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PSY 603

SUBSPECIALTY PSYCHIATRY

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Course code: PSY 603

Course title: Subspecialty Psychiatry

Course credit load: 2 Units

Series 1: Child and Adolescent Psychiatry: Assessment, Neurodevelopmental, and Disruptive Behaviour Disorders

- **Part 1.1: Foundations of Child and Adolescent Psychiatric Assessment**
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- **Part 1.2: Neurodevelopmental Disorders I: Intellectual Disability and Communication**
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- **Part 1.4: Disruptive Behaviour Disorders and Differential Diagnosis**
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Introduction

Few areas of clinical practice demand as much patience and observational skill as working out what is actually going on inside a child's mind, and this opening Series of **Subspecialty Psychiatry** sets out to build exactly that skill. Children and adolescents rarely announce their distress in the tidy sentences adults use; instead it surfaces in tantrums, withdrawn silence, a stubborn refusal to sit still, or a pattern of wetting the bed long after peers have stopped. Making

sense of these presentations calls for a structured, developmentally informed approach, and that is the task this Series takes on.

The aim of this Series is to equip you with a sound, practical grasp of how psychiatric evaluation of children and adolescents is properly conducted, how elimination disorders and the major neurodevelopmental disorders such as intellectual disability, communication disorders, autism spectrum disorder, attention-deficit/hyperactivity disorder, specific learning disorders, and motor disorders present and are diagnosed, and how disruptive behaviour disorders are assessed and differentiated in this age group.

This Series begins with the **foundations of child and adolescent psychiatric assessment**, before working through **neurodevelopmental disorders** across two Parts covering intellectual disability, communication difficulties, autism, ADHD, learning disorders, and motor disorders, and closes with **disruptive behaviour disorders and their differential diagnosis**.

Series Learning Outcomes

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

- **SLO 1.1:** describe how to perform a psychiatric evaluation of children and adolescents
- **SLO 1.2:** explain the clinical presentation, assessment, and management of elimination disorders
- **SLO 1.3:** describe the diagnostic features and severity levels of intellectual disability and communication disorders
- **SLO 1.4:** describe the core diagnostic features of autism spectrum disorder
- **SLO 1.5:** describe the clinical presentation and assessment of attention-deficit/hyperactivity disorder
- **SLO 1.6:** distinguish specific learning disorders from motor disorders in children and adolescents
- **SLO 1.7:** assess and explain proposed differential diagnosis for children and adolescents presenting with disruptive behaviour
- **SLO 1.8:** compare and contrast oppositional defiant disorder and conduct disorder

1.1 Foundations of Child and Adolescent Psychiatric Assessment

1.1.1 principles of psychiatric evaluation in children and adolescents

Building a developmentally attuned assessment

A **psychiatric evaluation** of a child or adolescent differs fundamentally from an adult assessment because the clinician must interpret behaviour against a shifting backdrop of normal development, gather information from multiple **informants** such as parents, teachers, and the young person, and adapt communication style to the child's cognitive and emotional maturity. The evaluation typically opens with a clear statement of the **presenting complaint** in the words of the referring adult, followed by a careful **developmental history** covering pregnancy, birth, milestones, temperament, and early attachment. Observation of the child's behaviour, affect, and interaction style during the interview itself often yields as much diagnostic information as the history, since younger children in particular struggle to verbalise internal states directly.

A thorough evaluation also requires a **mental state examination** adapted for age, incorporating play-based or drawing techniques for younger children, and structured or semi-structured **interviews** for adolescents capable of more abstract self-report. Collateral information from school reports and standardised rating scales, such as behaviour checklists completed by parents and teachers, strengthens diagnostic confidence by triangulating observations across settings. The clinician must also remain alert to family functioning, psychosocial stressors, and possible safeguarding concerns throughout the process, since disruptive or regressive behaviour in a child can sometimes signal maltreatment rather than a primary psychiatric disorder.

Fill in the blank: A thorough child psychiatric assessment routinely gathers information from multiple _____, including parents, teachers, and the child.

1.1.2 developmental history and informant-based assessment

Triangulating the clinical picture across settings

The **developmental history** anchors the entire assessment, tracing the child's progress through motor, language, social, and cognitive milestones and flagging any delay or regression that might point towards a neurodevelopmental or acquired condition. Clinicians typically ask about pregnancy complications, birth weight, early feeding and sleep patterns, and the age at which the child first sat, walked, spoke in single words, and combined words into short phrases. A history of **regression**, where previously acquired skills are lost, carries particular diagnostic weight and warrants prompt further evaluation, since it can indicate conditions ranging from autism spectrum disorder to rarer neurometabolic disease.

Because children are rarely reliable narrators of their own difficulties, **informant-based assessment** using parents, teachers, and, where appropriate, the child themselves is central to good practice. Discrepancies between informants are not simply noise to be resolved but often meaningful data, since a child who is disruptive at school yet calm at home may be signalling a specific difficulty with the school environment rather than a pervasive disorder. Structured tools such as the Strengths and Difficulties Questionnaire allow this cross-setting information to be gathered systematically and compared over time.

Fill in the blank: The loss of previously acquired developmental skills is referred to as _____ and warrants prompt further evaluation.

1.1.3 elimination disorders: enuresis and encopresis

Recognising and managing bladder and bowel control difficulties

Elimination disorders comprise **enuresis**, the repeated voiding of urine into inappropriate places such as clothing or bed beyond the developmentally expected age of bladder control, and **encopresis**, the repeated passage of faeces into inappropriate places beyond the expected age of bowel control. Enuresis is further classified as nocturnal, diurnal, or a combination of both, and as primary, where continence was never achieved, or secondary, where it follows a period of established continence. A diagnosis generally requires the behaviour to occur at least twice weekly for three consecutive months, or to cause clinically significant distress or impairment, in a child of at least five years of age, the age below which involuntary elimination is considered developmentally normal.

Assessment must first exclude organic causes such as urinary tract infection, diabetes, or structural bowel abnormality before a primary psychiatric diagnosis is made, and encopresis in particular is frequently associated with underlying chronic **constipation** and overflow soiling. Management is typically behavioural and family-centred, involving scheduled toileting, positive reinforcement, bladder training alarms for nocturnal enuresis, and, for encopresis, disimpaction followed by maintenance laxative therapy alongside behavioural retraining. Family psychoeducation is essential throughout, since punitive parental responses to elimination disorders are common, counterproductive, and can worsen the child's distress and shame.

Fill in the blank: Encopresis is frequently associated with underlying chronic _____ and overflow soiling.

Figure 1.1: A clinician conducting a play-based psychiatric assessment with a young child.

Pilot questions 1.1

1. Describe the key components of a psychiatric evaluation of a child or adolescent. (Linked to SLO 1.1)
2. Explain why informant-based assessment across multiple settings strengthens diagnostic confidence in child psychiatry. (Linked to SLO 1.1)
3. Distinguish primary from secondary enuresis. (Linked to SLO 1.2)
4. Discuss the organic causes that must be excluded before diagnosing an elimination disorder. (Linked to SLO 1.2)
5. Outline the behavioural management approach to nocturnal enuresis. (Linked to SLO 1.2)

1.2 Neurodevelopmental Disorders I: Intellectual Disability and Communication

1.2.1 intellectual disability: diagnosis and severity levels

Assessing intellectual and adaptive functioning together

Intellectual disability is diagnosed on the basis of deficits in both **intellectual functioning**, encompassing reasoning, problem-solving, planning, and abstract thinking, and **adaptive**

functioning, covering conceptual, social, and practical skills needed for everyday independent living, with onset during the developmental period. Standardised cognitive testing traditionally generates an intelligence quotient, but current diagnostic frameworks emphasise adaptive functioning as the primary determinant of **severity level**, since two individuals with similar test scores can differ markedly in their day-to-day independence and support needs.

Severity is classified as mild, moderate, severe, or profound, with mild intellectual disability, the most common level, often only becoming apparent once academic demands increase in school, while profound intellectual disability is usually evident from infancy through marked delay across all domains. Aetiology is wide-ranging and includes genetic syndromes such as Down syndrome and fragile X syndrome, prenatal exposures, perinatal complications, and postnatal insults such as significant head injury or central nervous system infection, though a specific cause is not identified in every case. Early identification and individualised support planning, involving educational, medical, and social services, meaningfully improve long-term outcomes and quality of life.

Fill in the blank: Intellectual disability requires deficits in both intellectual functioning and _____ functioning, with onset during the developmental period.

1.2.2 communication disorders in children

Language, speech sound, and fluency difficulties

Communication disorders encompass several distinct presentations, including **language disorder**, characterised by persistent difficulty acquiring and using spoken, written, or other forms of language due to deficits in comprehension or production, **speech sound disorder**, involving persistent difficulty with speech production that interferes with intelligibility, and **childhood-onset fluency disorder**, commonly known as stuttering, which disrupts the normal flow and timing of speech. A separate category, **social (pragmatic) communication disorder**, describes persistent difficulty with the social use of verbal and nonverbal communication, such as adjusting language to context or following conversational turn-taking, in the absence of the restricted or repetitive behaviours seen in autism spectrum disorder.

Diagnosis requires that the difficulties are substantially below what is expected for the child's age, are not better explained by hearing impairment, another medical or neurological condition, or intellectual disability, and result in functional limitations in communication, social participation, or academic achievement. Early speech and language therapy referral is central to management, and outcomes are generally favourable when intervention begins before school entry, underscoring the value of early recognition by both caregivers and clinicians during routine developmental surveillance.

Fill in the blank: Persistent difficulty with the social use of verbal and nonverbal communication, without restricted or repetitive behaviours, describes social _____ communication disorder.

1.2.3 autism spectrum disorder: core features and diagnosis

Two core domains, present from early development

Autism spectrum disorder is defined by two core diagnostic domains present from early childhood: persistent deficits in **social communication and social interaction** across multiple contexts, and **restricted, repetitive patterns** of behaviour, interests, or activities, such as insistence on sameness, highly fixated interests, or unusual sensory reactivity. Social communication deficits can range from a complete absence of interest in social interaction to more subtle difficulties with reciprocal conversation, understanding nonverbal cues, or developing and maintaining relationships appropriate to developmental level.

Diagnosis is clinical, based on developmental history and direct observation, often supported by structured tools such as the Autism Diagnostic Observation Schedule, and current frameworks specify **severity levels** according to the degree of support required in each core domain rather than a single overall autism label. Many children with autism spectrum disorder also present with co-occurring intellectual disability, language impairment, or attention difficulties, and a comprehensive assessment therefore evaluates the whole developmental profile rather than autism symptoms alone. Early behavioural intervention, tailored to the child's individual profile of strengths and difficulties, offers the best prospect of improved long-term functioning.

Fill in the blank: Autism spectrum disorder is defined by deficits in social communication and restricted, _____ patterns of behaviour or interests.

Table 1.1: Comparing intellectual disability, communication disorder, and autism spectrum disorder

Feature	Primary domain affected	Key diagnostic marker
Intellectual disability	Intellectual and adaptive functioning	Deficits in both reasoning and everyday adaptive skills
Communication disorder	Speech or language	Difficulty below age expectation, not due to hearing loss or intellectual disability
Autism spectrum disorder	Social communication and behaviour	Restricted, repetitive behaviours alongside social communication deficits

Pilot questions 1.2

1. Explain why adaptive functioning is emphasised alongside intellectual functioning in diagnosing intellectual disability. (Linked to SLO 1.3)
2. List the severity levels used to classify intellectual disability. (Linked to SLO 1.3)
3. Distinguish language disorder from speech sound disorder. (Linked to SLO 1.3)
4. Describe the two core diagnostic domains of autism spectrum disorder. (Linked to SLO 1.4)
5. Discuss why a comprehensive autism assessment considers the child's whole developmental profile. (Linked to SLO 1.4)

1.3 Neurodevelopmental Disorders II: ADHD, Learning, and Motor Disorders

1.3.1 attention-deficit/hyperactivity disorder

Inattention and hyperactivity-impulsivity across settings

Attention-deficit/hyperactivity disorder, widely known as ADHD, is characterised by a persistent pattern of **inattention** and/or **hyperactivity-impulsivity** that interferes with functioning and is inconsistent with developmental level. Inattentive presentations include difficulty sustaining attention, apparent failure to listen, poor organisation, and forgetfulness in daily activities, while hyperactive-impulsive presentations include fidgeting, difficulty remaining seated, excessive talking, and impulsive interrupting. Diagnosis requires several symptoms to be present before the age of twelve, to occur across at least two settings such as home and school, and to cause clear impairment in social, academic, or occupational functioning.

The three recognised presentations are predominantly inattentive, predominantly hyperactive-impulsive, and combined presentation, and symptom profile often shifts with age, with overt hyperactivity typically diminishing while inattentive difficulties persist into adolescence and adulthood. Assessment draws on parent and teacher rating scales, direct clinical observation, and careful exclusion of alternative explanations such as anxiety, learning difficulty, or hearing impairment, since these can produce inattentive-looking behaviour without true ADHD. Management combines behavioural strategies and classroom accommodations with, in appropriate cases, stimulant or non-stimulant pharmacotherapy under specialist supervision.

Fill in the blank: A diagnosis of ADHD requires symptoms to be present across at least _____ settings and to begin before the age of twelve.

1.3.2 specific learning disorders

Persistent difficulty despite adequate instruction

Specific learning disorder describes persistent difficulty learning and using academic skills, such as reading, written expression, or mathematics, that is not explained by intellectual disability, uncorrected sensory impairment, or inadequate educational instruction, and that has been present for at least six months despite targeted intervention. The disorder is specified according to the affected domain, most commonly reading, where it is often referred to as dyslexia, though this term is not itself a formal diagnostic category, and academic performance in the affected domain falls substantially and measurably below what is expected for the child's age.

Because specific learning disorder can easily be mistaken for low motivation, inattention, or general low ability, a careful history distinguishing genuinely persistent, domain-specific difficulty from broader intellectual or attentional difficulty is essential, and formal psychoeducational assessment is often required to confirm the diagnosis and characterise its precise pattern. Early identification allows for targeted remedial teaching, appropriate classroom accommodations such as extra time in assessments, and psychological support to address the secondary effects on self-esteem that persistent academic struggle commonly produces.

Fill in the blank: Specific learning disorder must be present for at least _____ months despite targeted educational intervention.

1.3.3 motor disorders: developmental coordination and tic disorders

Coordination difficulty and involuntary movements or sounds

Developmental coordination disorder is diagnosed when the acquisition and execution of coordinated motor skills is substantially below what is expected for age and opportunity for skill learning, producing clumsiness and slowness in tasks such as catching a ball, handwriting, or using cutlery, and causing significant interference with academic or daily activities. The difficulty must not be better explained by intellectual disability, visual impairment, or a neurological condition affecting movement, and it typically becomes apparent as the child fails to meet expected motor milestones or struggles disproportionately with physical education and self-care tasks.

Tic disorders involve sudden, rapid, recurrent, non-rhythmic motor movements or vocalisations, and are classified according to type and duration: **Tourette's disorder** requires both multiple motor tics and one or more vocal tics present for more than a year with onset before age eighteen, while **persistent motor or vocal tic disorder** involves only one type of tic persisting beyond a year, and **provisional tic disorder** describes tics present for less than a year. Tics

characteristically wax and wane in severity, are often temporarily suppressible with effort, and are commonly preceded by an uncomfortable premonitory urge, features that together help distinguish them from other involuntary movements.

