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PSY 605

TUTORIAL AND SEMINAR IN PSYCHIATRY

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Course code: PSY 605

Course title: Tutorial and Seminar in Psychiatry

Course credit load: 1 Unit

Series 1: Tutorial and Seminar Foundations: Psychiatric Assessment and Core Competencies

- **Part 1.1: Foundations and History of Psychiatry**
    - Sub Part 1.1.1: Historical milestones in psychiatry
    - Sub Part 1.1.2: Aetiological factors in psychiatric disorders
    - Sub Part 1.1.3: Classification of psychiatric disorders: ICD and DSM
- **Part 1.2: Psychiatric Assessment Skills**
    - Sub Part 1.2.1: History taking in psychiatry
    - Sub Part 1.2.2: Mental state examination
    - Sub Part 1.2.3: Physical examination and psychological assessment in psychiatry
- **Part 1.3: Ethics and Core Competencies in Clinical Practice**
    - Sub Part 1.3.1: Principles of medical ethics in psychiatry
    - Sub Part 1.3.2: Interview technique in emergency and general practice settings
    - Sub Part 1.3.3: Must-know competencies for tutorial and seminar teaching

Introduction

A tutorial is only as strong as the foundation it builds on. This opening Series of **Tutorial and Seminar in Psychiatry** revisits the essential groundwork from earlier courses, the history and classification of psychiatry, core assessment skills, and the ethics and competencies every trainee must carry into clinical teaching.

The aim of this Series is to consolidate your understanding of the historical and classificatory foundations of psychiatry, psychiatric assessment skills, and the ethical principles and core competencies that underpin sound clinical teaching and practice.

This Series opens with the **foundations and history of psychiatry**, moves to **psychiatric assessment skills**, and closes with **ethics and core competencies in clinical practice**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 1.1:** illustrate milestones in the historical development of psychiatry
- **SLO 1.2:** list factors and hypotheses in the causation of mental illness, and apply ICD and DSM in classifying mental disorders
- **SLO 1.3:** describe the components of psychiatric history taking and the mental state examination
- **SLO 1.4:** describe physical examination and psychological assessment in psychiatry
- **SLO 1.5:** explain the application of principles of medical ethics in psychiatry
- **SLO 1.6:** describe interview technique in emergency and general practice settings, and identify must-know competencies for clinical teaching

1.1 Foundations and History of Psychiatry

1.1.1 historical milestones in psychiatry

From moral treatment to modern classification

Psychiatry developed through several distinct eras, moving from early moral treatment reforms that replaced restraint with humane asylum care, through the emergence of descriptive psychopathology in the nineteenth century, to the biological and pharmacological advances of the twentieth century that transformed treatment options.

Key milestones include the introduction of the first effective antipsychotic medication in the 1950s, the development of structured diagnostic classification systems, and the more recent shift towards community-based and biopsychosocial models of care, each reshaping how psychiatric illness is understood and treated.

Fill in the blank: Early moral treatment reforms replaced restraint with humane _____ care.

1.1.2 aetiological factors in psychiatric disorders

Biological, psychological, and social contributions

Aetiological factors in psychiatric disorders are generally understood through a biopsychosocial framework, encompassing genetic vulnerability and neurochemical factors, psychological factors such as early attachment and cognitive style, and social factors including adverse life events and socioeconomic circumstances.

No single factor typically explains a psychiatric disorder in isolation, and clinical teaching emphasises that most conditions arise from an interaction between predisposing vulnerability and precipitating stress, a distinction useful for both diagnosis and management planning.

Fill in the blank: Most psychiatric disorders arise from an interaction between predisposing vulnerability and _____ stress.

1.1.3 classification of psychiatric disorders: icd and dsm

Two parallel diagnostic systems

The **ICD** and **DSM** are the two major classification systems used in psychiatry, both organising disorders into categories based on defined symptom criteria. The ICD is published by the World Health Organization and used globally, while the DSM is published by the American Psychiatric Association and widely used in research and North American practice.

Both systems undergo periodic revision to reflect advancing evidence, and while their criteria are broadly aligned, subtle differences exist that trainees must be aware of, particularly when interpreting research literature or working across settings that use different systems.

Fill in the blank: The ICD is published by the World Health _____ and used globally.

Figure 1.1: A historic asylum ward from the era of moral treatment reform.

Pilot questions 1.1

1. Describe one milestone in the historical development of psychiatry. (Linked to SLO 1.1)
2. Explain the shift from moral treatment to modern classification. (Linked to SLO 1.1)
3. List the three domains of the biopsychosocial framework. (Linked to SLO 1.2)
4. Distinguish predisposing from precipitating factors. (Linked to SLO 1.2)
5. Distinguish the ICD from the DSM. (Linked to SLO 1.2)

1.2 Psychiatric Assessment Skills

1.2.1 history taking in psychiatry

A structured, comprehensive clinical narrative

Psychiatric history taking follows a structured format covering the presenting complaint, history of presenting illness, past psychiatric and medical history, family history, personal and social history, and a systematic review of relevant symptoms, building a comprehensive picture of the patient's difficulties in context.

Effective history taking requires both structured questioning and open, empathic listening, since rigid adherence to a checklist can miss important spontaneous disclosures, while purely open interviewing risks missing essential diagnostic detail.

Fill in the blank: Psychiatric history taking requires both structured questioning and open, _____ listening.

1.2.2 mental state examination

A structured snapshot of current mental functioning

The **mental state examination** systematically assesses appearance and behaviour, speech, mood and affect, thought form and content, perception, cognition, and insight, providing a structured snapshot of the patient's current mental functioning independent of the history.

Unlike the history, which covers the patient's past, the mental state examination reflects the clinician's direct observations and findings at the time of assessment, and the two together form the core evidence base for psychiatric diagnosis.

Fill in the blank: The mental state examination reflects the clinician's direct observations at the time of _____.

1.2.3 physical examination and psychological assessment in psychiatry

Complementary sources of clinical evidence

Physical examination remains essential in psychiatric assessment to identify or exclude medical causes of presenting symptoms, and **psychological assessment**, including neuropsychological, cognitive, behavioural, and personality assessment, adds structured, standardised evidence beyond clinical interview alone.

Together these complementary sources of evidence strengthen diagnostic confidence, particularly in complex presentations where interview findings alone may be ambiguous or where an underlying medical or neurocognitive contribution is suspected.

Fill in the blank: Physical examination helps identify or exclude _____ causes of presenting psychiatric symptoms.

Table 1.1: Comparing history, mental state examination, and psychological assessment

Component	Time frame	Primary source
History	Past and background	Patient and informant report
Mental state examination	Present, at time of assessment	Clinician observation
Psychological assessment	Structured, standardised	Formal testing instruments

Pilot questions 1.2

1. List the components of a psychiatric history. (Linked to SLO 1.3)
2. Explain why both structured and open interviewing matter in history taking. (Linked to SLO 1.3)
3. List the domains assessed in a mental state examination. (Linked to SLO 1.3)
4. Distinguish the mental state examination from the history. (Linked to SLO 1.4)
5. Explain the value of psychological assessment alongside clinical interview. (Linked to SLO 1.4)

1.3 Ethics and Core Competencies in Clinical Practice

1.3.1 principles of medical ethics in psychiatry

Four principles applied to psychiatric care

The four core principles of medical ethics, **autonomy**, **beneficence**, **non-maleficence**, and **justice**, apply directly to psychiatric practice, though psychiatry raises particular tension around autonomy when a patient's capacity is affected by their mental disorder.

Confidentiality, informed consent, and the careful use of compulsory treatment powers where legally permitted are recurring ethical considerations in psychiatric practice, each requiring the clinician to balance the patient's rights against genuine risk of harm.

Fill in the blank: The four core principles of medical ethics are autonomy, beneficence, non-maleficence, and _____.

1.3.2 interview technique in emergency and general practice settings

Adapting technique to context and time pressure

Interview technique must adapt to context: emergency settings demand a rapid, focused assessment prioritising immediate risk and safety, while general practice settings allow a more extended, exploratory interview building rapport over potentially several consultations.

In both settings, empathic communication remains essential, since a rushed or dismissive manner can undermine trust and reduce the accuracy of information gathered, regardless of how limited the available time may be.

Fill in the blank: Emergency interview technique prioritises immediate risk and _____.

1.3.3 must-know competencies for tutorial and seminar teaching

What every trainee should be able to demonstrate

Must-know competencies for tutorial and seminar teaching include accurate history taking and mental state examination, safe risk assessment, sound differential diagnosis reasoning, and clear, structured case presentation, skills that underpin performance across every psychiatric subspecialty.

Tutorial and seminar teaching reinforces these competencies through case-based discussion, structured feedback, and repeated practice, ensuring that trainees can apply theoretical knowledge confidently and safely in real clinical encounters.

Fill in the blank: Must-know competencies include safe risk assessment and clear, structured case _____.

Figure 1.2: Trainees engaged in case-based tutorial discussion with a facilitator.

Pilot questions 1.3

1. List the four core principles of medical ethics. (Linked to SLO 1.5)
2. Explain the ethical tension around autonomy in psychiatric practice. (Linked to SLO 1.5)
3. Describe how interview technique differs between emergency and general practice settings. (Linked to SLO 1.6)
4. List the must-know competencies for tutorial and seminar teaching. (Linked to SLO 1.6)
5. Explain how case-based discussion reinforces core competencies. (Linked to SLO 1.6)

Series Summary

This opening Series set out to consolidate the essential groundwork for tutorial and seminar teaching in psychiatry. Part 1.1 covered the historical and aetiological foundations of psychiatry along with the ICD and DSM classification systems, while Part 1.2 turned to core assessment skills, history taking, the mental state examination, and physical and psychological assessment. Part 1.3 closed with the ethical principles and must-know competencies underpinning safe clinical practice.

You should now be able to illustrate key milestones in psychiatric history, describe classification systems and core assessment skills, and explain the ethical principles and competencies expected of every trainee, meeting the outcomes set for this Series. Series 2 turns next to tutorial and seminar teaching in mood, psychotic, and anxiety disorders.

Glossary of Terms

- **Aetiological factors:** biological, psychological, and social contributors to psychiatric disorder.
- **Autonomy:** the ethical principle respecting a patient's right to make their own decisions.
- **Biopsychosocial framework:** a model explaining illness through biological, psychological, and social factors.
- **Confidentiality:** the ethical and professional obligation to protect patient information.
- **DSM:** the Diagnostic and Statistical Manual of Mental Disorders, a major classification system.
- **History taking:** structured gathering of a patient's background and presenting difficulties.

- **ICD:** the International Statistical Classification of Diseases, a major classification system.
- **Informed consent:** voluntary agreement to treatment based on adequate understanding.
- **Mental state examination:** a structured assessment of a patient's current mental functioning.
- **Non-maleficence:** the ethical principle of avoiding harm to the patient.
- **Precipitating factor:** an event or stressor that triggers the onset of a disorder.
- **Predisposing factor:** an underlying vulnerability that increases risk of a disorder.

Concept Check Questions [Series 1]

Objective questions

1. Early moral treatment reforms replaced restraint with humane _____ care. (Linked to SLO 1.1)
2. The ICD is published by the World Health _____ and used globally. (Linked to SLO 1.2)
3. The mental state examination reflects the clinician's direct observations at the time of _____. (Linked to SLO 1.3)
4. The four core principles of medical ethics are autonomy, beneficence, non-maleficence, and _____. (Linked to SLO 1.5)
5. Emergency interview technique prioritises immediate risk and _____. (Linked to SLO 1.6)

Short-answer questions

6. Distinguish predisposing from precipitating factors. (Linked to SLO 1.2)
7. List the components of a psychiatric history. (Linked to SLO 1.3)
8. Distinguish the mental state examination from the history. (Linked to SLO 1.4)
9. Explain the ethical tension around autonomy in psychiatric practice. (Linked to SLO 1.5)
10. List two must-know competencies for tutorial and seminar teaching. (Linked to SLO 1.6)

Long-answer questions

11. Discuss key milestones in the historical development of psychiatry and the biopsychosocial framework for aetiology. (Linked to SLO 1.1, 1.2)
12. Compare the ICD and DSM classification systems. (Linked to SLO 1.2)
13. Describe the components of psychiatric history taking and the mental state examination. (Linked to SLO 1.3)

14. Discuss the role of physical examination and psychological assessment in psychiatry. (Linked to SLO 1.4)
15. Discuss the principles of medical ethics, interview technique across settings, and must-know competencies for clinical teaching. (Linked to SLO 1.5, 1.6)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Asylum.
2. Organization.
3. Assessment.
4. Justice.
5. Safety.

