

FOUNDATION YEARS JOURNAL

SEPTEMBER 2009

Volume 3, Issue 7: Psychiatry



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FOUNDATION YEARS JOURNAL 2009

Volume 3, Issue 7

Foundation Years Journal

Foundation Years Journal is an international peer-viewed journal which seeks to be the pre-eminent journal in the field of patient safety and clinical practice for Foundation Years' doctors and educators. The Journal welcomes papers on any aspect of health care and medical education which will be of benefit to doctors in the Foundation training grade in the UK or international equivalents.

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Volume 3, Issue 7: Psychiatry

Foundation Years Journal is the ONLY journal for Foundation Years doctors and educators, specifically written according to the MMC curriculum. It focuses on one or two medical specialties per month, each issue delivers practical and informative articles tailored to the needs of junior doctors. The Journal closely follows the Foundation Years syllabus to provide the best educational value for junior doctors. In addition to good clinical and acute care articles, assessment questions give junior doctors the chance to gauge their learning. The answers will be published in the next issue, but 123Doc will advance answers to clinical tutor subscribers so they can engage their students in the learning process. Each issue provides comprehensive clinical cases for trainees as well as practical teaching assessments for educators. Readers will benefit from:

- **MMC CURRICULAR-BASED CONTENT** to enhance understanding of the core competencies required from future leading doctors.
- **FOCUS ON SPECIALTY-SPECIFIC CLINICAL CASES** each month to form broad subject coverage.
- **ADDITIONAL IN-DEPTH** good clinical and acute care articles aligned with the case-based discussion assessments.
- **TRAINING GUIDE FOR FOUNDATION YEAR (FY)** educators with proposed clinical cases for teaching sessions.
- **PRACTICAL & INFORMATIVE** articles written by senior doctors & consultants.
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E-Health Professionals is a new online peer reviewed journal focused on the delivery of case reports and review articles for all health care professionals. Dr Neel Sharma, Managing Director of E-Health Professionals Limited and a medical SHO based in London, feels that E-journals have become an increasingly popular avenue to publish such work. He comments, "At present there is no single journal that caters for all health care professionals from doctors to nurses to physiotherapists. The onus of this journal is to essentially bring together all professionals and enable us to learn and educate ourselves on all aspects of multidisciplinary care". E-Health Professionals can be accessed at www.e-healthprofessionals.com.

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Aim and scope

The Foundation Years Journal is published by 123doc and is aimed at doctors in Foundation Training programmes, their educational and clinical supervisors, as well as medical students and other doctors (particularly international medical graduates) who intend to start Foundation training in the United Kingdom.

Journal sections

The Journal has been redesigned and various sections have been introduced to map the Journal more closely to the Foundation programme curriculum. You can view the curriculum from <http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment>.

The sections are the following:

1. Good Clinical Care (syllabus section 1)

This section deals with various aspects of patient management including history, examination, diagnosis, record keeping, safe prescribing and reflective practice. Articles could also refer to other aspects of care including time management, decision-making, patient safety, infection control, clinical governance, nutrition, health promotion, patient education, public health and ethical and legal issues.

2. Good Medical Practice (syllabus section 2)

Articles could be on learning, research, evidence-based guidelines and audit.

3. Training and Teaching (syllabus section 3)

4. Professionalism in Practice (syllabus sections 4, 5 and 6)

This section includes relationship with patients, communication skills, working with colleagues, probity, professional behavior and personal health.

5. Patient Management (syllabus section 7)

Articles should be focused on the recognition and management of the acutely ill patients, core skills in relation to acute illness, resuscitation, management of the "take", discharge planning, selection and interpretation of investigations.

6. Practical Procedures (syllabus section 8)

7. Test Yourself

The intention is to provide a vehicle whereby trainees and educational supervisors can present original and review articles mapped against the Foundation curriculum.

Submission of manuscript

All articles submitted to the Journal must comply with these instructions. Failure to do so will result in return of the manuscript and possible delay in publication.

Manuscripts must be submitted exclusively by email (see detailed instructions below). Manuscripts should be written in English of a sufficiently high standard that is intelligible to the professional reader who is not a specialist in the particular field. Where contributions are judged as acceptable for publication, the Editor or the Publisher reserve the right to modify the manuscripts to improve communication between author and reader. Authors whose native language is not English are strongly recommended to have their submissions checked by a person knowledgeable of the language. If extensive alterations are required, the manuscript will be returned to the author for revision.

Covering letter

The manuscript must be accompanied by a covering letter bearing the corresponding author's signature. Papers are accepted for publication in the Journal on the understanding that the content has not been published or is being considered for publication elsewhere. This must be stated in the covering letter. If authors submit manuscripts relating to original research in the field of education, the corresponding author must state that the protocol for the research project has been approved by a suitably constituted Ethics Committee and that it conforms to the provisions of the Declaration of Helsinki (as revised in Edinburgh 2000), available at <http://www.wma.net/e/policy/b3.htm>. All investigations involving human subjects must include a statement that the subject gave informed consent and patient anonymity should be preserved.

The covering letter must contain an acknowledgement that all authors have contributed significantly and that all authors are in agreement with the content of the manuscript.

Authors should declare any financial support or relationships that may give rise to a conflict of interest.

Submitting a manuscript

Manuscripts should be submitted by email to (agnes@123doc.com). We do not accept manuscripts submitted by post. Corresponding authors must supply an email address as all correspondence will be by email. Authors should use double spacing when submitting their manuscript. Two files or documents should be supplied: the covering letter and manuscript. The covering letter should mention the title, authors, their contribution, provenance, journal section where their work is to be considered (see above) and any conflict of interests. Please supply the files in Word 2003 format.

Figures should be supplied as a separate file, with the figure number incorporated in the file name. High-resolution figures (at least 300 d.p.i.) saved as jpeg files should be submitted.

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Manuscript style

Unless otherwise stated manuscripts should follow the style of the Vancouver agreement detailed in the International Committee of Medical Journal Editors' revised "Uniform Requirements for Manuscripts Submitted to Biomedical Journals: Writing and Editing for Biomedical Publication", as presented at <http://www.ICMJE.org/>.

Abbreviations

Abbreviations should be used sparingly to facilitate reading the article by reducing repetition of long, technical terms. Initially you must use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

Units

All measurements must be given in SI or SI-derived units.

Trade names

Drugs should be referred to by their generic names, rather than brand names.

References

All articles must be referenced appropriately. To reference the Journal please use the following abbreviation FYJ-123Doc. (The Vancouver system of referencing should be used and some examples are given below).

References should be cited using superscript Arabic numerals in the order in which they appear. If cited in tables or figure legends, number according to the first identification of the table or figure in the text.

In the reference list, the references should be numbered and listed in order of appearance in the text. Cite the names of all authors, when seven or more list the first three followed by et al. Names of journals should be abbreviated in the style used in Index Medicus, and be in italic font. Reference to unpublished data and personal communications should appear in the text only.

