The phenomenon popularly referred to as “gut feelings” is a fusion of many inter-related internal elements, encompassing factual information, personal experience, particular belief systems, peer group attitudes and many others. This concept is commonplace in many cultures and nations, and is a familiar and entrusted process, underpinning the daily actions of countless individuals.

One example is that doctors may intuitively sense that their patient is at risk, without being able to pinpoint exactly how they have arrived at this insight. The metaphorical alarm bell ringing activates the doctor’s vigilance in relation to that particular patient’s condition, and this heightened awareness may be accompanied by bodily sensations in the doctor’s stomach or chest. Despite the universality of this experience, it may appear unscientific, and any health professional would naturally wish to obtain scientific verification to support their “gut feeling.”

The significance of this phenomenon should be investigated, as we humans have evolved the ability to rapidly, and often accurately, intuit situations by transcending the limited evidence gathered by our own senses. We thoroughly depend upon this ability, but as yet we have not developed a coherent scientific explanation of why this should be so.

We humans possess an instinctive capacity to scrutinise our surroundings, to pinpoint any dangerous features, to distinguish between safe and unsafe situations, and to respond accordingly, which is intrinsically built into our DNA. Conversely, intuition is a learned skill. The “gut feeling” phenomenon can be regarded as the synthesis of instinct and intuition which dominates our subconscious perceptions and actions, but can also be inducted into the state of conscious awareness, where it is open to analysis which can then be verbally expressed.

Some professionals working in the field of mental health favour an intuitive approach to patient care above a rational approach, contrary to the principles of evidence-based medicine. The researchers counsel against a reliance on intuition, recommending instead the ‘actuarial method’ which bases clinical decisions on statistical data correlating treatments and outcomes. Doctors may experience either of two erroneous intuited sentiments towards a patient. Either they may experience an unsubstantiated “gut” feeling that some undisclosed condition is seriously undermining a patient’s state of health, leading to consternation, or they may experience an unsubstantiated “gut” feeling of reassurance that the patient’s condition is being correctly managed, so that despite the absence of a diagnosis, there is no further cause for alarm.

The ubiquitous presence of the benevolent intuitive impulse has already been acknowledged to exist amongst doctors and the …………..

Contd... pg 2
Women may have an evolutionary advantage over men in the area of intuition because ancestral females had to ensure the survival of the species by protecting their infants from potential danger on a moment by moment basis. In order to achieve this, they had to empathise with the needs of their babies whilst simultaneously appraising their surroundings for threats to their safety. If dangers were detected, they had to gauge the appropriate response and act quickly. Over time, this acquired ability has developed into a greater female ability to intuit the safety of people and situations.

Contemporary clinical training does not refer to the role of intuition in medical settings. Klein (2003) addressed this issue by devising a training programme which aimed to raise the effectiveness of the intuitive element of diagnosis and treatment. Klein instructed medical students to imagine a situation in which mistakes had been made and had led to a negative outcome. He then asked them to imagine all the different factors that might have contributed to this situation, thereby honing their understanding of cause and effect. We have already seen that a doctor’s experience leads to more intuitive decision-making, and Klein’s programme attempts to speed up this process by simulating real-life experience. Further research is needed to determine whether similar programmes may be able to help trainees to circumvent some of the experiential stages of acquiring medical intuition. In a mental healthcare setting, the role of intuition should be regarded as complementary to evidence-based decision-making.

Conclusion

To conclude, it has been convincingly proposed that intuition, or ‘gut feeling’ has a significant part to play in the field of mental health diagnosis and treatment. Medical professionals who experience feelings of anxiety in relation to their patients should be counselled to take the time to switch to an analytical approach, whilst acknowledging the validity of their intuitive early-warning signal. In the absence of any clinical evidence identifying a specific cause for concern, the doctor’s ‘gut feeling,’ should be taken into consideration, allowing the medical team to be alert for clinical signs which may appear later.

References


Authors

Dr M. Shaffullha & Dr Reehana Kauser, Birmingham and Solihull Mental health Foundation trust. Dr M. Ismail, North West London NHS Foundation Trust
Tocophobia: A case report and literature review

Dr N Kataria (ST6) Dr S Sangha (Consultant Psychiatrist) Dr M Z Iqbal (Consultant Psychiatrist) Bushey-fields Hospital, Dudley, DY1 2LZ

Introduction
We have observed in clinical practice that Tocophobia (extreme fear of childbirth) may be overlooked with patients not receiving appropriate management. We want to highlight the case of AB who suffered anxiety throughout her pregnancy. With appropriate assessment and management, we were able to achieve desired outcome for both mother and baby.

