PSYCHIATRY DEMYSTIFIED

A HANDBOOK ON

MENTAL HEALTH PROBLEMS

IN PLAIN ENGLISH

Dr PRASANNA N DE SILVA

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Introduction

I wrote this book having spoken to carers of some of my patients. Their common concern was the lack of usable information on psychiatric illnesses, especially requirements for a diagnosis and the logic behind various treatments on offer. They often had difficulties with the leaflets we provided them with, in that the information was superficial on diagnosis, treatments and risks. They also expressed concern about doctors (I suspect including myself) who had difficulty explaining in layman's terms the features of a particular psychiatric condition and the basis for various treatments.

In medical school, doctors are trained to assess a patient and give feedback to senior doctors in technical and academic language. Unfortunately, less training is provided for medical students in speaking to relatives and support staff. As a medical teacher, I am involved in observing consultations between doctors and carers. I have been struck on a number of occasions by the obvious power difference between these two groups in terms of available knowledge, including knowledge of effective treatments. I believe there has to be more equity between doctors and carers, so that the best package of treatment can be delivered to a patient.

By definition, mental health carers not only include family and friends, but also non specialist professional staff, such as general practitioners, health visitors, home helps, police and housing benefits staff. Improving awareness among these groups is essential to deliver a high quality, seamless service for people with mental illness.

I approached a family friend, Dr. Bert Cargill, who is a layman in terms of mental health. He offered to be my editor, with responsibility for removing jargon from my text. We decided that each chapter would be limited to a maximum of 2500 words. I am extremely grateful to Bert, who has not only discharged his responsibilities fully but also maintained my motivation to continue with this book. I am indebted to my secretaries, Lillian Atkinson, Helen Clarke and Connie Bellamy who have faithfully typed and retyped the script.

I have not been able to cover all mental health problems, for example, difficulties affecting children, due to reasons of brevity and lack of specialist knowledge. In turn, I have included medical problems, like strokes and cancer, which have undisputed psychological manifestations and consequences.

In conclusion, I have selected a few findings about carers, compiled by Scarborough and Ryedale Carers' Resource (tel. 01751 473727), kindly supplied to me by Liz Brown, the co-ordinator for carers with mentally ill relatives. I suspect some of these facts would also apply to healthcare assistants, who are an increasing body of formal carers in the mental health field.

- More than 9 out of 10 mental health carers want contact with professionals within the mental health sector but less than half achieve this. (*Our Point of View*, Rethink Survey of 1400 carers, 2003)

- Less than a quarter of the carers who took part in the survey said professionals always valued their skills and help, and more than half did not know what level of care was in place for the person they care for. (*Our Point of View*, Rethink Survey of 1400 carers, 2003)

- In a PRTC survey mental health carers were least likely to be directed to sources of information and support, and 47% of mental health carers in the survey had not been directed to sources of help. (p12, *Carers Speak Out Project*, Princess Royal Trust for Carers, 2002)

- "90% of new carers of people with a mental illness….did not receive information about contacting [SSD] when they first became a carer." (p13, *Carers Speak Out Project*, Princess Royal Trust for Carers, 2002)

- 29% of young carers care for someone with mental health problems. (*Young Carers - the facts*, Young Carers Research Group, 1995)

- At any one time up to 17,000 young people will be looking after a parent who has a mental illness. (from a 2 year study by Loughborough University Young Carers Research Group and Rethink, 2003)

- The value of care provided by friends and relatives of people with mental health problems is estimated to be £3.9 billion. (Press release from Sainsbury Centre for Mental Health re new research carried out by the centre, June 2003)

Dr. Prasanna de Silva (October 2011)

HELPING A SUICIDAL PERSON AND HIS FAMILY

Jargon-free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- First Aid
- Access to Mental Health Services
- Suicide Prevention
- Aftercare following suicide

Helping a Suicidal Person and his Family

Suicide is a relatively rare occurrence, with around 1000 deaths per year in the UK. For every completed suicide there are around 1000 acts mimicking suicide, which do not end in death but need hospital treatment. In fact, suicidal acts count for about a fifth of all hospital admissions, usually involving one or two days. However, suicide is commoner than deaths due to road traffic accidents, and the rate of suicide among young men is rising rapidly, especially in the north of the country, in particular Scotland.

Despite suicide being uncommon, the distress involves a large number of people, including immediate family, medical staff and mental health staff. Often police have to recover bodies and break the news to family members. Other professions can get involved, for example train drivers and firemen, in terms of witnessing a suicide or recovering bodies. Usually there is a Coroner's enquiry, often many months after the suicide, which further rekindles grief and other emotions for all concerned. In the past, suicide was seen as a criminal act and a person committing suicide was not buried within church precincts. However, these attitudes have changed over the last 50 years, although ambiguity remains among both secular and religious people about the ethics of suicide.

First Aid when Suicide is contemplated

It is often assumed by the lay public that talking about suicide can worsen the risk of its completion in predisposed people, because of "planting the thought in their minds". However, this is definitely not the case. Allowing the person to talk about suicide, including the reasons for committing suicide and plans for it, does not increase the risk of suicide occurring. There is some evidence that the rate of suicide can be reduced if, following discussion, verifiable plans of harm avoidance can be agreed and put into place. These include keeping potentially harmful items such as shotguns, ropes and medication out of the way and achieving a network of support which sees the person on a regular basis during the next few weeks.

When suicidal intentions are made known, it is helpful to make the person's social and family contacts aware of it so that further discussion is facilitated and access to medical and mental health staff is possible. Through this process, the person realises that he or she is supported by a number of people with the opportunity of discussing real life difficulties, which have led to thinking about suicide. These difficulties can include severe financial and employment

difficulties, relationship difficulties, substance abuse (especially alcohol), and various losses, with which they have not fully come to terms.

In young men, work and relationship difficulties coupled with alcohol misuse appear to be the biggest predictors of suicide. In older people where the rate of suicide is much higher, previous depression, recent bereavements and current physical disabilities or pain appear to be the highest risk factors. In the case of people attending medical services, either considering or having actually carried out self-harm, a history of previous psychiatric contact, especially inpatient psychiatric contact, predicts completed suicide over the next year. Consequently these factors need to be noted and discussed with the person in order to facilitate a referral to mental health services. Effective treatment for both physical and mental illness reduces the risk of completed suicide.

Access to Mental Health Services

The simplest method of accessing mental health services would be for the person to attend either the A&E department at the local district hospital or the out of hours GP co-operative service which is increasingly being provided on a 24 hour basis in medium to large towns. However, if access to the person's immediate GP is possible at short notice, this is the preferred route as the GP will be aware of previous mental health problems, physical problems and family history. Some areas have ready access to Samaritans or some form of Crisis Call service, which is accessed by telephone. They would then either contact the person or visit the person, with access to mental health being provided thereafter. The police services are increasingly aware of people with suicidal intention presenting to them and have relatively easy access to general practice and mental health services. Some psychiatric hospitals have a service for "walk in" patients, where a junior psychiatrist may see them on site. Therefore, access to mental health services can vary from place to place. It is helpful to be aware beforehand how to access mental health services.

Prevention of Suicide

From a mental health perspective, active treatment of mental illness, including maintenance of compliance in the long term, helps prevent suicide. This applies to both depression and psychotic illness. Sometimes mental health staff discuss the damaging effects of completed suicide with a suicidal person and their family. These include talking about the distressed families, especially in the context of a police investigation and Coroner's hearing. Also, mental health staff sometimes talk about the failure rate when attempting suicide in order to plant a seed of doubt in the person's mind whether they will be successful in carrying out this act. However, randomised trials have not shown that these techniques are effective and are very much a decision for an individual practitioner in the context of a particular patient, who appears to be receptive to these ideas. It is not recommended that people not qualified in mental health training regards suicide consider using these techniques. However, it is to be emphasised that talking about suicide in depth does not increase the risk of completed suicide and may indeed reduce the risk if potential times and sources of risk are managed adequately.

There is much more evidence about reducing suicide rates by removing or neutralising the method of suicide. There was a significant drop in suicide rates following changes from coal gas to North Sea gas in terms of suicides being completed using gas ovens. Similarly, there was a further reduction of suicide following the reduction of Phenobarbitone prescription by doctors. Recently, over the counter sales of paracetamol and aspirin have been reduced by reducing the number of tablets provided on each occasion, and by blister package. There is some evidence that this has reduced the overdose rates of analgesics, although a problem remains with

analgesics prescribed to elderly people by GPs, which tend to be in relatively large quantities, without much supervision. The older Tricyclic antidepressant drugs (for example Dothiepin, Amitriptyline and Prothiedin) remain toxic in overdose, particularly to a person's heart. Consequently the prescription of these drugs is being gradually reduced by doctors with the advent of newer antidepressant drugs like Prozac which are equally effective but less damaging when taken as an overdose. Unfortunately, even these newer drugs can be toxic if mixed with other medications because of interactions which raise the toxicity of the other drugs in the body.

There have been attempts to reduce the risk present in high-rise buildings by closer supervision (for example through closed circuit TV), placing security locks on windows, and reducing access to balconies etc. Similarly, changing to catalytic converters in car exhausts has reduced the likelihood of carbon monoxide poisoning being used as a method of suicide. Some local authorities have instituted measures to prevent people jumping off high cliffs and high bridges. However, these continue to be areas of high risk in terms of suicide.
Continuing efforts are thus being made to reduce the likelihood of suicide, particularly using harm reduction measures. However, it is known that hanging is difficult to prevent. Similarly admitting to a hospital, including psychiatric hospital, is by no means preventative of completed suicide in the short or long term. This is often emphasised by mental health staff when patients with suicidal intent are admitted to a psychiatric hospital.

Aftercare following a Suicide
Following a suicide, it is helpful to allow the relevant family members, friends and various staff, to ventilate their immediate feelings and thoughts. Often a receptive ear and a sympathetic silence are extremely helpful. For most people experiencing this event, there is a combination of guilt and blame. The person often wonders what they had said (or not said) to the victim, which contributed to their death. They repeatedly go through what might have happened if certain measures were taken or not taken prior to the person's death. It is worth gently pointing out that these thoughts are common after most suicides and, given time, become less important in the grieving process. It is helpful to assist the person to attend any police interviews, identification of the body and subsequent funeral proceedings. Similarly they might need support when a Coroner's Hearing is held, as quite often the whole process leading up to suicide is reviewed yet again.

Suicide is often traumatic to professional mental health and medical staff who were treating the person prior to their death. These might include General Practitioners, Community Psychiatric Nurses, Psychiatrists, and hospital nurses. Often there is a fear that they will be blamed for the suicide with the consequent medico-legal repercussions. Along with this, people genuinely feel sad about the loss of someone with whom they have had a close therapeutic relationship. They tend to worry about other people under their care suffering a similar consequence, and if currently overworked, might actually become depressed themselves as an aftermath of a suicide. Often they need more family support themselves, which may or may not be there at the time. There is an increased risk of such professionals failing at work and also indulging in substance abuse to get away from the guilt and other emotions. This needs to be kept in mind and discussed appropriately.

Following a suicide, often there is a sense of stigma for family, friends and professional staff. Suicide is not an acceptable death, particularly in the context of police investigations and media enquiries. There has to be some form of protection from unnecessary intrusion in what is essentially a private grief process.

Some people however, do not become particularly distressed after a death of a family member, friend or patient from suicide. There is an understanding in these situations that suicide is inevitable and understandable in the context of the distress the person suffered or indeed produced in other people. It is wise to accept the lack of "appropriate" grief and guilt. Comments about the lack of these expressions would be unhelpful for the people concerned.

Summary

Suicide continues to be a distressing topic for most people. It is important to think about suicide prevention both in the immediate context of a person talking about suicide, and following a suicide attempt. Discussing suicide does not worsen the risk already present, and might reduce the risk if suitable preventative measures are put into place. Plans to reduce the risk of potential methods appear to be the most effective method of preventing suicide. Active and continuing treatment of mental illness also appears to have benefit, as does a network of people around the potentially suicidal person. It is helpful to protect and listen to people after a suicide of their loved one, or their patient. These negative experiences can recur in the context of a Coroner's hearing many months after a suicide and the people concerned will need extra help during this period also.

HELPING A YOUNG PERSON WITH PSYCHOSIS

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- How psychosis presents
- How to seek medical help
- Treatment options
- Prognosis
- Medical problems
- Risk of family transmission

Helping a Young Person with Psychosis

Psychosis affects around 1% of the population, with a majority being described as schizophrenia which predominantly affects young people between mid teens and late twenties. Consequently, most of these young people are either living with their parents or in close contact with them, having recently left home. Because young patients are often unaware that they are ill, parents and other family members bear the brunt of keeping the youngsters safe, accessing help and, at times, supervising treatment. There is a growing body of evidence on the strain which families experience caring for a psychotic youngster. Also some research indicates that family members can, by their attitudes and behaviours, influence the course of illness in schizophrenia. This and previous literature about schizophrenia being caused by parents, have ensured a climate of parental guilt, which often needs correction. The burden of illness cannot simply be measured in terms of the sick person, but also of family members who are involved in caring for him or her.

How psychosis presents

Psychosis in young people often presents with gradual withdrawal from social and educational life which rely on memory and concentration. In terms of relationships, they appear to have difficulties achieving normal eye contact, either looking “shifty” or alternatively, appearing to stare at people. They might have difficulties sleeping and might appear depressed in mood. In addition to this, they commence experiencing the so-called positive symptoms of psychosis, which include hearing voices on a daily basis, which they are unable to avoid. They might experience intrusive thoughts or emotions, which they experience as emanating from the outside and have no power to control.

Often these experiences are accompanied by unusual beliefs, mostly centring on themselves being persecuted by other people or agencies. Occasionally the person might believe that others around him have been replaced by impostors or that a particular person has changed personality to become malevolent. This might result in some sort of aggression towards the person concerned. Aggression or self-harm can also occur if the ill person is directed by voices to do so. This behaviour is also worsened by the use of alcohol or drugs such as cannabis, which make the person more disinhibited. Alternatively, the person might develop “negative symptoms” of lacking motivation and losing previous skills. This might show up in terms of lying in bed during the day.

Controversy remains about whether various drugs can precipitate schizophrenia or simply bring forward the illness which was going to present at some stage. Most of the research supports the latter view, although there appears to be evidence that heavy use of cannabis in early teenage, appears to increase the risk of schizophrenia in later life. Certainly there is evidence that the sooner the positive symptoms are treated consistently, the better the outlook for psychosis. These include a greater chance of full recovery after the first episode, reduced rates of hospital admission and reduced rates of self-harm or violence to others. Therefore the sooner the person is helped to seek medical attention by family and others, the better the outlook appears to be. Thus it is imperative that the community in general, especially teachers, police, GPs, and young people, are aware of presenting features of schizophrenia.

The other group of psychotic conditions are drug-induced psychosis and manic depressive psychosis. Drug-induced psychosis is predominantly mediated by LSD, cocaine and cannabis. The psychotic manifestations include beliefs of persecution and visually experiencing unusual images as well as hearing voices. These experiences rapidly disappear within three to seven days of stopping the causative drug, which often has to be taken persistently in large quantities, in order to produce psychosis. Unfortunately drug-induced psychosis is often associated with criminal activity, including damaging property or people because of disinhibition, abnormal beliefs and visual hallucinations (seeing things which are not there).

Manic-depressive psychosis is rare amongst young people, usually presenting in people in their mid-twenties to mid-thirties. A manic episode rapidly commences with someone not sleeping, becoming over active and exhibiting ideas of having special powers, responsibilities or talents. The person speaks excessively and is overactive in movement, although they do not appear to achieve very much. They can spend money excessively, sometimes on drugs, which can then present as a psychotic illness with ideas of persecution etc. The depressive aspect of manic-depressive psychosis presents with the person becoming sad, not eating or sleeping and experiencing suicidal thoughts. Unfortunately a manic person can very quickly switch to depression with the accompanying risk of suicide. In a depressed phase, the person can believe the opposite of mania, for example being responsible for serious crimes or having no talents whatsoever.

There are hybrids of psychosis and manic depression known as schizo-affective illness, usually precipitated by stresses such as not sleeping for a few days due to work or travel, following bereavement or childbirth and following major breakdowns in work or relationships. In this condition, the person exhibits severe anxiety and either ideas of persecution or ideas of being physically unwell. There is usually agitation and over activity coupled with the anxiety. The person is unable to sleep and loses concentration. The onset is relatively rapid and is easily distinguished from normality. Similar to manic depression, this condition affects people in their mid-twenties onwards.

How to seek medical help

Parents often find it is helpful to get support from the youngster's friends or other trusted people, in order to persuade acceptance of medical help. It is helpful to alert the GP at an early stage, ideally with the young person's consent. If there is concern about risk in terms of the youngster threatening to harm anyone else, it is reasonable to call the police for advice. Similarly, accessing the local Accident and Emergency Department is acceptable in this situation, as this would quickly access mental health help. The situation can be more difficult when the person has become ill insidiously with evidence of significant self-neglect (for example not eating and cleaning), accompanied by some evidence of hearing voices. The problem in this situation is that the person might not accept help but also might not be considered for a Section of the

Mental Health Act, which allows admission to a psychiatric hospital, without the person's consent. For a "Section", there has to be evidence of significant risk, either to the person or to others. Clearly detention in hospital is a traumatic event for both parents and the sufferer alike. This can cause breakdown in family relationships although it has to be remembered that parents have no immediate responsibility in placing someone on a Section as this is done by two independent doctors and a social worker, without the next of kin having to give consent.

What treatments would you expect in psychosis?

