Unit 533 November 2016

Mental health
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Facsimile 03 8699 0400
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Mental health

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ABOUT THIS ACTIVITY

In 2013–14, Bettering the Evaluation and Care of Health (BEACH) data showed that about 13% of general practice encounters were for issues relating to mental health.1 Research in New Zealand has placed the prevalence of gender dysphoria to be somewhere around 1 in 6000;2 however, the true figure is often thought to be much higher.3 More than one in seven children and adolescents aged between four and 17 years of age has experienced a mental health disorder in the past 12 months.4 Refugees in Australia are particularly vulnerable as a result of previous substantial health inequalities, and exposure to torture and trauma. As such, they are likely to have significant mental health problems.5 Depression is the most commonly managed mental health–related illness in general practice. About one in three general practice encounters in 2013–14 were for depression.1 Eating disorders affect approximately one in 10 Australians.6 The effects of an eating disorder may result in long-term impairments in an individual’s mental and physical health. Intimate partner violence is a common encounter in general practice, with one in 10 women who attend a general practice noting that they were afraid of their partners in the previous 12 months. Furthermore, one in three women would have experienced fear from their partners over their lifetime.7 This edition of check considers the diagnosis, management and treatment of various mental health conditions in general practice.

LEARNING OUTCOMES

At the end of this activity, participants will be able to:

• discuss issues to consider when managing gender dysphoria in children
• describe the approach to the management of depression
• identify clinical indicators of domestic violence
• outline the assessment of patients with eating disorders
• explain goals for the treatment of childhood trauma
• discuss mental healthcare issues for refugees

AUTHORS

Penny Burns (Case 1) BMed, MPHTM, is undertaking a PhD at the Australian National University on general practitioners’ roles in healthcare during and after disasters. Dr Burns is a senior lecturer in general practice at Western Sydney University. She is also the general practitioner representative on the NSW Mental Health Advisory Disaster Committee, The Royal Australian College of General Practitioners’ (RACGP’s) representative on the national GP Round Table and deputy chair of the RACGP Specific Interests’ Disaster Medicine Group. She is chair of the World Association of Disaster and Emergency Medicine (WADEM). Dr Burns has worked with teachers in supporting children after the Victorian bushfires.

Kirsty Forsdike-Young (Case 6) BA (Hons), PgDip Law, PgDip Legal Practice, is a senior research officer, programme and educational coordinator of the research into abuse and violence team in the Department of General Practice, the University of Melbourne. She has a special interest in the delivery of family violence education to general practitioners.

Kelsey Hegarty (Case 6) FRACGP, MBBS, DRACOG, PhD, is chair of Family Violence Prevention at the University of Melbourne and the Royal Women’s Hospital and a part-time general practitioner at Clifton Hill Medical Group, Melbourne. Professor Hegarty leads a program of research into abuse and violence and is director of postgraduate primary care nursing in the Department of General Practice of the University of Melbourne, and co-chair of the Melbourne Research Alliance to End Violence against women and their children (MAEVE).

Cate Howell CSM, OAM (Case 3) BAppSci (OT), BMBs, FRACGP, FACPm, MHSM, PhD (Med), DipClinHyp, is a general practitioner, educator, therapist and author. Dr Howell has a special interest in mental health, and her clinical work is focused on this area. She was awarded the Order of Australia Medal in 2012 for her contribution to mental health and professional organisations. Dr Howell is a visiting lecturer at the University of Adelaide, and a general practitioner education consultant for several organisations. She is a member of a number of national committees, including the RACGP Mental Health Advisory Group.

Caroline Johnson (Case 3) MBBS, FRACGP, GCUT, PhD, is a general practitioner and medical educator from Melbourne. She is also the clinical lead for mental health for the RACGP’s Expert Committee – Quality Care.

Jan Orman (Case 4) MBBS, MPSychMed, is a general practitioner in Sydney with a special interest in mental health, focusing on mood disorders and eating disorders. As well as working clinically, she is an educator and program facilitator with the Black Dog Institute’s Professional Education Program and also has a role as the institute’s general practitioner services consultant. Dr Orman is currently writing and presenting a series of educational programs for general practitioners as part of the Black Dog Institute’s arm of the e-Mental Health in Practice Project (eMHPrac).

Christine Phillips (Case 2) MBBS, BMedSc, MA, MPH, FRACGP, is associate professor of Social Foundations of Medicine, Medical School, Australian National University, and medical director of Companion House Medical Service.

Beverley Raphael AM (Case 1) MBBS, MD, FRANZCP, is Professor of Psychological Medicine at the Australian National University, emeritus professor of Population Mental Health & Disasters, University of Western Sydney, and emeritus professor of Psychiatry, University of Queensland. Professor Raphael has worked with children involved in disasters, including Cyclone Tracey in Darwin and the Granville train accident. She is currently involved in work supporting teachers to manage trauma in schools.

Jessica Sandy (Case 1) MBBS (Hons), is a paediatric registrar at Sydney Children’s Hospital and a member of the Australian Child & Adolescent Trauma Loss & Grief Network (ACATLGN). Dr Sandy has presented on the effect of disasters on diabetes and continues to develop an interest in the effects of disasters and trauma on vulnerable groups, such as children.

Michelle Telfer (Case 5) MBBS (Hons), FRACP, is a paediatrician and head of the Department of Adolescent Medicine at the Royal Children’s Hospital (RCH) Melbourne. She is also the director of the RCH Gender Service, being instrumental in the expansion of the service with the rising demand for trans-medicine in children and adolescents over the past four years. In 2015, the RCH Gender Service was awarded the Minister for Mental Health’s Award for excellence in consumer leadership and advocacy at the Victorian Public Healthcare Awards. In addition to improving medical and mental health services for the transgender
population, Associate Professor Telfer is currently advocating for legal change to allow transgender young people to access hormone treatment without the need for approval by the Family Court of Australia. Prior to studying medicine at the University of Western Australia, Associate Professor Telfer was a gymnast with the Western Australian Institute of Sport. At 16 years of age, she won silver and bronze medals at the 1990 Commonwealth Games in Auckland, and was a member of the 1992 Olympic Gymnastics Team in Barcelona.

Claudio Villella (Case 5) MBBS, MMed, has worked exclusively with young people in general practice for more than 12 years in a variety of settings, including youth justice, secure welfare, drug and alcohol use and headspace. He commenced working as the first general practitioner in a headspace centre nearly 10 years ago and continued that work until last year. Dr Villella joined the headspace National Office four years ago to support and develop the general practitioner workforce, as well as to develop primary care service delivery within the headspace model. This has included a leading contribution to the content development for the headspace/RACGP youth mental health general practitioner online training module. He is passionate and experienced at assisting general practitioners to build confidence and skills in the important work they do with young people. He is also passionate about the environment and sustainability and enjoys working and relaxing in his productive garden.

PEER REVIEWERS

Adina Hayek MBBS, BSc (Nutr) (Hons), is currently working in clinical general practice and has an interest in mental health. She is also a PhD student with the George Institute/University of Sydney with an HCF Research Foundation Postgraduate Scholarship in Health Services.

Andrew Linn MBBS, DCH, FRACGP, enjoys a dual role as a general practitioner and health professions educator. He is a general practitioner in inner Adelaide, and is a medical educator for the RACGP. Dr Linn has a special clinical interest in general practice–based mental health and child health, and consults regularly in these areas. His background in education extends through undergraduate, postgraduate and continuing education. He is currently a medical educator for practice-based assessment at the RACGP, has been an educator with the MBBS program at the University of Adelaide for over 10 years, currently a clinical senior lecturer in the School of Medicine. For the past four years, Dr Linn has also been a faculty member of the Harvard Macy Institute, a CPD institute focusing on health professions education, at Harvard Medical School in Boston.

REFERENCES


ACRONYMS

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<thead>
<tr>
<th>ACRONYMS</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>ACE</td>
<td>adverse childhood experience</td>
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<tr>
<td>BEACH</td>
<td>Bettering the Evaluation and Care of Health</td>
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<tr>
<td>BMI</td>
<td>body mass index</td>
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<tr>
<td>CBT</td>
<td>cognitive behavioural therapy</td>
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<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<tr>
<td>DASS</td>
<td>Depression, Anxiety and Stress Scale</td>
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<tr>
<td>DSM-5</td>
<td>Diagnostic and statistical manual of mental disorders, 5th edition</td>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and statistical manual of mental disorders, 4th edition</td>
</tr>
<tr>
<td>ECG</td>
<td>electrocardiogram</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>GPMHTP</td>
<td>GP mental health treatment plan</td>
</tr>
<tr>
<td>HEADSSS</td>
<td>home, education, activities, drugs and alcohol, sexuality, suicide, safety</td>
</tr>
<tr>
<td>MHTP</td>
<td>mental health assessment and treatment plan</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>OCD</td>
<td>obsessive compulsive disorder</td>
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<td>PTSD</td>
<td>post-traumatic stress disorder</td>
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<tr>
<td>RACGP</td>
<td>The Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>SSRI</td>
<td>selective serotonin reuptake inhibitor</td>
</tr>
<tr>
<td>TIS</td>
<td>Translating and Interpreting Service</td>
</tr>
</tbody>
</table>
MARY’S BEHAVIOUR TOWARDS HER BROTHER HAS CHANGED

Julie, a single parent aged 34 years, is a long-term patient at your clinic. She attends for routine renewal of her migraine medication. She is accompanied by her two children, Mary, aged eight years, and Thomas, aged four years. While taking Julie’s blood pressure, you notice the children, whom you know well, interacting in an uncharacteristic manner. Thomas is playing on an iPad and Mary grabs it from him and hits him hard on the shoulder with it. Thomas just stares at his sister and does not make a sound. Julie looks at you apologetically and says sheepishly, ‘She never used to be like this … before the bushfire. I just don’t know what to do’.

QUESTION 1
What factors affect how Mary and Thomas may have experienced or been affected by a disaster such as a bushfire?

FURTHER INFORMATION
Julie is tired but says she is well supported by her mother and feels she is coping at the moment.

QUESTION 3
What history do you want to know about the children?

FURTHER INFORMATION
Julie tells you that two months ago, the family’s home was one of 16 destroyed by the local bushfire, which also destroyed their local school. During the fire, Mary was separated from her mother for half an hour when a huge burning tree fell across their yard, killing their pet dog, Russell.

The family has moved in with their grandmother who is very supportive and lives five minutes away from their original house. The children do not remember their father who left before the birth of Thomas. Their school is temporarily in demountables near the school oval while the new school is being built.

Before the fire, Mary was a relaxed, happy, well-behaved child who was performing well at school and had lots of friends. Since the fire, she has become isolated from her friends and mother. Her teachers have expressed concern about her deteriorating school grades and her inability to concentrate. She is irritable at home, particularly with Thomas, and has regular tantrums. By contrast, Thomas, who used to be a handful and was very active, now sits quietly and plays on his iPad much of the time.

From the history and examination you have not found any abnormalities or any reason to suspect child abuse.

QUESTION 4
At this stage, what is the most likely cause for the changes in Mary and Thomas’s behaviour? What else would you consider?
FURTHER INFORMATION
You conclude that Mary and Thomas are displaying distress through behavioural changes due to their recent traumatic experience. At this early stage, they would benefit from ongoing family and school support complemented by follow-up from you and a local psychologist with experience in child trauma. In discussion with Julie, you decide a referral is needed and ask her to come back in a few days to do a GP mental health treatment plan (GPMHTP) for the children.

QUESTION 5
What are your indications for referral and to whom would you refer? What screening tool would you use for the GPMHTP?

QUESTION 7
How do you answer Julie’s question?

QUESTION 8
Are there any potential long-term effects of trauma on a child’s health?

FURTHER INFORMATION
Julie asks if Mary and Thomas are likely to be permanently affected by this event.
CASE 1

CASE 1 ANSWERS

ANSWER 1

Each child, family and community is different. Before we can gain an understanding of how a disaster may have affected Mary and Thomas, we need a comprehensive understanding of who the child is and their context. As the family general practitioner (GP), you will already have background knowledge of many of the following factors that influence the effects of a disaster on a child.