References should be listed in the following forms:**Journal article**

Vassallo M, Vignaraja R, Sharma JC, et al. The Impact of Changing Practice on fall Prevention in a Rehabilitative Hospital. The Hospital Injury Prevention (HIP) Study. *J Am Geriatr Soc* 2004, 52:335-9. Book Azeem T, Vassallo M, Samani NJ. *Rapid review of ECG interpretation*. London UK: Manson Publishing 2005.

Chapter in a book

Martin GM. Biological mechanisms of ageing. In: J Grimley Evans, T Franklin Williams (eds), *Oxford Textbook of Geriatric Medicine*, 1st edn. New York: Oxford University Press 1992, 41-48.

Journal article on the internet

British Geriatrics Society position paper. Dementia ethical issues http://www.bgs.org.uk/Publications/Position%20Papers/psn_dementia_ethics.html.

Tables

Tables should be self-contained and complement, but not duplicate, information contained in the text. Number tables consecutively in the text in Arabic numerals. Table should be double-spaced and vertical lines should not be used to separate columns. Column headings should be brief, with units of measurement in parentheses; all abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, should be used (in that order) and *, **, *** should be reserved for P-values. The table and its legend/footnotes should be understandable without reference to the text.

Line figures

Line figures should be sharp, black and white graphs or diagrams, drawn professionally or with a computer graphics package. Lettering must be included and should be sized to be no larger than the Journal text.

Colour figures

We encourage authors to submit colour figures and graphics that facilitate the comprehension of the article.

Figure legends

Type figure legends on a separate page. Legends should be concise but comprehensive - the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement. The Journal accepts the following types of articles (as title please):

Case Based Discussion

These are mainly intended for inclusion in sections 1 and 5 as highlighted above and should be about 1000-1500 words long. The CBD can focus on various aspect of patient care such as presentation, treatment or prescribing. The articles should include areas that are evaluated in the case based discussion assessment tool of the foundation programme .

The manuscript should be set out in the following sections:

- Abstract: this should refer to salient points from the case being presented together with a mention of what aspects are being discussed.
- Case History: this relates to the initial presentation and should include the clinical setting, clinical problem, investigations and treatment. The history section should also include an ongoing update (e.g. 2 days later, a week later, etc.) of patient progress and management.
- Discussion: this section should include a critical analysis of patient management in relation to clinical assessment, investigations, differential diagnosis, treatment, follow-up, professionalism and clinical judgement. The discussion should also include a discussion about the ongoing management issues and decisions. It is important to note that the case based discussion is not a review of a particular condition.
- Two best of 5 MCQs to be included in the Test Yourself section, with answers and detailed teaching notes explaining the answers. The answers only are NOT sufficient and it should be kept in mind when writing the teaching notes that the reader may take the test questions independently from reading the article.

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Authors writing a case based discussion should not write a short history and then write an article about the condition that the patient presented with. Such information can easily be obtained from a text book and is not the scope of Journal. Case based discussions written in this style will be returned to the author without being published.

Practical Procedures

Manuscripts on practical procedures should be about 1000–1500 words long. They should be set out in the following sections:

- History: this should describe the presentation of the patient and mention why or how the patient ended up needing the procedure.
- The procedure itself.

This should include:

- indications and contraindications
- explaining the procedure to the patient (including possible complications) and gaining informed consent for procedures
- preparing the required equipment, including a sterile field
- position the patient and give pre-medication/sedation or local anaesthesia as required and involving the anaesthetist where appropriate
- safely disposing of equipment, including sharps
- documenting the procedure, including labelling samples and giving instructions for monitoring and aftercare
- recording complications and the emergency management of such complications when appropriate.

Adequate pictures and diagrams need to be supplied in order to make the procedure as clear as possible.

Two best of 5 MCQs for inclusion in the test yourself section, including answers and detailed teaching notes. The answers only are NOT sufficient and it should be kept in mind when writing the teaching notes that the reader may take the test questions independently from reading the article.

Audit

Manuscripts, 1500–2000 words long, on audit are encouraged. The Journal will only publish high quality audit i.e. completed audit cycles or audits that have led to guideline development. Part 1 audits or surveys will not be accepted for publication.

Review Articles

We are interested in review articles on any aspect of the curriculum that is of relevance to our readership. They should be a maximum 3000 words long, 30 references, 250 word structured abstract, 4 tables OR figures.

We would consider reviews on any of the following:

- Good Medical Practice
- Teaching and Training
- Professionalism
- Medical reviews subject to prior discussion with the editorial team as to the appropriateness of the article

Shorter Reflective Practice Articles

We are always pleased to receive short pieces of a thoughtful nature that describes the personal or professional experiences of colleagues working with patients or their relatives. They should have a maximum of 1000 words. As suggested in the Foundation Programme Portfolio (Reflective Practice) these articles should describe:

- What made the experience memorable?
- How did it affect you?
- How did it affect the patient?
- How did it affect the team?
- What did you learn from the experience and what if anything would you do differently next time?

Some aspects to be considered in these articles are:

Communication with the patient, ethical issues, aspect of your works with colleagues, probity and honesty, personal health.

Research Papers

The **Foundation Years Journal** would welcome research articles on Medical Education. Other research papers would be considered if thought to be of interest to the readership of the Journal. Articles should be written using the following headings (title page, abstract, introduction, methods, results, discussion acknowledgements, references, tables, illustrations legends.). They should be of a maximum of 2500 words of text, plus abstract, 30 references, 3 tables or figures. Manuscripts including a structured abstracts should have a maximum of 250 words using the headings introduction, methods, results, conclusion. The title page should contain (i) the title of the paper; (ii) the full names of the authors; and (iii) the addresses of the institutions at which the work was carried out together with; (iv) the full postal and email address, plus facsimile and telephone numbers, of the author to whom correspondence about the manuscript should be sent.

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OBSESSIVE-COMPULSIVE DISORDER

Ashlesha Bagadia and Lynne M Drummond



She spends 3 hours getting herself up and clean in the morning. She spends the rest of the day in extensive cleaning of her house which involves wiping all surfaces with bleach, vacuuming and wet-wiping soft furnishings with antibacterial wipes.
Good Clinical Care.

Melissa, a 34-year-old single parent attends her GP due to her concerns that her preoccupation with dirt and germs is having an adverse effect on her 6-year-old daughter. She gives a 18-year history of avoidance of dirt and germs for fear she or a close family member will contract an illness. She worked in a library until 8 years ago when she felt unable to cope with touching items handled by other people she considered "dirty". It was around this time that her general predisposition to cleanliness began to take control of her life.

Currently she spends 3 hours getting herself up and clean in the morning. She spends the rest of the day in extensive cleaning of her house which involves wiping all surfaces with bleach, vacuuming and wet-wiping soft furnishings with antibacterial wipes. The only time she leaves home is to drop-off and pick up her daughter from school. All journeys are undertaken on foot as she is unable to use public transport for fear of sitting on "contaminated seats". When away from home, she avoids public toilets and uses paper tissues to hold door knobs in public areas. Her grocery and other shopping is done via the Internet to avoid crowded shops. When her daughter returns from school she is subjected to extensive cleaning and bathing for up to an hour. She would often miss school events and rarely took her daughter out to play.

