How psychiatric injuries are caused and how to spot whether your client has such an injury

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Normal Matters!

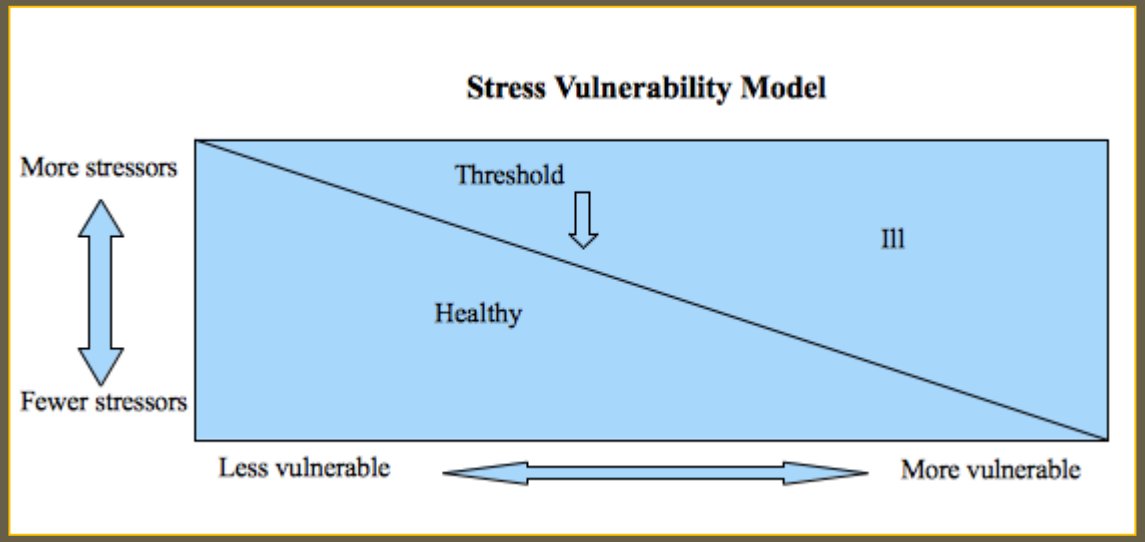
- Consider:
  - Underlying personality
  - Normal level of social functioning
  - Culture, beliefs

Clues

- Ability to form and keep stable relationships
- Ability to complete education
- Ability to keep work
- Cultural background
- How is life different now?

Stress-vulnerability Model

- Intrinsic vulnerabilities + Psychosocial stressors = Mental illness



(Zubin 1977)

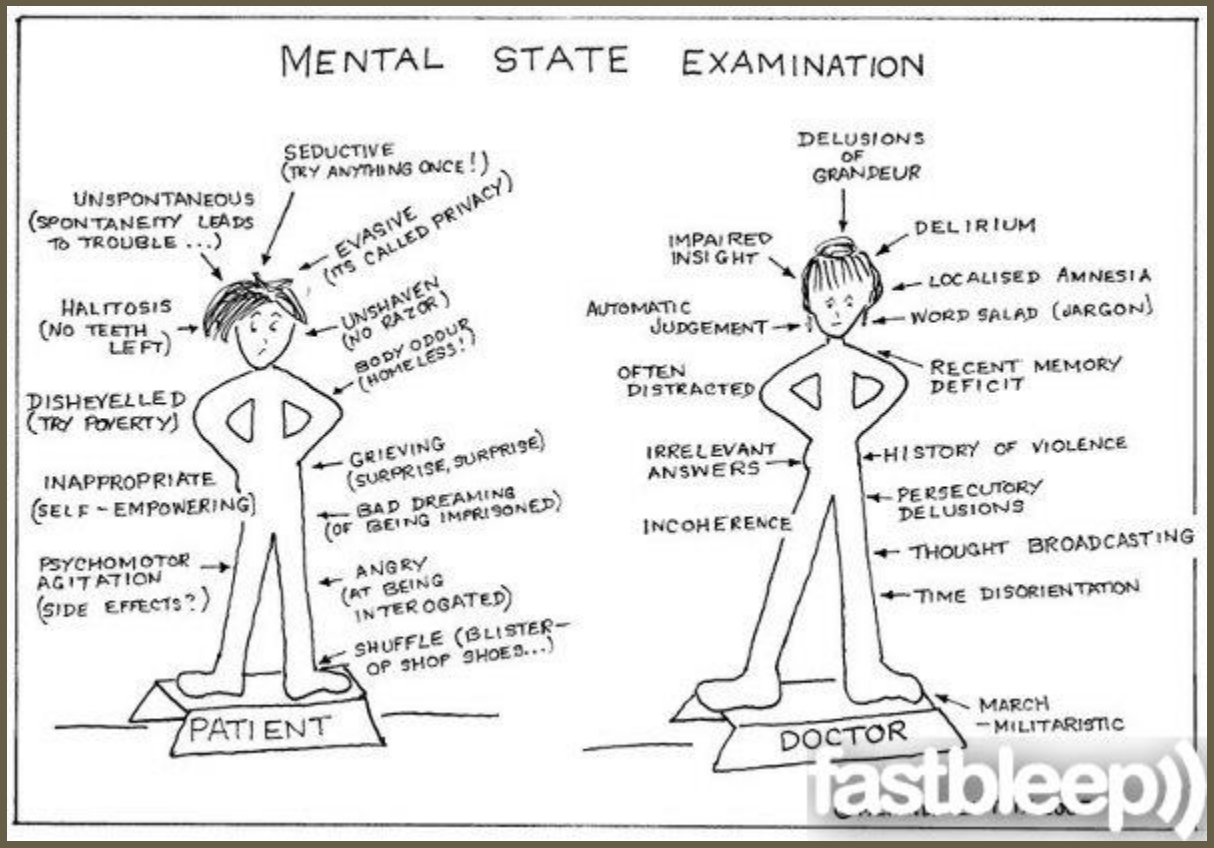
Intrinsic vulnerabilities Psychosocial stressors