AB, a 41 year old, Caucasian woman who lived with her supportive husband, suffered anxiety throughout her first pregnancy. She was commenced on Sertraline 50 mg at 26 weeks gestation by her GP, which reduced her anxiety to some extent.

At 34 weeks gestation she attended the Antenatal Unit at the local General Hospital with Braxton Hicks contractions. At this time she presented with increasing anxiety, low mood, disturbed sleep, lack of motivation, feelings of guilt, panic attacks and fear of the delivery process of childbirth. She was also anxious that she would not bond well with the baby. The pregnancy was unplanned; there was no history of miscarriage or termination of pregnancy. She was assessed by Psychiatric Services who suggested supportive counselling and information classes for her to talk about her fears. A few days later she presented in Accident and Emergency in a state of distress with heightened anxiety and suicidal thoughts. She was admitted informally to the local Psychiatric Unit to manage the worsening anxiety and risks to herself and baby.

The ward Psychologist provided supportive therapy and relaxation techniques. AB was referred to the Regional Perinatal Mental Health Unit for assessment and specialist advice on further management. On their advice, she was started on Quetiapine 25 mg BD and Sertraline was increased to 100 mg mane. Her anxiety worsened with panic attacks and immediate desire to terminate her pregnancy. One evening, she took a knife from the kitchen and attempted to make a cut to terminate the pregnancy. She was nursed on 1:1 observations to minimise the risks to herself and the baby.

A multi-disciplinary meeting was arranged with the Obstetrics team; due to increasing risks, an elective caesarean section was planned at 36 weeks gestation. Following this decision, there was improvement in anxiety and mood. Caesarean section was carried out at 36 weeks, with no complications. After discharge from the postnatal ward, she was seen by the Home Treatment team for 2-3 weeks. There was dramatic improvement in her mood and anxiety symptoms with no suicidal thoughts after the birth of the baby and she bonded well with the baby. Her symptoms appeared to be directly related to pregnancy with recovery after giving birth. There were no signs or symptoms of postnatal depression or psychosis. She was followed up in Psychiatric Outpatient clinic and she made good recovery with reduced need for medication.

Discussion:
The word tocophobia comes from the Greek words ‘Tokoś’ (childbirth) and “phobos” (fear). Tocophobia (extreme fear of childbirth) can be primary or secondary in origin. Primary tocophobia may have onset in adolescent affecting nulliparous women that they might opt not to bear a child. Few may choose to remain childless or adopt a child. Secondary tocophobia may be due to previous traumatic childbirth including prolonged, complicated or painful labour, or may be associated with stillbirth or termination of pregnancy.1

Tocophobia initially can present as behavioural, emotional and physical symptoms in the form of feeling of terror or dread, rapid heartbeat, shortness of breath, nausea, dry mouth, trembling, sleeplessness, crying episodes, restlessness or nervousness and anxiety. Anxiety during the antenatal period has been associated with increase risk of postnatal depression, bonding and attachment issues.2 High levels of anxiety can lead to complications of labour and caesarean section. Laursen et al. (2009) reported that the risks of emergency caesarean section and dystocia/protracted labour were higher in women who feared childbirth. NICE guidelines 2011 on Caesarean Section (CS) reports that the rates of preference for CS expressed by the women that were surveyed during pregnancy in UK, Australia and Sweden range from 6% - 8%, there was a consistent relationship between women’s preference for CS and either previous CS, previous negative birth experience, a complication in the current pregnancy or a fear of giving birth3. A trusting relationship with the midwife is important for early recognition of symptoms and exploring beliefs about childbirth during antenatal appointments. Visiting the maternity ward can be helpful to resolve fears associated with childbirth. Medication and Psychological treatments such as Behaviour therapy, Cognitive-behavioural therapy (CBT), Exposure therapy and relaxation techniques may all be helpful4.

Conclusion:
The outcome of tocophobia can be favourable if identified early and managed in a multidisciplinary /multi-professional team in severe cases. The patient improved with collaborative care between Obstetric and Mental Health Services.