The treatment of schizophrenia has significantly altered and improved over the last ten years. This has been due to the advent of new medications which have less side effects in terms of sedation and abnormal movements. It is usual practice that these drugs are tried first, particularly in a young person. Usually these drugs are commenced at low doses, then gradually increased to control symptoms, particularly thoughts of harm and voices. If the drugs are kept at a relatively low dose, there are beneficial effects on concentration and motivation. With first line medication there is an overall improvement in around 70% of cases. In others where the symptoms are more resistant, doctors might try a stronger drug called Clozapine, which has a much higher success rate in treating schizophrenia. Unfortunately Clozapine has a 1 in 200 risk of reducing white cells in the blood, hence the necessity for a weekly blood test, which can thereafter be reduced to once a month. In the past, patients were given long-term depot injections on a two to four weekly basis. This is not now common practice as there is a likelihood of movement disorders. Similarly, young patients prefer an unobtrusive method of treatment, which does not involve attending for regular injections. However, the newer drugs have been converted to two weekly depot injections, which some people prefer for convenience.

Apart from drugs, there is a group of treatments known as psychosocial interventions (PSI). These include a talking treatment called cognitive behaviour therapy, which helps the person to check the validity of unusual beliefs or voices. This treatment has a good success rate and can be used conjointly with medication. Other treatments include helping the person to sort out specific problems such as housing, jobs and finances. This is called problem-solving therapy. An associated form of treatment called compliance therapy, is directed at helping the person work out the benefits or otherwise of taking treatment consistently. There is also family therapy, which involves seeing the patient with the family, to reduce unhelpful expectations of family members towards the ill person and vice versa. This treatment appears to reduce so-called "high expressed emotion" which has been noticed in families of people suffering from schizophrenia. High expressed emotion is a combination of negative attitudes towards the person (for example, believing that the person is lazy), emotional over-involvement, and comments which undermine any potential capabilities of the ill person. Family therapy helps family members to identify these attitudes and behaviours, in order to reduce them.

Risk management is very much part of the package of treatment for schizophrenia and other psychosis. This involves discussing the potential risks overtly with the ill person and their family jointly, leading to plans of harm reduction and supervision. This intervention is successful in reducing untoward incidents including suicide. It is also noted that active treatment which is maintained, appears to reduce the risk of untoward incidents, both in terms of harming oneself or others. There is some evidence that Clozapine itself has an anti-suicidal and anti-aggressive property, which is independent of its treatment of psychosis.

Communicating with a psychotic person

It is unhelpful in general to directly contradict the person's paranoid beliefs or experiences of hallucination such as voices. It is more helpful to agree that these views are held by the person but not necessarily by others around. A quiet voice and manner are also reassuring to the

patient. In terms of encouraging the person to carry out daily activity, suggesting a collaborative approach is more helpful than repeated instructions.

Prognosis of psychosis

Drug-induced psychosis, as mentioned before, is short-lasting and stops when drug misuse ceases. Occasionally people with repeated drug-induced psychosis, move on to a chronic psychosis, although it is likely that they were suffering from schizophrenia unmasked by drug misuse. Regards manic depression and schizo-affective disease, these are recurrent conditions, and are on the whole, life-long in nature, needing long-term treatment with mood stabilisers such as Lithium, or small doses of antipsychotic drugs such as Risperidone. If the episodes are separated by five to ten years, and if the person is not at a crucial stage of development, such as university education or starting a family, they might elect to use medication when the episodes of illness occur. On the whole, the medical recommendation is that people with recurrent illness (i.e. more than two episodes over a period of three years), should remain on long-term, low dose maintenance therapy.

Regards schizophrenia, a third of affected people have a single episode with no further symptoms, although this is usually due to medication, which is continued up to two years. A further third have recurrent episodes, which can be reduced in frequency and severity with medication. The other third of people with schizophrenia have a chronic, unremitting illness, with a predominance of so-called negative symptoms, including poor motivation and concentration. However, with the advent of Clozapine, this group of people have had their symptoms largely improved due to this drug. Most of the psychosocial interventions are directed at people with repeated episodes or chronic disease. Consequently these people are in contact with the local community mental health teams as well as their General Practitioner.

Medical Problems

Drugs used to treat psychosis, especially Clozapine, give a slightly higher risk of diabetes, which needs screening through blood testing on an annual basis. Similarly, people with psychosis have a tendency to smoke, which increases the risk of heart disease, especially in the context of obesity and diabetes. Consequently, health promotion in people with psychosis has to be kept in mind, with regular check-ups through the General Practitioner, who usually delegates this process to the practice nurse. Clozapine blood testing is also carried out by the practice nurse, although some areas have Clozapine clinics which carry out the blood testing and the other health promotional activities. It is important to be aware of variations in local practice by clarifying follow-up arrangements with the treating psychiatric doctor and the GP.

Risk of family transmission

Manic-depression, schizoaffective illness and schizophrenia have some risk of being passed on within families. The overall risk of schizophrenia among first degree relatives (parents, siblings and children), amounts to less than 10%, although this figure rises to around 15% for manic-depression and schizo-affective disease. In the rare situation of children of two psychotic parents, the percentage rises further to around 20% to 40%. This is particularly the case if manic-depression is involved. The issue of family transmission tends to be an emotive one and can interfere with the relationships between the psychotic person, their treating doctors and members of the family. Therefore, this has to be addressed openly but with care.

Advice for people helping family members

The general principles of helping families in these situations include supportive listening, allowing family members to ventilate their feelings. It is helpful to give salient information at the appropriate time, particularly in terms of access points to mental health services. It is always

helpful to guide people through their mixed feelings and to separate them from deficits of knowledge and difficulties in appreciating levels of risk.

Often families of youngsters with psychosis have difficulties accessing information, which this chapter is an attempt to remedy. Organisations such as MIND and The Manic Depressive Fellowship are helpful sources of information. Families can access local telephone services such as the Samaritans and Crisis Call. Similarly, they can access mental health counsellors through the General Practitioner.

Support is needed when a young person has been involved in an untoward incident, or is admitted to hospital under the Mental Health Act. Often this involves recrimination within families, which has to be dealt with sensitively. If there is any concern about how the person has been treated in hospital, it is helpful for someone to advocate on behalf of the family with the Ward Manager or the Consultant responsible for the youngster's care. Increasingly, there are "early intervention" services for young people with psychosis, which will become involved at an early stage, either prior to or during an admission to hospital. These teams are mostly found in big cities but have special expertise in psychosis amongst young people, and are extremely useful for families.

Conclusion

A youngster with psychosis presents a complex problem for most families. This is largely because of the lack of information about these conditions and a tendency for the young person to not seek help themselves, needing persuasion and direction by family members. In addition, the family might experience guilt, particularly about why the illness started and when the person gets admitted to hospital, especially in the context of the Mental Health Act.

There are risks with psychotic illnesses including drug misuse, aggression, self-harm and self-neglect, which causes further strain on families. However, services directed at young people with psychosis are being developed and are a useful access source, along with the General Practitioner and the A&E/Casualty department. New medications are increasingly successful in dealing with positive and negative symptoms of these illnesses and have some role in preventing untoward incidents. The GP has a significant role in dealing with medical complications of psychosis, including screening for diabetes and heart disease in vulnerable patients. Although the services appear to be somewhat fragmented, with salient information about access, the family should be able to get the help they need.

HELPING SOMEONE WITH AN ALCOHOL PROBLEM

Jargon free guidance for carers, helpers and friends.

Dr Prasanna N de Silva

INCLUDES

- Early warning of dependence on alcohol
- Physical effects of alcohol misuse
- Withdrawal effects
- Social effects
- How to intervene when early signs exist
- Techniques of managing alcohol misuse
- Help for families and partners
- Alcohol co-morbid with psychiatric illness

Helping Someone with an Alcohol Problem

Alcohol continues to be the major substance of abuse throughout the world and in all age groups, largely because of its easy accessibility at a relatively low price. Alcohol is also advertised widely and is considered to be socially acceptable for relaxing in company and at sporting events. Sport is a global entertainment industry, which is partly financed by alcohol advertising revenue. There is also major tax revenue from alcohol, hence an ambiguous response from government about placing limits on alcohol advertising and about publicising the damaging effects of alcohol.

It is estimated that around 10% of the population consumes alcohol to a level amounting to dependency, although the rate of harmful use of alcohol (resulting in harm to either oneself or to other people, including time off work), could amount to 20% of the general population. The health promotion message has been somewhat clouded by evidence that moderate alcohol use in most people appears to reduce heart disease. However, the beneficial use of moderate drinking seems to apply predominantly to physically healthy people. There is also some evidence that additives in alcohol, known as congeners, which are used to produce colour and flavour might have damaging effects predominantly to the liver and gut.

Early warning of dependence on alcohol

Alcohol dependency is characterised by the person getting into a situation involving regular consumption of alcohol, lasting at least three days in a row, associated with thinking about alcohol most days of the week (known as craving), and starting to feel guilty about their use of alcohol. Often there might be concern expressed by friends or colleagues about their use of alcohol, which elicits anger or resentment on the person's part. It is estimated that if consumption exceeds 28 units per week for a man and 22 units for a woman, there is a much greater likelihood of alcohol dependency. Obviously these units could be consumed as a binge over an extended weekend or daily, for example commencing in an evening. A unit of alcohol amounts to a measure of spirits or half a pint of beer, with a bottle of wine probably containing around 6 units of alcohol.

Craving, guilt and irritability are early psychological manifestations of dependency. At a later stage, people commence hiding their alcohol use. They will hide evidence of consumption at home or at work. They might narrow their repertoire of drinking by concentrating on drinking on their own, rather than with other people. At this stage, there is also evidence of a phenomenon called tolerance when the person needs more alcohol to get drunk compared to previously. Physical dependency occurs when the body experiences alcohol withdrawal when drinking is stopped. This first manifests itself during the night when the person wakes up after vivid nightmares, sweating excessively. Thereafter the person might experience withdrawal first thing in the morning with shakes and retching, which they soon find is alleviated by further consumption of alcohol. The physical dependency gets combined with psychological dependency at this stage, in that the person increasingly plans the day according to drink, in terms of where and when they can recommence drinking. At this stage, they are likely to be caught under the influence of alcohol while out driving or at work.

Physical effects of alcohol misuse

The commonest physical manifestation would be unexpected falls or injuries sustained either at home or at work. Road traffic accidents are not uncommon. Increasingly, the person might experience stomach pain, heartburn and diarrhoea. Alcohol also increases blood pressure, particularly when large volumes of lager or wine are consumed. The liver is affected, partly by congeners, but partly by alcohol itself. This initially manifests in terms of increased fat deposition and consequent enlargement of the size of the liver. Thereafter the person might get jaundiced because of alcohol toxicity. There is a possibility that the person's heart muscle might also get enlarged, with subsequent heart failure. The brain gets affected by alcohol initially in terms of reduced size, due to dehydration. Thereafter the brain can shrink due to damaged nerve cells, particularly affecting memory and balance systems. If the person's gut is involved to a sufficient extent where nutrition becomes impaired, the lack of Vitamin B produces severe and persistent memory deficit known as Korsakoff syndrome. Unfortunately the early manifestation of this can be masked by intoxication and infections. Consequently, vitamin replacement is not done as often as it should by doctors, resulting in memory difficulties, which can become permanent.

Withdrawal effects

Alcohol withdrawal can precipitate seizures (fits). This happens within 24 hours of stopping alcohol with a further risk period after about a week. Sudden alcohol withdrawal can produce a condition named delirium tremens (DTs), in which the person rapidly gets confused with conviction that they are being persecuted by persons and groups unknown to them. They might experience seeing animals or humans which are threatening in nature. DTs usually commence around 72 hours of discontinuing alcohol, for example, after admission to hospital or being in a police cell. Other physical problems such as dehydration and infection can worsen DTs with a small but significant death rate in this condition. Obviously seizures can also have serious physical consequences such as broken bones or death due to swallowing vomit etc.

Social effects of alcohol misuse

Alcohol misuse has socially damaging effects including inefficiency or periods off work. Clearly the influence of alcohol has damaging effects on driving, and there is a much greater likelihood of domestic violence when either the assailant or the victim is under the influence. Socially there is an increased likelihood of violence, with perpetrators or victims being under the influence. There is a financial cost due to excessive consumption of alcohol, with associated debts and a tendency to borrow excessively. There is also some evidence that child abuse is more likely when adults are under the influence of alcohol, leading to disinhibition of social control or lack of

supervision. Consequently, alcohol abuse among people looking after children has child protection repercussions both in the family and educational setting.

Alcohol often produces difficulties with sexual drive for both men and women. This, coupled with relationship difficulties produced by verbal disinhibition and financial difficulties, can cause marital break-up. Unfortunately alcohol overuse, reduced sexual drive and relationship difficulties, produce a sense of jealousy in men, which is characterised by the person believing his spouse is unfaithful. Morbid jealousy syndrome, as this is called, can become a significant problem with the woman being stalked by the person who checks up on her activities. There is danger associated with morbid jealousy in terms of assaults and possibly murder.

How to intervene when early signs exist

This is always difficult as there is a huge potential of breakdown in the relationship between the person making the enquiry and the person suspected of using alcohol excessively. It is helpful to wait until some evidence is presented, for example, physical symptoms or social difficulties associated with alcohol. Sometimes a major consequence (such as being found drink-driving, or being suspended from work) can be the start of discussion on alcohol misuse. The alternative is a family member of an alcohol user presenting with complaints or difficulties. In this situation, it is helpful to support this person to express their concerns to the alcohol misuser. It is also helpful to suggest to the person misusing alcohol, that they should make an appointment with the GP or practice nurse, for a health promotion check-up. This might be an opening for the health professional to take matters further from an independent perspective.

There are voluntary agencies in most areas of the country, which offer counselling appointments without this being documented in the health records. Alternatively most mental health services have some form of addictive behaviours service, which predominantly works with alcohol misuse patients, usually with associated mental health symptoms such as depression or anxiety. The police and courts can encourage a person to seek help for their alcohol problem. Similarly employers can make a contact with alcohol services a pre-requisite before the person returns to work. Finally, but by no means a last resort, Alcoholics Anonymous runs groups for people to attend to confront their problem along with other alcohol misusers in a supportive setting. AA groups vary from area to area, with some groups being more therapeutic than others. Support may include a “buddy system” when someone at risk of recommencing alcohol misuse can phone his buddy to come and prevent this from happening.

Techniques of managing alcohol misuse

Motivational analysis is a technique used by mental health services to help people with alcohol misuse. This involves discussing the motivation behind drinking alcohol, with a comparison about positive outcomes of drinking versus the negative. This discussion leads to a decision on the person’s part, hopefully to reduce or stop drinking alcohol, depending on their balance of positive and negative features. This technique is highly effective in helping someone to make a decision about issues of alcohol, although severe dependence inevitably needs a period of abstinence before the person can make a rational decision about his or her use of alcohol.

A major life event such as drink-driving, suspension from work or some form of assault can be a motivator to change someone’s drinking habits. Similarly, doctors use a diagnosis of a heart attack, stroke or ulcer to persuade people to stop drinking. This does have benefits - particularly GP follow-up is possible and there is support from family and friends. In terms of research, there appears to be beneficial effects of having secure housing, non-abusive relationships (including not having friends or family members who also abuse alcohol or other drugs), and having a useful daytime activity, either in terms of a job or a hobby. There appears to be some benefit in

religious faith, although this is often connected with supportive company and prayer, both of which might have beneficial effect on the affected person.

Harm reduction is another technique, which involves proper nutrition (including vitamin supplementation), avoidance of unhealthy binge type drinking patterns and avoidance of drinking partners. Harm reduction also involves preventing the person from driving when consuming alcohol and safeguarding the drunken person from assault. Doctors have used admission to hospital to detoxify people from alcohol as a harm reduction measure, although this rarely works unless there is a significant continuing motivator. Alcohol rehabilitation hostels (often based on the AA principle of complete abstinence and seeing alcohol dependency as a disease), exist in most places, but need the person to be completely free of any other drugs (including antidepressants and sometimes anti-epileptics), before they are considered for admission. Medications used for alcohol withdrawal have damaging effects in their own right, including Diazepam and Chlormethiazole. These medications often combine badly with alcohol, producing severe disorientation and unsteady gait. In addition Heminevrin appears also to produce breathing problems, which can increase the likelihood of the person having chest infections.

Help for families and partners

An organisation called Al-anon caters for families and partners of a person dependent on alcohol. Families often need guidance about feelings of guilt caused by the activities of the dependent person. Occasionally, there are some features of the relationship which can contribute to the alcohol misuser continuing in his habits. In this situation, it is helpful to have a trial separation in order to break into the cycle of relationship difficulty and alcohol misuse. Family and friends are often financially dependent on the alcohol misuser and might have to seek legal and financial advice about their predicament. Clearly children who are affected by an alcohol misuser need child protection and childcare advice, which needs to be accessed through the local social services department or the NSPCC. If there is evidence of danger to children from an alcohol misuser, it is everyone's right and indeed responsibility, that child protection services should be alerted either directly or through the child's General Practitioner. Similarly, if the carer of an older person (especially suffering from dementia) is going through an alcohol misuse period, the elderly person might be at risk of falls, wandering or self-neglect. In this situation, it is appropriate to warn the relevant authorities including social services and the GP. Passing information about suspected alcohol misuse should be discussed with the person concerned although this is not always possible. However, the safety of children and vulnerable elderly people is paramount in these situations.

Alcohol co-morbidity with psychiatric illness

Alcohol misuse can be associated with psychiatric illness such as depression, anxiety and psychosis. Young people with social phobia (a fear of meeting or speaking to people in public), can develop alcohol dependency because they find that alcohol is helpful to combat these fears. Similarly a person frightened of going into shops or buses might use alcohol to do so, resulting in dependency. Young mothers with postnatal depression can at times resort to alcohol in the face of childcare, financial and marital responsibilities. Occasionally people with psychotic illness misuse alcohol to get rid of fears produced by voices or unusual beliefs. Similarly, alcohol can be used to get rid of troublesome side effects produced by their medication. Alcohol appears to worsen people's mental illness due to the person either forgetting to take their medication, or medication not being absorbed because of alcohol related damage to the gut. Alcohol itself has been considered to be a cause of depression and anxiety, largely due to the chemical breakdown products produced by the body affecting the brain, producing these effects. Consequently, a careful watch is kept on psychiatric patients by psychiatric staff about the

existence of alcohol misuse as this can interfere with psychiatric treatment and increase risks of harm to oneself or harm by other people as well as self-neglect.

