensus_Guideline_Document.pdf

E-Learning

RCPsych CPD Online

- First episode psychosis: Part 1 -assessment, diagnosis and rationale
- First episode psychosis: Part 2 -treatment approaches and service delivery

Journal Articles

- Feedman, R (2003) Schizophrenia. N Engl J Med 349:1738-1749
- Woolley, J & McGuire P (2005) Neuroimaging in schizophrenia: what does it tell the clinician? APT 11: 195-202.
- Cardno A (2014) Genetics and psychosis. APT 20: 69-70
- Torrey EF (1987) Prevalence studies in schizophrenia. BJPsych 150:598-608.
- Macleod J (2007) Cannabis use and psychosis: the origins and implications of an association. APT 13:400-411.
- Martindale B (2007) Psychodynamic contributions to early intervention in psychosis. APT 13:34-42.
- Connolly M & Kelly C (2005) Lifestyle and physical health in schizophrenia. APT 11:125-132.
- Mullen P (2006) Schizophrenia and violence: from correlations to preventive strategies. APT 12:239-248
- Schleifer JJ (2011) Management of acute agitation in psychosis: an evidence-based approach in the USA. APT 17:91-100.

DEPRESSION

Guidelines

- NICE Guidance Pathway: Depression Pathway- http://pathways.nice.org.uk/pathways/depression
- Nice guidelines: CG90- Depression in adults (update)- http://www.nice.org.uk/nicemedia/live/12329/45890/45890.pdf
- BAP guidelines: Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2000 British Association for Psychopharmacology guidelines- http://www.bap.org.uk/pdfs/antidepressants.pdf

E-Learning

RCPsych CPD Online

- The pharmacological treatment of resistant depression- an overview
- Dual diagnosis: the diagnosis and treatment of depression with co-existing substance misuse
- Managing depression in physically ill patients
- Prescription of ECT
- Antidepressants and psychosexual dysfunction: Part 1 – diagnosis
- Antidepressants and psychosexual dysfunction: Part 2 – treatment

Journal Articles

- Belmaker, RH & Agam G (2008). Major depressive disorder, N Engl J Med, 358: 55-68.
- Jacob KS (2009) Major depression: revisiting the concept and diagnosis. APT 15:279-285.
- Taylor D (2008) Psychoanalytic and psychodynamic therapies for depression: the evidence base. APT 14:401-413.
- Branney P & White A (2008) Big boys don't cry: depression and men. *APT 14:256-262.*
- Cowen P (2005) New drugs, old problems: Revisiting Pharmacological management of treatment-resistant depression. APT 11:19-27.
- Oakley C, Hynes F, Clark T (2009). Mood disorders and violence: a new focus, APT, 15:263-270.

BIPOLAR DISORDER

Guidelines

- Nice guidelines: CG38- Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care- http://www.nice.org.uk/guidance/CG38
- BAP guidelines: Evidence-based guidelines for treating bipolar disorder: revised second edition - http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf

E-Learning

RCPsych CPD Online

- The pharmacological management of mania
- Safe Lithium Prescribing: initiation and monitoring

Journal Articles

- Elanjithara T, Frangou S, McGuire P (2011) Treatment of the early stages of bipolar disorder. *APT 17:283-291.*
- Bouch J (2010) Bipolar disorder. *APT 16:317.*
- Saunders KEA & Goodwin GM (2010) The course of bipolar disorder. *APT 16:318-328.*

MENTAL HEALTH ACT & MENTAL CAPACITY ACT

E-Learning

RCPsych CPD Online

- The Mental Health Act 1983: criteria for detention
- Supervised community treatment
- Competence, capacity and decision-making ability in mental disorder
- Mental capacity Act 2005: Part 1
- Mental Capacity Act 2005: Part 2

Journal Articles

- Bindman J, Maingay S, Szmukler G (2003) The Human Rights Act and mental health legislation. BJPsych 182: 91-94.
- Brindle N & Branton T (2010) Interface between the Mental Health Act and Mental Capacity Act: deprivation of liberty safeguards. APT 16:430-437.
- Jones C, Nimmagadda S, Paul Veitch P (2013) Mental health tribunals in England and Wales: a representative's guide. APT 19:40-47.
- Hampson M (2011) Raising standards in relation to Section 136 of the Mental Health Act 1983. APT 17:365-371.
- Branton T & Brookes G (2010) Definitions and criteria: the 2007 amendments to the Mental Health Act 1983. APT 16:161-167.
- Branton T & Brookes G (2010) Compulsion in the community? The introduction of supervised community treatment. APT 16:245-252.

SELF-HARM & SUICIDE

E-Learning

RCPsych CPD Online

- The psychosocial management of self-harm: Part 1
- The psychosocial management of self-harm: Part 2

Journal Articles

- Bouch J, Marshall JJ (2005) Suicide risk: structured professional judgement. Advances in Psychiatric Treatment 11: 84-91.
- Heeringen K, Mann JJ (2014) The neurobiology of suicide. Lancet Psychiatry 1:63-72.
- O'Connor RC, Nock MK (2014) The psychology of suicidal behaviour. Lancet Psychiatry 1:73-85.