Short-answer questions

6. Predisposing factors are underlying vulnerabilities, while precipitating factors are events or stressors that trigger onset.
7. The psychiatric history covers presenting complaint, history of presenting illness, past history, family history, personal and social history, and systems review.
8. The mental state examination reflects present-moment observations, while the history covers the patient's past.
9. Autonomy can be limited when a patient's capacity is affected by their mental disorder, creating tension with beneficence.
10. Must-know competencies include accurate history taking and safe risk assessment.

Long-answer questions

11. **Basic response:** Psychiatry moved from moral treatment through descriptive psychopathology to biological and pharmacological advances; aetiology is understood through biological, psychological, and social factors interacting together.

    Value-added response: A value-added response notes that most disorders reflect an interaction between predisposing vulnerability and precipitating stress, rather than a single isolated cause.

12. **Basic response:** The ICD is published by the World Health Organization and used globally; the DSM is published by the American Psychiatric Association and widely used in research and North American practice.

Value-added response: A value-added response notes that both undergo periodic revision and remain broadly aligned, though subtle criteria differences matter when interpreting research literature.

13. **Basic response:** History taking covers presenting complaint, past history, family history, and social history; the mental state examination covers appearance, speech, mood, thought, perception, cognition, and insight.

    Value-added response: A value-added response notes that effective history taking balances structured questioning with open, empathic listening to avoid missing spontaneous disclosures.

14. **Basic response:** Physical examination excludes medical causes of symptoms; psychological assessment adds structured, standardised evidence through neuropsychological, cognitive, behavioural, and personality testing.

    Value-added response: A value-added response notes that both are particularly valuable in complex presentations where interview findings alone are ambiguous.

15. **Basic response:** The four ethical principles are autonomy, beneficence, non-maleficence, and justice; interview technique adapts to emergency versus general practice settings; must-know competencies include history taking, risk assessment, and case presentation.

    Value-added response: A value-added response notes that empathic communication remains essential across all settings regardless of time pressure, and that tutorial teaching reinforces competencies through repeated case-based practice.

Answers to Pilot Questions [Series 1]

Part 1.1

1. The introduction of the first effective antipsychotic medication in the 1950s is a key historical milestone.
2. Psychiatry moved from restraint-based asylum care towards structured, evidence-based diagnostic classification.
3. The three domains are biological, psychological, and social factors.
4. Predisposing factors are underlying vulnerabilities, while precipitating factors trigger onset.

5. The ICD is published by the World Health Organization; the DSM is published by the American Psychiatric Association.

Part 1.2

1. A psychiatric history includes presenting complaint, past history, family history, and social history.
2. Structured questioning ensures diagnostic completeness, while open listening captures spontaneous disclosures.
3. Domains include appearance, speech, mood, thought, perception, cognition, and insight.
4. The mental state examination reflects present-moment findings, while the history covers the past.
5. Psychological assessment adds standardised evidence that strengthens diagnostic confidence beyond interview alone.

Part 1.3

1. The four principles are autonomy, beneficence, non-maleficence, and justice.
2. A patient's capacity may be affected by their mental disorder, creating tension between respecting autonomy and preventing harm.
3. Emergency interviews are rapid and risk-focused, while general practice interviews are more extended and exploratory.
4. Competencies include history taking, mental state examination, risk assessment, differential diagnosis, and case presentation.
5. Case-based discussion allows repeated, structured practice that builds confidence in applying theoretical knowledge safely.

References and Attributions [Series 1]

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- World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.
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Course code: PSY 605

Course title: Tutorial and Seminar in Psychiatry

Course credit load: 1 Unit

Series 3: Tutorial and Seminar in Substance Use, Personality Disorders, and Psychopharmacology

- **Part 3.1: Substance Use and Addictive Disorders**
    - Sub Part 3.1.1: Principles of substance use history and screening
    - Sub Part 3.1.2: Intoxication and withdrawal across common substances
    - Sub Part 3.1.3: Typical presentations of substance use disorders in clinical settings
- **Part 3.2: Personality Disorders**
    - Sub Part 3.2.1: Concepts and relevance of personality traits and disorders
    - Sub Part 3.2.2: Cluster A and cluster B personality disorders
    - Sub Part 3.2.3: Cluster C personality disorders and personality change due to another medical condition
- **Part 3.3: Clinical Psychopharmacology**
    - Sub Part 3.3.1: Principles of rational prescribing
    - Sub Part 3.3.2: Major psychotropic drug classes
    - Sub Part 3.3.3: Adverse drug reactions and special prescribing considerations

Introduction

A patient smelling of alcohol, a young adult with a fixed and inflexible way of relating to the world, a prescription that needs careful titration, these are everyday tutorial scenarios that test how well theory translates into safe practice. This Series returns to **substance use, personality disorders, and clinical psychopharmacology**, three areas where getting the history, the diagnosis, and the prescription right genuinely changes outcomes for patients. Each topic draws directly on foundational teaching from earlier courses, but this Series reframes that material

through the lens of tutorial and seminar discussion, sharpening the practical skills trainees are expected to demonstrate.

The aim of this Series is to consolidate your understanding of substance use history taking and the clinical features of intoxication and withdrawal, the concepts underlying personality traits and disorders across the three recognised clusters, and the principles of rational psychotropic prescribing, including the major drug classes and the factors relevant to safe, ongoing pharmacotherapy. Together these three areas represent some of the most frequently tested and most clinically consequential domains in general psychiatric practice, making them a natural focus for structured tutorial revision.

This Series opens with **substance use and addictive disorders**, moves to **personality disorders**, and closes with **clinical psychopharmacology**, building from history-taking and diagnostic skills through to the pharmacological knowledge that underpins day-to-day prescribing decisions.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 3.1:** explain how to obtain a thorough substance use history through empathic, non-judgemental interviewing techniques and established screening instruments
- **SLO 3.2:** list the clinical features of intoxication and withdrawal across commonly encountered substances
- **SLO 3.3:** enumerate typical presentations of substance use disorders in general medical and psychiatric clinical settings
- **SLO 3.4:** discuss the concepts and relevance of personality traits and disorders, and list the three-cluster conceptualisation of personality disorders
- **SLO 3.5:** discuss common psychotropic medications with regard to clinical indications, mechanisms of action, and adverse effects
- **SLO 3.6:** enumerate the factors relevant to implementing, monitoring, and discontinuing psychotropic pharmacotherapy

3.1 Substance Use and Addictive Disorders

3.1.1 principles of substance use history and screening

Building trust before gathering detail

Taking a **substance use history** well depends less on the specific questions asked and more on the manner in which they are asked, since patients frequently anticipate judgement and respond to perceived criticism with minimisation or outright denial. An **empathic, non-judgemental interviewing** style, beginning with open questions before narrowing to specifics, creates the conditions under which a patient is more likely to disclose accurately. Establishing rapport early, normalising the discussion as a routine part of comprehensive assessment, and avoiding moralising language all contribute meaningfully to the quality of information obtained.

Structured **screening instruments**, such as brief standardised questionnaires covering quantity, frequency, and associated harms, complement clinical interview by offering a consistent, validated starting point that can be repeated over time to track change. These instruments are particularly useful in busy general medical settings where time constraints limit the scope of open-ended history taking, allowing at-risk patients to be identified efficiently before a more detailed assessment is pursued. Screening should be considered a routine part of general psychiatric and medical assessment rather than reserved only for patients who volunteer concern about their own use.

Fill in the blank: An empathic, non-judgemental interviewing style helps counter patients' tendency towards _____ or denial.

3.1.2 intoxication and withdrawal across common substances

Recognising substance-specific clinical patterns

Intoxication and **withdrawal** present with characteristic, substance-specific clinical patterns that trainees must be able to recognise rapidly, since accurate identification directly shapes emergency management. Alcohol intoxication produces disinhibition, slurred speech, and incoordination, while alcohol withdrawal presents with tremor, autonomic hyperactivity, and, in severe cases, seizures or delirium. Opiate intoxication causes sedation and pinpoint pupils, while opiate withdrawal produces a strikingly different picture of agitation, dilated pupils, and marked physical discomfort without being immediately life-threatening in most uncomplicated cases.

Benzodiazepine withdrawal, like alcohol withdrawal, carries genuine seizure risk and must be managed with a structured tapering approach rather than abrupt cessation, whereas cannabis intoxication and withdrawal are generally less severe but can still produce marked anxiety or, in some presentations, transient psychotic symptoms. Stimulant intoxication, covering cocaine and amphetamines, produces elevated mood, increased energy, and cardiovascular strain, while stimulant withdrawal typically presents as a crash into low mood and fatigue rather than a dangerous physiological state. Recognising these substance-specific patterns, rather than treating

all presentations as interchangeable, is essential for both accurate diagnosis and appropriately targeted management.

Fill in the blank: Alcohol withdrawal carries genuine _____ risk and can progress to delirium if untreated.

3.1.3 typical presentations of substance use disorders in clinical settings

How substance use disorders actually present

Substance use disorders present differently across general medical and psychiatric clinical settings, and trainees are often surprised by how rarely a patient presents with an explicit statement of substance-related concern. In general medical settings, substance use disorder more commonly presents indirectly, through recurrent injuries, unexplained gastrointestinal or hepatic complaints, poorly controlled chronic disease, or a pattern of missed appointments and erratic engagement with care. In psychiatric settings, substance use disorder frequently coexists with another primary psychiatric diagnosis, complicating the clinical picture and sometimes masking or mimicking symptoms of the coexisting disorder.

Recognising these typical, often indirect, presentations requires a degree of clinical suspicion that goes beyond waiting for a patient to raise the issue themselves, and routine screening across settings helps counter the tendency to overlook substance use as a contributing factor. Because comorbid substance use and psychiatric illness, sometimes referred to as dual diagnosis, complicates both diagnosis and treatment response, an integrated approach addressing both conditions together generally produces better outcomes than treating either in isolation.

Fill in the blank: Comorbid substance use and psychiatric illness is sometimes referred to as _____ diagnosis.

Figure 3.1: A clinician taking a substance use history from a patient empathically.

Pilot questions 3.1

- Explain why an empathic, non-judgemental approach improves the accuracy of substance use history taking. (Linked to SLO 3.1)
- Describe the value of structured screening instruments in busy clinical settings. (Linked to SLO 3.1)
- Compare the clinical features of alcohol and opiate withdrawal. (Linked to SLO 3.2)
- Explain why benzodiazepine withdrawal requires a structured tapering approach. (Linked to SLO 3.2)
- Describe how substance use disorder often presents indirectly in general medical settings. (Linked to SLO 3.3)

3.2 Personality Disorders

3.2.1 concepts and relevance of personality traits and disorders

When enduring traits become a genuine disorder

Personality traits are enduring patterns of thinking, feeling, and relating that remain relatively stable across a person's life and across different situations, and everyone possesses a personality shaped by this stable pattern of traits. A **personality disorder** is diagnosed only when these traits become genuinely inflexible and pervasive across essentially every context, causing significant distress to the individual or meaningful impairment in their social and occupational functioning, distinguishing disorder from the ordinary variation in personality seen across the general population.

Personality disorders carry direct relevance to clinical care well beyond their own diagnostic criteria, since they shape how a patient engages with treatment, relates to the therapeutic relationship, and responds to stress within the clinical encounter itself. Recognising an underlying personality disorder, or even significant personality traits falling short of full diagnostic threshold, helps clinicians anticipate difficulties in engagement and adapt their communication and management approach accordingly, rather than being caught off guard by patterns of behaviour that are, in fact, entirely predictable once the underlying personality structure is understood.

Fill in the blank: A personality disorder is diagnosed when traits become genuinely inflexible and _____ across essentially every context.

3.2.2 cluster a and cluster b personality disorders

Odd, eccentric, and dramatic presentations

Cluster A personality disorders, comprising paranoid, schizoid, and schizotypal personality disorder, share an odd or eccentric quality, with patients displaying pervasive suspiciousness, social detachment, or unusual beliefs and perceptual experiences that fall short of frank psychosis. Patients with cluster A traits often struggle with trust in the therapeutic relationship itself, making a calm, consistent, and non-intrusive clinical approach particularly important when engaging with this group.

Cluster B personality disorders, comprising antisocial, borderline, histrionic, and narcissistic personality disorder, share a dramatic, emotional, or erratic quality. Antisocial personality disorder involves disregard for the rights of others, borderline personality disorder involves instability in relationships, self-image, and affect alongside marked impulsivity, histrionic personality disorder involves excessive emotionality and attention-seeking, and narcissistic personality disorder involves grandiosity and a pervasive need for admiration. Cluster B presentations are frequently encountered in emergency and crisis settings, given the intensity of affect and behaviour that characterises this cluster.

