

The Dean of Medicine at your university asks you to see Declan, a 21-year-old third year medical student. Declan came to his attention the first time 1 month ago when his then consultant wrote to the Dean. During his psychiatry attachment, he started to question patients' diagnoses. This would not have been a problem but for the manner with which he did this – in front of vulnerable patients and, on three occasions, shouting and making accusations against the professionals involved. When his consultant tried to speak with Declan about this, he told her to 'rev up and f*** off'. He did not settle into his attachment for the previous month and, prior to these confrontations, he had regularly interrupted ward meetings (where everyone sat to discuss cases) by standing up and walking around the room. He said this was as a result of back pain.

Declan has signed consent for you to interview him and send a written report to the Dean, with copies to his GP.

How might you begin the interview?

- Remind him that he has waived confidentiality and that you are seeing him for the purposes of a report to the Dean. This will require detailed questioning – with collateral history – not unlike a court report (Table 33, p. 114)
- Has he had any psychiatric assessments before this one?
- How does he see his difficulties in the light of the allegations against him?
- Does he have any psychological symptoms?

What are the possibilities here?

- *Organic illness* is always a possibility. Back pain is unusual in someone so young, and a primary or secondary tumour could have caused confusion (Table 20, p. 69), mood (Table 14, p. 47) or psychotic (Table 16, p. 53) symptoms. You need to decide if he requires further medical evaluation
- As with other cases, do not let his background distract you from investigating *alcohol and/or substance misuse*

- He has crossed a line in behaving so inappropriately towards vulnerable patients, with verbal abuse to his consultant. That this is 'new' raises concerns about functional *mood* or *psychotic* symptoms
- A primary *anxiety disorder* (Table 11, p. 38) seems unlikely. He might be restless (Fig. 2, p. 37) but he has behaved in an excessive manner – unusual even for severe disorders such as post-traumatic stress disorder (PTSD; Table 32, p. 108)
- There may be evidence of *personality disorder* (PD) here, specifically *dissocial PD* (Box 19, p. 149). Does Declan have features suggesting *psychopathy* (Box 18, p. 148)? He might have paranoid traits that were activated by discussions on the ward rounds or by specific psychiatric patients
- The possibility remains that Declan has been *unjustly accused* of these charges as punishment for challenging a (malevolent) consultant psychiatrist. The Dean should have verified he had a case to answer based on more than one account
- Less likely is *voluntary symptom production*. He could be malingering to get time off his studies or 'special consideration' at exam time. Your assessment of him presents another opportunity for direct gain in escaping a disciplinary hearing or achieving mitigation in front of the Dean. Factitious psychiatric illness (without a clear direct gain) is reported as being more common in medical and other health professionals

Declan arrives 20 minutes' late, dressed in a suit but wearing trainers with one lace missing and a crumpled dirty shirt. His hair is long and uncombed. He appears restless but stays seated. His eyes wander around the room and eye contact is only fleeting. At the start of the interview, Declan makes a brief reply then falls silent: 'There's nothing about me or my personality you can tell me that I do not already know. And what you don't hear from me, you'll make up anyway. You, Dr Hooper (the consultant who contacted the Dean) and Professor Brown (the Dean) are three sides of the same coin. Just greedy stenocrats. That is it, the end.'

With that, he terminated the interview. Will you?

No. You can continue to observe him for a limited mental state examination (MSE):

KEY POINT

When patients stop speaking during an interview, try to make the silence more comfortable. Do not blame or confront them. Use stock phrases, repeated once or twice: 'We both have set aside this time to hear your side of the story. Whenever you're ready, we can start again'. And use the time to think through your management options.

- *Appearance and behaviour*: as summarized above. There are signs of anxiety. He looked anxious as he left
- *Speech*: thought disorder ('three sides of the same coin') and neologism (use of the term 'stencrats' – was he distracted by seeing you writing?)
- *Mood*: subjectively unknown, objectively anxious affect that failed to calm during the interview. Just before he walked out (10 minutes after his comments), his eyes watered. He could be depressed
- *Suicidality*: not yet established
- *Thoughts*: possibility of paranoid delusions. He describes three doctors as 'greedy', and may have additional ideas about this
- *Perception*: no abnormalities could be elicited based on truncated interview
- *Cognition*: untested
- *Insight*: unknown. Unlikely to be good

Declan's cousin has left his phone number with your secretary. You had intended to speak with him after your assessment, but call him immediately in the light of your new concerns. He grew up with Declan – he knows him well, and shared a house with him for 2 years until they fell out 2 months ago. At that point, Declan said he wanted to buy a derelict house to fix it up for them and for others. 'There was no talking to him about it – he was going to do it, even if the bank would not lend the money.' Since then, they have not been in contact and he knows nothing about recent events: Declan tells his parents nothing. The last he heard of Declan, he was sleeping at the hospital in rooms usually given to relatives who stay over.