Conclusion

Alcohol misuse is a complex topic but there are key early warning signs of dependency, both psychological and physical. A variety of physical, psychological and social consequences of alcohol misuse can be observed and can be used as prompts to seek help. There are evidence-based approaches in treating alcohol misuse, which might involve controlled drinking or complete abstinence. Sometimes it is helpful to use a major life event to push the person towards seeking treatment for the problem. There are mental health associations with alcohol, which are largely due to the person self-medicating with alcohol. However, this can be counter-productive in terms of risks and ineffectiveness of medication for their psychiatric symptoms. There is a need to consider support for family and friends of an alcohol misuser, including protection of vulnerable people.

HELPING SOMEONE WITH DEPRESSION

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Features of clinical depression
- Presentation in different age groups
- Chemical explanations of depression
- Medical treatments
- Non medical treatments

Helping Someone with Depression

Sadness is very much part of human life, eloquently described in poetry and music. Clinical depression, which is pathological sadness, happens to about 20% of the population, independent of culture, age, sex or creed. This is a lifetime risk figure for the population in general but for people who have had one episode of clinical depression, the risk of a further episode is as high as 50%. In this group of people with recurrent depressions, there is an increased risk of physical illness, such as heart disease and cancer. Similarly they have a higher than expected rate of suicide amounting up to 10% lifetime risk. Often people with recurrent depression have a family history of depression or manic depression.

Traditional mental health teaching has described a dichotomy between depression produced by life events, and "endogenous" depression where there are no obvious precipitants. However, in clinical practice, most people with clinical depression have one or more causative factors, which often include loss events and stressful personal or work life. Often depression is complicated by co-existing physical illness and abuse of substances such as alcohol and caffeine. There has been a reluctance to treat so-called reactive depression medically, which has led to chronic illness and resistance to treatment.

Features of Clinical Depression

Clinical depression is best described in terms of core symptoms which involve extreme sadness or tearfulness which is persistent, in that it is present most days for two weeks, and pervasive, in that the symptoms are present in more than one situation, for example, home, work and in areas of social activity. The third feature of clinical depression involves the pathological element, with ideas of pointlessness of life, at times coupled with suicidal thoughts, at least in the form of a wish to die.

There are two sub-syndromes of clinical depression. Firstly, thinking patterns become altered, the person becoming pre-occupied with ideas of guilt, believing that he is a burden on other people and having thoughts of hopelessness regards the immediate and long-term future. The second syndrome involves physical symptoms, which are predominantly disturbances of sleep, both in terms of getting to sleep and waking up early in the morning. There are also difficulties with concentration and energy, and problems with appetite both for food and for recreational activities. Due to poor appetite, the person might well lose significant amounts of weight, often over half a stone.

In around 30% of people presenting with depression, there is a pattern of “bipolarity”, i.e. fluctuating moods between clinical depression and its opposite, “hypomania”, characterised by over-activity, disinhibition and over-optimism. It is essential that bipolarity is recognised before treatment with antidepressants is considered, as these medications can cause worsening mood fluctuation and agitation. Asking for symptoms of hypomania is essential. Speaking to a carer who has known the person for a few years is sometimes necessary.

Clinical depression has significant consequences, usually when not treated within the first two or three months. These involve difficulties at work or in education. There is, as mentioned before, a tendency for the person to treat their symptoms with alcohol, drugs or coffee, which might produce some benefit initially but thereafter, becomes counter-productive by making symptoms worse. Often, the person experiences irritability and panic as a consequence of depression, which result in avoidance of social company and break-down of relationships. Also as mentioned before, there is a higher than expected incidence of heart disease and cancer in people with chronic depression. Attempts at suicide can occur as a consequence of untreated depression, or indeed can happen when the person’s mood starts to lift following initial treatment of depression. Unfortunately some of the older generation antidepressant medication can have serious cardiac side effects, which are heightened if taken as an overdose.

Presentation of depression in different age groups

In elderly people, depression presents somewhat differently from a younger person. Older people naturally have more physical disease involving pain and disability such as arthritis and heart failure. Consequently depression can present in terms of worsening physical symptoms, often due to non-compliance of medication. They have more difficulties with sleep and become even more socially isolated than before. At times they can present with lack of interest in personal care or difficulties with memory, although families often notice the onset to be rather abrupt, compared to the gradual decline in memory in dementing conditions such as Alzheimer’s disease. Older people are more likely to be bereaved, which, in combination with physical disease and social isolation, increases the risk of depression. They might well present to their GP complaining of being unable to cope with bereavement or physical problems, rather than complaining of depression as such.

It is helpful for primary care doctors and other helpers to elicit a background history from a carer in order to make a judgement whether or not the person is depressed. The assessment might also have to include seeing the person on two separate occasions. Similarly carers’ assessments are helpful in judging the success of undertaking a course of treatment, especially regards compliance.

In younger people, depression presents with episodes of panic, irritability and ideas of life being pointless. Often there are associated work and domestic difficulties which are secondary to depression although clearly depression can get worse following a separation or being put out of work. Abuse of drugs, such as alcohol, is commoner. Unfortunately alcohol in particular can interfere with the outcome in depression by reducing the absorption of medication through the gut and because breakdown products of alcohol are depressants on the brain, thereby worsening the symptoms. Young people are more liable to threaten or carry out self-harm, which is often how the primary care physician or other helpers spot depression.

Occasionally depression presents with motoring offences and mistakes at work, quite often due to concentration and memory difficulties. Also occasionally the person might present with preoccupations about an event in the past with associated ideas of guilt. In young people

depression can proceed to more psychotic manifestations involving ideas of persecution, commonly about others laughing at them or discussing them behind his or her back. Very occasionally the person experiences voices telling him that he is useless and should be put to death. In comparison, psychotic symptoms associated with depression in the elderly are more physical in nature, for example the belief that there is something seriously wrong with their body in terms of the gut getting blocked or rotting away or some kind of cancer affecting a part of their body.

Children can also become depressed, quite often in association with life events. Childhood depression presents with failure to thrive in terms of appetite and growth. This is often accompanied by disturbances at school in terms of relationships with peers and at times, a tendency to run away. For an eight year old, using a pencil to puncture the stomach is serious suicidal ideation as the child is unable to comprehend the actual severity of the method. In common with young adults, children are unable to comprehend the potential toxicity of certain drugs such as painkillers. Therefore, in children and young adults the actual toxicity and the associated suicidal ideation have to be kept separate and not be inferred from one to the other. Children and teenagers are more at risk of physical and sexual abuse in the context of depression. However, abuse of different kinds can also precipitate or worsen depression.

Chemical explanations of depression

Depression has been described as “an imbalance of chemicals”. Although there is some truth to this, the more likely explanation for depression involves the body stress hormone Cortisol. In normal human beings, cortisol excretion follows a so-called diurnal pattern with a peak in the early hours of the morning and a low period late evening. In depression, this diurnal pattern stops and the overall Cortisol level is raised. This phenomenon appears to be associated with depressive symptoms as demonstrated by people who suffer depression as a consequence of being treated with Cortisol or when there is a Cortisol-producing tumour in the brain. The more effective antidepressant drugs appear to reduce Cortisol and re-establish the diurnal variation pattern. There has been research in finding a Cortisol blocking drug for treating depression. Pathological Cortisol production has also immediate effects on disturbed sleep and poor concentration/memory. Excessive Cortisol production could also explain the association between depression and heart disease. Another method of reducing Cortisol production is exercise on a daily basis. This is consistent with exercise being one of the more effective non-medical treatments for depression.

Medical treatments for depression

On the basis of clinical depression defined earlier, antidepressant medication benefits around 70% of sufferers. However, depression is a self-limiting condition in most people, lasting on average less than six months. Therefore antidepressants simply bring forward eventual improvements and minimise the risks associated with depression including suicide, neglect and physical disease. There is substantial evidence that continuing the dose of antidepressants which fully treated all the depressive symptoms, appears to prevent relapse of depression within the first six months and reduces risk of recurrence from around 40% to 20% if taken over a one-year period. People with recurrent episodes of depression, might be advised to take medication consistently for a two year period, in order to prevent a further relapse. This is particularly relevant in people going through a stressful period in their life, for example completing university, commencing work or in the process of grieving.

It is helpful to use a single drug, preferably on a once daily basis, which can be built up over a one week period. The newer serotonin and nor-adrenaline antidepressants can be given once daily, with better compliance and minimal side effects. Older fashioned Tricyclic antidepressants

have a number of side effects including dry mouth, constipation, blurred vision and dizziness, sufficient to impair driving and handling machinery. There is some evidence that Tricyclic antidepressants also impair heart rhythm, which can be potentially fatal if taken as an overdose. On the whole, most antidepressants reduce associated anxiety and panic and thereby improve the capacity for the person to socialise and get back to either education or work. Occasionally there are sexual side effects in terms of difficulty in achieving erection or ejaculation for men and difficulties in arousal for women. Similarly there is the risk of weight gain, largely due to improved appetite following antidepressant treatment. Very occasionally antidepressants produce significant imbalances of the various salts in the blood and can at times reduce the white cell count, increasing the risk of infections. These are rare side effects, affecting around one in a thousand people using these drugs.

In cases of resistant depression, the options include the addition of mood stabilising drugs such as Lithium, Carbamazepine and Lamotrigine. Similarly using two antidepressants together can be a reasonable measure to take without resorting to mood stabilisers. Mood stabilisers are preferable to antidepressant drugs in people with fluctuating mood - especially if a history of hypomania (the opposite of depression) is present. In these people, an antidepressant can provoke frequent mood fluctuation, agitation and sometimes suicidal impulses.

When the person is actively suicidal in intent, or is not eating or drinking adequately to maintain their physical integrity, the option of electroconvulsive therapy is considered. This treatment needs a full consent procedure and a general anaesthetic and tends to be given in courses up to six to eight treatments, usually twice weekly. In this treatment, an electric current is passed through the temples of the person who is under a general anaesthetic with muscles relaxed with another drug. This appears to be the safest method of producing a rush of blood into the brain, which appears to improve depression temporarily, thereby allowing medications and other treatments to continue the beneficial effect. The rush of blood is caused by a minor seizure in the brain and therefore ECT cannot be given in people who have epilepsy or major cardiac problems, such as a recent heart attack (myocardial infarction). Increasingly the use of electric treatment is becoming less common, particularly due to adverse publicity about long-term memory impairment, which has never been objectively verified. It is possible that the newer antidepressants are also much more effective, particularly when given in combination, so that the need for electroconvulsive therapy might be reduced.

Non-medical treatments for depression

These are led by a psychological treatment known as Cognitive Behaviour Therapy (CBT). In this treatment, the person is encouraged to note down automatic negative thoughts (ANTs), for example, “I’m incompetent”, or “I wish I was dead”. These thoughts are often accompanied by feelings of anxiety or sadness with associated behaviours, which include avoidance of social or work situations and resorting to various self-harm methods including abusing substances. During this treatment, the therapist encourages a person to think about the situations which led to the automatic thoughts appearing and thereafter reanalyse these situations with respect to the evidence which made the person react with an automatic negative thought. Often recall of the incidents leads to alternative explanations about what happened, which thereafter leads to various methods of checking out the reality of these situations by the patient as homework between sessions. For this treatment to be successful it is important that homework is completed fully between treatments and that there is a good working relationship between the therapist and the patient. Treatments are usually brief in duration, lasting around six sessions, over a period of three months. Cognitive behaviour therapy appears to have an additive effect to antidepressants and also appears to show a protective effect on the risk of recurrence of depression. It is possible that antidepressants might provoke the person to carry out a less overt

form of cognitive behaviour therapy themselves by checking out their feelings and thoughts on a day-to-day basis without much guidance. These alternative methods of looking at day-to-day situations appear to persist after the antidepressants have been discontinued.

Alternative psychological treatments include forms of interpersonal therapy, which deal with previous losses and relationship difficulties which have resurfaced in the context of current life difficulties. Interpersonal therapy is also brief and appears to be equally beneficial in addition to antidepressants. The longer-term protective effect of interpersonal therapy in preventing relapse is however yet to be elucidated. At times, the patient is seen with carers in order to help them cope with depression. This is a form of family therapy, which might involve an extended family at times. In cases of severe chronic depression, family therapy is also helpful to limit negative influences by other family members towards the ill person, and also provide some realistic assessment regards individual risk for each of the family members in terms of developing depression themselves.

Conclusion

Depression is a significant disease, which occurs throughout the world, relatively frequently. There are major consequences in terms of suicide, physical disease, loss of livelihood and impaired opportunities for education and training. There is also a significant likelihood of the person abusing substances and not complying with medication, including their antidepressant treatment.

Specific psychological treatment such as cognitive behaviour therapy and interpersonal therapy appear to be beneficial alongside antidepressants. These treatments are more difficult to access compared to medications because of limited numbers of therapists and relatively long waiting times for treatment. Recently there has been a move towards psychological treatments being written up as “cook books” which a person can use with the help of the friends or carers. This approach remains unproven in terms of efficacy, although it is probably helpful for the person to read prior to attending a psychological therapist so that there are no false expectations and fears of psychological treatment.

Overall, there is justifiable optimism regards treatment of depression in that at least 70% of people get better, especially with early intervention and consistent treatment supervised by a qualified practitioner whom the patient trusts. Increasingly, primary care doctors are trained to detect and manage depression, thereby avoiding the need for more specialist treatment.

HELPING CARERS OF DEMENTIA SUFFERERS

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Alzheimer's disease
- Vascular dementia
- Lewy Body dementia
- Overall prognosis
- Non medical treatment of symptoms
- Practical help for carers

Helping Carers of Dementia Sufferers

Dementia is the commonest brain disease affecting elderly people. It affects 5% of people over the age of 65, increasing to around 20% over the age of 80. The commonest cause of dementia is Alzheimer's disease, affecting around 60% of demented people, followed by vascular dementia, which affects around 20%. A number of other conditions produce dementia, notably Lewy Body dementia and normal pressure hydrocephalus (an excess collection of fluid in the brain).

All forms of dementia are characterised by three phenomena. Firstly there is evidence of memory difficulty, affecting names and recent events. Secondly there are difficulties in daily activities, commonly shopping, housework and driving. Thirdly there is personality change, including lack of interest (apathy), coupled with irritability, anxiety or depressive symptoms. The different types of dementia run a different course and have slightly different attributes in addition to these problems.

Often there are mixtures of forms of dementia affecting a person, commonly Alzheimer's disease and vascular dementia. These mixtures are noticed when the brain is examined after death. There is a recent suggestion that the person clinically presents with dementia when a threshold is reached due to a multiplicity of causes. For example, Alzheimer's disease might present following a stroke or a head injury.

Most people with dementia are looked after by carers in the community, who are often the person's spouse or siblings, who themselves tend to be elderly with their own problems, including isolation, depression and physical disease such as arthritis and heart disease. Occasionally they too can suffer from an early stage of dementia. When children are the carers, there is difficulty combining a caring role with work and childcare.

On occasion, people with dementia are cared for by neighbours and friends, which can place an excessive strain on these relationships, as the person with dementia might not appreciate their attention. Carers are often aware that there is a problem well before the person's doctor, health visitor or Social Services. Often they end up being the person's advocate but are hampered by inadequate knowledge, including how to access specialist services. Often too, there has to be a diagnosis of dementia, including the particular type, before people have access to benefits such

as Attendance Allowance and Carer's Allowance. Consequently the caring role is often complicated by financial loss and loss of available free time.

Alzheimer's disease

This condition is seen mainly in people over the age of 65. People being admitted to hospital in a state of acute confusion often have evidence of Alzheimer's disease when the confusion settles. However, in most people, Alzheimer's disease presents gradually over a period of eighteen months to three years, with difficulties in recalling events and remembering appointments. Thereafter the person's activities of daily living such as driving, shopping, and cooking get difficult. For example, the person might buy the same type of food repeatedly, or forget to pick up medication or pensions. Cooking or heating at home can be difficult due to misusing gas appliances or forgetting to remove pans from cookers. The person's capacity to dress adequately can become impaired. Regards driving, the person might have difficulties using gears or negotiating roundabouts. Because of the gradual nature of deterioration, the person rarely notices the severity of the problems themselves, the carer often having to explain the difficulty to the GP. This can cause a degree of friction between the person and the carer. The GP has to be cognisant of this issue when referring to specialist services.

Alzheimer's disease is diagnosed mainly from the history of the condition, coupled with brief tests for memory, concentration and attention. The diagnosis is confirmed using an X-ray of the brain (a CT scan), with more complicated brain scans such as MRI or SPECT used predominantly in research practice.

If Alzheimer's disease affects a person below the age of 60 with a family history of this disease affecting at least one other generation, it is possible that there might be a genetic predisposition. In this situation, a referral to the regional genetics unit is often made, so that this possibility can be investigated and family members counselled accordingly. However, it is rare to find a strain of familial Alzheimer's disease in clinical practice. Therefore even family members of a person with Alzheimer's disease have the same risk, (ie one in ten) as the general population of developing this condition.