Fill in the blank: Cluster B personality disorders share a dramatic, emotional, or _____ quality.

3.2.3 cluster c personality disorders and personality change due to another medical condition

Anxious presentations and secondary personality change

Cluster C personality disorders, comprising avoidant, dependent, and obsessive-compulsive personality disorder, share an anxious or fearful quality. Avoidant personality disorder involves pervasive social inhibition driven by fear of criticism, dependent personality disorder involves an excessive need to be cared for leading to submissive and clinging behaviour, and obsessive-compulsive personality disorder involves preoccupation with orderliness, control, and perfectionism, distinct from obsessive-compulsive disorder itself despite the similar name.

Personality change due to another medical condition describes a persistent alteration in personality directly attributable to the physiological effects of a medical condition, such as significant traumatic brain injury or a neurodegenerative disease, rather than a primary personality disorder that developed independently of any medical cause. Distinguishing this secondary personality change from a lifelong primary personality disorder requires careful attention to the timing of onset relative to the medical event, since a personality shift emerging clearly after a specific neurological insult points strongly towards a secondary, medically caused process rather than an enduring developmental pattern.

Fill in the blank: Obsessive-compulsive personality disorder involves preoccupation with orderliness, control, and _____.

Table 3.1: The three-cluster conceptualisation of personality disorders

Cluster	Quality	Example disorders
Cluster A	Odd or eccentric	Paranoid, schizoid, schizotypal
Cluster B	Dramatic or erratic	Antisocial, borderline, histrionic, narcissistic
Cluster C	Anxious or fearful	Avoidant, dependent, obsessive-compulsive

Pilot questions 3.2

1. Distinguish a personality trait from a personality disorder. (Linked to SLO 3.4)
2. Explain why personality disorders carry relevance beyond their own diagnostic criteria. (Linked to SLO 3.4)
3. List the disorders within cluster A. (Linked to SLO 3.4)
4. Describe the core feature of borderline personality disorder. (Linked to SLO 3.4)
5. Distinguish personality change due to another medical condition from a primary personality disorder. (Linked to SLO 3.4)

3.3 Clinical Psychopharmacology

3.3.1 principles of rational prescribing

Matching medication choice to the individual patient

Rational prescribing in psychiatry begins with a clear diagnostic formulation and an explicit treatment goal, since starting a medication without a specific target symptom or outcome in mind makes it difficult to judge whether treatment is actually working. Selection among medications within a class should account for the individual patient's symptom profile, comorbidities, prior treatment response, side effect tolerability, and, where relevant, cost and access, rather than defaulting reflexively to the most familiar agent regardless of fit.

Good prescribing practice also involves starting at an appropriate dose, titrating gradually while monitoring both response and side effects, and reviewing regularly rather than prescribing indefinitely without reassessment. Trainees are expected to understand not just which medication to choose but why, including the presumed mechanism of action underlying the choice, since this understanding supports better troubleshooting when a patient does not respond as expected or develops an unanticipated adverse effect.

Fill in the blank: Rational prescribing begins with a clear diagnostic formulation and an explicit treatment _____.

3.3.2 major psychotropic drug classes

A working knowledge of each major class

The major **psychotropic drug classes** include antipsychotics, used for psychotic disorders and, in some cases, mood stabilisation, anticonvulsants and mood stabilisers, used in bipolar disorder, antidepressants, used across depressive and anxiety disorders, and anxiolytics and hypnotics, used for short-term management of anxiety and insomnia given their potential for dependence with prolonged use. Cognitive enhancers and drugs used in dementia target neurocognitive decline, while stimulants are used primarily in attention-deficit/hyperactivity disorder, and drugs used in substance dependence support withdrawal management and relapse prevention across different substances.

For each class, trainees are expected to know the clinical indications, common and adverse effects, and broad pharmacokinetic principles relevant to safe prescribing, including how onset of action, half-life, and metabolism influence dosing and monitoring decisions. This breadth of knowledge across classes, rather than deep expertise in a single drug, is what tutorial and seminar teaching in this area aims to consolidate, since general psychiatric practice requires comfort prescribing across the full spectrum of common presentations.

Fill in the blank: Anxiolytics and hypnotics carry potential for _____ with prolonged use.

3.3.3 adverse drug reactions and special prescribing considerations

Safety monitoring and vulnerable prescribing scenarios

Adverse drug reactions range from common, tolerable side effects that resolve with time or dose adjustment to rare but serious reactions requiring immediate discontinuation and urgent management, and trainees must be able to distinguish between the two categories confidently in a clinical encounter. Systematic monitoring, including relevant baseline and follow-up investigations for certain drug classes, forms an essential part of safe long-term prescribing rather than an optional addition to routine care.

Special prescribing considerations include pregnancy, where the risks and benefits of continuing or changing medication must be weighed carefully against the risks of untreated illness itself, since relapse during pregnancy carries its own significant risks to both mother and fetus. The factors relevant to implementing, monitoring, and eventually discontinuing psychotropic pharmacotherapy, including gradual tapering to minimise discontinuation symptoms and close follow-up during any medication change, together form a core competency every trainee is expected to demonstrate by the end of general psychiatric training.

Fill in the blank: Relapse during pregnancy carries its own significant risks to both mother and _____.

Figure 3.2: A psychiatrist reviewing a patient's medication chart during a follow-up consultation.

Pilot questions 3.3

1. Describe the key elements of rational prescribing. (Linked to SLO 3.5)
2. List the major psychotropic drug classes. (Linked to SLO 3.5)
3. Explain why pharmacokinetic knowledge matters for safe prescribing. (Linked to SLO 3.5)
4. Describe the special prescribing considerations relevant to pregnancy. (Linked to SLO 3.6)
5. Explain why gradual tapering matters when discontinuing psychotropic medication. (Linked to SLO 3.6)

Series Summary

This Series revisited three practically demanding areas of general psychiatric practice. Part 3.1 covered substance use history taking, the clinical patterns of intoxication and withdrawal, and typical presentations of substance use disorder across settings, while Part 3.2 turned to the concepts underlying personality traits and disorders and the three-cluster conceptualisation. Part 3.3 closed with the principles of rational prescribing, the major psychotropic drug classes, and adverse drug reactions and special prescribing considerations.

You should now be able to obtain a substance use history using empathic technique, recognise the clinical features of intoxication and withdrawal, discuss personality disorders across the three clusters, and prescribe rationally across the major psychotropic drug classes, meeting the outcomes set for this Series. Series 4 turns next to tutorial and seminar teaching in child, geriatric, and subspecialty psychiatric disorders.

Glossary of Terms

1. **Antisocial personality disorder:** a cluster B disorder marked by disregard for the rights of others.
2. **Avoidant personality disorder:** a cluster C disorder marked by social inhibition driven by fear of criticism.
3. **Borderline personality disorder:** a cluster B disorder marked by instability in relationships, self-image, and affect.
4. **Dual diagnosis:** the coexistence of a substance use disorder and another psychiatric diagnosis.
5. **Intoxication:** the acute clinical state produced by recent use of a psychoactive substance.
6. **Personality change due to another medical condition:** personality alteration attributable to a medical condition.
7. **Personality disorder:** inflexible, pervasive personality traits causing distress or functional impairment.
8. **Rational prescribing:** medication selection guided by diagnosis, evidence, and individual patient factors.
9. **Schizotypal personality disorder:** a cluster A disorder marked by unusual beliefs and perceptual experiences.
10. **Screening instrument:** a standardised tool used to identify at-risk substance use efficiently.
11. **Titration:** the gradual adjustment of medication dose to achieve optimal response with minimal side effects.

12. **Withdrawal:** the clinical syndrome following reduction or cessation of a substance after regular use.

Concept Check Questions [Series 3]

Objective questions

1. An empathic, non-judgemental interviewing style helps counter patients' tendency towards _____ or denial. (Linked to SLO 3.1)
2. Alcohol withdrawal carries genuine _____ risk and can progress to delirium if untreated. (Linked to SLO 3.2)
3. A personality disorder is diagnosed when traits become genuinely inflexible and _____ across essentially every context. (Linked to SLO 3.4)
4. Cluster B personality disorders share a dramatic, emotional, or _____ quality. (Linked to SLO 3.4)
5. Anxiolytics and hypnotics carry potential for _____ with prolonged use. (Linked to SLO 3.5)

Short-answer questions

- Describe the value of structured screening instruments in busy clinical settings. (Linked to SLO 3.1)
- Compare the clinical features of alcohol and opiate withdrawal. (Linked to SLO 3.2)
- List the disorders within cluster A. (Linked to SLO 3.4)
- Describe the core feature of borderline personality disorder. (Linked to SLO 3.4)
- List the major psychotropic drug classes. (Linked to SLO 3.5)

Long-answer questions

1. Discuss the principles of substance use history taking and the clinical features of intoxication and withdrawal across common substances. (Linked to SLO 3.1, 3.2)
2. Describe how substance use disorders present in general medical and psychiatric clinical settings. (Linked to SLO 3.3)
3. Discuss the concepts underlying personality traits and disorders and the three-cluster conceptualisation. (Linked to SLO 3.4)
4. Discuss the principles of rational prescribing and the major psychotropic drug classes. (Linked to SLO 3.5)
5. Discuss adverse drug reactions and the factors relevant to implementing, monitoring, and discontinuing psychotropic pharmacotherapy. (Linked to SLO 3.6)

Answers to Concept Check Questions [Series 3]

Objective questions

6. Minimisation.
7. Seizure.
8. Pervasive.
9. Erratic.
10. Dependence.

Short-answer questions

11. Screening instruments offer a consistent, validated starting point that identifies at-risk patients efficiently within limited consultation time.
12. Alcohol withdrawal presents with tremor and autonomic hyperactivity with seizure risk, while opiate withdrawal presents with agitation and physical discomfort without being immediately life-threatening.
13. Cluster A includes paranoid, schizoid, and schizotypal personality disorder.
14. Borderline personality disorder involves instability in relationships, self-image, and affect alongside marked impulsivity.
15. The major classes are antipsychotics, mood stabilisers, antidepressants, anxiolytics and hypnotics, cognitive enhancers, and stimulants.

Long-answer questions

16. **Basic response:** Substance use history relies on empathic, non-judgemental interviewing and structured screening; intoxication and withdrawal present with substance-specific patterns, such as alcohol's seizure risk and opiate's agitation without life threat.

    Value-added response: A value-added response notes that recognising these patterns rapidly directly shapes emergency management decisions and prevents misattribution between substances.

17. **Basic response:** In general medical settings, substance use disorder presents indirectly through recurrent injuries or poorly controlled disease; in psychiatric settings it frequently coexists with another diagnosis as dual diagnosis.

    Value-added response: A value-added response notes that an integrated approach addressing both conditions together produces better outcomes than treating either in isolation.

18. **Basic response:** Personality traits become a disorder when inflexible and pervasive, causing distress or impairment; the three clusters are odd or eccentric, dramatic or erratic, and anxious or fearful.

    Value-added response: A value-added response notes that recognising personality disorder helps clinicians anticipate engagement difficulties and adapt their communication approach accordingly.

19. **Basic response:** Rational prescribing requires a clear diagnostic formulation and explicit treatment goal; major classes include antipsychotics, mood stabilisers, antidepressants, anxiolytics, cognitive enhancers, and stimulants.

    Value-added response: A value-added response notes that understanding mechanism of action supports better troubleshooting when a patient does not respond as expected.

20. **Basic response:** Adverse reactions range from tolerable to serious requiring discontinuation; special considerations include pregnancy, where risks of treatment must be weighed against risks of untreated illness; discontinuation requires gradual tapering.

    Value-added response: A value-added response notes that relapse during pregnancy carries significant risks to both mother and fetus, making careful risk-benefit weighing essential.

Answers to Pilot Questions [Series 3]

Part 3.1

11. An empathic approach reduces perceived judgement, making patients more likely to disclose accurately rather than minimise.
12. Screening instruments offer a consistent, validated starting point that is efficient within limited consultation time.
13. Alcohol withdrawal presents with tremor and seizure risk, while opiate withdrawal presents with agitation and discomfort without being immediately life-threatening.
14. Benzodiazepine withdrawal carries seizure risk, so abrupt cessation is unsafe and a structured taper is required.
15. Substance use disorder often presents through recurrent injuries, unexplained complaints, or erratic engagement with care rather than explicit disclosure.

Part 3.2

1. A personality trait is a stable pattern present in everyone, while a personality disorder involves inflexible, pervasive traits causing distress or impairment.
2. Personality disorders shape how a patient engages with treatment and the therapeutic relationship, affecting clinical care beyond diagnosis itself.
3. Cluster A includes paranoid, schizoid, and schizotypal personality disorder.
4. Borderline personality disorder involves instability in relationships, self-image, and affect with marked impulsivity.
5. Personality change due to a medical condition has a clear onset following a medical event, unlike a lifelong primary personality disorder.