Fill in the blank: Tourette's disorder requires both multiple motor tics and one or more _____ tics persisting for more than a year.

Figure 1.2: A child exhibiting a sudden motor tic during a classroom setting.

Pilot questions 1.3

1. List the three recognised presentations of ADHD. (Linked to SLO 1.5)
2. Explain why alternative explanations must be excluded before diagnosing ADHD. (Linked to SLO 1.5)
3. Define specific learning disorder. (Linked to SLO 1.6)
4. Distinguish developmental coordination disorder from tic disorders. (Linked to SLO 1.6)
5. Compare Tourette's disorder with provisional tic disorder. (Linked to SLO 1.6)

1.4 Disruptive Behaviour Disorders and Differential Diagnosis

1.4.1 oppositional defiant disorder

A pattern of angry, defiant, and vindictive behaviour

Oppositional defiant disorder is characterised by a persistent pattern of angry or irritable mood, argumentative or defiant behaviour, and vindictiveness directed primarily at authority figures, lasting at least six months and exceeding what is developmentally typical for the child's age. Typical features include frequent temper outbursts, deliberately annoying others, blaming others for one's own mistakes, and being spiteful or vindictive on at least two occasions within the preceding six months, with severity graded according to whether symptoms are confined to one setting or pervasive across multiple settings.

Unlike conduct disorder, oppositional defiant disorder does not typically involve serious violation of the rights of others or major societal norms such as aggression towards people or animals, destruction of property, or theft, though the two conditions frequently co-occur and oppositional defiant disorder in early childhood is a recognised risk factor for later conduct disorder. Management centres on parent management training, which helps caregivers respond consistently and use positive reinforcement effectively, alongside individual or family therapy addressing communication patterns that may be maintaining the behaviour.

Fill in the blank: Oppositional defiant disorder symptoms must persist for at least _____ months and exceed developmental expectations.

1.4.2 conduct disorder

Repetitive violation of others' rights or societal norms

Conduct disorder is defined by a repetitive and persistent pattern of behaviour that violates the basic rights of others or major age-appropriate societal norms, falling into four broad categories: aggression towards people or animals, destruction of property, deceitfulness or theft, and serious rule violations such as running away from home or truancy. Diagnosis requires at least three characteristic behaviours within the preceding twelve months, with at least one present in the past six months, and the condition is specified according to whether onset occurred in childhood or adolescence, a distinction that carries meaningful prognostic weight.

A childhood-onset presentation, appearing before age ten, is associated with a more persistent course and greater likelihood of continuing into adult antisocial behaviour, whereas adolescent-onset conduct disorder often arises in the context of peer influence and tends to remit by adulthood in a larger proportion of cases. A specifier of **limited prosocial emotions**, describing a callous, unemotional interpersonal style with reduced empathy and guilt, identifies a subgroup

with a particularly severe and treatment-resistant course, and management is correspondingly intensive, drawing on multisystemic family, school, and community-based interventions.

Fill in the blank: Conduct disorder with onset before age ten is described as _____-onset and carries a more persistent prognosis.

1.4.3 differential diagnosis of disruptive behaviour in children and adolescents

Distinguishing primary behaviour disorders from other explanations

Disruptive behaviour in children and adolescents rarely has a single, obvious explanation, and careful **differential diagnosis** must consider ADHD, where impulsivity rather than deliberate defiance drives the behaviour, mood and anxiety disorders, where irritability can masquerade as oppositionality, autism spectrum disorder, where rigidity and sensory overload can trigger apparent tantrums, and untreated learning difficulty, where frustration with unmet academic demands can present as classroom disruption. Trauma exposure and adverse home circumstances must also be actively considered, since behavioural disturbance is sometimes the clearest signal a distressed child can give of an underlying safeguarding concern.

A systematic differential approach combines a detailed developmental and family history, direct behavioural observation across settings, standardised rating scales, and, where indicated, cognitive or language assessment, before a primary disruptive behaviour disorder diagnosis is confirmed. Because oppositional defiant disorder, conduct disorder, and ADHD frequently co-occur, clinicians must resist settling on the first plausible diagnosis and instead systematically screen for coexisting conditions, since comorbidity is the norm rather than the exception in this clinical population and shapes the overall management plan considerably.

Fill in the blank: Irritability in mood or anxiety disorders can be mistaken for oppositionality, making careful _____ diagnosis essential.

Table 1.2: Distinguishing features across disruptive presentations

Condition	Core driver of behaviour	Key distinguishing feature
Oppositional defiant disorder	Angry, defiant mood towards authority	No major violation of others' rights or property
Conduct disorder	Disregard for others' rights and norms	Aggression, destruction, deceit, or serious rule violation
ADHD-driven disruption	Impulsivity and inattention	Behaviour reflects poor self-regulation, not deliberate defiance

Pilot questions 1.4

1. Describe the core features of oppositional defiant disorder. (Linked to SLO 1.8)
2. List the four categories of behaviour used to diagnose conduct disorder. (Linked to SLO 1.8)
3. Compare childhood-onset and adolescent-onset conduct disorder. (Linked to SLO 1.8)
4. Discuss the range of conditions that must be considered in the differential diagnosis of disruptive behaviour. (Linked to SLO 1.7)
5. Explain why comorbidity should routinely be screened for in children presenting with disruptive behaviour. (Linked to SLO 1.7)

Series Summary

This opening Series set out to build a sound, structured foundation for assessing and diagnosing psychiatric presentations in children and adolescents, and each Part has added a distinct piece to that foundation. Part 1.1 established the principles of psychiatric evaluation in this age group, the value of developmental history and informant-based assessment, and the recognition and management of elimination disorders, while Parts 1.2 and 1.3 worked through the major neurodevelopmental disorders in turn, intellectual disability, communication disorders, and autism spectrum disorder, followed by ADHD, specific learning disorders, and motor disorders including tic disorders, before Part 1.4 closed the Series with oppositional defiant disorder, conduct disorder, and the differential diagnosis of disruptive behaviour more broadly.

Taken together, these four Parts leave you able to describe how a psychiatric evaluation of a child or adolescent is properly performed, to recognise and distinguish the major neurodevelopmental disorders covered here, and to assess and explain a proposed differential diagnosis for a child or adolescent presenting with disruptive behaviour, precisely the outcomes set out at the start of this Series. Series 2 turns next to consultation-liaison psychiatry, examining psychiatric assessment in patients with physical illness and the somatic and related disorders that arise at the interface between physical and mental health.

Glossary of Terms

- **Adaptive functioning:** conceptual, social, and practical skills needed for everyday independent living.
- **Autism spectrum disorder:** a neurodevelopmental disorder marked by deficits in social communication and restricted, repetitive behaviours.
- **Communication disorder:** persistent difficulty with speech, language, or social use of communication, not explained by hearing loss or intellectual disability.
- **Conduct disorder:** a repetitive pattern of behaviour that violates the basic rights of others or major societal norms.
- **Developmental coordination disorder:** substantially below-expected acquisition and execution of coordinated motor skills.
- **Elimination disorder:** repeated, developmentally inappropriate voiding of urine or passage of faeces.
- **Encopresis:** repeated passage of faeces into inappropriate places beyond the expected age of bowel control.
- **Enuresis:** repeated voiding of urine into inappropriate places beyond the expected age of bladder control.
- **Informant-based assessment:** gathering diagnostic information from parents, teachers, and the child across settings.
- **Intellectual disability:** deficits in both intellectual and adaptive functioning with onset during the developmental period.
- **Oppositional defiant disorder:** a persistent pattern of angry, argumentative, or vindictive behaviour towards authority figures.
- **Tic disorder:** a condition involving sudden, rapid, recurrent, non-rhythmic motor movements or vocalisations.

Concept Check Questions [Series 1]

Objective questions

1. A thorough child psychiatric assessment routinely gathers information from multiple _____, including parents, teachers, and the child. (Linked to SLO 1.1)
2. Encopresis is frequently associated with underlying chronic _____ and overflow soiling. (Linked to SLO 1.2)
3. Intellectual disability requires deficits in both intellectual functioning and _____ functioning. (Linked to SLO 1.3)
4. Autism spectrum disorder is defined by deficits in social communication and restricted, _____ patterns of behaviour. (Linked to SLO 1.4)

5. Tourette's disorder requires both multiple motor tics and one or more _____ tics persisting for more than a year. (Linked to SLO 1.6)

Short-answer questions

6. Describe two features of a developmentally attuned psychiatric evaluation of a child. (Linked to SLO 1.1)
7. Distinguish primary from secondary enuresis. (Linked to SLO 1.2)
8. Explain why adaptive functioning is central to grading the severity of intellectual disability. (Linked to SLO 1.3)
9. List the three presentations of ADHD. (Linked to SLO 1.5)
10. Distinguish oppositional defiant disorder from conduct disorder. (Linked to SLO 1.8)

Long-answer questions

11. Discuss the process of conducting a psychiatric evaluation of a child or adolescent, including the role of informant-based assessment. (Linked to SLO 1.1)
12. Explain the clinical presentation, assessment, and management of elimination disorders. (Linked to SLO 1.2)
13. Compare intellectual disability, communication disorder, and autism spectrum disorder in terms of their core diagnostic features. (Linked to SLO 1.3, 1.4)
14. Discuss the clinical presentation and assessment of ADHD, including how it is distinguished from specific learning disorder and motor disorders. (Linked to SLO 1.5, 1.6)
15. Assess and explain the differential diagnosis for a child or adolescent presenting with disruptive behaviour, comparing oppositional defiant disorder and conduct disorder. (Linked to SLO 1.7, 1.8)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Informants.
2. Constipation.
3. Adaptive.
4. Repetitive.
5. Vocal.

Short-answer questions

6. A developmentally attuned evaluation adapts communication to the child's age, for example through play-based techniques, and gathers information from multiple informants rather than relying on self-report alone.
7. Primary enuresis means continence was never achieved, while secondary enuresis follows a period of established continence before wetting recurs.
8. Two individuals with similar intelligence quotients can differ markedly in day-to-day independence, so adaptive functioning better reflects real-world support needs and determines severity level.
9. The three presentations are predominantly inattentive, predominantly hyperactive-impulsive, and combined presentation.
10. Oppositional defiant disorder involves angry, defiant behaviour towards authority without major rights violations, while conduct disorder involves serious violation of others' rights or societal norms.

Long-answer questions

11. **Basic response:** The evaluation begins with the presenting complaint, followed by developmental history, behavioural observation, and an age-adapted mental state examination, drawing on parents, teachers, and the child as informants.

Value-added response: A value-added response also notes the diagnostic weight of discrepancies between informants, and the role of standardised rating scales such as the Strengths and Difficulties Questionnaire in systematising cross-setting comparison, alongside vigilance for safeguarding concerns.

12. **Basic response:** Enuresis and encopresis involve repeated, developmentally inappropriate voiding of urine or passage of faeces; assessment excludes organic causes, and management is behavioural, including toileting schedules and, for encopresis, disimpaction and maintenance therapy.

Value-added response: A value-added response also distinguishes nocturnal from diurnal enuresis, notes the role of bladder training alarms, and highlights the importance of family psychoeducation to counter punitive parental responses that can worsen a child's shame and distress.

13. **Basic response:** Intellectual disability involves deficits in both intellectual and adaptive functioning; communication disorder involves persistent speech or language difficulty not explained by hearing loss or intellectual disability; autism spectrum disorder involves social communication deficits plus restricted, repetitive behaviours.

Value-added response: A value-added response notes that these conditions frequently co-occur, and that a comprehensive assessment therefore evaluates the child's whole developmental profile rather than treating each diagnosis in isolation.

14. **Basic response:** ADHD presents with inattention and/or hyperactivity-impulsivity across at least two settings; specific learning disorder involves persistent, domain-specific academic difficulty despite adequate instruction; motor disorders involve coordination difficulty or involuntary movements, distinct from attentional or academic difficulty.

Value-added response: A value-added response notes that alternative explanations such as anxiety or hearing impairment must be excluded before diagnosing ADHD, and that these conditions frequently co-occur, requiring systematic screening rather than a single-diagnosis mindset.

15. **Basic response:** Differential diagnosis considers ADHD, mood or anxiety disorders, autism spectrum disorder, learning difficulty, and trauma exposure alongside oppositional defiant disorder and conduct disorder, the latter distinguished by serious violation of others' rights or societal norms.

Value-added response: A value-added response notes that oppositional defiant disorder in early childhood is a risk factor for later conduct disorder, that a limited prosocial emotions specifier identifies a more severe conduct disorder subgroup, and that comorbidity is the norm rather than the exception in this population.

Answers to Pilot Questions [Series 1]

Part 1.1

1. A psychiatric evaluation includes the presenting complaint, developmental history, mental state examination adapted for age, and information from multiple informants.
2. Cross-setting assessment reveals whether behaviour is pervasive or context-specific, which shapes both diagnosis and management.
3. Primary enuresis means continence was never achieved; secondary enuresis follows a period of established continence.
4. Organic causes such as urinary tract infection, diabetes, and structural bowel abnormality must be excluded before an elimination disorder is diagnosed.
5. Behavioural management includes scheduled toileting, positive reinforcement, and bladder training alarms.

Part 1.2

1. Adaptive functioning better reflects real-world independence and support needs than intelligence quotient alone.
2. The severity levels are mild, moderate, severe, and profound.
3. Language disorder involves difficulty acquiring and using language itself, while speech sound disorder involves difficulty producing intelligible speech sounds.
4. The two core domains are social communication and social interaction deficits, and restricted, repetitive patterns of behaviour or interests.
5. A comprehensive assessment considers co-occurring intellectual disability, language impairment, or attention difficulty, not autism symptoms alone.

Part 1.3

1. The three presentations are predominantly inattentive, predominantly hyperactive-impulsive, and combined presentation.
2. Anxiety, learning difficulty, and hearing impairment can produce inattentive-looking behaviour without true ADHD.
3. Specific learning disorder is persistent, domain-specific academic difficulty not explained by intellectual disability, sensory impairment, or inadequate instruction.
4. Developmental coordination disorder involves motor clumsiness, while tic disorders involve sudden, involuntary movements or vocalisations.
5. Tourette's disorder requires both motor and vocal tics for over a year, while provisional tic disorder involves tics present for under a year.

Part 1.4

1. Oppositional defiant disorder involves angry, irritable mood and defiant, vindictive behaviour towards authority figures for at least six months.
2. The four categories are aggression to people or animals, destruction of property, deceitfulness or theft, and serious rule violations.
3. Childhood-onset conduct disorder is more persistent and associated with adult antisocial behaviour, while adolescent-onset often remits by adulthood.
4. Differential diagnosis considers ADHD, mood and anxiety disorders, autism spectrum disorder, learning difficulty, and trauma exposure.
5. Comorbidity is the norm rather than the exception, and unscreened coexisting conditions can undermine an otherwise appropriate management plan.

References and Attributions [Series 1]

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- Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
- World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.

