

**University of Newcastle upon
Tyne**



Student Teaching Resource

Last updated July 2001

Contents

Chapter	Page
General	
Introduction	7
Overview of psychiatry	9
History and Mental State Examination	13
Disorders	
Schizophrenia	19
Mood Disorders	25
Anxiety Disorders	33
Alcohol and Substance Misuse	39
Suicide and Deliberate Self Harm	47
Psychiatry of Old Age	51
Personality Disorders	57
Organic Psychiatric Disorders	61
Eating Disorders	67
Learning disability	71
Management	
Drug Treatments in Psychiatry	77
Psychological Therapies	87
Mental Health Act (1983)	93
Appendices	
Glossary	99
Reading List	103

General

Introduction

Welcome

Welcome to the Department of Psychiatry Student Resource. This handout is intended as a grounding in the subject matter that will be covered in your attachments during Phase II of your course. It is neither meant to replace the Study Guide nor to be a definitive resource. Indeed by the time you are in the final year some of what is included here may well have been updated. Drug treatments in particular may change (recent examples of this have included the withdrawal of two commonly used antipsychotics). We do update materials and post them on our website (see below). If this happens you will be emailed to be informed of the changes.

The handout is divided into three main sections:

1. **General**; this section that includes an overview of psychiatry including diagnosis, basic principles of management, history taking and mental state examination.
2. **Disorders**; this section covers some of the range of psychiatric disorders encountered in adult and old age psychiatry.
3. **Management**; this section touches on pharmacological and psychological management of psychiatric disorders as well as a brief overview of the 1983 Mental Health Act.

There is also an appendix that contains our reading list and a glossary of new terms you are liable to encounter in your attachments and/or reading. It is strongly recommended that you pay regard to the reading list which highlights 'Essential' and 'Further' reading.

Other resources

As mentioned above there the Department has a website on which there is a considerable body of teaching materials. At the time you receive this there is no discrepancy between the content of the materials on the site and this handout. That being said there are additional materials on the website and one or two of the web based sections are more comprehensive. If you lose this handout it, and sections from it, can be downloaded from the site. Note that access to the site is currently limited to .ncl.ac.uk domain registered computers only (this includes access via the UCS service 'Dialup').

In addition to the more comprehensive text based materials there are additional web based materials. These include:

- A self assessment section with multiple choice questions that are automatically marked with links back to the section of the handout that gives the correct answer in many cases.
- Guidelines to various components of the EJR attachment including case presentation and primary care sessions, the 'Assessment Day', the Old Age Psychiatry attachment, timetables and in the near future information relating to Stage IV attachments
- Video clips. This is still in its early stages but will be expanded over coming months. Clips will be mainly used to illustrate psychopathology but in time will be expanded to include longer 'streamed' clips.

The Department is in the process of creating a video library using role players and the old patient based materials will be phased out. We are also developing a CD-ROM to deliver all the above content with longer video clips and other interactive components.

We hope that you enjoy your attachments in psychiatry and find them stimulating and rewarding. If there are problems let us know as soon as possible so that we can try and deal with them. In case of difficulties or if you need any assistance during your attachment please contact Glynis Williams, Departmental Administrator on RVI extension 24380 (email glynis.williams@ncl.ac.uk).

Brian Lunn
Course Director

Overview of Psychiatry

Introduction

This section will deal with three, general, aspects of psychiatry:

- Why it is important for all doctors to have at least some knowledge of psychiatry.
- Why diagnoses in psychiatry are important, how they are made, and an introductory discussion of some of the important diagnostic categories.
- A brief introduction into the principles of management of psychiatric patients.

Why is Psychiatry Important?

Only a minority of medical students become psychiatrists, however:

Psychiatric symptoms are common

Around 260 per 1000 people per year suffer from psychiatric symptoms
Around 230 per 1000 patients presenting to GP's have psychiatric symptoms
Up to 38% of patients in general medical out-patient clinics have psychiatric disorders and no discernible physical illness.

Psychiatric disorders are common e.g. (point prevalence, unless otherwise stated)

Childhood disorders 10-20%
Depression 7%
Anxiety 7%
Schizophrenia 1% life time risk
Dementia 10% of over 65 year olds
Personality disorders 2-20%

Psychiatric illness can occur secondary to physical conditions

Medical illnesses:

- endocrine disorders e.g. hypothyroidism, Cushing's
- neurological disorders e.g. Parkinson's Disease, MS, CVA
- infections
- malignant disease
- as a reaction to any serious illness
- Childbirth

Psychiatric illness can occur secondary to physical treatments

Steroids
OCP
Antihypertensives, calcium channel antagonists, beta-blockers
Anti-Parkinsonian treatments

Psychiatric illness is often missed

Less than half of patients presenting to GP's with psychiatric symptoms are diagnosed
50% of patients with psychiatric disorders present with physical symptoms

Psychiatric illness can be fatal

Between 4000 and 8000 suicides occur each year and around 90% have psychiatric symptoms
Having an affective disorder increases risk of suicide 30 times; 15% of depressives die by suicide
Up to 10% of schizophrenics and alcoholics die by suicide

Psychiatric Diagnoses

Should psychiatric diagnoses be made?

The "Pro's & Con's" are summarised in the table below:

"Pro's"	"Con's"
Allows rational treatment	They are not always possible
Enables prognostication	Most are not based on pathology
Essential for meaningful research	They may ignore individuality
Used to justify resources	Pejorative
	Labels deviant behaviour as illness

How are psychiatric diagnoses made?

Psychiatric diagnoses are generally not based on pathology and there are no diagnostic tests. Instead they are empirically based on symptom clusters. The main problems with this are validity and reliability.

Reliability of psychiatric diagnoses.

As already mentioned diagnostic categories are based on symptom clusters. To try and ensure that diagnoses are reliable diagnostic classification guidelines and schedules have been developed. The World Health Organisation has produced the International Classification of Diseases (ICD-10). Current psychiatric diagnostic categories from this include:

- Organic
- Psychoactive substance use
- Schizophrenia, schizotypal and delusional disorders
- Mood disorders
- Neurotic, stress-related and somatoform disorders
- Behavioural syndromes associated with physiological disturbances
- Disorders of adult personality
- Mental retardation
- Disorders of psychological development
- Child and adolescent disorders

The American Psychiatric Association has produced the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) which uses an axial classification; the axes of which are:

Clinical disorders
 Personality disorders and mental retardation
 General medical conditions
 Psychosocial and environmental problems
 Global assessment of functioning

These diagnostic tools largely overlap with each other and may overlap to a greater or lesser extent with diagnostic practices of a psychiatrist who doesn't rigorously apply either of these. The area of maximal overlap clearly has maximal validity.

Principles of Management

In the management of mental illness a number of approaches to management are used. For clarity these have been divide into three, arbitrary, groups. It is important to bear in mind that usually various approaches need to be combined to suit the needs of the individual

- Physical interventions e.g. drugs, ECT
- Psychological interventions e.g. psychotherapy
- Social interventions e.g. housing, sheltered employment

The multidisciplinary team is the most common model for delivery of care. Such a team may consist of:

- Psychiatrists
- Nurses - hospital and community based
- Psychologists
- Occupational therapists
- Art & Music therapists
- Social workers
- General Practitioners

Psychiatric disorders tend to be either chronic or relapsing-remitting with treatment therefore divided into:

- Short term – treatment of the acute episode
- Long term – prophylaxis – rehabilitation – support

History & Mental State Examination

Introduction

The psychiatric interview is the opportunity for the clinician to make an assessment of the patient's mental state and establish a therapeutic relationship. The ability to do this well requires the use of non-directive (open) questioning followed up by systematic probe (closed) questions. Ambiguities and inconsistencies require clarification by sensitive enquiry or recapitulation.

Common errors made in this process include failure to seek precise clarification, failure to pick up on non-verbal cues and a willingness to rely on patient's use of jargon.

Many students when starting their psychiatric attachment feel intimidated by this process, feeling it to be alien to their previous history taking experiences. It is, however, simply a variant of normal medical history taking but with a greater emphasis in exploring the meaning behind what the patient reports.

This section gives a model for history taking and mental state examination, including cognitive testing. It is not intended to be used as a checklist, nor to be prescriptive and, as with all patient contact, will need to be shaped by the actual interaction between you and the patient.

History

Like everything else taking and, eventually, presenting a good history relies upon a structure being imposed upon the information obtained from the interview. In the early stages this seems daunting, particularly when you are trying to think of pertinent questions. A few tips that may help include using big enough paper (i.e. A4 not a reporters notebook), numbering your pages and writing out the headings, with plenty of space to fill in your information, in advance as patients rarely give a linear narrative. Presentation will be covered in the section on the Formulation seminars.

Referral and informants

Here you need to record where and when the patient was seen, were they voluntary or detained patients, how they came to be seen (GP, self, police referral *etc.*) and who the history and other information was obtained from.

Presenting complaints

Record in the patients own words what they feel their problems are and how long they have been present. They may feel they have no problems, in which case it may be appropriate to comment on the presenting complaint as described by an informant.

History of presenting complaints

In this section record the information obtained as the patients complaints are explored, and the details surrounding them, for example if a patient complains of hearing voices this needs to be explored in the same way that a complaint of pain would be. It is also important at this point to describe the impact of the patient's problems on their life and the lives of those around them.

Past psychiatric history

Explore in detail previous contact with psychiatric and other services for mental health problems. Include dates, diagnoses, treatment and duration and legal status of admissions.

Past medical history

This is little different from any other discipline but remember to ask about obstetric complications, epilepsy, head injury *etc.*

Family psychiatric & medical history

Try and obtain the same sort of information about the family as you did for the patient. Remember to include history of neurological disorders, suicides/DSH, criminal behaviour, abuse, alcoholism *etc.*

Personal history

The following topics need to be covered:

- Early development
- Childhood behaviour
- School history
- Occupational history
- Sexual History
- Relationships/marriage history
- Children
- Forensic history

Current social circumstances

Consideration needs to be given to alcohol consumption, illicit substance use and smoking, finances, legal problems, employment (or not), current social supports/relationships, dependants, housing *etc.*

Premorbid personality

The following should be covered:

- Social relationships
- Hobbies/interests
- Predominant mood e.g. anxious, pessimistic, optimistic, stable or fluctuating *etc.*
- Character e.g. shy, suspicious, irritable, self-centred, impulsive, unconfident, obsessional
- Habits : food, alcohol, tobacco, drugs

Medication

Include **all** medication, prescribed and otherwise.

Mental State Examination (MSE)

This seems to be the one aspect of psychiatric assessment that intimidates students the most. It begins as soon as you see the patient, if not before i.e. when they are shouting, or when you turn up to their house and see windows covered in tin foil *etc.* It may seem obvious, but it is worth stressing, that this is an *examination* of the patient's mental *state* at the *time* you see them. It is not the history of their morbid experiences. So, if you see a patient that was hallucinating the day before you saw them, their morbid experiences would be described in their history not the MSE.

Appearance & Behaviour

Self care - often impaired, in severe depression and dementia especially.

Agitation - excessive motor activity with a background of anxiety e.g. pacing hand wringing. A feature of depression (elderly in particular) or marked anxiety. Also a high level of activity or excitement may be seen in mania but then anxiety is usually not a feature.

Motor retardation - slowing of movements, to a variable degree. Think of depression but other causes include psychotropics.

Superimposed abnormal movements

Dyskinesias, - a wide variety of movement patterns e.g. choreoathetosis, rocking, pouting, with a wide range of causes e.g. drugs, schizophrenia, structural brain disease.

Tremors - assorted, may be related to level of arousal, medication or neurological disorder.

Stereotypies - uniform, repetitive non goal-directed actions (may take a variety of forms from simple movement to an utterance. Usually ascribed to schizophrenia.

Speech

Slowing - may be a feature of retardation. Usually associated with a lack of spontaneous, and reduced speed of, reply.

Mutism - may be elective or involuntary; like slowing it is a feature of retardation and shares its causes, or may result from schizophrenia, hysteria or be behavioural (e.g. elective in children).

Fast speech - often results from 'normal' anxiety, but may indicate mania or schizophrenia.

Pressure of speech - far less common and is highly suggestive of mania.

Neologism - found mainly in schizophrenia and structural brain disease.

Incoherence and other abnormalities of semantics and syntax - see Thought.

Perseveration - mainly seen in dementia.

Mood

Persistent abnormalities of mood may indicate an affective disorder for instance depression (anxiety is often a feature of depression in addition to low mood) or mania. Altered mood is often secondary to other psychiatric disorders, however, for example the not uncommon co-existence of depression and schizophrenia, or depression and dementia. The mood exhibited by an individual may also be normal!

Thought

Be aware that when assessing thought we are dependent greatly on its manifestation through speech and thus also how much of thought disorder is in truth 'speech disorder'.

Content -thought content may betray illness by virtue of morbid thoughts and preoccupations; obsessional ruminations, rituals and compulsions or phobias.

Form - the form of thought may be disrupted in any of a number of recognised patterns which benefit verbatim description as much as the allocations of a label:

Flight of ideas - exhibited in pressured speech and highly suggestive of mania.

Thought block - found in schizophrenia. It is quite distinct from the loss of train of thought that is a normal experience.

Abnormal ideas fall into a number of categories:

Overvalued ideas - may be of doubtful psychiatric significance.

Delusions - primary or secondary delusions. Delusions may develop one from the other becoming intertwined or 'systematised'.

Simply being deluded does not offer a single diagnosis however certain delusions are commoner in certain conditions such as: primary delusions, persecutory delusions and thought alienation in schizophrenia; nihilistic and hypochondriacal delusions, delusions of worthlessness, guilt and poverty in depression; grandiose delusions in mania.

Obsessions (see OCD)

Perception

Hallucinations - auditory hallucinations are commonest; in schizophrenia third person voices can help to make the diagnosis; in depression the patient may hear voices (second person) abusing him (and feel that he deserves it). Visual hallucinations raise suspicions of organic brain disease. These are generalisations and must be taken in the context of all other symptoms and signs.

Illusions - these may be normal or may occur in the clouded consciousness of delirium.

Depersonalisation and derealisation - both states may occur through fatigue or marked anxiety.

Cognitive testing

Like every other facet of the MSE this commences as soon as the interviewer comes in contact with the patient. It can be divided into multitude of functions only a few of which will be discussed here. Remember that cognitive tests test the ability of the patient to perform on that task from which inference can be drawn about their cognitive function.

Abnormalities of cognitive function occur in a wide range of psychiatric and neurological conditions. Progressive dementia results in a global impairment of higher function, in the early stages remote memory may appear spared though later this too will be affected. An isolated memory deficit is best called an amnesic (or dysmnesic) syndrome, a classic example being Korsakoff's psychosis, although this is also characterised by confabulation. Occasionally an apparent global cognitive deficit or pseudodementia is seen in elderly depressives. An acute confusional episode (delirium) may be indicated by drowsiness, impaired concentration and attention and poor memory.

The areas that a student should be able to cover are:

Orientation.

Attention and concentration - impaired concentration is frequently seen in depression and anxiety.

Memory. (this includes, at the very least, registration and recall of 3 objects or 5 part name and address plus recent and remote memories)

Insight

Insight can usefully be regarded as having four facets of awareness:

- that the abnormal experiences are extraordinary.
- that they are the result of a disease process.
- That the disease process is psychiatric/psychological
- that they are open to medical intervention.

Disorders

Schizophrenia

Introduction

Schizophrenia is a major health problem in the United Kingdom. It is a common condition, at least one third of patients in psychiatric beds suffer from this disorder. The first acute symptoms of schizophrenia delusions and hallucinations usually occur in early adult life. Characteristically patients have no insight into the abnormal nature of these experiences. These symptoms are followed by a gradual deteriorating course characterised by blunting of normal responses and a decline in social functioning. The symptoms cause severe distress to the patients and their relatives. Extensive resources are required for the management of the acute illness and long term support in the community.

The Diagnosis of Schizophrenia

The diagnosis of schizophrenia like many medical conditions is not made on the basis of one symptom but on the occurrence of several symptoms, which together support the diagnosis of the syndrome.

Schizophrenia was first recognised as a discrete syndrome in the middle of the last century, though the term schizophrenia was first used by Bleuler in 1911.

Historical Perspective

The first European psychopathological description of the disorder similar to what we now know as schizophrenia was by Morel in 1856. He named this disorder *Démence Précoce* describing characteristic features that included bizarre behaviour and mental function, withdrawal and self neglect which started in adolescence. Later Kraepelin (1871) considered hallucinations, delusions, thought disorder, negativism and emotional blunting to be characteristic of a disorder he named *Dementia Praecox*. He also observed that the onset was usually in early adult life and often progressed to a "demented" end stage. However he realised that the breakdown was not intellectual, the onset was not necessarily in adolescence and the prognosis was not always poor.

The term schizophrenia was introduced by Bleuler in 1911. He described the four "A's", symptoms which he thought were characteristic of schizophrenia: **A**mbivalence, **A**utism, flattened **A**ffect, loosening of **A**ssociations.

Increasing confusion arose as the term schizophrenia was used to describe a wide spectrum of disorders in America and Europe. In the 1950's with the advent of research into the new groups of drugs used in the treatment of schizophrenia there was an increasing need for clear diagnostic criteria. This was assisted by Schneider who, in 1959, described *First Rank Symptoms*. These were a group of symptoms that he proposed were diagnostic of schizophrenia in the absence of overt brain disease.

1. Auditory hallucinations of a specific type:
 - Audible thoughts: a voice anticipating or repeating the patient's thoughts aloud.
 - Two or more voices discussing the patient in the third person.
 - Voices commenting on the patient's behaviour.
2. Thought alienation:
 - Thought insertion.
 - Thought withdrawal.
 - Thought broadcasting.
3. Passivity phenomena:
 - Experiences of bodily influence.
 - Made acts/impulses/affects - experiences which are imposed on the individual or influenced by others.
4. Delusional perceptions (A two stage process) where first a normal object is perceived then secondly there is a sudden intense delusional insight into the objects meaning for the patient e.g. "The traffic light is green therefore I am the King".

The problem with Schneider's symptoms is that they are:

not specific for schizophrenia - 8% of psychotic patients with these symptoms are not schizophrenic for example they may be suffering from delusions or hallucinations in the context of a severely elated or depressed mood state or an organic disorder.

not present in some patients with schizophrenia - 20% of chronic schizophrenics do not have them and never had. This is partly explained by the fact that Schneider concentrated on the acute phase of the illness when formulating his first rank symptoms.

Schneider's work stimulated the search for optimal diagnostic criteria - one set of criteria used both in clinical work and research are those published in I.C.D.-10 Classification of Mental and Behavioural Disorders. These diagnostic criteria enable a diagnosis of schizophrenia to be made in both acute and chronic phases of the illness. They also reduce the likelihood of the misdiagnosis schizophrenia in those with primary disorders of mood (depression and mania) and organic syndromes such as toxic confusional states and epilepsy.

Summary of I.C.D. - 10 Diagnostic Criteria for Schizophrenia

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging as one of the groups listed a) to d) below, or symptoms of at least two of the groups referred to as e) to h), should have been clearly present for most of the time during a period of 1 month or more. Symptom i) applies only to a diagnosis of simple schizophrenia.

- a) thought echo, thought insertion, or withdrawal, and thought broadcasting;
- b) delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions or sensations; delusional perception;
- c) hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves or other types of hallucinatory voices coming from some part of the body;
- d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);
- e) persistent hallucinations in any modality, when accompanied either by fleeting or half formed delusions without clear affective content, or by persistent over-valued ideas. or when occurring every day for weeks or months on end;
- f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;
- g) catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism, and stupor;
- h) "negative" symptoms such as marked apathy, paucity of speech, resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or neuroleptic medication;
- i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifested as loss of interest, aimlessness, idleness, a self absorbed attitude, and social withdrawal.

Symptoms and Sub-types

Prodromal and Residual Symptoms of Schizophrenia

Prior to the onset of acute symptoms, (and not due to mood disturbance or substance abuse) and following an acute episode, many patients exhibit less dramatic symptoms.

- Marked social isolation and withdrawal.
- Impairment in social role e.g. as a wage earner or student.
- Peculiar eccentric behaviour.
- Poor personal hygiene.
- Blunted or inappropriate affect.
- Vague speech.
- Odd beliefs.
- Unusual perceptual experiences
- Lack of initiative or energy.

Summary of the Symptoms of Schizophrenia

The symptoms of schizophrenia can therefore be divided into positive symptoms, seen during acute phases of the illness, and negative symptoms, which are more chronic and responsible for the long term social impairment of patients with chronic schizophrenia.

Positive features of schizophrenia:

- Hallucinations.
- Delusions.
- Ideas of reference.
- Thought disorder - abnormal patterns of thought reflected in speech. Characterised by the breakdown of normal associations. The associations are often incomprehensible to the listener.

Negative features of schizophrenia:

- Social withdrawal.
- Emotional blunting.
- Underactivity.
- Lack of motivation.

Subtypes of Schizophrenia

Four subtypes of schizophrenia have been described where particular clinical patterns have been observed.

Simple Schizophrenia. Negative symptoms predominate.

Hebephrenic schizophrenia. Mood is inappropriate with giggling and shallowness, behaviour is irresponsible. Delusions and hallucinations are fragmented. Thoughts are disorganised. Onset typically age 15-25.

Paranoid schizophrenia. Complex delusions and hallucinations. Delusions may be persecutory, grandiose or religious.

Catatonic schizophrenia. Psychomotor disturbance varying from stupor to sudden outbursts of activity. Waxy flexibility, automatic obedience and negativism.

Schizoaffective disorder

This diagnosis should be limited to cases where diagnostic criteria for **both** schizophrenia **and** a mood disorder occur during the same episode. Otherwise the diagnosis is of the predominant syndrome.

Epidemiology

Schizophrenia is a common disorder requiring extensive health care provision.

Incidence

- point prevalence is 0.5%
- lifetime risk of developing schizophrenia is 1%
- there is equal incidence in both sexes
- it often manifests in the second and third decade people but can occur at any age

Social class

Increased rates are found in deprived socially isolated areas of large cities. This may be due to social drift i.e. the sufferer drifts to these areas as a result of their illness (e.g. cardboard city). Comparison of the socio-economic classes of the fathers of schizophrenics reveals no increased incidence in any particular class.

Genetics

When the risk for an individual related to a patient with schizophrenia is explored the prevalence is dependent on their relationship to sufferer. So that the risk for each subset of relatives is:

- Parent - 5%
- Child of one schizophrenic parent - 12%
- Child of two schizophrenic parents - 46%
- Sibling - 8%

In twin studies the concordance rates were:

- Dizygotic twins 9%
- Monozygotic twins 42%

Aetiology

Dopamine hypothesis

Abnormalities in the dopamine pathways have been implicated as:

- Amphetamines, LSD, bromocriptine and L-dopa can cause schizophrenic like symptoms and are known to enhance dopamine.
- Many ('typical') anti-schizophrenic drugs are dopamine antagonists and can cause Parkinsonian like symptoms.
- Drugs with geometric isomers are only effective when the isomer is anti-dopaminergic.
- Some limbic pathways that are thought to control mood, behaviour and thought processing utilise dopamine as a neurotransmitter (e.g. mesolimbic, mesocortical).

Neurological dysfunction

Symptoms similar to schizophrenia are seen in complex partial seizures where left temporal lobe limbic structures are involved e.g. temporal lobe epilepsy.