What is the most likely diagnosis?

This is a typical case of obsessive compulsive disorder where she presents with a fear of contamination leading to acts of decontamination and repeated cleaning behaviour.

OCD is a form of anxiety disorder which has a lifetime prevalence of approximately 1.1% in adults¹ and over 0.5% in adolescents which increased with age² and only 0.25% in children². It occurs equally in men and women and most sufferers present in early adult life. The usual presentation is with obsessions and compulsions.

Obsessions

These are persistent, intrusive, thoughts, images or ideas which are distressing and anxiety provoking and hence initially resisted by the individuals. Obsessional thoughts usually fall into the following categories³:

- Fear of contamination.
- Fear of causing harm to others/self by acts of omission (e.g. forgetting to turn off the gas).
- Fear of causing harm to others/self by acts of commission (e.g. thoughts of stabbing someone).
- Fear of loss of objects or information (e.g. burglary if door is left unlocked).
- Fear of committing blasphemy with or without religious preoccupation.
- Requirement for symmetry and perfection. (e.g. fear of not being liked by others if not perfect).

OBSESSIVE-COMPULSIVE DISORDER

Ashlesha Bagadia and Lynne M Drummond

Compulsions

In order to prevent the discomfort of the anxiety caused by the obsessions, the OCD sufferer engages in a number of anxiety reducing compulsions or rituals. These compulsions may be either behaviours or neutralising thoughts which lessen the distress. Although the compulsions may seem purposeful, they are either not realistically linked to the obsessive fear or they are clearly excessive. In addition they are inefficient as they do not completely relieve the anxiety. Their effect is short-lived and are thus repeated. The OCD sufferer is hence caught in a vicious cycle of repetitive behaviours in an effort to reduce the anxiety caused by the obsessional thoughts. Examples of frequently occurring compulsions include³:

- Decontamination, cleaning and washing.
- Checking and repeating.
- “Magical” rituals, (e.g. repeating actions a fixed “number” of times to undo the harm of the obsessive thought).
- Hoarding.

In addition people with OCD often have other symptoms including avoidance and reassurance seeking.

Avoidance

Eventually most people with OCD start to avoid the situations which provoke the obsessional thoughts. This maybe straightforward avoidance of certain objects or situations or more subtle, such as ensuring that someone was with them at all times to prevent acting on thoughts of harming others.

Reassurance seeking

Some sufferers ask for reassurance repeatedly as a form of anxiety relieving behaviour. In the same way as compulsions, however, these are inefficient strategies and end up getting repeated.

How should the GP proceed from here?

What are the common differential diagnoses for OCD and what are the co-morbidities?

Following are some of the screening questions for OCD^{4, 5, 6}. People with OCD may present to other specialties long before they seek psychiatric help. (e.g. to a dermatologist with chapped hands from excessive washing or to a genitourinary specialist for fear of HIV).

1. Do you have frequent unwanted thoughts that seem uncontrollable?
2. Do you try to get rid of these thoughts and, if so, what do you do?
3. Do you have rituals or repetitive behaviours that take a lot of time in a day?
4. Do you wash or clean a lot?
5. Do you keep checking things over and over again?
6. Are you concerned with symmetry and putting things in order?
7. Do your daily activities take a long time to complete?
8. Do these problems trouble you?
9. Does this behaviour make sense to you?

Assessment of OCD

Once OCD has been suspected, a full psychiatric assessment needs to take place ensuring that a full risk assessment is always included. It is useful to outline the anxiety – provoking obsessions as well as the anxiety relieving compulsions.

Differential diagnoses for OCD

The most common problem with OCD is distinguishing it from other anxiety disorders and from depression. Indeed most people with OCD are also depressed to some extent. Careful history taking will normally reveal the correct diagnosis.

Depressive illness

Although most people with OCD are also depressed, in some cases the depression commences before the OCD symptoms. There may also be evidence that the OCD symptoms abate when the depression lifts.

Phobic disorder

In phobic disorder the fear is of a specific object or situation. In OCD, the fear is not of the object or situation themselves but of the consequences of such contact or situation.

Panic disorder

The same situation as with phobic disorder.

Body dysmorphic disorder

This is often co-existent with OCD. In this case, however, the worrying thoughts and checking rituals are concerned with bodily appearance.

Health Anxiety

This is often co-existent with OCD. In this case, however, the worrying thoughts and checking rituals are concerned with fear of specific illnesses.

Schizophrenia

Particularly in the early stages of schizophrenia, sufferers may develop elaborate obsessions and compulsions. These are often quite removed from normality and appear very “strange” to others. In addition, clozapine may result in exacerbation or emergence of OC symptoms.

Anorexia nervosa or eating disorder

Anorexia nervosa patients often have apparent OC symptoms but these concern food, bodily size and weight.

Autism or Asperger’s syndrome

These conditions generally start in early life and the OC symptoms seem to be an integral part of the person’s personality structure

OBSESSIVE-COMPULSIVE DISORDER

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Co-morbidity and OCD

- Depression is frequently co-morbid with OCD. In these cases the presentation may be purely with depression.
- Alcohol or other psychopharmacological substances may be misused to try and reduce the anxiety symptoms.

What are the risks which the GP should consider?

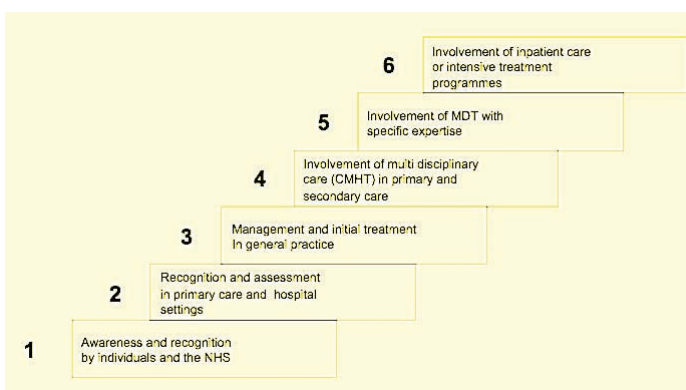
Contrary to the belief of many, suicide and self-harm are relatively common in OCD with a similar rate of suicide to that found in depressive disorder.

The other important issue is the effect of the illness on the child, not only in terms of their physical safety but also in relation to his or her psychological development. It is usually advisable to inform social services early if there is any suspicion of negative impact on the child.

Melissa admits she is worried about her daughter and informs the GP that her mother is also concerned and has agreed to come and stay with Melissa while she undertakes treatment. The GP is reassured that the child will be properly cared for.

What are the treatment options for Melissa?