Three main factors influence the effects of a disaster on a child:

• characteristics of the child
  – developmental age and stage of the child (Table 1)
  – pre-existing mental health
  – temperament
  – strengths and vulnerabilities
  – past experiences

Table 1. Children’s reactions to trauma by age and developmental stage

<table>
<thead>
<tr>
<th>Age and stage</th>
<th>Reactions to trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy and preschool</td>
<td>Developmental regression, including speech and toileting skills, sleep and appetite changes, difficulty separating from parents even at bedtime, nightmares, repetitive questioning, behaviour change from good to bad or bad to good, changes in play</td>
</tr>
<tr>
<td>School age</td>
<td>Re-experiencing, avoidance, distressing memories</td>
</tr>
<tr>
<td></td>
<td>Confused, disorganised behaviour</td>
</tr>
<tr>
<td></td>
<td>Somatic symptoms (eg stomach, head and body aches)</td>
</tr>
<tr>
<td></td>
<td>Emotional changes, anxious, moody, teary, defiant, angry, flat, withdrawn</td>
</tr>
<tr>
<td></td>
<td>Difficulty concentrating, tired, worsening grades</td>
</tr>
<tr>
<td></td>
<td>Re-enacting in play, drawing or writing</td>
</tr>
<tr>
<td>High school/adolescence</td>
<td>Concern about ability to actualise lives and goals</td>
</tr>
<tr>
<td></td>
<td>Behavioural changes — risk-taking, self-harming, relationship difficulties, changes to social media profile, threatening to leave home</td>
</tr>
<tr>
<td></td>
<td>Symptoms of anxiety, depression, guilt, anger, fear, disillusionment</td>
</tr>
<tr>
<td></td>
<td>Somatic complaints – headaches, palpitations, tiredness</td>
</tr>
<tr>
<td></td>
<td>Re-experiencing, avoidance/numbing, hyperarousal</td>
</tr>
<tr>
<td></td>
<td>Academic difficulties, dropping out of school</td>
</tr>
</tbody>
</table>

• characteristics of the family and other supports
  – response of the family members to the event
  – parental coping ability and own support network
  – family mental health, disruption, drug and alcohol use, employment, culture

– school evacuation/closure
– community factors, including neighbourhood, sporting or online groups (note: online support can be positive or negative – the latter through, for example, misinformation or re-exposure to details)

• child’s experience of the disaster, which depends on
  – belief that they or a loved one might die
  – experience of death or injury to self, family member, friend or animal
  – greater horror/injury
  – separation from caring adults
  – ongoing dislocation, adversity and disruption to family routines
  – closer proximity to the event/greater degree of exposure
  – nature of the disaster (repetitive incidents usually have a greater effect than single incidents).

ANSWER 2

This scenario may be interpreted as normal transitory behaviour. However, Julie has just informed you that there has been persistent behavioural change in both her children following a specific traumatic event, and you have noticed the dramatic change yourself. Clarification is therefore required to assess for risk and need for clinical care.

Trauma refers to an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person’s resources for coping.

A trauma-informed care approach for this consultation means having an awareness of the effect trauma can have on individuals, families and communities. It is a strengths-based approach that ‘emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment’.

Appropriate goals for this consultation would be to:

• Engage the children and mother to maintain/establish a trusting, ongoing, supportive, empathetic relationship. Sustain an awareness of their vulnerability after such a traumatic event and the risk of re-traumatisation of both mother and children.

• Identify current risks and issues. Risk assessment and safety from any ongoing trauma is a priority. An underlying trauma may be due to the fire, but other considerations include instability in the family following the traumatic event, or mental or physical health conditions. A definitive diagnosis is not necessary where symptoms may be transient or subthreshold. There may be a significant level of distress and functional impairment before a clear diagnosis emerges.

• Understand the perspectives and priorities of each child and the family to help recognise the cognitive, emotional and behavioural impact of the trauma.

• Respond by developing a management plan in consultation with the children and mother to help them regain a sense of control over their lives. Use a strengths-based approach to identify strengths and vulnerabilities. The aim is to decrease the children’s distress and help them self-regulate through providing a sense of safety, with ongoing support and education from involvement of family, school and health professionals. This ongoing care may take place over several visits. An important factor in how trauma affects the children is the...
response of the parent; so, to support the children, we need to support the parent. ‘If a community values its children, it must cherish their parents.’ — John Bowlby

- Review regularly as part of holistic ongoing patient care. Set in place a plan in case of crisis.
- Refer as appropriate.6–8,12

Note: be aware of what is discussed in front of the children. Given the risk of re-traumatising the children, it may be appropriate to send them to the play room with the practice nurse or medical student while you talk carefully with Julie to first assess the situation.

**ANSWER 3**

It is important to get a good understanding of the children and their family and context from Julie, along with the changes that have occurred since the bushfire. Sensitivity is required as re-traumatising can also affect parents. Any questions that are disturbing for Julie should be omitted. Collateral history from teachers can be obtained with permission.

Issues to consider include the following:

- **The child (pre-trauma)**
  - pre-event functioning and personality
  - age and stage
  - previous trauma and how they coped

- **Changes in the child post-trauma**
  - behavioural changes
  - emotional changes – anxiety/depression
  - somatic symptoms
  - school performance
  - relationship issues
  - difficulty sleeping
  - re-experiencing/re-imagining
  - intrusive thoughts
  - avoidance/withdrawal
  - hyperarousal

- **The bushfire experience**
  - What was the child and parent’s experience of the event?
  - Did they believe that they or someone they loved would die or be injured?
  - Were the children separated from supportive adults at any time?
  - What is the extent of loss and after-effects (ie loss of home and subsequent relocation)?
  - Were they repeatedly re-exposed to the traumatic event via media?
  - Is any other cause of trauma/abuse identifiable?

- **Protective factors**
  - resilience and strengths
  - school and routine
  - family/social supports
  - parent’s coping abilities and explanation of the event

- **Parent/sibling mental health**

  A history from Mary (with Julie present) is also important. Opportunistic gathering of information from Mary’s perspective on her strengths and challenges, and the effect of her symptoms at home, school and relationships, will be useful. Again, be mindful that a child can be re-traumatised by questioning around trauma, so if unsure, it is better to refer to a specialist with trauma training. This would be the case for Thomas given his young age, unless your early management strategies are successful.

**ANSWER 4**

Mary and Thomas have been exposed to a number of stresses recently, including:

- being threatened by a fire
- witnessing the death of their dog and the destruction of their home along with their possessions
- for Mary, separation from her mother during the event
- destruction of their school and part of their environment
- relocation.

Following a disaster, distress in children may be manifested as behavioural, emotional or cognitive changes. For most children, this is transient and resolves within weeks to months after the event.5 This may include children who were not personally affected by the disaster, but in fact experienced it via media, print or video. Studies have shown a link between terrorism violence through the media and adverse mental health effects and post-traumatic stress in children.13–15

It is not possible to predict from initial behaviour which children will continue to show symptoms, but the three factors mentioned in Answer 1 (characteristics of the child, their family/supports and their experience of the event) will help to identify those more at risk. Most children are resilient and, with support from their family and school community, will not develop ongoing mental health conditions.5,9 Some will benefit from several sessions with a psychologist, and a few may require referral for more intensive and prolonged management.

Mary and Thomas are showing signs of distress through changes in behaviour. They need support from Julie and their school, and ongoing monitoring by you. These symptoms may abate over time or may intensify and require ongoing specialist review.7

You should also make a note to check on Julie when she returns for her next consultation, as although she seems to be managing at the moment with help from her mother, she may require more support with time.

**Differentials**

In general, other traumatic experiences, such as child abuse, need to be considered. In this case, as previously mentioned, there was no suspicion of child abuse. Potential clinical conditions that may occur in children over time after disasters include disorders of anxiety, depression, bereavement, grief and/or post-traumatic stress disorder (PTSD).5 Pre-disaster levels of anxiety or depression may contribute to post-level symptoms.4,5 While PTSD usually occurs in the first weeks to months following a disaster, some may have a delayed presentation of more than six months. PTSD may present in very young children, as young as one year of age.5,16

These are not common outcomes, and would require specialist review and diagnosis.16,17
ANSWER 5
Referral may be needed after the first weeks if there is:
• persisting or worsening behavioural, emotional or physical symptoms
• significant decline in concentration and academic performance that interferes with daily functioning or disrupts the classroom
• difficult relationship issues or changes in social functioning that cause problems
• evidence that the problems exist in multiple settings
• regressive behaviour to that of a younger child (eg baby talk or toileting issues)
• the presence of ongoing stressors that may exacerbate difficulties (eg divorce, housing or financial issues, death)
• indicators that the parent is not coping or unable to put in place supports for the children.

You consider pathways of referral with Julie. To provide the best care, a cross-disciplinary team with the right mix of professionals with experience working with children and trauma should be involved to help the children and their family. This may include referral to a psychologist, mental health nurse, paediatrician or early childhood programs. Involvement of the school and their welfare professionals is crucial.

You could ask Julie to complete the strengths and difficulties questionnaire for both children. It is a commonly used brief behavioural screening questionnaire completed by the parents or teachers of children aged 4–16 years (refer to ‘Resources for doctors’). There is a self-reporting version available for suitable children aged 11–16 years. There are five items, each on five groups of symptoms (emotional, conduct, hyperactivity/inattention, peer relationships and prosocial behaviour).

ANSWER 6
You could give Julie the following strategies and information:
• Parents are a crucial part of the children’s recovery and ability to feel safe again. If Julie is distressed and not able to provide this, help her identify another caring adult, such as her mother, to assist.
• Return to normal routine, school, environment and family functioning as much as possible.
• Relationships with other important people such as teachers and extended family help the children feel safe. Talking to the children’s school is essential to avoid teacher misunderstanding of distressed behaviours at school.
• Care is needed when discussing the traumatic event around children, and their exposure to media should be limited and supervised. However, children need information about what is going on, depending on their age, stage and readiness, to help make sense of what has happened. Some young children may feel they are responsible for what happened.
• Recovery is different for everyone and may take days, weeks, months or years. There is no right way to recover.
• Safety netting: Julie should return before the next scheduled visit if she is at all concerned.
• Resources are available at the school, in the community, online and on the phone (refer to ‘Resources for parents’).

• Parents/carers need to look after their own wellbeing in order to help the children.

Regular review of Mary and Thomas with Julie in general practice is an important ‘holding’ role until behaviours return to a normal level and the distress in the family has abated.

ANSWER 7
Initial reactions and signs of distress do not predict long-term effects. However, early intervention to resolve symptoms and distress does improve outcomes. The aim is to lessen Mary and Thomas’s distress, and increase their sense of safety and trust in the world. Through understanding and patient support, they have the best chance of coping with this event, and of learning how to cope better with future life stressors.

ANSWER 8
While there is no clear evidence of this from disasters and their sequela, there has been increasing recognition of the effect of multiple early traumatic experiences on mental and physical health in adulthood. The adverse childhood experiences (ACEs) study on the effect of traumatic life experiences in more than 17,000 individuals during their first 18 years of life has shown a relationship between the number of ACEs and health effects on later wellbeing and health.

There was a relationship with conditions such as coronary artery disease, liver disease and chronic obstructive pulmonary disease (COPD, even after correction for conventional risk factors such as smoking and cholesterol), antidepressant medication use, suicide attempts, hallucinations, intravenous (IV) drug use, teen pregnancy and poor self-rated job performance.

The adverse experiences were:
• abuse
  – emotional, physical, sexual abuse
• household dysfunction
  – mother treated violently
  – householder alcoholic or drug user
  – householder incarcerated
  – householder with particular mental health issues
  – not raised by both biological parents
• neglect
  – physical or emotional.