Birth complications are associated with an increased risk of schizophrenia suggesting that neurological insults at an early age may play a role in the development of schizophrenia in some individuals.

The increased rates of winter or spring births (around 10%) found in sufferers may be associated with an increased risk of schizophrenia. The cause, is as yet, unclear but third trimester maternal infection with viruses such as influenza or polio has been postulated.

Scanning studies in schizophrenics have found smaller structures in the left temporal lobe, ventricular enlargement (correlated with the severity of negative symptoms) and hypofrontality (with functional imaging).

Movement disorders occur in even unmedicated schizophrenics.

Genetic

The risk for individuals with an affected relative has already been discussed in the section on epidemiology. In addition, since the concordance in twins and other relatives living with a schizophrenic could be attributed to "psychosocial" factors, adoption studies have been carried out. In one study by Heston *et al* 5 out of 47 children of schizophrenic mothers who were adopted out at birth developed schizophrenia, as opposed to 0 out of 50 controls. In addition around 20% of biological relatives suffered from some form of the disorder, compared to only 6% of adoptive relatives. (These figures became 13% and 1.6% respectively when DSM-III criteria were used).

Prognosis

Because of case-to-case variability, prognosis cannot be confidently predicted for an individual case, but studies of large patient groups revealed the following prognostic indicators.

Good prognosis associated with:

- Sudden onset
- Precipitants
- Family history of affective illness
- Good premorbid adjustment

Poor prognosis associated with:

- Early onset and/or insidious onset
- Lack of precipitants
- Lack of affective components
- Abnormal pre-morbid personality
- Family history
- Exposure high expressed emotion in the patient's family
- Low IQ
- Negative symptoms

With treatment the average outcome rates are:

- 25% good recovery
- 50% chronic fluctuating course
- 15% continuous symptoms requiring long-term care
- 10% severe incapacity

Management of schizophrenia

As with all patients suffering from a mental illness, management should be divided into assessment and treatment. At both stages psychological, physical, social factors should be considered.

Assessment

The initial assessment during the acute illness often takes place in hospital but may be carried out on an out-patient or day-patient basis by various members of hospital and community mental health team staff.

This assessment should include:

- Full history and mental state examination in particular identify delusions, hallucinations, thought disorder.
- Check for clouding of consciousness.
- Interview with an informant.
- Physical examination and appropriate investigations e.g. urine drug screen to exclude a drug induced psychosis, EEG to exclude temporal lobe epilepsy, brain imaging.
- Social assessment; housing, work, *etc.*

By the end of the assessment:

- Information supporting the diagnosis should have been collected.
- Particular risks the patient may present to themselves and others should have been identified.
- Vulnerability factors such as a family history of schizophrenia should have been considered.
- Possible precipitants to the acute illness should have been identified (why now?).
- Factors which may maintain the illness or make relapse more likely should be explored such as high critical expressed emotion within the family or stresses at work.
- Decide whether the patient is prepared to accept treatment.
- Consider a differential or coexisting disorder such as:
 - a) Drug induced psychosis, amphetamines, LSD.
 - b) Alcoholic hallucinosis.
 - c) Organic causes, acute confusional state, DT's, temporal lobe epilepsy.
 - d) Affective psychosis, depression, hypomania.

Treatment

Physical

The mainstay of treatment is pharmacotherapy. A group of drugs called the neuroleptics also known as major tranquillisers are used. The drugs that have been in longest use (the 'typical' antipsychotics/neuroleptics) block dopamine receptors and are classified according to their chemical structure. More recently a number of drugs have been introduced that act mostly on transmitter systems other than dopamine and are therefore termed 'atypical antipsychotics/neuroleptics'.

Depot preparations administered every 2-4 weeks allow monitoring of patient compliance. They are usually given by a community psychiatric nurse, which also has the advantage of close monitoring of the patient's mental state and anticipation and prevention of relapse.

Further discussion of this group of drugs is given in the pharmacotherapy handout.

Psychological Treatments

These are aimed at support and reduction of stress. Family work with education about the illness may be particularly important when the family is hostile and critical towards the patient e.g. having unrealistic expectations of them. High critical expressed emotion is associated with an increased risk of relapse, particularly when the sufferer spends long periods at home with their family.

Social Rehabilitation

Rehabilitation into work where relevant or attendance at a day centre. Balance between too much stress and under-stimulation with social withdrawal and apathy.

Where return home is not possible (e.g. rejected by the family and/or independent living not possible) alternative accommodation may be sought in a hostel, group home or supportive lodging.

Mood Disorders

Introduction

The term mood disorder refers to a range of conditions in which a disturbance of mood is the central feature. Most of us experience low moods as the natural consequences of loss or disappointment and a common response to success or achievement is an elevated mood. In a mood disorder the mood may be abnormally lowered as in depression or abnormally elevated as in mania. In psychiatry we need to distinguish between these natural "lows" and "highs" and pathological mood states. This can create confusion in both terminology and diagnosis.

Terminology

A number of terms are used interchangeably in describing mood disorders. This handout shall conform to ICD-10 usage, but in this section some alternative terminology is discussed so that if you come across these terms on your clinical attachment you will not be confused. It is important to note that some of these terms should not be used (particularly in exams!), when this is the case they will be highlighted.

Affect - Subjective experience of emotional state.

Mood - Pervasive and sustained emotion.

Affective disorder (syn. Mood disorder) - disorder in which the central feature is mood disturbance.

Depression - refers both to the *symptom* of low mood and an *episode* of a mood disorder.

Mania - an episode of a mood disorder characterised by elevated mood.

Hypomania - milder episode of mood disorder than mania, without hallucinations or delusions.

Bipolar affective disorder - recurrent mood disorder consisting of manic/hypomanic episodes with or without depressive episodes

Unipolar affective disorder - recurrent mood disorder consisting *solely* of episodes of depression.

Major depressive episode (DSM-IV) - a depressive episode with 5 or more biological features of depression.

NB. Do not use the terms Minor depressive episode, Endogenous depression or Reactive depression.

Definitions

The word "depression" provides an example of terminological difficulty. Among lay users the word is generally used to refer to a normal state of dejection. In a clinical setting it is used both to describe a symptom (as in "her mood appeared consistently depressed") and to label a syndrome (as in "severe depressive disorder"). Depression is common, as an isolated symptom and is one of the most common complaints presented to doctors and as a result its management forms a large part of medical, as well as psychiatric, practice particularly as depressive symptoms or syndromes often accompany physical ailments.

There is little difficulty in distinguishing severe cases of mania or major depression from normal mood states. However, when a mood disorder is milder it can be difficult to distinguish from a "normal" emotional response to circumstances. In distinguishing a normal from a pathological mood state a clinician will make the following judgements:

Whether the severity and duration exceed normal expectations.

Whether the individual's ability to care for himself/herself has been impaired.

Whether there are physical, psychomotor or cognitive changes that accompany the depressed or elevated mood.

Episodes of mood disorders may be of low mood (depressive episode), high mood (hypomanic or manic episode) or occasionally a mixture of high and low features (mixed affective state). In both ICD-10 and DSM-IV recurrent episodes of hypomania/mania with or without depression are termed bipolar disorder.

Diagnosis

There are no laboratory tests to assist in the diagnostic process, so instead we look for clusters of clinical symptoms that we associate together as a syndrome. The various affective syndromes are made up of symptoms involving mood, thought, perception, biological functioning and behaviour and are classified using systems of classification such as DSM-IV (Diagnostic and Statistical Manual IV) and ICD-10 (International Classification of Disease 10). Both provide specific diagnostic criteria for each disorder and these handout are based on the latter as it is the one used most widely by doctors in the UK.

For clinical purposes we suggest a systematic description of the disorder based on ICD-10:

- 1 The Episode
 - a. Type
 - b. Special Features
 - c. Severity
- 2 The Course
- 3 Preceding Stressors
- 4 Other Diagnostic Categories

The Episode

Type:

	Manic Episode	Depressive Episode
Mood	elation irritability	mood low most of the time anhedonia anxiety (common)
Speech & Thought	over talkative pressure of speech flight of ideas full of plans(usually unfulfilled) grandiose ideas may develop delusions (mood congruent)	slow speech poverty of thought pessimistic, hopeless suicidal ideas and/or intent may develop delusions (mood congruent)
Biological functions	diminished sleep reduced or increased appetite increased libido	disturbed sleep (often early morning waking) anergia decreased appetite/weight loss reduced libido
Perception	may develop hallucinations if severe	may develop hallucinations if severe
Behaviour	overactive unrealistic plans impulsive overspending aggressive disinhibited (inc. sexually)	avoids social interaction self neglect may show psychomotor retardation or agitation actions in preparation for suicide
Minimum duration	1 week	2 weeks

Special Features:

Psychotic symptoms - Hallucinations and delusions can occur in severe depression and mania. Delusions are usually mood congruent e.g. delusions of grandeur in mania. Delusions of poverty or guilt in depression. Hallucinations are usually auditory and in the second person.

"Neurotic" Symptoms - Most commonly anxiety symptoms but prominent obsessive compulsive or hypochondriacal symptoms may occur, particularly in the elderly.

Melancholia -This refers to a severe depression where biological symptoms are prominent i.e. weight loss or marked anorexia, early morning waking, diurnal variation (with mood worse in the morning), psychomotor retardation or agitation.

Severity:

The severity of a depressive episode depends upon the number of individual key symptoms, which are present, the intensity of these symptoms and the effect upon the person's level of functioning.

	Symptoms	Duration
Mild	At least 2 typical symptoms (depressed mood, anhedonia, fatigability) and at least 2 other symptoms (biological symptoms and/or suicidal ideation). No symptoms are present to an intense degree.	At least 2 weeks
Moderate	At least 2 typical symptoms (see above) plus at least 3 (and preferably 4) other symptoms. Several symptoms are liable to be present to a marked degree but this is not essential if a particularly wide range of symptoms are present.	At least 2 weeks
Severe	All 3 typical symptoms plus at least 4 other symptoms, some of which should be of severe intensity, should be present. Note that marked agitation or retardation may make the patient unable to describe their symptoms fully. Mood congruent delusions and/or hallucinations may be present.	Usually 2 weeks but if particularly severe may be made sooner.

The Course

There are four common patterns :

Single episode**Recurrent depressive disorder**

(a.k.a. unipolar affective disorder) - There should have been at least 2 episodes reaching the criteria for mild, moderate or severe depression, lasting at least 2 weeks and they should have been separated by several months without significant mood disturbance.

Bipolar affective disorder

(a.k.a. manic depression) - There should have been at least 2 episodes reaching the criteria for a mood disorder, one of which must have been mania/hypomania, lasting at least 2 weeks and they should have been separated by several months without significant mood disturbance.

Chronic depression

Meets the criteria for mild, moderate or severe depression, lasting at least 2 years.

Mixed affective episode

Lasts for at least 2 weeks and is characterised by either a mixture or a rapid alteration (usually within a few hours) of hypomanic/manic, and depressive symptoms.

Preceding Stressors

Stressful life events or experiences of varying severity frequently precede affective disorders.

Other diagnostic categories:

Dysthymia is a form of mild depression which has a chronic course and does not meet the criteria for a recurrent depressive disorder (DSM-IV requires that the symptoms should be present for at least two years).

Cyclothymia is a milder form of bipolar disorder with persistent instability of mood, involving numerous periods of mild depression and elation.
It may be a personality variant.

Schizoaffective disorder – This diagnosis should be limited to cases where diagnostic criteria for both schizophrenia and a mood disorder occur during the same episode. Otherwise the diagnosis is of the predominant syndrome.

Epidemiology

The epidemiology of recurrent depressive and bipolar affective disorders are summarised in the table below.

	Recurrent Depressive Disorder	Bipolar Affective Disorder
Sex ratio (M:F)	1:2	equal
Social class	greater in lower socio-economic class	no social class differences
Prevalence	male = 2-3%; female = 2-9%	less than 0.3%
Lifetime risk	male = 10%; female = 20%	1%
Age	onset - 50% before the age of 40 years peak age - 25-40 (50-70 when psychotic features)	both onset and peak age is in the late 20's to early 30's
Other factors	urban population > rural	more episodes than for recurrent depression but they tend to be shorter in the majority first episode is depressive 10-20% experience only manic episodes

It is probably worth while at this point to consider the epidemiology of suicide.

There are between 4000-8000 deaths in the England and Wales per year (as compared to around 5000 road deaths).

There are in excess of (probably greatly) 150 000 attempted suicides per year.

15% of those with depression die by suicide.

Aetiology

The aetiology of mood disorders is not fully understood but is clearly multi-factorial. It is probable that biological and genetic factors play an important role particularly in the aetiology of bipolar affective disorders and melancholic depression. The biological systems that are likely to be involved include monoamine systems, particularly 5-HT (5-hydroxytryptamine), and the hypothalamic-pituitary-adrenal axis.

Personality and psychosocial factors are probably more significant in dysthymic disorders.

Theoretical models often suggest an interaction between vulnerability, which is usually biological/genetic and precipitating factors, which may be a life event or biological (e.g. secondary to a viral illness, medication, hypothyroidism). The impact of the resulting stress will depend on social supports and the psychological capacity to cope.

Aetiological factors are summarised below under the headings:

- Biological
Genetic; Endocrine; Neurotransmitters
- Psychological
Psychodynamic; Cognitive; Behavioural
- Social
Predisposing; Precipitating

Biological.**Genetic:**

In bipolar disorder twin studies show monozygotic concordance rates of ~70%; dizygotic rates of ~20%; monozygotic reared apart rates of ~66%.

Family studies in recurrent depressive disorder show an overall risk of ~7% for first degree relatives as compared to ~20% for first degree relatives of bipolars.

Endocrine:

Hypothalamic-pituitary adrenal axis - Many depressives have elevated plasma, CSF and urine cortisol. The diurnal variation of cortisol may be varied.

Thyroid function - The TSH response to TRH is impaired in some patients and in some with treatment resistant depression the addition of thyroxine may be beneficial. Hypo- and hyperthyroidism are recognised to cause alteration in mood.

Neurotransmitters:

In those individuals who develop an affective disorder a dysregulation of neurotransmitter systems is initiated with serotonin (5-HT) and noradrenaline the neurotransmitters most commonly implicated.

The disorders are not simply due to low levels of transmitters, but may be connected with alterations in the functioning of specific receptors.

Psychological.**Psychodynamic:**

This emphasises the importance of loss, as in bereavement or separation, and also self-esteem and self-image. Psychoanalytic theory also views depression as a turning inward of aggression and hostility.

Cognitive:

This stresses the importance of cognitive distortions and errors that occur in depression. The cognitive theory of depression suggests that these are not just a result of the lowered mood but are instrumental in the origin and persistence of the disorder.

Behavioural:

Based on animal models where it has been noted that chronic stress can result in loss of ability to act and avoid the stress. These animals show behavioural and neurotransmitter system changes similar to that seen in depressed humans.

Social.**Predisposing:**

Brown and Harris identified a number of factors that predisposed an individual to depression:

- lack of a confiding relationship;
- unemployment;
- 3 or more children under the age of 14 years at home;
- loss of mother before the age of 11 years

Precipitating:

In the 6 months after a life event (*exit events* - bereavement or separation; *undesirable events* - assault, redundancy etc.) the chance of an episode of depression is increased 5 to 6 times.

Prognosis

Regardless of treatment most patients (90%) suffering from mood disorders recover. They are, however, likely to relapse and in both recurrent depressive disorder and bipolar disorder a percentage will develop chronic symptoms (around 10-15%).

	Recurrent Depressive Disorder	Bipolar Disorder
Duration	without treatment ~6 to 13 months with treatment ~3 to 6 months	~3 months
Repeated episodes	over a 20 year period the mean number of relapses is around 5 or 6	in a lifetime a patient can have between 2 and 30 episodes, with a mean of 9
Other variables	15% will die by suicide	manic episodes may be followed by a depressive phase with a 25% risk of an episode of depression following on immediately afterwards

Management

In common with the management of all psychiatric disorders management is divided into managing the acute and chronic phases, and also consists of using management strategies which may include physical, psychological and social. This section will first consider treatment strategies for manic and depressive episodes, then will look at specific issues in the use of antidepressants and electroconvulsive therapy (E.C.T.). Pharmacotherapy and psychotherapies are covered more generally in their specific sections.

Manic episode.

	Short term	Long term
Physical	neuroleptic medication consider lithium	consider lithium, carbamazepine or sodium valproate as prophylaxis
Psychological	support for patient and family	support may need to continue specific psychotherapies not currently proven
Social	admission to hospital should be considered to minimise risk to patient and others	a minority need rehabilitation and supervised care most need advice regarding return to normal life and spotting future relapses

Depressive episode

	Short term	Long term
Physical	antidepressant medication E.C.T. neuroleptics in cases where there are psychotic features	if treatment resistance consider; second or an alternative antidepressant, lithium, anti-epileptic medication continue antidepressants for at least 6 months after recovery to decrease risk of relapse
Psychological	support specific psychotherapies; e.g. cognitive-behavioural (C.B.T.), bereavement counselling	more emphasis on specific psychotherapies such as C.B.T., dynamic, family therapy etc.
Social	support for carers admission if risk to patient or others specific social interventions	specific social interventions e.g. housing, finance in some cases social and/or occupational rehabilitation

Antidepressants.

Tricyclic antidepressants (TCAs) are the longest established pharmacological treatment for depressive disorders, but are associated with a higher rate of adverse effects (including toxicity in overdose) compared with the newer serotonin selective reuptake inhibitors (SSRIs).

Patients may not persevere with treatment if they are not warned to expect unwanted effects and a delay before improvement. Anticholinergic side effects can be minimised by starting at a low dose e.g. amitriptyline 25 mg, increasing to a "treatment" dose of 150 mg.

75 mg of TCAs are often used in general practice. This is sometimes reported as being effective, perhaps because a milder form of depression is often seen in the community. However, most studies have strongly suggested that generally, and particularly in hospital practice, a dose of 75 mg is sub-therapeutic and 150 mg or greater is usually required.

There is dispute about whether TCAs or SSRIs should be the first line treatment for depression. SSRIs should probably be first choice in the elderly, those with cardiac problems or epilepsy, those with high suicidal intent, and those who have been over sedated or put on weight when on TCA's.

Monoamine oxidase inhibitors (MAOIs) are very much second line treatments, though the new reversible MAOI, moclobamide, does not need the same dietary restrictions, and therefore may gain favour. Newer antidepressants such as venlafaxine, a serotonin and noradrenaline reuptake inhibitor (SNRI), and reboxetine, a noradrenaline reuptake inhibitor (NARI), are now being used in clinical practice.

Electroconvulsive therapy (E.C.T.).

Despite its adverse image modern E.C.T. is a relatively safe procedure, particularly when compared to TCA use. The main side effects are headache, myalgia (probably related to the muscle relaxant used in the anaesthetic) and mild memory problems (retrograde and anterograde) that settle over the 6 weeks after treatment finishes.

E.C.T. is particularly useful in severe depression i.e. where there are marked melancholic or psychotic features. It is also strongly indicated where a delay in the treatment is unacceptable such as in cases where there is a serious risk of suicide or the patient is not eating or drinking.

E.C.T. use may also be indicated in resistant mania and in the elderly (due to its comparative safety and rapid onset of action).

Anxiety Disorders

Introduction

Anxiety is a normal response to threat or danger. At times it is helpful since it mobilises energy reserves for action, and the increased level of arousal involved can improve performance in a range of situations. Anxiety is unhelpful, or pathological when it is experienced intensely, frequently and persistently and interferes with a persons daily living.

Overview

State v.'s trait:

Each individual has typical enduring tendencies to react anxiously or not, and this is referred to as trait anxiety. At times people may experience anxiety because of specific experiences and this is termed state anxiety. Enduring tendencies to experience problematic anxiety may stem from early relationships in childhood, and be understood in terms of personality development or may be a product of genetic/ biological predisposition. High trait anxiety will mean that an individual is particularly vulnerable to experiencing high state anxiety in stressful situations. The perceived threat or danger prompting anxiety can be physical or social, where people experience a threat to their social and/or emotional well being.

Origins:

Anxiety problems are typically found to have physiological, behavioural and cognitive aspects. People tend to avoid situations in which they have become anxious. This avoidance is reinforced (by the principle of negative reinforcement) since anxiety is reduced. However, avoidance increases the likelihood that anxiety will be experienced in similar situations in the future. People also tend to have negative, anxiety provoking thoughts and images (cognitions) about such situations and about their own physiological reactions.

Pathological anxiety may occur as a component of specific anxiety disorders, other psychiatric disorders or physical illnesses. The total point prevalence for anxiety disorders is 4.5% (GAD 2.5%; OCD 0.05%). Anxiety problems account for about 27% of GP consultations for emotional difficulties. The overall sex ratio (M:F) for anxiety disorders is between 1:2 and 2:3 with a peak age of onset between the ages of 25 and 44.

Symptoms

Anxiety can manifest itself in a number of ways, whilst quite arbitrary, symptoms can be grouped together as:

Psychological.

- Inner tension
- Agitation
- Fear of loss of control
- Dread (that something catastrophic is going to happen - blackout, seizure, MI, death)
- Irritability
- Depersonalisation
- Derealisation

Physical.

- Cardiovascular - tachycardia, palpitation
- Respiratory - dyspnoea, hyperventilation, chest tightness
- Gastrointestinal - borborygmi, urge to defecate/ loose bowels, dry mouth, epigastric sensation (butterflies), nausea
- Uro-genital - urinary urge
- Motor - tremor
- Autonomic - sweating

Hyperventilation Syndrome

As a component of anxiety disorders hyperventilation is of particular significance as it can be misdiagnosed as physical disorders, the treatment of which can have potentially hazardous outcomes, such as epilepsy (known as non-epileptic attack disorder) or myocardial ischaemia.

Rapid shallow breathing leads to hypocapnia and respiratory alkalosis. This in turn leads to physical symptoms such as paraesthesia (typically fingertip or peri-oral), lightheadedness, tetany/carpo-pedal spasm *etc.* The pattern of breathing itself, without adequate expiration taking place, leads to a feeling of chest tightness. These symptoms in turn lead to an increase in anxiety and the development of a "vicious circle".

Hyperventilation can occur in many psychiatric disorders, but not exclusively and can occur in "normal" individuals during unaccustomed exercise, SCUBA diving *etc.*

Treatment is classically by rebreathing into a paper bag. This, however, is unpleasant and compliance is unlikely. More useful is to encourage slowing of respiration with complete expiration. Longer term management is usually behavioural in addition to treatment of the primary disorder.

Classification

The various diagnostic classifications of anxiety disorders are listed below. Since there are general and specific principles in the treatment of anxiety disorders specifics will be covered on these pages and general principles will be covered on a subsequent page.

Generalised Anxiety Disorder (GAD)

This is characterised by pervasive anxiety symptoms that are not restricted to specific situations (phobic disorder). Generalised anxiety may accompany phobias, and may be associated with other problems such as depression and substance abuse; it may also be caused by physical illness e.g. overactive thyroid, and may be associated with the emotional response to illness, e.g. myocardial infarction. Some 15% of people with anxiety problems have a sibling or parent with a similar problem. This may reflect a genetic component to vulnerability, or the effects of family environment. Although there is biological component to anxiety disorders, psychological factors invariably play an important part. Two thirds of sufferers are female.