Alzheimer's disease progresses to a more severe stage, characterised by deterioration of the person's personality, which might include aggression or sexual misbehaviour. Often there is evidence of restlessness, which requires the carer to be constantly on watch. Someone with dementia wandering outside the house has obvious risks of getting knocked down, or becoming excessively cold if inadequately dressed. The person's nutrition might suffer due to the excessive demands of over activity and apathy resulting in poor food intake. Therefore malnutrition in people with Alzheimer's disease is common, including lack of appropriate proteins, vitamins and minerals, producing a worsening of osteoporosis (thinning of the bones). Sedative drugs to control agitation and restlessness can worsen osteoporosis, due to lack of mobility. Osteoporosis increases the risk of bony fractures on falling. Elderly people with mild to moderate Alzheimer's disease who have fractured their hip, is a common cause of admission to hospital with a poor prognosis in terms of being able to return home.

On a positive note, medications have been designed to improve memory, attention and mood of people with Alzheimer's disease. These drugs have been in use since the mid 1990s and work on a brain chemical called acetylcholine, reducing its breakdown. Often these drugs are tried at an early stage of the disease, which offers the greatest chance of success. There is evidence that patients who do not smoke, and have a socially stimulating life do better on these drugs. They appear to halt the progression of disease for a period of two to five years while improving the manifestation of the condition. However, they are not free of side effects, which include

nausea in the short term, and occasionally epileptic seizures, although these side effects are rare and transient in most cases. Currently these drugs are only available following assessment by hospital specialists in dementia, and cannot be directly prescribed by the GP.

Vascular dementia
This condition is characterised by a relatively rapid onset of symptoms, usually after a stroke or an operation involving a general anaesthetic. Often there is a step-wise deterioration, compared to Alzheimer's disease. Similarly heart disease, diabetes or high blood pressure is often present. Vascular dementia is characterised by a predominant difficulty remembering names, and associated depression of mood, with the person more able to recognise that their memory and other cognitive abilities are failing. Obviously depression is also more likely to happen if the person has cardiac disease such as angina or heart failure.

Vascular dementia is less readily treatable with drugs although aspirin and drugs to reduce lipids in the blood appear to have some benefit. Drugs used to treat Alzheimer's disease have been used with some success in this group of patients most likely due to the co-existing presence of Alzheimer's changes.

Complications of vascular dementia include an increased likelihood of seizures, more so than in Alzheimer's disease. These seizures can be full seizures involving some loss or complete loss of consciousness, or partial seizures affecting attention for periods of time. They are commonly treated with antiepileptic drugs, notably sodium Valproate which has some benefit in reducing seizure rates, although they in themselves produce tiredness as a side effect. Depression associated with Vascular dementia can be treated with antidepressant drugs, although not as successfully as in people who are depressed without evidence of dementia.

Lewy Body Dementia
This disease has recently been recognised as another cause of dementia with different characteristics and risks. Affected people have parkinsonian type symptoms, involving tremor and reduced mobility due to slowness of movements. In addition, there is memory difficulty and rapid fluctuations of attention, resulting in unexpected falls. They also experience visual hallucinations, ie seeing objects and people when awake, in the absence of any such stimuli.

The condition is called Lewy Body dementia because the Lewy Bodies, which are present in Parkinson's disease in the base of the brain, have extended throughout the brain. This condition is important to diagnose, as it is likely that drugs which boost acetylcholine have a significant benefit in terms of reducing the visual hallucinations and possibly reducing the risk of falls. However, antipsychotic drugs used to treat agitation and visual hallucinations can increase the risk of severe parkinsonian symptoms and falls. Therefore these drugs, such as Haloperidol, Chlorpromazine and Risperidone should be avoided in this condition. Nursing a patient with Lewy Body disease requires attention to managing risks due to falls, and proper explanation to both patient and carers on potential manifestations, especially visual hallucinations and tremor. Lewy Body disease presents relatively rapidly and has a worse prognosis, particularly when treated with antipsychotic drugs.

Overall prognosis of dementia
Alzheimer's disease can proceed from diagnosis to the person's death over a period of five to ten years. Normally the deterioration is gradual with the person needing residential care half way through their expected life span. Drugs used to treat Alzheimer's disease, can increase the length of time in the community, but the terminal period can be as short as six months. During

this period the person is often in hospital or in a nursing home. However, most carers appreciate a drug which can increase the length of time a person spends in the community.

Vascular dementia gives a slightly shorter life span, largely due to the person dying from other events such as strokes and heart attacks. Lewy Body disease has a similar, shorter life span, partly due to the associated risks of falls and the consequences of these, such as a fractured hip. It is likely that overall, life expectancy is equally governed by the person's quality of life including social contact and nutrition, as much as the actual diagnosis.

Non-medical treatment of symptoms associated with dementia
It appears that for carers the main problem with dementia is agitation, anxiety and restlessness. There is some evidence that bright light and certain aromatherapy oils can improve these symptoms. These approaches have no side effects. Psychological treatment involving skills to improve recall appear to be of benefit. A substance called Ginkgo Biloba appears to show some benefit regards memory disturbance in Alzheimer's disease.

Practical help for carers
Carers need a proper explanation of the person's condition and symptoms. In addition, they need periods of respite either on a day-to-day basis, or for a longer period when they can go on holiday.

Most services offer day facilities, either at a day hospital or a day centre run by Social Services or the voluntary sector. Supervision at these units varies with more medical input at a day hospital along with proper supervision of nutrition and provision of exercise. On the other hand, day centres are better at providing social and other meaningful activities, such as taking people out on visits etc. Day hospitals would be a better option for people who have hallucinations, are more liable to wander or indeed, have falls. However, it needs to be kept in mind that a person commencing day care might be distressed by the sight of other people with more advanced dementia. Therefore a considered judgement has to be made by the carer and professionals in terms of deciding on the ideal day care site.

Respite services are available in both hospital and Social Services accommodation. Respite can be extremely helpful for the carer in terms of getting a complete break for one to two weeks perhaps every two or three months. However, transferring between hospital and their own home on a regular basis can create difficulties for the patient. It is usual practice that the person attends for day care once or twice a week for a while before considering a period of respite care. Day care provides the patient with some reassurance about where they are going to stay, including the actual design of the building.

Carers often benefit from joining a voluntary group such as the Alzheimer's Society, which provides information and companionship. Most areas have a sitter service, which provides someone to look after the person at home, allowing the carer to go out shopping or take some leisure activity.

Most of the care in the community is provided by various home care agencies, including Social Services Home Care. These agencies are supervised by the local Social Services department, and, on the whole, provide good quality care. This might include visits up to three times per day, with the home care staff providing cooking, cleaning and supervision of medication. Home carers can take people out shopping and maintain social activity outside home.

In the latter stages of dementia, it is always useful to have a palliative care service available for the carer, either in hospital, nursing home or at home itself. This involves judicious use of medication to keep the patient comfortable and to protect from distressing physical symptoms such as bedsores, contractures (tightening of the muscles of limbs), or falls. Nutrition has to be kept in mind with the possibility that the food might have to be liquidised. Decisions have to be made about treating chest infections, with a balance between avoiding distressing side effects such as cough or breathlessness, and treating infections aggressively despite side effects such as diarrhoea produced by antibiotics. There is no evidence that treating chest infections in a person with dementia prolongs life.

Carers need assistance in applying for benefits such as Attendance Allowance and Carers Allowance. The application forms for these benefits can be difficult to complete, and to fill in these forms help is available, for example, from workers from specialist services such as Community Psychiatric Nurses. The adjudication of benefits is based on the actual time and effort spent by a carer, including loss of earnings due to this activity.

Conclusion

Dementia is common, and its incidence might be rising. With elderly people working into later life, it is likely that dementia is picked up at an earlier age, with the option of earlier treatment, which appears to prolong the period the person is able to live in the community in relative independence. There is a huge burden on carers who are often not given adequate attention. Without carers, the burden in terms of hospital care would be significantly increased. Adequate investment on carers would be financially and ethically advisable, such as the provision of information and practical help including benefits and respite care. Palliative care in the context of dementia needs to be carefully considered in terms of the location and symptom relief, balanced with the benefit of active treatment.

BEREAVEMENT AND POST TRAUMATIC STRESS DISORDER

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Abnormal grief
- Bereavement reactions following suicide
- Post traumatic stress disorder (PTSD)

Bereavement and Post-traumatic Stress Disorder

Bereavement and post-traumatic stress disorder (PTSD) are increasingly recognised in western societies as problematic for certain people, depending on their previous personality, the actual event, and the presence or absence of support factors following the event. Although bereavement is not considered to be a psychiatric disorder, apart from the limited number of situations where there is evidence of abnormal grief, post traumatic stress disorder is recognised as a psychiatric condition meriting treatment. Most people suffering from abnormal grief or PTSD receive drug treatment usually in terms of a minor tranquilliser such as benzodiazepines. However, medication in itself is often unhelpful and can lead to side-effects and dependency problems. It is not uncommon for a person suffering from abnormal grief or PTSD also to misuse drugs such as coffee and alcohol.

Grief is often presented on television as a consequence of unexpected or violent death. Similarly PTSD has been recognised recently after multiple violent deaths in public situations such as the Hillsborough and King's Cross disasters. Unfortunately this condition has also been associated with compensation resulting in arguments as to whether the affected people suffer from PTSD or not. There are continuing controversies involving abnormal grief and PTSD in the theatre of military conflict, again usually associated with compensation. However, both these conditions have been recognised and described in military literature from the first and second world wars.

Abnormal Grief

This can happen after any serious loss, but particularly after the death of a person who is emotionally close to the sufferer. Normal grief involves the process which usually commences with a period of shock and disbelief, progressing to a period of pining where the survivor will search for the deceased person among other people, usually with features of anxiety and tearfulness. Then there is a period of coming to terms with the loss, which usually involves a degree of sadness and isolation from normal activities of daily living which include work, domestic and social life along with hobbies. Consequently, a person can lose weight and appear to be neglectful although these features are not particularly severe. The final stage involves resolution and moving on from the grief process to return to normal functioning and perhaps a move towards an alternative life style without reliance on the person who has been lost.

A person can get a prolonged grief reaction lasting for more than two years associated with persistent distress, usually accompanied by evidence of clinical depression. Alternatively a

person can get stuck at one of these stages described above. Occasionally a person can get clinically depressed with serious suicidal intent (which includes stopping eating and drinking altogether with a risk of dehydration, malnutrition and infections). Alternatively, a predisposed person can become psychotic or become elated up to a manic illness. Serious psychiatric illness following bereavement however is rare and usually happens in people who have a predisposition to major psychiatric illness as evidenced by previous psychiatric history or a family history.

Occasionally, the death of a partner or carer can unmask ongoing mental illness such as psychosis or dementia. The symptoms of the illness can be confused with abnormal grief, for example when an elderly person with dementia acts as if the dead person is still alive.

There is no particular psychosocial help for normal grief although it has been noted that people with a religious or spiritual belief have less of a problem with this process. It is helpful to give a sympathetic ear and generally help the person maintain activities of daily living. It is also helpful to ensure that they are financially and domestically stable following bereavement.

There are psychosocial treatments for abnormal grief. These include psychological treatments such as graduated and controlled mourning which involves setting a number of targets to move from one stage to another. This might include, for example, a visit to the grave or a remembrance ceremony. Also at times, the person has to be persuaded to release the belongings of a loved one as a concrete measure of coming to terms with the loss. At times it is helpful for the grieving person to revisit the relationship she or he had with the dead person in order to lay to rest ambiguous emotions they feel after the person's death. It is often necessary to help a grieving person avoid, or recover from, dependency on alcohol, coffee or prescribed drugs such as benzodiazepines. This needs collaboration between the psychological therapist and the General Practitioner. Often delayed grief is handled by a community psychiatric nurse, or by a clinical psychologist. Obviously, if there are significant risk factors, the psychiatric consultant might have to be involved to coordinate the recovery process. Psychotic manifestations or severe depression following bereavement needs 24 hour inpatient care although, more recently, day hospitals have been used in managing such problems.

Bereavement reactions following suicide

Following suicide, bereavement is particularly distressing and somewhat complex. It affects members of the family, staff who cared for the patient prior to his death including GPs, hospital workers and community staff, and people who were at the scene immediately after the death, for example, police and passers by. There is particular distress for people who were helpless spectators when the suicide was being completed, for example, train drivers.

Apart from the usual features of bereavement mentioned above, there are extra features such as anger and fear. There is often repeated questioning about the person's last contact with the suicide victim as to whether anything in that final interaction led to the person deciding on suicide. Often there are statements which begin with "if only". These feelings are quickly followed by a sense of extreme isolation and a sense of shame, usually compounded by police, media and legal involvement.

For medical staff following a suicide, there are extra concerns about possible medico-legal repercussions including blame by family members and other services. Often, there is a sense of being blamed for the suicide which comes to the surface when case notes and other documents are impounded by various managers to look for evidence, or otherwise, of defensible

documentation. Clearly, managers are extremely sensitive to the feelings of staff in these situations but, despite this, staff feel under extreme scrutiny and threat.

A Coroner's Hearing brings all these emotions back to the surface. Unfortunately Coroner's Hearings can take place a significant period of time after the suicide and are often attended by lawyers and members of the media. In addition a Coroner's Hearing might be the first occasion where family members can find out the truth about what happened to a person leading up to their death. Consequently, issues about the person's past life and recent lifestyle may emerge, which could be an unpleasant shock to them. Unfortunately this includes knowledge that the person had been feeling depressed and suicidal unbeknown to them.

Among mental health services, there is normally a debriefing session for all relevant staff, usually around one month following the suicide, when people can release their emotions in a suitably supportive environment. Some staff find this extremely difficult as they prefer individual debriefing rather than a group activity. These wishes need to be respected by their managers and arrangements made accordingly.

Voluntary organisations such as Cruise and Samaritans have specific services for family and carers following suicide. Working through grief after suicide might well include coming to terms with bitterness about the suicidal behaviour of the person and the consequences for others left behind in terms of broken relationships and financial difficulties. However, it has to be noted that some people do not need counselling following suicide as they accept that this was either an expected consequence of a mental illness or was the sole responsibility of the person concerned rather than anyone else.

Post Traumatic Stress Disorder (PTSD)

PTSD is a rarer condition where there is an unexpected trauma in which the affected person is a spectator and generally helpless to alleviate or prevent injury or death from occurring. Although PTSD has been described in trauma involving a large number of victims and spectators, it is commoner for this condition to present in trauma involving a single spectator, for example following a road traffic accident. Another common feature is the affected person feeling that their own life was under threat and that they were completely unable to help anyone else.

Symptoms of PTSD include generalised over arousal and persistent anxiety. This is often accompanied by difficulties with sleep, and nightmares where the incident is partially or fully replayed. In addition, during the day time, people get intrusive memories and images of the incident sometimes including "flash-backs" where they appear to be experiencing the incident once again in real time. Usually flash-backs are triggered by innocuous triggers such as TV or going past a particular site. Occasionally, hearing a person utter a sentence or a word can trigger flashbacks, although this is often in the context of a person who is vulnerable in their personality prior to the incident.

There is evidence that children or young adults who have been severely abused (both sexually and physically) experience PTSD. It is not uncommon for these people to present to a psychiatric service with PTSD type symptoms as often these are accompanied by chronic disorders, usually depression. These people also have the usual PTSD symptoms of general over arousal, severe anxiety, insomnia and intrusive recollections of their violent incidents in the past. Alcohol and certain drugs (such as benzodiazepines) can worsen symptoms of PTSD, especially the intrusive recollections.

Treatment of PTSD is complex but usually commences with an accurate diagnosis and a list of problems which might include the intrusive memories or flash backs, difficulties with over arousal and sleep difficulties. Often there is evidence of avoidance of certain common day to day activities such as going past certain places, avoiding meeting certain people and misusing certain drugs to cope with avoidance. Generally PTSD is treated with a predominance of psychological treatment involving managing anxiety, rehabilitation (getting back to useful daytime activity and relating to ordinary people), as well as coming off various drugs of dependency. Medical treatment involves drugs such as Seroxat and Prozac which help to reduce intrusive thoughts. Occasionally the newer atypical type tranquillising drugs such as Risperidone have to be used to reduce over arousal, although this is usually on a short term basis as these people do not have psychotic illnesses.

If there are issues involving compensation, these have to be dealt with efficiently and completely before full recovery are possible. However, it is not unusual for symptoms of PTSD to persist after financial compensation is settled in a large number of contested cases. Consequently the outcome for PTSD is less than satisfactory with a relatively high incidence of suicide, substance abuse and relationship breakdown in the context of this condition. Consequently, it is important that early recognition is available. Most of the services such as fire, police and ambulance, have an early recognition system in place to offer suitable referral either through in-house psychology services or the mental health services locally. There is no such service provided for victims of road traffic accidents or indeed victims of assault, including sexual assault. Therefore, general awareness needs to be maintained, especially by general practitioners.

Conclusion

Abnormal grief and post traumatic stress disorder have, over the last 10 years, been recognised as major mental health problems. They need systematic assessment to reach a diagnosis and produce a problem list before suitable treatment strategies are arranged. It is essential that early recognition is instilled in the public in general and GPs in particular. There is evidence that people suffering these conditions can have their symptoms worsened by unnecessary drug treatment, along with substance misuse. There is also evidence that there is a relatively high risk of suicide when other problems such as marital and work difficulty exist, if these conditions are not recognised early and treated appropriately. Psychological treatment appears to be the mainstay in providing recovery from both these conditions. These include graded exposure to situations avoided by the sufferers and a programme of rehabilitation geared towards returning to normal lifestyles. Occasionally psychotropic drugs are helpful in the treatment of these conditions but should be used with caution for an appropriate duration.

RISK ASSOCIATED WITH MENTAL ILLNESS

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Detention under the Mental Health Act
- Specific risks (violence, self-harm, neglect, falls)
- Managing risks
- Managing violence

Risks Associated with Mental Illness

Introduction

Mental illness is inherently risky. Mentally ill people have difficulties judging risk for themselves and for other people because their mental illness might well include false beliefs and a lack of insight about their condition. Also mental health services tend not to be explicit about risks to the patient and their family at an early stage so that these risks may be openly discussed and managed collectively. There can be conflict between treatment and risk management for mental health staff, particularly if treatment involves gradually placing a degree of responsibility on the patient for his behaviours.