Despite the lack of equivalent research on the effect of exposure to other severe traumatic events, such as a devastating fire and its sequelae, it is important to be aware of the potential risk to children and families until more evidence is available.

To prevent ill-health and promote wellbeing, current research supports a comprehensive biopsychosocial evaluation of children who have experienced disasters.

CONCLUSION
Julie, Thomas and Mary have been seeing you regularly and have also attended several sessions with a child psychologist who has experience in trauma. You see the family six months after the initial consultation and Julie
is overjoyed. ‘We’re still riding some of the ups and downs of life, but I do really feel that I have my little Mary back!’ Thomas is still a little quiet, but is getting more cheeky every day and responding to his sister’s improved behaviour. Mary shows you the pictures she drew of her new home and their new dog, Charlie.

Most children are resilient and go through trauma without lasting issues or mental health conditions. However, it is important to identify those at risk, and assess how each and every individual is affected. As children often do not volunteer information, we have to be even more observant with them. ‘Children don’t have a narrative for trauma. They are more likely to show you than tell. Our job is to notice.’ (J William-Smith 2015, personal communication, 27 Oct)

RESOURCES FOR DOCTORS

- Introduction to trauma informed care, http://learn.earlytraumagrief.anu.edu.au
- Strengths and difficulties questionnaire, www.sdqinfo.com
- Reach Out! — information for health professionals with navigating adolescent issues (sex, drugs, friends and family), http://au.reachout.com
- Surviving traumatic grief is a book by families who are surviving traumatic grief, initiated after the Victorian Bushfires, www.sueevansfund.com.au

RESOURCES FOR PARENTS

- Australian Child & Adolescent Trauma Loss & Grief Network (ACATGLN), http://tgn.anu.edu.au
- Reach Out! and Reach Out Parents provides help with navigating adolescent issues (sex, drugs, friends and family), http://au.reachout.com
- Parent line: 13 22 89
- Lifeline: 13 11 14

RESOURCES FOR CHILDREN

- Kids Helpline: 1800 551 800 – Available for children to phone and ask to speak to the same trained counsellor each time. Ages up to 25 years.
- Reach Out! and Reach Out Parents provides help with navigating adolescent issues (sex, drugs, friends and family), http://au.reachout.com
- Bite Back is interactive website with a focus on mental fitness but lots of activities including ability to share stories, photos and read and respond to blogs, all anonymously, www.biteback.org.au
- Headspace — mental health for young Australians through anonymous support for individual or online group chat with experts, online at www.headspace.org.au or telephone service at 1800 650 890
- Mobile apps
  - Smiling Mind — modern meditation for young people
  - Mind the Bump — mindfulness for expecting parents
  - Worry Time (Reach Out app)
  - The Desk — for students

REFERENCES


CASE 2

TARSHAN IS VISITED BY A DEMON

Tarshan, 25 years of age, is a student in his first year of an engineering degree at university. He came to Australia from Sri Lanka six years ago and was awarded a permanent protection visa. Tarshan lives in a share house with other university students. He comes to see you with one of his housemates, who reports that over the past month, Tarshan has been sleeping fitfully and shouting at night. On several occasions, Tarshan was found standing and weeping on the road outside their house.

Tarshan is Tamil. Since coming to Australia, he worked hard at learning English and getting an education so that he can sponsor his younger brother and sister to come to Australia. Tarshan has come to your general practice on previous occasions for intercurrent illnesses, but has been reluctant to focus on events he experienced before coming to Australia. You are struck by the fact that he appears to be quite anxious and is struggling to settle himself today.

FURTHER INFORMATION

Tarshan tells you that for the past month, he has been possessed by a demon who makes him feel as if ‘bad things’ from the past are happening again now. He describes these not as nightmares, but as waking experiences, which he has to a lesser degree during the day. Tarshan has taken to staying awake through the night by pacing around the neighbourhood to avoid the memories brought to him by the demon. Over the past two months, he has been increasingly irritable and becomes angry with his housemates for no real reason. Tarshan is concerned that his brain has stopped working. During this consultation, you notice that there are long pauses as he loses his train of thought.

QUESTION 1 🎙️

What questions should you ask Tarshan?

QUESTION 2 🎙️

In previous consultations, Tarshan spoke in reasonable colloquial English. Is there any need for an interpreter?

QUESTION 3 🎙️

What are the potential diagnoses?

QUESTION 4 🎙️

What assessment tools are available for you to use?
FURTHER INFORMATION
Tarshan spent three months in an onshore immigration detention centre. He now has a permanent visa under the humanitarian program. Tarshan has been working and studying to send money back to his two siblings; he applied to sponsor them to Australia three years ago. He has support from a local church. Tarshan tells you that two months ago, his sister died while clearing landmines and his brother's wife was murdered. Since then, he has been visited by a demon. He does not wish to discuss what happened to him in Sri Lanka.

QUESTION 5
What are your clinical priorities?

QUESTION 6
What tests (if any) should you perform?

QUESTION 7
What is your treatment approach for Tarshan?

QUESTION 8
What challenges and supports exist for clinicians working with refugees?

FURTHER INFORMATION
Tarshan does not have a religious framework for the demon, and can readily accommodate the notion that the demon could have emerged during a time of increased arousal raised by a recrudescence of post-traumatic stress disorder (PTSD). He does not want to take medication, as in the past, he became very sedated on an antidepressant prescribed while in immigration detention. Tarshan spent six months consulting a psychologist who was skilled in trauma-informed cognitive behavioural therapy (CBT), and learned to control his level of arousal. He also became very engaged in the local Tamil cricket team, finding that the structured physical exercise was also very useful in controlling his symptoms.
CASE 2 ANSWERS

ANSWER 1
You should gently explore Tarshan’s mental health, bearing in mind the issues that were raised by his housemate. Cross-cultural mental health history-taking, like all mental health history-taking, rests on the development of rapport between patient and clinician. A useful framework is to use the cultural awareness tool (Box 1) to frame this part of the consultation. This framework encourages general practitioners (GPs) to listen to Tarshan explain the events over the past month and how he has been feeling in his own words.

Box 1. Cultural awareness tool
- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your problem does to you? What are the main problems it has caused for you?
- How severe is your problem? What do you fear most about it?
- What kind of treatment/help do you think you should receive?
- Within your own culture, how would you be treated?
- Is your community helping you with your problem? If so, how?
- What have you been doing so far for your problem?
- What are the most important outcomes you hope to get from treatment?

ANSWER 2
Even though Tarshan’s command of English is sufficient to study at university, there are two reasons why he may benefit from an interpreter at this consultation. First, competence in a second language often slips when the speaker is distressed or unwell. Second, this situation may be one of the four ‘Cs’ when an interpreter should be used:2
- in a crisis
- assessing cognitive competence
- giving complex instructions
- obtaining consent.

Free interpreter services are available for Medicare-rebateable services through the Doctors Priority Line (1300 131 450) of the national Translating and Interpreting Service (TIS), 24 hours a day, within three minutes of request (this service requires a code number, which is available at https://tisonline.tsnational.gov.au/RegisterAgency). Telephone interpreters may be preferred in consultations with refugees as the patient’s anonymity can be preserved. It is prudent to explain to the TIS telephone operator that the consultation will address mental health, so that the interpreter is prepared. It is not necessary to disclose the patient’s name when arranging an interpreter.3 Patients should be informed that the interpreter service is confidential.

ANSWER 3
Post-traumatic stress disorder
The diagnosis of PTSD focuses around both:
- direct experience of a traumatic event
- re-experiencing of the event, avoidance of stimuli that may trigger recollection of the event, negative alterations in cognitions and mood, and alterations in arousal and reactivity.

Depression
Depression may co-exist with PTSD and, in this case, agitated depression is a possibility. However, Tarshan reports that he has previously functioned well, has no change in appetite and does not feel sad.

Psychotic episode
Tarshan’s belief in a demon could be indicative of a delusion; however, it seems more likely that this is a culturally congruent expression of distress. Importantly, he does not report hallucinations and his intrusive symptoms relate to events from the past.

ANSWER 4
Routine psychological assessment tools used in primary care of mental health can, in general, be used, provided they are placed within a broader context that also assesses the context of the refugee (Table 1).

Table 1. Contextual issues to be considered4,5

<table>
<thead>
<tr>
<th>Pre-migration experiences</th>
<th>Family functioning and social support</th>
<th>Visa status</th>
<th>Post-migration circumstances including housing, employment, language barriers, social isolation</th>
<th>Potential sources of stress or strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experiences in natal country</td>
<td>• Post-migration circumstances, including housing, employment, language barriers, social isolation</td>
<td>Visa status frames rights and entitlements for refugees, and thereby, the stresses of the patient’s everyday environment</td>
<td>Sponsorship issues and refugee determination processes are major sources of stress and mental health problems</td>
<td></td>
</tr>
<tr>
<td>• Journey to settlement country</td>
<td>• Length of time in immigration detention (&gt;6 months is associated with persistent psychological symptoms)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ANSWER 5
The clinical priorities are to establish rapport and ensure that Tarshan is safe. It is not important at this stage to explore his history of trauma beyond a “thumbnail” sketch. It may be unwise to expect him to disclose a traumatising event, or events at all, when he is acutely distressed. There is very little published data on suicide among resettled refugees as they tend to be an invisible population in summary statistics, although some subpopulations of refugees, such as the Bhutanese, have higher rates of suicide in their own countries and after resettlement. It is important to check with Tarshan if he has a plan for self-harm or suicide, any other comorbidities (especially substance use) and the level of support that exists for him in the community. If there is any concern about his safety, seek specialist advice from a mental health crisis service.

ANSWER 6
Tarshan is financially distressed and may be nutritionally compromised. Food insecurity is very common in newly arrived refugees, particularly those who are remitting to relatives in other countries. Baseline tests should include thyroid function tests, ferritin, B12 and folate levels.

ANSWER 7
Approaches to refugees with psychological disorders, including PTSD, should extend beyond the disease itself to focus on the psychosocial context. It should also encompass the resilience capabilities that the person has always had and accommodate their own understanding of the illness. This should be accompanied by a focus on Tarshan’s strengths (eg his ongoing support of his brother and determination to succeed in Australia) and practical supports in the community (eg ensuring he has support from the disability support officer at his university and connections with the Tamil community in the region). Decisions to initiate pharmacotherapy or referral to a specialised service for trauma-informed CBT will be determined by Tarshan’s own views on appropriate therapy and his level of psychological distress.

ANSWER 8
Clinicians working with refugees can sometimes become traumatised themselves, or be overwhelmed and disengage from the care of patients who are refugees. Clinicians who work with refugees may find it useful to seek support from a refugee health service network, such as The Royal Australian College of General Practitioners’ (RACGP’s) Specific Interests Refugee endorsed network or the state-based networks operating under the umbrella of the Refugee Health Network of Australia, www.refugeehealthaustralia.org

REFERENCES
CASE 3

JIM IS FORCED TO SEE YOU
Jim, 52 years of age, works as a storeman and is married to Sue, a teacher. They have two teenage children, Rosie and Tom, who are both in high school. Jim presents to you with Sue. She booked a single appointment and insisted that Jim come in to see you, as she believes he has been ignoring his physical health issues. Jim has a history of hypercholesterolaemia and glucose intolerance, and you discussed lifestyle changes and monitoring with him when you saw him six months ago. Sue is also worried because Jim has been increasingly irritable with the children and her over the past three to four months. There have been some work and financial stressors on the family. Sue leaves after a few minutes and you continue the consultation with Jim.

QUESTION 1
What further history should you take from Jim? In particular, what questions will you ask him about his mental health?

FURTHER INFORMATION
In this consultation, you determine that Jim has had several previous periods of mild, low mood in his life, starting in his teenage years. History-taking confirms that he has been feeling low for about three months, has lost interest in going to his darts competition nights and is irritable. Jim has been waking up early and having difficulty getting back to sleep, and feels tired as a result. Workload has been high in his job, but this is not uncommon. The family has been under financial stress for several years. A brief physical examination does not reveal any new concerns.