Treatment:

Psychological.

In the acute state anxiety management is useful, as can be cognitive behavioural therapy. For chronic anxiety there may be a role for psychodynamic psychotherapy.

Physical.

Sedative tranquillisers should be avoided due to the high risk of dependency.

There is frequently a role for tricyclic antidepressants such as clomipramine or SSRIs.

Panic Disorder

In panic disorder there are recurrent attacks of panic that occur unpredictably and without obvious precipitants. It commonly co-exists with GAD or agoraphobia.

Panic attacks consist of attacks of severe anxiety with physical and psychological symptoms. Physical symptoms include tachycardia, palpitation, sweating, tremor *etc.* and may include hyperventilation. Psychological symptoms typically include dread, particularly of extreme events such as dying, having a seizure, losing control or going mad.

Treatment:**Psychological.**

Anxiety management is useful, as can be cognitive behavioural therapy. Where hyperventilation is present behavioural approaches to deal with this are appropriate.

Physical.

Sedative tranquillisers should be avoided due to the high risk of dependency.

There is frequently a role for tricyclic antidepressants such as imipramine and clomipramine or SSRIs.

Phobic Disorders

A phobia is a fear that is disproportionate to the specific situation that prompts it and cannot be explained away. The person typically avoids the feared stimulus since the reduction of anxiety is powerfully reinforcing (known as negative reinforcement).

Some phobias represent heightened anxiety towards situations which people are evolutionarily 'prepared' to fear e.g. snakes, heights, sharp objects *etc.* In other instances a phobia may arise through conditioning. A traumatic experience may be associated with a neutral, non-threatening situation, which then itself becomes feared.

Phobias are typically situational, predictable and with anticipatory anxiety and avoidance. They are common in the general population but in only 2% are severe enough to prove disabling.

Some common phobias are:

Simple phobias - Here the phobia is specific to objects or situations and in many cases can be understood from an evolutionary perspective. Specific phobias include:

Animal Phobias (e.g. dogs, snakes, spiders [arachnophobia]) - onset is often in childhood, usually less than seven years and people were often shy and timid as children.

Blood and Injury Phobias - fear of blood tests, sight of blood *etc.*, results in fainting.

Vertigo

Agoraphobia (syn. fear of the marketplace) - 75% of sufferers are women with a prevalence of 6.3 per 1000 population. Symptoms consist of intense fear of leaving the home, being in crowded spaces, travelling on public transport *etc.* that are difficult to leave. Agoraphobia may follow a life event threatening a person's security, or a physical illness. It can often be associated with marital problems, and may often mask them.

Social phobia - The sex ratio in contrast to agoraphobia is equal. Typically it involves a diffuse fear of social interaction, of talking to others eating, drinking and speaking in public.

Treatment:**Psychological.**

Behaviour therapy involving graded exposure or desensitisation to the feared stimulus. A hierarchy of stages is worked out with the person, from least to most anxiety provoking.

Anxiety management is useful as can be cognitive behavioural therapy with strategies being taught to help people cope with the anxiety evoked, and the support of therapist and/or relatives is often crucial.

Physical.

Sedative tranquillisers should be avoided due to the high risk of dependency.

There may be a role for antidepressants but only as an adjunct to psychological approaches.

Obsessive Compulsive Disorder (OCD)

OCD is a relatively rare disorder. Whilst minor obsessional symptoms may occur in around 14% of a general population sample, OCD itself has a point prevalence of only 0.05% (6 month prevalence 1.3-2%; lifetime prevalence 1.9-3.3). It is distributed equally between both sexes and may only present late on after many years of active symptoms.

Symptoms.

Obsessional thoughts:

- These come repeatedly into the subjects mind against their will.
- They are unpleasant and often abhorrent.
- They are recognised as being the subjects own.
- They may be resisted (usually early, in around 50% at the time of presentation). This causes an increase in anxiety.
- Examples: contamination, doubting, images...

Compulsive acts (a.k.a. obsessional acts):

- Repetitive actions based on obsessional thoughts.
- Not directly pleasurable (different from relieving the distress of the thoughts).
- Temporary relief of the tension and anxiety caused by the provoking thought.
- May have a symbolic quality (c.f. Lady Macbeth).
- Examples: checking, cleaning...

Aetiology.

This has the strongest evidence for a biological aetiology for any of the anxiety disorders. There is a strong link with Gilles de la Tourette syndrome. Neuroimaging studies show abnormality in the basal ganglia, anterior cingulate cortex and orbitofrontal cortex.

33% of those with OCD do not have premorbid obsessional (anankastic) personality traits, indeed those with these traits are more likely to develop depression.

There are a number of theories predicated on the role of learning and development. The former considers the role of negative reinforcement and the reduction of anxiety caused by the obsessional rituals. The latter psychoanalytic theory emphasises the role of repression of unacceptable impulses and regression to the anal stage of development, with thought patterns dominated by magical thinking.

Treatment:

Psychological.

Obsessional thoughts can be challenged using a technique known as *thought stopping*, where a distraction is used to interrupt the thought.

Compulsive acts are treated by graduated exposure to the environmental stimulus, either *in vivo* or using imagery, whilst the patient resists the rituals. This is known as *response prevention*.

Anxiety management is useful as can be cognitive behavioural therapy with strategies being taught to help people cope with the anxiety evoked, and the support of therapist and/or relatives is often crucial.

Physical.

Clomipramine, SSRIs, lithium and tryptophan all are used in the pharmacological management of OCD. This is the most effective management technique in the short term but its efficacy and duration of action is increased when used in conjunction with behavioural or cognitive behavioural techniques.

ECT has been used in cases where the disorder is severe, unresponsive to medication and/or there is significant depressive symptomatology.

In the most severely disabled patients neurosurgery may be considered.

Stress Related Disorders

The psychological sequelae to stressful events often include symptoms of anxiety. There are three types of reactions that are partly characterised by their differing symptomatology, but also by their different temporal relationship to the stressful event.

Acute stress reaction.

Onset is within minutes, if not immediately, and resolves rapidly. When removal from the stressor is possible resolution is within a few hours, but when it is maintained there is a more gradual, albeit still rapid, reduction in symptoms, with only minimal symptoms remaining after 3 days.

Symptoms are mixed and usually changing with the patient appearing dazed and disorientated. In addition to symptoms of anxiety anger and withdrawal may be seen.

Adjustment reaction.

Onset is usually within 1 month of the stressful event and symptoms tend not to endure beyond 6 months.

Symptoms may include depression, anxiety, irritability and a feeling of being unable to cope.

Post traumatic stress disorder (PTSD).

Onset is delayed weeks to months from a stressor that is of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. It may persist for years.

Symptoms include flashbacks, nightmares, avoidance, autonomic hyperarousal with hypervigilance, anxiety, depression, guilt, emotional blunting

Somatoform Disorders

Somatoform disorders are characterised by the primary problem being a physical presentation or concern secondary to a psychological problem. They are an important group of disorders to be aware of since patients with them often present to GP's and physicians rather than psychiatrists.

Somatisation disorder.

Dramatic presentation of multiple, recurrent and frequently changing physical symptoms. Many negative investigations have usually been carried out in the years prior to referral to a psychiatrist.

The disorder is more common in women than men and usually starts in early adult life.

Hypochondriasis.

A persistent belief in the presence of at least one serious physical illness despite negative physical findings and reassurance. Alternatively the patient may have a persistent preoccupation with a presumed deformity or disfigurement.

Dissociative (conversion) disorders.

Occurs secondary to internal conflict.

Includes conversion symptoms (the conversion of underlying conflict into, often representative, physical symptoms, amnesia, fugues (amnesia plus an apparently purposeful journey away from home or workplace with maintenance of self-care), stupor.

Treatment

Specific management of disorders is considered under each heading above.

General principles.

As with all psychiatric disorders a careful history needs to be taken. Particular attention being paid to physiological, emotional, cognitive and behavioural aspects. Physical illness needs to be excluded e.g. tachycardia and weight loss may be due to hyperthyroidism; palpitation and other panic symptoms may be due to mitral valve prolapse; sweating, tachycardia etc. may be due to a phaeochromocytoma. The presence of other psychiatric disorder needs to be explored.

Physical investigations may be necessary where the history suggests physical illness, however, needless investigations in hypochondriasis, to reassure the physician, may reinforce anxiety in these patients.

Address social problems as well as using specific approaches e.g. poor housing, financial problems. Always explore the topic of substance misuse.

Avoid use of benzodiazepines.

Alcohol & Substance Misuse

Introduction

The phrases substance use disorder or disorders due to psychoactive drug use refer to conditions arising from the abuse of alcohol and psychoactive drugs.

Alcohol and other substances can have varied physiological and psychological effects. In the short term, the individual may perceive these effects as quite desirable. For example, the anxiety-relieving properties of alcohol, the alerting effects of caffeine and the sense of well being induced by options. However, prolonged and heavy usage may result in physical harm, dependency and withdrawal problems and long term psychological damage or social harm.

In this handout, problems related to alcohol will be discussed first under the general heading of alcohol use disorders. The problems related to drugs would be discussed subsequently under the general heading of substance use disorders.

Alcohol Use Disorders

Alcohol taken in any amount may be harmful if the time and situation are inappropriate, for example when driving. The risk of sustaining alcohol-related injuries begins to increase with blood ethanol concentrations as low as 20mg / 100mls. It is therefore difficult to identify a level of alcohol consumption that can be considered 'safe'.

However, the Department of Health specifies what is generally regarded as safe drinking limits for the adult population. It should be noted that these levels are higher than those specified by the Royal College of Psychiatrists.

Safe Drinking(Units per week)	Males	Females
Department of Health	28	21
Royal College of Psychiatrists	21	14

One Unit of alcohol : 10mls or 8gms absolute alcohol approximately.
 ½ pint (284mls) ordinary strength beer or lager
 1 glass (125mls) average strength wine
 1 glass (50mls) of fortified wine; eg. Sherry
 1 single measure (25mls) spirits.

Women are more sensitive than men to the harm-inducing effects of alcohol.

The legal limit for driving a motor vehicle, (80mg/100 ml) roughly corresponds to the level achieved after 3 units of alcohol have been consumed over the space of a few minutes. However, individuals vary and there are gender differences. It is also important to note that a substantially lower consumption and resultant blood alcohol impairs driving ability and judgement.

Problem Drinking

It is now recognised that levels of alcohol consumption (and alcohol-related problems) exist within a continuum, ranging from low risk to harmful.

Low risk	'Safe drinking', where intake is unlikely to be associated with harm	Males \leq 21 units/week Females \leq 14 units/week
Hazardous drinking	Intake likely to increase risk of developing alcohol related harm	Males = 22 - 50 units/week Females = 15-35 units/week
Harmful drinking	'Alcohol Misuse'. A pattern of drinking associated with the development of alcohol related harm (physical or psychological).	Males $>$ 50 units/week Females $>$ 35 units/week

Alcohol Dependence

The term dependence refers to certain physiological and psychological phenomena induced by the repeated taking of a substance.

- Alcohol dependence syndrome is characterised by the presence of three or more of the following:
 - A strong desire or compulsion to drink
 - Difficulty in controlling the onset or termination of drinking or the levels of alcohol use
 - A physiological withdrawal state on cessation of alcohol or its use to avoid withdrawal symptoms
 - Increasing tolerance to alcohol *
 - Progressive neglect of other interests
 - Persisting use of alcohol despite awareness and clear evidence of the harm it is causing.

* Tolerance is the need to consume more alcohol to achieve the same effect produced originally by smaller amounts.

Alcohol related problems

About 27% of men and 11% of women drink over the 'safe' limits.

Cost of alcohol is probably the major determinant of the level of alcohol consumption in society with the prevalence of alcohol related difficulties matching it well. Customs and moral beliefs and formal governmental controls are also important factors.

At the individual level multiple causes determine the levels of consumption, including genetic and personality factors and psychiatric disorders.

The scale of alcohol related problems in the United Kingdom

Each year alcohol use plays a role in up to 40,000 deaths (including 500 young people) and 15 million lost working days. Alcohol related problems account for 25-35% of all general hospital admissions, 33% of domestic accidents, 26% of domestic deaths, 40% of fatal domestic fires, 15-29% of serious accidents in the workplace, 50% of homicides and 80% of domestic violence.

Psychiatric disorders**Intoxication phenomena**

Such as lability of mood, belligerence and memory black outs.

Alcohol withdrawal phenomena

Withdrawal symptoms occur in people who have been drinking heavily for years and who maintain a high intake of alcohol for weeks at a time. They occur when alcohol consumption is abruptly discontinued or substantially reduced. The first symptoms usually appear within 8-12 hours of the last drink and progression to a state of delirium may occur within 2-3 days. The withdrawal symptoms may be:

- **Mild** such as tremor, nausea, sweating, insomnia, mood disturbances, restless, agitation, anxiety and fear. Other recognised symptoms include tinnitus, cramps and noise sensitivity.
Many heavy drinkers continue with drinking to alleviate these symptoms.
- **Severe** namely:
 - i) Alcohol withdrawal seizures, which can occur in the first 12-48 hours after substantial reduction in alcohol consumption or abrupt discontinuation.
 - ii) Delirium Tremens (DT's), which is an acute confusional state usually occurring about 3 days after the last drink and may go on for up to 7 days. It is characterised by disorientation, visual hallucinations (e.g. snakes in the bed), agitation, fearfulness, sweating and tremors. It has a significant mortality rate.
It constitutes a medical emergency.

Depression

Alcohol is a CNS depressant and the biological changes induced by it can mimic those seen in depressive disorders. It is also clear that the life of a problem drinker with anxieties and guilt about their behaviour and possible social repercussions all contribute to feelings of depression. In some patients alcohol misuse is a symptom of underlying depressive illness.

Suicide and deliberate self-harm are significant risks in-patients with serious alcohol problems particularly when associated with depression or impulsive behaviour.

Anxiety

Alcohol can be used as a means of coping with anxiety. In addition, symptoms of alcohol withdrawal state may mimic an anxiety state.

Alcoholic Hallucinosis

This is usually characterised by auditory hallucinations occurring in clear consciousness. They can occur during heavy drinking or following withdrawal or a sudden reduction in alcohol intake. Sometimes they resemble those in schizophrenia.

Morbid jealousy (Othello Syndrome)

The excessive drinker develops the delusion that his or her partner is unfaithful which may result in domiciliary violence and death of the partner.

Psychotic illnesses

Alcohol problems may be associated with or may precipitate psychotic illnesses such as schizophrenia.

Alcoholic dementia

Specific cognitive deficits are demonstrable in problem drinkers that may or may not be accompanied by non-progressive impairment of intellectual capacity.

Wernicke's encephalopathy and Korsakoff's syndrome

This is caused by thiamine deficiency resulting in haemorrhage in the mammillary bodies of the posterior hypothalamus and nearby midline structures.

Wernicke's encephalopathy is characterised by ophthalmoplegia, ataxia and a confusional state, which can be reversed to a large extent by administration of thiamine.

Korsakoff's syndrome is characterised by profound short-term memory loss with relative preservation of other intellectual abilities. The gaps in short term memory are filled in by confabulation. Its resolution is less predictable.

Physical disorders.

Physical risks to health can be due to intoxication, e.g. accidents or long term physical disorders resulting from heavy alcohol usage. These relate to organ systems as follows:

- GI: Hepatitis; hepatic cirrhosis and its complications; pancreatitis; Mallory-Weiss tears;
- CVS: Hypertension; alcohol cardiomyopathy
- CNS: Seizures, peripheral neuropathy; cerebellar degeneration; dementia; myopathy.
- Others: Malnutrition and vitamin deficiency; damage to foetus in pregnant women.

Details of these can be found in medical textbooks (e.g. Oxford Textbook of Medicine).

Social disorders

These are multifactorial and relate partly to several of the physical and psychiatric consequences of alcohol misuse, listed above. In addition other factors such as poverty, poor performance at work and difficulties in interpersonal relationships lead to a self-perpetuating vicious cycle.

Some of the adverse social consequences of alcohol misuse identified include domestic violence, poor parenting, unemployment, involvement in crime and public disorder and drink driving.

Assessment

Many individuals are unaware of how much they drink and its potential impact on their health. It is therefore important to obtain an alcohol history from all patients, during the first encounter and periodically thereafter. While history taking:

1. Be aware of clues to heavy drinking, e.g. unexplained trauma, marital violence, history of drink driving, and repeated work absenteeism,
2. Know those who are at high risk on epidemiological grounds, e.g. doctors, pub and brewery workers, sales executives, seamen, journalists and police officers.
3. A quick screening questionnaire such as the CAGE questionnaire is a useful tool:
 - Cut down on drinking - do you need to?
 - Annoyed by anybody criticising your drinking?
 - Guilty about drinking too much?
 - Eye opener - do you need a drink first thing in the morning?

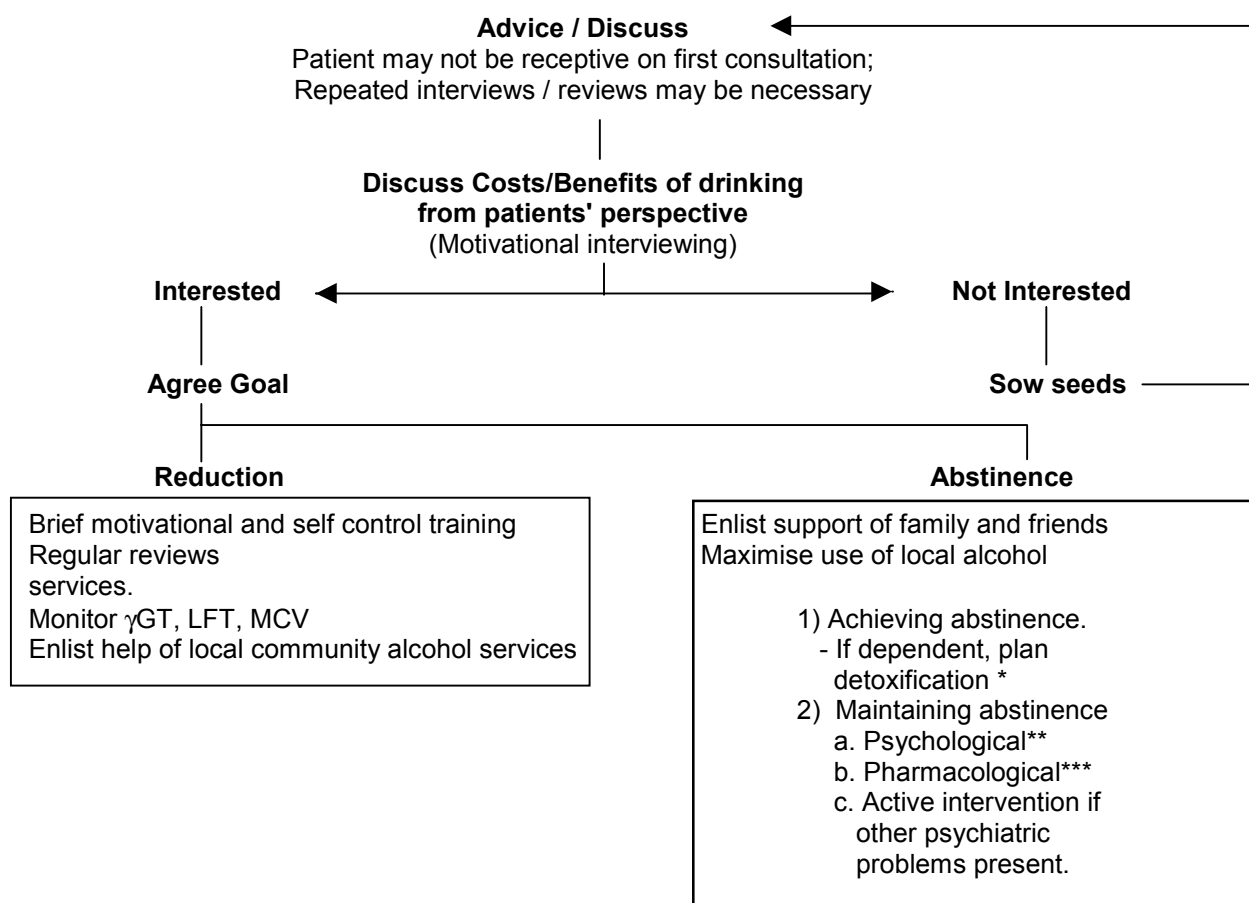
The 'AUDIT' questionnaire is a reliable, validated tool developed by the WHO to identify persons whose alcohol consumption has become hazardous or harmful to their health.

If you have any suspicions, you should elicit and record:

- A Consumption over past 3 months:
 1. Typical day's drinking
 2. Frequency
 3. Maximum / day
- B Severity of dependence
 1. Morning drinking to stop shakes and
 2. Previous failed attempts to control drinking
- C Alcohol related physical, emotional and social problems.
- D And consider Lab investigations: Raised γ GT, LFT's and MCV.

Treatment of alcohol use disorders (A flow chart for management)

Early detection of excessive consumption of alcohol is important because treatment of established cases is difficult.



Key to interventions achieving and maintaining abstinence:

*** Detoxification**

This can range from:

- Intensive, rapid in-patient programme. The patient stops drinking and receives medication e.g. diazepam to alleviate the suffering of the withdrawal state and to prevent life-threatening withdrawal fits. Thiamine is administered to prevent neurological damage.
- A supervised out-patient detoxification when the dependency and withdrawal problems are expected to be small. Diazepam is used in smaller doses for the withdrawal period.
- Slow, progressive reduction in alcohol consumption

**** Psychological**

- Long term counselling and support, e.g. Alcoholics Anonymous
- Cognitive Behaviour Therapy (CBT)
- Relapse prevention.

*****Pharmacological:**

To help dependent drinkers, pharmacological support is sometimes used, namely:

- Disulfiram
- Acamprosate.

Note: Treatment of co-morbid physical problems, when identified, is part of management plan.

Prevention

In seeking to prevent excessive drinking, two approaches are possible.

1. Improve the help and guidance available to the individual as already described.
2. Introduce social changes likely to improve drinking patterns in the population as a whole, including
 - Putting up the price of alcohol
 - Controlling advertising of alcoholic beverages
 - Controlling the sale of alcohol
 - Health education

The above have varying degrees of success, as would be expected.

Substances Use Disorders

The variety of substances abused is very wide, but common ones are stimulants (cocaine, amphetamine and ecstasy), sedatives (temazepam and diazepam), hallucinogens (LSD, magic mushrooms), opioids, cannabis and tobacco.

Experimentation with one or more drugs (polydrug abuse) is particularly common amongst teenagers. Some people use drugs recreationally (e.g. at weekends only). Regular use (e.g. daily) may lead to dependence (e.g. opiates) where continued use is required to prevent withdrawal symptoms.

Common drugs of misuse.

Cannabis

(Dope, Hash, Weed, Skunk and Tack.) The active element is Tetrahydrocannabinol. It is usually smoked, producing a profound sense of relaxation and mild euphoria. Its use is widespread and subject to controversy about whether it should be legalised.

It may produce mild paranoid ideation. There are some suggestions that it can produce an acute confusional state with delusions and hallucinations. It is now being used increasingly by those suffering chronic disorders such as multiple sclerosis allegedly for pain relief.