Part 3.3

6. Rational prescribing requires a clear diagnostic formulation, explicit treatment goal, and individualised medication selection.
7. The major classes include antipsychotics, mood stabilisers, antidepressants, anxiolytics and hypnotics, cognitive enhancers, and stimulants.
8. Pharmacokinetic knowledge, including half-life and metabolism, informs safe dosing and monitoring decisions.
9. In pregnancy, the risks of continuing or changing medication must be weighed against the risks of untreated illness itself.
10. Gradual tapering minimises discontinuation symptoms and allows close monitoring during medication change.

References and Attributions [Series 3]

11. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing.
12. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
13. World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.
14. Stahl, S. M. (2021). Stahl's Essential Psychopharmacology (5th ed.). Cambridge University Press.

Figures, Plates, Tables, and Boxes

1. Figure 3.1: A clinician taking a substance use history from a patient empathically. AI-generated using the prompt: "Create a realistic clinical illustration titled Taking a Substance Use History, showing a clinician and patient seated facing each other in a calm consulting room, clinician listening attentively with an open posture. Clean clinical illustration style, no text."
2. Table 3.1: The three-cluster conceptualisation of personality disorders. AI-generated using the prompt: "Create a clean reference table titled The Three-Cluster Conceptualisation of Personality Disorders, listing cluster, quality, and example disorders. Simple clinical reference table style with outside border."
3. Figure 3.2: A psychiatrist reviewing a patient's medication chart during a follow-up consultation. AI-generated using the prompt: "Create a realistic clinical illustration titled Reviewing a Medication Chart at Follow-Up, showing a psychiatrist seated at a desk reviewing a medication chart with a patient present, attentive consultation atmosphere. Clean clinical illustration style, no text."

Course code: PSY 605

Course title: Tutorial and Seminar in Psychiatry

Course credit load: 1 Unit

Series 2: Tutorial and Seminar in Mood, Psychotic, and Anxiety Disorders

- **Part 2.1: Mood Disorders**
  - Sub Part 2.1.1: Depression
  - Sub Part 2.1.2: Bipolar disorder
  - Sub Part 2.1.3: Other mood disorders
- **Part 2.2: Schizophrenia Spectrum and Psychotic Disorders**
  - Sub Part 2.2.1: Schizophrenia: epidemiology, course, and symptoms
  - Sub Part 2.2.2: Management of schizophrenia
  - Sub Part 2.2.3: Delusional disorder and other psychotic presentations
- **Part 2.3: Anxiety, OCD, and Trauma-Related Disorders**
  - Sub Part 2.3.1: Primary anxiety disorders
  - Sub Part 2.3.2: Obsessive-compulsive and related disorders
  - Sub Part 2.3.3: Trauma and stress-related disorders

Introduction

Low mood, elevated mood, false beliefs, and persistent worry sit among the most common reasons a patient walks into a psychiatric clinic. This Series revisits **mood, psychotic, and anxiety disorders** through a tutorial lens, sharpening the differential diagnosis skills every trainee needs.

The aim of this Series is to consolidate your understanding of mood disorders, schizophrenia spectrum and other psychotic disorders, and anxiety, obsessive-compulsive, and trauma-related disorders, with emphasis on the features that distinguish one from another.

This Series opens with **mood disorders**, moves to **schizophrenia spectrum and psychotic disorders**, and closes with **anxiety, OCD, and trauma-related disorders**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 2.1:** differentiate the features of unipolar and bipolar disorders
- **SLO 2.2:** enumerate the risk of suicide in patients with mood disorders, and describe other mood disorders
- **SLO 2.3:** describe the epidemiology, clinical course, and symptoms of schizophrenia
- **SLO 2.4:** explain management of schizophrenia and differentiate other psychotic disorders
- **SLO 2.5:** list differential diagnosis for patients presenting with anxiety, including primary and secondary anxiety disorders and obsessive-compulsive and related disorders
- **SLO 2.6:** discuss the epidemiology and clinical course of PTSD and other trauma-related disorders

2.1 Mood Disorders

2.1.1 depression

A common, treatable mood disorder

Major depressive disorder presents with persistent low mood or loss of interest, alongside symptoms such as sleep and appetite disturbance, poor concentration, and feelings of worthlessness, present for at least two weeks and causing significant functional impairment.

Suicide risk must be actively assessed in every depressed patient, since mood disorders carry a substantially elevated risk compared with the general population, and risk assessment should directly inform the intensity of the management plan chosen.

Fill in the blank: Depressive symptoms must be present for at least _____ weeks to meet diagnostic threshold.

2.1.2 bipolar disorder

Alternating mood episodes

Bipolar disorder is distinguished from unipolar depression by the presence of at least one manic or hypomanic episode, characterised by elevated or irritable mood, increased energy, reduced need for sleep, and impulsive or risky behaviour, contrasting with the low mood and reduced energy of depressive episodes.

Correctly distinguishing bipolar from unipolar depression matters clinically, since antidepressant monotherapy in bipolar disorder can precipitate a manic episode, making an accurate history of past mood episodes essential before starting treatment.

Fill in the blank: Bipolar disorder is distinguished from unipolar depression by at least one manic or _____ episode.

2.1.3 other mood disorders

Beyond depression and bipolar disorder

Other mood disorders include **dysthymia**, a chronic, low-grade depressive state lasting at least two years, **cyclothymia**, a chronic pattern of mild mood fluctuation, **premenstrual dysphoric disorder**, mood symptoms tied to the menstrual cycle, and **seasonal affective disorder**, depressive episodes following a seasonal pattern.

Recognising these variants matters because their chronicity or cyclical pattern can be mistaken for personality traits or normal mood variation, delaying appropriate treatment for patients who might otherwise benefit significantly from it.

Fill in the blank: Dysthymia is a chronic, low-grade depressive state lasting at least _____ years.

Figure 2.1: A patient displaying withdrawn, low-mood affect during a clinical interview.

Pilot questions 2.1

- List the core symptoms of major depressive disorder. (Linked to SLO 2.1)
- Explain why suicide risk must be actively assessed in depression. (Linked to SLO 2.2)
- Distinguish bipolar disorder from unipolar depression. (Linked to SLO 2.1)
- Explain why misdiagnosing bipolar disorder as unipolar depression is clinically risky. (Linked to SLO 2.1)
- Define seasonal affective disorder. (Linked to SLO 2.2)

2.2 Schizophrenia Spectrum and Psychotic Disorders

2.2.1 schizophrenia: epidemiology, course, and symptoms

A chronic disorder with characteristic symptom clusters

Schizophrenia typically has onset in late adolescence or early adulthood, often preceded by a **prodromal stage** of subtle social withdrawal and functional decline. Symptoms are grouped into positive symptoms, such as hallucinations and delusions, negative symptoms, such as flattened affect and social withdrawal, and cognitive symptoms affecting memory and executive function.

Clinical course is variable, with some patients experiencing a single episode with good recovery and others following a chronic, relapsing pattern, and early, accurate diagnosis meaningfully improves the long-term trajectory of the illness.

Fill in the blank: Positive symptoms of schizophrenia include hallucinations and _____.

2.2.2 management of schizophrenia

A combined pharmacological and psychosocial approach

Management of schizophrenia combines antipsychotic medication, targeting primarily positive symptoms, with psychosocial interventions including family therapy, social skills training, and supported employment, addressing negative and cognitive symptoms that medication alone often does not fully resolve.

Long-term management also requires monitoring for medication side effects, supporting treatment adherence, and early relapse recognition, since untreated relapse carries cumulative risk to both functioning and long-term prognosis.

Fill in the blank: Antipsychotic medication in schizophrenia targets primarily _____ symptoms.

2.2.3 delusional disorder and other psychotic presentations

Psychosis beyond schizophrenia

Delusional disorder is characterised by one or more fixed, false beliefs persisting for at least a month, without the prominent hallucinations, disorganised speech, or negative symptoms typical of schizophrenia, and with relatively preserved functioning outside the delusional belief itself.

Psychotic symptoms can also arise directly from another medical condition, or present as **catatonia**, a syndrome of marked psychomotor disturbance, associated with another mental or medical condition, both requiring careful medical evaluation before attributing symptoms to a primary psychiatric disorder.

Fill in the blank: Delusional disorder involves fixed, false beliefs persisting for at least _____ month.

Table 2.1: Comparing schizophrenia and delusional disorder

Feature	Schizophrenia	Delusional disorder
Hallucinations	Common, prominent	Uncommon or absent
Functioning	Often significantly impaired	Relatively preserved
Belief type	Often bizarre or disorganised	Fixed, non-bizarre delusion

Pilot questions 2.2

1. Describe the prodromal stage of schizophrenia. (Linked to SLO 2.3)
2. List the three symptom clusters of schizophrenia. (Linked to SLO 2.3)
3. Describe the combined approach to managing schizophrenia. (Linked to SLO 2.4)
4. Distinguish delusional disorder from schizophrenia. (Linked to SLO 2.4)
5. Explain why medical evaluation is important before diagnosing catatonia as primary psychiatric. (Linked to SLO 2.4)

2.3 Anxiety, OCD, and Trauma-Related Disorders

2.3.1 primary anxiety disorders

A broad differential requiring careful sorting

Primary anxiety disorders include specific phobia, social phobia, generalised anxiety disorder, agoraphobia, panic disorder, selective mutism, and separation anxiety disorder, each defined by a distinct pattern of feared situations or triggers and the accompanying physiological and cognitive symptoms.

Differential diagnosis must also consider anxiety secondary to another medical condition, such as thyroid disease, or substance use, since treating the primary cause differs fundamentally from treating a primary anxiety disorder with psychotherapy or medication.

Fill in the blank: Differential diagnosis of anxiety must consider anxiety secondary to another medical _____.

2.3.2 obsessive-compulsive and related disorders

Intrusive thoughts and repetitive behaviours

Obsessive-compulsive disorder involves recurrent, intrusive obsessions and repetitive compulsions performed to reduce the anxiety obsessions generate. Related disorders include **body dysmorphic disorder**, preoccupation with perceived appearance flaws, **hoarding disorder**, persistent difficulty discarding possessions, and **trichotillomania**, recurrent hair pulling.

These related disorders share a common thread of repetitive, hard-to-control behaviour aimed at reducing distress, and recognising the OCD-related cluster as a group helps clinicians consider the full differential rather than anchoring on OCD alone.

Fill in the blank: Obsessive-compulsive disorder involves obsessions and repetitive _____ performed to reduce anxiety.

2.3.3 trauma and stress-related disorders

Disorders arising after exposure to trauma or stress

Post-traumatic stress disorder develops following exposure to a traumatic event, presenting with intrusive memories, avoidance, negative alterations in mood and cognition, and hyperarousal, persisting beyond one month, while **acute stress disorder** describes a similar but shorter-duration presentation.

Adjustment disorder describes emotional or behavioural symptoms in response to an identifiable stressor without meeting full criteria for another disorder, and epidemiological studies show trauma and stress-related disorders carry significant comorbidity with depression and substance use, complicating both diagnosis and management.

Fill in the blank: PTSD symptoms must persist beyond _____ month to meet diagnostic threshold.

Figure 2.2: A patient experiencing a distressing flashback during a clinical assessment.

Pilot questions 2.3

1. List the primary anxiety disorders. (Linked to SLO 2.5)
2. Explain why anxiety secondary to a medical condition must be considered in differential diagnosis. (Linked to SLO 2.5)
3. Describe body dysmorphic disorder. (Linked to SLO 2.5)
4. Distinguish PTSD from acute stress disorder. (Linked to SLO 2.6)
5. Describe adjustment disorder. (Linked to SLO 2.6)

Series Summary

This Series revisited three of the most commonly encountered clusters of psychiatric presentation. Part 2.1 covered depression, bipolar disorder, and other mood disorders, while Part 2.2 turned to schizophrenia, its management, and delusional disorder and other psychotic presentations. Part 2.3 closed with primary anxiety disorders, obsessive-compulsive and related disorders, and trauma and stress-related disorders.

You should now be able to differentiate mood disorder presentations, describe the epidemiology and management of schizophrenia, and construct a sound differential diagnosis for anxiety, OCD-related, and trauma-related presentations, meeting the outcomes set for this Series. Series 3 turns next to tutorial and seminar teaching in substance use, personality disorders, and psychopharmacology.