Do you have any further questions for this informant?

You can now fill in the rest of his history: medical and family history, and his premorbid personality. You might also get the details of the people best placed now to describe recent events to support or refute your working diagnosis.

Declan was always 'one of a kind'. By the time he knew him well (about 15 years ago), he would approach complete strangers to tell them about himself. He made up wild stories which he insisted were true 'until the very end'. 'Very popular with the ladies', Declan 'is the life and soul of every party, but when the party's over, you don't want to be there': he hates being on his own and will phone anyone to keep himself going. His cousin could not name one family event in the past 10 years that did not become 'all about Declan'. The only quiet time for him was a few months some years ago when their cousin died in a car accident. He took her death 'the hardest of everyone', and went in on himself. There is also a family history of mental illness: your informant's mother has been on haloperidol for 20 years. The rest of his birth, medical and other history are unremarkable. He enjoys a drink, but he has never used illegal drugs.

Does your new understanding of his personality explain the presentation?

No. Even if Declan has a histrionic personality disorder (Box 30), this could not explain his recent behaviour – on the wards or during your assessment. If anything, someone with histrionic traits might have enjoyed a long interview. The fact that he achieved a place in medical school and stayed below the radar for so long indicates he is able to keep his personality in check and achieve his goals.

There has been a clear change of behaviour, beginning with his ambitions to buy a house but now characterized by his falling out with a succession of people. His previous personality could be *contributing* to this presentation – but it is unlikely to be the sole cause.

We are left with the first three diagnostic headings listed above. All raise the possibility of risks to him (physical illness, effects of intoxication/withdrawal, suicide, exploitation by others) if they remain undiagnosed, and psychosis adds the more remote possibility that Declan might pose a risk to other people.

Box 30 Features of histrionic personality disorder (ICD-10)

Histrionic PD shows features of:

- Self-dramatization, exaggerated expression of emotions
- Feelings that are easily hurt
- Shallow and labile affectivity
- Impulsive seeking out of exciting situations, the appreciation of others or striving to be the centre of attention
- Inappropriate seductiveness in appearance or behaviour
- Easily influenced by others (suggestibility)
- Over-concern with physical attractiveness
- Others may feel manipulated by their behaviour

Histrionic personality disorder is wrongly stereotyped as being a caricature of excessive femininity (it occurs in men too). Its name is less than perfect, but it has replaced highly stigmatizing terms such as 'oral hysterics', 'good hysterics' and 'psychoinfantile personality'. Additional confusion arises in that American classification (DSM-IV) includes a category of hysterical PD, but ICD-10 does not. While people with this latter diagnosis tend to share some of the traits above, they have better impulse control and are less exhibitionistic.

KEY POINT

Just as we do not accept our patients' accounts of their own personality as the definitive one, be cautious in accepting the views of one informant. They may be too close or not familiar enough with the patient, could have their own agenda (relationship problems, individual issues) or be just plain wrong. Record details for later reflection.

Declan is outside in the car park as you leave to go home. There are other people around and he does not appear surprised to see you. His jacket is torn and he has a bundle of A4 pages, perhaps 100. He wants to show you 'the evidence'. He spreads the pages on the ground, making several points at once: about his studies, his family, his investments and his plans for the future. The notes indicate disturbed thinking and are mostly indecipherable. He wants to show you a mathematical formula for his 'ready reckoner', but when he cannot find it, he throws the papers down and runs away.

Will you physically restrain him?

No. A physical confrontation *on your own* (short of a declaration he is going to end his life *right now*) is not

justified. If you were based in an A&E department or a psychiatric ward, gentle restraint by suitably trained personnel could be justified – at least until you are more certain of what is happening for him.

Will you await further contact from him?

No. You now have good presumptive evidence of *hypomania or mania* (Table 13, p. 45).

You do not know *why* his mood is elevated. In order of likeliness, its causes are functional, substance-induced or organic – but he requires urgent physical examination, investigations that include urine drug screen, and assessment of risk.

There is a past depressive episode (his cousin's death) and a family history of psychosis (aunt).

Discuss his case with the on-call psychiatry team. He may present elsewhere this evening. Copy any correspondence to the sector team for his area.

KEY POINT

Boundaries are important to define in all situations. It was reasonable to talk to him in the car park – once your safety was considered – until you knew what was happening. Your original brief was to provide a report about him, but events turned this into a psychiatric emergency.

Overnight, Declan presented to A&E but he did not accept any treatment. He did agree to come to your office the next morning. You are able to complete an MSE.

Set out the degrees of elevated mood that are possible here. Which does he have?