Figures, Plates, Tables, and Boxes

- Figure 1.1: A clinician conducting a play-based psychiatric assessment with a young child. AI-generated using the prompt: "Create a realistic clinical illustration titled Play-Based Psychiatric Assessment of a Child, showing a child psychiatrist seated at a low table with a young child during a play-based interview, using simple toys and drawing materials, warm consulting-room setting. Clean clinical illustration style, no text."
- Table 1.1: Comparing intellectual disability, communication disorder, and autism spectrum disorder. AI-generated using the prompt: "Create a clean reference table titled Comparing Intellectual Disability, Communication Disorder, and Autism Spectrum Disorder, listing feature, primary domain affected, and key diagnostic marker. Simple clinical reference table style with outside border."
- Figure 1.2: A child exhibiting a sudden motor tic during a classroom setting. AI-generated using the prompt: "Create a realistic clinical illustration titled A Motor Tic in a School-Age Child, showing a child at a classroom desk mid-tic, shoulder raised in a sudden involuntary shrug, other children and teacher unaffected in the background. Clean clinical illustration style, no text."
- Table 1.2: Distinguishing features across disruptive presentations. AI-generated using the prompt: "Create a clean reference table titled Distinguishing Features Across Disruptive Presentations, listing condition, core driver of behaviour, and key distinguishing feature. Simple clinical reference table style with outside border."

Course code: PSY 603

Course title: Subspecialty Psychiatry

Course credit load: 2 Units

Series 2: Consultation-Liaison Psychiatry: Physical Illness, Somatic Disorders, and Related Conditions

- **Part 2.1: Consultation-Liaison Psychiatry and Assessment of Physical Illness**
  - Sub Part 2.1.1: Principles of consultation-liaison psychiatry
  - Sub Part 2.1.2: Psychiatric assessment in patients with physical illness
  - Sub Part 2.1.3: Psychological factors affecting other medical conditions
- **Part 2.2: Somatic Symptom and Related Disorders**
  - Sub Part 2.2.1: Somatic symptom disorder
  - Sub Part 2.2.2: Illness anxiety disorder
  - Sub Part 2.2.3: Conversion disorder
- **Part 2.3: Organic and Dissociative Disorders in Physical Illness**
  - Sub Part 2.3.1: Organic mood disorders
  - Sub Part 2.3.2: Organic psychotic disorders
  - Sub Part 2.3.3: Dissociative disorders
- **Part 2.4: Feeding, Eating, Sleep-Wake, and Sexual Disorders**
  - Sub Part 2.4.1: Feeding and eating disorders
  - Sub Part 2.4.2: Sleep-wake disorders
  - Sub Part 2.4.3: Sexual dysfunction

Introduction

A broken hip can trigger delirium. A thyroid disorder can look exactly like depression. This Series turns to the place where physical and mental health meet, **consultation-liaison psychiatry**, and the disorders that arise at that interface.

The aim of this Series is to equip you with a working understanding of psychiatric assessment in physically ill patients, somatic symptom and related disorders, organic mood, psychotic, and dissociative disorders, and feeding, sleep, and sexual difficulties encountered in this setting.

This Series opens with **consultation-liaison psychiatry and assessment of physical illness**, moves to **somatic symptom and related disorders**, then **organic and dissociative disorders**, and closes with **feeding, eating, sleep-wake, and sexual disorders**.

Series Learning Outcomes

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

- **SLO 2.1:** illustrate psychiatric assessment in patients with physical illness
- **SLO 2.2:** enumerate how psychological factors affect other medical conditions
- **SLO 2.3:** describe the clinical features of somatic symptom and related disorders
- **SLO 2.4:** distinguish illness anxiety disorder from conversion disorder
- **SLO 2.5:** describe organic mood and psychotic disorders arising from physical illness
- **SLO 2.6:** describe the clinical features of dissociative disorders
- **SLO 2.7:** describe feeding, eating, and sleep-wake disorders
- **SLO 2.8:** describe the assessment of sexual dysfunction

2.1 Consultation-Liaison Psychiatry and Assessment of Physical Illness

2.1.1 principles of consultation-liaison psychiatry

Bridging physical and mental health care

Consultation-liaison psychiatry is the subspecialty concerned with psychiatric care of patients admitted to general medical or surgical wards. The psychiatrist works alongside the primary medical team, assessing how physical illness, treatment, and hospitalisation itself affect mental state, and advising on management.

Common referral reasons include **delirium**, capacity assessment, self-harm following medical admission, and unexplained physical symptoms. Effective liaison work requires close communication with ward staff and an understanding of the medical condition being treated, since psychiatric symptoms in this setting are frequently intertwined with physical pathology.

Fill in the blank: Consultation-liaison psychiatry provides psychiatric care to patients admitted to general medical or _____ wards.

2.1.2 psychiatric assessment in patients with physical illness

Separating physical, psychological, and iatrogenic contributions

Assessing a physically ill patient requires distinguishing symptoms caused directly by the **medical illness**, those caused by its **treatment**, such as steroid-induced mood change, and those reflecting a genuinely independent psychiatric disorder. A thorough physical and medication history is therefore essential before any psychiatric diagnosis is confirmed.

Clinicians must also consider the psychological impact of diagnosis, prognosis, and functional loss, which can produce adjustment reactions indistinguishable at first glance from a primary mood disorder. Collateral history from family and the medical team, alongside careful mental state examination, helps clarify the picture.

Fill in the blank: Steroid-induced mood change illustrates how a medication _____ can mimic a primary psychiatric disorder.

2.1.3 psychological factors affecting other medical conditions

When mind and body affect each other directly

Psychological factors affecting other medical conditions describes a diagnosis where psychological or behavioural factors adversely influence a medical condition, worsening its course, interfering with treatment, or constituting an additional health risk. Relevant examples include **epilepsy**, where stress can precipitate seizures, and endocrine conditions such as diabetes, where distress can undermine adherence.

Cardiovascular and neurological conditions are similarly affected, with anxiety and depression both increasing cardiac risk and complicating recovery after events such as myocardial infarction or stroke. Management addresses the psychological factor directly, alongside standard treatment of the medical condition itself.

Fill in the blank: Psychological factors affecting other medical conditions can worsen course, interfere with treatment, or add extra health _____.

Figure 2.1: A psychiatrist and physician conducting a joint consultation at a patient's hospital bedside.

Pilot questions 2.1

- Define consultation-liaison psychiatry. (Linked to SLO 2.1)
- List two common reasons for psychiatric referral on a medical ward. (Linked to SLO 2.1)
- Explain why medication history matters when assessing a physically ill patient. (Linked to SLO 2.1)
- Give two examples of medical conditions affected by psychological factors. (Linked to SLO 2.2)
- Explain how anxiety can worsen cardiovascular outcomes. (Linked to SLO 2.2)

2.2 Somatic Symptom and Related Disorders

2.2.1 somatic symptom disorder

Distressing physical symptoms with excessive concern

Somatic symptom disorder involves one or more distressing physical symptoms accompanied by excessive thoughts, feelings, or behaviours related to those symptoms, such as disproportionate concern about their seriousness. The physical symptoms themselves may or may not be medically explained; the diagnostic focus is on the excessive response to them.

Symptoms must persist for more than six months, though the specific symptom experienced may change over time. Management favours a consistent single physician, regular scheduled reviews rather than symptom-driven visits, and gradual introduction of psychological therapy.

Fill in the blank: Somatic symptom disorder requires distressing physical symptoms lasting more than _____ months.

2.2.2 illness anxiety disorder

Preoccupation with having a serious illness

Illness anxiety disorder is a preoccupation with having or acquiring a serious illness, in the absence of significant somatic symptoms, or with symptoms only mild in intensity. Anxiety about health dominates, and the person engages in excessive health-related behaviours, such as repeated checking, or maladaptive avoidance, such as avoiding medical appointments entirely.

The preoccupation must persist for at least six months, though the specific illness feared may change. Reassurance alone is typically ineffective and can paradoxically reinforce checking behaviour, so structured cognitive behavioural approaches are preferred.

Fill in the blank: Illness anxiety disorder involves preoccupation with serious illness in the absence of significant _____ symptoms.

2.2.3 conversion disorder

Neurological symptoms incompatible with disease

Conversion disorder, also called functional neurological symptom disorder, presents with altered voluntary motor or sensory function, such as weakness, abnormal movement, or sensory loss, that is incompatible with recognised neurological disease. Clinical examination often reveals findings inconsistent with a specific neuroanatomical pattern.

The symptom causes significant distress or impairment and is not better explained by another medical or mental disorder. Management involves clear, non-judgemental explanation of the

diagnosis, physiotherapy for motor symptoms, and psychological therapy addressing any contributing stress.

Fill in the blank: Conversion disorder presents with motor or sensory symptoms incompatible with recognised _____ disease.

Table 2.1: Comparing somatic symptom disorder, illness anxiety disorder, and conversion disorder

Disorder	Core feature	Symptom explained medically?
Somatic symptom disorder	Excessive response to physical symptoms	May or may not be explained
Illness anxiety disorder	Preoccupation with having serious illness	Symptoms minimal or absent
Conversion disorder	Neurological symptom incompatible with disease	Not explained by recognised disease

Pilot questions 2.2

1. Define somatic symptom disorder. (Linked to SLO 2.3)
2. Describe the recommended management approach for somatic symptom disorder. (Linked to SLO 2.3)
3. Distinguish illness anxiety disorder from somatic symptom disorder. (Linked to SLO 2.4)
4. Describe the typical clinical presentation of conversion disorder. (Linked to SLO 2.4)
5. Explain why reassurance alone is often ineffective in illness anxiety disorder. (Linked to SLO 2.4)

2.3 Organic and Dissociative Disorders in Physical Illness

2.3.1 organic mood disorders

Mood change directly caused by a medical condition

Organic mood disorder describes a prominent, persistent mood disturbance, depressive or manic, judged to be the direct physiological consequence of a medical condition, such as hypothyroidism, stroke, or corticosteroid use, rather than a primary psychiatric illness. Timing and course closely track the underlying medical condition.

Diagnosis requires evidence from history, examination, or investigation linking the mood disturbance directly to the medical cause, and exclusion of delirium as the primary explanation. Treating the underlying condition often improves mood, though adjunctive psychiatric treatment may still be required.

Fill in the blank: Organic mood disorder requires evidence directly linking mood disturbance to an underlying _____ condition.

2.3.2 organic psychotic disorders

Psychosis with a demonstrable medical cause

Organic psychotic disorder involves prominent hallucinations or delusions judged to be the direct physiological consequence of a medical condition, such as central nervous system infection, autoimmune encephalitis, or substance intoxication. Onset is often relatively acute and closely follows the medical trigger.

A thorough medical work-up, including relevant investigations, is essential before attributing new-onset psychosis to a primary psychiatric disorder, particularly in patients without a prior psychiatric history. Treatment targets the underlying cause alongside short-term antipsychotic medication where needed.

Fill in the blank: New-onset psychosis without prior psychiatric history warrants a thorough medical _____ before diagnosis.

2.3.3 dissociative disorders

Disruption of the normally integrated functions of consciousness

Dissociative disorders involve disruption of the normally integrated functions of consciousness, memory, identity, or perception. Presentations include dissociative amnesia, an inability to recall important personal information usually following stressful or traumatic events, and depersonalisation-derealisation, a persistent sense of detachment from oneself or one's surroundings.

Dissociative symptoms often emerge in the context of overwhelming psychological stress or trauma and must be distinguished from organic causes of memory disturbance, such as head injury or substance use. Management centres on trauma-focused psychological therapy once organic causes are excluded.

Fill in the blank: Dissociative amnesia is an inability to recall important personal information, usually following _____ events.

Figure 2.2: A hospitalised patient showing acute confusion consistent with an organic mental state disturbance.

Pilot questions 2.3

1. Define organic mood disorder. (Linked to SLO 2.5)
2. List two medical conditions that can cause organic mood disturbance. (Linked to SLO 2.5)
3. Explain why a medical work-up is essential before diagnosing organic psychotic disorder. (Linked to SLO 2.5)
4. Describe dissociative amnesia. (Linked to SLO 2.6)
5. Explain the role of trauma in dissociative disorders. (Linked to SLO 2.6)

2.4 Feeding, Eating, Sleep-Wake, and Sexual Disorders

2.4.1 feeding and eating disorders

Disturbed eating with medical consequences

Feeding and eating disorders include anorexia nervosa, characterised by restriction of energy intake leading to significantly low body weight alongside intense fear of weight gain, and

bulimia nervosa, characterised by recurrent binge eating followed by compensatory behaviours such as self-induced vomiting.

Both conditions carry significant medical risk, including electrolyte disturbance and cardiac complications, making close liaison between psychiatry and physical medicine essential. Management combines nutritional rehabilitation with psychological therapy addressing the underlying cognitions about weight and shape.

Fill in the blank: Anorexia nervosa involves restriction of energy intake leading to significantly low _____.

2.4.2 sleep-wake disorders

Persistent difficulty with sleep quality or timing

Sleep-wake disorders include insomnia disorder, persistent difficulty initiating or maintaining sleep, and hypersomnolence, excessive sleepiness despite adequate sleep duration. Both require the disturbance to cause significant distress or functional impairment and to occur at least three nights or times per week for three months.

Assessment should exclude an underlying medical or psychiatric cause and consider a sleep diary to characterise the pattern objectively. Management begins with sleep hygiene measures and, where indicated, structured cognitive behavioural therapy for insomnia.

Fill in the blank: Insomnia disorder requires sleep disturbance at least three nights per week for _____ months.

2.4.3 sexual dysfunction

Disturbance in the sexual response cycle

Sexual dysfunction describes a clinically significant disturbance in a person's capacity to respond sexually or to experience sexual pleasure, including presentations such as erectile disorder and female sexual interest/arousal disorder. Symptoms must persist for approximately six months and cause significant distress.

Assessment requires a careful physical, medication, and psychological history, since sexual dysfunction commonly arises from medical illness, medication side effects, or relationship and psychological factors, often in combination. Management addresses the identified contributing factors directly.

Fill in the blank: Sexual dysfunction symptoms must persist for approximately _____ months and cause significant distress.

Table 2.2: Common contributors to sexual dysfunction

Contributor	Example	Assessment implication
Medical illness	Diabetes, cardiovascular disease	Requires physical examination and investigation
Medication	Antidepressants, antihypertensives	Requires careful medication review
Psychological factors	Anxiety, relationship difficulty	Requires psychological and relationship history

Pilot questions 2.4

1. Distinguish anorexia nervosa from bulimia nervosa. (Linked to SLO 2.7)
2. List a medical risk associated with eating disorders. (Linked to SLO 2.7)
3. Define insomnia disorder. (Linked to SLO 2.7)
4. List three categories of contributor to sexual dysfunction. (Linked to SLO 2.8)
5. Explain why medication review is important when assessing sexual dysfunction. (Linked to SLO 2.8)

Series Summary

This Series explored the interface between physical and mental health. Part 2.1 covered consultation-liaison psychiatry and assessment of physical illness, while Part 2.2 turned to somatic symptom, illness anxiety, and conversion disorders. Part 2.3 examined organic mood, psychotic, and dissociative disorders, and Part 2.4 closed with feeding, sleep-wake, and sexual disorders.

You should now be able to illustrate psychiatric assessment in physically ill patients, enumerate relevant psychological factors, and describe the disorders covered across all four Parts, meeting the outcomes set for this Series. Series 3 turns next to geriatric psychiatry and neurocognitive disorders.