ANXIETY DISORDERS

Guidelines

- NICE Guidance Pathway for GAD and panic disorder (with or without agoraphobia): http://pathways.nice.org.uk/pathways/generalised-anxiety-disorder
- NICE guidelines on GAD and panic disorder (with or without agoraphobia): CG113- http://www.nice.org.uk/nicemedia/live/13314/52601/52601.pdf
- BAP guidelines: Evidence-based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology- https://tavaana.org/sites/default/files/Reading%201_3.pdf

E-Learning

RCPsych CPD Online

- The pharmacological management of anxiety disorders

Journal Articles

- Kessler RC, Chiu WT, Jim R, Ruscio AM, Shear C, Walters E. (2006). The epidemiology of panic attacks, panic disorder and agoraphobia in the national co-morbidity survey replication. Archives of General Psychiatry (now JAMA Psychiatry), 63(4), 415-424.
- Shader RJ, Greenblatt DJ. (1993). Use of benzodiazepines in anxiety disorders. N Engl J of Med, 328, 1398-1405.
- Hamilton, M. (1959) The assessment of anxiety states by rating scale. British Journal of Medical Psychology, 32(1), 50-55.
- Linden, .M. Zubraegel .D. Baer .T. et al. (2005) Efficacy of cognitive behaviour therapy in generalised anxiety disorders. Psychotherapy and Psychosomatics 74, 36-42.

PERSONALITY DISORDERS

Guidelines

- Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K (2010) Pharmacological interventions for borderline personality disorder, The Cochrane Library, DOI: 10.1002/14651858.CD005653.pub2
- Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K (2010) Psychological therapies for people with borderline personality disorder**,** The Cochrane Library, DOI: 10.1002/14651858.CD005652.pub2
- NICE guideline CG78: Borderline Personality disorder: treatment and management.
- NICE guideline CG77: Antisocial Personality disorder: treatment and management and prevention.

E-Learning

RCPsych CPD Online

- The assessment of personality

Journal Articles

- Raju R, Corrigan FM, Davidson AJW, Johnson D (2012). The nature of personality disorder. APT, 18:162-172.
- Sarkar J & Duggan C (2010). Personality disorder and the Mental Health Act 1983 (amended), APT, 16:329-335.
- Thomson LDG (2010). Diagnosis and classification of personality disorder: difficulties, their resolution and implications for practice, APT, 16:388-396.
- Carroll A (2009). Assessment of personality disorder, APT, 15:389-397.
- Lewis G & Appleby L (1988) Personality disorder: the patients psychiatrists dislike. BJPsych 153:44 -49.

POST-TRAUMATIC STRESS DISORDER

Guidelines

- NICE guidelines for PTSD
- BAP guidelines for anxiety disorders

Journal Articles

- Starcevic V (*2013)* Post-traumatic stress disorder: new directions in pharmacotherapy. *APT, 19:181-190.*
- Ahmed A (2007) Post-traumatic stress disorder, resilience and vulnerability. APT, 13, 369–375.

Other resources

- Royal College of Psychiatrists leaflets
  http://www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx
- Links to the ICD10 online:
  http://apps.who.int/classifications/icd10/browse/2016/en#/V
  http://www.who.int/classifications/icd/en/bluebook.pdf (Bluebook)
  http://www.who.int/classifications/icd/en/GRNBOOK.pdf (for research criteria)
- TrOn: www.tron.rcpsych.ac.uk

Bibliography

- Gelder M, Andreason N, Lopez-Ibor J, Geddes J (Eds.) 2012. New Oxford textbook of Psychiatry. Oxford University Press.
- Stein G & Wilkinson G (Eds.) 2007. Seminars in General Adult Psychiatry (2nd Ed). The Royal College of Psychiatrists. Gaskell, London.
- Semple D & Smyth R (Eds.) 2013. Oxford Handbook of Psychiatry. Oxford University Press.
- Brown T & Wilkinson D (Eds.) 2005. Critical Reviews in Psychiatry (3nd Ed). The Royal College of Psychiatrists. Gaskell, London.
- Taylor D, Paton C, Kapur S (Eds) (2014). Maudsley guidelines, 11th Ed. Wiley-Blackwell, London.
- Bazire S (2014) Psychotropic Drug Directory, Lloyd-Reinhold Communications, London.
- Zigmond T (2012) A clinician's brief guide to the Mental Health Act, 2nd Ed. RCPsych Publications, London.
- Brindle N, Branton T, Standfield A, Zigmond T (2013) A clinician's brief guide to Mental Capacity Act, RCPsych Publications, London.
- DoH Code of Practice Mental Health Act 1983 (2008) TSO, London.

- David A, Fleminger S, Michael K, Lovestone S , Mellers J (2009) Lishman's Organic Psychiatry: A Textbook of Neuropsychiatry, 4th Ed. Wiley-Blackwell, London.
- Lloyd G and Guthrie E (Eds) 2012 Handbook of Liaison Psychiatry. Cambridge Medicine.
- Guthrie E and Creed F (Eds) 1996. Seminars in Liaison Psychiatry. College Seminar Series. Gaskell. London.