QUESTION 2
How would you assess the severity of depressive symptoms in Jim’s case?

QUESTION 3
How would you manage the competing demands of this consultation (physical and mental health, and interpersonal and work issues)?

QUESTION 4
What are the treatment guidelines for mild depression?

QUESTION 5
Is treatment with an antidepressant indicated at this stage?

FURTHER INFORMATION
You believe that Jim is currently stressed, and you are concerned that he meets the criteria for mild depression. You briefly discuss the physical health issues and nature of depressive symptoms, whether part of major depression or an adjustment disorder. You organise comprehensive blood tests, provide a handout on sleep hygiene, and suggest some low-intensity treatment (a cognitive behavioural therapy (CBT) phone-coaching program; see ‘Resources for doctors’ for other programs). You also organise follow-up in one month.

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QUESTION 6
What would the advantages have been of either undertaking a mental health assessment and treatment plan (MHTP) at the first consultation, or getting Jim back soon after to complete one?

FURTHER INFORMATION
Jim attends for the appointment one month later and he reports that his mood has somewhat improved and that he has started some exercise. He has been speaking with the CBT coach and find this to be helpful. You discuss the blood test results, which do not show any deterioration or new problems, and reinforce the lifestyle measures that will assist Jim’s physical and mental health. A further appointment is made a month later to monitor progress. However, Jim does not attend because of work issues. He tells the receptionist that he will make another appointment, but this does not occur.

Jim presents with Sue three months later. She made a long appointment because Jim was made redundant from his work six weeks ago. Sue reports that he has been more withdrawn and argumentative, and his sleep has deteriorated. She is tearful about the impact of Jim’s mood and behaviour on the family. You explore the history further with Jim on his own, and he reports feeling depressed, and thinking ‘work doesn’t want me, and now the family hates me’. He has not had suicidal thoughts, but has considered that the family might be better if he left them alone. Jim does not have plans for self-harm, and has made no suicide attempts recently or in the past.

QUESTION 7
How would you assess suicide risk?

QUESTION 8
How will you manage the new developments in Jim’s case?

QUESTION 9
What factors need to be considered when commencing antidepressants? What information do you give patients when commencing antidepressants?

QUESTION 10
Reflect on how the situation of a failure to attend, and then re-presenting more severely depressed, could have been avoided?
CASE 3 ANSWERS

ANSWER 1
A comprehensive assessment is vital. This involves asking about current social stressors and symptoms in relation to mood (e.g., duration, depressed mood, elevated mood), anxiety symptoms, and past history or family history in relation to mental health issues. Questions about substance use and risk of self-harm and suicide are part of the assessment.

Depressive symptoms can be summarised as follows:  
- **affective** (emotions) – depression, anxiety, guilt, anger, hostility, irritability, inability to experience pleasure
- **behavioural** – agitation, facial expression, slowing down of movements, speech and thought, and crying
- **attitudes** towards self and world – self-criticism, low self-belief, feelings of helplessness, hopelessness, pessimism, thoughts of death or suicide
- **cognitive** – impaired thinking and concentration

• **bodily complaints** – loss of appetite, sleep disturbance, low energy or libido.

Given the competing demands of this consultation and possible time constraints, it is vital to be clear in your mind about the criteria for depression. According to *Diagnostic and statistical manual of mental disorders*, 5th edition (DSM-5), the diagnosis requires pervasive and persistent symptoms (at least two weeks), with at least five symptoms, including one of either persistent low mood and/or loss of enjoyment of activities, as well as potentially lowered energy, changes in appetite/weight, sleep, libido, memory and concentration, psychomotor agitation/retardation, or feelings of hopelessness or suicidal thoughts. There is clinically significant loss of function.

ANSWER 2
A global assessment of severity can be made through history-taking and asking about the range and intensity of symptoms, including hopelessness and melancholia, and including functional impairment and suicidality. Table 1 and the beyondblue clinical practice guidelines serve as guides to severity. An assessment tool such as the Kessler 10 (which measures distress) or the DASS (Depression, Anxiety and Stress Scale) will assist with this determination.

<table>
<thead>
<tr>
<th>Table 1. Assessing the severity of depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom cluster</strong></td>
</tr>
</tbody>
</table>
| **Mood** | • Lowered mood  
  • Reduced joy  
  • Crying  
  • Anxiety  
  • Irritability | • Reduced pleasure in things  
  • Reduced interest in things  
  • Reduced reactivity of mood | • No pleasure in things  
  • No interest in things  
  • No reactivity of mood |
| **Depressive thought** | • Loss of confidence | • Feeling worthless or a failure  
  • Pessimism about things generally | • Hopeless, see no future  
  • Self-reproach, guilt, shame  
  • Consider illness a punishment  
  • Paranoid or nihilistic delusions |
| **Cognition** | • Minor forgetfulness or lack of concentration | • Indecisiveness  
  • Forgetfulness | • Unable to make decisions  
  • Slowed thinking, seems cognitively impaired (pseudodementia) |
| **Somatic** | • Low drive  
  • Loss of interest in food  
  • Lowered libido  
  • Mild initial insomnia; wake one to two times a night | • Low energy, drive  
  • Eat with encouragement; mild weight loss  
  • Loss of libido  
  • Initial insomnia, wake several times a night | • No energy, drive  
  • Unable to eat; severe weight loss  
  • No libido  
  • Psychomotor retardation or agitation  
  • Sleep only a few hours |
| **Social** | • Mild social withdrawal | • Apathy and social withdrawal  
  • Work impairment | • Apathy and social withdrawal  
  • Marked work impairment  
  • Poor self-care |
| **Suicidality** | • Life not enjoyable  
  • Helplessness | • Hopelessness  
  • Life not worth living  
  • Thoughts of death or suicide | • Evidence of intent to suicide (plans, attempts) |

ANSWER 3
It is difficult to manage this consultation given the multiple issues and time constraints. Being confident in your knowledge about depression and treatment guidelines, prioritising the various issues, and ensuring key issues (including risk) are addressed will assist. Sound communication skills are essential. Many general practitioners (GPs) will allocate extra time to a patient when needed, and therefore run overtime, or get the patient back for a longer appointment to complete the assessment.

ANSWER 4
Active monitoring and non-drug treatments (e.g., behavioural activation) are recommended first in mild, major depression. A meta-analysis found that the benefit from antidepressants for mild depression is minimal. Psycho-education (e.g., information about depressive symptoms, sleep hygiene) and psychological therapy are first-line treatments. Note that The Royal Australian College of General Practitioners’ (RACGP’s) e-Mental health guide: A guide for GPs provides information on the use of the internet to deliver mental health information.

ANSWER 5
Being aware of depression treatment guidelines, such as the National Institute for Health and Care Excellence (NICE) or beyondblue clinical practice guidelines, is helpful in making decisions such as whether to prescribe antidepressants. Assessment of the severity of the depression and applying the ‘stepped-care model’ are keys to this decision. The stepped-care model provides a framework to assist with the provision of services and supports (Table 2).

Table 2. The stepped-care model

<table>
<thead>
<tr>
<th>Focus of the intervention</th>
<th>Nature of the intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: All known and suspected presentations of depression</td>
<td>Assessment, support, psychoeducation, active monitoring, and referral for further assessment and interventions</td>
</tr>
<tr>
<td>Step 2: Persistent subthreshold depressive symptoms/mild-to-moderate depression</td>
<td>Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions</td>
</tr>
<tr>
<td>Step 3: Persistent subthreshold depressive symptoms or mild-to-moderate depression with inadequate response to initial interventions; moderate depression</td>
<td>Medication, low-intensity psychological interventions, combined treatments, collaborative care, and referral for further assessment and interventions</td>
</tr>
<tr>
<td>Step 4: Severe and complex depression; risk to life; severe self-neglect</td>
<td>Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care</td>
</tr>
</tbody>
</table>

ANSWER 6
The MHTP provides an opportunity to complete a comprehensive assessment, including mental state examination and risk assessment. The MHTP framework includes diagnosis/formulation and use of an outcome tool. It is a collaborative process that involves discussion about the assessment with the patient, and identification of treatment goals and strategies to achieve these. Psycho-education, addressing lifestyle factors, crisis planning and relapse prevention are part of the process. Further information may have been elicited from Jim that may have influenced treatment decisions, such as considering referral options. Crisis and relapse prevention planning would be in place. Follow-up arrangements (including potentially recall) would be part of the plan. Arranging a second appointment to complete an MHTP is recommended, as it is unlikely that this level of planning can be undertaken at the initial visit in Jim’s case.

ANSWER 7
To assist in assessing suicidal risk, the following questions with respect to the past month are useful:

- Do you want to harm yourself?
- Have you thought about suicide?
- Have you made any plans to take your own life? (If yes, ask for specific details)
- Have you attempted suicide? (This refers to more recent attempts)
- Have you ever attempted suicide at any time in life?

Suicidal risk accelerates with an increasing number of ‘yes’ responses. However, if the patient responds with ‘yes’ to any of the questions, it is vital to carefully assess the suicidal risk in more detail. More comprehensive suicide risk assessment tools are available (refer to “Resources for doctors”).

In general, increases in frequency, intensity and duration of suicidal behaviour are indicators of severity. Red flags in relation to risk include patients talking about killing themselves, having no reason to live, being a burden to others or being in unbearable pain. Behaviours may also change, such as increased risk-taking behaviours, substance use, withdrawing from people and activities or giving away possessions.

ANSWER 8
Completion of an MHTP (if not done earlier) is desirable and, considering the severity of the depressive symptoms, is vital at this stage. Further treatment options can then be discussed with Jim. His depressed mood is now moderate: antidepressant medication, such as a selective serotonin reuptake inhibitor (SSRI), would be appropriate. More intense psychological
treatment is also indicated, such as referral to a mental health professional (eg psychologist; for further evaluation, psychological therapies like CBT and mindfulness). You may choose to refer to a psychiatry for an opinion.

ANSWER 9
The following factors are considered:
- severity and duration of the depressive symptoms
- other health issues and medications
- past use and effectiveness of particular antidepressants
- start at a low dose and increase the dosage as tolerated
- length of use to be advised (whether 6–12 months for a first episode, or longer for relapses).

It is important to educate the patient about antidepressants:
- the nature of current antidepressants (eg different types, mechanisms of actions, effectiveness)
- commencement dosage and when to increase dosage under the supervision of the GP
- time for response to occur (two to six weeks)
- potential short-term adverse effects, particularly nausea, headache or anxiety, and their usual time to resolution (one to two weeks)
- potential long-term adverse effects (eg sexual dysfunction)
- talking with their GP if they have any concerns or questions about the antidepressant
- potential drug interactions
- length of use
- not stopping antidepressants abruptly or without consulting the GP
- perpetuating effect of alcohol on depressive symptoms and the benefit of avoiding alcohol consumption during treatment
- addressing any myths about antidepressants (eg that they are associated with addiction)
- always contacting the GP if anxiety worsens considerably or suicidal thoughts increase (can occur in a small percentage and can be dangerous)
- refer to a psychiatrist if the patient is not responding to medication after an appropriate period of time at optimal dose.

The literature consistently confirms that such education about antidepressant medication improves adherence.12

ANSWER 10
It is not always possible to predict events such as being made redundant, but use of the MHTP, firm follow-up arrangements and recall systems, would have assisted. Adopting crisis and relapse prevention planning (involves identifying early warning symptoms, identifying possible high-risk situations for relapse and preparing an emergency plan).13 Education of the patient and their family plays an important role.