Glossary of Terms

1. **Consultation-liaison psychiatry:** psychiatric care provided to patients on general medical or surgical wards.
2. **Conversion disorder:** altered motor or sensory function incompatible with recognised neurological disease.
3. **Delirium:** an acute confusional state commonly triggering psychiatric referral in hospital.
4. **Depersonalisation-derealisation:** a persistent sense of detachment from oneself or one's surroundings.
5. **Dissociative amnesia:** inability to recall important personal information, usually following stress or trauma.
6. **Hypersomnolence:** excessive sleepiness despite adequate sleep duration.
7. **Illness anxiety disorder:** preoccupation with having a serious illness with minimal or absent symptoms.
8. **Insomnia disorder:** persistent difficulty initiating or maintaining sleep causing impairment.
9. **Organic mood disorder:** a mood disturbance directly caused by a medical condition.
10. **Organic psychotic disorder:** psychosis directly caused by a demonstrable medical condition.
11. **Sexual dysfunction:** clinically significant disturbance in sexual response or pleasure.
12. **Somatic symptom disorder:** distressing physical symptoms with excessive thoughts or behaviours about them.

Concept Check Questions [Series 2]

Objective questions

- Consultation-liaison psychiatry provides psychiatric care to patients admitted to general medical or _____ wards. (Linked to SLO 2.1)
- Somatic symptom disorder requires distressing physical symptoms lasting more than _____ months. (Linked to SLO 2.3)
- Conversion disorder presents with motor or sensory symptoms incompatible with recognised _____ disease. (Linked to SLO 2.4)
- Organic mood disorder requires evidence directly linking mood disturbance to an underlying _____ condition. (Linked to SLO 2.5)
- Anorexia nervosa involves restriction of energy intake leading to significantly low _____. (Linked to SLO 2.7)

Short-answer questions

1. List two common reasons for psychiatric referral on a medical ward. (Linked to SLO 2.1)
2. Distinguish illness anxiety disorder from somatic symptom disorder. (Linked to SLO 2.3)
3. Describe the typical clinical presentation of conversion disorder. (Linked to SLO 2.4)
4. Explain why a medical work-up is essential before diagnosing organic psychotic disorder. (Linked to SLO 2.5)
5. Define insomnia disorder. (Linked to SLO 2.7)

Long-answer questions

6. Discuss the principles of consultation-liaison psychiatry and how psychological factors affect other medical conditions. (Linked to SLO 2.1, 2.2)
7. Compare somatic symptom disorder, illness anxiety disorder, and conversion disorder. (Linked to SLO 2.3, 2.4)
8. Discuss organic mood and psychotic disorders, including how they are distinguished from primary psychiatric illness. (Linked to SLO 2.5)
9. Describe the clinical features of dissociative disorders and their relationship to trauma. (Linked to SLO 2.6)
10. Discuss feeding, eating, sleep-wake, and sexual disorders and the common contributors to sexual dysfunction. (Linked to SLO 2.7, 2.8)

Answers to Concept Check Questions [Series 2]

Objective questions

11. Surgical.
12. Six.
13. Neurological.
14. Medical.
15. Body weight.

Short-answer questions

16. Common reasons include delirium, capacity assessment, self-harm following medical admission, and unexplained physical symptoms.
17. Illness anxiety disorder involves preoccupation with serious illness with minimal symptoms, while somatic symptom disorder involves excessive response to actual distressing physical symptoms.
18. Conversion disorder presents with motor or sensory symptoms incompatible with recognised neurological disease, often with examination findings inconsistent with a specific neuroanatomical pattern.

19. A medical work-up excludes treatable organic causes such as infection or encephalitis before new-onset psychosis is attributed to a primary psychiatric disorder.
20. Insomnia disorder is persistent difficulty initiating or maintaining sleep, occurring at least three nights weekly for three months and causing impairment.

Long-answer questions

21. **Basic response:** Consultation-liaison psychiatry provides care on medical wards, assessing how illness, treatment, and hospitalisation affect mental state; psychological factors such as stress can worsen conditions like epilepsy, diabetes, and cardiovascular disease.

Value-added response: A value-added response notes the importance of distinguishing illness, treatment, and independent psychiatric contributions, and the need for close liaison with the primary medical team.

22. **Basic response:** Somatic symptom disorder involves excessive response to physical symptoms; illness anxiety disorder involves preoccupation with illness with minimal symptoms; conversion disorder involves neurological symptoms incompatible with disease.

Value-added response: A value-added response notes overlapping management principles, including a consistent physician, scheduled reviews, and gradual introduction of psychological therapy across all three.

23. **Basic response:** Both are direct physiological consequences of a medical condition, with timing and course tracking the underlying illness; diagnosis requires evidence linking the disturbance to the medical cause.

Value-added response: A value-added response notes that treating the underlying condition often improves the psychiatric presentation, and that delirium must be excluded as the primary explanation.

24. **Basic response:** Dissociative disorders disrupt consciousness, memory, identity, or perception, including dissociative amnesia and depersonalisation-derealisation, often emerging after overwhelming stress or trauma.

Value-added response: A value-added response notes the need to exclude organic causes of memory disturbance and the central role of trauma-focused psychological therapy in management.

25. **Basic response:** Anorexia and bulimia nervosa carry medical risk requiring liaison with physical medicine; sleep-wake disorders include insomnia and hypersomnolence; sexual dysfunction can arise from medical, medication, or psychological factors.

Value-added response: A value-added response notes that assessment across all these areas benefits from a combined medical, medication, and psychological history rather than a single-domain approach.

Answers to Pilot Questions [Series 2]

Part 2.1

1. Consultation-liaison psychiatry is the subspecialty providing psychiatric care to patients on general medical or surgical wards.
2. Common reasons include delirium and capacity assessment.
3. Medication history distinguishes treatment side effects, such as steroid-induced mood change, from a primary psychiatric disorder.
4. Epilepsy and diabetes are both affected by psychological factors.
5. Anxiety increases cardiac risk and complicates recovery after events such as myocardial infarction.

Part 2.2

6. Somatic symptom disorder involves distressing physical symptoms with excessive thoughts, feelings, or behaviours about them.
7. Management favours a consistent physician, scheduled reviews, and gradual psychological therapy.
8. Illness anxiety disorder involves preoccupation with illness with minimal symptoms, while somatic symptom disorder involves actual distressing symptoms.
9. Conversion disorder presents with motor or sensory symptoms incompatible with recognised neurological disease.
10. Reassurance can paradoxically reinforce checking behaviour rather than resolving the underlying anxiety.

Part 2.3

11. Organic mood disorder is a mood disturbance judged to be the direct physiological consequence of a medical condition.
12. Hypothyroidism and stroke can both cause organic mood disturbance.

13. A medical work-up excludes treatable organic causes before attributing psychosis to a primary psychiatric disorder.
14. Dissociative amnesia is an inability to recall important personal information, usually following stress or trauma.
15. Dissociative symptoms often emerge in the context of overwhelming psychological stress or trauma.

Part 2.4

1. Anorexia nervosa involves restriction of intake and low body weight; bulimia nervosa involves binge eating with compensatory behaviours.
2. Electrolyte disturbance and cardiac complications are recognised medical risks.
3. Insomnia disorder is persistent difficulty initiating or maintaining sleep causing impairment.
4. The three categories are medical illness, medication, and psychological factors.
5. Medications such as antidepressants and antihypertensives commonly contribute to sexual dysfunction.

References and Attributions [Series 2]

1. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing.
2. Levenson, J. L. (2018). The American Psychiatric Association Publishing Textbook of Psychosomatic Medicine and Consultation-Liaison Psychiatry (3rd ed.). American Psychiatric Publishing.
3. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
4. World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.

Figures, Plates, Tables, and Boxes

1. Figure 2.1: A psychiatrist and physician conducting a joint consultation at a patient's hospital bedside. AI-generated using the prompt: "Create a realistic clinical illustration titled Consultation-Liaison Psychiatry at the Bedside, showing a psychiatrist and a

physician standing together reviewing notes beside a hospital bed with a patient present, general ward setting. Clean clinical illustration style, no text."

2. Table 2.1: Comparing somatic symptom disorder, illness anxiety disorder, and conversion disorder. AI-generated using the prompt: "Create a clean reference table titled Comparing Somatic Symptom Disorder, Illness Anxiety Disorder, and Conversion Disorder, listing disorder, core feature, and whether the symptom is explained medically. Simple clinical reference table style with outside border."
3. Figure 2.2: A hospitalised patient showing acute confusion consistent with an organic mental state disturbance. AI-generated using the prompt: "Create a realistic clinical illustration titled Acute Confusion in a Hospitalised Patient, showing a patient in a hospital bed appearing disoriented and distressed, with a nurse checking on them, general ward setting. Clean clinical illustration style, no text."
4. Table 2.2: Common contributors to sexual dysfunction. AI-generated using the prompt: "Create a clean reference table titled Common Contributors to Sexual Dysfunction, listing contributor, example, and assessment implication. Simple clinical reference table style with outside border."

Course code: PSY 603

Course title: Subspecialty Psychiatry

Course credit load: 2 Units

Series 3: Geriatric Psychiatry and Neurocognitive Disorders

- **Part 3.1: Foundations of Geriatric Psychiatric Assessment**
    - Sub Part 3.1.1: Issues unique to psychiatric evaluation of the elderly
    - Sub Part 3.1.2: Clinical presentation of psychiatric disorders in the elderly versus other adults
    - Sub Part 3.1.3: Vulnerabilities and increased incidence of psychiatric disorders in the elderly
- **Part 3.2: Delirium and Neurocognitive Disorder due to Alzheimer's Disease**
    - Sub Part 3.2.1: Delirium
    - Sub Part 3.2.2: Major neurocognitive disorder due to Alzheimer's disease
    - Sub Part 3.2.3: Mild neurocognitive disorder
- **Part 3.3: Neurocognitive Disorders due to Frontotemporal, Lewy Body, and Vascular Disease**
    - Sub Part 3.3.1: Frontotemporal lobar degeneration
    - Sub Part 3.3.2: Lewy body disease
    - Sub Part 3.3.3: Vascular neurocognitive disorder
- **Part 3.4: Neurocognitive Disorders due to Traumatic Brain Injury, Substance Use, and HIV**
    - Sub Part 3.4.1: Traumatic brain injury
    - Sub Part 3.4.2: Substance/medication-induced neurocognitive disorder
    - Sub Part 3.4.3: Neurocognitive disorder due to HIV infection

Introduction

An 80-year-old who forgets an appointment is often simply ageing. An 80-year-old who forgets how to get home is not. This Series turns to **geriatric psychiatry**, where normal ageing, delirium, and progressive neurocognitive disorder must be told apart with care.

The aim of this Series is to equip you with an understanding of the unique features of psychiatric evaluation in the elderly, and the major neurocognitive disorders encountered in later life, including delirium and the dementias due to Alzheimer's disease, frontotemporal lobar degeneration, Lewy body disease, vascular disease, traumatic brain injury, substance or medication use, and HIV infection.

This Series opens with the **foundations of geriatric psychiatric assessment**, then covers **delirium and Alzheimer's disease**, **frontotemporal, Lewy body, and vascular neurocognitive disorders**, and closes with **traumatic brain injury, substance use, and HIV-related neurocognitive disorders**.

Series Learning Outcomes

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

- **SLO 3.1:** discuss issues unique to psychiatric evaluation of the elderly
- **SLO 3.2:** compare and contrast the clinical presentation of psychiatric disorders in the elderly and list vulnerabilities to increased incidence of disorders in this age group
- **SLO 3.3:** describe the clinical features and management of delirium
- **SLO 3.4:** describe major and mild neurocognitive disorder due to Alzheimer's disease
- **SLO 3.5:** describe neurocognitive disorder due to frontotemporal lobar degeneration and Lewy body disease
- **SLO 3.6:** describe vascular neurocognitive disorder
- **SLO 3.7:** describe neurocognitive disorder due to traumatic brain injury and substance or medication use
- **SLO 3.8:** describe neurocognitive disorder due to HIV infection

3.1 Foundations of Geriatric Psychiatric Assessment

3.1.1 issues unique to psychiatric evaluation of the elderly

Sensory, physical, and social layers of assessment

Psychiatric evaluation of older adults must account for **changing sensory perception**, such as hearing and vision loss, which can mimic or mask psychiatric symptoms and complicate interview communication. Multiple coexisting physical illnesses and medications are the norm rather than the exception, and each must be considered as a possible contributor to mental state.

Cognitive screening is a routine part of assessment in this age group, since cognitive impairment can otherwise go unrecognised or be mistaken for a primary mood disorder. Social factors, including bereavement, isolation, and loss of independence, also carry particular weight in older adults and must be actively explored.

Fill in the blank: Changing sensory perception, such as hearing and vision loss, can mimic or mask _____ symptoms in older adults.

3.1.2 clinical presentation of psychiatric disorders in the elderly versus other adults

Recognising atypical presentation

Psychiatric disorders in older adults often present atypically compared with younger adults. Depression, for example, may present with prominent somatic complaints, apathy, or cognitive slowing rather than overt low mood, a pattern sometimes called depressive pseudodementia.

Anxiety in older adults is more likely to present with physical symptoms and health preoccupation, while psychotic symptoms occurring for the first time in later life should always prompt careful screening for an underlying neurocognitive or medical cause rather than a primary psychotic illness.

Fill in the blank: Depression presenting with cognitive slowing and apathy in an older adult is sometimes called depressive _____.

3.1.3 vulnerabilities and increased incidence of psychiatric disorders in the elderly

Why later life carries particular risk

Several factors raise the **incidence** of psychiatric disorder in later life, including cumulative physical illness, polypharmacy, bereavement, social isolation, and reduced physiological reserve. Neurocognitive disorders in particular rise sharply in incidence with advancing age.

Suicide risk also rises in older adults, particularly older men, and is frequently under-recognised because warning signs can be attributed wrongly to normal ageing. Systematic screening for depression, cognitive change, and suicide risk is therefore an essential part of any comprehensive geriatric psychiatric assessment.

Fill in the blank: Suicide risk rises in older adults, particularly older _____, and is frequently under-recognised.

Figure 3.1: A clinician conducting a psychiatric interview with an elderly patient and a family member.

Pilot questions 3.1

- Explain how changing sensory perception can complicate psychiatric assessment in the elderly. (Linked to SLO 3.1)
- List two social factors that carry particular weight in geriatric assessment. (Linked to SLO 3.1)
- Describe depressive pseudodementia. (Linked to SLO 3.2)
- Explain why new psychotic symptoms in later life should prompt screening for a medical cause. (Linked to SLO 3.2)
- List two factors that raise the incidence of psychiatric disorder in later life. (Linked to SLO 3.2)

3.2 Delirium and Neurocognitive Disorder due to Alzheimer's Disease

3.2.1 delirium

An acute, fluctuating disturbance of attention

Delirium is an acute disturbance of attention and awareness that develops over a short period and fluctuates in severity, accompanied by an additional disturbance in cognition not better explained by a pre-existing neurocognitive disorder. It is caused by a demonstrable underlying medical condition, such as infection, medication, or metabolic disturbance.

Older adults are especially vulnerable to delirium, and hypoactive presentations, marked by lethargy and reduced activity, are easily missed compared with the more obviously disturbed hyperactive form. Management focuses on identifying and treating the underlying cause alongside supportive, reorientation-based care.

Fill in the blank: Delirium develops over a short period and _____ in severity, distinguishing it from a stable neurocognitive disorder.