NICE⁵ recommends a stepped care model for OCD starting with increasing public awareness at step 1 and moving through to step 6 which is involving highly-specialised teams for the most refractory conditions.



In the first instance at primary care level NICE⁵ recommends two approaches of either cognitive behavioural psychotherapy treatment involving graded **exposure** and self-imposed **response prevention** (ERP) or pharmacological treatment. ERP can be offered as self-help through computer and telephone-aided packages or by self-help manual⁷; in groups both in the NHS or via self-help charitable organisations¹⁸ or in individual treatment with a therapist.

ERP is a very successful treatment with 80% of those who embark on the treatment showing significant clinical improvements⁹.



Treatment for OCD⁹ consists of asking the individual to face up to the feared situations and to let the obsessive thoughts occur. This will cause anxiety but, as long as the OCD sufferer does not perform the anxiety-reducing compulsions, this anxiety will permanently reduce after approximately 1 hour. This anxiety reduction is known as habituation.

Clearly, the most handicapped individuals cannot be expected to plunge into the most difficult situations immediately. Exposure therapy needs to be performed in a structured way. The sufferer needs to identify a hierarchy of increasingly anxiety-provoking situations. The least anxiety-provoking situation is then picked and the OCD sufferer asked to expose to this for at least 1 hour or until the anxiety has reduced by at least half without performing compulsions.

A good way of estimating this anxiety is to score the severity on a 9-point scale (0 = no anxiety; 1/2=mild; 3/4/5=moderate; 6/7=severe and 8 complete panic). The person with OCD is then asked to score the anxiety at the beginning of the exposure and at intervals throughout. The anxiety will vary but, as long as no compulsions are performed, there should be an overall reduction.

Once this has been done, the sufferer needs to repeat this exposure task, ideally three times a day, and should find that the anxiety reduces both in severity and duration. Once the first task has been successfully mastered in this way, the next item on the hierarchy can be tackled until the problem is overcome.

The sufferer needs to remember the three "golden rules" about anxiety:

- Anxiety is unpleasant but it does no long-term harm.
- Anxiety will reduce if you persist with exposure.
- Regular practice makes exposure easier.

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Other first line treatments involve the use of antidepressant drugs which act preferentially on the serotonin system in the brain and increase its level. These drugs are known as serotonin reuptake inhibitor (SRIs). Drugs which can be used are:

Drug	Recommended Dose	Comments
Clomipramine	Upto 225mg at night, increased slowly as tolerated	A tricyclic antidepressant. Has been used for the longest time. High number of side effects, such as seizures (less likely if dose less than 250mg); sexual dysfunction in 80%; dry mouth; blurred vision drowsiness; weight gain; and orthostatic hypotension
Fluvoxamine	50mg–300mg gradual increase (divided doses for >150mg)	The first SSRI to be widely used for OCD. Side effects include gastro-intestinal upsets; anorexia and weight loss; insomnia; hypersensitivity reactions; sexual dysfunction in 30%; rare side effects include movement disorders; galactorrhoea and urinary retention
Fluoxetine	20mg (usually morning) and then if inadequate response after 2 weeks increase up to maximum of 60mg	Has a long half-life. Side effects as above
Paroxetine	10mg–50mg	Side effects as above
Sertraline	50mg to a maximum of 200mg gradual increase	Side effects as above
Citalopram	20mg–60mg (morning or evening)	Side effects as above. Not licensed for OCD yet.
Escitalopram	10mg–20mg (morning or evening)	The active enantiomer of Citalopram. Not licensed for OCD yet, although recent evidence shows some efficacy in preventing relapse of OCD ¹⁰ .

Drug treatment is effective with more than 50% of those receiving drug therapy showing benefit. SSRI's are used as first line because of a better side effect profile than clomipramine (SRI).



Melissa did not wish to take medication at this time and decided to embark on a graded exposure treatment in collaboration with a therapist attached to her GP practice. What is her prognosis?

Most patients who engage in ERP will improve. However, for some this is too stressful. In these cases, medication should be offered. It is important to consider and explain that medication needs to be continued long term and this may potentially have influence on decision-making in patients of childbearing age. In these cases, or where there are other complications, combination of ERP and drugs are used. Although there is some evidence to suggest this is particularly helpful, no controlled trial has systematically demonstrated the benefits at this time⁸.

Most patients will respond to the treatments but some individuals have more refractory conditions. What options are available for refractory patients?

Patients with OCD who are refractory to first line treatments

If the patient does not respond to ERP and/or appropriate medication, a number of questions should be considered. These are:

- Check accuracy of the diagnosis with full psychiatric assessment.
- Severe co-morbid depression may hinder the efficacy of ERP due to poor concentration and heightened arousal in the patient.
- Has the patient performed ERP correctly? Have they been able to carry out exposure instructions and resist the urge to neutralise anxiety with compulsions? If not it is worth revisiting and gradually introducing exposure items.
- Has the patient taken the prescribed medication correctly? If not why not?

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Once these have been answered it may be worthwhile considering alternative strategies. These include:

- Combining medication and ERP.
- Adding targeted cognitive therapy techniques to ERP^{11, 12}.
- Changing SRI. Although the SRIs are effective in OCD, certain drugs seem to work better for specific patients. It is thus always worthwhile switching to a new drug. The onset of action is often slow and the drug sometimes needs to be continued for at least 3 months before benefit is apparent. Patients sometimes slowly improve over months and years with drug therapy.
- Once these strategies have been tried to no avail, the next psychopharmacological step is to try to augment the SRI with either dopamine blockers or mood stabilisers¹³.

Recommendations for refractory OCD¹³

Dopamine blockade

This is the most likely intervention outside of a specialist centre and is the most extensively researched. Doses of the drug is normally considerably lower than that used for psychotic illness.

Supranormal doses of SSRI

Some patients are rapid metabolisers of SSRIs and thus higher doses are required. Blood levels should be checked and so this is best done at a specialist OCD clinic.

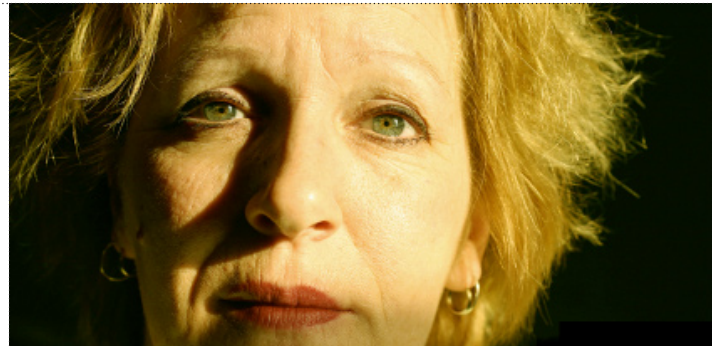
Other

Addition of mood stabilisers/Buspirone/Clomipramine and SSRI, etc. Likely to be performed at a specialist OCD service.