Stimulants

(Amphetamine, MDA family (MDMA - Ecstasy/E, MDEA, MDA))

When ingested they produce an elevation of mood, increased alertness and physical activity. They may be taken orally or injected intravenously (amphetamine). Rapid tolerance is common.

Amphetamine can cause what is known as Amphetamine Psychosis - a florid, schizophrenia like illness. The condition usually subsides in about a week though it can occasionally persist for months.

Sedatives

(Benzodiazepines especially Temazepam - 'Wobbly Eggs')

Many problems with benzodiazepines were, until recently iatrogenic.

Though benzodiazepines were initially considered safe hypnotic and anxiolytic drugs their capacity to produce tolerance, dependence and withdrawal states is now widely recognised. Hence, they are now used only for short courses of treatment and short acting variants e.g. Lorazepam should be avoided in most circumstances.

In more recent times, injecting the short-acting drug, Temazepam has become widespread practice, leading to it being rescheduled under the Misuse of Drugs Act.

Hallucinogens

(LSD - 'acid'; Phencyclidine - 'Angel Dust'; Magic Mushrooms)

These have been known and used for many years. They are usually taken orally, giving rise to heightened perceptions, vivid imagery, illusions and hallucinations and often a state of euphoria. Sometimes a 'bad trip' occurs with terrifying hallucinations and delusional thinking.

Those who use the drug regularly may experience 'flash backs' to a 'bad trip'. Neurological damage can occur.

Cocaine (and Crack Cocaine)

This stimulant is derived from the leaves of the Coca plant. It is usually smoked or snorted although it can also be injected intravenously. In the North East of England, its use has been limited by its very high price but this is changing.

It rapidly produces CNS stimulation and a sense of euphoria. Persons often develop a craving for cocaine, tolerance and psychological dependency. Chronic usage can lead to paranoid psychosis. Cocaine abusers sometimes experience Formication (Cocaine bugs), a feeling as if insects are crawling under the skin.

Opiates

These are a group of alkaloids, diamorphine (heroin) being the most commonly abused among them. They are frequently inhaled (smoked) but may be taken intravenously. They produce a sense of euphoria, detachment and well being in addition to analgesia. They are rapidly fatal in overdose - often by respiratory depression, which leads to cardiac arrest.

Prolonged use leads to the development of tolerance and dependence. Cessation of use leads to an unpleasant though not life-threatening (c.f. alcohol) withdrawal state ('Cold Turkey') characterised by:

Restlessness, insomnia, piloerection, pupillary dilatation, nasal discharge, sweating, vomiting, diarrhoea, abdominal pain, hyperaesthesia, paraesthesia and cramps.

Harmful effects of drug use

Drug users, particularly injecting drug users, have high morbidity and mortality rates. Complications of drug use may be related to:

- Drugs effects (intoxication, dependence/withdrawal, accidental overdose)
- Social problems related to the drug use (legal, financial, family problems and occupational).
- Method of administration (needle sharing, unsterile injecting techniques and contaminants like talc) which can cause infections such as tetanus, abscesses, endocarditis, hepatitis B/C/D, HIV, HTLV and septicaemia.

- Miscellaneous non-infectious medical problems, pertaining to different organ systems:
 - a) Vascular: Track marks, thrombophlebitis, venous thrombosis and arterial insufficiency.
 - b) Pulmonary: Respiratory failure (excess sedatives/opiates/stimulants), pulmonary oedema (opiates, cocaine), polyarteritis nodosa (due to hepatitis B), pulmonary hypertension (talc granulomas), pulmonary emboli.
 - c) Neuropsychiatric: Psychosis, depression, neuropathy and brain damage.

Treatment of substance misuse

The key to successful intervention is to bring about change; in the individual, his/her life situation or the availability of drugs, otherwise continued drug taking is likely. The first step is a thorough and accurate assessment. General measures of intervention aim at long term change and may involve one or more of the following:

- Establishing a therapeutic/supportive relationship
- Motivational interviewing
- Behavioural techniques
- Cognitive behavioural therapy
- Contingency management
- Cue exposure
- Relapse prevention
- Group/family therapy, drug counselling

In addition, specific drug related problems might require treatment (e.g. physical or psychiatric illness).

Specific Treatment Approaches:

Detoxification

Although opiate withdrawal is not fatal it can be very unpleasant deterring the client from abstaining. Detoxification can be carried out relatively rapidly as an in-patient, or more slowly (sometimes after a period of stabilisation) as an outpatient using, for example, methadone (an opioid with long duration of action).

Harm reduction /minimisation

Many clients will choose to continue using drugs despite intervention. For these limiting harm may be the aim and includes needle/syringe exchange facilities and methadone maintenance programmes.

Rehabilitation/therapeutic communities

Self-help groups e.g. narcotics anonymous

Suicide & Deliberate Self Harm

Introduction

This section deals with both the subject of people who commit suicide and those that survive after taking an overdose or harming themselves (deliberate self-harm, DSH, previously known as parasuicide). These two groups of people have rather different characteristics. The first group are more often male with a psychiatric illness. Typically they also plan their acts carefully, take steps to avoid detection, and use dangerous methods. Those in the DSH group more often are female, act impulsively, and in such a way as to be discovered. These differences will be discussed further later. However, it is important to realise that despite these differences there is considerable overlap between the groups.

Suicide

Overview

There are around 4000 suicides per year in the UK, it being amongst the 10 commonest causes of death, and the fourth commonest for young adults. In addition, due to the strict legal criteria required for a verdict of suicide, it is estimated that it is under-reported by 30% to 50%. It is often classed by Coroners as 'accidental death', or 'open verdict', since for a verdict of suicide to be given it must be proven beyond reasonable doubt. When it comes to the actual suicidal act 2/3 of women and 1/3 of men who commit suicide take overdoses, although with increasing numbers of men taking overdoses these figures are converging. Men are more likely to use violent means (hanging, shooting, jumping, cutting) or car exhaust than women. 1 in 6 people who kill themselves leaves a note.

Such is the importance of suicide in epidemiological terms that there is currently a government funded research project looking at both suicide and homicide in psychiatric patients with the aim of making recommendations to reduce the incidence of both in this population group.

Epidemiology

There have been few dramatic changes in the crude rate of suicide over the years, the exceptions being:

- falls during the two world wars
- a rise during the depression in the 1930's
- a fall after 1960 when carbon monoxide was removed from domestic gas.

Since the 1960's the rates have been increasing.

Season: Suicides peak in April, May and June and are at their lowest in December. This variation is most marked in women.

Age & Sex: Men are more likely to kill themselves than women for all age groups. Rates increase with age to peak at 60-75. However, in recent years there has been a large and steady increase in the incidence in younger age groups and some decline in the elderly, so the rates are now more evenly distributed with age.

Marital Status: The greatest incidence is in divorcees, widows, and widowers the lowest in those that are married.

Social Class: Highest rates are in socio-economic classes 1 and 5, the lowest in 2 and 3.

Employment: Rates are higher in the unemployed. Some employment groups have high rates, including university students, doctors, lawyers, farmers, policemen and insurance agents.

Psychiatric Illness: Up to 90% of suicides have a psychiatric illness. Around 70% of people committing suicide have some depressive symptoms if not a clear depressive illness. Patients treated for an affective disorder have 30 times the risk of suicide than the general population, and overall 15% of depressives will commit suicide. Also note that suicide in depression often occurs during early recovery when energy and motivation have returned, but hopelessness continues. Other important psychiatric diagnoses include alcoholism (around 15% of suicides), antisocial personality disorder, drug misuse, early dementia, and schizophrenia. Schizophrenics make up a small number of suicides, although their lifetime risk is around 10%. Most schizophrenic suicides are young men early in the course of their illness, particularly if there are depressive symptoms. Note that only in a small minority suicide was a 'rational' or 'existential' act.

Other Correlates: These include immigrant status, social isolation, previous episodes of DSH, family history of psychiatric illness, recent loss (bereavement, separation, redundancy), chronic physical illness.

Assessment

To do this direct but tactful questions need to be asked (these do **not** increase the risk of suicide) with reference to epidemiological risk factors (see above). In particular consider:

- A direct statement of intent.
- Presence of psychiatric illness, particularly depression.
- Previous suicidal attempts.
- Feelings of hopelessness.

Also beware social isolation, elderly, males, chronic painful illnesses, misuse of alcohol, and bereavement. Find out not only reasons why suicide is being considered, but also reasons to hold back (e.g. religion, family). If suicidal thoughts are expressed, have plans been made, and if so what are they?

Prevention and Management

There is an "urban myth" that people who are seriously considering suicide do not talk about their feelings or intentions. Nothing could be further from the truth suicidal ideas are expressed by 68% before they act and 67% visit their GP in previous month, 40% in the previous week. Also remember that 25% are currently psychiatric out-patients.

The most important aspect of management is recognition of suicidal risk (see above).

Any psychiatric illness present needs to be adequately treated. This might entail admission to hospital (perhaps under the terms of the Mental Health Act), with high levels of observation by hospital staff.

Effective follow-up with social and psychological support is essential for patients who have had contact with psychiatric services.

In addition to the psychiatric services, voluntary organisations, such as the Samaritans, may also help to prevent suicide.

N.B. Despite all efforts suicides do occur, and in these circumstances support for relatives, and staff, is vital.

Deliberate Self Harm

Overview

Deliberate Self Harm (DSH) can be defined as a self-initiated act in which the patient injures themselves, or takes a substance in greater quantities than the therapeutic dose or the level which they are habituated to, that does not result in death.

DSH patients are clearly a heterogeneous group comprising those who have 'failed' to complete suicide, those with rather ambivalent feeling about death, and those whose intention is not to die. The evidence for this is as much as anything the striking difference in the epidemiology of DSH from suicide. There are extremely high rates with up to 1 in 100 young

women being admitted at least once with DSH, and it is the commonest single cause of acute medical admission to hospital for women, and second only to ischaemic heart disease in men.

Around 90% of DSH acts are drug overdoses, most commonly with NSAIDs, anxiolytics, and antidepressants (in that order). Around 80% use prescription drugs (70% their own, 10% other people's). 50% of men and 25-45% of women have taken alcohol within the last 6 hours. Of non-overdose DSH, self-laceration is the most common, otherwise it tends to comprise failed violent suicide attempts.

Self-laceration

This can be of three forms:

Deep and dangerous wound with high suicidal intent.

Self-mutilation e.g. by schizophrenic in response to psychotic symptomatology.

Superficial wounds. This third group is the most common, and represent an important subgroup of DSH that can be extremely difficult to manage. They are mostly young women with severe personality disorders characterised by low self-esteem, impulsivity, unstable moods, difficulty with interpersonal relationships, and a tendency to abuse alcohol and drugs. They sometimes fit the criteria for borderline personality disorder. High rates of childhood sexual abuse have also been reported. Multiple lacerations seem to relieve increasing tension, appear to be associated with little pain, and are followed by feelings of shame and guilt. The behaviour can occur as an imitation of others in psychiatric in-patients.

Epidemiology

Rates of DSH appeared to increase substantially in the 1960's and 70's, although they may have been stabilising or falling since then.

Age & Sex: DSH is more common in the young than the old. Peak age for men is between 20 and 24, and for women between 15 and 19. Women > men (c.f. suicide) up to around 50 years of age, and then similar rates between the sexes are seen.

Marital Status: Divorced, and single people, plus those who married young are more at likely to self-harm.

Social Class: DSH increases dramatically with decreasing social class (c.f. suicide).

Employment: Unemployed rates are much higher than for the employed.

Psychiatric Illness: 15-20% of DSH is in those with psychiatric illness (c.f. suicide). Of these 50% depression, 30% personality disorders, 15% alcoholism.

Other Correlates: The majority of those who self-harm have experienced major life events, also disruption in interpersonal relationships, broken homes, criminal records, suffered child abuse, social isolation, anxiety over job/ housing etc. (c.f. suicide).

Motivation: Most commonly DSH is impulsive following a situational crisis. Serious suicidal intent is present in 5-15% of those who self-harm. Reasons given include:

- 'cry for help'
- 'escape from intolerable situation'
- 'relief from state of mind'
- 'attempt to influence others'
- 'testing the benevolence of fate'.

Assessment

Because of the considerable overlap between DSH and suicide, plus the significant rates of psychiatric illness in DSH patients, DSH should never be underestimated. 1 to 2% of DSH kill themselves within 1 to 2 years. An episode of DSH increases the risk of death in that person by 50 to 100 times.

Following an episode of DSH the first task is to assess the degree of suicidal intent. This may be suggested by:

- A clear intention to die, and remorse for having failed.
- Planning of the episode in advance.
- Steps taken to avoid discovery.
- No attempt made to obtain help afterwards.
- Using violent methods.
- Undertaking 'final acts' e.g. leaving a note, paying off bills, writing will.

This then needs to be followed by a general psychiatric assessment and an assessment of suicidal risk (see above). Note that there is **no** correlation between the medical seriousness of the DSH and the risk of suicide in the future.

The overall risk of repetition of DSH is 15 to 25% in the year following the episode. The best predictors of DSH repetition include:

- Previous history of DSH.
- Psychiatric treatment.
- Criminal record.
- Personality disorder.

Other predictors include being separated, low social class, drug or alcohol problems, early separation from mother, the episode not being precipitated by a situational crisis.

Prevention and Management

It is worthwhile noting that 1/3 of all patients who self-harm attend their GP for relief of emotional symptoms and 1/4 are recurrent psychiatric attendees. This implies that prevention should in theory be possible, and entails treatment of any psychiatric illness, social intervention, and family and individual counselling.

Following an episode, precedence should be given to medical treatment of the episode. Management may then follow the lines described above for suicide (see above).

First ever episodes respond best to intervention.

There are high rates of default from psychiatric clinics in DSH patients that are referred.

Psychiatry of Old Age

Introduction

Although mental disorder is relatively common in old age, it still affects a minority and when present reflects a state of illness rather than the effects of ageing alone. Mental disorder can be divided into two broad categories:

Symptoms of "brain failure" or organic disorders

These may be acute (confusional state/delirium) or chronic (dementia).

Functional disorders

The most common is depression, often with many symptoms of anxiety. A psychotic illness similar to schizophrenia in young adults may occur (formerly known as late paraphrenia). Drug and alcohol addiction are perhaps more prevalent in older people than we care to recognise. Anxiety disorders and personality difficulties may persist into old age and the former may indeed arise for the first time when a vulnerable personality is confronted by severe adversity.

The prevalence of these two categories of illness in elderly people depends on exactly which age group is examined and where they are living. In community surveys of all people aged over 65 years, approximately 5% are found to have severe organic brain disorders (mainly dementia) and a further 5% to have mild symptoms of forgetfulness. 2.5-5% will have depression severe enough to warrant treatment with a further 10% complaining of minor depressive/anxiety symptoms. Late onset schizophrenic illnesses are much less common, perhaps 0.5-1.0%.

If one looks at the very elderly (greater than 80 years) the rates of organic disorders, mainly dementia, are much increased, (e.g. 20%) whereas other diagnoses may occur less frequently - in other words organic disorder is (as one might expect) a disorder associated with increasing age.

If one looks at residents in local authority homes, hospitals or other institutional care, the rates for both organic and functional disorder (particularly depression) are much increased - about 30% each type. It is probable that mental disorder will have contributed to the person entering the institution, e.g. dementia making them unable to survive safely in their own home - but the combination of losing one's home and familiar surroundings can also aggravate existing confusion and/or depression.

The Ageing Population

The table shows the predicted age structure of the UK population for the years 1981 to 2001. The increase in the proportion of elderly people is in the 75-84 year group (+11%) and more particularly in those 85+ years (67+) - numbers of younger people changing little. The vast majority of these older people live at the present time in their own homes, only 6% being in institutional care (residential homes or hospital)

Age Band	1981 (millions)	2001 (millions)	% change
65-74	5.2	4.7	-9
75-84	2.7	3.0	+11
85+	0.6	1.0	+67
All 65+	8.5	8.7	+2

Those over-85's are predominantly women, the majority widowed and living alone. This very elderly group have high consultation rates with general practitioners, with many more home visits from these doctors, and occupy up to 50% of all NHS beds (medical, surgical and psychiatric). They are more likely to have complex combinations of physical, psychological and social difficulties which require multidisciplinary assessment and treatment.

Dementia

About 5% of the general population over 65 years suffer from severe cognitive impairment with a further 5% showing mild changes which may progress with time. Dementia refers to a global impairment of mental function which follows a chronic and progressive course. It is related to progressive cerebral degeneration which may be caused by a variety of pathological processes. Post mortem changes found in the brains of demented patients include (approximate figures):

Alzheimer's disease	50%
Vascular dementia	10%
Dementia with Lewy bodies	15%
Mixed vascular/Alzheimer's disease	15%
Other causes	10%

Alzheimer's disease

Alzheimer's disease is characterised by a gradual insidious onset and progressive course, often beginning with memory failure before other cognitive functions (e.g. language, praxis) become affected. Non-cognitive features (depression, psychosis, wandering, aggression, incontinence) are common. Physical examination is often normal, as our routine blood investigations. CT scan may be normal or show generalised atrophy.

Dementia with Lewy bodies

Dementia with Lewy bodies is characterised by the triad of fluctuating cognitive impairment, recurrent visual hallucinations and spontaneous Parkinsonism, though not all occur in every patient. As with Alzheimer's disease, onset is insidious and may begin with cognitive problems, Parkinsonism, or both. Cognitive impairment initially affects attentional and visuospatial function, with memory initially relatively spared. As with Alzheimer's disease, non-cognitive features are common. Parkinsonism consists mainly of bradykinesia rather than tremor and, once again, routine blood investigations are normal. CT scan may be normal or show generalised atrophy.

Vascular dementia

In contrast vascular dementia usually has an abrupt onset, often in association with a recognised stroke, and is associated with a fluctuating course, a stepwise decline and often reasonable insight at least in the early stages of illness. An exception to this course is subcortical vascular dementia, which may cause some 20% of all vascular dementia, when sudden onset and stepwise course may not be seen. Patients will often have risk factors for vascular disease and other evidence of this, for example ischaemic heart disease or peripheral vascular disease. Physical examination is likely to reveal focal neurology and CT scan would be expected to show evidence of cerebrovascular disease.

Other dementias

Other causes include rarer degenerative processes, e.g. Picks disease, Huntington's chorea, in addition to alcoholic brain failure, tumour, haematoma, etc. In some cases no discernible pathology is found.

By careful history taking and examination of both physical (particularly neurological) and mental state, it is possible to predict the likely underlying pathology in most patients with dementia. No specific diagnostic tests are yet available, but clinical diagnosis may be usefully supported by structural brain imaging methods such as CT or MRI scanning and functional imaging techniques such as SPET (Single Photon Emission Tomography) scanning. It is important to develop methods of establishing the aetiology of dementia during lifetime:

- To assist in predicting course of illness and determining prognosis.
- To inform management decisions; for example specific treatments are becoming available for Alzheimer's disease (cholinesterase inhibitors) and vascular dementia and it is necessary to know which patients should receive which treatment.

Patients with dementia usually present *either* because of failure to cope *or* with disturbed behaviour occasionally with both. They often lack insight into their illness or, in the early stages, deny it. Demented patients need:

- Assessment of cause and severity of dementia (cognitive impairment and behavioural abnormalities)
- Assessment of deficits in function and need for care (dependency)
- Assessment of the social situation
- Provision of treatment and care appropriate to the needs which have been identified
- Support for carers - practical and emotional
- Review of the above points - is the treatment and care appropriate and beneficial?

About 50% of cases of dementia have concurrent physical health problems. The burden of care produced by a physically sick patient with dementia is greater than that of a fit one, therefore, diseases should be sought and treated where appropriate. Dementia may also be complicated by:

- Emotional lability
- Depression
- Psychotic features (i.e. delusions and hallucinations)
- Behavioural disturbances (i.e., wandering, aggression, incontinence)

These may be helped by pharmacotherapy, counselling and explanation and support to relatives. Such patients may respond either to antidepressants for lability and depression, or antipsychotic agents for psychotic features and some behavioural disturbances. Patients with dementia are very usually sensitive to side effects of psychotropic drugs and so it is important to begin therapy with very low doses of medication (e.g. risperidone 0.5 mg) and monitor carefully for side-effects, particularly extrapyramidal problems.

Acute Confusion (a.k.a. Delirium).

Elderly people seem particularly likely to develop confusion in response to a wide range of stimuli - either physical insults or sudden social change. This presumably reflects the reduced ability of the aged brain to cope with such events, particularly if it is additionally damaged by a dementing process. An acute confusional episode may sometimes be the first evidence of an underlying dementia. Elderly patients with acute confusion are seen throughout medical practice, e.g. 20% of all acute medical ward admissions are found to be acutely confused. In elderly people apathy, under-activity and clouding of consciousness are more common presentations of delirium than the florid, overactive restless, hallucinating states usually described in relation to younger patients. Causes include:

- Intercurrent physical ill-health
- Adverse reaction to a prescribed drug or drugs
- Catastrophic social situations, e.g. a move into residential care

Acute confusion should be regarded as indicative of underlying disease and investigated medically. Untreated it has a 40% mortality rate.

The clinical approach is to complete a full physical examination looking for evidence of infection, stroke, MI or other illness. A review of medication should focus on drugs started or stopped recently. Until the underlying cause is determined and treated, a small dose of an antipsychotic agent may reduce the severity of delirious episodes.

Depression

This is the most common psychiatric disorder found in old people (if milder cases are counted) and the second commonest single underlying cause for all GP consultations for people over 70. The majority of depressive syndromes are of mild to moderate severity. About one fifth of cases are severe and carry the risk of suicide - especially in men, in those which fail to remit within 6 months of onset and in those who feel physically ill (hypochondriacal) especially if they have the delusional belief that they suffer from cancer. Depression in old age may be precipitated by adverse life circumstances:- bereavement; loss of health; threat of bereavement or loss of health in a key figure. As with younger patients those who suffer may

have vulnerable personalities (i.e. anxious and obsessional by nature) or may have no close confidantes (i.e. the socially isolated). More recently evidence has emerged suggesting that depression occurring for the first time in later life may be associated with subtle brain abnormalities, such as an increase in white matter lesions on neuroimaging, which may reflect hidden or undetected cerebrovascular disease.

The clinical approach with mild cases of depression is unlikely to involve the Old Age Psychiatry Service, since they will be treated by the Primary Health Care Team. Support and counselling may be supplemented by the use of antidepressants. More severe or persistent cases are likely to be referred for specialist assessment and treatment. Depressive illness in old people shows a wide range of clinical presentations - the typical picture of low mood and vegetative disturbance of sleep and appetite seen in younger people may predominate. Some patients become apathetic, withdrawn and appear to lose their cognitive abilities (this is called depressive "pseudodementia" as cognitive impairment may be so marked as to mimic organic dementia). Others may present with a picture of severe agitation and restlessness, accompanied by delusions of ill health or poverty, e.g. that they are dying of a brain tumour, that their bowels have stopped working and are rotting inside them, or that they are unable to pay for their hospital treatments.

The majority of cases respond as well to treatment as younger patients - perhaps even better! Poor outcome is often the consequence of inadequate treatment. The older tricyclic antidepressants are often not well tolerated, postural hypotension, urinary and gastrointestinal side effects being prominent.

