symptoms, is crucial for accurate diagnosis and improving patient outcomes. A more targeted approach, including trauma-informed care and psychotherapy, would have been beneficial and should be considered in similar cases.

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Organic Delusional Disorder in the Context of Huntington's Disease (ICD 11 F06.2): A Case Report

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Aims: Miss X, a 39-year-old postpartum mother with a strong family history and previous diagnosis of Huntington's disease, was admitted to mother and baby unit three months after delivery due to psychotic symptoms and delusional disorder. Initially admitted informally, her deteriorating mental state necessitated detention under Section 2 of the Mental Health Act. Her symptoms significantly impaired her ability to care for herself and her children.

Methods: Her psychiatric history included past depression and anxiety, previously managed with counselling, but no prior inpatient admissions. Family history was significant for Huntington's disease in her mother, maternal aunt, and grandfather, as well as schizophrenia in her paternal aunt.

Miss X presented with persistent paranoid delusions, believing she was being stalked by both a male and female figure whom she could see and hear throughout the day. These hallucinations interfered with her sleep, appetite, and self-care. Additionally, she reported intrusive thoughts of accidentally harming her baby, further affecting her ability to meet the needs of her children. She lacked insight into her condition and was treated with risperidone for her psychotic symptoms and mirtazapine for depressive symptoms, given the history of Huntington's disease and the distress following the loss of custody of her baby.

Investigations revealed no acute intracranial abnormality on CT Head, but there was mild diffuse cerebral and hippocampal atrophy disproportionate for her age. Cognitive assessments included a Frontal Assessment Battery score of 16/18 and an ACE-III score of 78/100. Urine dip on admission was negative. Blood investigations and ECG were largely unremarkable. Differential diagnoses considered included Post-partum psychosis, Schizophrenia, Schizophreniform disorder.

Results: Miss X's lack of insight into her Huntington's disease has contributed to a significant breakdown in her caregiving ability. The persistence of her paranoid delusions, particularly the belief of being stalked, suggests a deeply entrenched belief system that may have been reinforced over time, making it more resistant to treatment. The overlap between neurodegenerative and psychiatric symptoms presents a challenge in management, requiring a tailored, multidisciplinary approach.

Conclusion: This case highlights the complex interplay between Huntington's disease and severe psychiatric manifestations, particularly delusional disorder. Her enduring psychotic symptoms, compounded by cognitive impairment, significantly impact her functionality and caregiving capacity. Early intervention, close psychiatric monitoring, and integrated neurological care are essential to improve patient outcomes.

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Case Study: Harnessing Art Therapy for Patients With Learning Disability

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doi: 10.1192/bjo.2025.10708

Aims: Individuals with learning disabilities (LD) have a higher rate of mental health disorders and behavioural difficulties.

Conventional interventions may be limited in addressing non-verbal emotional expression.

Art therapy offers a creative, structured medium for self-expression, emotional regulation and social skill development.

Methods: Case Report

A 42-year-old lady, Ms X, with moderate LD with challenging behaviour, paranoid schizophrenia and past history of mixed anxiety and depressive disorder and impact of art therapy in her treatment and quality of life.

Ms X has gone through a series of unfortunate events, for example, her brother committed suicide by jumping off a bridge. She lost her mother and her father had been diagnosed with Alzheimer's dementia. Considering her level of LD and the trauma that she has gone through and the past history of risky behaviours including verbal and physical aggression, requiring inpatient admission and intensive support, she has been doing well.

There are times she tends to become increasingly anxious needing reassurance, however, these are more infrequent now. In general, she has been compliant with the prescribed medications, Depakote and olanzapine. She goes out for swimming quite frequently and also she enjoys walking along the beach with staff. She keeps herself active.

A significant improvement in her presentation is attributed to the art therapy she has been having regularly since September 2024–January 2025. She has completed 12 sessions and a remarkable positive change has been noted by staff supporting her.

Results: Discussion.

1. Improvement in Psychosocial Functioning.

A systematic review (37 studies) indicated that art therapy interventions significantly enhanced psychosocial well-being.

Key therapeutic factors included varied artistic mediums and therapist-guided sessions.

2. Reduction of Aggression.

Ms X had reduced episodes of aggression which is also supported by a quasi-experimental study (Egypt) that found 85% of participants exhibited reduced aggression.

3. Alleviation of Mental Health Symptoms.

Art therapy provides a non-verbal mode of expression, effective in treating patients with learning disabilities and comorbid anxiety/

depression. Shown to improve emotional processing and engagement in therapy.

4. Enhancement of Social Skills.

Studies indicate that art therapy significantly improves social interactions, particularly in patients with learning disabilities.

Conclusion: Art therapy is a valuable adjunct that provides alternative communication channel, especially for non-verbal or emotionally withdrawn individuals.

Clinical Implications and Future Directions:

Incorporate art therapy into multidisciplinary-treatment plans for patients with learning disabilities.