If none of the above strategies are successful, then referral to a specialist centre is indicated. Even when dealing with such refractory patients, good outcome can be achieved with specialist intervention with an average reduction in OCD symptoms of at least a third^{11, 12, 14}.

Self-assessment Questions

1. Obsessions are usually pleasant and enjoyable.
2. Resistance to performing the compulsion is necessary for the diagnosis of OCD.
3. Compulsions may manifest as thoughts.
4. Psychodynamic psychotherapy is a proven treatment for OCD.
5. Drug treatment is rarely effective in OCD.
6. Most OCD sufferers who commence on a graded exposure treatment programme will improve significantly.
7. Dopamine – blocking drugs may be used to augment treatment in OCD patients who fail to respond to SRIs or psychological treatment.
8. Patients with OCD may present to dermatology or other medical clinics initially.
9. The NICE stepped care recommends that all patients with OCD are referred to specialist psychiatric centres on diagnosis.
10. OCD is a rare condition with few patients on each GPs list.



Self-assessment Answers

1. False
2. False
3. True
4. False
5. False
6. True
7. True
8. True
9. False
10. False

Notes on self-assessment

1. In everyday life, someone may be described as having an “obsession” with football meaning that they enjoy and pursue activities to do with football. In psychiatry, however, an obsession is an intrusive, unwanted, distressing or anxiety-provoking thought, image or impulse. Thus obsessions are far from enjoyable.
2. Although during the early stages of OCD, most sufferers try to resist the obsessions and the need to perform rituals or compulsions, much of this resistance disappears as the condition becomes more chronic.
3. Whereas many people think of a compulsion as an act, they can also be thoughts. For example, someone may have an obsessive thought that they have physically assaulted someone in the street. This individual may then feel the urge to recall all their recent movements to ensure that they did not, in fact, attack anyone. Another example of a covert compulsion is repeatedly praying in a repetitive and stereotypical manner to “undo” a “bad” thought.
4. Psychodynamic psychotherapy is ineffective in the treatment of OCD. There is evidence for drug treatment with serotonin reuptake inhibiting drugs and for psychological treatment known as cognitive behavioural psychotherapy, which involves graded exposure to the fears combined with encouraging the sufferer not to engage in compulsive rituals.
5. As many as 60% of OCD sufferers improve when treated with serotonin reuptake inhibiting (SRI) agents.
6. Grade exposure is very successful with approximately 80% of OCD sufferers who do this therapy being clinically significantly improved.
7. If the OCD is resistant to SRIs then second line treatment can often improve the situation greatly. The most usual second line treatment is adding in a small dose of a dopamine blocking agent to the SRI.

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8. Patients may appear in dermatology with eczema of the hands or other parts of the body due to excessive washing. Other medical clinics where OCD sufferers are most frequently seen include genital-urinary medicine where OCD sufferers may repeatedly ask for reassurance and blood test to ensure they have not contracted HIV or other illnesses.

9. The NICE stepped care model for OCD starts with public awareness and recognition through to recognition and treatment in primary care before treatment in secondary care and lastly referral to specialised OCD treatment centres.

10. OCD is a relatively common condition, 1–3% of the adult population suffer from OCD at some point in their lives. Thus every GP practice is likely to have a small but substantial number of sufferers.

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Useful websites

- <http://www.nice.org.uk/Guidance/CG31> The National Institute of Health and Clinical Excellence. Provides NICE guidelines on OCD.
- http://www.swlstg-tr.nhs.uk/ocd_web_guide.asp Web-based learning guide for treatment of OCD.
- <http://www.nice.org.uk/usingguidance/sharedlearningimplementingnicedguidance/examplesofimplementation/eximpresults.jsp?o=150>. Description of Community Service for OCD.
- www.topuk.org.uk Charity offering self-help therapy groups for OCD and phobic anxiety sufferers.
- www.ocdyouth.info Information from the South London and Maudsley NHS Trust directed at young people and their carers.
- www.ocdaction.org.uk Run by a UK-based charity, this website provides an informative description of OCD and associated therapies. Also provides support groups, recommended reading and news articles as well as advice for families and carers.
- www.ocduk.org UK website run by OCD sufferers, for OCD sufferers. Includes advice and facts about OCD, treatment and support for patients and families. It also provides a local support group locator.

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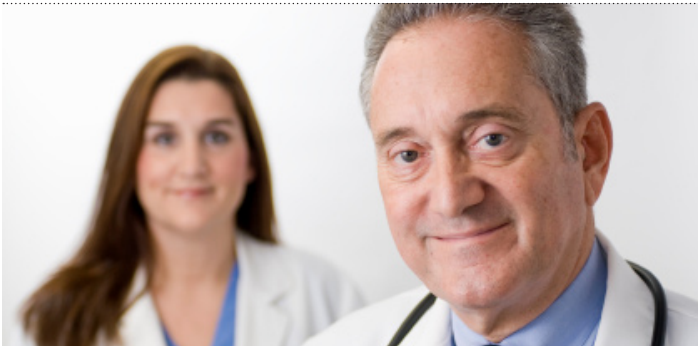
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MENTAL CAPACITY ACT 2005

Alok Kumar Rana, Ankush Singhal and Richard Eggar



Every doctor will have experience of caring for somebody who may lack the mental capacity to consent to treatment.
Good Clinical Care.

Every doctor will have experience of caring for somebody who may lack the mental capacity to consent to treatment. Whether it is somebody with delirium trying to leave a hospital ward or a person with dementia facing a serious treatment decision, the Mental Capacity Act (MCA) is there to support and protect the patient and ourselves.

This article should be seen as an introduction to the Mental Capacity Act and not a substitute for familiarity with the Code of Practice which is a comprehensive tool for the application of the Act¹. Although it is a statutory document, it is set out in an informative and approachable form.

What is mental capacity?

Decision-making capacity refers to the ability that individuals possess to make decisions. This would involve different decisions from the very simple, such as what to have for a meal, to far more significant decisions, for example, whether to have a particular medical treatment.

The process for assessing capacity and making decisions on behalf of people who lack capacity has been set in statute law within the Mental Capacity Act, 2005¹.

What is the Mental Capacity Act 2005?

The Mental Capacity Act 2005 for England and Wales came fully into force on 1 October 2007². The Act generally covers people aged 16 or above. The only exceptions to age are that one has to be aged 18 or over to create a "Lasting Power of Attorney" or to make an advance decision to refuse treatment. The Act provides a statutory framework for working with people who may lack capacity to make any decisions for themselves. These may include people with dementia, learning disabilities, mental health problems, delirium, stroke, head injuries, etc. The act also covers conditions giving rise to situation when capacity is fluctuating or absent for a short period. These conditions may include delirium, head trauma, inflammatory illnesses involving brain, encephalopathy, depression, seizures, intoxication with alcohol or illicit substances and cognitive impairments due to prescribed medications, etc. to name a few. The Act also covers other conditions which may impair capacity like older people experiencing frailty as well as people who are imminently dying or are unconscious and who no longer have mental capacity³.