Dosage should be titrated to the maximum tolerated, starting doses generally being 1/3 - 1/2 of those for younger patients. Newer antidepressants such as SSRIs have a particular place in the treatment of the elderly. Delusional depressions require the addition of neuroleptics - for unresponsive or severe depressions ECT is a safe and effective treatment. Lithium carbonate has a valuable place in prophylaxis of recurrent episodes and is also effective in potentiating or augmenting the antidepressant actions of tricyclics.

Many elderly depressed patients have previous or current physical illness, not only must this be taken into account during treatment, e.g. caution with tricyclic antidepressants in a patient with ischaemic heart disease, but physical illness must be treated in its own right to maximise the patient's chances of recovering from their depression.

Paranoid States

It appears to be a normal feature of ageing that individuals become rather more inflexible in their attitudes and fearful of adverse influence by the outside world. Elderly people are often not only physically and financially disadvantaged, but they enjoy relatively low social status and are often the victims of attack or deception. It is, therefore, perhaps not surprising that persecutory ideas (which we tend to lump together as paranoid symptoms) often emerge. The main conditions in which this occurs are:

Late onset schizophrenia/delusional disorder

This was formerly known as paraphrenia. The typical subject is an elderly spinster, with sensory impairments (deafness or visual impairment), living alone and isolated. Her self-care skills are good and she is apparently normal apart from the possession of a complex delusional system in which she believes she is the victim of a conspiracy (usually to defraud her). She hears third person auditory hallucinations, may smell odours, which she interprets as poison gas pumped into her room and misinterprets chance occurrences as having special significance. This psychotic illness, similar to schizophrenia in younger life, responds to antipsychotic drugs if the patient can be persuaded to take them. A depot injection given by a Community Psychiatric Nurse is often a useful vehicle which improves compliance with medication and provides regular contact with the patient.

Acute confusional state/delirium

Paranoid symptoms are common during delirium, the patient misinterpreting events because of his/her altered level of consciousness. The management of these symptoms has already been described - neuroleptic medication may help to reduce agitation and behavioural disturbances.

Paranoid Reactions to Forgetfulness

These usually occur in independent old people who explain their experience of forgetting where things have been placed by accusing others of stealing them. Objects stolen are usually everyday ones, e.g. cups, teapots, pension book or glasses. Stolen objects often are returned or reappear in the usual place. The most likely cause of forgetfulness and paranoid misinterpretation is, of course, a dementing process. Neuroleptic medication is seldom of benefit in these circumstances.

Anxiety Disorders

Anxiety disorders do occur in old people, about half of it persisting from early life and half coming on for the first time in response to the stresses of ageing. A common precipitant stress is that of failing physical health, e.g. developing an acute phobic state after a fall from a bus, leading to a fracture and a period of reduced mobility.

Behavioural methods of treatment may be effective. Diffuse anxiety and loss of confidence, even if precipitated by an adverse event, may indicate an atypical form of depression. Such patients respond better to antidepressant, rather than anxiolytic, drugs.

Assessment Procedures

Diagnostic Procedures

These are of primary importance and include both psychiatric and medical history taking together with physical examination and mental state assessment (including cognitive examination). Diagnostic procedures, e.g. EEG, blood tests or CT scan are used as necessary. Illnesses in old age are commonly multiple, so that patients often suffer from two to three definable illnesses.

Disorder of Function

Diagnosis alone does not tell you how severely disabled someone is. Two people with the same condition may behave very differently, e.g. dementia due to Alzheimer's disease may render one person unsafe for independent living, but simply slow the other one down in the time taken to complete the daily crossword. It is important therefore to assess the *functional disability* that an old person suffers from and decide whether it can be relieved. Occupational Therapists and Physiotherapists play an important part here, but the doctor needs to be aware of this aspect of illness when he/she is taking a history. Not all functional disability is caused by illness - some is due to failure to learn (e.g. a widower who cannot cook and never could) or due to disuse atrophy, (e.g. taking to bed with an illness and then losing the ability to walk).

Quantifying Functional Disability

It is possible to quantify the changes referred to above and this assists not only in judging their severity but also watching their response to rehabilitation or observing any deteriorating with time or treatment. During your placements you will be shown standardised methods of measuring - cognitive performance, skills in activities of daily living and mood state.

Personality Disorders

Introduction

Personality

Personality was defined by Schneider in 1959 as "The unique quality of the individual, his feelings and personal goals.". 'Personality' has been further defined as the set of enduring qualities of an individual which are revealed in the ways she s/he behaves across a wide range of situations. Such characteristics are apparent from late adolescence onwards.

Personality Disorder

Personality traits are described as constituting 'Disorder' when two criteria are met:

Deviance - the individual's behaviour differs from the 'norm' on at least one aspect of behaviour; e.g. attachment behaviour: over attached ('Dependent') at one end of the spectrum to lacking attachment ('Schizoid') at the other

Distress - the behaviour causes suffering to the individual or to others.

Such a definition obviously creates problems; many psychiatrists and social commentators are uneasy with the medicalisation of social deviance; it is difficult to see how personality disorders could be described as illnesses in the way that say schizophrenia can be. Most psychiatrists take the pragmatic view that medical and psychiatric skills may ameliorate the suffering caused by personality disorder and therefore where possible they have a duty to offer help. Furthermore, individuals, their families and society make demands for intervention. (Understandably, but not always appropriately).

Classification

Attempts have been made to group personality disorders into categories. These have not been highly successful. Most psychiatrists (and in fact lay-people) would agree when a person's behaviour constitutes personality disorder, but there is much less agreement over which category of disorder a given person would have. In an attempt to tackle this problem ICD-10 has grouped together "a variety of clinically significant conditions and behaviour patterns which tend to be persistent and are the expression of an individual's characteristic lifestyle and mode of relating to self and others." These 8 groupings are:

Paranoid personality disorder.

These individuals have strong beliefs that others are intent upon causing harm to them and that they would not be able to cope with this. This results in excessive vigilance for signs of danger, questioning of other peoples motives and tendency to counter-attack in response to a perceived threat or insult.

Schizoid personality disorder.

This grouping includes those who have an indifference to relationships and others' feelings. This results in solitariness, few friendships and a restricted range of emotional expression.

Dissocial personality disorder

(previously called 'psychopathy' or 'antisocial').

These individuals' believe their desires justify their actions. They regard themselves as infallible and other peoples' needs and the risks of their conduct are not important. Such people appear impulsive, irresponsible, and callous, they exploit others, have unstable relationships and are drawn to criminality. This is an important category because of the forensic implications of the psychopathic personality disorders in the Mental Health Act.

Emotionally unstable personality disorder.

A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. Two subtypes are described:

Impulsive type: the predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

Borderline type: there is marked instability of mood, relationships and self-image. They exhibit marked rapid mood shifts, intense unstable relationships and recurring impulsive self-damaging behaviour. They experience a persistent lack of identity, a sense of emptiness or boredom and they may engage in frantic efforts to avoid real or imagined abandonment.

Histrionic personality disorder.

These individuals believe that they are incapable of looking after themselves, that other people hold the key to fulfilment and that being loved by virtually everyone is essential. They therefore conduct a relentless search for reassurance, approval and praise, seek to be the centre of attention and exhibit exaggerated and inconsistent emotional responses.

Anankastic personality disorder.

This categorisation is characterised by feelings of excessive doubt and caution, preoccupation with details, rules, lists, order etc., perfectionism that interferes with task completion, pedantry, rigidity and stubbornness.

Anxious (avoidant) personality disorder.

These individuals have underlying beliefs that they are defective and unlikeable, they wish to be accepted but expect others to reject them. Such people exhibit excessive hurt following criticism, they avoid involvement with others and fear being embarrassed.

Dependent personality disorder.

These individuals believe that they are helpless and that they should be protected by someone else. They are excessively submissive, leaving important decisions to others, they are helpless when alone, they are easily hurt by criticism and fear rejection.

Great care should be made before diagnosing some categories such as histrionic. Some studies have shown the only consistent findings regarding these patients are that they are young women, treated by male doctors, with depressive symptoms but not being treated for depression. Personality disorders also confer non-specific vulnerability to developing mental illnesses, particularly of the depressive, anxious or adjustment disorder categories.

The similarities between some features of personality disorder and mental illness can bring about diagnostic confusion. It is vital that the diagnosis of personality disorder only be made after a careful longitudinal history, ideally from a reliable other. Personality influences responses to physical as well as mental illnesses and should therefore be taken into account in the assessment of patients in a wide variety of settings.

Aetiology

Little is known for certain about the exact origins of personality. Genetic and environmental factors clearly play a part, and both of these are involved in psychological development. In addition, cerebral pathology may play a part in some disorders.

Genetic

Some general aspects of behaviour are inherited and can be seen even in very young infants. This is referred to as temperament. There is evidence that some temperamental characteristics persist over time. Adult monozygotic twins brought up apart share similar personality profiles. Twin studies of probands with dissociative personality disorder show a

higher concordance rate for mono-zygotic twins than dizygotic. Note that genetic factors can greatly influence a person's interaction with their environment, with consequent "environmental factors" modifying personality. For example genetically determined behaviour may provoke specific types of responses that further reinforce the behaviour. In addition, the environment that an individual "seeks out" will depend in part on genetically determined factors.

Psychological Development

Different schools of thought speculate that certain different aspects of development are important to the origins of personality disorder. Thus attachment theory emphasises the role of disruption in a person's key relationships (i.e. mother/infant bond). Learning theory proposes that a person's experiences lead to some behaviours being reinforced by the patterns of rewards and punishments in their environment while other behaviours may be acquired by imitating (modelling) other people. Psychodynamic theory proposes that failure to negotiate certain critical developmental stages may lead to a person failing to relinquish patterns of behaviour characteristic of that stage of development. Thus a model for the development of dissocial personality disorder may be that:

The individual did not enjoy a stable secure relationship with a mother figure (attachment theory).

They failed to learn the normal rules of human behaviour either because his/her family of origin was antisocial or because they could not apply normal rules consistently (learning theory).

Their development was arrested at the oral stage of libidinal development resulting in self-centred patterns of behaviour (psychodynamic theory).

Cerebral Pathology

A higher incidence of EEG abnormalities is seen among individuals with dissocial personality disorder

Prognosis

Personality disorders which do not bring about the social isolation of the individual, such as the dissocial, emotionally unstable (impulsive, borderline), histrionic and dependent do seem to become less florid over time. As they grow older they have fewer crises and make less demands upon services.

In contrast, personality disorders which isolate the individual from opportunities to learn from experience, such as the paranoid, schizoid and anankastic change little and may actually become more fixed as the person ages.

Management

There is great variation in the presentation of personality disorders, but there are a few common principles for all when it comes to management. Inevitably progress will be slow since ingrained behaviour is being dealt with. It should never be forgotten that people who have personality disorders also get conventional psychiatric illnesses, particularly depression, and those should be treated. Often the main aim of therapy is to help the individual change their situation to one that is less discordant with their personality. Finally, it should be borne in mind that these patients do badly being passed from one doctor to another every few months.

Personality Restructuring.

Individuals with milder forms of personality disorder may benefit from a long term psychotherapy (psychodynamic or cognitive). Such a therapy would enable him/her to understand the effects his/her behaviour has on others, to understand their feelings and to make changes. Often there is benefit from conducting this in a group setting.

Support and Problem Solving

Most patients with personality disorders will not be suitable for restructuring psychotherapy. They will need support, particularly through times of crisis. A long-term consistent relationship with a concerned clinician (GP, psychiatrist etc.) is often of fundamental importance. Such a relationship will emphasise the importance of the patient taking responsibility for themselves and will seek to limit the damage caused by the patient's unhelpful behaviours. Some will benefit from problem focused therapies to ameliorate specific difficulties, e.g. assertiveness training for anxious (avoidant) personality disorder.

Medication

Drug treatments are of limited benefit in most personality disorders. Particularly care should be taken with the prescription of any drug with potential for dependence formation, e.g. benzodiazepines and attention should be paid to the risk of deliberate over-dosage. Occasionally patients who are prone to suspiciousness and patients who have poor impulse control benefit from low doses of major tranquillisers. In addition patients with impulsive, borderline and dissocial may gain benefit from SSRIs, which can ameliorate impulsive behaviours.

Organic Psychiatric Disorders

Introduction

The central clinical feature of most organic psychiatric disorders is impaired cognitive functioning. Cerebral dysfunction can however also cause organic mood states, personality change as well as organic psychotic and even neurotic states. The cerebral dysfunction may be caused by a disruption of brain structures or by alterations in neurophysiology. A vast array of medical and surgical conditions are capable of producing this disruption, they may be systemic or originate within the brain.

The disorders most frequently seen by psychiatrists are the neurodegenerative conditions associated with brain ageing which cause the chronic organic brain syndrome of the dementias (dealt with in the Psychiatry of Old Age section). Delirium, an acute organic brain syndrome is frequently encountered amongst medical and surgical inpatients.

Overview

General Principles

In assessing a patient where an organic psychiatric disorder is suspected a standard assessment of mental state should be carried out and in addition greater attention paid cognitive function testing and other specific details. Cognitive impairment can be broken down into deficits in attention, orientation, memory, intelligence, and higher executive functions. The pattern of deficits is affected by whether the pathology is acute or chronic and whether it is diffuse or focal. Note that an informant may be needed to allow a full and clear history to be elicited.

Acute v.'s Chronic

	Acute	Chronic
Example	Acute confusional state secondary to drug intoxication, cerebral anoxia, liver failure etc.	The dementias e.g. Senile Dementia of the Alzheimer's Type.
Onset	Rapid	Insidious
Course	Usually short lived, fluctuating picture	Chronic, progressive course
Consciousness	Impaired	Clear
Perception	Usually altered causing misperception or hallucinations	Hallucinations may occur in the later stages
Sleep	Sleep-wake cycle often disturbed	Sleep-wake cycle usually intact
Memory & Orientation	Impaired	Impaired

A brain suffering an acute insult is likely to show signs of impaired consciousness. The degree of impairment varies from slight problems with concentration and attention to coma.

Focal v.'s Diffuse

Organic mental states are caused by both focal pathology (e.g. tumour, stroke) and diffuse pathological conditions (e.g. Alzheimer dementia, generalised cerebral anoxia etc.). However focal lesions may cause general cerebral dysfunction and hence cause global cognitive impairment, as may systemic disease.

There is considerable localisation of brain function. Hence a discrete lesion confined to the posterior part of the inferior frontal gyrus on the dominant lobe (Broca's area) will cause an expressive dysphasia, and a lesion confined to the posterior part of the superior temporal gyrus (Wernicke's area) causes a receptive dysphasia. When widespread cortical neurodegeneration occurs, as is the case in dementia, these brain areas are frequently affected as well and language functions are often impaired. Language deficits occurring in

dementia are quite variable and various combinations of expressive and receptive deficits may occur.

Definitions

- **Aphasia** (c.f. dysphasia): failure of language output (may be motor, sensory, syntactical, nominal, receptive, expressive).
- **Agnosia**: failure to identify or recognise objects despite intact sensory function.
 - Anosagnosia**: failure to recognise ones own physical disability
 - Autotopagnosia**: misidentifies parts of own body
 - Topographical agnosia**: unable to orientate to familiar geography
 - Hemisomatagnosia**: ignores half of body
 - Tactile agnosia**: unable to recognise letters or shapes traced on hand
 - Astereognosis**: does not recognise familiar objects by touch alone
- **Apraxia**: failure to carry out motor function despite intact sense organs and peripheral motor system.
 - Constructional apraxia**: unable to copy design using pen/matchsticks, blocks etc. (may be a visuospatial agnosia).
 - Dressing apraxia**: unable to dress self.

Localisation of Cortical Function

For convenience this has been organised per lobe:

Frontal lobe.

The frontal lobe connects with motor and sensory areas and the limbic system.

	Functions	Dysfunctions
Motor area	Controls contralateral movement.	Contralateral spastic paresis.
Broca's area	Speech	Motor aphasia
Prefrontal area	Critical for personality, abstract thought, judgement.	"Frontal lobe syndrome": disinhibited, facetious humour, apathy, distractible perseveration, urinary incontinence.

Temporal lobe.

	Functions	Dysfunctions
Hippocampus	Episodic memory	Bilateral lesions cause an amnesic syndrome.
Wernicke's Area	Comprehension of language	Sensory aphasia

Parietal lobe.

Functions	Dysfunctions
Receives and identifies tactile information.	Cortical sensory loss e.g. (impaired two point discrimination).
Processes visual and auditory sensations.	Agnosias and apraxias. Dominant: right-left orientation, literacy and numeracy impaired.
Planning and sequencing of motor acts.	Non-dominant loss visuospatial and body awareness, L-spatial neglect, anosagnosia and autotopagnosia.

Occipital lobe

Functions	Dysfunctions
Interprets visual images.	Disturbed spatial orientation. Visual illusions and hallucinations. Cortical blindness.

Delirium

Delirium (a.k.a. Acute Confusional State) is an organic mental syndrome characterised by acute onset and fluctuating course. It occurs in the context of physical illness. Its duration is brief and the prognosis (either death or recovery) depends on the underlying physical condition.

Epidemiology

10-20% of hospital inpatients, in general wards, manifest some degree of delirium.

Elderly people seem particularly likely to develop confusion in response to a wide range of stimuli - either physical insults or sudden social change. This presumably reflects the reduced ability of the aged brain to cope with such events, particularly if it is additionally damaged by a dementing process. An acute confusional episode may sometimes be the first evidence of an underlying dementia

Clinical Features

The cardinal feature is impaired consciousness. This may manifest as impaired or fluctuating attention.

- Disorientation (time, place and person)
- New Learning impaired.
- Disorganised thinking. Conversation may be rambling or incoherent.
- Perceptual disturbances are frequent misinterpretations, illusions and hallucinations. (Benign stimuli may be misinterpreted as threatening).
- Diurnal fluctuation.
- Sleep wake cycle disturbed.
- EEG shows diffuse slow wave activity.
- In elderly people apathy, under-activity and clouding of consciousness are more common presentations of delirium, than the florid, overactive restless, hallucinating states usually described in relation to younger patients.

Acute confusion should be regarded as indicative of underlying disease and investigated medically. Untreated it has a 40% mortality rate.

Aetiology

High risk groups include the very young and the elderly, individuals with pre-existing organic brain disease (e.g. dementia), alcohol and drug abusers.

Cause is usually multifactorial e.g. in postoperative delirium such factors as patients age, the stress of surgery, pain, insomnia, medication, electrolyte imbalance, fever, infection and the dim ward lighting, may all be contributory.

Intracranial causes include:

- Epilepsy and post ictal states
- Brain tumour
- Infection
- Haemorrhage.
- Extracranial causes include:
- Drugs (medical and recreational).
- Endocrine dysfunction.
- Disease of non-endocrine organs e.g. heart, liver, kidney or respiratory failure.
- Deficiency states e.g. thiamine deficiency.
- Electrolyte imbalance.
- Withdrawal states - e.g. delirium tremens.
- Operations, e.g. (black patch delirium following eye operations).
- Catastrophic social situations, e.g. move into residential care

Assessment

A full physical assessment mandatory.

Sometimes it is difficult to distinguish delirium from dementia but if in doubt assume it is delirium so that an immediate and vigorous therapeutic response is ensured.

Treatment

Identify and treat cause.

Nursing care. Provide reassurance and explanation. If sensory deprivation is a factor improve lighting conditions.

A neuroleptic such as haloperidol may calm an agitated, restless patient and benzodiazepines are useful in the treatment of some withdrawal syndromes.

Amnestic Syndrome

A syndrome of memory loss with relative sparing of intellect and personality. The memory deficit is mainly of new learning.

Clinical features

New learning is lost but immediate memory is intact enabling the patient to carry a conversation. Insight is often lacking and the patient may compensate for the failure of memory by confabulating. The individual cannot recall events that occurred subsequent to the time of onset of the illness (anterograde amnesia).

The onset is usually sudden and once established treatment brings improvement only to a minority. It is usually a persistent disorder.

Aetiology

Thiamine deficiency due to chronic alcoholism, malnutrition, hyper-emesis gravis, Ca stomach etc. (Where thiamine deficiency is the cause the syndrome may be preceded by Wernicke's encephalopathy which is characterised by confusion, ataxia, ocular palsies, nystagmus and peripheral neuropathy. This condition passes after a number of weeks often leaving an amnestic syndrome. The term Korsakoff's syndrome is often used in this context.)

- Herpes encephalitis.
- Tumours.
- Trauma.
- Subarachnoid haemorrhage.
- Carbon monoxide poisoning.

Pathology

Punctate haemorrhage in the mamillary bodies and diencephalon are found in the Korsakoff syndrome.

Bilateral hippocampal damage, as occurs with post-encephalitic states.

Treatment

Treat the underlying pathology.

Prevent Wernicke-Korsakoff syndrome by treating alcoholics with large doses of thiamine and other B vitamins. (Remember that there are other causes of Wernicke-Korsakoff syndrome and consider treating individuals with these disorders too.)

Supportive measures once the syndrome has become fixed.

Psychiatric Consequences of Epilepsy

Epilepsy is a common neurological disorder having a prevalence of around 1%. It is estimated that between 30-50% of epileptics have significant psychiatric difficulties. The incidence of psychosis and affective disorders is high in this population and personality disturbance is also more common than in the general population. Epileptics are at greater risk of developing schizophrenia particularly those with temporal lobe epilepsy. Personality disturbance is also more common in the group with focal temporal lobe seizures. Aggressiveness of an explosive nature is characteristic and libido is often reduced. Impulsiveness, moodiness and suspiciousness have been described but these findings are open to criticism.

Classification of Epilepsy

Definition

Epilepsy is a brain disorder characterised by recurring excessive neuronal discharge, manifested by transient episodes of motor, sensory or psychological dysfunction, with or without loss of consciousness or convulsive movements. The seizure is associated with marked electroencephalographic (EEG) changes.

Classification

Current classification follows the following structure:

Generalised seizures

These involve all brain structures and may be primary (generalised from the outset) or secondary (arising secondary to a partial seizure).

- **Tonic-clonic** (grand mal)- either phase can occur alone. In the tonic phase respiratory arrest, tongue biting and bladder emptying can occur.
- **Absence** (petit mal) - transient loss of consciousness with retention of postural tone, lasting a few seconds, More common in childhood. Automatic movements in 80% of patients.
- **Myoclonic**
- **Atonic**

Partial seizures

The seizure originates in a focal area of cortex or sub-cortex. They may become secondary generalised seizures.

- **Simple partial seizures** - marked by simple motor or sensory symptoms **without** impairment of consciousness.
- **Complex partial seizures** - there is disturbance of consciousness. Most commonly temporal lobe in origin (TLE) but may be frontal. Two types of onset; simple partial onset or impaired consciousness at onset. Automatisms may be present.

Psychiatric complications of epilepsy:

Peri-ictal.

The period surrounding the seizure.

Precipitation of seizures - precipitants can be external (reflex epilepsy; photic epilepsy) or internal (stress; anxiety, hyperventilation; fatigue; sleep loss; withdrawal from drugs such as benzodiazepines, antiepileptics, alcohol; drugs which lower the seizure threshold such as antidepressants, neuroleptics).

Prodrome - changes in mood (particularly dysphoria and irritability) may appear minutes to days before a seizure and are not directly related to seizure activity.

Auras - these represent the initial focal onset of the seizure, last only seconds to a few minutes and typically have a stereotyped form. In temporal lobe epilepsy (TLE) these may include hallucinations in any modality, epigastric sensations, déjà or jamais vu. These can comprise the sole feature of a complex partial seizure.