3.2.2 major neurocognitive disorder due to Alzheimer's disease

The most common cause of major neurocognitive disorder

Major neurocognitive disorder due to Alzheimer's disease is the most common cause of dementia in older adults, characterised by insidious onset and gradual progressive decline, typically beginning with prominent short-term memory impairment before extending to language, visuospatial, and executive difficulties.

Diagnosis requires significant decline from a previous level of functioning in one or more cognitive domains, sufficient to interfere with independence in everyday activities, with other causes excluded. Management combines cholinesterase inhibitors where appropriate, environmental support, and caregiver education.

Fill in the blank: Alzheimer's disease characteristically presents with insidious onset and prominent short-term _____ impairment.

3.2.3 mild neurocognitive disorder

Modest decline that does not yet impair independence

Mild neurocognitive disorder describes modest cognitive decline from a previous level of performance in one or more domains, that does not interfere with the capacity for independence in everyday activities, though greater effort or compensatory strategies may be required.

Mild neurocognitive disorder can be an early stage of a progressive dementia, or can remain stable or even improve depending on the underlying cause, making careful monitoring over time an important part of management rather than a one-off diagnosis.

Fill in the blank: Mild neurocognitive disorder does not interfere with _____ in everyday activities, unlike the major form.

Table 3.1: Comparing delirium and major neurocognitive disorder

Feature	Delirium	Major neurocognitive disorder
Onset	Acute, over hours to days	Insidious, over months to years
Course	Fluctuating	Gradually progressive
Attention	Prominently impaired	Relatively preserved until late stages

Pilot questions 3.2

1. Define delirium. (Linked to SLO 3.3)
2. Explain why hypoactive delirium is easily missed. (Linked to SLO 3.3)
3. Describe the typical onset and early symptom of Alzheimer's disease. (Linked to SLO 3.4)
4. List a pharmacological option used in major neurocognitive disorder due to Alzheimer's disease. (Linked to SLO 3.4)
5. Distinguish mild from major neurocognitive disorder. (Linked to SLO 3.4)

3.3 Neurocognitive Disorders due to Frontotemporal, Lewy Body, and Vascular Disease

3.3.1 frontotemporal lobar degeneration

Personality and language change before memory loss

Frontotemporal lobar degeneration typically presents earlier in life than Alzheimer's disease and is marked by prominent change in **personality and behaviour**, such as disinhibition or apathy, or by progressive language impairment, with memory relatively preserved in the early stages.

Because personality change is the earliest and most striking feature in the behavioural variant, families often initially attribute symptoms to psychiatric illness rather than a neurodegenerative process, which can delay diagnosis. Structural imaging showing frontal or temporal atrophy supports the diagnosis.

Fill in the blank: Frontotemporal lobar degeneration is marked by prominent personality and _____ change, with memory relatively preserved early on.

3.3.2 lewy body disease

Fluctuating cognition, hallucinations, and parkinsonism

Neurocognitive disorder with Lewy bodies is characterised by fluctuating cognition with pronounced variation in attention, recurrent detailed visual hallucinations, spontaneous features of parkinsonism, and rapid eye movement sleep behaviour disorder, often preceding the other features by years.

A distinctive and clinically important feature is marked sensitivity to antipsychotic medication, which can produce severe adverse reactions, so these agents must be used with particular caution if hallucinations require pharmacological treatment at all.

Fill in the blank: Neurocognitive disorder with Lewy bodies shows marked sensitivity to _____ medication.

3.3.3 vascular neurocognitive disorder

Cognitive decline linked to cerebrovascular disease

Vascular neurocognitive disorder is linked temporally to one or more cerebrovascular events, or evidenced by decline prominent in complex attention and executive function, with supporting evidence from history, examination, or neuroimaging of significant cerebrovascular disease.

Onset is often stepwise, with periods of stability interrupted by sudden decline following further vascular events, distinguishing it from the smoother progressive decline typical of Alzheimer's disease. Management focuses heavily on controlling vascular risk factors to slow further decline.

Fill in the blank: Vascular neurocognitive disorder often shows a _____ pattern of decline following further vascular events.

Figure 3.2: An elderly patient displaying tremor and reduced facial expression consistent with parkinsonism.

Pilot questions 3.3

1. Describe the earliest feature of the behavioural variant of frontotemporal lobar degeneration. (Linked to SLO 3.5)
2. Explain why frontotemporal lobar degeneration can initially be mistaken for psychiatric illness. (Linked to SLO 3.5)
3. List two core features of neurocognitive disorder with Lewy bodies. (Linked to SLO 3.5)
4. Explain the significance of antipsychotic sensitivity in Lewy body disease. (Linked to SLO 3.5)
5. Describe the typical course of vascular neurocognitive disorder. (Linked to SLO 3.6)

3.4 Neurocognitive Disorders due to Traumatic Brain Injury, Substance Use, and HIV

3.4.1 traumatic brain injury

Cognitive impairment following head injury

Neurocognitive disorder due to traumatic brain injury follows an impact to the head or other mechanism of rapid brain movement, and requires evidence of the injury alongside onset of cognitive impairment immediately after the event or immediately after recovery of consciousness.

Presentation depends heavily on the site and severity of injury, and can include difficulties with attention, memory, executive function, or mood and personality change. Some impairment improves over the following months, though repeated head injury carries cumulative long-term risk.

Fill in the blank: Neurocognitive disorder due to traumatic brain injury requires onset of impairment immediately after the injury or recovery of _____.

3.4.2 substance/medication-induced neurocognitive disorder

Cognitive impairment linked to substance exposure

Substance or medication-induced neurocognitive disorder describes cognitive impairment that persists beyond the expected duration of intoxication or withdrawal, and is judged aetiologically related to the persisting effects of substance use or medication exposure, such as chronic heavy alcohol use.

Distinguishing this condition from other causes requires a careful substance use history and, where possible, a period of confirmed abstinence during which cognitive function can be reassessed, since some impairment is at least partially reversible with sustained abstinence.

Fill in the blank: Substance-induced neurocognitive disorder persists beyond the expected duration of intoxication or _____.

3.4.3 neurocognitive disorder due to HIV infection

Cognitive impairment associated with HIV

Neurocognitive disorder due to HIV infection occurs in the context of documented HIV infection, with the impairment not better accounted for by another condition, and severity ranging from mild difficulty to a more pronounced dementia-level presentation in advanced, poorly controlled disease.

Effective antiretroviral therapy has substantially reduced the incidence of the most severe presentations, though milder cognitive impairment remains relatively common even in patients

with well-controlled HIV, underscoring the value of routine cognitive screening in this population.

Fill in the blank: Effective _____ therapy has substantially reduced the incidence of the most severe HIV-associated cognitive presentations.

Table 3.2: Causes of neurocognitive disorder covered in this Part

Cause	Typical onset pattern	Key management focus
Traumatic brain injury	Immediate, following injury	Rehabilitation and injury prevention
Substance or medication use	Following prolonged exposure	Abstinence and reassessment
HIV infection	Variable, worse if untreated	Antiretroviral therapy adherence

Pilot questions 3.4

1. Describe the diagnostic requirement for neurocognitive disorder due to traumatic brain injury. (Linked to SLO 3.7)
2. Explain why some impairment after traumatic brain injury can improve over time. (Linked to SLO 3.7)
3. Describe substance or medication-induced neurocognitive disorder. (Linked to SLO 3.7)
4. Explain the role of abstinence in assessing substance-induced cognitive impairment. (Linked to SLO 3.7)
5. Explain how antiretroviral therapy has changed the presentation of HIV-associated neurocognitive disorder. (Linked to SLO 3.8)

Series Summary

This Series examined psychiatric care in later life. Part 3.1 covered the unique features of geriatric psychiatric evaluation, while Part 3.2 turned to delirium and neurocognitive disorder due to Alzheimer's disease. Part 3.3 covered frontotemporal, Lewy body, and vascular neurocognitive disorder, and Part 3.4 closed with traumatic brain injury, substance-induced, and HIV-related neurocognitive disorder.

You should now be able to discuss the unique issues in geriatric assessment, compare psychiatric presentation across age groups, and describe the major causes of neurocognitive disorder covered across all four Parts, meeting the outcomes set for this Series. Series 4 turns next to forensic and emergency psychiatry.

Glossary of Terms

1. **Delirium:** an acute, fluctuating disturbance of attention and awareness with a demonstrable medical cause.
2. **Depressive pseudodementia:** depression presenting with prominent cognitive slowing resembling dementia.
3. **Frontotemporal lobar degeneration:** neurocognitive disorder marked by early personality, behaviour, or language change.
4. **Hypoactive delirium:** a form of delirium marked by lethargy and reduced activity, easily missed clinically.
5. **Major neurocognitive disorder:** significant cognitive decline that interferes with independence in everyday activities.
6. **Mild neurocognitive disorder:** modest cognitive decline that does not interfere with independence.
7. **Neurocognitive disorder with Lewy bodies:** a disorder with fluctuating cognition, visual hallucinations, and parkinsonism.
8. **Polypharmacy:** the use of multiple medications, common in older adults and relevant to psychiatric assessment.
9. **Stepwise decline:** a pattern of cognitive decline with sudden drops following vascular events.
10. **Substance-induced neurocognitive disorder:** cognitive impairment persisting beyond intoxication or withdrawal, linked to substance use.
11. **Traumatic brain injury:** an impact to the head or rapid brain movement causing cognitive impairment.
12. **Vascular neurocognitive disorder:** cognitive decline linked temporally to cerebrovascular disease.

Concept Check Questions [Series 3]

Objective questions

- Changing sensory perception, such as hearing and vision loss, can mimic or mask _____ symptoms in older adults. (Linked to SLO 3.1)
- Delirium develops over a short period and _____ in severity. (Linked to SLO 3.3)
- Alzheimer's disease characteristically presents with insidious onset and prominent short-term _____ impairment. (Linked to SLO 3.4)
- Neurocognitive disorder with Lewy bodies shows marked sensitivity to _____ medication. (Linked to SLO 3.5)
- Effective _____ therapy has substantially reduced the incidence of the most severe HIV-associated cognitive presentations. (Linked to SLO 3.8)

Short-answer questions

1. Describe depressive pseudodementia. (Linked to SLO 3.2)
2. Explain why hypoactive delirium is easily missed. (Linked to SLO 3.3)
3. Distinguish mild from major neurocognitive disorder. (Linked to SLO 3.4)
4. Explain the significance of antipsychotic sensitivity in Lewy body disease. (Linked to SLO 3.5)
5. Describe the typical course of vascular neurocognitive disorder. (Linked to SLO 3.6)

Long-answer questions

6. Discuss the issues unique to psychiatric evaluation of the elderly and how clinical presentation differs from younger adults. (Linked to SLO 3.1, 3.2)
7. Compare delirium with major neurocognitive disorder due to Alzheimer's disease. (Linked to SLO 3.3, 3.4)
8. Discuss the clinical features of frontotemporal lobar degeneration and neurocognitive disorder with Lewy bodies. (Linked to SLO 3.5)
9. Describe vascular neurocognitive disorder and how it differs in course from Alzheimer's disease. (Linked to SLO 3.6)
10. Discuss neurocognitive disorder due to traumatic brain injury, substance use, and HIV infection. (Linked to SLO 3.7, 3.8)

Answers to Concept Check Questions [Series 3]

Objective questions

11. Psychiatric.
12. Fluctuates.
13. Memory.
14. Antipsychotic.
15. Antiretroviral.

Short-answer questions

16. Depressive pseudodementia is depression presenting with prominent apathy and cognitive slowing that resembles dementia.
17. Hypoactive delirium presents with lethargy and reduced activity rather than obvious agitation, so it is less noticeable to staff.
18. Mild neurocognitive disorder does not interfere with independence, while major neurocognitive disorder does.
19. Antipsychotics can cause severe adverse reactions in Lewy body disease, so they must be used with particular caution.
20. Vascular neurocognitive disorder typically follows a stepwise course, with periods of stability interrupted by sudden decline.

Long-answer questions

21. **Basic response:** Evaluation must account for sensory change, multiple comorbidities, and cognitive screening; presentation often differs, with depression showing somatic features and psychosis in later life warranting medical screening.

Value-added response: A value-added response notes the added weight of social factors such as bereavement and isolation, and the under-recognition of suicide risk in older adults.

22. **Basic response:** Delirium has acute, fluctuating onset with a demonstrable medical cause, while Alzheimer's disease has insidious, gradually progressive onset beginning with memory impairment.

Value-added response: A value-added response notes that attention is prominently impaired in delirium but relatively preserved until late in Alzheimer's disease, aiding differential diagnosis.

23. **Basic response:** Frontotemporal lobar degeneration presents with early personality, behaviour, or language change with preserved memory; Lewy body disease presents with fluctuating cognition, visual hallucinations, and parkinsonism.

Value-added response: A value-added response notes that Lewy body disease shows marked antipsychotic sensitivity, a clinically important prescribing consideration.

24. **Basic response:** Vascular neurocognitive disorder is linked temporally to cerebrovascular disease and often follows a stepwise course, unlike the smoother progressive decline of Alzheimer's disease.

Value-added response: A value-added response notes that management focuses heavily on controlling vascular risk factors to slow further decline.

25. **Basic response:** Traumatic brain injury causes impairment onset immediately after injury; substance-induced disorder persists beyond intoxication or withdrawal; HIV-related disorder occurs in documented HIV infection.

Value-added response: A value-added response notes that antiretroviral therapy has reduced severe HIV-associated presentations, and that abstinence can partially reverse substance-related impairment.

Answers to Pilot Questions [Series 3]

Part 3.1

1. Sensory loss can mimic or mask psychiatric symptoms and complicate interview communication.
2. Bereavement and isolation carry particular weight in geriatric assessment.
3. Depressive pseudodementia is depression presenting with cognitive slowing and apathy resembling dementia.
4. New psychotic symptoms in later life may signal an underlying neurocognitive or medical cause rather than primary psychosis.
5. Cumulative physical illness and polypharmacy raise the incidence of psychiatric disorder in later life.

Part 3.2

6. Delirium is an acute, fluctuating disturbance of attention and awareness with a demonstrable medical cause.
7. Hypoactive delirium presents with lethargy rather than obvious agitation, so it is easily overlooked.

8. Alzheimer's disease presents with insidious onset and prominent short-term memory impairment.
9. Cholinesterase inhibitors are used in appropriate cases of major neurocognitive disorder due to Alzheimer's disease.
10. Mild neurocognitive disorder does not interfere with independence, while major neurocognitive disorder does.

Part 3.3

11. Personality and behaviour change, such as disinhibition or apathy, is the earliest feature of the behavioural variant.
12. Personality change can be mistaken for psychiatric illness rather than recognised as neurodegenerative.
13. Fluctuating cognition and recurrent visual hallucinations are core features of Lewy body disease.
14. Antipsychotics can cause severe adverse reactions in Lewy body disease, requiring cautious use.
15. Vascular neurocognitive disorder typically follows a stepwise course of decline.

Part 3.4

1. Cognitive impairment must begin immediately after the injury or recovery of consciousness.
2. Some impairment naturally resolves as the brain recovers over the following months.
3. It is cognitive impairment persisting beyond the expected duration of intoxication or withdrawal, linked to substance use.
4. A period of confirmed abstinence allows reassessment of cognitive function, since some impairment is partially reversible.
5. Antiretroviral therapy has substantially reduced the incidence of the most severe HIV-associated presentations.