The Act safeguards their rights by providing a legal framework for professionals and carers to identify ways to support them as well as identifying the responsible person to make such decisions on their behalf. It also enables people to plan ahead for a time when they may lack capacity. The Act covers most major decisions which people face in their lives, advanced decisions and the appointment of attorneys or deputies for future decisions. Other issues covered by the Act are the conducting of research on incapacitated people and specialised advocacy for people without friends or family. For the first time, this Act has introduced the criminal offence of ill-treatment or wilful neglect of people who lack capacity⁴.

What are the key principles of the Act?

The Act is based on five statutory principles which are⁴:

1. Presumption of capacity – "An adult must be assumed to have capacity to make a decision unless it is established that they lack capacity."
2. Supporting individuals to improve decision-making capacity – "A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success."
3. Acceptability of unwise decisions – "A person is not to be treated as unable to make a decision merely because he makes an unwise decision."
4. Best interests consideration – "An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests," and
5. Choosing least restrictive option – "Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

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The capacity assessment is the responsibility of the person who needs to make a decision on behalf of the incapable person. Good Clinical Care.

Who should assess capacity?

The capacity assessment is the responsibility of the person who needs to make a decision on behalf of the incapable person. For any medical treatment, it is the responsibility of health professional, proposing the treatment (e.g. the surgeon if surgery is offered as a treatment), to judge the capacity of the person. Social care decisions typically would be the remit of a social care professional. Assessment of capacity is not a mental health issue in routine circumstances, however, in difficult cases advice might need to be sought from a specialist, for example, a learning disability consultant. However, the responsibility for the final decision rests with the professional responsible for the decision at hand. The capacity assessment should be recorded in the medical notes including reasons for the assessment, assessment procedure and its outcome. For all serious and important decisions a formal assessment of capacity is expected⁵. As a result, many NHS trusts have included assessment of mental capacity to consent for management as a routine for all admission in psychiatric units⁶.

How do you assess capacity and what are the important points to consider during mental capacity assessment?

Capacity is the legal ability to enter into a valid contract. For the purpose of the Act, a person lacks capacity if in relation to a particular subject; they are unable to make the decision, at the time the decision needs to be made. Capacity is therefore both time and task specific¹.

This means that capacity may vary from decision to decision or in regards to the same decision at different times. As a consequence there is no scope within the Act to attribute a blanket lack of capacity to an individual.

A person should not be assumed to lack capacity just because of their age, appearance, any specific aspect of their behaviour or any condition which may lead to unjustifiable assumptions about them. For example, a man with Down's syndrome may be recognisable by his appearance and as a consequence assumptions are made about this capacity. This is clearly prejudicial and contrary to the principles of the Act.

The Act contains a two-stage test of capacity¹:

1. Is there an impairment of or disturbance in the functioning of, the person's mind or brain? If so,
2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

The first part of the two-stage test is very broad and covers any medical, emotional, psychiatric, neurological or psychological state which could alter a person's ability to reason a sound decision. It would include somebody in a coma or in a highly distressed state following an accident. A formal diagnosis is not required if the impairment or disturbance is obvious.

Second, there is a functional test pertaining to the decision at hand; a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she fails any one or more of the following⁵:

1. To understand the information relevant to the decision.
2. To retain the information relevant to the decision.
3. To use or weigh that information to reach the decision, or
4. To communicate that decision to the assessor (by any means, such as talking, writing, sign language, hand movements, eye blinking, etc.).

When an individual fails one or more parts of this test, they fail the entire test which means they do not have the necessary capacity.

In order to assess a person's understanding, it is essential that the assessor has a clear understanding of the issue themselves. Therefore all necessary assessments need to have been completed before capacity assessment, for example, an occupational therapy assessment prior to a decision concerning care needs. This information should be shared, explained and explored with the person in a way which is most appropriate to their needs. This may include written information or sign language. The onus is on the assessor to prepare for the assessment adequately and ensure the information and form of delivery is sufficient. Only in an emergency would it be considered appropriate to provide the information in an unprepared or rushed fashion.

To understand the information, the person needs to appreciate:

- the nature of the decision
- the reason why the decision is needed, and
- the likely effects of deciding one way or another, or making no decision at all.

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A person needs to be able to retain the information for long enough to make the decision. People who can only retain information for a short period may well have capacity especially if the issue is fairly simple and can be summed up briefly. Memory aids, such as notes, photos, etc. may enhance somebody's recollection sufficiently to safeguard their capacity.

To assess a person's ability to use or weigh the information, it is necessary to see whether the person can show how the information has led them to their decision. It is important to ascertain that the decision reached was based on understanding. Open questions, such as "Explain to me how you reached your decision?"; "Which factors were most important to you in reaching your decision?", will inform this aspect of the assessment.

The assessment of a person's ability to communicate may not be as straightforward as is imagined. While obvious for somebody unconscious or in a coma, many people with neurological conditions or learning difficulties can communicate given the right approach, aids and patience. Carers who know the person well are usually best placed to advise on how to communicate most effectively. Sometimes even a simple nod, eye blink or finger movement may suffice. It is important therefore that all practical and appropriate steps are taken before deciding that somebody cannot communicate in any way.

When somebody's capacity is fluctuant or likely to recover with treatment, if possible the decision should wait till they are at their most able. When this is not possible or the person's condition is changing rapidly, it is prudent to assess their capacity more than once to help establish the consistency of their wishes.

What is the "best interest" principle as described in the Act?

One of the fundamental principles of the Act is that any action or decision taken for the incapacitated person must be in their best interest. The Act has provided a statutory checklist (rather than any definition of best interest). The checklist as a guide says that the following factors should be taken into consideration⁴:

- The participation of the person themselves.
- All relevant circumstances.
- The person's views past and present, whether expressed verbally, in writing or interpreted through their behaviour or habits. Any beliefs and values held by the person likely to influence a decision if they were able to make it themselves.
- Avoid discrimination.
- Assess whether the person might regain capacity.
- If the decision concerns life-sustaining treatment that the decision taken is not motivated by a desire to bring about the person's death.



The code of practice says that when practical and appropriate, the following people should be consulted⁴:

- Anyone previously named by the person as somebody to be consulted on either the decision in question or on similar issues.
- Anyone engaged in caring for the person.
- Close relatives, friends or others who take an interest in the person's welfare.
- Any attorney appointed under Lasting Power of Attorney or Enduring Power of Attorney made by the person.
- Any deputy appointed by the Court of Protection to make decisions for the person.

There are two circumstances when a best interest decision is not appropriate⁴:

- When somebody has a valid Advanced Decision which covers the question at hand, this should be respected.
- The involvement of the person in research.

Best interest decisions are led by the decision maker. This is the person with the most expertise within the area of the decision. For everyday decisions this would be the carer most involved with the person. For medical treatment the decision maker would be the professional responsible for that treatment likewise a social care decision would be the remit of the social care professional considering the issue.