RESOURCES FOR DOCTORS
- Information on antidepressant prescribing:
  - www.nps.org.au/conditions/mental-health-conditions/mood-disorders/depression
  - www.racgp.org.au/your-practice/guidelines/handl
  - www.racgp.org.au/your-practice/guidelines/e-mental-health
- Books:
- Website:
  - beyondblue, www.beyondblue.org.au
  - Blue Pages depression information, www.bluepages.anu.edu.au
  - Centre for Clinical Interventions, www.cci.health.wa.gov.au
  - Mindhealthconnect mental health and wellbeing, www.mindhealthconnect.org.au
  - MoodGym Online treatment program for depression (CBT), https://moodgym.anu.edu.au
  - The Royal Australian and New Zealand College of Psychiatrists, www.ranzcp.org
  - Youth beyondblue, www.youthbeyondblue.com
- Phone app:
REFERENCES

QUESTION 1
What more do you need to do?

FURTHER INFORMATION
Holly reveals a history of minor self-harm many years ago to explain the marks on her wrists. Those events coincided with the latter stages of her experience of anorexia nervosa, which she struggled with from the ages of 13 to 20 years. She explains that she was always fat as a child. Although she did very well academically and swam in the swimming squads in early high school, she was teased about her weight. Finally, when she was 13 years of age, with the encouragement of her coach, she embarked on a strict weight-reduction diet and lost more than 10 kg in three months. Her mother eventually became alarmed and took her to see the family doctor. Unaware of Holly’s mother’s own struggle with an eating disorder earlier in her life, the general practitioner (GP) congratulated Holly on her weight loss.

QUESTION 2
What are the risk factors for the development of eating disorders? Were any of these factors relevant for Holly when she was younger?

QUESTION 3
What are the early warning signs of the development of an eating disorder?

QUESTION 4
Holly’s original presentation with her eating disorder was with intentional weight loss. In what other ways do eating disorders present to GPs?

FURTHER INFORMATION
Holly reveals that during her illness, she was admitted to hospital a number of times for acute medical complications of starvation. On one occasion, she spent a week in intensive care after developing refeeding syndrome.
CASE 4

QUESTION 5
What are generally considered the criteria for urgent admission in eating disorders?

FURTHER INFORMATION
Holly says she maintains her weight with exercise and a ‘healthy’ diet. She says she does not restrict her intake, but avoids fat and excessive amounts of processed food. Holly admits to doing six 90 minute sessions of aerobic exercise per week, taking 10–20 laxative tablets per night, and self-induced vomiting three to four times a week when she feels she has eaten too much or the ‘wrong’ kinds of food. She vomits by drinking water to ‘flush’ her stomach. Holly does not use alcohol or other substances. Holly also mentions that her periods are erratic and that she had several years during her teens when she did not menstruate at all.

QUESTION 6
What is ‘refeeding syndrome’? Which patients are most at risk?

FURTHER INFORMATION
Holly says she has been weight-restored and psychologically improved since her early 20s. This episode of self-harm is the first in many years. It was precipitated by a workplace conflict that left her afraid she would lose her job.

QUESTION 7
What further history do you now need from Holly?

QUESTION 8
What further action is now required?

QUESTION 9
What results do you expect your investigations to show?

QUESTION 10
What ongoing management will Holly require? What are the goals of treatment for Holly?
CASE 4 ANSWERS

ANSWER 1

Priorities for this first consultation include:

- management of the injury
- establishing rapport – patients like Holly who self-injure as a way of managing otherwise intolerable emotions often experience great shame, and seeking help is very difficult for them. They are very sensitive to perceived criticism. Time taken to establish rapport and understand their situation is time well spent. Care must be taken to adopt an absolutely non-judgemental stance in dealing with such a patient
- assessing the risk of further self-injury
- assessing suicidality
- taking enough medical and social history to have an understanding of Holly’s current situation and the basis for an ongoing relationship.

ANSWER 2

The most potent trigger for the development of an eating disorder is dieting for weight loss (or weight loss due to medical illness). However, not everyone who diets for weight loss develops an eating disorder. Box 1 lists some of the important factors that predispose a person who diets to developing an eating disorder.

Box 1. Risk factors for the development of eating disorders

- Dieting for weight loss (or illness resulting in weight loss)
- Family history of eating disorders (and other mental health disorders)
- Characteristics of personality style: Clinical perfectionism in the case of anorexia nervosa and impulsivity in bulimia nervosa
- Competitive family and peer environments (including academic and social environments, and sporting contexts)
- Family and peer environments that overvalue thinness (often reframed as ‘health’)
- Involvement in activities and cultural groups that focus on appearance and give it precedence over other personal attributes
- Experience of weight-related and shape-related teasing
- History of obesity or overweight
- History of anxiety disorders or depression
- Type 1 diabetes (adolescents with type 1 diabetes have a 2.4 fold higher risk of developing an eating disorder than their counterparts)

It may have been helpful if Holly’s original GP (when she presented in her early teens) had noted that there were a number of factors increasing her risk of developing an eating disorder, including dieting for weight loss, family history, teasing about her weight with resultant poor self-esteem and involvement in competitive sports. Further exploration at that time may have revealed other risk factors and behaviours indicative of an early eating disorder.

ANSWER 3

Early identification is key to the prevention and treatment of eating disorders. The mortality rate for established eating disorders is the highest of all psychiatric illnesses, and the longer an eating disorder persists, the lower the chances of recovery. Box 2 shows some of the early warning signs that may indicate the development of an eating disorder.

Box 2. Early warning signs of eating disorders

- Failure to grow as expected or delay or interruption of pubertal development
- Restrictive dietary fads and intentional removal of food groups from the diet (eg animal products, gluten, lactose, sugar) and unsupported claims of ‘food allergies’
- Skipping meals and avoidance of activities involving eating, including meals with the family
- Obsessional exercising, over–exercise–related injuries
- Going to the toilet immediately after or during meals (to vomit)
- Rapid weight loss irrespective of the starting weight (applies when the starting weight is in the obese or overweight range as well as the normal range)
- Rapid weight fluctuations

ANSWER 4

Eating disorders are serious psychiatric disorders with life-threatening physical and psychological complications. Many with eating disorders do not realise or do not accept that they are ill, and this is a symptom of their illness. In due course, medical complications can seriously compromise every organ system and physical complications may be evident at initial presentation.

While adolescent females remain the most likely group to experience eating disorders, the disorders are being recognised increasingly in both genders and across the lifespan. Presentation may be weight-related, but it is more likely to be related to the effects of the eating disorder on other aspects of health. This will require a high index of suspicion on the part of the practitioner in order to elicit the eating disorder history.

Issues at presentation to the GP may include emotional issues such as anxiety and depression, general physical issues, or symptoms related to the impact of the disorder on specific organ systems.

Table 1 provides a summary of the possible reasons for presentation. Encounters with any of these problems should lead to a discussion that includes nutrition, dietary habits and food-related behaviours.

The SCOFF questionnaire (Table 2) can be used to help determine whether these presentations are related to an eating disorder. It is a reliable screening tool for eating disorders, but is not sufficiently comprehensive to replace clinical assessment.
### Table 1. Reasons patients with eating disorders present to their GPs

<table>
<thead>
<tr>
<th>Reason for presentation</th>
<th>Possible causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to reach developmental milestones/delayed puberty</td>
<td>Nutritional deficit due to restrictive eating</td>
</tr>
<tr>
<td>Emotional problems</td>
<td>May be secondary to the eating disorder or pre-date the onset of the disorder</td>
</tr>
<tr>
<td></td>
<td>An obsessive compulsive disorder (OCD)-like syndrome occurs at very low weight</td>
</tr>
<tr>
<td></td>
<td>Nutritional deficit is associated with depression</td>
</tr>
<tr>
<td></td>
<td>Suicidality is very common – 12 times higher than those without an eating disorder</td>
</tr>
<tr>
<td></td>
<td>Intentional self-harm is high, especially in people with bulimia nervosa</td>
</tr>
<tr>
<td>Drug and alcohol misuse</td>
<td>May use substances to avoid emotional distress or substitute alcohol for food</td>
</tr>
<tr>
<td>Weight loss or weight gain</td>
<td>Due to erratic eating behaviour or extreme dieting</td>
</tr>
<tr>
<td>Request for help to lose weight (may or may not be overweight or obese)</td>
<td>Emotional distress, body dysmorphia, overweight/obesity</td>
</tr>
<tr>
<td>Fatigue, weakness, lethargy</td>
<td>Inadequate intake, over-exercising, specific nutritional deficit</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Anxiety or depression, inadequate intake causing night hunger, exercising during the night, abdominal pain (reflux/laxatives), night sweats</td>
</tr>
<tr>
<td>Light-headedness and dizziness/syncope</td>
<td>Low blood sugar level, dehydration, electrolyte disturbance, bradycardia, postural hypotension</td>
</tr>
<tr>
<td>Cardiorespiratory symptoms: chest pain, palpitations, shortness of breath, peripheral oedema</td>
<td>Dehydration, electrolyte disturbance, specific nutritional deficiency causing anaemia, cardiomyopathy secondary to nutritional deficit, over-exercising injury to chest wall</td>
</tr>
<tr>
<td>Musculoskeletal problems</td>
<td>Sporting or repetitive strain injuries related to over-exercise, stress or other fractures related to hypogonadal osteoporosis</td>
</tr>
<tr>
<td>Oral and dental problems</td>
<td>Oral trauma/laceration, dental erosion or parotid enlargement due to self-induced vomiting</td>
</tr>
<tr>
<td>Gastrointestinal problems</td>
<td>Epigastric discomfort and reflux symptoms, haematemesis, delayed gastric emptying and early satiety, abdominal discomfort and bloating, haemorrhoids, rectal prolapse, perianal rashes, constipation (due to vomiting, dehydration or laxative abuse)</td>
</tr>
<tr>
<td>Endocrine problems</td>
<td>Irregular cycles, amenorrhoea, unexplained infertility, loss of libido, osteoporosis</td>
</tr>
<tr>
<td>Dermatological problems</td>
<td>Hair loss, lanugo hair growth, pallor, dry skin due to dehydration and nutritional deficiency, poor healing, callous skin on the backs of fingers due to vomiting (Russell’s sign)</td>
</tr>
<tr>
<td>Haematological problems</td>
<td>Anaemia and thrombocytopenia (presenting with bruising/bleeding) due to nutritional deficiency</td>
</tr>
</tbody>
</table>

### Table 2. SCOFF questionnaire

<table>
<thead>
<tr>
<th>S</th>
<th>Do you make yourself SICK because you feel uncomfortably full?</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Do you worry that you have lost CONTROL over how much you eat?</td>
</tr>
<tr>
<td>O</td>
<td>Have you recently lost more than ONE stone (6.35 kg) in a three-month period?</td>
</tr>
<tr>
<td>F</td>
<td>Do you believe yourself to be FAT when others say you are too thin?</td>
</tr>
<tr>
<td>F</td>
<td>Would you say that FOOD dominates your life?</td>
</tr>
</tbody>
</table>

Two or more ‘Yes’ answers to the SCOFF questionnaire indicate the need for a more comprehensive assessment. The following two additional questions increase the sensitivity of the SCOFF questionnaire:

- Are you satisfied with your eating patterns?
- Do you ever eat in secret?

There are various types of eating disorders. Table 3 summarises the Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5), categories of disorder.