Ictal - automatisms can occur when the seizure starts in the periamygdaloid region and spreads bilaterally. 80% last less than 5 minutes and ictal automatisms never last more than 1 hour. More protracted automatisms can occur due to complex partial status.

Post-ictal - some degree of post-ictal confusion is common after any generalised seizure. Examination would reveal confusion, reduced attention, disorientation and impaired co-ordination.

Inter-ictal.

The period between seizures.

Schizophreniform psychosis - this has been described as a psychosis with characteristic features of schizophrenia, on average starting some 14 years after the onset of epilepsy. Visual hallucinations appear more common than in schizophrenia. Incidence may be around 2% of epileptics, the majority having left temporal lesions. It appears to be a non-specific effect of underlying brain damage rather than directly due to seizure activity.

Affective psychosis - in epilepsy overall there is a 5-fold increase in the risk of suicide, but in TLE this figure rises to 25-fold.

Non Epileptic Attack Disorder - previously known as pseudoseizures, these are attacks which may be mistaken for epilepsy but are not of epileptic origin. Most patients have or have had epilepsy. Clinical pictures include atypical pattern of the attacks, rarity of injuries or incontinence (note these do happen in this disorder). Aetiologies include previous sexual abuse, hyperventilation syndrome etc.

Cognitive impairment - this can be temporary, due to continuing seizures plus/minus the effects of antiepileptic medication, or progressive, probably due to brain injury from continuing seizure activity.

Personality - whilst an "epileptic personality" has been described in older literature this construct appears to have little actual validity. Irritability and impulsive behaviour (including aggression and violence) may be part of an episodic dyscontrol syndrome secondary to complex partial seizures.

Psychiatric Consequences of HIV Infection

The mental disorders seen in people with HIV infection are similar to those that occur in individuals suffering from other potentially fatal conditions that have an unpredictable course. They include a range of normal psychological reactions (such as shock, denial and distress), as well as abnormal responses (such as suicidal behaviour and major depression). There are, however, differences in comparison with other disorders, due to features specific to HIV infection:

Brain-related complications of HIV can give rise to organic psychiatric disorders, including dementia.

Individuals with HIV infection are at increased risk of developing mental health problems (there is often a history of psychological and social difficulties prior to acquiring HIV).

The social stigma associated with HIV and AIDS often adds to the problems faced by those trying to adjust to the physical consequences of the condition.

Eating Disorders

Introduction

In western cultures eating problems ranging from severe morbid obesity to anorexia nervosa have achieved an increasing amount of media interest. Morbid obesity and obesity probably have the most impact on medical health economics, medical problems such as type II diabetes becoming increasingly common in those who are overweight. However, within our society there has also been much debate about the impact on health of very thin supermodels who are considered as role models for growing teenagers. Clearly there are many social and cultural issues which impinge on the subject of eating disorders, however, these lecture notes will be confined to those eating disorders which may present to a psychiatric clinic with a specialist interest in eating disorder.

The eating disorders range from anorexia nervosa where the body mass index (BMI = wtkg/Htm^2) < 17.5 to morbid obesity with binge eating where body mass index can range from 31 to over 50. In the middle ground is bulimia nervosa where a normal body rate is maintained (BMI between 20 and 25) where the eating pattern is grossly abnormal with episodes of binge eating compensated by behaviour to prevent weight gain.

Bulimia Nervosa

Clinical Features

Bulimia nervosa is characterised by the following clinical features:

- More than three episodes of binge eating per week (a binge being defined as a large amount of food eaten rapidly with a subjective feeling of loss of control).
- Behaviours to prevent weight gain. Two thirds of bulimics vomit but exercise, laxative abuse and amphetamine abuse are other ways in which weight is commonly controlled.
- Preoccupation with body weight and shape.

Bulimia nervosa is the most common eating disorder and in community studies it has been shown to affect 1 in 50 women. Male sufferers are less common with prevalence rates of 1 in 500 being found. The peak age of onset of binge eating which defines the syndrome is at 18. The usual clinical history is of a period of dieting around age 16 to 17, weight is lost and binge eating ensues followed by a compensatory mechanism to prevent weight gain. Characteristically the individual has low self-esteem their worries becoming centred on their body shape and weight. As the syndrome takes hold further lowering of self-esteem occurs secondary to the binge eating and purging behaviours.

Medical Complications

Generally speaking women with bulimia nervosa maintain their weight within a normal range. Medical consequences are secondary to purging behaviours. Self-induced vomiting may cause erosion of dental enamel, oesophagitis and severe electrolyte disturbances. Hypokalaemia is common though cardiac dysrhythmias are relatively unusual. It is thought the chronic hypokalaemia is less likely to cause cardiac dysrhythmias than an acute change in serum potassium. Other physical consequences include irregular menstruation, parotid enlargement and disturbed bowel habit.

Treatment

Studies have shown that for women suffering from bulimia nervosa, who do not have a diagnosis of personality disorder, short term focused psychotherapy is effective. Long term follow up studies have shown both cognitive behavioural psychotherapy and interpersonal psychotherapy either individually or in groups to be effective. As a basis for all these therapies health education with regard to a healthy diet is important plus exploration of the emotional triggers to binge eating. The success rate for treatment is relatively high varying between 60% and 70%.

Where bulimia nervosa is accompanied by symptoms suggestive of borderline personality disorder (multiple deliberate self-harm, rapid mood fluctuations and difficulties in relationships) more intensive long term psychotherapy is required. Often this is only effective within an in-patient setting.

The SSRI fluoxetine has been shown to be effective in reducing frequency of binge eating, when prescribed at a dose of Fluoxetine 60 mg daily. However, though this may result in dramatic improvement in symptoms, symptom recurrence is likely to occur when medication is discontinued therefore fluoxetine should generally be used as an adjunct to psychological treatment.

Anorexia Nervosa

Clinical Features

Although anorexia nervosa probably has more media attention it is much less common than bulimia nervosa, prevalence rates being found to be around 0.5 per 100,000. The incidence, however, in young females particularly those who are ambitious and 'perfectionistic' may be as high as 1 in 250. Anorexia nervosa has a high mortality and morbidity rate, mortality being estimated between 5 and 20%. Recovery is often slow, 50% of patients recovering at 6 years and 70% at 33 years, other patients will following a relapsing remitting course and a significant proportion will die from the disorder.

Characteristic clinical features of anorexia nervosa include:

- Maintenance of a low body weight less than a body mass index of 17.5.
- Amenorrhoea either primary or secondary in females, in males loss of libido.
- A severe fear of fatness and phobia of normal body weight.
- A distorted body image where the individual does not recognise the degree of their emaciation. In particular as weight is gained they misinterpret changes in body weight and shape.

There are many aetiological factors involved in anorexia nervosa these include genetic, social and environmental. There does seem to be a clustering of anorexia nervosa within families in particular identical twins. Other factors in the family that are thought to promote the development of anorexia nervosa include parental discord and a history of childhood sexual abuse.

Medical Complications

On examination of an anorexic their skin, typically, is dry with a covering of soft, downy hair (lanugo). Secondary sexual characteristics are maintained. Examination may also reveal hypothermia, hypotension, bradycardia and/or oedema. The oestrogen deficiency that can occur may result in osteoporosis, and secondary fractures, type II hyperlipoproteinaemia and hypercholesterolaemia.

Starvation and purging in particular may result in hypokalaemia and hypochloraemic alkalosis. As a consequence the severely ill anorexic is prone to arrhythmia's an possible cardiac arrest.

A full blood count may show a microcytic anaemia with a low white count (note that as there may be B12 as well as iron deficiency the anaemia may be normocytic). Endocrine investigations show

- Elevated basal cortisol and loss of diurnal variation.
- Gonadotrophins and gonadal steroids are reduced.
- Thyrotrophin-releasing hormone test is impaired and T3 is low.
- Elevated growth hormone.

The last abnormality is due to carbohydrate restriction, the former three to low body weight.

Treatment

Treatment of anorexia nervosa has to combine both re-feeding and psychological therapies. At very low body weights the capacity of the patient to use psychological treatments is often poor with concrete thinking and sometimes confusional states being evident. In patients developing anorexia under the age of 18 family therapy is found to be effective although its use in older age groups is less clear. In less severely effected patients out-patient or day-patient treatment is of benefit but in those whose body mass index is less than 13 in-patient treatment is frequently required. Most in-patient treatments have a multidisciplinary approach with assessments being carried out by nurses, psychiatrists, psychologists, occupational therapists and dieticians. The treatment combines individual work and group therapy some patients responding to a cognitive behavioural approach, others to a more long term psychodynamic approach.

Binge Eating Disorder

This disorder recently defined in DMS IV describes a group of patients who binge eat at high body weights, i.e. they binge eat but do not indulge in compensatory mechanisms to prevent weight gain. Treatment needs to be long term, the initial treatment entailing a period of weight maintenance with the development of regular eating patterns followed by a very long period of gradual weight loss.

Learning Disability

Introduction

Definition of learning disability

The patient must have significant impairment in 2 main areas:

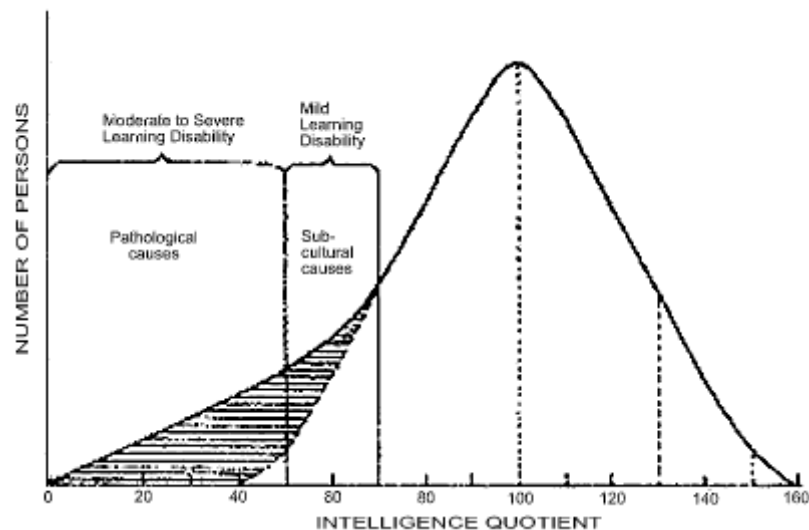
- Impairment in intellectual development
- Impairment in social adaptation/functioning.

IQ levels for different levels of learning disability

Mild learning disability	50 to 70
Moderate learning disability	35 to 50
Severe learning disability	20 to 35
Profound learning disability	<20

Aetiology

IQ levels follow a normal distribution curve for IQ's above 70. For lower levels of IQ the curve is skewed due to the addition of pathological (organic) causes of learning disability. The shaded area on the diagram below indicates the organic causes of learning disability.



Distribution of intelligence in the population from *Companion to Psychiatric Studies*. R Kendall & A Zeally Eds.

Mild learning disability

Individuals with an IQ of between 50 and 70 often form part of the lower end of the normal distribution curve for IQ. This group is often referred to as having "sub-cultural causes" for their learning disability. This group is less likely to have an identifiable organic cause for their learning disability than individuals with a more severe level of learning disability.

Moderate to profound level of learning disability

This group (IQ less than 50) is much more likely to have an identifiable organic cause for their learning disability as described below:

- 40% Chromosomal
- 15% Genetic
- 10% Pre and Peri-natal
- 10% Post-natal
- 25% Unknown

Down's syndrome is the commonest cause of learning disability (causing a third of all cases). Fragile X is the second commonest cause

Epidemiology

Prevalence

- 2-3% of the population has an IQ less than 70
- 0.35% of population has an IQ less than 50

Rates of behavioural and psychiatric impairment

Emotional and behavioural disorder are commoner in children and adults with a learning disability.

Schizophrenia

It is only possible to diagnose schizophrenia in individuals with an IQ greater than 45. The prevalence of schizophrenia in a learning disability population is raised. (N.B prevalence of schizophrenia in general population is <1%.)

- IQ 68-85 = 3.3%
- IQ 52-67 = 2.6%

Physical disorders associated with learning disability

Epilepsy

Rates are much increased in the learning disabled population

Rates of epilepsy:

IQ of more than 70:	0.5%
IQ of 50 to 70:	4%
IQ of less than 50:	30%
IQ of less than 20:	50%

Motor and sensory impairments

High rates of visual and hearing impairment.

Cerebral palsy

Associated, particularly in those with more severe levels of learning disability.

Osteoporosis

This is common due to poor mobility and treatment with older anti-epileptics.

Others

Earwax and constipation are common and frequently cause behavioural disorders. Specific syndromes have particular medical problems associated with them.

Syndromes associated with Learning Disability

Down's Syndrome

Usually have moderate to severe learning disability.

Physical features

- Typical facial appearance with small eyes and ears, small head and protruding tongue.
- Short stature

Physical complications

- Congenital heart disease
- Gastrointestinal atresia
- Hirschprung's disease
- Respiratory infections
- Epilepsy
- Hypothyroidism
- Strabismus
- Deafness

Psychiatric complications

- Alzheimer's dementia
- Depression

Fragile X Syndrome

Borderline to moderate degree of Learning Disability

Physical features

- Large floppy ears
- Projecting jaw
- Macro-orchidism
- Mitral valve prolapse
- Scoliosis
- Finger joint hypermobility and joint instability

Behavioural features:

- High-pitched voice
- Poor concentration
- Hyper-kinetic behaviour
- Avoidance of eye contact

Lesch-Nyhan Syndrome

Compulsive self-mutilation.

Prader-Willi

Insatiable hunger drive with resulting obesity.

Management

Management of individuals with learning disabilities should involve assessment of their family/carers and social circumstances as well as the learning disabled individual. A multidisciplinary team should be involved in assessment and management and in adult services the following disciplines are often involved:

- Psychiatrist
- Community nurse
- Social worker
- Psychologist
- Speech therapist
- Physiotherapist
- Occupational therapist

Close contact with other professionals in the community is important, particularly with the GP and other medical specialities.

Prevention of learning disabilities

This is clearly of paramount importance but, with recent debates about eugenics sparked by the human genome project, a sensitive issue. Components of this may include:

- Genetic counselling
- Early treatment of reversible disorders (e.g. phenylketonuria)
- Amniocentesis
- Rubella immunisation
- Improvement of obstetric care (avoidance of harmful drugs in pregnancy, improved surveillance of pregnancy and delivery, improved neonatal care)
- Folate supplements in pregnancy
- Avoidance of maternal drug and alcohol abuse
- Public education about these issues

Management

Drug Treatments in Psychiatry

Introduction

Since the 1950's effective drug treatments have revolutionised the management of many psychiatric disorders. However, there is no such thing as a "miracle cure" and the use of drugs in psychiatry requires psychological as well as pharmacological skills. Because of the sensitivity and complexity of the central nervous system interactions and adverse effects with psychotropic (i.e. psychologically active) drugs are common. The pharmacokinetics and pharmacodynamics of these compounds must therefore be understood. It is not obvious to patients that drugs can improve their psychological difficulties, especially if insight is impaired, and steps to encourage compliance are vital.

Psychosocial effects of taking medication may be positive (e.g. placebo effect) or negative (e.g. less motivation in psychotherapy because tablets are seen as a panacea). Medication is often just one component of a treatment plan that also includes psychosocial therapies. The place of drugs in this combined approach should be explained to the patient.

Compliance is increased by attention to the following:

- Empathy: the patient feels understood.
- Education: about the diagnosis and its implications.
- Explanation: about the drug, its intended action and the likely adverse effect.
- Efficiency: simplify the drug regime as much as possible and avoid polypharmacy.

Pharmacokinetics

As psychotropic drugs need to be lipophilic to cross the blood brain barrier they are readily absorbed and widely distributed. Almost all are metabolised in the liver to hydrophilic compounds excreted by the kidney. Many have long half-lives and therefore only need to be administered once a day.

Interactions:

Many interactions occur between psychotropic drugs and other psychotropics as well as other classes of drugs. It is important that you are aware that both adverse and advantageous interactions can occur. An example of an advantageous interaction may include the use of multiple anticonvulsants in the treatment of epilepsy. There is emerging evidence regarding the use of multiple mood stabilisers, antipsychotics and antidepressants. However these are strictly for use by specialists and the general rule of avoiding polypharmacy should be adhered to as far as possible. The list of interactions below only gives examples – you should consult a source such as the British National Formulary for specific information. Interactions can be divided into:

Pharmacokinetic

These interactions commonly result from induction or competitive inhibition of hepatic enzymes, for example antimuscarinics induce metabolism of phenothiazines and reduce serum level; phenothiazines compete for metabolism with tricyclics and may increase serum levels; some SSRIs inhibit the enzymes that metabolise tricyclics and phenothiazines.

Pharmacodynamic

These interactions occur when compounds act at the same receptor, synapse or system, e.g. alcohol potentiates other sedatives.

Adverse Effects:

Important adverse events for specific drug groups are detailed under each of the groups described below. However you should consult a source such as the British National Formulary for more comprehensive information. When considering adverse effects generally, it is helpful to use a simple checklist:

Dose dependent (e.g. via receptor mechanism):

- **Autonomic:** e.g. Antimuscarinic (phenothiazines, tricyclics) namely: dry mouth, blurred vision, closed angle glaucoma, tachycardia, constipation, ileus, urinary retention.
- **Cardiovascular:** e.g. Hypotension, Arrhythmia (phenothiazines, tricyclics)
- **Psychiatric:** e.g. Delirium (phenothiazines, tricyclics)
- **Neurological:** e.g. Seizures (phenothiazines, tricyclics)
- **Endocrine:** e.g. Amenorrhoea, weight gain (phenothiazines)

Dose independent (e.g. via autoimmune mechanism):

- **Hepatitis:** (phenothiazines, tricyclics)
- **Blood dyscrasias:** (phenothiazines, tricyclics, N.B. clozapine)
- **Skin rashes:** (phenothiazines, tricyclics)

High risk situations (Pregnancy, breast feeding, the elderly and the physically ill):

Lipophilic drugs readily cross the placenta and also enter breast milk. Teratogenesis (e.g. carbamazepine) and neonatal toxicity (e.g. sedation with benzodiazepines) may occur. Whenever possible psychotropics should be avoided in early pregnancy or when there is a risk of pregnancy and many are contraindicated in late pregnancy or breast-feeding. When they are required their use should only be used under the supervision of a specialist. An evidence based approach can be aided with use of information from local Drug Information Centres or organisations such as Motherisk.

The elderly may have low body mass, reduced hepatic metabolism and a less adaptable central nervous system, rendering them prone to adverse effects (e.g. delirium). Reduced dosages are often advisable. Beware interactions with concurrent physical illness and its treatment.

Drug Groups

Psychotropic drugs can be considered in six main classes. Examples of commonly used compounds are given but the British National Formulary or Data Sheet Compendium should be consulted for dosages and more detailed information regarding adverse effects and interactions before prescribing.

Hypnotics and Anxiolytics

There is no clear distinction between hypnotics and anxiolytics. Short half-life compounds tend to be used as hypnotics because of the reduced risk of "hangover" effects. Like alcohol, they probably act on GABA receptors and, like alcohol impair ones ability to drive or operate machinery and, like alcohol, cause tolerance with physical and/or psychological dependence. It is important to understand that other than for short-term amelioration of anxiety, antidepressants are the treatment of choice for the pharmacological management of anxiety.

Benzodiazepines

Mechanism of action:

It is believed that benzodiazepines act by enhancing the action of GABA at GABA_A receptors. These receptor complexes have been identified as having specific benzodiazepine (as well as barbiturate and alcohol) binding sites on them.

Examples:

Diazepam, because of its long half-life it is used as an anxiolytic.

Temazepam has a short half-life and is used as a hypnotic.

Lorazepam and Triazolam are more potent short half-life benzodiazepines and generally should be avoided as they cause intense withdrawal phenomena and dependence. Lorazepam can be given intramuscularly and is used for rapid tranquillisation of severely disturbed patients in an in-patient setting.

Cautions:

Respiratory failure, breast feeding, previous addiction.

Adverse effects:

Drowsiness, confusion, disinhibition or aggression.

Interactions:

Potentiate other sedatives, e.g. alcohol.

Tolerance:

May develop within 3 to 14 days.

Withdrawal:

Insomnia, anxiety, sweating, tremor, perceptual disturbance, delirium and seizures. Can manifest within hours of last dose or take up to 3 weeks depending on drug half-life and may persist for months. Because of dependency and withdrawal problems current guidelines limit their use to a maximum of 2-4 weeks for severe, disabling anxiety or insomnia. Alternatives include advice about insomnia, counselling, cognitive or behavioural psychotherapy and antidepressants.

Others

Alternative hypnotics and anxiolytics are similar to benzodiazepines in terms of indications, tolerance and withdrawal but they have some different adverse effects.

Examples:

Barbiturates; these should be avoided as they are dangerous in overdose.

Chlormethiazole; causes conjunctival, nasal and gastric irritation. Its stimulant properties are addictive.

Zopiclone; short acting drug and hence used as a hypnotic. Addictive properties probably similar to benzodiazepines.

Buspirone: This drug is occasionally used as an anxiolytic. It has a totally different mechanism of action compared to all of the other drugs described above, being a 5-HT_{1A} receptor agonist. There is no evidence of addiction or abuse potential associated with its use. However it may be less potent at reducing anxiety than benzodiazepines. In addition, its therapeutic effects take 2-3 weeks to develop, rather than occurring rapidly as seen following a single dose of a benzodiazepine. Buspirone is also mildly antidepressant.

Antidepressants

It is important to remember that antidepressants do not alter normal mood. This group of drugs is effective in the treatment and prophylaxis of depressive disorders. Antidepressant action takes 2-4 weeks to develop, therefore it is important to encourage persistence. Some antidepressant may also be used to treat anxiety disorders. Whilst it is important to emphasise that they are not addictive some are very toxic in overdose and a discontinuation syndrome may occur unless a gradual withdrawal programme is used.

Tricyclics (TCAs)

This group of antidepressants used to be the main stay of treatment of depressive illness. However they are characterised by a number of drawbacks including a high rate of side effects that may lead to lowered compliance. Selection of a drug from within the class tends to be on the basis of adverse effect profile. Long half-lives allow single daily dose regime and they are often given at night when their sedative effect may be helpful. Most are too dangerous for unsupervised supply if the patient is a suicide risk.

Mechanism of action:

The therapeutic effect of TCAs derives from their ability to block the re-uptake of 5-HT and/or noradrenaline into neurones. This effect occurs after a single dose of the drug, while the therapeutic benefit takes some weeks to occur (see above). It is believed that this requires adaptive changes need to occur in various receptor systems as a result of the increased levels of 5-HT and noradrenaline. Note that some TCAs are relatively 5-HT selective (e.g. clomipramine) and some relatively noradrenaline selective (e.g. lofepramine). It is not known if sub groups of patients respond better to one type rather than another.

Examples:

Amitriptyline and Dothiepin are more sedative and used to be used particularly for agitated depression.

Imipramine is less sedative and used to be used particularly for retarded patients.

Lofepramine has less marked anticholinergic effects and is less likely to cause dangerous cardiac arrhythmia in overdose.