It is important to note that a best interest decision by nature of the above is not a vote held by the participants; it is a balanced decision reached by the decision maker following consultation of participants and consideration of the relevant facts.

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What is the legal standing of next of kin in the Act?
What if there is nobody to consult?

The Mental Capacity Act gives a clear legal right to family, carers and friends to be consulted regarding best interests decisions³. The Act also has special provisions for incapable people who have no one other than professionals or paid carers to advise them. Under these circumstances, an Independent Mental Capacity Advocate (IMCA) must be consulted. Other than in a genuine emergency an IMCA must be contacted if⁴:

- An NHS body is proposing to provide serious medical treatment.
- An NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home and:
 - the person will stay in hospital longer than 28 days, or
 - they will stay in the care home for more than 8 weeks¹.

Each hospital and local authority will have its own arrangements for providing the IMCA service. This aspect of the Act is often overlooked especially in acute trusts, it is, however, a clear legal responsibility.

How else can decisions be made for an incapacitated person?

There are three additional specific mechanisms allowing decisions to be made:

1. Advance Decisions to refuse treatment – the Act has created statutory rules to direct people so that they may make a decision in advance to refuse treatment should they lack capacity in the future. The Act distinguishes between “advance decisions to refuse medical treatment” and “advance decisions to request medical treatment”³. The important thing to remember is that only advance decisions to refuse treatment are legally binding (advance decisions to request medical treatment are not legally binding) and that too only if they are valid and applicable. It is worth checking their validity and applicability as clarified below:

Validity: It becomes invalid if the person⁴:

- Has withdrawn it either in writing or orally whilst they had capacity.
- Has subsequently created a Lasting Power of Attorney and authorised somebody to decide about such treatment.
- Has subsequently acted in a fashion inconsistent with the advance decision.

Applicability: an advance decision is not applicable if⁴:

- At the time of decision, the person has capacity in relation to the treatment in question.
- The treatment currently proposed is not the same as specified in the advance decision.
- The circumstances are different from those that may have been set out in the advance decision.
- There are reasonable grounds to believe that current circumstances were not anticipated when the advance decision was made and which would have affected the advance decision.

In addition, an advance decision concerning the refusal of “life-sustaining treatment” must be in writing, signed, dated and witnessed. Also, there must be an explicit statement that the decision stands “even if life is at risk”. There are no such requirements for other advance decisions.

2. Lasting Powers of Attorney (LPA) – under the Act, any person with capacity can nominate and appoint a designated person (or persons) to act on their behalf should they lose capacity. This is known as a “Lasting Power of Attorney (LPA)”. LPA is a formal document so it should always be in writing and it is not possible to create an LPA verbally. The designated person(s) to whom the authority is given is known as the “donee” and the person authorising is known as the “donor”¹. This has replaced the old system of Enduring Power of Attorney (EPA). The major difference between the old EPA and the new LPA is that in addition to financial affairs, an LPA can also cover health and welfare decisions, if explicitly created to do so. The act gives complete freedom to the donor to choose the decisions they want to give to the donee, however, a donee is not allowed to make any decision about life sustaining treatment unless specifically authorised in the LPA document. The donees must make decisions in the best interests of the donor. An LPA must be registered with the Office of Public Guardian (OPG) to make it legally valid for use³.

3. Court appointed deputies – this system can be used when there are serious health care, welfare or financial decisions that need to be made in the absence of an Advance Decision or LPA or there is a dispute. The Court of Protection can appoint a designated person(s) as deputy(s) to act on behalf of the person. While the court could make a decision itself there are occasions when this is not practical or appropriate, for example, there is a need to make ongoing decisions. This system of court appointed deputies has replaced the old system of receivership³. The court appointed deputies can be allowed to take decisions on welfare, health care and financial matters as authorised by the Court of Protection. This appointment should be as limited in scope as possible and for the shortest time. The deputies can not make a decision about life-sustaining treatment; if this issue arises then the decision must be taken by the court.

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What does the Act say in connection with care or treatment?

The MCA, 2005 gives legal protection to professionals and carers providing support to people who lack capacity. In essence, the Act offers protection from liability if the principles upon which the Act is based are being followed.

This protection goes as far as saying a person who lacks capacity and is at risk of coming to harm may be restrained, provided the restraint is proportionate and the minimum necessary to make the person safe⁷.

Somebody is using restraint if they⁴:

- use force – or threaten to use force – to make somebody do something that they are resisting, or
- restrict the persons freedom of movement, whether they are resisting or not.

Whilst restraint may be lawful under the Act under specific circumstances, deprivation of liberty is not⁷. Following the Bournemouth case (*HL v UK*) new legislation known as the Deprivation of Liberty Safeguards (DoLS) has been made law⁸. These safeguards are beyond the scope of this article but are clearly explained by the Deprivation of Liberty Safeguards Code of Practice which should be consulted.

What new institutions has the Act created to support this statutory framework?

The Act has created a new public body and a new official to support the statutory framework⁹.

- **New Court of Protection** – the new court will have jurisdiction relating to the whole Act. It will have its own procedures and nominated judges. It will be able to make declarations, decisions and orders affecting people who lack capacity and make decisions for or appoint deputies to make decisions on behalf of people lacking capacity. It will deal with decisions concerning both property and affairs, as well as health and welfare decisions. It will be particularly important in resolving complex or disputed cases involving, for example, about whether someone lacks capacity or what is in their best interests. The court will be based in venues in a small number of locations across England and Wales and will be supported by a central administration in London.

- **New Public Guardian** – the Public Guardian has several duties under the Act and will be supported in carrying these out by an Office of the Public Guardian (OPG). The Public Guardian and his staff will be the registering authority for LPAs and deputies. They will supervise deputies appointed by the court and provide information to help the court make decisions. They will also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the Public Guardian discharges his functions. The Public Guardian will be required to produce an annual report about the discharge of these functions.



The MCA, 2005 gives legal protection to professionals and carers providing support to people who lack capacity. In essence, the Act offers protection from liability if the principles upon which the Act is based are being followed. Good Clinical Care.

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What does the Act say about research involving incapacitated people?

The Act sets out clear parameters for research, stating that any research involving, or in relation to, a person lacking capacity may be lawfully carried out if it is agreed by an “appropriate body” usually a research ethics committee, that the research is safe, relates to the person’s condition and/or treatment and cannot be done as effectively using people who have mental capacity. Also, the proportionate benefit of the research must outweigh any risk or burden. Alternatively, if the purpose of the research is to derive new scientific knowledge, it must be of minimal risk to the person, should be carried out with minimal intrusion and restriction and should not cause interference with their rights like freedom of action or privacy⁹.

Researcher must consult the carers or nominated third parties and they agree that the person would want to join an approved research project. If the person indicates in any way that he or she does not wish to take part or shows any signs of resistance, the researcher should withdraw the person from research immediately³.

Does the Act has any powers in criminal justice system?