Risk in mental illness is divided into risks from the ill person directed at himself or others, risks from other people directed at the ill person, and risk inherent in the environment in which the mentally ill person is living. Therefore in assessing and managing risks, all these aspects need to be considered systematically.

Often, risk assessment and management do not include key people, for example, the patient, key family members or carers, and the general practitioner who often has the longest experience of the person and probably has access to the most comprehensive information base about the person. Therefore a formal risk assessment ought to include these people along with the treating staff so that a comprehensive management plan is agreed by all concerned, having looked jointly at all the possible risks. Obviously in a busy clinical setting, this process can be arduous. It is better for the key worker to contact different people by phone, rather than having a single large meeting, which, in any case, might inhibit some people from being open with their worries about and for the patient.

Detention under the Mental Health Act 1983

To detain a person under the Mental Health Act requires evidence of mental illness and risk either to the person or to other people. Additionally, for longer periods of detention (for example on a Section for a period of 6 months), there needs to be some evidence of the person's condition being treatable either through drug or psychosocial therapy. Obviously there are risks associated with treatment which have to be considered in the process involved in detaining someone under the Mental Health Act. There are safeguards for detained people including hospital manager's hearings and reviews by the Mental Health Tribunal. At these meetings, assessment and management of risk has to be discussed, with clear plans for aftercare if the person is to be discharged from a Section.

Specific Risks

The commonly discussed risk involving mentally ill patients, unfortunately, is violence to other people. This includes sexual and physical abuse of children. However all the available evidence suggests that mentally ill people have a similar if not a slightly lower risk of committing violence than other members of the public. Violence by mentally ill people appears to be commoner in young men with a history of drug or alcohol abuse and with a history of previous violence. These features also characterise members of the general public who commit violence. In addition, violence appears to be commoner among people with psychosis who have not been treated adequately, particularly with ideas of persecution from others as well as people experiencing thought interference from outside sources. A condition called Capgras Syndrome, which happens in people with psychosis and dementia, also appears to produce a higher risk of violence since the people concerned believe that others known to them have been replaced by impostors, resulting in them attempting to check this out by committing violence. However, Capgras Syndrome is extremely rare and is normally picked up at an early stage because of its unusual nature, and is treated appropriately.

The main risk for people with mental illness continues to be self-harm and suicide. For example, in schizophrenia there is a 15% lifetime risk of suicide. Bipolar affective disorder and recurrent major depression have a 10% lifetime risk. In mentally ill people, the risk appears to be greatest soon after discharge from a psychiatric ward and in the process of recovering from mental illness, particularly depression. Episodes of self-harm among people with major psychiatric illness appear to be attempted suicide, although some patients might use self-harm as a means of getting readmitted to hospital. Consequently, self-harm among people having major psychiatric illness with previous or current contact with psychiatric services, has to be considered extremely seriously regarding the ultimate risk of suicide.

There is a group of risks which pertain to more vulnerable people with mental illness, especially dementia and chronic psychosis, in older age. These are self-neglect, exploitation and falls. Self-neglect means not attending to personal care including food, clothing and hygiene. Potentially these people can become malnourished and get infections secondary to this, and the associated low weight. Regards exploitation, people can be financially, occupationally and sexually exploited because of their lack of awareness and lack of assertive skills. Falls are a particular problem for patients suffering from dementia, particularly vascular dementia and Lewy Body disease. Often there are environmental reasons for falls, for example carpets, slippery floors and stairs. Dementia itself carries high risk of associated thinning of bones (osteoporosis) which increases the risk of bone fractures following falls. Following a serious fracture such as a fractured neck of femur (hip) there are future problems in terms of the patient becoming bed-bound, needing 24-hour nursing care.

Prevention of self-neglect and falls needs careful supervision of the person and the environment. There are no immediate medical solutions apart from stopping unnecessary medication, removing dangerous items of furniture and providing non-slip flooring. There is some evidence that in elderly people, a graduated programme of exercise concentrating on mobility and balance appears to reduce the risk of falls, particularly at home. There is also evidence that improving the older person's diet reduces the risk of osteoporosis and also has the benefit of preventing fractures. These need to be considered in the multi-disciplinary assessment of an older person regarding falls. Similarly regular multi-disciplinary assessments about the person's self-care can prevent situations of serious self-neglect, particularly in the community.

Non-compliance with medication by both medical and psychiatric drugs can be a problem especially in the older patient group due to dementia or depression. Also there is a high degree

of non-compliance with medication by younger people due to the presence of intolerable side effects, particularly in the context of the older psychiatric drugs. Therefore compliance is an issue which is regularly discussed in psychiatric practice. Lack of compliance increases the risk of recurrence of mental illness and the worsening of physical illness. Also, there is a significant financial burden of non-compliance with medication, partly due to the cost of medication and the cost of hospital care.

Occasionally people with mental illness have a predisposition for damaging the environment. The commonest of this is arson, i.e. deliberately setting fire to buildings or furniture. The rate of arson among psychiatric patients is broadly similar to the rate in the general community. The people particularly at risk include those with mild learning disability who have difficulties communicating their distress, or resentment about their care. However, arson can become a habit, for gaining attention. Occasionally it can be an attempt to harm themselves or other people.

There have been concerns about risk to children from mentally ill adults. This is particularly the case in the context of very young children and post natal depression or psychosis in their mothers. Therefore services are expected to pick up mental illness among new mothers, particularly depression and psychosis. It is expected that questions about harming or disliking their children should be routinely asked of a mentally ill parent. Regarding schizophrenia, unfortunately, this illness can become worse leading up to and following childbirth. In this situation it is usual for a full assessment to take place concerning mothering skills in a psychiatric mother and baby unit. There is a possibility that the child might have to be taken into care if there is evidence that a schizophrenic mother is unable to look after her baby and is potentially at risk of neglecting herself and the baby because of her illness.

Managing Risk

As a general issue, asking specific, relevant questions about risk does not appear to worsen that particular risk. This applies to suicide, self-harm and violence to others. There is some evidence that a full discussion about managing risk can, if anything, reduce the particular risk. Therefore it is recommended that explicit questions about risk should be asked of mentally ill people although this should be done in a sensitive manner. Similarly in terms of risk management, there has to be involvement of all the people looking after the patient. This includes carers, general practitioners and the patient himself. It is helpful if a list of all possible risks is considered by a core group of people involved in the patient's care, with a provisional management plan made by the core group to be confirmed by other relevant people. Plans need to be clearly documented and available to out-of-hours services, especially GPs.

Long-term management of risk among people with severe mental illness usually depends on safe accommodation where supervision of the person (including compliance with medication) can take place. Also there is evidence that careful follow-up in the community by a mental health worker improves compliance, and reduces risk. There appears to be some specific benefit of the gold standard antipsychotic drug, Clozapine, in terms of reducing self-harm and suicide. There also appears to be benefit of the mood stabilising drug Lithium in bipolar affective disorder, if this is supervised carefully in the community through an outpatient clinic.

Managing Violence

Management of violence is split into short-term and medium-term plans. In the short-term, mental health staff are trained in using behaviours which are non-confrontational, including helping the person to air grievances in a specific manner, thereafter providing means of achieving reconciliation and finding solutions. It always helps the "talking down process" to use

a low voice, a gentle manner and not to breach the patient's personal space. Summarising and clarifying the person's areas of concern is also helpful. Obviously safety measures are important such as having escape routes available if the person does become violent and also ensuring that the person is not carrying potentially offensive weapons such as knives. Extra care should be taken when people are intoxicated with drugs or alcohol. Potentially it is helpful to contact police at an early stage so that they can be present if needed during the process potentially leading to violence, for example placement on a Section of the Mental Health Act and transfer to hospital.

There are intramuscular and oral medications which are used safely to reduce agitation and aggression. The older, tranquillising drugs have had serious side effects including effects on the heart which can be fatal.

Conclusion

Risk assessment and management in mental health is not a complex technological science. It is much more about common sense and involving all necessary people in the assessment, and agreeing on a pragmatic management plan. Often this includes the patient himself and the carer/relatives. The general practitioner has a valuable role to advise on future risk and its management. Also there are psychiatric drugs which appear to reduce some risks, for example, suicide and violence. However some psychiatric medications can increase risks, particularly in older people. Specific questions and pragmatic management plans remain the mainstay of risk prevention for people with mental illness.

HEALTH RELATED ANXIETY

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Panic attacks
- Chronic fatigue syndrome (ME)
- Chronic pain syndrome (fibromyalgia)
- Irritable bowel syndrome
- Premenstrual syndrome
- Other influences

Health Related Anxiety

Introduction

A number of conditions exist which do not amount to major psychiatric illness but do cause significant distress and disability to patients. These conditions are panic attacks, chronic fatigue syndrome (also known as ME), fibromyalgia, irritable bowel syndrome, chronic multi-system pain syndrome and possibly pre-menstrual syndrome. All these conditions have no consistent and clear-cut physical abnormality. There has been a suspicion that these symptoms derive from brain function but no structural abnormalities of the brain have been detected, and the limited study of functional brain activity measured by electrical activity or blood flow has not shown consistent results.

Panic Attacks

Experiences of panic are the commonest collection of symptoms which can be misinterpreted as evidence of serious physical disease such as a heart attack, stroke or seizure. Most people experience panic attacks at some time in their life, usually associated with stressful life events such as impending exams, after bereavement, general overwork and lack of sleep.

All symptoms commence rapidly, building up to a peak over a period of minutes and thereafter gradually reducing over the next one or two hours. The diagnostic aspect of panic disorder is the urge to fall down or run away at the time followed by avoidance of whatever the person was doing or wherever the person was at the time. The symptoms fall into 2 main types, the first commonly involving breathlessness and a tightness of muscles especially of the chest and throat. Usually there are palpitations (person's heart beating fast and strongly), sweating, dizziness and sometimes a feeling of nausea. There might also be an experience of lack of muscle strength. If the heavy breathing continues the person might experience tingling of fingers. Occasionally people might experience blurring of vision. The second category of symptoms is predominantly psychic, i.e. thoughts. There is fear of impending death, usually associated with the belief that a heart attack or a stroke is occurring. Alternatively the person might think that they are about to make a fool of themselves in company. Selective attention to breathing or swallowing might lead the person to imagine that they will stop breathing or swallowing altogether which would worsen the physical symptoms further.

It is important to remember that panic attacks are very likely to be part of the instinct of all animals to enable them to escape predators or to appear to them to be dead. This has been demonstrated in other mammals in the face of an obvious threat. However, in most human societies, a threat to life is a rare event. Consequently under stress, the brain will be actively looking for evidence of impending danger, so that a panic attack becomes more likely. Panic attacks do occur in the context of serious mental illness such as severe depression or psychosis but the onset of panic attacks does not usually mean that the person is proceeding towards major psychiatric illness. This is particularly true if the person is young and has a family history of panic disorder.

In terms of treatment, it is important to identify correctly this syndrome and reassure the person that they do not have major physical or mental illness. The person should be told not to avoid activities or situations as this could lead to further disability (sometimes called agoraphobia) and a greater likelihood of panic attacks reappearing if there has been some avoidance. The best advice to give to someone who has had a panic attack is to not escape from the situation, but to allow the panic to recede by itself so that they directly experience symptoms removing themselves naturally. If someone is breathing excessively (both in frequency and depth), sometimes it is helpful for them to breathe into a paper bag so that the build up of carbon dioxide inside reduces anxiety when breathed in. It is not helpful to use alcohol or anxiety relieving drugs such as Ativan to control panic. These drugs will inevitably lead to dependence and worsen panic when they are withdrawn. Sometimes doctors use the newer 5HT type antidepressant drugs at low dosage to take the edge off general anxiety and reduce the strength of panic attacks when they happen frequently. This choice should be undertaken with caution, preferably along with advice not to avoid feared situations.

Some people with panic disorder present frequently to casualty and emergency GP services. This should be avoided by an early intervention involving the diagnosis of panic attacks and avoidance of unnecessary medical investigations and treatments. Also hospital admission should be avoided as this reinforces the patient's view that something must be seriously wrong when doctors admit them to hospital.

Chronic fatigue syndrome (ME)

This condition is characterised by severe persistent fatigue lasting for over six months which limits the person's capacity for simple physical exertion such as walking. Often the affected people stop working and they can deteriorate to such an extent that they spend long periods in bed. Sufferers experience worsening of physical tiredness following exercise and also complain of dizziness, poor concentration, poor memory, and depression of mood. This depression does not have characteristics of major depression in that there is no persistent suicidal thinking.

When this condition was originally described, it was suggested that a period of fatigue commenced after a relatively minor self-limiting viral infection and was initially called post-viral fatigue syndrome. However, the evidence currently is that around only 15% of people appear to describe a viral illness prior to the symptoms commencing. Another minority of patients describe working and socialising long hours prior to chronic fatigue. However attempts to verify this from a research point of view have been difficult, as people tend to exaggerate their capacities prior to the onset of the symptoms.

There are continuing investigations about hormonal abnormalities particularly involving the stress response system. The level of the stress hormone cortisol has been shown to be below average among people with chronic fatigue syndrome. However, whether this abnormality is primary or secondary due to people not working and socialising, spending long times in bed, is

open to debate. Investigations also continue about the overlap between chronic fatigue and depression but there is no consistent evidence that any antidepressant medication has a reliable, positive response. Therefore the question about depression being primary or secondary to the symptoms remains unresolved. Investigations regards faulty diets have been largely inconclusive although dietary management is very much part of most chronic fatigue sufferers' experience of regaining health.

There are evidence-based approaches to dealing with chronic fatigue syndrome. The two main approaches are graded exercise and cognitive behaviour therapy, which helps to allow the person to re-evaluate his or her perceptions of the symptoms and the likelihood of success for various approaches to treatment. The combination of graded exercise and cognitive behaviour therapy has been the best predictor of success. There has been some evidence that patients who have recovered from the condition can help other sufferers in terms of group work. However, there is also evidence that chronic sufferers in a group encourage a uniformly bad outcome.

Chronic pain syndrome (fibromyalgia)

These syndromes involve persistent chronic pain involving more than one part of the body and more than one system. The pain appears not to be responsive to traditional pain-killers or other treatments such as acupuncture and physiotherapy. Sufferers of this type attend pain clinics run by anaesthetic specialists. Similar to chronic fatigue syndrome, there is a substantial overlap between pain syndromes and depression. A variety of antidepressants has been tried, therefore, along with some anti-epileptic drugs which have mood improving properties. There is evidence that people with chronic fatigue attempt to protect the painful organs (for example joints, muscles or head), as well as to use mixtures of analgesics. Both these manoeuvres end up with more symptoms and probably more pain. It is certain that over-use of analgesics when stopped results in a rebound pain syndrome. Similar to chronic fatigue syndrome, there is no obvious abnormality on examination of the affected muscle, joint or skin tissue. Brain structure and function have been looked at but again no abnormalities have been found consistently.

Cognitive behaviour therapy appears to be beneficial in terms of changing people's perceptions about pain and the consequences of pain. There is some evidence that brief interpersonal therapies are successful in that they often elicit evidence of delayed grief in the past, ambiguous relationships in the present and fears about job and family life in the future. Clarification and resolution (or coming to conclusions) on these issues also appear to improve symptoms although the relationship with a therapist appears to be highly significant in promoting recovery. The actual words (often metaphors) the sufferers use to describe the symptoms are often revealing about the associated life problem. Another treatment is rehabilitation where the patient is encouraged to limit the secondary disabilities stemming from pain. Therefore, graded exercise, along with return to normal activities, plays a significant role in rehabilitation along with motivation towards something the sufferer actually would like to do to gain self-respect and satisfaction.

Irritable Bowel Syndrome

This condition involves predominantly young people. Symptoms involve the gut including colicky pain and bloatedness after meals, constipation and diarrhoea on alternate occasions and intolerance of certain foods, usually involving carbohydrates. There are also associated symptoms of headache, nausea and dizziness. As with the above conditions, there is no clear structural abnormality of the person's gut. There is an overlap with anxiety and depression but causality between the two is uncertain. Usually these people present to general practitioners and subsequently to the gut physicians and surgeons. Doctors tend to recommend a balanced

diet and avoidance of over the counter preparations for constipation or diarrhoea. Abdominal colic can be improved with anti-colic medication although the effect is not reliable. There is evidence that cognitive behaviour therapy and brief interpersonal therapy, in terms of understanding symptoms and avoiding secondary disability, is beneficial. There is no consistent evidence that antidepressant medication is beneficial although these are commonly used in this condition to treat the related anxiety and depressive symptoms.

Premenstrual syndrome

Discussion of this condition is highly charged because of the potential of stigma towards the affected women. The syndrome comprises increasing anxiety, irritability and possible fluid retention for over two weeks prior to the onset of periods with relatively rapid resolution thereafter. There is often associated pain leading up to and during period time along with anticipatory anxiety and irritability beforehand. Similar to the previous conditions there is no clear cut physical abnormality detected consistently, including the evidence of increased weight gain due to fluid retention. There is a similar overlap between this condition and depression or generalised anxiety although the direction of causality is uncertain.

In terms of treatment, the main attempts have been to treat specific symptoms, for example discomfort of breast tissue and anxiety. There has been limited success with drugs in dealing with some symptoms although there is no single medication for the whole syndrome. Also specific treatments have side effects, which can be a major problem for the sufferer. There is no evidence that nutritional supplementation or relaxation therapy is beneficial, and interestingly, cognitive behaviour therapy does not appear to have a consistent positive response. Surgical removal of the womb and ovaries appear to cure the condition - with obvious major consequences. Physical exercise regimes appear to improve symptoms but evidence is limited because of an inadequate number of trials.