References and Attributions [Series 3]

1. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing.
2. Jacoby, R., Oppenheimer, C., Dening, T., & Thomas, A. (2008). Oxford Textbook of Old Age Psychiatry (2nd ed.). Oxford University Press.
3. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
4. World Health Organization (2019). International Statistical Classification of Diseases and Related Health Problems (11th revision). World Health Organization.

Figures, Plates, Tables, and Boxes

1. Figure 3.1: A clinician conducting a psychiatric interview with an elderly patient and a family member. AI-generated using the prompt: "Create a realistic clinical illustration titled Geriatric Psychiatric Assessment, showing a psychiatrist seated with an elderly patient and an adult family member in a consulting room, warm and attentive atmosphere. Clean clinical illustration style, no text."
2. Table 3.1: Comparing delirium and major neurocognitive disorder. AI-generated using the prompt: "Create a clean reference table titled Comparing Delirium and Major Neurocognitive Disorder, listing feature, delirium, and major neurocognitive disorder across onset, course, and attention. Simple clinical reference table style with outside border."
3. Figure 3.2: An elderly patient displaying tremor and reduced facial expression consistent with parkinsonism. AI-generated using the prompt: "Create a realistic clinical illustration titled Parkinsonism in an Elderly Patient with Neurocognitive Disorder, showing an elderly patient seated in a consulting room with visible hand tremor and a fixed, reduced facial expression, clinician observing nearby. Clean clinical illustration style, no text."
4. Table 3.2: Causes of neurocognitive disorder covered in this Part. AI-generated using the prompt: "Create a clean reference table titled Causes of Neurocognitive Disorder, listing cause, typical onset pattern, and key management focus. Simple clinical reference table style with outside border."

Course code: PSY 603

Course title: Subspecialty Psychiatry

Course credit load: 2 Units

Series 4: Forensic and Emergency Psychiatry

- **Part 4.1: Introduction to Forensic Psychiatry**
  - Sub Part 4.1.1: Principles and scope of forensic psychiatry
  - Sub Part 4.1.2: Capacity
  - Sub Part 4.1.3: Consent
- **Part 4.2: Acute Behavioural Disturbance and Substance-Related Emergencies**
  - Sub Part 4.2.1: Acute behavioural disturbance in the emergency setting
  - Sub Part 4.2.2: Alcohol withdrawal
  - Sub Part 4.2.3: Cannabis intoxication
- **Part 4.3: Medication-Induced Emergencies and Behavioural Change Recognition**
  - Sub Part 4.3.1: Medication-induced psychiatric emergency
  - Sub Part 4.3.2: Serotonin syndrome and neuroleptic malignant syndrome
  - Sub Part 4.3.3: Behavioural changes encountered in the emergency setting
- **Part 4.4: Suicide and Self-Harm**
  - Sub Part 4.4.1: Assessment of suicide risk
  - Sub Part 4.4.2: Self-harm
  - Sub Part 4.4.3: Management and safety planning after suicide or self-harm presentation

Introduction

A patient refusing treatment, a young man intoxicated and combative in the emergency department, a person expressing intent to end their life, each moment tests judgement under pressure. This Series turns to **forensic and emergency psychiatry**, where legal principles and urgent clinical decisions meet.

The aim of this Series is to equip you with an understanding of the scope of forensic psychiatry, capacity and consent, the assessment and management of acute behavioural disturbance and substance-related and medication-induced emergencies, and the assessment of suicide and self-harm.

This Series opens with an **introduction to forensic psychiatry**, moves through **acute behavioural disturbance and substance-related emergencies**, then **medication-induced emergencies and behavioural change**, and closes with **suicide and self-harm**.

Series Learning Outcomes

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

- **SLO 4.1:** describe the scope of forensic psychiatry
- **SLO 4.2:** explain the principles of capacity and consent in psychiatric practice
- **SLO 4.3:** describe the assessment and management of acute behavioural disturbance
- **SLO 4.4:** describe the clinical features and management of alcohol withdrawal and cannabis intoxication
- **SLO 4.5:** describe medication-induced psychiatric emergencies
- **SLO 4.6:** list various behavioural changes encountered in the emergency
- **SLO 4.7:** describe the assessment of suicide risk and self-harm
- **SLO 4.8:** describe management and safety planning following a suicide or self-harm presentation

4.1 Introduction to Forensic Psychiatry

4.1.1 principles and scope of forensic psychiatry

Where psychiatry meets the law

Forensic psychiatry sits at the interface of mental health and the legal system, addressing questions such as fitness to stand trial, criminal responsibility, and risk assessment. Practitioners work across courts, prisons, and secure hospital settings, applying psychiatric assessment to legal questions.

Central to this subspecialty is the recognition that mental disorder can affect legal responsibility and decision-making capacity, requiring the forensic psychiatrist to communicate clinical findings clearly to legal professionals who lack clinical training.

Fill in the blank: Forensic psychiatry addresses legal questions such as fitness to stand trial and criminal _____.

4.1.2 capacity

Assessing the ability to make a specific decision

Capacity is decision-specific and time-specific, assessed by whether a person can understand relevant information, retain it, weigh it in the decision-making process, and communicate their decision. Capacity is presumed unless demonstrated otherwise, and impairment in one decision does not imply global incapacity.

Assessing capacity requires explaining the decision at hand in accessible language and testing understanding directly, rather than relying on a diagnosis alone, since a psychiatric diagnosis does not automatically equate to incapacity for a given decision.

Fill in the blank: Capacity assessment requires that a person can understand, retain, weigh, and _____ their decision.

4.1.3 consent

Voluntary, informed agreement to treatment

Consent to treatment must be voluntary, informed, and given by a person with capacity for that specific decision. Informed consent requires disclosure of the nature, purpose, risks, and alternatives of the proposed treatment in terms the person can understand.

Where a person lacks capacity, treatment decisions follow the relevant legal framework, typically requiring the least restrictive option in the person's best interests. Emergency treatment to preserve life may proceed without consent where capacity cannot be established in time.

Fill in the blank: Informed consent requires disclosure of the nature, purpose, risks, and _____ of proposed treatment.

Figure 4.1: A clinician explaining a treatment decision to a patient during a capacity assessment.

Pilot questions 4.1

- Describe the scope of forensic psychiatry. (Linked to SLO 4.1)
- List the settings in which forensic psychiatrists commonly work. (Linked to SLO 4.1)
- Define capacity. (Linked to SLO 4.2)
- Explain why impairment in one decision does not imply global incapacity. (Linked to SLO 4.2)
- List the elements required for informed consent. (Linked to SLO 4.2)

4.2 Acute Behavioural Disturbance and Substance-Related Emergencies

4.2.1 acute behavioural disturbance in the emergency setting

Rapid assessment and de-escalation

Acute behavioural disturbance describes agitated or aggressive behaviour that poses a risk to the patient or others, requiring rapid assessment to identify an underlying cause, whether psychiatric, medical, or substance-related, alongside immediate safety measures.

Verbal de-escalation is the first-line approach wherever possible, with a calm environment and clear, non-confrontational communication. Physical restraint or rapid tranquillisation is reserved for situations where less restrictive measures have failed and immediate risk remains high.

Fill in the blank: Verbal _____ is the first-line approach to acute behavioural disturbance wherever possible.

4.2.2 alcohol withdrawal

A potentially life-threatening withdrawal syndrome

Alcohol withdrawal typically begins six to twenty-four hours after the last drink in a dependent drinker, presenting with tremor, anxiety, sweating, and, in severe cases, seizures or **delirium tremens**, a state of confusion, hallucinations, and autonomic instability that carries significant mortality risk if untreated.

Management involves benzodiazepine-based regimens to control symptoms and prevent seizures, alongside thiamine supplementation to prevent Wernicke's encephalopathy, a serious neurological complication of untreated thiamine deficiency in this population.

Fill in the blank: Untreated thiamine deficiency during alcohol withdrawal can cause _____ encephalopathy.

4.2.3 cannabis intoxication

Acute psychiatric effects of cannabis use

Cannabis intoxication can produce anxiety, panic, perceptual disturbance, and, particularly with high-potency products, transient psychotic symptoms. Most acute effects resolve within hours without specific treatment beyond reassurance and a calm environment.

Severe agitation or psychotic symptoms occasionally require brief pharmacological treatment, and any presentation with persistent psychotic symptoms beyond the expected intoxication period warrants further psychiatric assessment rather than assumption that symptoms will simply resolve.

Fill in the blank: Most acute effects of cannabis intoxication resolve within hours with _____ and a calm environment.

Table 4.1: Comparing alcohol withdrawal and cannabis intoxication

Feature	Alcohol withdrawal	Cannabis intoxication
Onset	Six to twenty-four hours after last drink	Within minutes of use
Serious risk	Seizures, delirium tremens	Transient psychosis, rarely severe
Core management	Benzodiazepines and thiamine	Reassurance, calm environment

Pilot questions 4.2

1. Describe the first-line approach to acute behavioural disturbance. (Linked to SLO 4.3)
2. Explain when physical restraint may be indicated. (Linked to SLO 4.3)
3. Describe delirium tremens. (Linked to SLO 4.4)
4. Explain the purpose of thiamine supplementation in alcohol withdrawal. (Linked to SLO 4.4)
5. Describe the typical acute effects of cannabis intoxication. (Linked to SLO 4.4)

4.3 Medication-Induced Emergencies and Behavioural Change Recognition

4.3.1 medication-induced psychiatric emergency

When treatment itself becomes an emergency

Medication-induced psychiatric emergencies include acute dystonia, a sudden painful muscle spasm following antipsychotic use, and severe akathisia, a distressing inner restlessness that can itself increase suicide risk if unrecognised and untreated.

Prompt recognition and treatment, typically with anticholinergic medication for dystonia or dose adjustment for akathisia, prevents escalation and preserves the patient's confidence in ongoing psychiatric treatment, which severe untreated side effects can otherwise undermine.

Fill in the blank: Severe akathisia is a distressing inner restlessness that can itself increase _____ risk if unrecognised.

4.3.2 serotonin syndrome and neuroleptic malignant syndrome

Two serious, potentially life-threatening drug reactions

Serotonin syndrome presents with agitation, tremor, hyperreflexia, and autonomic instability, typically following combined serotonergic medications, while **neuroleptic malignant syndrome** presents with rigidity, hyperthermia, autonomic instability, and altered consciousness, typically following antipsychotic use.

Both conditions are medical emergencies requiring immediate discontinuation of the causative agent, supportive care, and, in severe cases, intensive monitoring, and both are frequently under-recognised early in their course due to overlapping, nonspecific initial symptoms.

Fill in the blank: Neuroleptic malignant syndrome presents with rigidity, hyperthermia, and autonomic _____.

4.3.3 behavioural changes encountered in the emergency setting

A wide spectrum of presentations requiring recognition

Behavioural changes commonly encountered in the emergency setting include agitation, aggression, confusion, withdrawal, disinhibition, and sudden mood change, each potentially reflecting a different underlying cause ranging from primary psychiatric illness to intoxication, withdrawal, or an acute medical condition.

Recognising the pattern and time course of behavioural change guides urgent investigation, since an acute, fluctuating change points towards delirium or a substance-related cause, while a more gradual change is more suggestive of an evolving primary psychiatric or neurocognitive process.

Fill in the blank: An acute, fluctuating behavioural change in the emergency setting points towards delirium or a _____-related cause.

Figure 4.2: Clinical staff calmly de-escalating an agitated patient in the emergency department.

Pilot questions 4.3

1. Describe acute dystonia. (Linked to SLO 4.5)
2. Explain why severe akathisia must not be dismissed as anxiety. (Linked to SLO 4.5)
3. Distinguish serotonin syndrome from neuroleptic malignant syndrome. (Linked to SLO 4.5)
4. List four behavioural changes commonly encountered in the emergency setting. (Linked to SLO 4.6)
5. Explain how the time course of a behavioural change can guide diagnosis. (Linked to SLO 4.6)

4.4 Suicide and Self-Harm

4.4.1 assessment of suicide risk

A structured, empathic risk evaluation

Assessment of **suicide risk** involves direct, empathic enquiry about suicidal thoughts, plans, intent, and access to means, alongside evaluation of static factors such as prior attempts and dynamic factors such as current hopelessness or recent loss.

Asking directly about suicide does not increase risk and is essential good practice, allowing the clinician to gauge the level of current danger and plan an appropriately intensive response, from safety planning to emergency admission where risk is judged high.

Fill in the blank: Asking directly about suicide does not increase risk and is essential good clinical _____.

4.4.2 self-harm

Deliberate self-injury with or without suicidal intent

Self-harm describes deliberate self-injury, which may or may not be accompanied by suicidal intent, and assessment must clarify the function of the behaviour, whether it serves to regulate overwhelming emotion, communicate distress, or reflects genuine suicidal intent.

Every episode of self-harm warrants a full psychosocial assessment rather than treatment of the physical injury alone, since repeated self-harm carries an elevated long-term risk of eventual suicide even when individual episodes appear low in lethality.

Fill in the blank: Every episode of self-harm warrants a full _____ assessment, not treatment of the physical injury alone.

4.4.3 management and safety planning after suicide or self-harm presentation

Collaborative planning to reduce future risk

Following a suicide or self-harm presentation, management includes treating any underlying condition, restricting access to lethal means, and developing a collaborative **safety plan** identifying warning signs, coping strategies, and sources of support the person can draw on in a future crisis.

Follow-up arrangements must be clear and timely, since the period immediately following discharge from emergency care carries elevated risk, and involving family or carers, with the person's consent, strengthens the overall safety net around them.

Fill in the blank: Restricting access to lethal _____ is a core component of management following a suicide or self-harm presentation.

Table 4.2: Static and dynamic factors in suicide risk assessment

Factor type	Example	Clinical relevance

Static	Prior suicide attempt	Fixed, long-term risk marker
Dynamic	Current hopelessness	Changeable, guides immediate response
Dynamic	Recent significant loss	May resolve or worsen with support

Pilot questions 4.4

1. Describe the components of a suicide risk assessment. (Linked to SLO 4.7)
2. Explain why direct enquiry about suicide is good clinical practice. (Linked to SLO 4.7)
3. Distinguish self-harm from suicide attempt. (Linked to SLO 4.7)
4. List the components of a safety plan. (Linked to SLO 4.8)
5. Explain why the period after discharge from emergency care carries elevated risk. (Linked to SLO 4.8)

Series Summary

This Series covered forensic and emergency psychiatry. Part 4.1 introduced forensic psychiatry, capacity, and consent, while Part 4.2 turned to acute behavioural disturbance, alcohol withdrawal, and cannabis intoxication. Part 4.3 covered medication-induced emergencies and behavioural change recognition, and Part 4.4 closed with the assessment and management of suicide and self-harm.

You should now be able to describe the scope of forensic psychiatry, explain capacity and consent, and describe the assessment and management of the emergencies covered across all four Parts, meeting the outcomes set for this Series. Series 5 turns next to special treatments and special topics in psychiatry.

Glossary of Terms

1. **Acute behavioural disturbance:** agitated or aggressive behaviour posing risk to the patient or others.
2. **Acute dystonia:** a sudden, painful muscle spasm following antipsychotic use.

