Psychiatry and Behavioural Sciences

BEHAVIOURAL SCIENCES

Learning Objectives

At the end of the course, the student should be able to:

1. Understand the nature and development of different aspects of normal human behaviour like learning, memory, motivation, emotion, personality and intelligence.

2. Recognise differences between normal and abnormal behaviour

3. Understand how psychological and social factors influence human behaviour throughout his life cycle, and how they affect his response to health and illness.

4. Conduct psychosocial evaluation of the patient in respect to attributes like socio-economic status; attitude to health and disease and health services.

5. Establish harmonious doctor-patient relationship and create a therapeutic environment

6. Communicate effectively with patient, his family and community, rural and/or urban.

7. Possess and utilise the knowledge and skills of behavioural sciences/techniques for adoption of health practices.

8. To sensitise the medical student regarding human behaviour normal and abnormal and have the ability to observe and understand the same, a process which is continuous and life long in his profession.

COURSE CONTENT

Topics	Must know	Desirable to know
1. Introduction to types of behavioural sciences: sociology, psychology, anthropology relevant to health and disease.	√	
2.Family studies : role of family in health and disease	√	
3. Illness and health: Mores about health and illness.	√	
4. Socio-economic status: Relationship of socio-economic status with health and mental illness.	√	
5. Communication skills: interview techniques, methods of communication with patients and their relatives, role of communication in interpersonal relationship. Doctor- patient relationship. Empathy. Emotional Intelligence. Psychological methods of treatment: counselling	√	
6. Methods of social work: social case work;role of social worker in Psychiatry.Role of clinical psychologist in Psychiatry; concept of psychiatric team work.	√ √ √	

7. Introduction to psychology – Basis of human behaviour, application of psychology to medicine.	√	
8. Human development: Infancy to adolescence: Stages of development and individual differences.	√	
9. Human development: adulthood to old age – development tasks of adulthood and old age; adjustment problems of old age.	√	
10. Personality development : types of personality and pre-morbid personality and its relationship with illness and behaviour	√	
11. Death and dying: Reactions of terminally ill patient and family; breaking news of fatal illness /death to the family.	√	
12. Learning and conditioning: Nature of learning; performance role of motivation in learning and methods to make learning effective.	√ √ √	
13. Cognitive process: Sensory process- attention, perception, sensation and thinking; sensory process ;problem solving decision making and communication in thinking process.	√ √ √	
14. Emotion: relationship of emotion to illness.		√
15. Intelligence: Nature of intelligence; role of genetic and environmental influences in intelligence.	√	
16. Behavioural medicine: behavioural aspects applied to illness. Sick role; .Illness behaviour;role of socio- cultural background in illness behaviour.	√	
17. Stress and Coping : different stressors and their effects. .		
18.Attitudes : Nature and development of attitudes		
19. To be aware of the security aspects as per the demands of the situation, region: Security of the person, the citizen; physical trauma; Psychological trauma; 'psychological support and first aid-psychological support during disasters.		
BIO-PSYCHO-SOCIAL CONCEPT :		
The following items to be covered by the multidisciplinary team in the dept of psychiatry During the first and second terms –		√
20. Family studies: Types of families: structure and functions of families .		√
21. Illness and health: Beliefs, customs, norms.		√
22 Socio-economic status: Measurement of socio-economic status.		√
23.Mass Communication : Communication with patients in community and use of medias in health education and preventive mental health programmes and life style change of citizens Eg. Smoking behaviour and its relation to cancer.		√
24. Methods of social work: social group work and community organisation.		√