References
NICE Clinical Guidelines on Caesarean Section Nov 2011.
**Systematic Review of Prevalence of depression in Huntington’s Disease.**

*Dr Mohammed Shaffiullah (ST6), Birmingham and Solihull Mental Health Foundation Trust, Dr Naveed Ahmed ,Locum Staff grade, FTB.*

**Background:** Huntington’s Disease consists of a triad of symptoms. In conjunction with the motor abnormalities, individuals will experience cognitive and psychiatric manifestations. It is estimated that depression is the most common psychiatric symptom experienced in HD. Existing literature on prevalence rates of depression in Huntington’s Disease varies widely, ranging from 9% to 63% depending on the methodology of the study, different diagnostic approaches, types of depressive disorder and the nature of HD population studied. The depressive symptoms in HD occur many years prior to onset, and appear very similar to typical clinical depression in non-HD individuals. Depression has many negative effects such as morbidity, mortality, greater suffering for the individual, and disruption among families and can cause significant carer’s stress. Therefore, it would be beneficial to better understand the existence of depressive symptoms in HD to improve screening and diagnosis, as well as the treatment provided.

**Objective:** The aim of the study was to perform a systematic literature to determine the prevalence rates of depression in Huntington’s Disease individuals.

**Data Source:** An extensive literature search was carried out in electronic databases and journals for studies published and unpublished studies between January 1980 and May 2017. Several studies were analysed by means of various search engines to determine the prevalence of depressive disorders in HD. Reference lists and journals were hand-searched for additional reviews. In addition few of the authors were contacted and websites were checked to identify relevant articles.


**Conclusions:** The studies suggest that depression is common among HD individuals and that there is wide variation in the methods by which prevalence of depression is investigated in Huntington’s disease. Life time prevalence rates of Depression in motor symptomatic HD subjects have been reported at around 15% to 68%. In prodromal individuals, lifetime depression prevalence rates have been reported to be 8% to 39% and in both prodromal and motor manifested HD individuals, the prevalence rates ranged from 15% to 42.1%. Period or point prevalence rates of depression ranged from 8% to 60%. Prevalence rates for MDD ranged from 8% to 20%. This review suggests that the average prevalence of clinically significant depressive symptoms in HD is higher than previously reported reviews.

**References:**

‘Prevalence of tic disorders among primary school students in Khartoum, Sudan.’ Dr Muna Abdalla. Staff grade psychiatrist, Birmingham and Solihull Mental Health Foundation Trust.

Background: Vocal and motor tic disorders including Tourette syndrome (TS) have their onset during childhood. These disorders affect children in bouts of tic with wide variation in presentation such as swearing, clearing of the throat, neck movements and eye movements. They can cause significant stress in children because they often impede normal daily interaction and have been shown to inhibit normal learning. A number of studies have investigated the prevalence of TS and other conditions such as chronic tic disorder, but as yet no prevalence study has been conducted on the African continent. Tic disorders including TS appear to be evenly distributed worldwide with a prevalence of around 0.3-2% in school age children depending on the type of tic and the diagnostic tools used. Tics are predominantly a condition of childhood, with prevalence significantly decreasing to the point where it has proven difficult for researchers to discover a precise figure, although some estimates have placed the prevalence of all tic types at 0.4% in adults. More than 80% of those with TS report a reduction or disappearance of symptoms by adulthood, with an average age of worst tic severity at 10.6 years.

Study Design: A population-level point prevalence study undertaken in 10 schools in the Khartoum East administrative area of Khartoum, Sudan.

Methodology and protocol: Data collection was divided into four phases. Screening questionnaires in Arabic were completed by teachers and parents of children aged 6-14 years to select participants with suspected tic disorders. Participants with positive results were assessed by a neurologist at interview according to DSM-5 criteria for tic disorders to confirm diagnosis and subtype as TS, chronic tic disorder or transient tic disorder.

Results: A total of 3616 responses were received from teachers and 2532 from parents. Due to administrative problems, only the parents’ responses could be used to contact children for interview. 183 participants were assessed at interview. Mean age was 9.26 years. The prevalence of confirmed tic disorders among the total sample (n=2532) was 6%. TS (0.24%), chronic tic disorder (3.32%) and transient tic disorder (2.45%) were similar to figures obtained by European and North American studies. Average duration of symptoms were 49.3 months, 38 weeks and 6.42 weeks respectively. Prevalence was twice as high among males compared to females. Significant differences were found in relative prevalence of each tic disorder with increasing age.

Conclusions: The prevalence of tic disorders more generally is in line with findings of previous studies, suggesting that tic disorders are not unique to the Northern Hemisphere. However, TS prevalence was below what would be expected from systematic review evidence, while chronic tic disorder was raised. Gender and age differences noted by previous studies are largely confirmed in Sudan, although changes in relative prevalence of each disorder by age group are new with this study. Some novel findings were also reported by the present study, which analysed the change in relative prevalence of each of the three tic disorders according to age. It was found that TS remained relatively stable at 2.75-5.08% of all tic disorders diagnosed. There was large variation, however, in transient and chronic tic disorder diagnosis by age.