Investigating neurobiological mechanisms underpinning art therapy's impact could optimise therapeutic approaches.

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When Mind and Body Speaks: Understanding Dissociative Neurological Symptom Disorder-ICD–11

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Aims: Dissociative Neurological Symptom Disorder (DNSD), also known as Conversion Disorder, is a common diagnosis among mental health patients in Pakistan. Despite its prevalence, research on DNSD, especially regarding patient experiences, is limited. Family-related stressors are significant contributing factors in its development, with familial discord playing a key role in triggering symptoms.

Methods: A 24-year-old female was referred by a neurologist after presenting to the outpatient department in a wheelchair due to a fear of falling. She reported symptoms including jerky body movements, episodes of apparent loss of consciousness, diarrhoea, weakness, visual disturbances, headaches, and palpitations, which had persisted for over two years. Despite multiple consultations, no organic cause was identified. She had been prescribed various medications with no improvement. Upon evaluation, a diagnosis of DNSD was made, compounded by significant emotional stress, particularly familial discord. A multidisciplinary approach, involving specialists in neurology, ophthalmology, ENT, and gastroenterology, helped rule out underlying physical conditions. Her pre-morbid history indicated high academic achievement but chronic familial stress.

Results: This case emphasizes the importance of recognizing psychosomatic presentations in patients with unexplained neurological and physical symptoms. Despite extensive negative investigations, the patient's psychological stressors, such as familial discord and fear of stigma, were key contributors to the onset of her symptoms. The patient's fear of walking further exacerbated her physical disability. Treatment included sertraline, mirtazapine, and short-term benzodiazepines for anxiety and depression. Psychological therapies such as Cognitive Behavioural Therapy (CBT), deep breathing, safe-place visualization, imaginal exposure, systematic desensitization, and gratitude journalling were used to address emotional issues and reduce disability. This comprehensive approach resulted in symptom resolution, and the patient was symptom-free within 18 months, now pursuing an MPhil degree.

Conclusion: This case highlights the value of a multidisciplinary approach in diagnosing and treating complex physical symptoms with unclear aetiology. Addressing underlying psychological stressors and utilizing appropriate psychosocial interventions significantly improved the patient's condition. Early identification and holistic management combining medical, psychological, and emotional support are crucial for effective treatment of DNSD.

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Sodium Amytal – No Longer Prescribed, but Still Relevant (And Dangerous!)

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Aims: Sodium amytal is a barbiturate medication, first synthesised in Germany in the 1920s to treat anxiety and sleep disorders; as well as being used as an anaesthetic. This case report discusses sodium amytal prescription and subsequent dependence in an 82-year-old female with a history of anxiety and agoraphobia. It aims to highlight historical indications, mechanism of action of and potential dangers of cessation. As such, clinical management of withdrawal is discussed including the initial use of a more commonly prescribed barbiturate in place of amobarbital; with the ultimate aim being to cease such dangerous medication and to consider safer alternatives – pharmacological and psychological.

Methods: Mrs F was referred to Older Persons Psychiatric Services in 2024. At this time, her GP reported that she was 'one of only 30 patients in the UK' to be prescribed sodium amytal, and that it was 'no longer being produced'. At the time of referral, Mrs F had just a 7-day supply of medication left.

Guidance from the local Medicines Information team had been sought prior to admission. They recommended a phenobarbital taper for seizure prophylaxis when discontinuing other barbiturates, where 100 mg amobarbital was roughly equivalent to 30 mg phenobarbital. Phenobarbital is a long-acting barbiturate which would be more commonly found in practice, given its use in management of epilepsy.

As such, an attempt was made at the safe withdrawal of sodium amytal in the inpatient setting. This was due to the significant risks associated with abrupt withdrawal, including seizure, hallucinations and cardiovascular collapse tending to occur after 16 hours of cessation with such risk remaining up until approximately 5 days.

Mrs F had run out of medication on the day that she was admitted, and given the aforementioned risks, a thorough plan was developed to ensure close monitoring. She was commenced on 1:1 special observations initially due to the risk of seizures. Her clinical observations were performed on a regular basis and a CIWA (Clinical Institute Withdrawal Assessment for Alcohol) score was also performed hourly to monitor withdrawal severity. To this end, lorazepam was prescribed at a dose of 1 mg every 6 hours, as well as an 'as required' dose of 1 mg prescribed for when CIWA score was >8.

At consultant review the following day, Mrs F was commenced on phenobarbital at a dose of 30 mg QDS + 30 mg PRN to a maximum of 150 mg/day, continuing on regular lorazepam at 1 mg QDS. Of note, this is slightly lower than the aforementioned recommendation which would equate to 162 mg/day. Subsequently, owing to increasing agitation and anxiety, Mrs F's dose was increased to 60 mg mane, 30 mg TDS plus 30 mg PRN and her dose of lorazepam

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