- Genetics
- Prior history of mental health problems
- Vulnerable personality/low emotional resilience and skills
- Lack of support network
- History of addiction problems
- Poor physical health
- Marriage break-up…..

Current thinking

- *Chronic stress results in persistently elevated levels of cortisol. In all the above conditions, stress has been showed to lead to an imbalance in pro- and anti-inflammatory cytokines in brain, with increased proinflammatory cytokines mediating enhanced production of corticotrophin-releasing factor (CRF) in the hypothalamus.*
- *The resultant persistent hypercortisolaemia induces glucocorticoid receptor tolerance thus impairing the negative feedback mechanism of the HPA axis. This also results in neurodegenerative changes in the hippocampus (Myint 2009), which is involved in mood regulation together with the prefrontal cortex and the amygdala. The hippocampus is rich in corticosteroid receptors (Reul et al. 1986) and contributes to regulatory inhibitory feedback of the HPA axis (Squire et al. 2000, Fanselow 2000). Hippocampal dysfunction may be responsible for inappropriate context dependent emotional responses (Davidson et al. 2002). Hence, a cytokine-mediated immunological response may provide the link between hypercortisolaemia and hippocampal damage in chronic stress. Neuroimaging using MRI demonstrates that there is loss of hippocampal volume in many mental illnesses, reflecting the hippocampal atrophy described above. This occurs in Schizophrenia (Sumich et al. 2002), Posttraumatic Stress disorder (Felmingham et al. 2009), Borderline personality disorder (Weniger et al. 2009), and Depression (Sheline et al. 1999).*

Mental state examination



- Appearance and Behaviour
- Speech
- Mood
- Perceptual abnormalities
- Thought form and content (suicidal ideas, plans or intent)
- Cognitive state
- Insight

Post-traumatic stress disorder

- The patient must have been exposed to a stressful event or situation
- Persistent remembering or ‘reliving’ of the stressor in intrusive ‘flashbacks’(vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor)
- Actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor

- Either of the following must be present:
  - Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
  - Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
    - difficulty in falling or staying asleep
    - irritability or outbursts of anger
    - difficulty in concentrating
    - hypervigilance
    - exaggerated startle response
- Criteria must be met within 6 months

- Under and over modulation in PTSD
- Dissociative subtype/ complex PTSD in ICD-11

- Remember that PTSD is common in witnesses to traumatic events and those who perpetrate them

What might you see in someone with PTSD?

- Appearance and Behaviour
- Speech
- Mood
- Perceptual abnormalities
- Thought form and content (suicidal ideas, plans or intent)
- Cognitive state
- Insight

Depressive Disorder

- The depressive episode should last for at least 2 weeks
- There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode (F30.-) at any time in the individual's life

- At least 2 of the following criteria must be present:
  - depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks.
  - loss of interest or pleasure in activities that are normally pleasurable
  - decreased energy or increased fatiguability

- An additional symptom or symptoms from the following list should be present, to give a total of at least four:
  - loss of confidence and self-esteem
  - unreasonable feelings of self-reproach or excessive and inappropriate guilt;
  - recurrent thoughts of death or suicide, or any suicidal behaviour;
  - complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;
  - change in psychomotor activity, with agitation or retardation (either subjective or objective)
  - sleep disturbance of any type;
  - change in appetite (decrease or increase) with corresponding weight change

What might you see in someone with depressive disorder?

- Appearance and Behaviour
- Speech
- Mood
- Perceptual abnormalities
- Thought form and content (suicidal ideas, plans or intent)
- Cognitive state
- Insight

Questions to ask yourself or your client/s

- Do the changes in functioning correlate with the timeline?
- Does what you see match what you hear?
- How have social functioning /activities changed?
- If a couple, how has their relationship/ intimacy changed? (sex life is often significantly affected by physical and/or mental injury)
- What are they doing to cope/help-seeking?

Advanced skills

- Pattern recognition
- How did they make you feel? (transference/countertransference)

- If in doubt most experts you instruct would be willing to have a non-identifiable discussion about a potential instruction and give impartial advice

Reflection

- What was the expert’s opinion?
- Did it match your initial thoughts?
- If not, why not?

Any questions?