Glossary of Terms

1. **Acute stress disorder:** a trauma-related presentation similar to PTSD but of shorter duration.
2. **Bipolar disorder:** a mood disorder with at least one manic or hypomanic episode.
3. **Body dysmorphic disorder:** preoccupation with perceived flaws in physical appearance.
4. **Catatonia:** a syndrome of marked psychomotor disturbance associated with another condition.
5. **Delusional disorder:** fixed, false beliefs persisting for at least a month with preserved functioning.
6. **Dysthymia:** a chronic, low-grade depressive state lasting at least two years.
7. **Major depressive disorder:** persistent low mood or loss of interest causing significant impairment.
8. **Obsessive-compulsive disorder:** recurrent obsessions and compulsions performed to reduce anxiety.
9. **Prodromal stage:** an early period of subtle decline preceding full psychotic illness.
10. **Schizophrenia:** a chronic psychotic disorder with positive, negative, and cognitive symptoms.
11. **Seasonal affective disorder:** depressive episodes following a seasonal pattern.
12. **Trichotillomania:** recurrent hair pulling resulting in hair loss.

Concept Check Questions [Series 2]

Objective questions

1. Depressive symptoms must be present for at least _____ weeks to meet diagnostic threshold. (Linked to SLO 2.1)
2. Bipolar disorder is distinguished from unipolar depression by at least one manic or _____ episode. (Linked to SLO 2.1)
3. Positive symptoms of schizophrenia include hallucinations and _____. (Linked to SLO 2.3)

4. Delusional disorder involves fixed, false beliefs persisting for at least _____ month. (Linked to SLO 2.4)
5. PTSD symptoms must persist beyond _____ month to meet diagnostic threshold. (Linked to SLO 2.6)

Short-answer questions

- Explain why suicide risk must be actively assessed in depression. (Linked to SLO 2.2)
- Distinguish bipolar disorder from unipolar depression. (Linked to SLO 2.1)
- List the three symptom clusters of schizophrenia. (Linked to SLO 2.3)
- Distinguish delusional disorder from schizophrenia. (Linked to SLO 2.4)
- List the primary anxiety disorders. (Linked to SLO 2.5)

Long-answer questions

1. Discuss depression, bipolar disorder, and other mood disorders, including suicide risk assessment. (Linked to SLO 2.1, 2.2)
2. Describe the epidemiology, clinical course, symptoms, and management of schizophrenia. (Linked to SLO 2.3, 2.4)
3. Compare schizophrenia with delusional disorder and other psychotic presentations. (Linked to SLO 2.4)
4. Discuss the differential diagnosis of anxiety, including primary anxiety disorders and OCD-related disorders. (Linked to SLO 2.5)
5. Discuss the epidemiology and clinical course of PTSD and other trauma-related disorders. (Linked to SLO 2.6)

Answers to Concept Check Questions [Series 2]

Objective questions

6. Two.
7. Hypomanic.
8. Delusions.
9. One.
10. One.

Short-answer questions

11. Mood disorders carry substantially elevated suicide risk compared with the general population, so risk assessment directly informs management intensity.

12. Bipolar disorder involves at least one manic or hypomanic episode, while unipolar depression involves depressive episodes only.
13. The three symptom clusters are positive, negative, and cognitive symptoms.
14. Delusional disorder lacks the prominent hallucinations and negative symptoms of schizophrenia, with relatively preserved functioning.
15. Primary anxiety disorders include specific phobia, social phobia, generalised anxiety disorder, agoraphobia, panic disorder, selective mutism, and separation anxiety disorder.

Long-answer questions

16. **Basic response:** Depression presents with low mood and functional impairment; bipolar disorder adds manic or hypomanic episodes; other mood disorders include dysthymia, cyclothymia, and seasonal affective disorder; suicide risk must be actively assessed given elevated risk.

    Value-added response: A value-added response notes that antidepressant monotherapy can precipitate mania in undiagnosed bipolar disorder, making accurate history essential.

17. **Basic response:** Schizophrenia typically has onset in late adolescence with a prodromal stage, positive, negative, and cognitive symptoms, and variable course; management combines antipsychotic medication with psychosocial interventions.

    Value-added response: A value-added response notes that early, accurate diagnosis meaningfully improves long-term trajectory, and that ongoing monitoring supports adherence and relapse prevention.

18. **Basic response:** Schizophrenia involves prominent hallucinations and impaired functioning, while delusional disorder involves fixed beliefs with preserved functioning; psychotic symptoms can also arise from medical conditions or present as catatonia.

    Value-added response: A value-added response notes that careful medical evaluation is essential before attributing psychotic or catatonic presentations to a primary psychiatric disorder.

19. **Basic response:** Primary anxiety disorders include phobia, generalised anxiety, panic, and separation anxiety; OCD-related disorders include body dysmorphic disorder, hoarding disorder, and trichotillomania, sharing a repetitive, distress-reducing behaviour pattern.

    Value-added response: A value-added response notes that anxiety secondary to medical conditions or substance use must also be considered, since management differs fundamentally from primary anxiety disorder treatment.

20. **Basic response:** PTSD presents with intrusive memories, avoidance, negative mood and cognition changes, and hyperarousal persisting beyond a month; acute stress disorder is shorter in duration; adjustment disorder involves symptoms without meeting full criteria for another disorder.

    Value-added response: A value-added response notes that trauma and stress-related disorders carry significant comorbidity with depression and substance use, complicating diagnosis and management.

Answers to Pilot Questions [Series 2]

Part 2.1

11. Core symptoms include persistent low mood, loss of interest, sleep and appetite disturbance, and poor concentration.
12. Mood disorders carry substantially elevated suicide risk, so risk assessment must directly inform the management plan.
13. Bipolar disorder involves at least one manic or hypomanic episode, unlike unipolar depression.
14. Antidepressant monotherapy can precipitate mania if bipolar disorder is misdiagnosed as unipolar depression.
15. Seasonal affective disorder involves depressive episodes following a seasonal pattern.

Part 2.2

1. The prodromal stage involves subtle social withdrawal and functional decline before full psychotic symptoms emerge.
2. The three clusters are positive, negative, and cognitive symptoms.
3. Management combines antipsychotic medication with psychosocial interventions such as family therapy and social skills training.
4. Delusional disorder lacks prominent hallucinations and has relatively preserved functioning compared with schizophrenia.
5. Medical evaluation excludes an underlying medical cause before catatonia is attributed to a primary psychiatric disorder.

Part 2.3

6. Primary anxiety disorders include specific phobia, social phobia, generalised anxiety disorder, agoraphobia, and panic disorder.
7. Anxiety secondary to a medical condition such as thyroid disease requires treating the underlying cause rather than the anxiety directly.
8. Body dysmorphic disorder is preoccupation with perceived flaws in physical appearance.
9. PTSD persists beyond one month, while acute stress disorder is a shorter-duration presentation.
10. Adjustment disorder involves emotional or behavioural symptoms following an identifiable stressor without meeting full criteria for another disorder.

References and Attributions [Series 2]

11. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing.
12. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
13. World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.
14. Gelder, M., Andrew, P., & Geddes, J. (2012). New Oxford Textbook of Psychiatry (2nd ed.). Oxford University Press.

Figures, Plates, Tables, and Boxes

1. Figure 2.1: A patient displaying withdrawn, low-mood affect during a clinical interview. AI-generated using the prompt: "Create a realistic clinical illustration titled A Patient with Low Mood During Clinical Interview, showing a patient seated slumped with downcast eyes across from a clinician taking notes, quiet consulting room setting. Clean clinical illustration style, no text."
2. Table 2.1: Comparing schizophrenia and delusional disorder. AI-generated using the prompt: "Create a clean reference table titled Comparing Schizophrenia and Delusional Disorder, listing feature, schizophrenia, and delusional disorder across hallucinations, functioning, and belief type. Simple clinical reference table style with outside border."
3. Figure 2.2: A patient experiencing a distressing flashback during a clinical assessment. AI-generated using the prompt: "Create a realistic clinical illustration titled A Flashback During Clinical Assessment, showing a patient with a visibly distressed expression, hand raised to their head, clinician leaning forward with a concerned, supportive posture, consulting room setting. Clean clinical illustration style, no text."

Course code: PSY 605

Course title: Tutorial and Seminar in Psychiatry

Course credit load: 1 Unit

Series 4: Tutorial and Seminar in Child, Geriatric, and Subspecialty Psychiatric Disorders

- **Part 4.1: Child and Adolescent Psychiatric Disorders**
  - Sub Part 4.1.1: Assessment of children and adolescents in tutorial practice
  - Sub Part 4.1.2: Common neurodevelopmental disorders: a tutorial review
  - Sub Part 4.1.3: Disruptive behaviour disorders: differential diagnosis in tutorial cases
- **Part 4.2: Geriatric Psychiatric Disorders**
  - Sub Part 4.2.1: Unique features of psychiatric evaluation in the elderly
  - Sub Part 4.2.2: Delirium and major neurocognitive disorders: a tutorial review
  - Sub Part 4.2.3: Distinguishing neurocognitive disorder subtypes in tutorial cases
- **Part 4.3: Subspecialty Psychiatric Disorders in Practice**
  - Sub Part 4.3.1: Psychiatric assessment in patients with physical illness
  - Sub Part 4.3.2: Forensic psychiatry essentials: capacity and consent
  - Sub Part 4.3.3: Case-based review of subspecialty presentations

Introduction

Every clinical population brings its own diagnostic quirks, and this Series works through three of the trickiest, children, older adults, and patients whose psychiatric presentation sits alongside physical or legal complexity. Tutorial case discussion is especially valuable here, since these presentations rarely follow a textbook script.

The aim of this Series is to consolidate your understanding of child and adolescent psychiatric assessment and disorders, the unique features of geriatric psychiatric evaluation and

neurocognitive disorders, and subspecialty presentations in physical illness and forensic contexts, with emphasis on differential diagnosis skills.

This Series opens with **child and adolescent psychiatric disorders**, moves to **geriatric psychiatric disorders**, and closes with **subspecialty psychiatric disorders in practice**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 4.1:** describe how to perform a psychiatric evaluation of children and adolescents
- **SLO 4.2:** assess and explain proposed differential diagnosis for children and adolescents presenting with disruptive behaviour
- **SLO 4.3:** discuss issues unique to psychiatric evaluation of the elderly and compare clinical presentation across age groups
- **SLO 4.4:** describe delirium and the major neurocognitive disorders encountered in the elderly
- **SLO 4.5:** illustrate psychiatric assessment in patients with physical illness
- **SLO 4.6:** describe essential forensic psychiatry concepts including capacity and consent

4.1 Child and Adolescent Psychiatric Disorders

4.1.1 assessment of children and adolescents in tutorial practice

Applying assessment principles to real cases

Tutorial cases involving children require the same structured approach taught earlier in the course, developmental history, informant-based assessment, and age-adapted mental state examination, but with the added challenge of interpreting behaviour that a young patient cannot always articulate directly. Case discussion helps trainees practise translating this structured framework into a coherent clinical formulation under time pressure.

A recurring tutorial theme is the importance of collateral information from parents and teachers, since a single source of information, however detailed, rarely captures the full picture of a child's functioning across settings. Trainees are encouraged to practise weighing potentially conflicting reports rather than automatically favouring one informant over another.

Fill in the blank: Case discussion helps trainees practise translating structured assessment into a coherent clinical _____.

4.1.2 common neurodevelopmental disorders: a tutorial review

Revisiting the core neurodevelopmental presentations

Common **neurodevelopmental disorders** revisited in tutorial include intellectual disability, communication disorders, autism spectrum disorder, and ADHD, each requiring the trainee to hold several diagnostic possibilities in mind simultaneously rather than anchoring prematurely on the first plausible diagnosis. Case-based teaching is particularly effective here, since these conditions frequently co-occur and a single tutorial case can illustrate several overlapping presentations at once.

Trainees are expected to describe the core diagnostic features of each condition confidently and to recognise when co-occurring difficulties, such as language impairment alongside autism spectrum disorder, warrant a broader developmental assessment rather than a narrow single-diagnosis approach.

Fill in the blank: Several neurodevelopmental disorders frequently _____, requiring a broader assessment approach.

4.1.3 disruptive behaviour disorders: differential diagnosis in tutorial cases

Working through the differential systematically

Tutorial cases of disruptive behaviour require systematic differential diagnosis, distinguishing oppositional defiant disorder and conduct disorder from ADHD-driven impulsivity, mood or anxiety-related irritability, and, where relevant, safeguarding concerns that may underlie the presenting behaviour. Working through this differential methodically in a tutorial setting builds the habit of considering the full range of explanations before settling on a single diagnosis.

Trainees benefit from practising how to justify a chosen differential diagnosis using specific case details, since examiners in clinical assessments typically expect reasoning grounded in the presented history rather than a generic list of possibilities recited without direct application to the case at hand.