Clomipramine is the most serotonergic selective TCA and the only one that is effective in treating OCD. It may also be more effective than the others for treatment resistant depressed patients.

Indications:

Depressive disorders, anxiety disorders.

Cautions:

Cardiac disease, glaucoma (closed angle), prostatism, epilepsy, hepatic impairment.

Adverse effects:

Large number due to multiple pharmacological actions of the drugs:

- Muscarinic M₁ receptor antagonism - anticholinergic effects including dry mouth, blurred vision, constipation, urinary retention and impotence. Also delirium at high doses or in susceptible patients.
- Histamine H₁ receptor antagonism – sedation and weight gain.
- Adrenergic α receptor antagonism – postural hypotension.
- Direct membrane effects – reduced seizure threshold, arrhythmia.
- Serotonin 5-HT₂ receptor antagonism – weight gain (and reduced anxiety).
- 5-HT and NA reuptake blockade – mania (and antidepressant effects).

Interactions:

Hypertensive crisis with adrenaline or MAOIs.

Monoamine Oxidase Inhibitors (MAOIs)

Traditional MAOIs non-selectively and irreversibly inhibit monoamine oxidase (MAO-A and MAO-B). MAO-A metabolises noradrenaline and 5-HT, MAO-B phenylethylamine and benzylamine, while dopamine and tyramine and metabolised by either. MAOIs may have a role in atypical and treatment resistant depressions, though nowadays their use is limited due to the dietary restrictions, interactions and toxicity in overdose of this group of drugs.

Mechanism of action:

MAOIs led to increases in 5-HT and noradrenaline (and to a certain extent dopamine) due to blocking their metabolism. However, like other antidepressants, the therapeutic response is delayed and depends on neuronal adaptation to increases in monoamine levels.

Examples:

Tranylcypromine is an amphetamine analogue and is the only antidepressant that causes dependency. It is best avoided.

Phenelzine is safer because it is less stimulant.

Moclobemide is a non-traditional MAOI. It is both reversible and selective, just blocking MAO-A. As a result there is less of a problem with dietary restrictions.

Cautions:

Cardiac disease, epilepsy, hepatic impairment, ECT.

Adverse effects:

Anticholinergic effects, hypotension, oedema, fits, neuropathy, drowsiness, delirium, mania, hepatitis, leucopenia.

Interactions:

Hypertensive crisis with sympathomimetics and tricyclics due to monoamine excess, potentiates CNS depression with opiates.

Tyramine reaction: Tyramine is a naturally occurring sympathomimetic normally inactivated by MAO in the gut. Matured protein foods (e.g. cheese, meat or yeast extract, game, alcoholic or de-alcoholised drinks) are tyramine rich and therefore cause hypertensive crisis. A warning card must be given to patients on traditional MAOIs. Remember these restrictions apply for at least 2 weeks after MAOIs are stopped (the time taken for MAO to regenerate following their irreversible blockade by traditional MAOIs).

Selective Serotonin Re-uptake Inhibitors (SSRIs)

These newer antidepressants are no more effective than TCAs or MAOIs but they have relatively few adverse effects and are much safer in overdose. As a result they have become the mainstay for the treatment of depression. In addition they are effective in treating anxiety disorders, including OCD, and possibly bulimia nervosa and impulse control disorders.

Mechanism of action:

These drugs selectively block the re-uptake of 5-HT leading to neuronal adaptive processes that produce the therapeutic effect.

Examples:

Fluoxetine has a long half-life (takes 5 weeks to be excreted fully). This is a disadvantage if patients require the drug to be swapped to another, but is useful in patients who occasionally forget their medication. Also helps to prevent any discontinuation syndrome on stopping.

Paroxetine has a short half-life so its advantages and disadvantages are the converse of fluoxetine. It can still be prescribed once a day.

Citalopram is the pharmacologically cleanest drug. Its half-life is slightly longer than paroxetine.

Indications:

Depressive disorders, anxiety disorders, panic disorder, OCD, impulse control disorders.

Cautions:

Renal or hepatic impairment, pregnancy, epilepsy (though may be better than TCAs).

Adverse effects:

These can be divided into:

Short lived. Last for 3 or 4 days following institution or increases in dose. Include nausea, anorexia, and increased anxiety. It is especially important to warn patients that these drugs may transiently increase their anxiety symptoms before they improve.

Long term. Last throughout the course of treatment. Include headache, insomnia, and sexual dysfunction (delayed ejaculation, anorgasmia).

Interactions:

Toxicity with MAOIs and anti-migraine drugs such as sumatriptan.

Other antidepressants

There are an increasing number of newer antidepressants that do not fall into the categories above. They are increasing in usage and may carry some specific advantages. They include:

Reboxetine:

Selective inhibitor of noradrenaline re-uptake (NARI). May be indicated for depression with anergia, poor motivation and concentration though definitive research awaited.

Caution in renal and hepatic impairment, urinary retention and glaucoma. Adverse effects mainly "anticholinergic" (because of increased noradrenergic activity) – see under TCAs. Interacts with MAOIs

Venlafaxine:

Inhibits 5-HT and noradrenaline re-uptake (like TCAs) but doesn't have other pharmacological actions of TCAs therefore much better tolerated and much safer. Some research and a lot of anecdote that it is effective in severe and treatment resistant depression. Also effective for anxiety disorders including panic disorder and OCD

Caution if history of myocardial infarction. Adverse events essentially the same as for SSRIs. Can also cause increases in blood pressure at higher doses. Avoid use with MAOIs

Trazodone

Primary therapeutic action appears to derive from potent 5-HT₂ receptor antagonism and weak 5-HT re-uptake inhibition. Particularly used for generalised anxiety or as a non-specific sedative – it is well tolerated, non-addictive and safe in overdose. It is not infrequently added in small doses to an SSRI to help improve sleep.

Adverse effects are primarily sedation (histamine H₁ antagonism). A rare serious side effect is priapism.

Mirtazepine

Complex pharmacological actions. Its therapeutic effect is believed to derive from adrenergic α_2 receptor antagonism which leads to increased 5-HT and noradrenergic neurotransmission, since these receptors inhibit both systems. In addition: blocks 5-HT₂ receptors which helps treat anxiety; blocks 5-HT₃ receptors which helps prevent sexual dysfunction with the drug; blocks histamine H₁ receptors which produces sedation. May be of benefit in severe and treatment resistant depression due to potent effects on both 5-HT and noradrenergic systems (c.f. clomipramine and venlafaxine). Also useful where sedation is required.

Caution in epilepsy, hepatic and renal impairment, cardiac disorders, urinary retention, diabetes mellitus. Adverse effects include weight gain, sedation and rarely a reversible agranulocytosis.

Mood Stabilisers

This group of drugs' primary indication is bipolar affective disorder where they are useful for prophylaxis. There is an expanding number of drugs in this group and some may be effective in the treatment of mania and others in the treatment of depressive episodes. In addition some may be useful as adjuncts to antidepressants in resistant unipolar affective disorder.

Lithium

Lithium is an inorganic, hydrophilic substance distributed and excreted via sodium transport mechanisms. As a result changes in sodium balance may alter excretion. Its therapeutic range is very close to toxic levels and it is therefore important to check serum levels at least 3 monthly (initially weekly). Blood samples should be taken 12 hours after last dose (time for distribution of drug) and a maintenance level of between 0.4 and 1.0 millimoles per litre should be aimed for.

Mechanism of action:

It is unknown how lithium exerts its therapeutic effects. One possibility relates to its ability to block steps in the inositol phosphate second messenger system.

Indications:

The acute treatment of mania, prophylaxis of bipolar disorder and antidepressant augmentation in treatment resistant depression.

Cautions:

Renal or cardiac impairment, pregnancy, breast-feeding.

Interactions:

Diuretics, NSAIDs, ACE inhibitors (increased levels); MAOIs, carbamazepine, high dose antipsychotics.

Adverse effects:

Polyuria and polydipsia, fine tremor, gastrointestinal disturbances, oedema, weight gain, hypothyroidism and goitre, ECG changes.

Intoxication:

Rare below levels of 1.5 millimoles per litre but can occur within the therapeutic range. Anorexia, vomiting, diarrhoea, weakness, ataxia, drowsiness, confusion and coma may progress to renal and circulatory failure, convulsions and death.

Preparation for lithium:

Renal function, electrolytes, thyroid status and ECG must all be checked. Patients must know signs of intoxication and risk that a low sodium diet, dehydration or other drugs may dangerously increase levels. Initially check levels weekly. A warning card should be given.

Other Mood Stabilisers

These are all anticonvulsants. Recently there have been several new anticonvulsants introduced to treat epilepsy. Their utility in bipolar disorder is generally unknown. However it should be noted that not all anticonvulsants are mood stabilisers (for example phenytoin).

Mechanism of action: How anticonvulsants are mood stabilisers is unknown. It has been hypothesised that it relates to their ability to prevent 'kindling' the process by which epilepsy may develop. This is because the life time course of bipolar disorder is for an increase in the frequency of episodes over time.

Examples:

Carbamazepine is used at levels therapeutic in epilepsy. It is not as effective as lithium but is less toxic. Adverse effects include drowsiness or neutropenia. Interaction with lithium or MAOIs may cause neurotoxicity.

Sodium valproate may be as effective as lithium. In addition it may be better for patients who have very frequent episodes of illness (3 or 4 episodes a year or more). It may be most appropriate for patients who have a high proportion of manic episodes. Adverse effects include hepatic dysfunction, blood disorders, nausea, ataxia and tremor.

Lamotrigine has recently been shown to be helpful in depressed bipolar patients and for prophylaxis. It is associated with serious and sometimes fatal skin disorders (Stevens-Johnson syndrome) The drug needs to be introduced slowly and patients warned to look out for flu like symptoms and skin rashes. Other adverse effects include headaches, ataxia, nausea. It can alter the levels of other anticonvulsants so great care is needed if used in combination with other mood stabilisers.

Gabapentin. This drug has been increasingly used due to early reports of benefit and good tolerability. Recent research suggests it is ineffective in bipolar disorder.

Antipsychotics

These are also called neuroleptics or major tranquillisers. They are indicated in schizophrenia, mania and psychotic depression and may be useful for short-term sedation in aggression or agitation. Their antipsychotic effect may take several weeks to develop. Antipsychotics also have important prophylactic effect in schizophrenia. Generally, because of their long half-lives a single dose may be prescribed. Antipsychotics are divided into "typical" and "atypical".

Typical Antipsychotics

These drugs have been in use for around 5 decades and their introduction was a major advance in the treatment of schizophrenia.

Mechanism of action:

The therapeutic effect of typical antipsychotics depends on their ability to block dopamine D₂ receptors. Indeed the clinical dose of these drugs correlated highly with their affinity for these receptors. This is a major argument in favour of the "dopamine hypothesis" of schizophrenia. Some of these drugs are available in depot form that can be administered to patients by intramuscular injection every 1-4 weeks. This is a great advantage in-patients with poor compliance.

Cautions:

Cardiovascular and cerebrovascular disease, parkinsonism, epilepsy, pregnancy and breast feeding, renal and hepatic impairment, prostatism, glaucoma.

Adverse effects:

Pharmacologically they are similar to TCAs without significant monoamine re-uptake blockade (and so they are not antidepressant) but with dopamine antagonism (so that they are antipsychotic). As a general rule therefore their side effects are similar to TCAs. However they have important additional extrapyramidal effects (EPS) due to the dopamine antagonism in the basal ganglia:

- An immediate effect may be acute dystonia often of jaw, neck or external ocular muscles.
- After days or weeks of treatment; parkinsonism with the classical triad of akinesia, rigidity and tremor may manifest. Both of these earlier effects respond to antimuscarinic drugs (e.g. procyclidine, orphenadrine).
- Akathisia, a subjective restlessness of the legs often leading to pacing, may appear within weeks of starting treatment but does not respond to antimuscarinics.
- Tardive dyskinesia, appears later, after at least several months. It manifests in involuntary, choreiform movements mainly of mouth and face but sometimes also limbs and trunk. The condition is often irreversible despite neuroleptic withdrawal.

- Dopamine blockade in hypothalamus also leads to hyperprolactinaemia with gynaecomastia, galactorrhoea and amenorrhoea.

Other adverse effects include:

- Neuroleptic Malignant Syndrome (NMS): A rare but potentially fatal syndrome of rigidity, hyperpyrexia and clouding of consciousness. Serum creatinine phosphokinase levels are elevated. There is a higher risk in hot weather or pyrexial patients.
- Blood dyscrasias, hepatitis, skin rashes and photosensitivity

Interactions:

Increased effect of other hypotensives or sedatives.

Examples:

These drugs may be usefully grouped according to adverse effective profile:

- Sedation +++; anticholinergic ++; Extrapyramidal ++
Chlorpromazine; an aliphatic phenothiazine also a potent alpha adrenergic antagonist causing marked hypotension.
- Sedation ++; anticholinergic +++; extrapyramidal +
Thioridazine; a piperidine phenothiazine. The intrinsic anticholinergic activity of these drugs limits their extrapyramidal effects by the same mechanisms that anticholinergic medication is effective in Parkinson's disease. However thioridazine has a high risk of leading to ECG changes and in the future this may severely limit its use.
- Sedation +; anticholinergic +; extrapyramidal +++
Trifluoperazine; a piperazine phenothiazine
Haloperidol; a butyrophenone
Flupenthixol decanoate; *Fluphenazine decanoate*; depot preparations

Atypical Antipsychotics

In recent years there has been the development of several new antipsychotics. These have often been referred to as "atypical". A confusing aspect is that the word "atypical" has developed two different meanings. Some people use it to refer to drugs that have a low incidence of extrapyramidal side effects (EPS). However others use it to refer to a slightly different pharmacology of some drugs that includes a lower potency at blocking D₂ receptors but also a high potency at blocking 5-HT₂ receptors. Such drugs are 'modelled' on clozapine (see below) and have led to hypotheses that the ratio between D₂ and 5-HT₂ receptor blockade is important in the treatment of schizophrenia. All these drugs tend to be better tolerated than typical antipsychotics. However they are considerably more expensive. There is an ongoing debate about whether they should be prescribed "first line" or reserved for patients who fail to respond or do not tolerate typical antipsychotics.

Sulpiride

Substituted benzamide that is a 'clean' dopamine antagonist therefore without many of the side effects of typical antipsychotics. In addition it has low affinity for basal ganglia dopamine receptors and therefore causes less EPS (hence it's classification by some people as atypical).

Should be avoided in renal impairment. Less sedating than some typical antipsychotics, though still can be used for acute psychosis

Clozapine

Mixed 5-HT₂/D₂ antagonist. The only drug that has been conclusively shown to have higher efficacy than typical antipsychotics in regard to treatment resistant schizophrenic patients. Also some evidence that it is able to treat 'negative' symptoms. However it is associated with potentially fatal agranulocytosis. As a result it is only indicated in schizophrenia which has not responded to other antipsychotics. In addition patients MUST have regular (initially weekly) blood counts performed before being prescribed the medication.

Other adverse events include marked sedation, hypersalivation, anticholinergic effects, but less EPS than typical antipsychotics.

Risperidone, Olanzapine, Quetiapine

All different but they have varying degrees of 5-HT₂/D₂ antagonism which is believed to produce their therapeutic benefit. It remains unclear whether they have advantages over typical with regard to efficacy in the same way that clozapine does. They may have some efficacy with regard to negative symptoms.

All are associated with marked weight gain but less EPS compared to typical antipsychotics.

- Risperidone can cause EPS at higher doses. Can also cause anticholinergic effects and hyperprolactinaemia. Given once or twice a day.
- Olanzapine is reasonably sedative and so of use in agitated patients. It is contraindicated in glaucoma and should be used with caution in myeloproliferative disease.
- Quetiapine needs to be administered twice a day.

Anti-dementia drugs

Currently there are two anticholinesterase drugs available to treat Alzheimer's disease. They are believed to act by increasing levels of acetylcholine. They are effective in treating mild to moderately impaired patients and appear to slow the rate of cognitive decline, rather than reversing it.

Examples:

Donepezil, Rivastigmine.

Cautions:

Cardiac conduction problems, asthma, Chronic Obstructive Airways Disease, peptic ulceration.

Adverse effects:

Nausea, vomiting, diarrhoea, bradycardia and AV block, peptic ulceration.

Interactions:

Antiarrhythmics and beta-blockers.

Drugs used in the treatment of addictions

There are a few drugs in this class at present. They are all very different and include:

Disulfiram

An adjunct treatment for alcohol dependency along with psychological treatments. The patient must be motivated to take the drug regularly for it to be helpful.

Produces an unpleasant systemic reaction (e.g. tachycardia, palpitations, flushing and headache) if alcohol is also taken. Large dose of alcohol can produce a severe reaction that potentially can be fatal. Can cause drowsiness, nausea and vomiting.

Acamprosate

Is believed to aid abstinence in combination with counselling.

Can cause gastrointestinal disturbance. Continued alcohol consumption negates the therapeutic effect.

Bupropion

Noradrenaline and dopamine re-uptake inhibitor that is used in the USA as an antidepressant. Recently launched in the UK to aid withdrawal from smoking.

Psychological Therapies

Introduction

This section is intended to describe the general area of psychological techniques that are applied in psychiatric and general medical practice to relieve the suffering of the patient. The subject is an important one, but is often confused by a plethora of terms, some of which may have different meanings in different settings. Thus, words like "counselling" or "psychotherapy" can be used to refer to all forms of psychological intervention. However, counselling also refers to a specific form of "client centred" treatment devised by Carl Rogers and psychotherapy is often taken to be synonymous with forms of treatment derived from psychoanalytic models of understanding human behaviour. Knowledge of the precise meanings of such terms is less important than an understanding of the principles involved. It is the latter which forms the aim of this section, so that students may have guidelines for rational decision making regarding the appropriateness of particular forms of treatment for patients.

There are several features that are common to all forms of psychological therapy:

- An intense confiding relationship
- They take place in a healing setting (surgery, clinic, community mental health centre)
- They are founded on rationales of therapy (model of understanding normal/abnormal behaviour or states of mind)
- They involve a therapeutic procedure.

Good therapists share several characteristics, most of which have to be developed through practise and training.

- Accurate empathy refers to the therapist's ability to perceive what the patient is experiencing.
- Positive regard is the attitude of respect to the patient as a person, which underlies a good therapeutic relationship.

These qualities are also important for the development of good doctor/patient relationships in all settings.

Broad "Types" of Therapy

The therapeutic approaches which are discussed in this section can all be used in a variety of different settings.

Individual Therapy

In this situation the therapy is used by one therapist with one individual patient.

Couple Therapy

The techniques are applied to both partners in a relationship, usually a marriage with either one or two therapists. In psychosexual therapy the methods used may include combination of therapeutic techniques directed towards the resolution of a sexual problem within the relationship.

Family Therapy

A group of family members comprising one or more generations of the same family are treated by one or more therapists.

Group Therapy

Typically, around eight individuals who are previously unknown to each other meet together with one or more therapists. Examples include anxiety management groups and social skills groups, where combinations of cognitive and behavioural techniques especially modelling, are used to treat specific problems which are experienced by all group members. Dynamic

psychotherapy can be practised in a group setting where the presence of greater numbers of individuals allows a wider variety of transference relationships to develop. Self-help groups are frequently an important part of the approaches used by voluntary organisations and these may enlist any of the techniques and approaches outlined above, but will particularly focus upon supportive techniques.

Patient Selection

There are no hard and fast rules governing suitability of patients for particular therapeutic techniques. The clinical indications given above, are broad outlines. The basic principles of selection are:

- Patients who are vulnerable to psychotic breakdown are unsuited to the non-directive approaches
- Patients who have little capacity of making and sustaining relationships are less well suited.
- Patients who are less verbally able are also relatively unsuited to non-directive approaches.

For such individuals supportive techniques may be most appropriate and they may occasionally benefit from a structured directive therapy involving behaviour and possibly cognitive techniques.

Supportive Psychotherapy

Characteristics

This is a widely used approach used by many different health professionals in both mental and physical health settings. It is used to facilitate optimal adjustment, either to situations of ongoing stress, such as in chronic mental or physical illness, or in acutely stressful situations such as following bereavement. Supportive psychotherapy may consist of a large number of brief contacts over a long period of time or of a few extended sessions during a brief period.

Key Elements

Careful listening including encouragement of the expression of emotional material (ventilation).

Explanation/education to increase the patient's understanding of their situation coupled with appropriate reassurance may boost self-confidence and hope.

Guidance involves giving advice usually with reference to a specific problem, such as when to seek help.

Client Centred Counselling

Characteristics

Client centred psychotherapy is frequently used by social workers and pastoral counsellors. There are no specific indications for the use of this approach in clinical settings. It is most often used to enable the patient or client to achieve greater levels of self-acceptance and personal growth.

Key Elements

Client centred psychotherapy is non-directive - that is the therapist's role is to listen whilst the client ventilates his/her feelings and describes their current problems. The therapist helps the client to clarify the major issues but leaves decisions to the client and withholds giving advice or interpretations. A major task for the therapist is to demonstrate their acceptance of the client through empathy, warmth and genuineness. The underlying philosophy of client centred therapy is that the solutions to problems lies within the client and through the therapeutic relationship, discussion of problems can lead to self-actualisation - that is an enhanced sense of self-confidence and acceptance.

Behavioural Therapy

Characteristics

Behaviour Therapy is a term used to describe a number of techniques which are based upon learning theory and which specifically focus upon changing symptoms or unwanted behaviours. Behaviour modification refers to a particular group of techniques based upon operant conditioning and behavioural psychotherapy generally refers to all other forms of behavioural treatment.

Behaviour therapies are most frequently encountered in mental health settings where clinical psychologists, psychiatrists and psychiatric nurses practise them. Behavioural psychotherapy is generally used in a highly structured short-term treatment to correct neurotic symptoms such as phobic anxiety and panic attacks. Behaviour modification is often used in institutional settings such as units dealing with people who have chronic mental health problems. Patients with disorders such as chronic schizophrenia and learning difficulties to correct problems such as lack of motivation or repeated self-damaging behaviours.

Key Elements

Desensitisation

This involves exposure to fear or anxiety provoking situations. In this approach the patient is taught to use relaxation as a substitute for the fear response. Patients progress through a hierarchy of situations beginning with those that evoke little fear and ending with the most difficult situations. This approach has been particularly useful for the treatment of agoraphobia. Its principles are also in common parlance where people are advised to get back "behind the wheel" or "into the saddle" after accidents.

Response prevention

This is a modification of desensitisation used in the treatment of compulsive rituals. Patients are exposed to situations of increasing anxiety provocation in which they would normally neutralise the anxiety by performance of a ritual. The patient is instead persuaded to refrain from performing the ritual and, with repeated exposure, the distress provoked by resisting the ritual is diminished.

Modelling

Modelling is an aspect of social learning theory that is used in group approaches designed to overcome deficits in skills such as assertiveness or social skills.

In behaviour modification the therapist's role is to produce a detailed behavioural analysis of the patient's problem behaviour by observing and describing the Antecedents to the behaviour, the Behaviour itself and the Consequences of the behaviour (the ABC approach). The aim is to identify the pattern of reinforcement which maintains the problem behaviour and with this information change the pattern of rewards and reinforcements so that the behaviour is less likely to occur and a substitute behaviour more likely.

Further details of this form of psychotherapy are contained in a more comprehensive section (Behavioural Psychotherapy).