**ANSWER 5**

Weight criteria for hospital admission in eating disorders vary between hospitals, but a BMI of <14 kg/m² is generally considered reason for admission, especially in the presence of other medical, social or psychiatric criteria (Box 3). Admission may also be necessary and advisable at higher weights if medical or psychiatric complications are present. Involuntary admission under the relevant Mental Health Act may be necessary as a life saving intervention under these circumstances. Application to the Guardianship
Table 3. DSM-5 classification of eating disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia nervosa</td>
<td>Self-imposed or maintained weight loss such that a person is underweight with associated overvaluation of weight and shape</td>
</tr>
<tr>
<td></td>
<td>1. Restrictive subtype – with or without compulsive exercising</td>
</tr>
<tr>
<td></td>
<td>2. Binge eating/purging subtype – periods of restriction alternating with periods of binging and purging or other compensatory behaviour</td>
</tr>
<tr>
<td></td>
<td>Severity defined by body mass index (BMI) status</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>Regular and sustained binge eating with regular extreme weight control behaviours such as purging or diuretic or laxative abuse</td>
</tr>
<tr>
<td></td>
<td>Likely to be in the normal weight range but may be overweight or obese</td>
</tr>
<tr>
<td>Binge eating disorder</td>
<td>Regular and sustained binge eating without compensatory behaviour, often overweight or obese</td>
</tr>
<tr>
<td>Other specified feeding and eating disorder, and unspecified feeding and eating disorders</td>
<td>These include:</td>
</tr>
<tr>
<td></td>
<td>• Atypical anorexia nervosa – meets all except the weight criteria (ie in the normal weight range having started losing weight from the overweight or obese range)</td>
</tr>
<tr>
<td></td>
<td>• Sub-threshold bulimia nervosa and binge eating disorder that do not meet the frequency or duration criteria for the full diagnosis</td>
</tr>
<tr>
<td>Avoidant/restrictive food intake disorder</td>
<td>Similar to binge eating disorder, but there is no associated body image disturbance</td>
</tr>
</tbody>
</table>

Box 3. Criteria for admission in eating disorders

- Body mass index (BMI) <14 kg/m²
- Electrolyte disturbance, especially hypokalaemia
- Bradycardia (<40 bpm) or postural hypotension >20 mmHg
- Prolonged QT interval or arrhythmia
- Hypothermia <35.5°C (especially in the presence of infection – at low weight there may be no febrile response to infection)
- Very rapid weight loss
- Intractable vomiting
- Refeeding syndrome
- Depression and suicidality
- Inadequate personal support

Board for a compulsory treatment order may also be necessary in circumstances to facilitate ongoing care in inpatient and outpatient settings. Outpatient care is sufficient for the majority of patients with eating disorders, and admission is generally reserved for attaining medical stability. The benefits of inpatient weight restoration and the assumption that hospital is the best venue for refeeding once medical stability has been achieved remain unsupported by current evidence. Outpatient and inpatient settings has the potential to result in this form of refeeding syndrome.

During refeeding, specific deficiencies develop as a result of the malnourished body’s limited store of nutrients. Increased carbohydrate intake provokes insulin secretion, which moves glucose and other important nutrients out of the circulation and into the cells. Clinical manifestations of refeeding syndrome are a result of deficiencies of potassium, magnesium and phosphate, and may lead to cardiac arrhythmias and diminishing levels of consciousness, including coma.

Patients at higher risk of refeeding syndrome include those who:
- are at extreme low weight (BMI <14 kg/m²)
- are dehydrated and/or have electrolyte disturbance
- are chronically undernourished, especially if there has been little or no energy intake for >10 days
- are at low weight and drink significant amounts of alcohol
- have had rapid and profound weight loss, including those in the obese range, especially after bariatric surgery
- have been abusing diuretics or laxatives or misusing insulin.

Protocols for managing refeeding to prevent refeeding syndrome are readily available. Strategies include:
- intravenous rehydration (with saline not glucose solutions) and correction of electrolyte disturbance prior to beginning nutritional rehabilitation
- appropriately balancing nutrients in the diet

The term ‘refeeding syndrome’ can be used to describe the symptoms and signs, including aches and pains in the legs and dependent oedema, that can occur in all underweight patients during the early phases of nutritional rehabilitation. It is more likely to occur in the presence of dehydration and low albumin. Refeeding syndrome also refers to the potentially life-threatening shift of fluid and electrolytes that can occur when refeeding a malnourished patient. Oral, parenteral and enteral nutritional rehabilitation in inpatient and outpatient settings has the potential to result in this form of refeeding syndrome.

Children and younger adolescents with eating disorders, and those at extremely low weight, are at the highest risk of rapid acute medical decompensation requiring stabilisation in an inpatient setting, especially if there is also compensatory purging behaviour.
• beginning with low caloric intake (1200 kcal/day) and slowly building up
• regular monitoring of potassium, phosphate and magnesium (daily in the first week), and correcting where necessary
• supplementing routinely with multivitamins, thiamine and zinc.

ANSWER 7
Further history to obtain from Holly includes the following:
• Dietary details – The definition of a ‘healthy’ diet varies widely in the community. Clear details of eating patterns and food group deletion are necessary to make a proper assessment. Many patients with restrictive eating will be vegetarian or vegan, or report undocumented food allergies or intolerances to explain their restrictive practices.
• Compensatory behaviour (that is, behaviour designed to compensate for food consumed) – This is common in eating disorders across the weight range. These behaviours include self-induced vomiting, overexercising, and misusing laxatives and diuretics. Any of these behaviours is dangerous across the weight range, but more so in the very young and patients at very low weights.
• Exercise history – Detailed information about amounts and types of exercise is necessary to assess the presence or absence of over-exercising. Patients who overexercise will spend significant portions of each day exercising, prioritise exercise over all other activities and become very distressed if circumstances, injury, commitments or weather prevent them from following their usual routine.12

ANSWER 8
Given her current situation, Holly is at risk of a number of complications as well as escalation of her maladaptive behaviour.

In the short term, Holly needs you to:
• Acknowledge that you understand that her self-harming and disordered eating behaviour are responses to her stress, but that you are concerned about the medical consequences and would like to try to help her.
• Check for acute medical complications:
  – Assess her level of hydration and weigh her (while this may not apply to Holly, bear in mind that underweight patients may drink excessive fluids prior to weighing to try to avoid detection of weight loss. Blood drawn close to the time of weighing should be helpful in determining whether this is the case. The possibility of concealed objects should also be considered, and where possible, patients should be weighed in their underwear)
  – Urgently check her electrolytes, especially her potassium levels
  – Check her pulse and blood pressure (lying and standing)
  – Check that her electrocardiogram (ECG) is normal, with no signs of arrhythmia or QTc prolongation.
• Assess risk of self-harm and suicide.

Arrange a follow-up visit to further investigate for longer term complications and to devise a treatment plan.

ANSWER 9
In most patients with eating disorders, even those who are very unwell, investigation results are all normal and, while this can be seen as reassuring on one level, it does not indicate the absence of significant medical complications. This needs to be explained to Holly so that she does not use normal test results to support her denial of illness.

In Holly’s case, if she is dehydrated, she may have a postural drop in blood pressure. Oral rehydration and monitoring of her blood pressure is the appropriate course of action unless the postural drop is great enough (>20 mmHg) to warrant intravenous rehydration.

Her potassium will be low as a result of a combination of self-induced vomiting and laxative misuse, in which case, she will require oral potassium supplements and more regular monitoring. Holly’s particular style of vomiting involving “flushing” the stomach repeatedly with water is more likely to produce hypokalaemia.

Holly’s ECG is likely to be normal, but it will provide a baseline measure of her QTc interval (which may become prolonged) for future reference. Patients with eating disorders can develop arrhythmias quite suddenly and chronic malnutrition can cause a cardiomyopathy.

Some test results are commonly misinterpreted in eating disorders, especially in patients at very low weight. The results are manifestations of malnutrition. These include starvation-induced transaminitis and high cholesterol related to malnutrition, both of which will resolve when weight and nutritional status are restored.

ANSWER 10
The GP’s role for Holly is primarily in medical monitoring and case management.

In the medium-to-long term, Holly needs assessment of her nutritional status and exclusion of medical and psychiatric complications, including:
• investigations to exclude nutritional deficiencies and their consequences, including iron deficiency anaemia, B12 and folate deficiency
• bone density study as the chronicity of her illness puts Holly at risk of osteopaenia and possible osteoporosis, which may require specific intervention
• endocrine review as Holly’s periods are erratic and her oestrogen levels may be quite low. As she is an adult, she may need oestrogen supplementation to protect her bones from further damage, or specific treatment for osteoporosis. Holly’s pelvic ultrasound, done as part of her endocrine review, is normal; however, at low weight, pelvic ultrasound will often reveal multiple ovarian cysts.13 Ovarian regression to this peripubertal state in anorexia does not indicate the need for concern about polycystic ovarian syndrome and the usual weight maintenance advice is obviously inappropriate
• ongoing medical monitoring, including weight, blood pressure and pulse, and electrolytes. Monitoring frequency can be determined
according to individual needs. While Holly’s compensatory behaviour remains unchanged, she should be monitored every two weeks
• establishment of a multidisciplinary professional care team should occur as soon as possible. Holly needs:
  – a psychologist to enhance motivation for recovery, explore and challenge distorted cognitions and address emotional management skills deficits
  – a dietitian with knowledge and skill in eating disorders to develop a meal plan and support dietary and behavioural change
  – she may also need other specialists such as a psychiatrist, a dentist, an endocrinologist or a sports physiologist.


Holly could use these workbooks independently or in collaboration with her GP if psychological support were not readily available.

Holly will need long-term multidisciplinary support.1,4,9,10 The goals of treatment include:
• maintaining her medical stability and management of any medical complications of her eating disorder
• normalising her eating behaviour
• stabilising her weight in the normal range
• eliminating her compensatory behaviours
• developing more adaptive emotional management skills to improve her resilience and reduce the likelihood of recurrence once she has recovered.

CONCLUSION

Key points about eating disorders:
• Eating disorders are serious psychiatric disorders with severe medical consequences affecting many organ systems
• Although the peak incidence is in adolescent females, eating disorders occur in males and females across the entire age and weight spectrum
• Duration of illness in eating disorders is inversely proportional to the likelihood of recovery, so early identification and intervention is imperative
• Psychological/psychiatric and medical intervention needs to occur as soon as the disorder is recognised
• A multidisciplinary team approach with an acknowledged case manager, ideally a GP, is required for effective ongoing care
• Outpatient management is often adequate treatment, but it is important to recognise acute medical decompensation where inpatient care is unavoidable
• Lack of understanding of the physiology of starvation and the nature of the illness can lead to serious errors in management

• Suicide is the most common cause of death in eating disorders and eating disorders have the highest mortality rate of any psychiatric disorder

RESOURCES FOR DOCTORS

REFERENCES
CASE 5

JACK IS WITHDRAWN AND ANXIOUS

Jack, a boy aged 12 years, is brought to your general practice by his mother, Gracie. She reports that Jack has been withdrawn and anxious. He seems particularly anxious about going to school and missed many days over the past few weeks. Gracie is concerned that Jack may be being bullied at school, but he does not talk to her about it and the school staff are unaware of any problem. You attempt to engage Jack and find that he offers little information, leaving Gracie to answer questions.

QUESTION 1 😞

How would you manage the consultation from here?

QUESTION 2 😞

What further information would you like to get from Jack at this stage?

FURTHER INFORMATION

Jack reveals that he has been feeling very anxious about school because he is teased about being ‘girly’. There has been no physical violence or threats. He has been feeling very ashamed about this and has not said anything to his teachers or parents as he is frightened about how they will react. Jack discloses that he has been feeling sad a lot longer than he has been feeling anxious because he thinks he is really a girl and does not think that anyone will understand.

QUESTION 3 😞

What are the general medical treatment phases of gender dysphoria? Are there any time-critical issues to consider?

FURTHER INFORMATION

Jack is reluctant for you to disclose his feelings about being a girl to Gracie.

QUESTION 4 😞

How do you handle Jack’s reluctance to reveal his feelings to his mother?

FURTHER INFORMATION

Jack discloses that he would prefer to be referred to as ‘she’ or ‘her’ when in consultation, unless other people are present, such as in the waiting room or when his family members are in the consultation (until disclosure is made). She has thought a lot about names and has wanted to be called Jazz for many years, which is short for Jasmine. Jazz is very excited about the option of treatment to stop her voice.
from deepening and getting facial hair. She is anxious for you to arrange a referral to a specialist clinic, and after a few sessions, agrees for you to disclose to Gracie. When you speak to Gracie, she is eager to support Jazz, although she is surprised and a little concerned about the future. She wants to know if this is ‘just a phase’ or ‘a trend’ and if treatment is really needed.