25. Introduction to psychology – Role of nature vs. nurture in shaping human behaviour --	√	
26. Human development: Infancy to adolescence: Behavioural expectancies and problems.		√
27. Human development: adulthood to old age – adjustment in old age to old age diseases.		√
28...Learning and conditioning: Learning of adaptive and maladaptive behaviours; Various learning methods like association, cognitive, verbal, motor and social.		√
28. Cognitive process: Methods of improving memory; forgetting and its determinants; thinking process- concept formation; role of language.		√
29. Emotion: Development of emotive behaviour and its physiological basis.		√
30. Intelligence: Assessment of intelligence in clinical setting; growth of intelligence from birth to old age.		√
31. Behavioural medicine: Methods of behavioural treatment for psychosomatic diseases.		√
32. Coping and stress: Methods of adaptive and maladaptive coping and stress management.		√
33...Attitudes and motivation to treat and achieve health.		√
34. Optimal Communication with one another in team and with patients and their families, regarding security of the citizen, as per the demands of the region and situation.		√
35. Social security: Social assistance and social insurance; social security schemes.		
36. To be aware of the disasters man-made or natural and the preparedness to disaster and management of disasters in team - work paradigm.		√
37. Mock-drill participation in disaster, in team work paradigm, behavioural aspects.		√

BEHAVIOURAL SCIENCES –SKILLS (To be acquired after integrated teaching in preclinical years-phase I
To be of use to clinical psychiatry during the clinical exposure)

Skill	Able to do independently	Able to do under supervision	Assist	Observe
1. Understanding Normal and abnormal behaviour , recognising abnormal behaviour		+		
2. Unconscious, Subconscious, Conscious mind ; Id, Ego Superego; transference and counter-tarnsference . humanistic therapies ; Rational Emotive Therapy; Transcendental meditation; Spiritual health;Spirituality practice for personal and interpersonal well being .		+		
3. Behavioural Analysis	+	+		
4.Behavioural changes in Anxiety; Normal Anxiety and Generalised Anxiety Disorder	+			
5. Detection of unhappiness, hopelessness, helplessness, worthlessness.	+			
6. Meaning of Bio-psycho-social in Causation and in Interventional Approaches	+			

PSYCHIATRY

Learning Objectives

Able to student to deliver mental health services at the primary care level:

1) Able to identify signs and symptoms of common psychiatric illnesses

2) Able to identify developmental delays including Cognitive delays

3.) Aware of common psychopharmacological interventions in Psychiatry.

4) Able to apply basic counselling skills and have comfort with discussing common psychological issues.

5) Able to understand the nature and development of normal human behaviour.

6) Able to appreciate the interplay between Psychological and Physical factors in medical presentations.

7) Aware of statutory and educational provisions with regard to psychiatric illnesses and disability.

8) Able to develop helpful and humane attitude towards psychological, psychiatric and behavioural difficulties.
9) And overall, able to deliver mental health services at the primary care level in the rural and urban communities .

PSYCHIATRY & DRUG /ALCOHOL DE-ADDICTION - COURSE CONTENT

Course contents	Must know	Desirable to know
1. Substance Abuse Ask about alcohol use, identify problem drinking, educate and advise, and refer appropriately. Substances abused like cannabis, and opioids, and newer addictive substances.	√	
2. Depression and Anxiety disorders Ask about Depression and Anxiety, Diagnose depression, assess suicide risk, educate and advise, prescribe rationally and discuss referral	√	
3. Unexplained Physical complaints Identify Physical symptom without Medical cause, Elicit stress and coping related Information, Educate, Reassure and refer appropriately.	√	
4. Cognitive Delays Identify developmental delay , Basic education and advise, Discuss referral	√	
5. Sleep Educate regarding Sleep Hygiene, Prescribe rationally, Look for other psychiatric	√	

Possibilities 6. Mental functions : primary and higher Elicit signs and symptoms of delirium Identify Early Cognitive decline Educate family, Plan referral.	√	
7. Agitated/Violent patient Emergency management keeping forensic and transportation needs in mind	√	
8. Psychoses - Identify, provide immediate care and refer. Educate regarding Continued care in discussion with the psychiatrist.	√	
9. Concept of mental hygiene and Mental Health promotional issues related to Death and Dying Breaking Bad news, Eliciting reactions and support	√	
10. Signs and symptoms of Alcoholism, Its Medical and Psychosocial impact, treatments available.	√	
11. Signs and symptoms of common mental illnesses- Depression, anxiety, somatoform disorders including conversion disorders and psychoses, dementia. Common antidepressants and tranquilisers.	√ √	
12. Child Development and Common emotional , behavioural and developmental disorders of children.	√	
13. Interplay of Psychological and Physical aspects in Medical presentations	√	
14. Common causes of delirium, in alcohol and substance abuse; behavioural management and safe sedation methods.	√	
15. Forensic aspects of violence, attempted suicide and suicide.	√ √	
16. Prevalent Social and Psychological concepts around death and dying		√
17. WHO Primary care classification of mental disorders		√
18. Psychosocial barriers to Help-Seeking for mental illnesses		
19. Educational and Statutory provisions regarding psychiatric illnesses and disability. Concepts of primary prevention,Early detection/Secondary prevention & Rehabilitation	√ √	