1 *Hypomania* is the mildest form of elevated mood. Many features are there (Table 13, p. 45) but, by definition, hypomania shows neither delusions nor hallucinations. It can be diagnosed after only a few days and causes 'considerable' disruption of work or social activity. Declan has progressed well beyond this stage of elevated mood.

2 *Mania* implies 'complete' disruption of work or social activity. It must last 1 week or more. By this point, the patient cannot control the associated behaviours and lacks insight that a psychiatric condition is causing them.

3 *Mania with psychotic features*, the most severe form of bipolar disorder, is his diagnosis. The vast majority of patients require admission. Extreme irritability or hostility may dominate, and it can be difficult to differentiate from a first episode of schizophrenia. Declan has grandiose and paranoid delusions and his pages of ‘evidence’ indicate thought disorder.

Declan needs hospital and will come in voluntarily, but not to the hospital he has been attached to as a student. Your clinical director tells you that we cannot afford to fund a bed for him in another facility.

What will you do?

You cannot admit him to the ward where he has been as a student as he already knows details of the patients there that could compromise them and him. With mood elevation or any disinhibition, he may be unable to keep confidential matters to himself. It might even be dangerous for him to be admitted there if patients resent the ‘them and us’ attitudes of staff.

It is unlikely that there is another ward in the same hospital that could manage him – the nature of most facilities is to mix patients for therapy interventions and at mealtimes. It would be wrong to put him in that hospital against his will. He has already given consent to an admission, and made a reasonable request of you.

Telephone other colleagues in neighbouring hospitals. This sort of situation arises frequently and even the most hard-hit services show flexibility.

If all else fails, you must insist to your managers that funding is found to treat Declan in a safe and secure environment.

You are allowed to admit Declan to a hospital 15 miles away that has no links with the university. The only condition is that you are the responsible consultant for his care: you agree. It is Friday, and a plan for the weekend is needed.

Will you prescribe? If so, what will you prescribe?

Observation of his mental state can continue on the ward, but you know enough to justify the prescription of a benzodiazepine.

In the short term, you should use an antipsychotic (AP) as adjunct (Box 11, p. 77; Table 8, p. 18): this way you do not have to choose a highly sedating AP

and, when he settles, he can go home on this AP but *not* the benzodiazepine. Better sleep with the tranquillizing effects of this combination will improve insight and help maintain his current resolve to stay on the ward.

It is the weekend, and extra doses can be given – provided he is reviewed by senior staff.

Will you prescribe a mood stabilizer?

Yes, but not now. We need to see his response to first line agents. Starting three medications at the same time is bad practice.

At Monday’s ward round, Declan is unrecognizable. He is pale and quiet, and has been crying for almost 24 hours. He says he has hit ‘rock bottom’, his food tastes like paper and he believes he will never leave hospital.

What might have happened?

- There could have been an *incident on the ward* that upset him: check this out
- Try to conceptualize each patient’s *reaction to illness* (and confinement) as unique: we can guess the significance of rheumatoid arthritis in a pianist, but how might a young medical student deal with a potentially lifelong psychiatric disorder?
- He could have *gained insight with full recollection* of his behaviours. Did he have any calls or visitors that might have precipitated this reaction?
- Check his medication chart: was he given *excessive doses of AP*? Most typical APs, and many atypicals, induce dysphoria at higher doses
- If this episode is short-lived (moments or hours), it may be an adjustment to medication and circumstances, and described as a *microdepression*
- *Mixed bipolar affective disorder* is defined as the presence of both sets of mood symptoms (low and elevated mood; Table 13, p. 45), prominent for 2 weeks or more
- You have not yet seen a clean urine drug screen here. Declan could be coming down from the effects of amphetamines or other *substances*
- As a diagnosis of exclusion, Declan could be ‘playing up’ mild dysphoria for a multitude of reasons (e.g. reducing AP dose). He has a high *degree of knowledge* of the disorder and the system (as a medical student) and he might have *histrionic traits*. This is not a judgement you should make lightly

KEY POINT

Mixed affective state is a common presentation of bipolar disorder. Rapid cycling disorder is four episodes in 1 year of any of: mania, hypomania, mixed affective state or depression. Its most common cause is antidepressants.

His dose of AP is maintained at a therapeutic dose and other sedation reduced gradually: he is observed taking these. He sleeps well and he is reported as enjoying his food. A visit from his mother was 'a great success' and she left word she wants to know his discharge date. Urine drug screen is negative. Two days later, he is just as high and irritated as when he presented.

Outline your management

- He has bipolar type I disorder (Box 31) and will require a mood stabilizer (Table 9, p. 19). Each of the three drugs are effective in acute mania in over 50% of patients. Careful discussion about which agent is important. He will need medication as prophylaxis following discharge.