While transient and chronic tic disorders had very similar relative prevalence of close to 50% at age 6-8 years, chronic tic disorder was noticeably raised and transient tic disorder depressed at age 9 to 11, when tic severity is thought to be greatest. There was a complete reversal at age 12 to 14, with more than 80% of all tic diagnoses deemed to be transient.

### Table: Absolute occurrence of each tic disorder, the percentage of total DSM-5 tic disorders and the estimated prevalence in the study population.

<table>
<thead>
<tr>
<th>Tic Disorder</th>
<th>No. of children</th>
<th>% age DSM-5 tics</th>
<th>Prevalence total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tourette Syndrome</td>
<td>6</td>
<td>3.95%</td>
<td>0.24%</td>
</tr>
<tr>
<td>Chronic Tic Disorder</td>
<td>84</td>
<td>55.26%</td>
<td>3.32%</td>
</tr>
<tr>
<td>Transient Tic Disorder</td>
<td>62</td>
<td>40.79%</td>
<td>2.45%</td>
</tr>
<tr>
<td>All DSM-5 tic disorders</td>
<td>152</td>
<td>100 %</td>
<td>6.00%</td>
</tr>
<tr>
<td>Nonspecific tic disorder</td>
<td>31</td>
<td></td>
<td>1.22%</td>
</tr>
<tr>
<td>Total</td>
<td>183</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Bibliography


My Experiences of Palliative Care – A Mental Health Perspective
Karen Romain, FY2 Doctor, New Cross Hospital, Wolverhampton. MbChB Keele University,

Patient’s receiving end of life care present clinical cases with complex mental health needs. This applies both to those with pre-existing mental health problems or those with a new diagnosis. Within palliative care there is a significant level of psychological distress for patients and their families and it is important to recognise commonly encountered problems which impact on mental health care.

During my own rotation in palliative care I was able to observe the mental health care options available in a hospice, hospital and community setting. It was also clear that palliative care teams are faced with a huge variety of mental health problems commonly as part of their role. From this I was able to learn about important questions which should be considered when treating palliative patients and how this can significantly change the best choice of treatment on a very individual basis.

The first element which became clear to me was that when considering the palliative care patient attention must be given to their current situation. In this case, the implications of their life limiting illness. Individual prognosis is often difficult to predict and this is a source of great anxiety for the patient and their family. This also produces problems when considering mental health treatment. For example, when faced with a patient with depression discussion included their expected prognosis and if there was enough time to establish the patient on the usual guideline antidepressant treatments. Or if this would be more likely to worsen symptoms of anxiety or nausea for example, in the short term without the patient having time to experience the full benefits (BNF, 2016). Psychological support was available through the hospice and palliative care teams, however there may not be sufficient time to complete the more extensive programmes usually considered. Access to specialist mental health support could also be difficult, with patients commonly less able to mobilise in order to attend outpatient appointments, group sessions or other support services.

Another important consideration when discussing treatment options was to look at which medication would help each individual patient best with both their mental and physical health symptoms. Many patients I met had symptoms of pain, agitation and nausea as a result of their underlying physical health pathology. As a result, I experienced the use of some mental health medications to treat these symptoms on top of treating the patients’ mental health. Side effects of these medications which are often problematic may in fact be of benefit in this population. For example, the common side effect of weight gain with some mental health medications (BNF, 2016). In a population where appetite is often low and weight loss high this may be a side effect which is in fact of benefit. If sleep is a problem medications with side effects such as increased drowsiness may help more in these cases and treat multiple problems with reduced risks of polypharmacy.

Alongside the psychological distress of the patient I met families who were struggling. Palliative care and mental health care both allow for a unique opportunity to really get to know our patient’s families and social situations. Bereavement support and good communication with families was therefore very important and helped to identify family members who were putting their own physical and mental health aside to focus on their loved one.

Discussion with the palliative care team I worked with concluded that a close relationship between palliative care and mental health services is important and will help this subgroup of patients to maintain the best possible quality of life, even when time may be short. It is also important to support relatives who are also at risk during this time of high psychological distress.

Key Points
The prognosis of palliative care patients can impact upon treatment decisions.
Medication choice should consider the patient’s other symptoms.
Close working between palliative and mental health teams would help ensure the best treatment for our patients.

MCQs: True or False
Current physical health symptoms should be considered as part of mental health treatment options? True
Mental health and palliative care patients could benefit from a close working relationship between teams? True

References
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