Fill in the blank: Trainees should justify a differential diagnosis using specific _____ details rather than a generic list.

Figure 4.1: A child displaying defiant behaviour during a clinical assessment with a caregiver present.

Pilot questions 4.1

- Explain the added challenge of assessing children compared with adults. (Linked to SLO 4.1)
- Describe why collateral information from multiple informants matters. (Linked to SLO 4.1)
- List two neurodevelopmental disorders that commonly co-occur. (Linked to SLO 4.1)
- Explain why a single tutorial case can illustrate several overlapping diagnoses. (Linked to SLO 4.1)
- Describe the systematic approach to differential diagnosis of disruptive behaviour. (Linked to SLO 4.2)

4.2 Geriatric Psychiatric Disorders

4.2.1 unique features of psychiatric evaluation in the elderly

Applying geriatric assessment principles in tutorial

Tutorial discussion of elderly patients revisits the unique features of geriatric assessment, sensory change, polypharmacy, and atypical symptom presentation, and asks trainees to identify these features actively within a case rather than simply recalling them from memory. Recognising an atypical presentation, such as depression masquerading as cognitive slowing, is a frequently tested tutorial skill.

Comparing presentation across age groups is a further recurring theme, since the same underlying disorder can look meaningfully different in an older adult compared with a younger adult, and trainees must be able to articulate these differences clearly when discussing a case.

Fill in the blank: Depression masquerading as cognitive slowing is a frequently tested example of an _____ presentation.

4.2.2 delirium and major neurocognitive disorders: a tutorial review

Distinguishing acute from chronic cognitive change

Tutorial cases involving cognitive change in an older adult require rapid, confident distinction between **delirium**, with its acute, fluctuating onset, and **major neurocognitive disorder**, with its insidious, progressive course, since this distinction has immediate implications for urgency of investigation and management.

Trainees revisit the key features separating the two, attention, course, and reversibility, and practise applying them to case vignettes designed to test whether a trainee defaults automatically to a dementia diagnosis in an older patient without first excluding a reversible, acute cause.

Fill in the blank: Delirium and major neurocognitive disorder are distinguished by course, attention, and _____.

4.2.3 distinguishing neurocognitive disorder subtypes in tutorial cases

Applying subtype-specific clinical clues

Tutorial cases of neurocognitive disorder test the trainee's ability to apply subtype-specific clues, memory-predominant onset suggesting Alzheimer's disease, early personality change suggesting frontotemporal lobar degeneration, fluctuating cognition and hallucinations suggesting Lewy body disease, and stepwise decline suggesting vascular disease.

This case-based revision reinforces that neurocognitive disorder is not a single diagnosis but a family of distinct conditions, each with characteristic clinical clues that, taken together with history and examination, guide the trainee towards the most likely underlying cause.

Fill in the blank: Early personality change in a tutorial case suggests _____ lobar degeneration rather than Alzheimer's disease.

Table 4.1: Key clinical clues across neurocognitive disorder subtypes

Subtype	Key clinical clue	Onset pattern
Alzheimer's disease	Memory-predominant decline	Insidious, gradual
Frontotemporal lobar degeneration	Early personality or language change	Insidious, earlier life
Vascular neurocognitive disorder	Stepwise decline after vascular events	Stepwise

Pilot questions 4.2

1. List two unique features of psychiatric evaluation in the elderly. (Linked to SLO 4.3)
2. Explain why comparing presentation across age groups matters clinically. (Linked to SLO 4.3)
3. Distinguish delirium from major neurocognitive disorder in a tutorial case. (Linked to SLO 4.4)
4. Describe the clinical clue suggesting Lewy body disease in a tutorial case. (Linked to SLO 4.4)
5. Explain why stepwise decline points towards vascular neurocognitive disorder. (Linked to SLO 4.4)

4.3 Subspecialty Psychiatric Disorders in Practice

4.3.1 psychiatric assessment in patients with physical illness

Applying consultation-liaison principles to cases

Tutorial cases at the interface of physical and mental health revisit how to distinguish symptoms caused by medical illness, its treatment, and an independent psychiatric disorder, a distinction

that examiners frequently probe by embedding a plausible medical explanation within an otherwise psychiatric-looking case.

Trainees practise structuring their case presentation to explicitly address all three possible contributors, demonstrating that the differential diagnosis has been considered systematically rather than jumping directly to a psychiatric conclusion.

Fill in the blank: Trainees should structure case presentations to address illness, treatment, and independent _____ contributors.

4.3.2 forensic psychiatry essentials: capacity and consent

Core legal concepts every trainee must apply confidently

Forensic psychiatry tutorial revision centres on **capacity** and **consent**, since these concepts recur across nearly every clinical scenario a trainee will encounter, not only in forensic settings specifically. Tutorial cases typically test whether the trainee can apply the four-step capacity framework, understanding, retaining, weighing, and communicating, to a specific decision rather than reciting the framework in the abstract.

Case discussion also reinforces that capacity assessment is decision-specific and that a patient's diagnosis alone never determines capacity, a common error trainees are specifically tested on and expected to correct with confidence.

Fill in the blank: Capacity assessment is decision-specific, and a patient's _____ alone never determines capacity.

4.3.3 case-based review of subspecialty presentations

Integrating knowledge across subspecialty domains

The closing tutorial topic brings together child, geriatric, consultation-liaison, and forensic material through integrated case vignettes designed to test whether trainees can move fluidly between subspecialty frameworks as a single case unfolds, rather than treating each domain as an isolated body of knowledge.

This integrated case-based review reflects real clinical practice, where a single patient can present features spanning several subspecialty areas simultaneously, and confident, flexible application of knowledge across domains is precisely the competency tutorial and seminar teaching aims to build.

Fill in the blank: Integrated case vignettes test whether trainees can move fluidly between subspecialty _____.

Figure 4.2: A multidisciplinary team discussing a complex patient case during a tutorial seminar.

Pilot questions 4.3

1. Explain why examiners often embed a medical explanation within a psychiatric-looking case. (Linked to SLO 4.5)
2. Describe how to structure a case presentation addressing illness, treatment, and psychiatric contributors. (Linked to SLO 4.5)
3. Describe the four-step capacity framework. (Linked to SLO 4.6)
4. Explain the common error trainees make regarding diagnosis and capacity. (Linked to SLO 4.6)
5. Explain the value of integrated case-based review across subspecialty domains. (Linked to SLO 4.6)

Series Summary

This Series revisited three clinically demanding populations through a tutorial lens. Part 4.1 covered child and adolescent assessment, neurodevelopmental disorders, and disruptive behaviour differential diagnosis, while Part 4.2 turned to the unique features of geriatric assessment, delirium, and neurocognitive disorder subtypes. Part 4.3 closed with psychiatric assessment in physical illness, forensic essentials, and an integrated case-based review.

You should now be able to perform a psychiatric evaluation of children and the elderly, construct a sound differential diagnosis for disruptive behaviour and neurocognitive disorder, and apply capacity and consent principles confidently, meeting the outcomes set for this Series. Series 5 turns next to tutorial and seminar teaching in emergency psychiatry and special topics in practice.

Glossary of Terms

1. **Capacity:** the decision-specific ability to understand, retain, weigh, and communicate a decision.
2. **Collateral information:** information gathered from sources other than the patient, such as family or teachers.
3. **Consent:** voluntary, informed agreement to treatment given by a person with capacity.
4. **Delirium:** an acute, fluctuating disturbance of attention and awareness with a demonstrable cause.
5. **Differential diagnosis:** the systematic process of distinguishing between possible explanations for a presentation.
6. **Frontotemporal lobar degeneration:** a neurocognitive disorder marked by early personality or language change.
7. **Integrated case review:** case-based teaching combining knowledge across multiple subspecialty domains.
8. **Major neurocognitive disorder:** significant, progressive cognitive decline interfering with independence.
9. **Neurodevelopmental disorder:** a disorder originating in the developmental period affecting brain function.
10. **Polypharmacy:** the use of multiple medications, common in older adults.
11. **Psychiatric assessment in physical illness:** evaluation distinguishing illness, treatment, and psychiatric contributors.
12. **Vascular neurocognitive disorder:** cognitive decline linked temporally to cerebrovascular disease.

Concept Check Questions [Series 4]

Objective questions

1. Case discussion helps trainees practise translating structured assessment into a coherent clinical _____. (Linked to SLO 4.1)
2. Depression masquerading as cognitive slowing is a frequently tested example of an _____ presentation. (Linked to SLO 4.3)
3. Delirium and major neurocognitive disorder are distinguished by course, attention, and _____. (Linked to SLO 4.4)
4. Trainees should structure case presentations to address illness, treatment, and independent _____ contributors. (Linked to SLO 4.5)
5. Capacity assessment is decision-specific, and a patient's _____ alone never determines capacity. (Linked to SLO 4.6)

Short-answer questions

- Describe why collateral information from multiple informants matters in child assessment. (Linked to SLO 4.1)
- Describe the systematic approach to differential diagnosis of disruptive behaviour. (Linked to SLO 4.2)
- List two unique features of psychiatric evaluation in the elderly. (Linked to SLO 4.3)
- Describe the clinical clue suggesting Lewy body disease in a tutorial case. (Linked to SLO 4.4)
- Describe the four-step capacity framework. (Linked to SLO 4.6)

Long-answer questions

1. Discuss the assessment of children and adolescents and the differential diagnosis of disruptive behaviour in tutorial practice. (Linked to SLO 4.1, 4.2)
2. Discuss the unique features of geriatric psychiatric evaluation and the distinction between delirium and major neurocognitive disorder. (Linked to SLO 4.3, 4.4)
3. Describe how tutorial cases test the differentiation of neurocognitive disorder subtypes. (Linked to SLO 4.4)
4. Discuss psychiatric assessment in patients with physical illness through a tutorial case lens. (Linked to SLO 4.5)
5. Discuss forensic psychiatry essentials and the value of integrated case-based review. (Linked to SLO 4.6)

Answers to Concept Check Questions [Series 4]

Objective questions

6. Formulation.
7. Atypical.
8. Reversibility.
9. Psychiatric.
10. Diagnosis.

Short-answer questions

11. A single informant rarely captures the full picture of a child's functioning across settings, so multiple sources strengthen assessment.
12. The approach systematically works through ADHD, mood disorder, oppositional defiant disorder, and conduct disorder before settling on a diagnosis.
13. Unique features include changing sensory perception and polypharmacy.
14. Fluctuating cognition with recurrent visual hallucinations suggests Lewy body disease.
15. The framework requires that a person can understand, retain, weigh, and communicate a specific decision.

Long-answer questions

16. **Basic response:** Child assessment uses developmental history and multi-informant collateral information; disruptive behaviour differential diagnosis systematically considers ADHD, mood disorder, oppositional defiant disorder, and conduct disorder.

    Value-added response: A value-added response notes that examiners expect reasoning grounded in specific case details rather than a generic list of possibilities.

17. **Basic response:** Geriatric evaluation accounts for sensory change, polypharmacy, and atypical presentation; delirium has acute, fluctuating onset with reversibility, while major neurocognitive disorder has insidious, progressive onset.

    Value-added response: A value-added response notes that tutorial cases specifically test whether trainees default to a dementia diagnosis without first excluding a reversible acute cause.

18. **Basic response:** Cases apply subtype-specific clues: memory-predominant onset for Alzheimer's disease, early personality change for frontotemporal disease, fluctuating cognition for Lewy body disease, and stepwise decline for vascular disease.

Value-added response: A value-added response notes that this reinforces neurocognitive disorder as a family of distinct conditions rather than a single diagnosis.

19. **Basic response:** Cases test distinguishing illness, treatment, and independent psychiatric contributors, often embedding a plausible medical explanation within an otherwise psychiatric-looking presentation.

    Value-added response: A value-added response notes that trainees should structure their presentation to explicitly address all three contributors rather than jumping directly to a psychiatric conclusion.

20. **Basic response:** Forensic essentials centre on capacity and consent, applying the four-step framework to specific decisions; integrated case review combines child, geriatric, consultation-liaison, and forensic knowledge in single cases.

    Value-added response: A value-added response notes that a patient's diagnosis alone never determines capacity, a common error trainees are specifically tested on.

Answers to Pilot Questions [Series 4]

Part 4.1

11. Children cannot always articulate their difficulties directly, requiring more reliance on observation and informants.
12. Multiple informants reduce the risk of missing important context-specific information.
13. Autism spectrum disorder and language impairment commonly co-occur.
14. A single case can present features spanning several developmental domains simultaneously.
15. The systematic approach works through ADHD, mood disorder, oppositional defiant disorder, and conduct disorder in turn.