Other influences

There is a good deal of evidence that a person's carers, work managers and doctors can be either therapeutic or unhelpful in terms of prolonging and worsening symptoms of anxiety. Sometimes there is a degree of collusion between the sufferer and their carer or doctor in terms of perpetuating symptoms. At times the symptoms are blamed on a particular traumatic event or continued stress in the context of work. Attempts at legal remedies lead to symptoms being perpetuated. Consequently, if there are any blame-related factors, it is helpful to come to a resolution about these issues as part of the treatment.

Conclusions

It is only recently that the above conditions have been grouped together into one general area of difficulty. Clearly there is no consensus about which health practitioners should treat these conditions or indeed the right form of treatment. However, there is a good deal of evidence that these symptoms become chronic and severely disabling without treatment. Work and relationship breakdown follows inevitably. Therefore early intervention in terms of a proper explanation for the symptoms (which do not include the symptoms being "all in the mind"), is helpful. In fact the correct approach should be not to ascertain the origin or the cause of the symptoms but to concentrate on rehabilitation and self-help in order to return back to normal living. Any other discouragements to return back to normal life have to be sorted out in the process of treatment. It is possible that these conditions are growing in prevalence, and this has clear consequences in terms of training of doctors and other health practitioners.

MENTAL ILLNESS ASSOCIATED WITH PHYSICAL DISEASE

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Hormonal disease (thyroid problems, diabetes)
- Stroke disease
- Parkinson's disease
- Cancer
- Heart disease
- Epilepsy

Mental Illness Associated with Physical Disease

Introduction

A number of diseases have repercussions on mental health. Patients are often unaware that mental symptoms could be a consequence of their physical disease. Often this is their first experience of mental health symptoms with associated fears of "going mad" and needing admission to an asylum. These fears can delay coming to terms with physical disease and have repercussions on continuing medical treatments. In conditions such as cancer, heart disease and epilepsy, not proceeding with treatment can result in premature death. Consequently early appropriate intervention, preferably from the specialist mental health services, can be extremely beneficial. However, inappropriate treatments – especially heavy sedation – can produce poor outcomes including the breakdown of relationships between the patient, family and health staff.

Hormonal Disease

The commonest of these diseases having psychiatric manifestations is myxodema, a low level of thyroxin secreted by the thyroid gland. Along with physical symptoms of weight gain, intolerance of cold, hair loss and coarsening of skin, there are psychiatric manifestations including depression, irritability, and at times, ideas of persecution, occasionally leading up to a psychotic illness. Treatment using thyroxin usually results in the disappearance of the mental health symptoms but this is not invariable. Usually, thyroid under-activity has a family history, which is helpful to know in the diagnosis, especially in the elderly.

The other main hormonal condition with psychiatric manifestations is diabetes, due to a deficiency of insulin, resulting in high blood sugar. This illness can present with features of anxiety, irritability and depression accompanied by the physical symptoms of excessive thirst, weight loss and the passage of large amounts of urine. Usually this condition affects young people including children. As the disease progresses, there may be an association with eating disorder, particularly in young women. Sometimes, diabetics with eating disorders will deliberately have poor control over their blood sugar, simply to lose weight with resulting major problems in terms of diabetic complications, which include heart failure, loss of vision and recurrent infections. Therefore, being aware of possible psychiatric manifestations and complications is essential for the proper management of diabetes.

Stroke Disease

Strokes are deficits in blood supply to the brain, of sudden onset either due to bleeding into the affected area or a clot obstructing the blood supply to the area. Strokes often affect older people, usually with a family history of stroke or a history of untreated high blood pressure. Usually there is no warning of a stroke but some people have short-lasting strokes called transient ischaemic attacks with no residual disability. The main disability involves weakness, typically involving one side of the body, with or without deficits in speech and vision. Occasionally there is evidence of the person ignoring one side of the body, for example by not shaving on one side. Strokes have a variable prognosis with around a third making a full recovery and a further 20% to 30% suffering a permanent disability.

There is a high incidence of depression amongst stroke survivors, perhaps up to 40%. There is no association between depression and the site of the stroke, the cause of the stroke or the extent of the brain damage in the local area. However, depression due to the disability is more likely if the person has had depression before, and is socially isolated, either as a pre-existing event or following the stroke. Often stroke patients are nursed in general medical wards where they observe other patients making a full recovery and being discharged fairly quickly. This can obviously cause isolation and demotivation resulting in depression. Stroke patients are often unable to express their difficulties to carers who cannot understand their requests due to speech impediments, leading to frustration and severe anxiety. Occasionally a stroke patient suffers from emotional lability in that they are often suddenly tearful or emotional for minor reasons. This can be misdiagnosed as depression but does not readily respond to standard antidepressant treatment.

Difficulties with concentration and memory often accompany stroke disease, particularly if there is evidence of a previous stroke or evidence of general lack of blood supply to the brain. The memory and concentration deficits make the rehabilitation of the basic stroke much more difficult because a person cannot learn new techniques which are recommended for mobility and other activities of daily living. Sometimes the memory difficulties can continue despite improvements of the physical manifestations of the stroke.

As with other sudden devastating physical diseases, stroke victims have fears about carrying out activities which require physical exertion because of the fear that they might get another stroke. This includes sex, sports and driving. However the evidence is that certain drugs such as statins and aspirin can prevent stroke recurrence and that physical exertion is not associated with stroke recurrence. There is some evidence that moderate exercise such as walking prevents stroke in most people including stroke victims. Therefore there is a significant role for staff caring for a stroke patient to advice about suitable activities to avoid secondary disability.

Depression associated with stroke is treated with antidepressant drugs with less than full evidence of benefit. However, removing social isolation and improving genuine communication between the stroke patient, the family and the caring team improves depressive symptoms significantly. There are ongoing studies using memory enhancing drugs and statins in the treatment of attention and memory deficits following stroke.

In the case of stroke patients who are either cognitively impaired or have associated difficulty with speech, there are significant medico-legal issues involving capacity to consent to rehabilitation, treatment and future care needs, including future accommodation. Psychiatrists are often asked to provide second opinions on capacity. In the context of the above disabilities, it is helpful to consider pre-existing wishes, current behaviour which might indicate the patient's current thinking, and the wishes of relatives and other informal carers. Quite often there is

dispute between various parties about future care, but the patient's best interest (including avoidance of unnecessary risk) needs to be kept in mind when balancing different opinions. Also there must be procedures to ensure review of a decision, especially regards accommodation. Usually a patient is appointed a social services care manager who would coordinate discharge from hospital having sought specialist and other opinions.

Parkinson's disease

This condition mostly affects elderly people and is characterised by slowness of physical movement, tremor and a particular difficulty in initiating movements. Usually this condition is of gradual onset presenting with generalised tiredness and difficulties with activities of daily living, for example, buttoning shirts, driving and cooking. Sometimes slowness of thinking is associated and other evidence of cognitive impairment, particularly memory deficits. Also there is evidence of around a 40% to 50% risk of depression but this is difficult to pick up in the context of Parkinson's disease, as facial reaction is slowed up as part of the Parkinson's process. Compared to stroke disease, there is a stronger evidence base for the use of antidepressant drugs in treating depression related to their disease. However, reducing social isolation and explaining symptoms of Parkinson's to the patient and carer is beneficial to avoid fear about the future.

The mainstay treatment for Parkinson's disease is a drug called L Dopa. This medication is given 4 – 6 times daily, initially in small doses increasing gradually to titrate against symptoms. However, at some stage, increasing dose regimes will produce psychosis, usually involving seeing objects and animals, as side effects. Consequently, the dose needs to be reduced thereafter. At times a newer antipsychotic drug might have to be used to combat the psychotic manifestations of Parkinson's treatment. This is a disease area where close liaison between psychiatrists and medical doctors dealing with Parkinson's is essential.

Cancer

Malignant disease has psychiatric manifestations both in the early treatment and palliative care phases. During treatment, the most likely problem is depression which is difficult to pick up in the context of ongoing lack of appetite, lack of energy and sleep difficulties, alongside hopelessness and ideas of being a burden on other people. However, if depression takes hold, the cancer sufferer might well discontinue treatment with serious consequences. There is a possibility that depression might prevent people from seeking help for early manifestations of cancer although this is not proven as yet. Treatment of depression involves a combination of antidepressant medication, which does not interact with the cancer drugs, and ensuring that proper information about the cancer and its treatment is given to the patient and carers alongside limiting isolation for the patient. Useful daytime activity for a person suffering from cancer is also helpful in alleviating depressive symptoms, so as they feel needed by the rest of society. Along with depression, there is a possibility that cancer sufferers might have anxiety symptoms including panic attacks, particularly regards the process of death. It is helpful to discuss openly the possibility of treatment not being successful with both the patient and carer, with suitable reassurances about symptom relief in the context of worsening cancer.

In the palliative care area (where the aim of treatment is to relieve distress as opposed to cure cancer), the main problem is toxic confusional states produced by the medical complications of cancer and interactions between different drugs. Confusional states readily lead to breakdown of care in the patient's home, resulting in unnecessary admissions. Relatives and other carers become increasingly distressed and frightened about the psychotic manifestations of a confusional state, which can worsen their fears about further deterioration, leading to death.

Consequently every effort needs to be made by training staff to recognise confusion for what it is, and institute the necessary management to minimise and stop this manifestation.

In the terminal care phase, patients do tend to get depressed for a multiplicity of reasons. These include isolation, reactions of carers and family, and the fear of the unknown, including events leading up to death and thereafter. It is helpful to receive pastoral care at this stage if the patient is willing to accept this. Similarly, it is helpful for patients and family members to get together to decide what family members wish to do following the patient's death. Often anxiety and depression in a terminal stage will produce worsened physical symptoms and surprisingly, some delay in the process of dying.

Heart Disease

As with cancer, around 25% of people suffer from severe anxiety or depression in the context of continuing heart disease such as angina or following a heart attack (myocardial infarction). Terminal heart failure involves severe breathlessness and increasing retention of fluid in the body resulting in pathological weight gain and greater strain on the heart. Clearly, angina is eminently treatable both with drugs and surgical procedures. Anxiety and depressive illnesses will make such active intervention less likely and more difficult to get consent. There is a greater likelihood of dropout of treatment including non-compliance of medication. Consequently, the risk of further readmissions to hospital is greater. People affected by heart disease have increased awareness of symptoms which might suggest a further heart attack, resulting in unnecessary attendances at hospital and unnecessary limitation of activity, which includes driving, shopping, sex and gardening.

Anxiety and depression in the context of heart disease have responded well to the newer antidepressant drugs. The older drugs appear to have a capacity to cause problems with blood pressure and heart rhythm. Care has also to be taken in terms of interactions between cardiac and psychiatric drugs. Avoidance of alcohol is strongly indicated if the patient is also on antidepressant drugs. Caution also needs to be exercised when using electric treatment for severe depression in the context of cardiac disease because of the anaesthetic risk.

Non-medical treatments for anxiety and depression involve providing basic information about the person's condition and the presence or otherwise of any limitations, exposure to feared situations or activities, and social integration including some form of useful daytime activity, which might include a graduated programme of getting back to work. Family members are useful in the rehabilitation process and may themselves have fears, which might have to be reconciled jointly with the patient.

Epilepsy

This condition has higher than average psychiatric concomitants, partly because one type of epilepsy, temporal lobe epilepsy (TLE), has at times psychiatric manifestations involving anxiety, panic or hallucinatory experiences. The usual ballpark figure of 25% applies for depression and anxiety among people with epilepsy. Drug treatment is used when these conditions are picked up but all antidepressant drugs can reduce the threshold for seizure activity, so adequate anti-epilepsy cover is required. A similar caution applies to psychosis arising in the context of epilepsy.

The diagnosis of epilepsy needs to be accurate as there is evidence that around 40% of people diagnosed to be epileptic do not have true epilepsy. People with true psychiatric conditions such as panic disorder and psychosis can get misdiagnosed as epileptic, especially temporal lobe epilepsy. There is also a condition called non-epileptic seizure disorder where people appear to

have seizures without the electrical abnormalities being demonstrated. People who appear to respond with this behaviour to stress, often have a background of childhood abuse including sexual abuse. There is a danger that these people can appear to have continuing epileptic activity when they present to casualty services. Unfortunately there is likelihood that Diazepam and other epilepsy drugs administered in this context have significant risk of serious side effects. Consequently, there needs to be a good exchange of information between the neurologist, who has made the diagnosis (or lack of diagnosis), and other services treating the patient in situations of non-epileptic seizures.

Epilepsy carries a slightly enhanced risk of suicide, which appears to be due to co-existing depression, psychosis or substance abuse. There is some evidence that active treatment for epilepsy reduces the suicide risk. Also there is some evidence that strong epileptic drugs (for example, Tiagabine), sometimes produce psychosis as a side effect, particularly at high doses. This possibility needs to be watched for carefully in the neurology outpatient clinic, with close liaison with psychiatric services if and when appropriate.

Conclusions

A number of medical conditions have psychiatric manifestations which are not simply of academic interest, but have a major consequence regards outlook. Dangers exist in not picking up psychiatric illness in this group of patients at an early stage, namely poor compliance with medical treatment, unnecessary admissions to hospital, and delayed discharge. Also rehabilitation from these illnesses back to previous levels of functioning can possibly be impaired due to psychiatric illness. Therefore it is imperative that these psychiatric symptoms are properly recognised with appropriate information given to the patients and carers along with appropriate treatment, with minimum side effects and drug interactions. Although mainstream psychiatric services do not cater for this group of patients, it is an area of increasing interest in psychiatry, particularly in the field of liaison psychiatry in general hospitals.

STRESS, PERSONALITY AND MENTAL HEALTH PROMOTION

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Stress (brain chemistry, high expressed emotion)
- Personality traits
- Mental Health Promotion

Stress, Personality and Mental Health Promotion

Stress

The term stress is often used loosely without clear understanding of its definition and characteristics. Often stress is described in relation to excessive demands in work or domestic life and is assumed to be a precursor to mental illness as suggested by the phrase "having a breakdown". There have been attempts to define stress by psychology researchers in terms of observed behaviour and by brain researchers in terms of specific brain chemicals produced in stressed subjects. In mental health, the common model used to explain stress is the "stress vulnerability model" which suggests that in vulnerable people, a small amount of stress is adequate to produce distress, compared to psychologically robust people who are less likely to be distressed or otherwise affected by stress.

From the point of view of brain chemistry, excessive demand for performance in animals and humans has been associated with increased production of a brain chemical CRH (corticotrophin releasing hormone). Persistent elevations of this chemical causes excess production of a hormone called cortisol, which leads to increased deposition of fat in the body as well as within blood vessels, in turn leading to heart disease and strokes. Similarly there are mental health effects including difficulties with attention and memory as well as general anxiety. Persistent elevation of cortisol is associated with depression, which is difficult to treat. In people who have severe chronic depression, similar persistent elevations of cortisol have been noted with some evidence of improvement when cortisol-blocking drugs have been used. Therefore there appears to be a relationship between performance stress, mental health difficulties, especially depression, and physical disease, particularly in the cardio-vascular realm. It has been suggested that CRH and cortisol elevations are a marker of stress in general, but further research is ongoing to substantiate this suggestion.

Research psychologists have looked at the behaviour of humans and animals under stress by provoking excessive demand for performance and forced segregation in close spaces. Animals tend to respond to stresses by becoming agitated and irritable, coupled with repetitive stereotypical movements such as rocking and pacing around their cages. Humans under stress behave similarly in terms of agitation and irritability but in addition, have distractibility, memory deficits and difficulties with sleep. It has been observed among humans that some people complain more about stress than others, and that this might be a learned behaviour along with the other behaviours described in research. In states of severe stress, both humans and animals show "learned helplessness" in that they continue stereotyped behaviours, long after the stress has disappeared. These include the most severe manifestations of distress, such as not avoiding harmful stimuli, and self-mutilation.

Research into stress at work has involved questioning people at work about what stresses them and a conceptual framework called “locus of control”. When people are asked the main cause of stress at work, inevitably the response appears to be the relationship with their immediate boss. In particular, people describe bosses who are (i) unrealistic in their demands, (ii) liable to undermine their subordinates, and (iii) do not compliment success, as causative of stress. Good employer qualities have included subordinates describing their bosses as understanding their job, complimenting their work and being willing to compromise on priorities and expectations. Respondents also talk about bullying at the work place and job insecurity as causing stress. Increasingly, because of unreliable pensions, people are expected to work well past their anticipated retirement date. There appears to be conflict between money and time to be managed in most people’s work. Similarly there are conflicts between expectations for family life and work life, which people find stressful. Researchers have gone on to conceptualise these complaints in terms of “locus of control”. In this theory, people with an external locus of control, i.e. having their daily activities controlled by external influences rather than their own needs and desires, experience more stress and physical/mental illness compared to people with an internal locus of control where their motivations for carrying out daily activities are personal needs and ambitions.

Another concept describing stress in relationships is called “high expressed emotion”. This has been studied mostly amongst people with severe mental illness such as depression and psychosis, although increasingly there is evidence that high expressed emotion is a condition experienced by most people within relationships. Perpetrators of high expressed emotion demonstrate critical comments towards another person as well as making comments which are undermining of them. In addition, high expressed emotion involves emotional over-involvement. Interestingly, both the person providing the high expressed emotion and the person experiencing these attitudes and behaviours, suffer stress. In mental health, depressed and psychotic patients in the context of high expressed emotion appear to have protracted symptoms and more relapses, needing hospital admission. High expressed emotion has been demonstrated in both western and eastern cultures and as mentioned before, among ordinary people who do not have mentally ill relatives. In mental health, there is evidence that reducing the time spent in high expressed emotion environments improves symptoms and reduces the likelihood of relapse.