20.Affective Disorders:Depression and Mania and Hypomania 21 .Schizophrenia and Paranoid Disorder 22 . PTSD 23. Chronic Organic Brain Syndrome(Dementia) and Delirium 24 .Issues related to Death and Dying Breaking Bad news, Eliciting reactions and support (√ MUST KNOW)	√	

PSYCHIATRY & DRUG / ALCOHOL DE-ADDICTION Skills

Skill	Able to do independently	Able to do under supervision	Assist	Observe
Psychiatric history taking & Drug/Alcohol abuse history taking.	√			
Mental status examination (primary mental functions)	√			
Mental status examination (higher mental functions)	√			
Diagnosis of common straight forward Psychiatric disorders		√		
Dealing with PTSD			√	
Dealing with Conversion / Dissociation Disorder /Concept of Somatisation and Somatoform.	√			
Sleep Hygiene		√		
Developmental delay assessment				√
Physical Methods of Treatment (E.g. ECT – Electro Convulsive Therapy)				
Supportive	√			

Psychotherapy Counselling (how it is different from psychotherapy) Suspect clinically and refer to the speciality (Psychiatrist)allied speciality (like , neurologist) Behavioural and psychological analysis of Self Destructive Behaviour; assessment of intentionality and risk for suicide.	√ √ √			
Skill	**Able to do independently**	**Able to do under supervision**	**Assist**	**Observe**
Child Psychiatric history taking Child and Adolescent Mental status examination (Primary and higher mental functions) Geriatric History taking Geriatric Mental status examination (Primary and higher mental functions) Initial and primary care for the children and adolescents and then refer to the psychiatrist/ child & Adolescent psychiatrist/ Geriatric Psychiatrist Terminal care Exercising empathy , compassion and establishing rapport and maintaining rapport , which is a must for all psychiatric interventions (need not necessarily in a long term psychotherapeutic contract) Psychotherapeutic and behaviour modification approaches for treating neurotic disorders	 √ √		√ √ √ √ √ √	

IMPARTING OF KNOWLEDGE / SKILLS: (BEHAVIOURAL SCIENCES)

Teaching / learning methods

Small Group discussions
Seminars
Written Case scenario discussions
Bedside teaching
Problem based learning
Community Observations

There will be flexibility with regard to the choice of the method of teaching/learning. All the above except the following specifically mentioned items will be covered by the multidisciplinary team in the psychiatry dept. in concert with the community medicine, in integrated teaching framework wherever felt necessary.

The items which are community based will be covered by the Community Medicine team in the first and second terms, as part of the foundation course –in the form of integrated lectures

The items which are clinical based will be included during the clinical psychiatry training.

The training of the following clinical items which are skills based will be done in concert with other clinical departments and community medicine department:

INTEGRATED LEARNING MODULES INVOLVING PSYCHIATRY AND BEHAVIORAL SCIENCES

Teaching / learning methods

Structured Interactive Sessions (SIS)
Group discussions
Seminars
Case discussions
Bedside teaching
Problem based learning
Community Observations (Rural Communities and Urban Communities)
Didactic Lectures

The following will have to be taught as Integrated modules in association with the other departments :-
1.No. 3 in the list -Unexplained physical complaints –Psychiatry and General Medicine.
2.No.15 in the list -Forensic aspects of violence , Attempted suicide and suicide –Psychiatry and General Medicine.
3.No.23 in the list-Chronic Organic Brain Syndrome (Dementia) and Acute Organic Brain Syndrome –Psychiatry and General Medicine.
4.No.24 in the list -Issues related to death and dying – Psychiatry and General Medicine.