Part 4.2

1. Unique features include sensory change and polypharmacy.
2. The same disorder can present very differently in older versus younger adults, affecting recognition.

3. Delirium has acute, fluctuating onset, while major neurocognitive disorder has insidious, progressive onset.
4. Fluctuating cognition with recurrent visual hallucinations suggests Lewy body disease.
5. Stepwise decline follows discrete vascular events, distinguishing it from smoother progressive decline.

Part 4.3

6. Embedding a medical explanation tests whether trainees consider physical causes before concluding a psychiatric diagnosis.
7. Presentations should explicitly address illness, treatment effects, and independent psychiatric contributors in turn.
8. The framework requires understanding, retaining, weighing, and communicating a specific decision.
9. Trainees sometimes assume a diagnosis automatically determines incapacity, which is incorrect.
10. Integrated review reflects real practice, where a single patient can present features spanning several subspecialty areas.

References and Attributions [Series 4]

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13. Jacoby, R., Oppenheimer, C., Dening, T., & Thomas, A. (2008). Oxford Textbook of Old Age Psychiatry (2nd ed.). Oxford University Press.
14. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.

Figures, Plates, Tables, and Boxes

1. Figure 4.1: A child displaying defiant behaviour during a clinical assessment with a caregiver present. AI-generated using the prompt: "Create a realistic clinical illustration titled A Child Displaying Defiant Behaviour in Assessment, showing a young child with

arms crossed and an oppositional expression, seated near a caregiver and clinician in a consulting room. Clean clinical illustration style, no text."

2. Table 4.1: Key clinical clues across neurocognitive disorder subtypes. AI-generated using the prompt: "Create a clean reference table titled Key Clinical Clues Across Neurocognitive Disorder Subtypes, listing subtype, key clinical clue, and onset pattern. Simple clinical reference table style with outside border."
3. Figure 4.2: A multidisciplinary team discussing a complex patient case during a tutorial seminar. AI-generated using the prompt: "Create a realistic clinical education illustration titled Multidisciplinary Case Discussion, showing a small group of clinicians and trainees seated around a table reviewing a case file together, engaged seminar room setting. Clean clinical illustration style, no text."

Course code: PSY 605

Course title: Tutorial and Seminar in Psychiatry

Course credit load: 1 Unit

Series 5: Tutorial and Seminar in Emergency Psychiatry and Special Topics in Practice

- **Part 5.1: Emergency Psychiatry Essentials**
    - Sub Part 5.1.1: Acute behavioural disturbance: tutorial approach to assessment and management
    - Sub Part 5.1.2: Substance-related and medication-induced emergencies: a tutorial review
    - Sub Part 5.1.3: Suicide risk assessment and management: tutorial case practice
- **Part 5.2: Special Topics in Psychiatric Practice**
    - Sub Part 5.2.1: Non-adherence, overweight and obesity, and malingering: tutorial cases
    - Sub Part 5.2.2: Recognising abuse and neglect in tutorial practice
    - Sub Part 5.2.3: Culture, stigma, and community mental health: tutorial discussion
- **Part 5.3: Consolidating Must-Know Competencies and Common Disorders**
    - Sub Part 5.3.1: Revisiting must-know competencies across the course
    - Sub Part 5.3.2: Common psychiatric disorders: a final tutorial synthesis
    - Sub Part 5.3.3: Preparing for clinical and seminar assessment

Introduction

This final Series brings the course to a close with two areas that test a trainee's readiness under pressure, emergency psychiatry and the special topics that shape everyday practice, before consolidating the must-know competencies and common disorders emphasised throughout PSY 601 to 603.

The aim of this Series is to consolidate your understanding of emergency psychiatric assessment and management, the special topics of non-adherence, weight, malingering, abuse and neglect, culture, stigma, and community mental health, and the must-know competencies and common disorders that anchor sound clinical and seminar performance.

This Series opens with **emergency psychiatry essentials**, moves to **special topics in psychiatric practice**, and closes with **consolidating must-know competencies and common disorders**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 5.1:** list various behavioural changes encountered in the emergency
- **SLO 5.2:** describe the assessment and management of substance-related and medication-induced psychiatric emergencies
- **SLO 5.3:** enumerate the risk of suicide in patients with mood disorders, and describe risk assessment and management strategy
- **SLO 5.4:** explain non-adherence to medical treatment, overweight and obesity, malingering, and child abuse and adult maltreatment and neglect
- **SLO 5.5:** discuss Nigerian culture, spiritual problems, culture-bound syndromes, stigma, and community mental health
- **SLO 5.6:** lay emphasis on the must-know desired competencies and common psychiatric disorders covered across the course

5.1 Emergency Psychiatry Essentials

5.1.1 acute behavioural disturbance: tutorial approach to assessment and management

Rapid, systematic tutorial reasoning under pressure

Tutorial cases of **acute behavioural disturbance** test whether a trainee can move rapidly through the key steps, ensuring immediate safety, attempting verbal de-escalation, and identifying an underlying psychiatric, medical, or substance-related cause, all within a compressed clinical timeframe that mirrors real emergency practice.

A recurring tutorial theme is recognising the full range of **behavioural changes** encountered in the emergency setting, agitation, aggression, confusion, withdrawal, disinhibition, and mood change, and using the pattern and time course of these changes to guide urgent investigation rather than treating every presentation identically.

Fill in the blank: Tutorial cases test whether trainees identify an underlying psychiatric, medical, or _____-related cause.

5.1.2 substance-related and medication-induced emergencies: a tutorial review

Recognising and managing serious drug-related presentations

This tutorial topic revisits **alcohol withdrawal**, **cannabis intoxication**, and **medication-induced emergencies** such as serotonin syndrome and neuroleptic malignant syndrome, asking trainees to recognise each presentation confidently and select the correct immediate management step under simulated time pressure.

Case discussion reinforces that these emergencies, while individually well described, are frequently confused in the heat of a tutorial scenario, making repeated, deliberate practice distinguishing overlapping symptoms, such as autonomic instability appearing in several conditions, a genuinely valuable use of seminar time.

Fill in the blank: Serotonin syndrome and neuroleptic malignant syndrome can both present with autonomic _____.

5.1.3 suicide risk assessment and management: tutorial case practice

Structured, empathic risk evaluation under scrutiny

Suicide risk assessment is one of the most heavily emphasised tutorial and seminar topics, since mood disorders carry substantially elevated suicide risk and trainees must demonstrate direct, empathic enquiry about thoughts, plans, intent, and access to means without hesitation or avoidance in a case scenario.

Tutorial practice also covers translating a risk assessment into an appropriately intensive management strategy, ranging from outpatient safety planning to emergency admission, and trainees are expected to justify their chosen management level explicitly by reference to the specific static and dynamic risk factors identified in the case.

Fill in the blank: Trainees must justify their chosen management level by reference to specific static and _____ risk factors.

Figure 5.1: Clinical staff calmly de-escalating an agitated patient in the emergency department.

Pilot questions 5.1

- List the key steps in assessing acute behavioural disturbance. (Linked to SLO 5.1)
- Explain how the time course of a behavioural change guides investigation. (Linked to SLO 5.1)
- Distinguish serotonin syndrome from neuroleptic malignant syndrome. (Linked to SLO 5.2)
- Describe the tutorial approach to suicide risk assessment. (Linked to SLO 5.3)
- Explain how risk factors inform the chosen management level. (Linked to SLO 5.3)

5.2 Special Topics in Psychiatric Practice

5.2.1 non-adherence, overweight and obesity, and malingering: tutorial cases

Applying nuanced clinical judgement in tutorial

Tutorial cases of **non-adherence** ask trainees to explore the patient's reasons for not following treatment through open, non-judgemental questioning rather than assuming forgetfulness, while

cases of **overweight and obesity** test whether trainees proactively consider medication-related metabolic side effects as a contributing factor.

Malingering cases are deliberately constructed to be ambiguous, requiring careful, non-confrontational assessment, since tutorial discussion consistently emphasises that wrongly accusing a genuinely unwell patient of malingering causes serious harm to the therapeutic relationship and must be avoided through careful, evidence-based reasoning.

Fill in the blank: Non-adherence cases test whether trainees explore reasons through open, non-judgemental _____.

5.2.2 recognising abuse and neglect in tutorial practice

Safeguarding vigilance across the lifespan

Tutorial cases of **child abuse and neglect** and **adult maltreatment and neglect** test a trainee's vigilance for behavioural or emotional signs that may indicate abuse, and their knowledge of the appropriate safeguarding pathway once a concern is identified, since prompt, correct action in these scenarios carries genuine real-world weight.

Case discussion reinforces that any suspicion of abuse or neglect triggers local safeguarding procedures immediately, and trainees are expected to demonstrate this response confidently in tutorial scenarios rather than hesitating or deferring the decision inappropriately.

Fill in the blank: Any suspicion of abuse or neglect triggers local _____ procedures immediately.

5.2.3 culture, stigma, and community mental health: tutorial discussion

Contextualising psychiatric care within Nigerian society

Tutorial discussion of **Nigerian culture**, **spiritual problems**, and **culture-bound syndromes** asks trainees to engage respectfully with a patient's own framing of their distress while still assessing for an underlying psychiatric disorder that may benefit from treatment, balancing cultural sensitivity with clinical rigour.

Stigma and **community mental health** round out this tutorial topic, with case discussion exploring how stigma delays help-seeking and how community-based services extend care beyond the hospital, reinforcing the population-level, public health dimension of psychiatric practice alongside individual clinical care.

Fill in the blank: Community mental health extends care beyond the hospital, reinforcing the population-level, public health _____.

Table 5.1: Special topics and their core tutorial focus

Topic	Core tutorial focus	Key clinical skill
Non-adherence	Exploring reasons non-judgementally	Open, empathic questioning
Malingering	Distinguishing from genuine illness	Careful, non-confrontational assessment
Abuse and neglect	Recognising signs and safeguarding pathway	Prompt, confident safeguarding response

Pilot questions 5.2

1. Explain the tutorial approach to exploring non-adherence. (Linked to SLO 5.4)
2. Describe why malingering cases are deliberately constructed to be ambiguous. (Linked to SLO 5.4)
3. Explain the trainee's responsibility when abuse or neglect is suspected in a tutorial case. (Linked to SLO 5.4)
4. Describe how a psychiatrist should engage with a spiritual framing of symptoms. (Linked to SLO 5.5)
5. Explain the role of community mental health services. (Linked to SLO 5.5)

5.3 Consolidating Must-Know Competencies and Common Disorders

5.3.1 revisiting must-know competencies across the course

Bringing every strand together

This closing tutorial topic revisits the **must-know competencies** established in Series 1, accurate history taking, mental state examination, safe risk assessment, sound differential diagnosis reasoning, and clear case presentation, and asks trainees to demonstrate all five fluently within a single integrated case.

Reinforcing these competencies at the end of the course, rather than only at the beginning, allows trainees to appreciate how much their clinical reasoning has developed since Series 1, and to identify any remaining gaps in confidence before final clinical and seminar assessment.

Fill in the blank: This topic asks trainees to demonstrate all five must-know competencies fluently within a single integrated _____.

5.3.2 common psychiatric disorders: a final tutorial synthesis

Pulling the major disorder categories together

A final tutorial synthesis works systematically through the **common psychiatric disorders** covered across PSY 601 to 603, mood, psychotic, anxiety, substance use, personality, child, geriatric, and emergency presentations, asking trainees to recall and apply key diagnostic features rapidly across this full breadth of material.

This synthesis exercise is intentionally comprehensive rather than narrowly focused, since seminar and clinical assessment can draw on any part of the course, and trainees benefit from practising rapid recall and application across categories rather than only within a single familiar topic.

Fill in the blank: A final synthesis exercise is intentionally comprehensive rather than narrowly _____.

5.3.3 preparing for clinical and seminar assessment

Translating tutorial practice into assessment readiness

Preparing for clinical and seminar assessment involves consolidating the case-based reasoning practised throughout this course into a confident, structured approach that a trainee can apply to any new case presented under examination conditions, rather than relying on having seen an identical scenario before.

Trainees are encouraged to practise structured case presentation aloud, seek and act on constructive feedback, and use the must-know competencies as a checklist against which to measure their own readiness, closing the course with genuine confidence in both knowledge and applied clinical skill.

Fill in the blank: Trainees are encouraged to use the must-know competencies as a _____ against which to measure their readiness.