There is a veritable industry aimed at alleviating stress. The rationales for interventions are largely those described above. However, the assumption that understanding the causes of stress leads to immediate and simple solutions is not proven. Radical changes of life-style can also produce unexpected untoward consequences, leading to greater stress in the longer term. There is also evidence that in certain work situations, a degree of stress is helpful for performance although increasing stress appears to plateau performance in the longer term. Therefore, a reasonable conclusion would be that stress is part of daily living and that a careful balance needs to be kept between opposites, for example, money earned versus free time, and work life versus family life, in order to limit the amount of stress experienced.

Personality Traits

A personality trait is a group of thoughts, emotions and behaviours, which a person experiences and demonstrates in most situations and in most relationships. These traits can be positive or negative. The negative traits cause difficulties in working with and relating to other people. Personality traits are divided into two main groups, persistent and maturational.

Regards persistent traits, these include traits of anxiousness, perfectionism, moodiness, aloofness and feeling generally persecuted. On the whole, people with these traits accept them

as part of their character makeup and are willing to tolerate them. Some people use their traits to assist them in their work, although their workmates might not find this entirely acceptable. These traits are often passed between generations and appear to last a whole lifetime. Treatment of mental illness, for example, depression and psychosis, have to take account of "premorbid" traits to ensure adequacy of treatment.

Maturational traits appear to present in late teens, achieving a peak with regard to observed behaviour, thoughts and emotions around the mid-twenties and thereafter, gradually becoming less obvious as the years go on. These traits appear to be associated with difficulties in expressing real feelings. When people have dissocial traits, the problems appear to be in expressing feelings of fear. Consequently their behaviour results in other people feeling extremely frightened, either for themselves or on the person's behalf. People who have borderline traits have difficulty expressing anger. Consequently, under stress, the person's behaviour makes other people feel angry, either towards the person or regards the situation as a whole. It has been suggested that attention deficit hyperactive disorder is a maturational trait, often passed between generations, especially from male to male. However, this disorder appears to be responsive to medication such as Ritalin. In addition, the behaviours of over-activity, impulsivity and inattention appear in school age children, suggesting overall that this is a disorder as opposed to a personality trait.

Treatment in mental illness in the context of unhelpful maturational personality traits can be difficult because of the difficulties achieving a therapeutic relationship and maintaining focus on treating illness. It is essential that the underlying personality trait is identified and taken into account, as this often improves the likelihood of a good outcome.

Overall, vulnerable personality traits which are either persistent or maturational, confer a poor outcome regards mental illness, both in terms of chronic symptoms and recurrence of illness. Similarly, people with vulnerable personality traits are more likely to suffer from ongoing stressful events which add to their distress with greater likelihood of relationship breakdown in context of general stress and life events. People with vulnerable personality traits, especially maturational traits, have an increased risk of suicide, partly due to untreated mental illness and partly due to their difficulties in achieving and maintaining relationships with others. Similarly, these people are also more likely to lose jobs and housing because of relationship difficulties. There is some evidence that they use more alcohol and street drugs, which appear to increase the risk of impulsive suicide independently. In treating a person with vulnerable personality traits, this risk has to be kept in mind, ideally with clear discussion between the practitioner and the patient with some input from carers.

Mental Health Promotion

Mental health promotion applies not only to people with pre-existing or current mental illness, but also to the general population. Clearly it is more valuable for people with vulnerable personality traits and mental illness, but in the context of increasing domestic and work stress, it is worthwhile discussing mental health promotion within the population as a whole. Some evidence based approaches towards mental health promotion are listed below.

There appears to be a significant benefit in terms of mental health by providing safe, good quality accommodation. Safety is about not facing harassment in the setting of the accommodation, as well as obvious risks of fire and various pollutants. In terms of good quality, the key characteristics appear to be reasonable living space, adequate heating and appropriate access to sunlight. In the example of psychosis there appears to be good evidence that

accommodation confers a significant reduction of severe episodes which result in hospital admission.

The next important mental health promoter appears to be useful daytime activity which the person feels comfortable to perform and is generally valuable to others. Daytime activities also confer a routine which appears to be beneficial for people with mental health difficulties in particular. Such activities include charitable work, part time and full time work. The authorities have made it easier for people to work on a part time basis while receiving benefits. Symptoms of depression and psychosis appear to be reduced by carrying out useful daytime activity. It is possible that social contact is enhanced in most activities although some people prefer to work alone.

The third mental health promoter appears to be mild to moderate daily exercise. The WHO recommendation of a brisk walk for thirty minutes at least five days a week, appears to confer improvements in mental health in depression and anxiety. Similarly, exercise of this nature appears to reduce the risk of strokes and heart disease. It was assumed that the benefit of exercise lay in exposing people to more light, but even without exposure to light, exercise in itself appears to promote improvement in depression. Exercise appears to reduce the level of cortisol, the stress related hormone.

Reducing the amount of face-to-face contact in situations of high expressed emotion (as described before) also appears to reduce stress, and, in the case of psychosis, appears to reduce severity of symptoms and risk of admission. In psychiatric care, this often involves spending time away from home in respite or day care, although amongst ordinary people, this might involve outside activities, both occupational and social. In the case of children, spending time with the extended family, or later on, leaving home to a less tense environment would be beneficial.

Finally there is clear evidence that attempting to treat stress with various drugs such as alcohol, cigarettes, cannabis, amphetamine, cocaine and caffeine increases stress in the long term due to the addition of withdrawal effects and effects of overdosing. When trying to reduce stress, it is helpful to consider carefully the prospect of avoiding any non-prescribed drugs. With prescribed medication, benzodiazepines drugs like Diazepam, Temazepam and Ativan have a similar effect to non-prescribed drugs. However, general practitioners often use low-dose antidepressants in the context of stress. This appears to be beneficial although care needs to be taken when withdrawing from this medication as unpleasant rebound effects can occur such as agitation, insomnia and panic experiences.

Conclusion

Stress appears to be a widespread problem in society, usually associated with work and domestic relationships. However, stress in moderate amounts appears to improve performance and is most likely an integral part of life in general. People with vulnerable personality traits appear to suffer and complain more about stress and appear also to benefit from stress mediation and avoidance. There are evidence-based approaches to mental health promotion, which do not involve spending excessive amounts of money and time. However, there are large amounts of unproven treatments and interventions dealing with stress management which should be approached with caution with due regard to untoward effects and side effects. Similar caution needs to be exercised when considering major changes of life-style and work/family relationships.

HELPING TROUBLED ADOLESCENTS

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Anxiety and depression
- Eating disorders
- ADHD
- Challenging behaviour
- Psychosis
- Compulsive disorders

Helping Troubled Adolescents

Introduction

Adolescence describes the period when children undergo changes towards adult sexual maturity, usually between the ages of twelve and seventeen. There is evidence that, with better nutrition and changing social circumstances, adolescence commences earlier than it did a century ago. Coupled with this, there have been major changes in social and educational patterns with greater incidence of parental separation, pressure to achieve at school and peer pressure (contributed to by advertising) to achieve the perfect shape, style of dress and friends. Therefore this period of discovery has become one of trepidation for a lot of children.

Despite this, adolescent mental health difficulties are not in excess of those found in adulthood. A difference exists between rural and urban areas with more of these difficulties in urban adolescents. The main concern recently has been the ready availability of cannabis, ecstasy, cocaine and heroin. By the end of adolescence, it is estimated that between ten and twenty percent have had access to drugs. It is known that the purity of these drugs have markedly increased resulting in adolescents getting a much heavier dose than previously. This is particularly true about cannabis, with respect to development of psychosis, which has been observed amongst children who have commenced regular use of this drug before the age of fifteen.

Anxiety and Depression

These conditions have a similar prevalence rate (10%) compared to adults. Often there are reasons for an adolescent becoming anxious or depressed, usually involving some form of bullying, either within the household or in a school or playground setting. There is an association with marital discord, separation or substance abuse among the parents. Often alternative adult role models such as grandparents or teachers are not available for the youngster. Consequently they might come under the influence of others who might use them for their own ends.

Depression in adolescence presents differently from that seen in adulthood. The young person tends to fail in their educational and extra curricular activities while withdrawing from their peer group and family. They become irritable and might begin using drugs or alcohol as a

consequence. The combination of irritability and suicidal thinking needs to be taken seriously and should precipitate access to specialist services.

In the context of depression, the adolescent might consider means of suicide, which are not based on correct estimation of damage. Therefore attempts at self harm which appear harmless need not necessarily suggest that suicidal intent is also mild.

Anxiety often presents as fear of attending school or social events. Alternatively, the adolescent might present with physical symptoms such as headache, stomach ache or general weakness. In some adolescents, anxiety presents as episodes of panic with sudden attacks of fear for no reason, often coupled with physical symptoms such as palpitations, sweating, dizziness and shakes. As with adults, adolescents believe that there is harm happening to their body or that they are about to lose control. Unfortunately adolescents are less likely to report symptoms of anxiety and panic, partly due to their difficulty in describing feelings and admitting thoughts which they suspect would be laughed at by others.

Treatment of adolescent depression and anxiety is predominantly psychological, involving clarifying thinking and achieving resolution of problems through compromise. Often a meaningful goal for the adolescent needs to be elicited and plans made to work towards this on a realistic timescale. It helps when resources available to the adolescent, such as friends, teachers and siblings, are utilised. It is always worthwhile resolving conflicts within the family so that there is a concerted effort to help the adolescent.

While helping the troubled adolescent, it is worth keeping in mind the needs of siblings who can feel neglected. A form of therapy called Family Therapy, where the whole family discusses the problems, can help younger siblings to accommodate to the situation. It is common practice for mental health staff to get information from teachers as a part of the assessment. This must be explained carefully to the youngster. If there is a situation of bullying at school, teachers have to be involved in resolution of the problem.

There has been disquiet about the use of antidepressants for treatment of childhood depression. In general, antidepressants are not used unless absolutely necessary, i.e. when there is major disruption in performance at school or when active suicidal thinking is present. Often a trial is suggested, involving one drug, commencing at a low dose, gradually built up to the necessary strength. These drugs also help anxiety. If successful, medication is continued for a period of six months to avoid the likelihood of relapse. There is some evidence that these drugs can sometimes make suicidal acts more likely. Therefore if they are used, careful supervision needs to be in place to manage suicidal thinking or attempts.

Eating Disorders

The various types of eating disorders are found in one to two percent of adolescents. The commonest condition is obesity, and others include a pattern of binging and vomiting known as bulimia, and restriction of weight either by dieting or exercising known as anorexia. Anorexia is the least common but has severe consequences such as failure to thrive, late development of sexual characteristics and specific problems with bone and heart muscle. Vomiting and abuse of laxatives associated with bulimia can cause difficulties for the heart, due to changes in the salt water balance in the blood. Childhood obesity however remains the main problem, with increased likelihood of adult obesity along with high blood pressure and heart disease.

All these types of eating disorders have psychological complications including depression and anxiety, with the increased likelihood of self harm due to low self image. There is a “chicken and

egg" association between low self image and eating disorders. Both these problems are dealt with simultaneously, during treatment.

Treatment involves education for both the adolescent and the carers on physical consequences. Similar to management of depression, a goal meaningful to the adolescent has to be identified and worked towards in a co-ordinated and timely manner. It is helpful to involve advice from a dietician and consider an exercise regime. However, in anorexia, exercise should not become directed towards maintaining weight loss.

Group therapy sometimes helps adolescents, providing mutual support and clarification of goals. However, in adolescents with very poor self esteem, group therapy can be potentially damaging, in terms of worsening self harming behaviour. The alternative treatment is family therapy which requires a good deal of preparation and consent by all concerned

Cognitive behaviour therapy is known to be effective in the treatment of eating disorders, and can be administered by a therapist or alternatively worked through by using a computer programme or a handbook, similar to modular homework at school. There is also the added benefit of confidentiality.

There is no evidence that drug treatment is effective in treating pure eating disorders. In severe obesity, stomach stapling operations have been used. Also in severe anorexia tube feeding has been used to help gain weight from life threatening levels. However these procedures carry some risk and require informed consent from the adolescent and carers. There are legal issues associated with consent of an adolescent which are complex and need to be applied to individual patients.

With careful management, especially with the involvement of family and other carers, eating disorders can be resolved. The earlier the eating disorder is identified, the better the outcome in terms of occupation, relationships and emotional maturity. The risk of completed suicide amongst youngsters with anorexia must be kept in mind by family, general practitioner and mental health staff.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a syndrome involving over activity, impulsiveness and poor attention (associated with poor memory). It presents in one per cent of schoolchildren in a severe form, involving major disruption of relationships with family, teachers and peers. In adolescents, there is a greater likelihood of difficulties with authority figures, alcohol misuse and mood disorder, due to low self esteem. Mild ADHD (involving a further four per cent of children) can present as poor academic achievement.

The condition is commoner in males and is seen in all social and ethnic groups around the world. There is a strong heritable component. The behaviour problems and mood disorders are seen as secondary phenomena, usually due to responses to the child by others. It is likely that neurochemicals such as dopamine and noradrenalin are involved, with medication acting on receptors associated with these chemicals.

The most effective remedy for ADHD is stimulant drugs (for example, methylphenidate) which raise dopamine/noradrenalin levels in the brain. These drugs can be given to cover periods when concentration is needed for learning. Most children stop medication when they leave school. Medication is sometimes continued after leaving school, particularly if further education

or training is planned. The main side effect is weight loss, which must be monitored carefully through regular weight checks and maintenance of adequate calorie intake.

Success with stimulant drugs in improving attention and impulsivity does not constitute a diagnosis of ADHD, which is a clinical judgement based on repeated observations at the clinic, home and school. For most people, methylphenidate will improve concentration and impulsivity.

In mild ADHD cognitive behavioural treatments are tried before a trial of methylphenidate in children and young adolescents. Usually this involves helping parents to negotiate a regular pattern of study, play and sleep with the adolescent. It is helpful to try alternatives to medication as this gives the child some confidence, having achieved control over their symptoms without medication.

Challenging Behaviour

Challenging behaviours are actions of an adolescent which are challenging to others. The commonest is oppositional behaviour or defiance for no particular gain. The more worrying challenging behaviour is self harming, either in terms of cutting skin (forearms, thighs, abdomen etc) or overdosing on pain killers.

There are various explanations for challenging behaviour, including using impulsive actions to maintain dopamine levels in the brain. There is also a suggestion that children who repeatedly cut themselves, lack the pain relieving brain chemical endorphin. The most likely explanation for all challenging behaviour is of “a cry for help” in the context of unattainable interpersonal or academic challenges. Often these young people have low self esteem and in particular have problems with body image or alcohol misuse.

Treatments are largely cognitive behavioural in theme, attempting to elicit the pattern of thinking which leads to challenging behaviour. Thereafter various methods are used to identify thoughts before impulsive action. In parallel, attempts are made to improve the young person’s self image, quite often directed towards extra curricular activity and peer support. If there is evidence that the adolescent is responding to abuse, for example bullying at school, the young person should be helped to talk about these painful experiences in order to make sense of what happened. Often this needs a degree of forgiveness towards perpetrators which can be difficult for a young person.

Generally, challenging behaviour tends to reduce gradually in frequency, particularly if an active therapeutic alliance is set up with the young person, maintained by group work. Often group work is accompanied by individual work either using cognitive behaviour therapy or supportive psychotherapy. Harm reduction is also discussed with the young person who undertakes persistent self harming behaviour. This includes learning about physical complications.

Self harming and aggressive behaviours can be accompanied by significant interpersonal difficulty, with evidence of escalation as the adolescent grows older. If this is accompanied by lack of insight, it is possible that the cluster of symptoms could be considered to be part of a personality disorder. However most mental health professionals will not diagnose personality disorder well past the age of eighteen as the personality is capable of maturing up to the mid twenties, when permanent maladaptive traits become evident.

Psychosis

Often the prodromal (incubation) period of psychosis (either schizophrenia or bipolar disorder) can take place in the context of adolescence. The features of the prodrome leading to

schizophrenia include neglect of personal care, severe anxiety and nervous tension, as well as changes of perceptions such as feeling that one's body is unreal or surroundings are unreal. However, not all youngsters with these symptoms proceed to schizophrenia, indeed a majority do not. There is no evidence that antipsychotic medication given at this stage has any benefit. However, supportive psychotherapy and helping to achieve independence in terms of managing accommodation, finances and personal relationships appear to be helpful.

Regards bipolar disorder, it is possible that the youngster will present with either depression or elation (hypomania). These features could be transient, but are often accompanied by poor insight and possibly ingestion of street drugs. Unlike schizophrenia, bi polar disorder is more likely to be recognised, particularly when depression is followed by hypomania. Occasionally hypomania is misdiagnosed as ADHD, with treatment with methylphenidate making matters worse. It is thought that children with bi polar disorder given antidepressants for depressive downswings can become agitated, with a greater risk of self harm. Consequently, caution is required in prescribing antidepressants, perhaps commencing with a low dose and gradually increasing the dosage. Ideally, antidepressants should be avoided using talking therapies instead. However, in severe depression this is not always possible.

Compulsive Disorders

These is a group of disorders starting in adolescence, where the core problem is that the person is compelled to think in a particular way about a particular topic (called obsessional ruminations) or feel compelled to act in a particular way (compulsions). Obsessional ruminations can be about internal concerns; for example about having cancer or AIDS, called hypochondriasis, or alternately about some bodily symptom called somatisation. Ruminations can alternately centre on fears of dirt, or of cutting oneself (or one's baby) with a knife. The more complex ruminations are associated with Compulsions such as repeated checking, cleaning or counting (called Obsessional Compulsive Disorder or OCD, which can occur among 1% of adolecents).