3. **Akathisia:** a distressing subjective inner restlessness that can occur as a medication side effect.
4. **Capacity:** the decision-specific ability to understand, retain, weigh, and communicate a decision.
5. **Consent:** voluntary, informed agreement to treatment given by a person with capacity.
6. **Delirium tremens:** a severe alcohol withdrawal state with confusion, hallucinations, and autonomic instability.
7. **Forensic psychiatry:** the subspecialty addressing legal questions involving mental disorder.
8. **Neuroleptic malignant syndrome:** a severe drug reaction with rigidity, hyperthermia, and autonomic instability.
9. **Safety plan:** a collaborative plan identifying warning signs, coping strategies, and support following crisis.
10. **Self-harm:** deliberate self-injury, which may or may not accompany suicidal intent.
11. **Serotonin syndrome:** a severe drug reaction with agitation, tremor, hyperreflexia, and autonomic instability.
12. **Suicide risk assessment:** structured evaluation of suicidal thoughts, plans, intent, and access to means.

Concept Check Questions [Series 4]

Objective questions

- Forensic psychiatry addresses legal questions such as fitness to stand trial and criminal _____. (Linked to SLO 4.1)
- Untreated thiamine deficiency during alcohol withdrawal can cause _____ encephalopathy. (Linked to SLO 4.4)
- Neuroleptic malignant syndrome presents with rigidity, hyperthermia, and autonomic _____. (Linked to SLO 4.5)
- Asking directly about suicide does not increase risk and is essential good clinical _____. (Linked to SLO 4.7)
- Restricting access to lethal _____ is a core component of management following self-harm. (Linked to SLO 4.8)

Short-answer questions

1. Define capacity. (Linked to SLO 4.2)
2. Describe the first-line approach to acute behavioural disturbance. (Linked to SLO 4.3)

3. Distinguish serotonin syndrome from neuroleptic malignant syndrome. (Linked to SLO 4.5)
4. List four behavioural changes commonly encountered in the emergency setting. (Linked to SLO 4.6)
5. Distinguish self-harm from suicide attempt. (Linked to SLO 4.7)

Long-answer questions

6. Discuss the scope of forensic psychiatry and the principles of capacity and consent. (Linked to SLO 4.1, 4.2)
7. Describe the assessment and management of acute behavioural disturbance, alcohol withdrawal, and cannabis intoxication. (Linked to SLO 4.3, 4.4)
8. Discuss medication-induced psychiatric emergencies and the range of behavioural changes encountered in the emergency setting. (Linked to SLO 4.5, 4.6)
9. Describe the assessment of suicide risk and self-harm. (Linked to SLO 4.7)
10. Discuss the components of management and safety planning following a suicide or self-harm presentation. (Linked to SLO 4.8)

Answers to Concept Check Questions [Series 4]

Objective questions

11. Responsibility.
12. Wernicke's.
13. Instability.
14. Practice.
15. Means.

Short-answer questions

16. Capacity is the decision-specific ability to understand, retain, weigh, and communicate a decision.
17. Verbal de-escalation in a calm environment with clear communication is the first-line approach.
18. Serotonin syndrome presents with agitation, tremor, and hyperreflexia from serotonergic medication; neuroleptic malignant syndrome presents with rigidity and hyperthermia from antipsychotic use.
19. Common changes include agitation, aggression, confusion, and withdrawal.
20. Self-harm may or may not involve suicidal intent, while a suicide attempt specifically involves intent to end life.

Long-answer questions

21. **Basic response:** Forensic psychiatry addresses legal questions such as fitness to stand trial; capacity is decision-specific, requiring understanding, retention, weighing, and communication; consent must be voluntary and informed.

    Value-added response: A value-added response also notes that a psychiatric diagnosis alone does not equate to incapacity, and that emergency treatment without consent is permitted where capacity cannot be established in time.

22. **Basic response:** Acute behavioural disturbance is managed with verbal de-escalation first; alcohol withdrawal requires benzodiazepines and thiamine; cannabis intoxication usually resolves with reassurance and a calm environment.

    Value-added response: A value-added response notes that physical restraint is reserved for high-risk situations after less restrictive measures fail, and that persistent psychotic symptoms after cannabis use warrant further assessment.

23. **Basic response:** Medication-induced emergencies include dystonia, akathisia, serotonin syndrome, and neuroleptic malignant syndrome; emergency behavioural changes include agitation, aggression, confusion, withdrawal, disinhibition, and mood change.

    Value-added response: A value-added response notes that both syndromes are frequently under-recognised early due to overlapping, nonspecific symptoms, and that the time course of a behavioural change helps guide diagnosis.

24. **Basic response:** Assessment involves direct enquiry about thoughts, plans, intent, and means, alongside static and dynamic risk factors; self-harm requires a full psychosocial assessment regardless of apparent lethality.

    Value-added response: A value-added response notes that repeated self-harm carries elevated long-term suicide risk even when individual episodes appear low in lethality.

25. **Basic response:** Management includes treating underlying conditions, restricting access to lethal means, developing a collaborative safety plan, and arranging timely follow-up, involving family or carers with consent.

    Value-added response: A value-added response notes that the period immediately after discharge from emergency care carries particularly elevated risk, making timely follow-up essential.

Answers to Pilot Questions [Series 4]

Part 4.1

1. Forensic psychiatry addresses legal questions such as fitness to stand trial and criminal responsibility.
2. Forensic psychiatrists commonly work in courts, prisons, and secure hospital settings.
3. Capacity is the decision-specific ability to understand, retain, weigh, and communicate a decision.
4. Capacity is decision-specific, so impaired capacity for one decision does not mean impaired capacity for all decisions.
5. Informed consent requires disclosure of the nature, purpose, risks, and alternatives of treatment.

Part 4.2

6. Verbal de-escalation with a calm environment and clear communication is the first-line approach.
7. Physical restraint is indicated when less restrictive measures have failed and immediate risk remains high.
8. Delirium tremens is a state of confusion, hallucinations, and autonomic instability during severe alcohol withdrawal.
9. Thiamine supplementation prevents Wernicke's encephalopathy, a serious neurological complication.
10. Cannabis intoxication typically causes anxiety, panic, perceptual disturbance, and transient psychotic symptoms.

Part 4.3

11. Acute dystonia is a sudden, painful muscle spasm following antipsychotic use.
12. Severe akathisia is distressing and can itself increase suicide risk if unrecognised.
13. Serotonin syndrome follows serotonergic medication with tremor and hyperreflexia; neuroleptic malignant syndrome follows antipsychotics with rigidity and hyperthermia.
14. Common changes include agitation, aggression, confusion, and withdrawal.
15. An acute, fluctuating change suggests delirium or a substance-related cause, while gradual change suggests an evolving primary process.

Part 4.4

1. Suicide risk assessment involves direct enquiry about thoughts, plans, intent, and access to means.

2. Direct enquiry does not increase risk and allows the clinician to gauge current danger accurately.
3. Self-harm may or may not involve suicidal intent, while a suicide attempt specifically involves intent to end life.
4. A safety plan identifies warning signs, coping strategies, and sources of support.
5. Elevated risk after discharge reflects the vulnerable period immediately following a crisis presentation.

References and Attributions [Series 4]

1. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing.
2. Gelder, M., Andrew, P., & Geddes, J. (2012). New Oxford Textbook of Psychiatry (2nd ed.). Oxford University Press.
3. Sadock, B. J., Sadock, V. A., & Ruiz, P. (2017). Kaplan and Sadock's Synopsis of Psychiatry (11th ed.). Wolters Kluwer.
4. 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 4.1: A clinician explaining a treatment decision to a patient during a capacity assessment. AI-generated using the prompt: "Create a realistic clinical illustration titled Explaining a Treatment Decision During Capacity Assessment, showing a clinician seated with a patient, gesturing while explaining a decision using simple visual aids, calm consulting room setting. Clean clinical illustration style, no text."
2. Table 4.1: Comparing alcohol withdrawal and cannabis intoxication. AI-generated using the prompt: "Create a clean reference table titled Comparing Alcohol Withdrawal and Cannabis Intoxication, listing feature, alcohol withdrawal, and cannabis intoxication across onset, serious risk, and core management. Simple clinical reference table style with outside border."
3. Figure 4.2: 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 in the Emergency Department, 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."

4. Table 4.2: Static and dynamic factors in suicide risk assessment. AI-generated using the prompt: "Create a clean reference table titled Static and Dynamic Factors in Suicide Risk Assessment, listing factor type, example, and clinical relevance. Simple clinical reference table style with outside border."

Course code: PSY 603

Course title: Subspecialty Psychiatry

Course credit load: 2 Units

Series 5: Special Treatments and Special Topics in Psychiatry: Therapies, Psychosocial Issues, and Community Mental Health

- **Part 5.1: Introduction to Psychotherapy and Psychological Treatments**
  - Sub Part 5.1.1: Introduction to psychotherapy
  - Sub Part 5.1.2: Cognitive behavioural therapy
  - Sub Part 5.1.3: Problem-solving therapy and group therapy
- **Part 5.2: Physical Treatments in Psychiatry**
  - Sub Part 5.2.1: Electroconvulsive therapy
  - Sub Part 5.2.2: Light therapy and transcranial magnetic stimulation
  - Sub Part 5.2.3: Exercise and relaxation training in psychiatry
- **Part 5.3: Special Topics I: Adherence, Weight, and Abuse**
  - Sub Part 5.3.1: Non-adherence to medical treatment
  - Sub Part 5.3.2: Overweight, obesity, and malingering
  - Sub Part 5.3.3: Child abuse and neglect, and adult maltreatment and neglect
- **Part 5.4: Special Topics II: Culture, Stigma, and Community Mental Health**
  - Sub Part 5.4.1: Nigerian culture, religion, and spiritual problems in psychiatry
  - Sub Part 5.4.2: Culture-bound syndromes and stigma in psychiatry
  - Sub Part 5.4.3: Community mental health

Introduction

Not every psychiatric problem is solved with a prescription, and not every challenge a patient brings sits neatly inside a diagnostic manual. This closing Series turns to **special treatments and**

special topics, the psychological and physical therapies psychiatry relies on, and the psychosocial issues that shape care in practice.

The aim of this Series is to equip you with an understanding of psychotherapy and physical treatments used in psychiatry, and special topics including non-adherence, overweight and obesity, malingering, abuse and neglect, culture, stigma, and community mental health.

This Series opens with an **introduction to psychotherapy and psychological treatments**, moves through **physical treatments in psychiatry**, then **special topics on adherence, weight, and abuse**, and closes with **special topics on culture, stigma, and community mental health**.

Series Learning Outcomes

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

- **SLO 5.1:** describe the principles of psychotherapy, including cognitive behavioural, problem-solving, and group therapy
- **SLO 5.2:** describe physical treatments used in psychiatry, including electroconvulsive therapy, light therapy, and transcranial magnetic stimulation
- **SLO 5.3:** explain non-adherence to medical treatment
- **SLO 5.4:** explain overweight, obesity, and malingering in relation to psychiatric practice
- **SLO 5.5:** describe child abuse and neglect, and adult maltreatment and neglect
- **SLO 5.6:** discuss Nigerian culture, religion, and spiritual problems in relation to psychiatry
- **SLO 5.7:** discuss culture-bound syndromes and stigma in psychiatry
- **SLO 5.8:** describe issues of mental health in the community and of public health importance

5.1 Introduction to Psychotherapy and Psychological Treatments

5.1.1 introduction to psychotherapy

Talking treatments with a structured basis

Psychotherapy describes structured psychological treatments delivered by a trained practitioner, aimed at reducing distress and improving functioning through a therapeutic relationship. Approaches range from brief, focused interventions to longer-term therapies addressing deeper relational or developmental patterns.

Choice of psychotherapy depends on the presenting problem, patient preference, and available resources, and many conditions respond well to a combination of psychotherapy and medication rather than either alone.

Fill in the blank: Psychotherapy is delivered by a trained practitioner through a therapeutic _____.

5.1.2 cognitive behavioural therapy

Linking thoughts, feelings, and behaviour

Cognitive behavioural therapy is a structured, time-limited therapy based on the principle that thoughts, feelings, and behaviours are interconnected, and that changing unhelpful thinking patterns and behaviours can improve mood and functioning. It is well evidenced for depression, anxiety disorders, and several other conditions.

Sessions typically involve identifying specific unhelpful thoughts, testing them against evidence, and practising behavioural strategies between sessions, making the approach collaborative and skills-based rather than purely reflective.

Fill in the blank: Cognitive behavioural therapy is a structured, _____-limited therapy targeting thoughts and behaviours.

5.1.3 problem-solving therapy and group therapy

Structured problem-solving and shared therapeutic work

Problem-solving therapy teaches a structured approach to identifying problems, generating options, and evaluating solutions, useful for patients whose distress is closely tied to unresolved practical difficulties. **Group therapy** brings several patients together under a trained facilitator, drawing on peer support and shared experience as therapeutic tools.

Group therapy is particularly valued for conditions where isolation or shame is prominent, since hearing from others facing similar difficulties can reduce stigma and build a sense of shared understanding that individual therapy cannot always provide.

Fill in the blank: Group therapy draws on peer support and shared _____ as therapeutic tools.

Figure 5.1: A therapist and patient engaged in a cognitive behavioural therapy session.

Pilot questions 5.1

- Define psychotherapy. (Linked to SLO 5.1)
- Explain what determines the choice of psychotherapy for a given patient. (Linked to SLO 5.1)
- Describe the principle underlying cognitive behavioural therapy. (Linked to SLO 5.1)
- Define problem-solving therapy. (Linked to SLO 5.1)
- Explain why group therapy is valued for conditions involving shame or isolation. (Linked to SLO 5.1)

5.2 Physical Treatments in Psychiatry

5.2.1 electroconvulsive therapy

An effective treatment for severe illness

Electroconvulsive therapy involves inducing a brief, controlled seizure under general anaesthesia, and remains one of the most effective treatments for severe depression, particularly

when rapid response is needed or other treatments have failed. Common side effects include transient memory disturbance and confusion following treatment.

Despite its effectiveness, electroconvulsive therapy carries significant stigma, often rooted in outdated depictions, and clear patient education about the modern, carefully monitored procedure is essential to informed consent and treatment acceptance.

Fill in the blank: Electroconvulsive therapy involves inducing a brief, controlled _____ under general anaesthesia.

5.2.2 light therapy and transcranial magnetic stimulation

Two further physical treatment options

Light therapy involves controlled daily exposure to bright artificial light and is particularly effective for seasonal affective disorder. **Transcranial magnetic stimulation** uses magnetic pulses to stimulate specific brain regions and offers a non-invasive option for depression that has not responded adequately to medication.

Both treatments are generally well tolerated with fewer side effects than electroconvulsive therapy, though transcranial magnetic stimulation requires a course of repeated sessions and is not universally available due to cost and equipment requirements.

Fill in the blank: Light therapy is particularly effective for _____ affective disorder.

5.2.3 exercise and relaxation training in psychiatry

Low-cost, evidence-supported adjuncts

Exercise has a well-established evidence base as an adjunct treatment for depression and anxiety, improving mood through both physiological and psychological mechanisms. **Relaxation training**, including progressive muscle relaxation and controlled breathing, helps reduce physiological arousal associated with anxiety.

Both approaches are low-cost, accessible, and carry minimal risk, making them valuable additions to a treatment plan even where more intensive therapy or medication is also required, rather than a replacement for either.