The rest are to be taken up by the Department of psychiatry as part of its training between III and VII terms.

E-LEARNING – TOPICS SUGGESTED :---

Neuroanatomy of Emotions

Neuroanatomy of Affective Disorders

Neuroanatomy of Schizophrenia

Neuroanatomy / Neuropathology of Dementia

PTSD – Disaster prone/ vulnerable areas in the country , available at websites .

INTERNSHIP: It was proposed that there be a minimum of TWO weeks of Compulsory Internship in psychiatry. During this period, a range of clinical and behavioural skills will be reinforced and assessed within the framework of their logbook requirements.

To summarise the above the Training and Formative Assessments related to Behavioural Sciences and Clinical Psychiatry during the training before the Final examinations would require the following:

1. **4 hours by Psychiatrists - part of the Foundation Course.**
2. **10 hours of teaching behavioural science, psychological concepts.**
3. **6 hours of practical training(role plays by volunteers)to teach behavioural skills ,communication skills, interviewing skills , interpersonal skills with patients, relatives of patients and colleagues with a view to promoting therapeutic atmosphere in the treating premises or families visited or communities visited – to be organised in concert with the Community Medicine Dept. .**

While teaching Psychology , only slightly touching on Psychopathology and abnormal behaviour , especially related to stress and coping mechanisms, and how Yoga, Pranayama, And transcendental meditaton and counselling and guidance and practice of spirituality , or

inclinations to spirituality could reduce stress ; to concentrate on imparting the bio-psycho-social approaches and conceptualisation of the same and relate the normal mental functions to their biological bases. Not to describe here at this stage of their training , elaorately on psychopathology.

Clinical Psychiatry training will need the following -

1. **12 full days of clinical postings**
2. **3 half day seminars and One whole day workshop as detailed under integrated modules.**

3. 20 hours of lectures which is a significant reduction from the present situation : 16 hours in Psychiatry including substance Abuse withdrawal symptoms and its treatment. And 2 hours in Pediatrics for Child Psychiatry , and 2 hours in General Medicine or Neurology for the familiarising of the Chronic and Acute Organic Brain syndromes, and Cranial Trauma and its complications/ consequences and treatment in emergency of the Deliberate Self Harm : Classes in clinical bedside orientation to be dealt with by the psychiatrist and physician jointly, thus imparting the concept of General Hospital Psychiatry – liaison with Pediatrics and General Medicine or Neurology and Emergency services .

ASSESSMENT

Formative assessment after each posting in psychiatry in the form of MCQs and short answer questions and OSCE for practical evaluation

Summative assessment at the end of ninth semester to be included as part of General Medicine.

ASSESSMENT TOOLS:

Theory (10 marks)

Structured long question 1 (3 marks)
Short answer questions 1 (2 marks)
OR
Short questions -2 (2 & ½ marks each)
AND
Structured MCQs- 10 (½ mark each)

Practical (5 marks)

OSCEs
Short case- 1 (5 marks)
OR
Spotters- 2 (2& ½ marks each)

Viva voce - based on theory paper answers to psychiatry questions and clinical cases.

(Total 15 marks for Psychiatry including Drug and Alcohol De-Addiction)

INTERNSHIP ASSESSMENT- also is based on the logbook and checklists and format of case taking they had followed during their clinical postings during their internship . This logbook will be the standard one for the nation used by all the medical colleges standardised prior to suit in general , the country's specific needs but with the flexibility for the therapists / teachers – clinical psychologists, social workers and psychiatrists – to innovate as per the local regional rural or urban needs , as the case may be. Some of the regional needs are specific and not shared by other regions and other communities . For example the monotony and psychological consequences of going repeatedly to the preclinical and medical situations in hospital for the investigations and treatment and counselling of sickle cell anaemia can be a special feature of Raipur in Chattisgarh and that region only will rpovide the student this specific aspect of consultation-liaison psychiatry with clinical and para-clinical depts. Another example may be that scorpion sting may be a common feature of Tamil Nadu regions but snake bite may be the common feature of some other regions with village agglomerations, with probable reactive child psychiatric consequences, whereas needle phobia can be common to all the regions in the country .

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