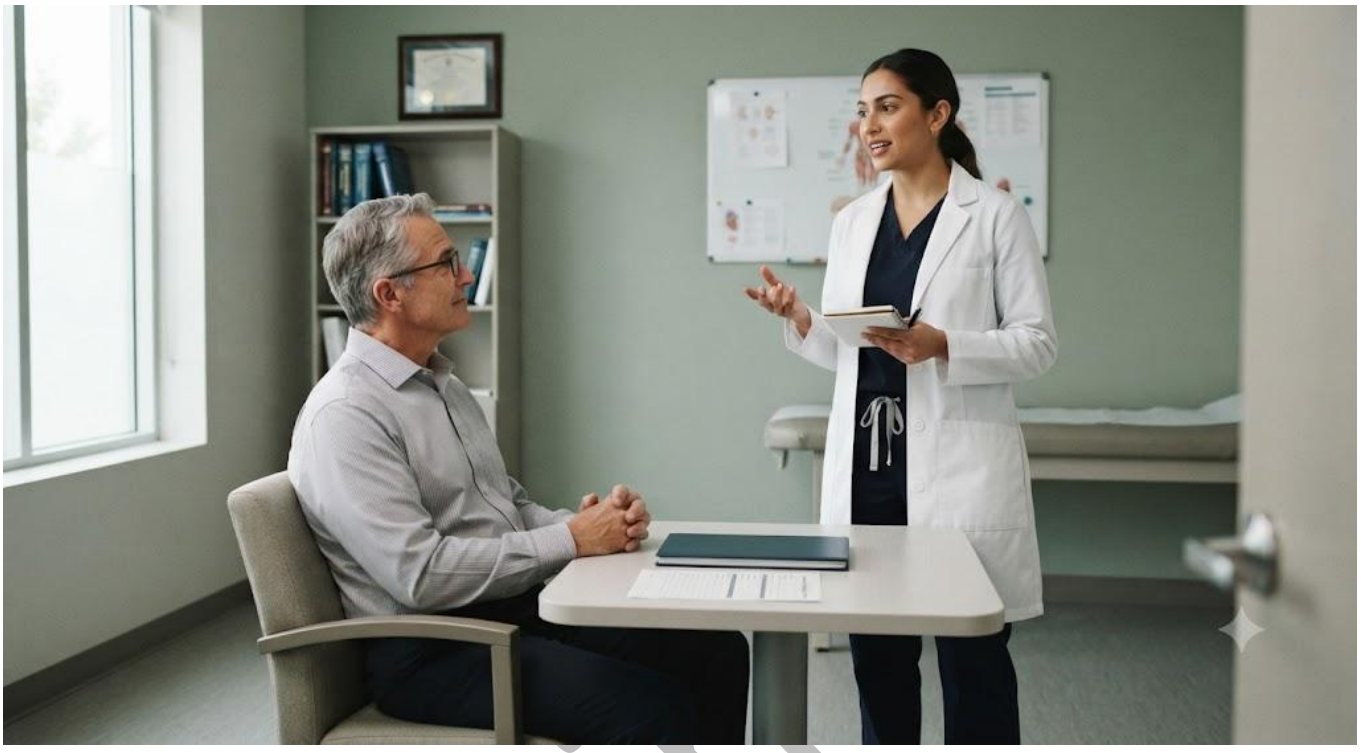

Figure 5.2: A trainee confidently presenting a clinical case to an examiner during assessment.

Pilot questions 5.3

1. List the five must-know competencies revisited in this final Part. (Linked to SLO 5.6)
2. Explain the value of revisiting competencies at the end rather than only at the start of the course. (Linked to SLO 5.6)
3. Describe the scope of the final tutorial synthesis of common psychiatric disorders. (Linked to SLO 5.6)
4. Explain why the synthesis exercise is intentionally comprehensive. (Linked to SLO 5.6)
5. Describe how trainees can use the must-know competencies to prepare for assessment. (Linked to SLO 5.6)

Series Summary

This final Series brought the course to a close with emergency psychiatry, special topics in practice, and a consolidation of must-know competencies and common disorders. Part 5.1 covered acute behavioural disturbance, substance-related and medication-induced emergencies, and suicide risk assessment, while Part 5.2 turned to non-adherence, weight, malingering, abuse and neglect, culture, stigma, and community mental health. Part 5.3 closed with a revisiting of

must-know competencies, a final synthesis of common disorders, and preparation for clinical and seminar assessment.

You should now be able to list behavioural changes encountered in the emergency, manage substance-related and medication-induced emergencies, assess suicide risk, discuss the special topics covered, and demonstrate the must-know competencies expected of every trainee, meeting the outcomes set for this Series. Across the full course, Series 1 consolidated psychiatric assessment and core competencies, Series 2 covered mood, psychotic, and anxiety disorders, Series 3 covered substance use, personality disorders, and psychopharmacology, Series 4 covered child, geriatric, and subspecialty psychiatric disorders, and this Series has closed the course with emergency psychiatry and special topics in practice, together forming a comprehensive tutorial and seminar foundation in psychiatry.

Glossary of Terms

1. **Acute behavioural disturbance:** agitated or aggressive behaviour posing risk to the patient or others.
2. **Case presentation:** the structured verbal communication of a patient's history and formulation.
3. **Community mental health:** services delivering psychiatric care close to a person's normal environment.
4. **Culture-bound syndrome:** a pattern of distress recognised within a specific cultural context.
5. **Malingering:** deliberate fabrication or exaggeration of symptoms for an external incentive.
6. **Must-know competencies:** the core clinical skills expected of every trainee by the end of training.
7. **Non-adherence:** a patient's failure to follow prescribed treatment as advised.
8. **Risk factor:** a static or dynamic characteristic contributing to suicide or other clinical risk.
9. **Safeguarding:** procedures protecting a vulnerable person from abuse or neglect.
10. **Static risk factor:** a fixed, unchangeable characteristic contributing to long-term risk.
11. **Stigma:** negative social attitudes towards mental illness acting as a barrier to help-seeking.
12. **Suicide risk assessment:** structured evaluation of suicidal thoughts, plans, intent, and access to means.

Concept Check Questions [Series 5]

Objective questions

1. Tutorial cases test whether trainees identify an underlying psychiatric, medical, or _____-related cause. (Linked to SLO 5.1)
2. Serotonin syndrome and neuroleptic malignant syndrome can both present with autonomic _____. (Linked to SLO 5.2)
3. Trainees must justify their chosen management level by reference to specific static and _____ risk factors. (Linked to SLO 5.3)
4. Any suspicion of abuse or neglect triggers local _____ procedures immediately. (Linked to SLO 5.4)
5. This topic asks trainees to demonstrate all five must-know competencies fluently within a single integrated _____. (Linked to SLO 5.6)

Short-answer questions

- List the key steps in assessing acute behavioural disturbance. (Linked to SLO 5.1)
- Distinguish serotonin syndrome from neuroleptic malignant syndrome. (Linked to SLO 5.2)
- Explain the tutorial approach to exploring non-adherence. (Linked to SLO 5.4)
- Describe how a psychiatrist should engage with a spiritual framing of symptoms. (Linked to SLO 5.5)
- List the five must-know competencies revisited in this final Part. (Linked to SLO 5.6)

Long-answer questions

1. Discuss the tutorial approach to acute behavioural disturbance, substance-related emergencies, and suicide risk assessment. (Linked to SLO 5.1, 5.2, 5.3)
2. Discuss non-adherence, overweight and obesity, malingering, and abuse and neglect through a tutorial case lens. (Linked to SLO 5.4)
3. Discuss Nigerian culture, spiritual problems, culture-bound syndromes, stigma, and community mental health. (Linked to SLO 5.5)
4. Describe the must-know competencies revisited in this Series and their value at the close of the course. (Linked to SLO 5.6)
5. Discuss how the final tutorial synthesis prepares trainees for clinical and seminar assessment. (Linked to SLO 5.6)

Answers to Concept Check Questions [Series 5]

Objective questions

6. Substance.
7. Instability.
8. Dynamic.
9. Safeguarding.
10. Case.

Short-answer questions

11. The key steps are ensuring safety, attempting verbal de-escalation, and identifying the underlying cause.
12. Serotonin syndrome follows serotonergic medication with tremor and hyperreflexia, while neuroleptic malignant syndrome follows antipsychotics with rigidity and hyperthermia.
13. Trainees explore reasons through open, non-judgemental questioning rather than assuming forgetfulness.
14. Psychiatrists should engage respectfully with the framing while still assessing for an underlying psychiatric disorder.
15. The five competencies are history taking, mental state examination, risk assessment, differential diagnosis, and case presentation.

Long-answer questions

16. **Basic response:** Acute behavioural disturbance is managed by ensuring safety, de-escalating, and identifying cause; substance-related emergencies require recognising alcohol withdrawal, cannabis intoxication, and medication-induced reactions; suicide risk assessment requires direct, empathic enquiry.

    Value-added response: A value-added response notes that trainees must justify management decisions explicitly by reference to specific risk factors rather than general impressions.

17. **Basic response:** Non-adherence is explored through open questioning; overweight and obesity require considering medication side effects; malingering requires careful, non-confrontational assessment; abuse and neglect require prompt safeguarding action.

    Value-added response: A value-added response notes that wrongly accusing a genuinely unwell patient of malingering can cause serious harm to the therapeutic relationship.

18. **Basic response:** Nigerian culture and spiritual framing shape help-seeking; culture-bound syndromes may not map onto standard categories; stigma delays help-seeking; community mental health delivers care close to a person's environment.

    Value-added response: A value-added response notes that community mental health also supports population-level public health goals such as prevention and early intervention.

19. **Basic response:** The competencies are history taking, mental state examination, risk assessment, differential diagnosis, and case presentation, revisited to demonstrate fluency within a single integrated case.

    Value-added response: A value-added response notes that revisiting these competencies at the end allows trainees to appreciate their development since Series 1 and identify remaining gaps.

20. **Basic response:** The synthesis works systematically through common disorders across the whole course, encouraging rapid recall and application, since assessment can draw on any part of the material.

    Value-added response: A value-added response notes that structured practice aloud and constructive feedback close the course with genuine confidence in both knowledge and applied clinical skill.

Answers to Pilot Questions [Series 5]

Part 5.1

11. Key steps are ensuring safety, attempting de-escalation, and identifying the underlying cause.
12. Acute, fluctuating change points towards delirium or a substance-related cause, while gradual change suggests an evolving primary process.
13. Serotonin syndrome presents with tremor and hyperreflexia from serotonergic medication; neuroleptic malignant syndrome presents with rigidity and hyperthermia from antipsychotics.
14. The tutorial approach involves direct, empathic enquiry about thoughts, plans, intent, and access to means.

15. Risk factors indicate the current level of danger, guiding whether outpatient safety planning or emergency admission is appropriate.

Part 5.2

1. Trainees explore reasons non-judgementally rather than assuming forgetfulness.
2. Malingering cases are ambiguous because wrongly accusing a genuinely unwell patient causes serious harm.
3. Trainees must trigger local safeguarding procedures immediately whenever abuse or neglect is suspected.
4. Psychiatrists should engage respectfully with a spiritual framing while still assessing for underlying psychiatric disorder.
5. Community mental health services deliver care close to a person's normal environment, reducing reliance on hospital admission.

Part 5.3

6. The five competencies are history taking, mental state examination, risk assessment, differential diagnosis, and case presentation.
7. Revisiting competencies at the end allows trainees to appreciate their development and identify remaining gaps.
8. The synthesis covers mood, psychotic, anxiety, substance use, personality, child, geriatric, and emergency presentations.
9. The exercise is comprehensive because assessment can draw on any part of the course material.
10. Trainees use the competencies as a checklist to measure their own readiness before assessment.

References and Attributions [Series 5]

11. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing.
12. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
13. World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.
14. National Institute for Health and Care Excellence (2011). Self-Harm in Over 8s: Long-Term Management (CG133). NICE.

Figures, Plates, Tables, and Boxes

1. Figure 5.1: Clinical staff calmly de-escalating an agitated patient in the emergency department. AI-generated using the prompt: "Create a realistic clinical illustration titled De-escalating an Agitated Patient, showing two clinical staff members calmly approaching an agitated standing patient with open, non-threatening body language, emergency department setting. Clean clinical illustration style, no text."
2. Table 5.1: Special topics and their core tutorial focus. AI-generated using the prompt: "Create a clean reference table titled Special Topics and Their Core Tutorial Focus, listing topic, core tutorial focus, and key clinical skill. Simple clinical reference table style with outside border."
3. Figure 5.2: A trainee confidently presenting a clinical case to an examiner during assessment. AI-generated using the prompt: "Create a realistic clinical education illustration titled Presenting a Case During Clinical Assessment, showing a trainee standing and speaking confidently with notes in hand, an examiner seated attentively listening, formal assessment room setting. Clean clinical illustration style, no text."