KEY POINT

Because of their potential toxicity (Table 9, p. 19) and narrow therapeutic ranges, mood stabilizers are the most hazardous of all psychoactive drugs.

- Check his physical health and review investigations for a physical cause of his elevated mood (Table 14, p. 47)
- Maximize management and ward environment (Box 11, p. 77)

Box 31 Classification of bipolar disorder (DSM-IV)

- Only a minority of patients with bipolar disorder experience mania
- Bipolar type II disorder has episodes of hypomania (but not mania) and episodes of major depression (the DSM-IV equivalent of moderate/severe depressive illness)
- Bipolar type I disorder is classic 'manic depression' (now an obsolete term) with episodes of mania and periods of major depression. The manic episodes do not need to have psychotic features to achieve this diagnosis

- Monitor his mood and any suicidal ideation at several points each day
- Cognitive-behavioural therapy (CBT) techniques are useful in symptom reduction and have been shown to prevent future relapses. CBT is an effective way to prevent and manage depression. You already know enough about the volatility of Declan's mood to make you very reluctant to prescribe an antidepressant should he become depressed in the future
- Even at this early stage, psychoeducation (to counter what *he thinks* he knows) will help with concordance and engagement
- Ward activities: Declan progressed from being a busy student to mania and is now doing little to occupy himself on the ward. Enlist the help of occupational therapy to programme activities. Practical projects would keep his day structured: where to live on discharge, managing his debts (it is likely he has been overspending), or building bridges with friends and family
- Future activities may be an issue. This is not the time to write a response to the Dean about his prior behaviour. Once he has responded to treatment, you can write a report to the Dean with his consent. He should arrange a meeting with the Dean, accompanied by a friend or family member

KEY POINT

Acute mania is unpredictable. With rapid changes in mood, suicidality varies considerably.

One month later, Declan has had 10 days' leave without incident. He approved your report to the Dean and Declan's apology has been accepted in full by Dr Hooper. The Dean will meet him next week to discuss a return to his studies. He is taking a mood stabilizer to excellent effect and agrees to remain on an AP for the next 6 months. At the discharge planning meeting, you explain to him that you cannot continue to be his psychiatrist and will be referring him to another team. Declan says that will not be necessary. His mother is a GP and wants to take things from here.

What needs to happen?

- His mother cannot be his doctor
- Declan needs formal follow-up, preferably by an Early Intervention Psychosis team as he is likely to relapse. We do not expect to find cognitive impairment but, if his functioning is lower than previously, formal testing would help decide future plans

Box 32 Early warning signs 'prodrome' of relapse in bipolar disorder (Watkins 2003):

Common prodromes of depression:

- Reduced interest in people or activities
- Feeling sad or depressed
- Disturbed sleep
- Tiredness
- Low motivation
- Increased worry
- Poor concentration

Common prodromes of mania:

- Reduced sleep/need for sleep
- Increased goal-directed activity
- Irritability
- More optimism
- Increased sociability/talking more
- Racing thoughts
- Distractibility

- He needs to agree safeguards to monitor his mental state with the university. In this episode, no patients were harmed (including Declan), but he may not be as fortunate next time
- His psychiatric illness should be notified to the medical licensing authority – with a clear relapse prevention plan (Box 32)

Reference

Watkins, E. (2003) Combining cognitive therapy with medication in bipolar disorder. *Advances in Psychiatric Treatment* **9**, 110–116.

CASE REVIEW

So far we have seen a spectrum of depressive illness (Cases 2, 7 and 12; Fig. 6, p. 146) and many other cases have presented with low mood and unhappiness, but short of the criteria for depression (Table 13, p. 45). Here, mania was characterized by irritability not infectious good humour. This feature is hard to tolerate by patients (suicidal acts are increased) and by those around them, in this case a consultant psychiatrist and you.

Declan's case was not complicated by alcohol or substance misuse – often used as the means of calming down or sleeping, but making mania worse and masking symptoms. Despite his degree of social impairment, he took 2 months to present: people with bipolar disorder can take years before the diagnosis is made. Unusually, he accepted admission: people with bipolar disorder are the most challenging Mental Health Act assessments. His treatment journey is only beginning here, and further episodes of high and low mood are likely.

Further reading

- Frangou, S. (2005) Advancing the psychological treatment of bipolar disorder. *Advances in Psychiatric Treatment* **11**, 28–37.
- Morriss, R. (2004) Early warning symptom intervention for patients with bipolar affective disorder. *Advances in Psychiatric Treatment* **10**, 18–26.
- Smith, D.J. & Ghaemi, S.N. (2006) Hypomania in clinical practice. *Advances in Psychiatric Treatment* **12**, 110–120.