Obsessional and compulsive behaviour can give the person a short term 'thrill', partly because it relieves their anxiety (which otherwise tends to get progressively worse, if they block the pattern of thinking or action). Various self destructive additive behaviours such as compulsive gambling, sexual activity and self harming have also being included in this group after brain scanning findings. Tourette syndrome or tic disorder is also seen as a compulsive disorder, where the person feels compelled to swear or use offensive gestures.

There appears to be a common neuronal circuit which is firing excessively in this whole group of conditions including both obsessions and compulsions. Medications such as the 5HT type antidepressants appear to dampen down the anxiety, making it easier for people to stop temporarily. The other approach is to use psychological treatment such as anxiety management, motivational interviewing and Cognitive behaviour therapy (CBT) to reduce activity. There is recent interest in a technique called deep brain stimulation, where an electrode is placed within this reverberating circuit to reduce electrical activity using continuous electrical impulses, which the person can control depending on the severity of symptoms at the time.

On the whole, most adolescents get out of obsessions and compulsions as they mature. However, OCD can last throught life, needing long term psychiatric treatment with drugs and psychological therapy. Occasionally it is necessary to delete the circuit entirely using brain surgery (with the person's full consent), although with the advent of deep brain stimulation, this is less likely to take place.

Conclusions

Adolescents have similar rates of mental illness compared to adults but a greater diversity, with conditions such as ADHD and challenging behaviour being more prevalent. These mental health difficulties arise in the context of rapid change in a number of areas, such as further education, peer groups and family structure. Often the younger person feels unsupported with extended family not readily available. However, increasingly young people seek help from their peers and friends.

There is evidence for effectiveness in treatments for mental health difficulties in young people. Talking treatments and group work are more effective and less productive of side effects than medication. It is possible that the young person has commenced using street drugs which has to be dealt with prior to using psychiatric medications. In any case it is helpful to have a trial of treatment with the young person and carers being aware of potential side effects and risks of medication.

Recently, there has been a rise in suicidal attempts and completed suicides among young people. This clearly is one of the targets for mental health promotion in adolescents. Since poor educational achievement is a consequence of mental illness, this has to be another target for mental health services in collaboration with teachers.

DRUG TREATMENTS

Jargon free guidance for carers, helpers and friends

Dr Prasanna N de Silva

INCLUDES

- Antipsychotics
- Antidepressants
- Mood stabilisers
- Memory enhancing drugs
- Anxiolytics
- Hypnotics

Drug Treatments

Treatment of symptoms associated with mental illness does not necessarily deal with the underlying cause. Most treatments deal with symptoms which are either positive - the presence of symptoms not experienced by healthy people, or negative - deficit of behaviours expected of people. For example, in schizophrenia positive symptoms include hearing voices or believing in persecutory ideas. Negative symptoms include being unable to carry out cooking or shopping.

It is estimated that around 70% of psychiatric treatments have evidence of effectiveness. However, treatments also have side effects, notably drug treatments, although some psychological treatments also foster untoward effects, such as dependency on the therapist. It is important that potential side effects are known by the therapist, patient and carer so that they can be minimised or avoided.

Drug treatments in mental illness include antipsychotic, antidepressant, anti-anxiety type drugs, mood stabilisers, drugs to promote sleep, and memory enhancing drugs. As a general principle antipsychotic and mood stabilising medications, usually given for people with schizophrenia or bi-polar disorder respectively, are used long terms, initially for a trial period of up to two years, whereas the other medications are given for more limited periods. Most medications are dispensed as tablets once or twice daily. Liquid preparations are sometimes available and antipsychotic medication can be given as an injection, effects of which last between two to four weeks.

Antipsychotic Medication

Antipsychotic medications are prescribed to relieve hallucinations and delusions in schizophrenia, and, in addition to antidepressants, for psychotic depression. They are also used to control aggressive or overactive behaviour in mental illness, and in patients with brain damage, such as learning disability and dementia. Treatment of psychotic symptoms takes at least two weeks, although these drugs control aggressive and overactive behaviour within a few days.

Antipsychotic medication has a relatively high rate of side effects, particularly the first generation drugs such as chlorpromazine, which can produce sedation, dry mouth, blurred vision, constipation and urinary retention. These drugs also produce so called “Parkinsonian” effects, including stiffness and tremors. Occasionally some drugs (for example haloperidol) can produce

physical restlessness, known as akathisia, which is accompanied by a sense of agitation. This can be extremely distressing to patients and cannot be relieved without discontinuing the drug.

Antipsychotic medication occasionally causes life threatening problems. In particular, a condition known as neuroleptic malignant syndrome has been seen with people given older antipsychotic medication such as haloperidol. There appears to be an individual predisposition to develop this syndrome, which has to be treated medically using muscle relaxant drugs, as patients become extremely stiff with a tendency to fluctuating temperature and blood pressure.

The most effective antipsychotic used to treat schizophrenia is clozapine, which is normally given as tablets, usually twice daily. This has a much higher success rate than any other antipsychotic in treating both the positive and negative symptoms of schizophrenia. However, clozapine has a 1 in 200 chance of producing a reduced white cell count in the blood, which can enhance the risk of infection. Consequently, clozapine treatment is monitored initially on a weekly basis following commencement, thereafter moving to a monthly blood test, without which clozapine cannot be dispensed by the pharmacist.

Antidepressants

These medications are designed to lift depressed mood, improve motivation and reduce pessimistic thinking (including suicidal thoughts). Most medications also improve anxiety associated with depression. Other symptoms, such as poor sleep, improve as a consequence of relieving depression. Antidepressants have to be taken for at least two weeks (more likely one month) to show significant improvement. Therefore it is helpful to negotiate a trial of treatment for one month in order to assess effectiveness. These medications work in depression 70% of the time compared to electric treatment (E.C.T.) which works in around 95% of cases. If there is a positive response to a trial of treatment, it is helpful to keep the same dose of antidepressants up to six months (even up to one year in the elderly) to prevent depression recurring. Some medications have a “rebound effect”, (agitation and insomnia), if stopped abruptly from full dose, therefore a 2 week period of gradual dose reduction is helpful.

There is no evidence that antidepressants are addictive. However there is concern about antidepressants being given to people with underlying manic depression or bipolar disorder, as these patients can react adversely with rapid mood swings and increasing agitation including suicidal impulses.

Antidepressants have side effects. The older generation drugs such as dothiepin, amitriptyline and clomipramine produce dry mouth, blurred vision, constipation, urinary retention and general drowsiness. The newer antidepressants such as Prozac, Seroxat, Cipramil and Venlafaxine produce less side effects but retain risks of rebound problems on abrupt discontinuation.

Mood Stabilisers

These drugs are used for people who suffer from bipolar disorder or manic depression. The traditional mood stabiliser, lithium, is available in tablet and liquid form, has been used in manic depression, as well as in people with severe recurrent depression. However, lithium is difficult to manage due to risk of side effects at higher doses, particularly in the elderly. At high doses (with blood levels over 1 m.mol per litre), there is a risk of confusion and tremors developing followed by kidney failure. Lithium can also produce difficulties for the thyroid gland, mostly producing underactivity.

Lithium is dangerous in overdose, due to risks of kidney failure. It is recommended that the blood levels are maintained between 0.3 and 0.8 m.mol per litre and checked at least three

monthly. Thyroid function must be checked annually. If underactive thyroid problems occur, it is helpful to add artificial thyroid replacement rather than stop lithium. It is important that in situations of dehydration, either due to excessive sweating, vomiting or diarrhoea, the lithium level should be checked for potential toxicity after about 12 hours. The ideal time to check lithium levels is 12 hours after the last dose - when the blood level has stabilised.

Recently, other mood stabilisers such as sodium valproate (Depakote) and carbamazepine (Tegretol) have been used. These medications are equally beneficial in bipolar disorder but have side effects of their own including liver problems with Valproate and gait unsteadiness with Tegretol, which can also produce low blood counts on occasion. Lithium appears to have a suicide preventative action in people with bipolar disorder, which Tegretol and valproate do not have.

Memory Enhancing Drugs

These drugs have been developed specifically for the treatment of Alzheimer's type dementia although recent evidence suggest that people with alternative types of dementia such as vascular dementia and Lewy Body disease also benefit. This group of drugs predominantly assist the neurochemical associated with memory, acetylcholine. It is recommended that these drugs are tried early on in the process of Alzheimer's dementia,. Usually these drugs are prescribed by dementia specialists as a three month trial, looking at evidence of effectiveness such as improved memory, sociability and activities of daily living, like being able to go out and dress. They do not entirely stop the gradual deterioration seen in dementia but appear to reduce the rate of decline, allowing a better quality of life for the person (and carers) in the community. The overall time to death due to dementia does not appear to be reduced.

These drugs are predominantly available in a once daily form. The main side effects appear to be gut related, including nausea and diarrhoea. However, if these drugs are taken along with food these symptoms can be significantly reduced.

The diagnosis of dementia is mentioned in the drug literature, which accompanies the medication; therefore it is important to avoid any misunderstandings by discussing the diagnosis before a trial of treatment. Similarly, it is important to back up drug treatment with "psychosocial intervention" involving support for carers, application for benefits and advice about maintaining sociability. These drugs appear to benefit people more if they do not smoke and continue their social contact. These drugs do not have interactions with other medications, apart from some cardiac drugs and drugs to reduce incontinence. The person's heart rate is normally checked, as a low heart rate can be worsened by memory enhancing drugs.

If there is evidence that these drugs produce benefit over the trial period of three months, it is helpful to continue at tolerable doses for as long as possible (usually up to three years). If there is any doubt about these drugs being effective, it is helpful to stop for two weeks and restart if there is significant evidence of deterioration. It is possible that the dose might have to be raised further if there is decline in activities of daily living which had previously improved.

Memory enhancing drug treatment has revolutionised the care of people with dementia in terms of earlier intervention. Most areas have memory clinics which are usually run by psychiatric services in conjunction with psychology and occasionally neurology. Most areas also have a "shared care protocol" involving general practitioners taking over the prescribing of these drugs after initial diagnosis and a trial of treatment through a memory clinic.

The current guidance in the UK suggests that memory drugs should be discontinued when the standard memory test (the mini mental state examination or MMSE) reaches a certain score. However, most clinicians prefer to look at the overall picture involving carers' comments before deciding on drug discontinuation. It is likely that clinicians might wish to change from one drug to another to maintain benefit as long as possible, although research evidence suggests that most of these drugs produce equivalent benefit.

Anxiolytics

Anxiety relieving drugs are predominantly benzodiazepines. These medications are used for short term relief of anxiety or sleep difficulties associated with anxiety. They are also used for alcohol withdrawal. Long acting benzodiazepines (such as diazepam and Nitrazapam) produce sedation, especially in the elderly. They can impair judgement when driving. Short acting benzodiazepines (such as Ativan or Temezapam) are addictive as they appear to produce an immediate effect. Ativan in particular is produces craving. In order to withdraw from Ativan, it is helpful to transfer to a long acting benzodiazepine and thereafter reduce gradually.

There are alternatives to benzodiazepines in treating anxiety. These include Beta blockers such as propranolol, often used in people who are socially anxious, Heminevrin (also used for alcohol withdrawal) and buspirone. These drugs also have serious side effects, for example the risks of developing wheeze with propranolol, reduced respiratory effort with Heminevrin and nausea with buspirone.

Hypnotics (sleeping tablets)

The general principle is to avoid combining drugs to help sleep - especially in the elderly. As mentioned above, benzodiazepines can be used when poor sleep is secondary to anxiety. However, there is a risk of daytime drowsiness and evidence that these drugs do not produce "refreshing" sleep. Newer drugs such as Zopiclone have been used to promote sleep quality. These drugs are not meant to be addictive but have side effects, particularly in the elderly, including sudden loss of muscle tone and risk of falls. Occasionally, antipsychotics such as chlorpromazine are used, in people with dementia who tend to wander, but carry risks of falls and heart rhythm abnormalities.

Overall it is wise to try other methods leading to sleep hygiene, such as avoiding tea or coffee prior to going to bed and taking some exercise during the day. Herbal remedies such as camomile tea can be effective in some people, alongside general environmental cues to promote sleep, such as avoidance of bright lights.

Conclusion

Drugs used in mental health have to be used carefully as a trial of treatment. All drugs have side effects and a potential to interact with others, including alcohol. Duration of treatment varies depending on the purpose of each drug. Dependence and withdrawal effects need to be considered when drugs are withdrawn.

Glossary

Addictive Behaviour Services – A mental health based service which counsels people with any kind of addiction, predominantly drugs and alcohol. Referrals are usually made by GPs or hospital doctors so that people suffering from other illnesses, both physical and medical, can be treated prior to the referral. The mode of treatment is "motivational analysis" which helps the person to look at positive and negative effects of the addictive activity, so that the persons themselves can make up their mind as to the benefit or otherwise of stopping or controlling their activity.

Bed Blocking – A common problem faced by elderly people with dementia who get admitted to hospital. Due to inadequate Local Authority funding or lack of local places, they cannot be discharged to residential or nursing home care and these hospital 'beds' are 'blocked' from further effective use. Consequences of a prolonged hospital stay, for example more dependency, infection and depression, make future placement even more difficult for these elderly people.

Cognitive Behaviour Therapy – A talking treatment looking at evidence for and against certain recurrent thoughts and firmly held beliefs. This treatment appears to be extremely effective in depression, psychosis and certain types of physical symptoms such as pain and tiredness. Usually the period of treatment is short, for example six to ten sessions. There are attempts to have a joint approach to problems and for the patient to carry out homework in between sessions. Unfortunately, CBT therapists are limited in number due to lack of training opportunities, although increasingly "do-it-yourself" cognitive behaviour therapy workbooks are becoming popular.

Delusion – A fixed, false belief, which a person holds persistently, despite evidence to the contrary. Usually these beliefs are of immense personal significance, with some evidence of acting on these beliefs as a secondary phenomenon. Usually these beliefs are outwith those supported by the person's immediate family and social peers. They can be secondary to other unusual phenomena such as hearing voices, but occasionally, can arise independently.

Dementia – A chronic disease affecting the whole of the brain, associated with damage and loss of brain cells of all types. The affected person is usually elderly and shows evidence of memory deficits, personality deterioration and difficulty carrying out the usual daytime activities which they carried out before. This condition leads eventually to death although newer treatments can delay the onset of severe disability.

Electro Convulsive Therapy (ECT) – A treatment for severe depression when there is a risk of suicide or severe self-neglect due to not eating and drinking. An electric current is passed through the person's head, between the temples, under general anaesthetic. The purpose of the electric current is to produce a small fit (seizure), which improves the blood supply to the brain as a whole. This appears to improve the person's mental condition although this effect is temporary. There are short-term side effects involving memory loss and at times, confusion. However, there is no evidence of long-term memory or other deficits. Increasingly this treatment is less common as these conditions are picked up earlier with effective treatment. In addition, usually this treatment needs a second opinion from another senior psychiatrist, working in a different area of the country. It also needs full consent from patients although occasionally it is used without the patient's consent under a Section of the Mental Health Act (see below).

Hallucinations – A term used to describe a person either hearing voices or other sensory phenomena such as smell, taste and bodily sensation, which are not experienced by anyone else in the vicinity. These experiences cannot be explained by physical phenomena and often lead to the person developing false beliefs (delusions), to explain why they are happening. Usually hallucinations are associated with a form of mental illness, although occasionally a type of epilepsy (temporal lobe epilepsy) can produce hallucinations. These are amenable to treatment with drugs although recently, cognitive behaviour therapy has been used to help the patient control these phenomena themselves.

Osteoporosis – A condition affecting older people (especially women after menopause), which involve thinning of the bone throughout the body but particularly spine and hip joints. Exercise and hormone replacement treatment appear to help along with diets rich in calcium and vitamin D which can also be supplied in tablet form. The main risk with osteoporosis is falls and secondary fractures which do not unite quickly. This becomes a major health burden for people, involving chronic pain and unnecessarily long-term care, either in hospital or in 24-hour residential homes. People with dementia and psychosis appear to have a higher risk of osteoporosis, possibly due to tranquillising and antipsychotic medication.

Psychosomatic – A term used to describe physical (somatic) symptoms which are present as a consequence of mental health difficulties. Often patients and carers find cause and effect difficult to ascertain. It is helpful to deal concurrently with physical and mental health symptoms. Stress hormones (for example Cortisol), could explain the psychosomatic phenomena, as would difficulties some people have in expressing mental distress.

Psychotropic Drugs – This group of drugs is targeted at dealing with mental health symptoms and have their predominant effect on the brain and the mind. They include drugs treating depression, anxiety, psychosis, mood instability and dementia. Broadly speaking, they are effective in around 70% of the cases but they also have significant side effects, for example, problems with heart rhythm with some antipsychotic drugs, and difficulty with attention and concentration (for example, regards driving) with drugs treating depression and anxiety. The group of drugs causing most concern is the benzodiazepines, which produce serious addiction in a significant minority of patients who use them. Extreme care has to be used in monitoring drug interactions and toxicity effects, although this group of drugs is less liable to produce harmful side effects than many other types of medication, for example treating arthritis, cancer and skin disease.

Section of the Mental Health Act – There are two major Mental Health Acts in the UK, i.e. English and Scottish. This Act provides a framework to detain people who are mentally ill and show evidence of significant risk to themselves or to others. Currently detention has to be in hospital although there are increasing efforts to change the law to detain people in the community including within their own houses, supervised by Community Mental Health Teams. The purpose of detention is firstly to observe for evidence of mental illness and treatability. Secondly, a further longer Section of the Mental Health Act is applied to provide a trial of treatment. Sections of the Mental Health Act are reviewed routinely by Hospital Managers and by a legal body called a Tribunal. This is to minimise the likelihood of unnecessary detention causing loss of human rights for the person and their carers. Doctors involved in this area (especially psychiatrists), have to observe strictly the letter of the law when dealing with the Mental Health Act regards detention and the subsequent care of these patients.

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