Cognitive Behavioural Therapy

Characteristics

Recent years have seen an increased interest in the use of cognitive techniques. The therapy was begun by Beck in the 1960's. Such approaches have been shown to be effective in the treatment of major depressive disorder, generalised anxiety, panic, obsessive compulsive disorder and eating disorders, especially bulimia nervosa. It has also been shown to be useful in the treatment of psychosis, personality disorders and in-patients suffering from ill health (such as chronic pain and cancer). Despite its effectiveness, the provision of service remains patchy around the country and it is often only contracted for short-term work, precluding its use with psychotic and personality-disordered patients. It is a brief problem-focused therapy.

Courses of treatment are typically around 8-12 sessions in duration, with an emphasis on homework tasks to be performed between therapy sessions.

Key Elements

Cognitive techniques are derived from the cognitive model of psychiatric disorders, which emphasises the role that a person's evaluation of events has in determining their emotional and behavioural reactions. Events may be external, such as losing a job ("I'm no good," "I'm all washed up," "it's not fair, the world is a terrible place," "I'll never find another job") or internal, such as a pain in the leg ("this could be cancer," "I'll be crippled with arthritis"). These thoughts, which evaluate an experience, are known as cognitions. Cognitions may also include distressing images such as themselves deformed or in pain, or sitting on the settee watching daytime TV!

Cognitions result from events activating schemata (core beliefs and assumptions with which a person shapes their understanding of and attitude to the world - basically using past experience to rapidly understand their environment). In depression for example, events may lead them to draw negatively distorted conclusions about themselves, the world and the future (the negative cognitive triad). This is illustrated in the example above. Such cognitions (or Negative Automatic Thoughts, as they are sometimes called) would lead to unpleasant emotions such as sadness, hopelessness, depression and unhelpful behaviours such as withdrawal, inactivity, suicidality etc., which serve to reinforce such evaluations.

Dysfunctional schemata are typically rigid and unrealistic:

- "I must succeed in everything I do"
- "If I ask for help then I am a failure"
- "I can only be happy if other people love me"

Cognitive therapy is a collaborative approach; that is the therapist does not direct the patient to do certain things or persuade them to change their views. Rather, working together, therapist and patient select the best approach for a particular problem. The therapist helps the patient to recognise their unhelpful or dysfunctional thoughts and to seek alternative interpretations. Behavioural techniques may be incorporated in order to generate new experiences that may test the validity of the patient's thoughts.

Psychodynamic Psychotherapy

Characteristics

In the NHS psychodynamic psychotherapy is practised by psychiatrists, psychologists, social workers and other professionals who have received additional specialised training in these techniques. Many practitioners have themselves undergone a period of personal psychotherapy as a component of their training. It is used to treat neurotic symptomatology and milder forms of personality disorder, especially where the patient has recurring problems in maintaining appropriate adult relationships.

Long-term dynamic psychotherapy aims to bring about extensive change in several aspects of a person's functioning. It is a prolonged treatment typically comprising of hourly meetings every week for periods of time up to three years.

Short-term or focal dynamic psychotherapy is a modification of the approach in which attention is focused on only one area of the person's experience. This shortens the amount of time required and usually this form of treatment requires between 10 and 20 sessions.

Key Elements

In the early stages of treatment by dynamic psychotherapy, the therapist's role is to establish the *therapeutic relationship* in which an atmosphere of trust and acceptance is created allowing the patient to disclose intimate information about themselves. As the patient explores the hidden facets of him/herself links between current experience and events in the past are made so allowing the patient to gain insight.

Of particular interest are the thoughts, feelings and behaviours which arose in important relationships in the patient's past, especially towards his/her parents. During the course of dynamic psychotherapy, such thoughts, feelings and behaviours may become transferred onto the therapeutic relationship and re-experienced in the course of therapy. The interpretation of this *transference* is an important task of the therapist. It may also be important for the therapist to interpret the mental tricks of *defences* that the patient habitually uses to protect them from the effects of powerful and pleasant feelings. The automatic or unconscious use of such defences is universal, but the overuse of certain mental defence mechanisms may be a component of the psychopathology that the patient presents for treatment.

For further information about this form of therapy, please refer to the handout "Psychodynamic Psychotherapy".

Crisis Intervention

Characteristics

A crisis occurs when an individual is confronted by events that he or she does not have the resources to cope with. The crisis may be precipitated by events that bring about sudden change in the person's environment, e.g. bereavement, redundancy, or childbirth. The crisis will evoke anxiety in the individual that he/she will attempt to control by use of their usual coping mechanisms. If these fail the person may devise new strategies to try and cope, but if these too are ineffective the person's state of anxiety increases with deterioration in their morale. They may well, at that point, utilise maladaptive coping strategies, such as substance abuse, deliberate self-harm or violent behaviour which may themselves bring the person to the attention of the helping professions (especially general practitioners, casualty departments, psychiatrists, social workers). Further escalation of anxiety leads to a state of *decompensation* in which normal psychological functioning breaks down.

Crisis therapy aims to intervene as soon as possible after the onset of the crisis and certainly no later than six weeks after its onset, in order to enable the individual to overcome the crisis, minimise the usage of maladaptive coping strategies and avoid complete psychological breakdown. It is a short-term intervention, which may require intensive involvement of the therapist with the patient and perhaps members of their family.

Key Elements

The earliest stages of crisis therapy are concerned with the clarification of the patient's problem, as well as the ventilation of their emotions.

Alternative problem-solving strategies are generated and their potential consequences discussed.

More adaptive methods of coping are identified and their implementation encouraged.

Research & Development

Several conclusions may be drawn from research into the efficacy of psychological approaches:

Non-directive techniques such as dynamic psychotherapy and client centred counselling, lead to improvements in social adjustment and interpersonal functioning. They appear to bring about rather less in the ways of specific symptom reduction.

Behavioural and cognitive approaches produce greater levels of symptomatic recovery, e.g. reduced severity of panic attacks. There is a possibility that cognitive therapy reduces relapse rate in depressive disorder and panic disorder.

Simultaneous treatment with physical approaches (medication) and psychological treatment may have greater benefits than either treatment given alone.

Psychological therapies are continually being developed and refined. For example, although it is currently held that psychotically ill patients should not be treated by psychodynamic or cognitive approaches, there are researchers who are beginning to apply experimental

techniques to these disorders. In addition research is being carried out to determine what the therapeutic ingredients are in each psychological therapy in the hope that stripping them down to their "bare essentials" may result in the development of briefer techniques. They may have wider applicability, particularly in situations where resources of time or expertise are less available, such as in non-psychiatric settings.

Mental Health Act (1983)

Introduction

To what extent should a person suffering mental disorder be held responsible for their behaviour (e.g. is it fair to punish a man who smashes a window in response to "voices")? If they are not fully responsible then should their freedom be limited "for their own good" (i.e. should the same man be taken to hospital against his will)? The law must provide practical responses to this type of question.

Legal Definition of Mental Disorder

The importance of such a definition is that it protects people regarded as "odd" or a "nuisance" from inappropriate compulsion. Persons cannot be considered mentally disordered simply on grounds of "immoral conduct, sexual deviancy or dependence on alcohol or drugs". It is important to remember that psychiatric diagnoses do not necessarily correspond to legal definitions!

Mental Disorder

In the Act this is defined as; "Mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind." It is a deliberately broad definition and when applied results in the liability of an individual to compulsory admission for up to 28 days.

There are four *legal* subtypes of mental disorder:

- **Mental Impairment** - "a state of arrested or incomplete development of mind resulting in significant impairment of intelligence and social functioning and associated with abnormally aggressive or seriously irresponsible conduct."
- **Psychopathic Disorder** - "a persistent disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct."
- **Severe Mental Impairment** - this has the same definition as for mental impairment but with "severe impairment of intelligence etc."
- **Mental Illness** - this is not specifically defined in the Act but left up to doctors

Mental Impairment and Psychopathic Disorder result in liability to compulsory admission for over 28 days **only** if treatment is likely to "alleviate or prevent a deterioration" in the condition.

Severe Mental Impairment and Mental Illness result in liability to prolonged compulsory admission regardless of likely outcome.

Compulsory Admission to Hospital

In the UK only about 5% of psychiatric patients are detained, 95% are "informal" so the vast majority of inpatient psychiatric treatment is not done under the auspices of the Mental Health Act. There are 8 procedures usually known by the Section of the Act in which they are found (hence the verb "to section"). Application forms for the compulsory admission or treatment of a patient must be completed by nearest relative or more commonly an "approved" Social Worker (ASW - appointed by the local authority). Recommendation forms must be completed by medical practitioner(s) and must state two grounds for compulsion.

- Patient is suffering from a mental disorder of appropriate severity.
- And compulsion is needed for this patient's health, safety or for the protection of other persons.

When two recommendations are needed at least one doctor should be:

- "approved" by the regional health authority as having special experience in mental disorder (usually a consultant or specialist registrar in psychiatry).
- at least one doctor (often their GP) should have previously known patient (this is not always possible).
- at least one doctor should be independent of the admitting hospital.

Patients have the right to appeal to Mental Health Review Tribunals on Sections lasting over 72 hours. Patients also have the right to appeal to the Hospital Managers, a misleading term for members of the Trust Board and associate members appointed for the purpose of reviewing compulsory detention. They may appeal at any time. Patients detained under Section 3 of the Mental Health Act may only appeal to the Mental Health Review Tribunal on one occasion during any period of detention. There is no limit set by statute on the number of appeals that may be made to the Hospital Managers. The Managers should conduct a review when asked by the patient unless they have done so recently and there is no evidence of change.

The Sections

Section	Grounds	Requires	Duration
"2" Assessment	Mental disorder "warranting admission" and patient requiring detention for "own health or safety or protection of others"	1 application and 2 medical recommendations.	Up to 28 days.
"3" Treatment	As Section 2 but applies only to mental illness, severe mental impairment, mental impairment or psychopathic disorder. For the latter two, treatment must be likely to help.	1 application and 2 medical recommendations.	Up to 6 months (third consecutive detention lasts up to one year).
"4" Emergency Assessment	As Section 2 but need for emergency admission before an assessment for Section 2 or 3 could be completed.	1 application and 1 medical recommendation.	Up to 72 hours if a Section 2 is being arranged.
"5(2)" Doctors' Holding Power	A patient previously admitted informally demands to leave and grounds for Section 2 apply.	Report by the responsible consultant (or nominated deputy) on an inpatient (includes general medical patients).	Up to 72 hours while further section is arranged.
"5(4)" Nurses' Holding Power	As section 5(2) but no doctor is available.	A report from qualified psychiatric nurse.	Up to 6 hours.
Guardianship ("7 & 8")	Mental illness, mental impairment, severe mental impairment or psychopathic disorder. Guardianship is necessary for welfare of patient or protection of others.	1 application, 2 recommendations and a named guardian.	Up to 6 months. The Guardian can require a patient to live at a specified place and to attend for treatment (but can't force them to take treatment).
"135" Warrant to Search For and Remove Patients	There is reason to believe a person with mental disorder is suffering neglect or ill treatment in private premises.	Warrant from magistrate.	Police accompanied by a doctor and ASW may enter the premises by force. The person may be removed to a "place of safety" (hospital or police station) for up to 72 hours.

Sections (cont.)

Section	Grounds	Requires	Duration
"136" Police Powers	Person in a public place appears to Police to be suffering from mental disorder and in immediate need of care and control.		Removal to "place of safety" for up to 72 hours.

Patients Involved in Criminal Proceedings

The Mental Health Act allows courts to deal with mentally disordered offenders. Whilst court sections require medical recommendations the decision as to whether the prisoner "deserves" punishment or treatment is for the court.

There are seven court sections: the two most important examples are:

- **Section 37:** This allows a person convicted of an imprisonable offence to be detained and treated in hospital. The patient is discharged when well regardless of the length of prison sentence they may have been given if they had not been detained in hospital.
- **Section 41:** This restricts discharge of "dangerous" patients detained under section 37 by requiring permission from the Home Secretary.

Some criminal law also involves psychiatric reports, for example the verdict of "not guilty by reason of insanity" or "unfit to plead" (person too mentally disordered to know right from wrong) results in the individuals detention as if under Section 37 with Section 41 restrictions. The verdict of "Diminished responsibility" can reduce a murder verdict to one of manslaughter.

Consent to Treatment

"Informal" patients cannot be treated for a psychiatric disorder without informed consent.

Patients detained under Sections 4, 5(2), 135, 136 (72 hour sections) and guardianship cannot be treated without informed consent.

Patients detained under Sections 2, 3, and 37 may be given some treatments without consent under the following conditions:

General treatments

There are no conditions applied here. Nursing care, occupational therapy etc. must be given to any of the specified detained patients without consent.

Medication and ECT

Consent or a second opinion (Section 58) are required. To be given ECT or prolonged medication, i.e. for more than 3 months, either the patient must give consent certified valid by the consultant (remember their wish to leave hospital is considered invalid!) or agreement to the treatment plan must be obtained from a doctor appointed by the Mental Health Act Commission.

Urgent treatment

(Section 62) If urgent, a course of ECT may be started with a detained patient while waiting for the second opinion.

Psychosurgery and hormone implants

Consent **and** a second opinion (Section 57) are required. For these treatments the second opinion appointed doctor must agree with the plan and the patient must give consent which is considered valid by a three person panel.

Consent to general medical treatment

The MHA applies only to treatment of mental disorder and **cannot** be used in treatment of physical conditions. Unconscious patients are treated under authority of Common Law which recognises a duty to save life *etc.* (Doctrine of Necessity). Restraint of a potentially violent or suicidal informal patient, whether in a general medical or a psychiatric ward, would be justified on the same basis.

Mental Health Act Commission & Patients Rights**Mental Health Act Commission.**

The Mental Health Act Commission (MHAC) consists of 90 psychiatrists, lawyers, psychologists, nurses, social workers and laypersons. It is directly responsible to the Secretary of State and has a statutory role to:

- Provide independent second opinions on consent to treatment.
- Protect the rights of detained patients through regular hospital visits and investigating complaints.

The MHAC has published a "Code of Practice" outlining good practice in the application of the MHA and other aspects of mental health care.

Patients Rights.

Under the MHA patients have their rights defined. Some of these are:

- Detained patients must be informed of their right to appeal.
- Health Authorities and Social Services have a duty to provide aftercare to patients discharged from Sections 3 or 37. A Section 117 meeting should be convened with all those professionals present who will be involved in treatment after discharge.
- Informal patients in psychiatric hospitals retain the right to vote.
- Mail to or from any patient may not be withheld except under special circumstances.
- All patients, formal or informal, retain the right to manage their financial affairs *etc.*

If a patient at home or in hospital seems incapable of running their affairs these can be taken over by "the Court of Protection" especially set up for this purpose.

Appendices

Glossary

Addiction - a stage, psychic and sometimes physical, resulting from interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. (W.H.O. 1969).

Affect - expression of an experience of an emotion.

- **Blunting of affect** - an objective absence of normal emotional responses, without evidence of depression or psychomotor retardation.
- **Loss of affect** - a purely subjective sense of an ability to feel deeply about anything or anyone.
- **Incongruity of affect** - Emotional responses which seem grossly out of tune with the situation or subject being discussed.

Agitation - a state of motor restlessness with a background of anxiety, especially seen in depression. A high level of activity or excitement may be seen in mania but anxiety usually not a feature.

Amnesia - loss or impairment of memory, whether psychogenic or due to cerebral disturbance.

Anxiety - a state consisting of psychic (dread, apprehension, fear) and somatic symptoms (palpitations, tremor, dry mouth, loose stools).

Apathy - emotional indifference and lack of activity, often associated with a sense of futility.

Autism - a form of thinking in which the individual withdraws from the real world to a private world of his own. This monopolises his interest and attention, objectivity is lacking and there is a complete disregard of reality. It serves to gratify unfulfilled desires and takes the form of daydreams, fantasies and delusions.

Catalepsy - the patient maintains a fixed posture that can be changed by the examiner without any resistance unlike waxy flexibility (see below).

Catatonia - a state of excited or inhibited motor activity in the absence of a mood disorder or neurological disease. It includes a number of other terms:

Circumstantiality - irrelevant wandering in conversation. Talking at great length around the point.

Compulsion - repetitive, apparently purposeful behaviour performed in a stereotyped way accompanied by a subjective sense that it must be carried out despite the recognition of its senselessness and often resistance by the patient. Recognised as morbid by the affected individual. Often associated with an obsession.

Confabulation - giving a false account to fill a gap in memory.

Conversion - Unconscious mechanism of symptom formation that operates in conversion disorders or is the transposition of a psychological conflict into somatic symptoms.

Defence Mechanism - a way of dealing with aspects of the self, which, if consciously experienced, might give rise to unbearable anxiety or psychic pain.

Déjà vu - an individual develops an intense feeling of having 'been here before'.

Delirium (a.k.a. acute confusional state) - a syndrome due to brain disturbance and characterised by impairment of consciousness. The mood is commonly one of terror and bewilderment, accompanied by transient delusions and hallucinatory experiences. Afterwards there is more or less complete amnesia for external events that occurred during the period of illness.

Delusions - false beliefs that persist in spite of incontrovertible evidence to the contrary and which are out of harmony with the individual's cultural and religious background.

- **Primary delusions** - arise 'out of the blue'
 - Sudden Delusional (Autochthonous) Ideas** - delusional ideas suddenly entering consciousness like a 'brainwave', unrelated to previous real or psychic events.
 - Delusional Perception** - a normal perception is suddenly interpreted in a delusional manner - one of Schneider's first rank symptoms of schizophrenia.
 - Delusional Mood** - a state of perplexity in which the patient has some sense of some inexplicable change in his environment. He senses 'something going on' which he cannot identify, but which has a peculiar significance for him.
- **Secondary delusions** - these arise from a 'morbid' experience such as an hallucination.

Depersonalisation - a feeling of some change in the self, associated with a sense of detachment from one's own body. Perception fails to awaken a feeling of reality, actions seem mechanical and the patient feels like an apathetic spectator of his own activities.

Depression - a subjective feeling of sadness, grief or dejection. The word is used to describe a symptom and also is a diagnostic label.

Derealisation - a sense of one's surroundings lacking reality, often appearing dull, grey and lifeless.

Denial - the person refuses to recognise the reality of a traumatic perception.

Disorders of Form of Thinking (Formal Thought Disorder) - there is a lack of logical association between succeeding thoughts. It gives rise to incoherent speech (in the absence of brain pathology). It is impossible to follow the patient's train of thought (c.f. loosening of associations; knight's move thinking).

Dyskinesia - a wide variety of movement patterns e.g. choreoathetosis, rocking, pouting, with a wide range of causes such as drugs, schizophrenia, structural brain disease.

Emotional Lability - a fluctuation of emotions more marked and intense than the existing circumstances might be expected to produce.

Flight of Ideas - rapid skipping from one thought to distantly related ideas, the relation often being so tentative as for instance the sound (rhyming) of different utterances.

Hallucination - a perception, indistinguishable from reality, occurring in the absence of an external stimulus.

- **Hypnagogic hallucination** - an hallucination occurring on falling asleep.
- **Hypnopompic hallucination** - an hallucination occurring on waking up.

Ideas of Reference - incorrect interpretation of remarks, incidents and external events as referring directly to oneself. May be of delusional intensity when it becomes known as a **Delusion of Reference**.

Illusion - misperception of a stimulus, usually occurring at times of environmental or personal dulling e.g. at night; when suffering a serious infection.

Insight - four facets, are;

- morbid experiences seen as abnormal
- as the result of illness
- as the result of a mental illness
- open to medical intervention.

Jamais vu - the feelings of strangeness in familiar surroundings as though one had never been there before.

Malingering - the *conscious* mimicry of physical disease to achieve some material gain.

Mannerism - a sometimes bizarre elaboration of normal activities.

Mood - pervasive and sustained emotion in the continuum between sad and happy.

Mutism - may be elective or involuntary; like slowing it is a feature of retardation and shares its causes, or may result from schizophrenia, hysteria or be behavioural (e.g. elective in children).

Neologism - a word holding no generally recognisable meaning, either completely new in form, or the condensation of pre-existing words e.g. 'conterbole' (meaning a difficult question) and found mainly in schizophrenia and structural brain disease.

Obsession - a recurrent persistent thought, image, or impulse that enters consciousness unbidden, is recognised as being one's own and often remains despite efforts to resist.

Obsessive Compulsive Disorder (OCD) - an illness characterised by the presence of obsessions and/or compulsions.

Overvalued Idea - an idea that takes disproportionate precedence in the individual's mind despite its often trivial content. It is firmly held but may be swayed with considerable effort.

Passivity phenomena - subjective experience that one's actions and/or thoughts are being controlled by some outside agency. Found in schizophrenia.

Perseveration - repetition of a word, theme or action beyond that point at which it was relevant and appropriate.

Phobia - an irrational, disproportionate fear of an object or situation leading to avoidance behaviour.

Pressure of speech - is manifest in a very rapid rate of delivery, a wealth of associations, which may be quite unusual, (e.g. rhymes and puns) and often wanders off the point of the original conversation. This is highly suggestive of mania.

Psychomotor Retardation - slowing of thoughts and movements, to a variable degree. Occurs in depression but other causes include psychotropics, Parkinson's disease *etc.*

Psychotic - this term causes confusion, because it is used in two different senses. In the past it was used to describe *illnesses* that are severe (e.g. dementia, schizophrenia and severe mood disorder). The other usage, which is more accepted nowadays, is referring to *symptoms* (hallucinations and delusions) that are qualitatively different to normal experience as opposed to quantitatively different (e.g. anxiety, depression).

Stereotypies - uniform, repetitive non goal-directed actions (may take a variety of forms from simple movement to an utterance. Usually ascribed to schizophrenia but may be due to an organic disorder.

Stupor (Akinetic Autism) - more or less complete loss of activity with no response to stimuli; may mark a progression of motor retardation; found in a wide range of neurological and psychiatric conditions.

Thought Broadcasting - the experience of thoughts escaping from the boundaries of the self and being known to others, even strangers or people some distance away.

Thought Alienation - the collective grouping for thought insertion, withdrawal and broadcasting

Thought Block - an objective phenomenon in which the patient abruptly breaks off his conversation and is silent for a few seconds and then resumes on a different topic. Subjectively they experience a complete cessation of all thought.

Thought Echo - a form of auditory hallucination in which the patient hears his thoughts spoken aloud, either simultaneous with him thinking it or a moment or two afterwards.

Thought Insertion - the subjective feeling that thoughts in one's mind are not one's own, often explained by a secondary delusion of insertion by some outside agency.

Thought Withdrawal - the subjective feeling that thoughts are missing from one's mind, often explained by a secondary delusion of extraction by some outside agency

Reading List

- Essential Reading** 'Departmental handouts'
'Lecture Notes on Psychiatry', Harrison, Geddes & Sharpe; 8th edition 1998
'Psychiatry: An Oxford Core Text'; Gelder et al 2nd edition 1998
- Further Reading** 'Oxford Textbook of Psychiatry'; Gelder, 3rd edition 1996
'Companion to Psychiatric Studies'; Johnstone et al 6th edition 1998
'Textbook of Psychiatry'; Puri, Laking & Trasanden 1996
'Essential Psychiatry'; Rose 2nd edition 1994
'Psychiatry'; Sims & Owens 6th edition 1993