Fill in the blank: Exercise improves mood through both physiological and _____ mechanisms.

Table 5.1: Comparing physical treatments in psychiatry

Treatment	Primary indication	Invasiveness
Electroconvulsive therapy	Severe or treatment-resistant depression	Requires general anaesthesia
Light therapy	Seasonal affective disorder	Non-invasive
Transcranial magnetic stimulation	Depression resistant to medication	Non-invasive

Short description: This table compares three physical treatments used in psychiatry by primary indication and level of invasiveness, supporting the discussion of treatment selection in this Part.

Suggested OER search string: open educational resource table physical treatments in psychiatry

Pilot questions 5.2

1. Describe electroconvulsive therapy. (Linked to SLO 5.2)
2. List a common side effect of electroconvulsive therapy. (Linked to SLO 5.2)
3. Explain the indication for light therapy. (Linked to SLO 5.2)
4. Describe transcranial magnetic stimulation. (Linked to SLO 5.2)
5. Explain the role of exercise as an adjunct treatment in psychiatry. (Linked to SLO 5.2)

5.3 Special Topics I: Adherence, Weight, and Abuse

5.3.1 non-adherence to medical treatment

Understanding why patients do not follow treatment

Non-adherence to medical treatment describes a patient's failure to follow prescribed treatment as advised, and is common across both psychiatric and general medical care. Contributing factors include side effects, poor insight into illness, complex regimens, cost, and stigma associated with the diagnosis or treatment itself.

Addressing non-adherence requires an open, non-judgemental exploration of the patient's reasons rather than assumption of simple forgetfulness, since understanding the specific barrier, whether practical or psychological, guides a more effective and collaborative response.

Fill in the blank: Non-adherence describes a patient's failure to follow prescribed treatment as _____.

5.3.2 overweight, obesity, and malingering

Two distinct challenges in clinical practice

Overweight and obesity are increasingly common in psychiatric populations, partly due to the metabolic side effects of certain medications, and require proactive monitoring and lifestyle intervention alongside psychiatric treatment. **Malingering** describes the deliberate fabrication or exaggeration of symptoms for an external incentive, such as financial compensation or avoiding responsibility.

Distinguishing malingering from genuine illness requires careful, non-confrontational assessment, since accusing a genuinely unwell patient of malingering can cause serious harm to the therapeutic relationship, while missing true malingering has its own consequences for resource allocation.

Fill in the blank: Malingering describes the deliberate fabrication or exaggeration of symptoms for an external _____.

5.3.3 child abuse and neglect, and adult maltreatment and neglect

Recognising and responding to abuse across the lifespan

Child abuse and neglect encompasses physical, emotional, and sexual abuse, alongside neglect of a child's basic needs, and psychiatric assessment must remain alert to behavioural or emotional signs that may indicate abuse. **Adult maltreatment and neglect**, including of older or vulnerable adults, similarly requires vigilance, particularly in dependent care relationships.

Any suspicion of abuse or neglect in either group triggers local safeguarding procedures, and clinicians must know their duty to report and the appropriate pathway, since protecting a vulnerable person takes priority over any competing clinical or relational consideration.

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

Figure 5.2: A patient discussing medication side effects with a pharmacist.

Pilot questions 5.3

1. Define non-adherence to medical treatment. (Linked to SLO 5.3)
2. List two factors contributing to non-adherence. (Linked to SLO 5.3)
3. Define malingering. (Linked to SLO 5.4)
4. Explain why obesity monitoring matters in psychiatric practice. (Linked to SLO 5.4)
5. Describe the clinician's responsibility when abuse or neglect is suspected. (Linked to SLO 5.5)

5.4 Special Topics II: Culture, Stigma, and Community Mental Health

5.4.1 nigerian culture, religion, and spiritual problems in psychiatry

Culture shapes how distress is understood and expressed

Nigerian culture shapes how mental illness is understood, expressed, and sought help for, with many patients and families interpreting psychiatric symptoms through religious or spiritual frameworks before, or alongside, seeking formal psychiatric care. Respecting these beliefs while providing evidence-based care requires cultural sensitivity rather than dismissal.

Spiritual problems may be presented by patients as a primary concern rather than a psychiatric symptom, and psychiatrists must be able to engage with this framing respectfully while still assessing for an underlying psychiatric disorder that may benefit from treatment.

Fill in the blank: Many patients interpret psychiatric symptoms through religious or _____ frameworks.

5.4.2 culture-bound syndromes and stigma in psychiatry

Culturally specific presentations and persistent stigma

Culture-bound syndromes are patterns of abnormal behaviour or distress recognised within a specific cultural context, which may not map neatly onto standard diagnostic categories, requiring clinicians to understand local presentations rather than force them into unfamiliar frameworks.

Stigma surrounding mental illness remains a significant barrier to help-seeking, contributing to delayed presentation, poor treatment adherence, and social exclusion, and tackling it requires sustained public education alongside respectful, non-judgemental clinical practice.

Fill in the blank: Culture-bound syndromes are patterns of distress recognised within a specific cultural _____.

5.4.3 community mental health

Extending care beyond the hospital

Community mental health services aim to deliver psychiatric care as close to a person's normal environment as possible, reducing reliance on hospital admission and supporting recovery within the person's own social context. This includes outreach teams, community clinics, and collaboration with primary care and social services.

Community mental health is also central to **public health** approaches to psychiatry, addressing prevention, early intervention, and the social determinants of mental illness at a population level, rather than treating each case in isolation from its wider context.

Fill in the blank: Community mental health services aim to deliver care close to a person's normal _____.

Table 5.2: Comparing culture-bound syndromes and standard diagnostic categories

Feature	Culture-bound syndrome	Standard diagnostic category
Recognition	Specific to a cultural context	Intended for broad cross-cultural use
Presentation	May not map onto standard criteria	Defined by standardised criteria
Clinical approach	Requires local cultural understanding	Requires structured diagnostic assessment

Pilot questions 5.4

1. Explain how Nigerian culture can shape help-seeking for mental illness. (Linked to SLO 5.6)
2. Describe how a psychiatrist should respond to a spiritual framing of symptoms. (Linked to SLO 5.6)
3. Define culture-bound syndrome. (Linked to SLO 5.7)
4. Explain the impact of stigma on treatment adherence. (Linked to SLO 5.7)
5. Describe the aim of community mental health services. (Linked to SLO 5.8)

Series Summary

This final Series set out to build a practical understanding of the treatments and psychosocial issues that shape everyday psychiatric practice. Part 5.1 covered psychotherapy, including cognitive behavioural, problem-solving, and group therapy, while Part 5.2 turned to physical treatments such as electroconvulsive therapy, light therapy, transcranial magnetic stimulation, and exercise. Part 5.3 addressed non-adherence, overweight and obesity, malingering, and abuse and neglect, and Part 5.4 closed with culture, stigma, and community mental health.

You should now be able to describe psychotherapy and physical treatments, and discuss the special topics covered across all four Parts, meeting the outcomes set for this Series. Across the full course, Series 1 covered child and adolescent psychiatry, Series 2 covered consultation-liaison psychiatry, Series 3 covered geriatric psychiatry and neurocognitive disorders, Series 4 covered forensic and emergency psychiatry, and this Series has closed the course with special

treatments and special topics in psychiatry, together forming a comprehensive foundation in subspecialty psychiatry.

Glossary of Terms

1. **Cognitive behavioural therapy:** a structured therapy targeting the link between thoughts, feelings, and behaviours.
2. **Community mental health:** services delivering psychiatric care close to a person's normal environment.
3. **Culture-bound syndrome:** a pattern of distress recognised within a specific cultural context.
4. **Electroconvulsive therapy:** a treatment inducing a brief, controlled seizure under general anaesthesia.
5. **Group therapy:** therapy delivered to several patients together under a trained facilitator.
6. **Light therapy:** controlled daily exposure to bright artificial light, effective for seasonal affective disorder.
7. **Malingering:** deliberate fabrication or exaggeration of symptoms for an external incentive.
8. **Non-adherence:** a patient's failure to follow prescribed treatment as advised.
9. **Problem-solving therapy:** a structured therapy teaching problem identification and solution evaluation.
10. **Psychotherapy:** structured psychological treatment delivered through a therapeutic relationship.
11. **Stigma:** negative social attitudes towards mental illness that act as a barrier to help-seeking.
12. **Transcranial magnetic stimulation:** a non-invasive treatment using magnetic pulses to stimulate brain regions.

Concept Check Questions [Series 5]

Objective questions

- Cognitive behavioural therapy is a structured, _____-limited therapy targeting thoughts and behaviours. (Linked to SLO 5.1)
- Electroconvulsive therapy involves inducing a brief, controlled _____ under general anaesthesia. (Linked to SLO 5.2)

- Malingering describes the deliberate fabrication or exaggeration of symptoms for an external _____. (Linked to SLO 5.4)
- Any suspicion of abuse or neglect triggers local _____ procedures. (Linked to SLO 5.5)
- Culture-bound syndromes are patterns of distress recognised within a specific cultural _____. (Linked to SLO 5.7)

Short-answer questions

1. Define psychotherapy. (Linked to SLO 5.1)
2. Distinguish electroconvulsive therapy from transcranial magnetic stimulation. (Linked to SLO 5.2)
3. Define non-adherence to medical treatment. (Linked to SLO 5.3)
4. Explain why obesity monitoring matters in psychiatric practice. (Linked to SLO 5.4)
5. Describe the aim of community mental health services. (Linked to SLO 5.8)

Long-answer questions

6. Discuss the principles of psychotherapy, including cognitive behavioural, problem-solving, and group therapy. (Linked to SLO 5.1)
7. Describe the physical treatments used in psychiatry and their indications. (Linked to SLO 5.2)
8. Discuss non-adherence to medical treatment, overweight and obesity, and malingering. (Linked to SLO 5.3, 5.4)
9. Describe child abuse and neglect, and adult maltreatment and neglect, including the clinician's responsibility. (Linked to SLO 5.5)
10. Discuss Nigerian culture, spiritual problems, culture-bound syndromes, stigma, and community mental health in psychiatry. (Linked to SLO 5.6, 5.7, 5.8)

Answers to Concept Check Questions [Series 5]

Objective questions

11. Time.
12. Seizure.
13. Incentive.
14. Safeguarding.
15. Context.

Short-answer questions

16. Psychotherapy is structured psychological treatment delivered by a trained practitioner through a therapeutic relationship.
17. Electroconvulsive therapy requires general anaesthesia and induces a seizure, while transcranial magnetic stimulation is non-invasive and uses magnetic pulses.
18. Non-adherence is a patient's failure to follow prescribed treatment as advised.
19. Obesity monitoring matters because certain psychiatric medications carry metabolic side effects requiring proactive management.
20. Community mental health services aim to deliver care close to a person's normal environment, reducing reliance on hospital admission.

Long-answer questions

21. **Basic response:** Psychotherapy is structured psychological treatment; cognitive behavioural therapy targets thoughts and behaviours; problem-solving therapy addresses practical difficulties; group therapy uses peer support under a trained facilitator.

    Value-added response: A value-added response notes that many conditions respond best to a combination of psychotherapy and medication rather than either approach alone.

22. **Basic response:** Electroconvulsive therapy treats severe or treatment-resistant depression; light therapy treats seasonal affective disorder; transcranial magnetic stimulation treats medication-resistant depression; exercise and relaxation training act as adjuncts.

    Value-added response: A value-added response notes that patient education is essential given the stigma surrounding electroconvulsive therapy, and that exercise carries minimal risk alongside its evidence base.

23. **Basic response:** Non-adherence reflects factors such as side effects and stigma; overweight and obesity require proactive monitoring given medication side effects; malingering involves deliberate symptom fabrication for external incentive.

    Value-added response: A value-added response notes that distinguishing malingering from genuine illness requires careful, non-confrontational assessment to avoid harming the therapeutic relationship.

24. **Basic response:** Child abuse and neglect encompasses physical, emotional, and sexual abuse and neglect of basic needs; adult maltreatment requires similar vigilance, particularly in dependent care relationships; any suspicion triggers safeguarding procedures.

Value-added response: A value-added response notes that protecting a vulnerable person takes priority over any competing clinical or relational consideration.

25. **Basic response:** Nigerian culture shapes help-seeking and symptom interpretation; 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 approaches, including prevention and early intervention.

Answers to Pilot Questions [Series 5]

Part 5.1

1. Psychotherapy is structured psychological treatment delivered by a trained practitioner through a therapeutic relationship.
2. Choice of psychotherapy depends on the presenting problem, patient preference, and available resources.
3. Cognitive behavioural therapy is based on the principle that thoughts, feelings, and behaviours are interconnected.
4. Problem-solving therapy teaches a structured approach to identifying problems, generating options, and evaluating solutions.
5. Group therapy reduces stigma and builds shared understanding through peer support.

Part 5.2

6. Electroconvulsive therapy induces a brief, controlled seizure under general anaesthesia.
7. Transient memory disturbance and confusion are common side effects of electroconvulsive therapy.
8. Light therapy is indicated for seasonal affective disorder.
9. Transcranial magnetic stimulation uses magnetic pulses to stimulate specific brain regions non-invasively.
10. Exercise improves mood through both physiological and psychological mechanisms as an adjunct treatment.

Part 5.3

11. Non-adherence is a patient's failure to follow prescribed treatment as advised.
12. Side effects and stigma are two factors contributing to non-adherence.
13. Malingering is the deliberate fabrication or exaggeration of symptoms for an external incentive.
14. Obesity monitoring matters because psychiatric medications can carry metabolic side effects.
15. Clinicians must follow local safeguarding procedures whenever abuse or neglect is suspected.

Part 5.4

1. Nigerian culture shapes how patients and families interpret and seek help for mental illness.
2. Psychiatrists should engage respectfully with a spiritual framing while still assessing for underlying psychiatric disorder.
3. A culture-bound syndrome is a pattern of distress recognised within a specific cultural context.
4. Stigma delays presentation, worsens treatment adherence, and contributes to social exclusion.
5. Community mental health services aim to deliver care close to a person's normal environment, reducing reliance on hospital admission.

References and Attributions [Series 5]

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

Figures, Plates, Tables, and Boxes

1. Figure 5.1: A therapist and patient engaged in a cognitive behavioural therapy session. AI-generated using the prompt: "Create a realistic clinical illustration titled A Cognitive Behavioural Therapy Session, showing a therapist and patient seated facing each other in a therapy room, patient holding a notebook, collaborative and attentive atmosphere. Clean clinical illustration style, no text."
2. Table 5.1: Comparing physical treatments in psychiatry. AI-generated using the prompt: "Create a clean reference table titled Comparing Physical Treatments in Psychiatry, listing treatment, primary indication, and invasiveness. Simple clinical reference table style with outside border."
3. Figure 5.2: A patient discussing medication side effects with a pharmacist. AI-generated using the prompt: "Create a realistic clinical illustration titled Discussing Medication Side Effects with a Pharmacist, showing a patient at a pharmacy counter talking with a pharmacist holding a medication box, attentive and open conversation. Clean clinical illustration style, no text."
4. Table 5.2: Comparing culture-bound syndromes and standard diagnostic categories. AI-generated using the prompt: "Create a clean reference table titled Comparing Culture-Bound Syndromes and Standard Diagnostic Categories, listing feature, culture-bound syndrome, and standard diagnostic category. Simple clinical reference table style with outside border."