**QUESTION 5**
Could this ‘just be a phase’? How likely are Jazz’s feelings to persist from here?

**QUESTION 6**
What steps should be considered from here?

**FURTHER INFORMATION**
Jazz is seen at a gender dysphoria clinic at the local children’s hospital. They confirm the diagnosis and commence treatment with hormone-blocking drugs. These drugs are available at no cost through the clinic in specialist gender services in tertiary hospitals in Australia.

**QUESTION 7**
What needs to be considered to support Jazz at school?

**CASE 5 ANSWERS**

**ANSWER 1**
It is important to spend some time with Jack on his own without his mother in the room. This should be encouraged by an explanation, while both are present in the room, of the principles of confidentiality and that this is a normal part of how general practitioners (GPs) work with young people. However, the GP should inform the patient that there are circumstances where confidentiality would not apply, for example, if there is the possibility of harm to self and others.1 Using the HEADSSS assessment (home, education, activities, drugs and alcohol, sexuality, suicide, safety) as a framework of engagement, the GP should take the time to focus on engaging Jack to build a more holistic sense of what is going on for him at home and at school with his peers, as well as building a picture of his inner thoughts and feelings. The HEADSSS assessment has been refined and extended with additional domains in the headspace psychological assessment for young people.2 Enquiring about Jack’s interests and strengths will also help to build rapport and engagement.3

**ANSWER 2**
It is important to build a picture and history of Jack’s feelings about his body, if he has any indicators that he has commenced puberty and what feelings he has about the development of secondary sexual characteristics. It is also important to assess Jack’s risk of self-harm or suicide, and the support network available to him.

This information will assist in assessing a possible diagnosis of gender dysphoria. This is the term used to describe the distress that people feel in response to the discrepancy between their gender assigned at birth and the gender they identify with.4 It is important to note that the old term ‘gender identity disorder’ in Diagnostic and statistical manual of mental disorders, 4th edition (DSM-IV) was replaced by ‘gender dysphoria’ in DSM-5 in order to ‘avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender’.5

**QUESTION 8**
What other avenues of support might be available for young people who identify as gender diverse as well as for their family and friends?
For gender dysphoria to be present, a patient must have met at least two criteria from DSM-5 for at least six months, and it must cause significant distress to the patient. This may include the following:

- a significant difference between their own experienced gender and their secondary sexual characteristics
- strong desire to be rid of their secondary sexual characteristics or prevent their development
- wanting secondary sexual characteristics of the opposite gender
- wanting to be treated as the other gender
- a strong belief that they have the feelings/reactions of the opposite gender
- a strong desire to be of the other gender (or some alternative gender different form one’s assigned gender).

**ANSWER 3**

In general, all states and territories use the principal of Gillick competence for consent. This means that if an individual is determined by their GP to be a mature minor for the procedure/intervention planned, then they can do so without parental consent. For example, a patient who is 14 years old can consent to having the oral contraceptive pill or an implant inserted for contraception without parents being informed.

However, in the case of young people with gender dysphoria, Gillick competence does not apply. Hormone treatment is considered a ‘special medical procedure’, and therefore, it is federal law that applies. The Family Court of Australia must decide if treatment is appropriate. The young person, parents and doctors do not have capacity to consent according to the court.

There are three phases of medical treatment. The young person should be referred to a specialist gender service for a multidisciplinary assessment. If this does not exist within the state or territory where the GP is located, the person should be referred to a psychiatrist and also a paediatrician/endocrinologist. A mental health assessment by a child psychiatrist must be done before starting blockers and hormones in children and adolescents. The GP is still very important both during the assessment and treatment phases.

**Stage 1: Puberty blocking**

Ideally, this stage is commenced soon after the onset of puberty (Tanner stage 2, commonly occurs at 10–12 years of age). Fully reversible, time-critical treatment helps to prevent the distress of developing non-reversible secondary sexual characteristics. Physical and mental health outcomes are better for transgender individuals when medical treatment commences at the optimal time (ie during early puberty). When commenced at Tanner stage 2, the main short-term benefit is minimisation of distress because secondary sexual characteristics fail to develop. Long-term benefits of commencement at Tanner stage 2 include reduced need for surgery in the future (mastectomy in an individual who was assigned female at birth but whose gender identity is that of a male), and prevention of voice changes and facial masculinisation in an individual who was assigned male at birth but whose gender identity is that of a female.

Treatment can be commenced later than Tanner stage 2, especially in an individual whose gender at birth was male but who identifies a female, where masculinisation of the face and body continues into the early 20s. Fertility preservation counselling should occur prior to commencement of treatment.

Counselling can be provided without parental consent, but is required in order to prescribe puberty blockers. If the parents object, then the court must decide whether it is in the child’s best interest to have the blockers.

**Stage 2: Hormone treatment**

Hormonal treatment (eg with oestrogen or testosterone) requires approval by the Family Court of Australia if the patient is under 18 years of age. International recommendations include commencement at around 16 years of age.

Hormonal treatment is partially reversible – breast growth and voice changes are not reversible. Fertility preservation procedures, including storage of sperm and testicular tissue, should be discussed prior to commencement of oestrogen treatment as there is a risk of infertility.

**Stage 3: Surgical treatment**

Surgical treatment is not recommended in patients under 18 years of age.

**ANSWER 4**

Before disclosing to Jack’s parents, it is essential to assess his risk should a disclosure be made and obtain his consent. This will include gaining an understanding of his concerns about what will happen as a result of disclosure. It is essential to focus on engaging Jack over a number of sessions to assist him to feel safe with disclosure, while affirming his gender identity. For example, you could ask about preferred names and pronouns, and agree on when to use these. This will greatly facilitate rapport and trust. Provide information to Jack about how common gender dysphoria is (about 1 in 100 people or 1.2% of the population) and that there are a number of support groups available to provide information and support (refer to ‘Resources for further information’). Reassure Jack that he is not alone.

Explain that treatment is available to prevent puberty, including prevention of facial hair and voice deepening; however, a referral is required to a specialist service and this will require parental consent.

It is important for Jack’s family to know what he is going through so they can provide support to him. This is advice that the GP can give Jack to allay his fears of disclosing to his family, but only when it is safe to do so. Jack’s family may also need support for themselves to assist them to understand and come to terms with his situation.

Offer to help Jack disclose his thoughts to his family if it is considered safe to do so. Provide support avenues for Jack and his parents (eg peer and parent support groups), as well as ongoing support and regular review.

**ANSWER 5**

This is very unlikely to be a phase given that Jazz has felt this way for many years and is now 12 years of age. The incidence of gender dysphoria has been increasing rapidly over the past decade due to increased social
acceptance and avenues of support and access to treatment. Research suggests that if someone experiences gender dysphoria during adolescence, there is a 99.5% likelihood that they will continue to identify as gender diverse throughout their adult life.

**ANSWER 6**

The next appropriate steps are:

- referral to a specialist centre to consider diagnosis and whether to commence treatment with puberty blocking drugs
- liaise with the school to address bullying. The family, school or GP can refer the matter to the Safe Schools Coalition to help with this.

It is critical that psychological or family counselling are undertaken by clinicians with expertise. This is best undertaken by specialist services or clinicians.

**ANSWER 7**

Australia’s third national survey about the health and wellbeing of transgender young people in 2010 found that almost half of gender-questioning young people had self-harmed and 28% had attempted suicide. There are also increased rates of bullying and physical assaults perpetrated against transgender young people, with discrimination experienced in accessing medical care, educational and employment opportunities. There are federal anti-discrimination laws enacted in 2013 (amendment 5B) that protect young people’s expression of their gender identity and access to facilities (e.g., use of toilet and sporting facilities, appropriate uniforms). As a GP, you have a role in advocating, assisting and supporting Jazz in the following ways:

- presenting her to school as Jazz
- providing bullying management through education for students and staff
- ensuring that Jazz is allowed to use the female toilets and other facilities
- ensuring that Jazz has access to female sporting teams and groups. You should also continue to monitor Jazz to assess any discrimination or bullying, as well as self-harm and suicidal thoughts or behaviour.

**ANSWER 8**

Young people with gender dysphoria as well as their family and friends can feel isolates. It is important to offer support with peers who have lived experience to allow them to better visualise hope for a positive future. A number of headspace centres have specific support groups for young people who identify as transgender or gender diverse as well as their family and friends. Refer to ‘Resources for patients’ for more information.

In terms of engagement and assessment of young people, headspace and The Royal Australian College of General Practitioners (RACGP) have collaborated to develop a youth mental health online training module available at www.racgp.org.au/education/courses/activitylist/activity?rid=40706&q=keywords%3dyouth%26activityType%3dALM (this will require signing in to gplearning and enrolling in this activity).

**RESOURCES FOR DOCTORS**

Refer to https://headspace.org.au to find your nearest headspace centre. Many local councils have similar support groups.

Other support services that are available include:

- http://au.reachout.com/lgbtiq-support-services
- www.transcendsupport.com.au

**RESOURCES FOR PARENTS**

- www.pgdc.org.au
- www.genderhelpforparents.com.au

**REFERENCES**

7. Family Court of Australia. To treat or not to treat: legal responses to transgender young people. Canberra: Family Court of Australia, 2015.
CASE 6

MARITA IS EXPERIENCING ONGOING HEADACHES

Marita, 32 years of age, comes to see you because she frequently has headaches across her right temple area and is now having trouble sleeping. She has seen you several times over the past five months regarding the headaches, but the examination, so far, has been normal and there are no red flags in the history of the headaches. Marita is six months pregnant with her first child. She is recently married, about two years, and her husband, Mike, has been a patient of yours in the past, although he rarely sees you.

QUESTION 1

What further information do you want to explore at this point?

FURTHER INFORMATION

Marita tells you that her trouble sleeping began about two months ago. She has never had trouble sleeping in the past, but is having difficulty getting to sleep and then wakes up very early, at around 3:00 am, and cannot get back to sleep. Her headaches are intermittent, but unchanged and no worse than before.

In response to your general questions about what has been happening over the past few months, Marita goes on to explain that she and her husband have been arguing more recently, and he has been getting increasingly stressed at work as there is a rumour regarding potential redundancies. Mike has been reluctant for Marita to talk to her family about the work issues or even see them as he feels they are too nosy and interfering. Marita has not seen her mother or sister in several months. She has also had to give up her part-time work as her husband thinks it will be bad for her pregnancy.

She has no past psychiatric or family history of mental disorders.

QUESTION 2

What are the differential diagnoses at this point? What further history or tests would you do to distinguish between the differential diagnoses?

FURTHER INFORMATION

You run through a K10 questionnaire with Marita and she scores in the high range. You are particularly concerned that she has feelings of worthlessness and nervousness all the time.

When asked what happens when Marita and Mike argue, Marita says it’s usually when she asks about his work or if she says her sister called her. Marita explains that he can get very angry when she irritates him and he has thrown a couple of things on the floor.

QUESTION 3

What is the priority issue that you should explore? How would you do this?

FURTHER INFORMATION

On direct questioning about whether Mike has ever hurt her physically, Marita says that when she tried to leave the house recently, when he was angry, he blocked her and then shoved her, which caused her to fall over. She shows you a bruise on her arm that she sustained when she fell. Mike has hit her a couple of times before, but he mostly just controls her and limits what she can do and say.
QUESTION 4
What management should take place at this visit?

ANSWER 1
You are concerned that the chronic headaches are still present, and that the history and examination have not shown anything of concern, so remain unexplained. You are now concerned that Marita is also experiencing insomnia. You should ask Marita whether her headaches have changed in any way, and also ask her about her sleeping patterns and whether there is anything concerning her that might have brought on the change in her sleeping pattern. You should ask about symptoms of depression and anxiety, and about past psychiatric and family history. A simple format for asking about depression is to ask the following two questions:1 'During the past month, have you often been bothered by “feeling down, depressed or hopeless?” or “little interest or pleasure in doing things?”’. For anxiety, ask questions about ‘feeling nervous, anxious or on edge’ and ‘not being able to stop or control worrying’. These two questions have been shown to be good at detecting depression and anxiety and can be followed with ‘Is this something with which you would like help?’

QUESTION 5
What is the GP’s ongoing role in working with a female patient experiencing intimate partner violence?

ANSWER 2
Conditions that should be considered include:
• depression
• anxiety and tension headaches
• pregnancy-related headaches and insomnia
• underlying social issues.

However, the insomnia and chronic, unexplained headaches are potential psychological and physical clinical indicators2,3 for intimate partner violence that Marita may be experiencing.

There are also some other risk factors for abuse from Marita’s description of what is happening at home:
• Pregnancy can trigger violence or can exacerbate violence in a relationship,4 with evidence suggesting that four to nine out of 100 pregnant women are abused.5,6
• Financial and employment pressures on the husband are potential risk factors for intimate partner violence.7
• Marita has been isolated by her husband from her family and her work.2

As depression is one of the strongest clinical indicators of abuse,8 you could run through the K10 with Marita. The K10 questionnaire is the most commonly used general mental health questionnaire in general practice in Australia and is often incorporated into mental health plans.

QUESTION 6
What should you, as the general practitioner (GP), do if you see Marita’s husband?

ANSWER 3
Intimate partner violence is very common among the general practice population. One in 10 women attending general practice have been afraid of their partners in the previous 12 months, and one in three women have experienced fear of a partner over their lifetime.9 A GP in full-time practice is likely to see up to five female patients a week who have experienced abuse in the past year.10
The World Health Organization defines intimate partner abuse as any behaviour by an intimate partner that causes physical, sexual or psychological harm, which includes any acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. Abuse can include emotional abuse, such as prohibiting the partner from seeing family and friends, and economic restrictions, such as preventing the partner from working, as Marita has experienced.

Women do not necessarily disclose abuse to their GP, with only one third disclosing abuse and one study showing only one in 10 being asked about abuse by their GP. However, women are more likely to disclose abuse if they are asked by their GP, particularly if asked in a sensitive manner, but can often minimise any violence as they may not see it as serious.

Given your concerns about the clinical indicators and risk factors in Marita’s case, together with the fact that guidelines suggest all women who are pregnant should be screened for intimate partner violence, your primary concern is to ask Marita more about what happens during arguments with her husband. You should ask more questions about what is going on, starting with some general questions, but funnelling to quite specific questions.

ANSWER 4

The Royal Australian College of General Practitioners’ (RAGCP’s) Abuse and violence: Working with our patients in general practice (White Book) provides detail of how to manage patients identified as experiencing abuse. Of particular concern is Marita’s safety, particularly considering...
her pregnancy. Abuse often starts with the first pregnancy and can result in women avoiding prenatal check-ups. Furthermore, abused pregnant women are twice as likely to miscarry as non-abused pregnant women. It is clear that Marita is experiencing some depressive and anxiety symptoms, and this is something you will need to follow up with Marita at subsequent appointments.

Ensure you respond to Marita in a non-judgemental way, providing support and belief of her experiences. Also ensure Marita’s needs, as identified by her, are put first and take the time to listen. Be clear to Marita that she deserves to feel safe at home, that intimate partner violence is a crime, and that you can refer her to relevant services should she wish.

A risk assessment should be undertaken (Figure 1).

Any assessment of risk should be informed by Marita’s own assessment of her risk, presence of risk indicators (see Chapter 3 of the White Book) and your own professional judgement. Marita is the best judge of whether she is safe to go home.

If Marita feels she is safe enough to go home, you should discuss a safety plan with her covering the following:

- compiling a list of emergency numbers
- helping to identify a safe place for Marita to go to and how she will get there
- identifying family and friends (eg mum and sister) who can provide support
- ensuring cash is available

• providing a safe place to store valuables and important documents that she can easily access.

The White Book advises that it is important to document Marita’s experiences of intimate partner abuse in her medical record. In particular:7
• record her chronic headaches and insomnia together with her K10 score as you would for any other woman
• include a history of her husband’s abuse towards her
• describe her physical injuries – in this case the bruising on her arm – specifically stating extent, location and age of the injury
• record the plan you agree with Marita – for example, any follow-up (particularly in relation to her depressive symptoms) and future discussions around referral to services when she feels ready to contact/attend.

Some general practices use a code to indicate abuse. If confidentiality cannot be assured, or if Marita asks that you not record the details, do not enter too much detail around any actions you take, risk level or discussions around referral services or consultations.

ANSWER 6
The White Book sets out the nine steps to intervention for GPs – the 9Rs. A GP’s role is key in identifying and responding to intimate partner violence.10 As Marita’s GP, you have a key role in the nine steps:
• role with patients who are experiencing abuse and violence
• readiness to be open
• recognise symptoms of abuse and violence, ask directly and sensitively
• respond to disclosures of violence with empathic listening
• explore risk and safety issues
• review the patient for follow-up and support
• refer appropriately and also
• reflect on your own attitudes and management of abuse and violence
• respect for your patients, your colleagues and yourself is an overarching principle of this sensitive work.

ANSWER 7
One key point to highlight in this case is that you have also seen Marita’s husband as a GP. It is not recommended for GPs to counsel both the woman and man about domestic violence.7,20 This is a very complex issue, but may be managed in several ways. Figure 2 sets out ways to manage such a situation.

ANSWER 5

CONCLUSION
Patients experiencing intimate partner violence are common in the general practice population and may openly disclose. The GP plays a key role in identifying and responding appropriately to such patients, following the 9Rs, and providing ongoing empathetic and non-judgemental support. On initial disclosure of intimate partner violence, a risk assessment and safety planning should be undertaken and the safety of any children identified as a priority. However, patients may not be ready to name the abuse or act upon it. As their GP, do not pressure disclosure or action but continue to provide support.

RESOURCES FOR DOCTORS AND PATIENTS
• 1800RESPECT: 1800 737 732 and www.1800respect.org.au
• Men’s Referral Service: 1300 766 491 and www.mrs.org.au
• Lifeline: 13 11 14 and www.lifeline.org.au

REFERENCES
CASE 1 – LOUISE
Jacquie comes to see you about her daughter Louise, 12 years of age. Jacquie is worried because Louise has been unhappy and withdrawn since she started high school this year. On your advice, Jacquie brings Louise to see you and allows you to talk to Louise on her own. You are able to engage Louise in conversation and she reveals that she is unhappy because nobody seems to realise that she is really a boy. She has felt like a boy all her life but everyone, especially at school, treats her like a girl. She tells you that she wishes she looked more like a boy and asks if you can do anything to help her.

QUESTION 1
Ideally, what initial steps should you take in this consultation?
A. Begin to establish whether gender dysphoria is present.
B. Explain to Louise that you’ll need to inform her parents about what she has told you.
C. Ask Jacquie to sit in on the rest of the consultation so that you can discuss the possibility commencing treatment.
D. All of the above

QUESTION 2
Which of the following statements regarding treatment is correct if Louise has gender dysphoria?
A. Louise would not be able to commence hormonal treatment with testosterone before the age of 18 years.
B. Louise should have fertility preservation counselling before commencing any treatment.
C. Time-critical puberty-blocking treatment would need to commence before the onset of puberty.
D. Puberty-blocking treatment is non-reversible.

CASE 2 – TREvor
Trevor, 38 years of age, comes to see you because he has been unable to sleep and lacks energy and motivation. He finds it difficult to concentrate at work, feels lethargic most of the time and has lost interest in his usual activities, including his weekly game of tennis with his brother. He has a general sense of hopelessness, which he has had for the past few months, but doesn’t know why and doesn’t recall ever feeling this way before. You are concerned that Trevor might have depression.

QUESTION 3
Which of Trevor’s symptoms may signal severe depression?
A. Lethargy
B. Difficulty concentrating
C. Inability to sleep
D. Sense of hopelessness

QUESTION 4
According to the stepped care model, which of the following interventions would you consider initially for Trevor?
A. Assessment and support
B. Psychoeducation and active monitoring
C. Referral for further assessment and interventions
D. All of the above

CASE 3 – COLLETTE
Collette, 24 years of age, presents with a recent history of gastrointestinal discomfort. In the last few days, she has been waking up at night with severe gastrointestinal cramps. She has no other medical history. She tells you that she has always considered herself to be fit and healthy, although she often finds it difficult to concentrate and sometimes feels light-headed. She exercises everyday, either at working out at the gym for two hours or going for a one-hour run. Sometimes she does both. She drinks plenty of water and avoids high-calorie, high-fat foods. Physical examination does not reveal any obvious abnormalities, but Collette is underweight. You use the SCOFF questionnaire to determine if Collette might have an eating disorder.
MULTIPLE CHOICE QUESTIONS

QUESTION 5
Which of the following questions is from the SCOFF questionnaire?
A. Do you make yourself SICK because you feel uncomfortably full?
B. Do you worry that you have no CONTROL over your weight?
C. Do you eat ONLY when hungry?
D. Do you worry that you’ll become FAT if you eat too much?
E. Would you say you enjoy the FOOD you eat?

QUESTION 6
Which of the following statements about eating disorders is true?
A. Eating disorders have the highest mortality rate of any psychiatric disorder.
B. Inpatient care is essential for adequately treating patients with eating disorders.
C. Patients usually have low cholesterol levels.
D. Potassium levels are usually elevated.

CASE 4 – GIANNA
Gianna, 32 years of age, presents for a flu vaccination as she has bad asthma. After giving Gianna the vaccination, you ask if there is anything else you can do for her. She tells you that she has not been sleeping well for the past several months and generally feels exhausted. You ask her about her sleeping difficulties and she nervously hints that she has become increasingly anxious since her marriage a year ago. She quickly adds that she realises that relationships can be ‘hard work’.

QUESTION 7
How should you respond to Gianna?
A. Respect any reluctance to talk about her difficulties and do not press for more information.
B. Advise her to make another appointment so you can discuss her sleeping difficulties.
C. Sensitively explore what is going on in her marriage, including asking about whether she feels afraid of him.
D. Provide information about how relationship issues can affect health.

FURTHER INFORMATION
Gianna discloses that she has experienced physical violence and threats from her husband. You listen and enquire about her needs, and discuss enhancing her safety and support with her. She feels safe to go home today and you plan a follow-up visit to discuss further.

QUESTION 8
The ongoing plan should include:
A. identifying family and friends who can provide support
B. discussing the issue with her husband when next you see him.

CASE 5 – FARID, AHMED AND AMIRA
Farid, 20 years of age, and his brother Ahmed and sister Amira (both 11 years of age), came to Australia as refugees from Syria three years ago and were granted permanent residence. They lived with their parents in Syria until their house was raided and their parents killed. Farid, Ahmed and Amira managed to escape with only the clothes they were wearing. Farid is now at university and Ahmed and Amira are in primary school. Farid brings Amira to see you as she has been complaining of headaches and feeling sick. Farid asks if he can speak to you alone before you see Amira and tells you that Amira is still struggling with the death of her parents. She often wakes up at night, fearful that Farid will be taken away.

QUESTION 9
What should be your priority for this consultation?
A. Establish a trusting, ongoing and supportive relationship with Farid and Amira.
B. Identify any ongoing instability in the family since their arrival in Australia.
C. Understand the effects of the experiences in Syria on Amira.
D. Elicit a history from Amira by asking questions about her experiences.

FURTHER INFORMATION
When talking to Farid on his own, you notice that he is clearly distressed and he frequently pauses as he tries to express himself. You consider asking Farid if he would like to have an interpreter at this consultation. He agrees to your suggestion of using a telephone interpreter.

QUESTION 10
What should you tell the interpreter before you begin?
A. The name of the patient.
B. The consultation may address mental health issues.
C. The patient may need to be given complex instructions.
D. The patient is a child.