The Act has introduced two new criminal offences⁴:

1. Ill treatment, or

2. Wilful neglect of a person who lacks capacity.

This clause is applicable to anyone caring for a person who lacks capacity – this includes family carers, health care and social care staff in hospital or care homes and those providing care in a person’s home. It is equally applicable to an attorney appointed under an LPA or an EPA or a court appointed deputy. A person found guilty of such an offence may be liable to a penalty which may range from fine to a sentence of imprisonment for a term of up to 5 years or both.

Conclusion

Mental Capacity is a clinico-legal concept. Mental Capacity Act 2005 provides a legal framework to protect the rights and ensure the best interests of the people who are not capable to make their own decisions. There is a provision of various statutory bodies to ensure the application of the Act. Therefore, it is of paramount importance for everyone who has responsibility for the care of incapacitated patients, to become familiar with the Act, not only to protect these vulnerable patients but themselves also.

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ELECTRO-CONVULSIVE THERAPY: DOES IT HAVE A ROLE IN THE MANAGEMENT OF DEPRESSION?

Rafael Euba

A 75-year-old woman, called Mrs K, is brought to the A&E by her daughter. She has not been eating properly for some time and has lost a considerable amount of weight as a result. Good Medical Practice.



A 75-year-old woman, called Mrs K, is brought to the A&E by her daughter. She has not been eating properly for some time and has lost a considerable amount of weight as a result. Mrs K takes a long time to answer questions and talks in a quiet voice. She says to the Casualty Officer that there is no point in eating because she is empty and hollow inside, and would not be able to digest the food. In any case, she adds, she is tired of life and would like to die; she feels she is a burden to her daughter and does not deserve to be looked after. In fact, she has been considering the possibility of taking an overdose of tablets in order to finish it all. Mrs K has been hearing a voice telling her that she is a wicked person and that she is going to be taken to prison. Her daughter explains that Mrs K has a previous history of depression and is on antidepressant medication: she had been on amitriptyline for a long time, but this was changed to sertraline a few weeks ago, when she started to develop her current symptoms. Her mood deteriorated after she received a letter from the council, threatening her with court action for non-payment of council tax, for which she was, in fact, exempt. Mrs K is generally independent, despite her belief that she is a burden to her daughter. She also takes medication for her blood pressure, as well as a laxative.

Mrs K has a depressive disorder. Her feelings of guilt in relation to her daughter, her wish to die, and her *nihilistic* belief that she is empty inside, are all symptoms of depression. She is also suffering auditory hallucinations, which together with her nihilistic delusion of being empty inside and her unfounded belief that she is going to be sent to prison, indicate that she has a *psychotic* depressive illness. Her delusions and hallucinations are congruent with her depressed affect because their content and prevailing themes – being empty and wicked – are consistent with a depressed mood. Psychotic experiences and mood are congruent in affective psychotic illnesses, whereas they are frequently incongruent in schizophrenia.

Mrs K has a particularly severe depressive illness. Not only she has psychotic features, but also biological symptoms, such as loss of weight and a degree of psychomotor retardation. She feels that life is not worth living and is entertaining thoughts about harming herself. The immediate management of the case should probably involve admission to hospital and perhaps a new adjustment or change of her antidepressant medication. However, even if the change in the dose of the antidepressant – or a change of the antidepressant itself – eventually helps to restore Mrs K's mood to normality, she will probably have to wait for 2 or 3 weeks to start feeling the improvement. She is not eating and there are concerns that she might harm herself, so time is an important consideration. In this context, ECT is a very valuable therapeutic tool.

ECT is especially effective in very severe depressions, but not particularly useful at the opposite end of the spectrum of illness severity. Patients with a psychotic depression, psychomotor changes – such as agitation or retardation – and biological symptoms, are comparatively more likely to respond to ECT, whereas those whose feelings of sadness are associated mainly with adjustment problems, dissatisfaction with life, neurotic symptoms or personality difficulties, are less likely to benefit from this treatment. Mrs K will probably start to notice her mood lifting after only 2 or 3 treatments. The earliest signs of improvement, however, may not be related to her subjective mood; instead, her objective *affect*, psychomotor retardation and other biological symptoms, will probably start improving before her mood gets noticeably better.

A brief history of ECT

LJ Meduna, a Hungarian neurologist, had induced epileptic fits by chemical means in the 1930s as a treatment for schizophrenia. However, inducing seizures chemically had serious risks and was unreliable. Ugo Cerletti, also in the 1930s, thought that inducing fits with electricity would be a better alternative. At the time, the aim was to treat schizophrenia, as many wrongly believed then that epilepsy relieved the symptoms of psychosis. In fact, it soon became clear that ECT did not improve schizophrenia, but it did make melancholy much better and it did so very effectively. Cerletti first tried ECT with a psychotic engineer from Milan. It has to be said that it is not terribly clear whether this particular patient got better with the treatment, but the technique soon became well established. It did not take long before ECT found its place in mainstream psychiatry and it quickly grew to be a very widely used treatment.

ECT has a difficult image in the media and in popular culture. The film *“One Flew Over the Cuckoo’s Nest”*, based on the novel by Ken Kesey – now considered a classic of American literature – and directed by Milos Forman in 1975, showed ECT as a tool for punishment and repression. A recent survey of the depiction of ECT in the British press has shown that this image of ECT is unfortunately still very prevalent in the written media¹.

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Detractors of ECT often mention the fact that we do not know very much about how it works. We have already seen that the basis on which it was developed was flawed. Good Medical Practice.

Mode of action

Detractors of ECT often mention the fact that we do not know very much about how it works. We have already seen that the basis on which it was developed was flawed. However, there have been many instances in medicine of effective cures that were found by accident and not understood for a long time. The example of the use of limes to prevent scurvy, long before vitamin C had been discovered, is often mentioned in this context³. It also seems unfair that many who criticise ECT on these grounds seem less prepared to demand exhaustive scientific explanations on the mode of action of alternative remedies.

In any case, we do know that ECT helps modulate neurotransmitter function in the brain and that it shares (paradoxically) anticonvulsant properties with some of the mood stabilisers that are commonly used in the prophylaxis of some affective disorders. Last, we also know that – contrary to popular belief – ECT has significant neuro-plastic and neuro-protective properties, which could conceivably be implicated in its mode of action.

Indications and efficacy:

- severe depression
- catatonic schizophrenia
- severe mania.

The main indication for ECT – by far – is the treatment of severe, or melancholic, depression. NICE tells us that it can also be used for the treatment of two other conditions: catatonic schizophrenia and mania (when it has not responded to standard pharmacological interventions), but ECT is not commonly used to treat these disorders. We need to bear in mind that sometimes a patient may have more than one psychiatric diagnosis, even during a given acute episode. For instance, a patient with schizophrenia may also be severely depressed. If that is the case, ECT may be useful as a treatment for the affective component of this patient's presentation.

A pooled meta-analysis of randomised controlled trials, commissioned by the Department of Health, compared the efficacy of ECT versus antidepressants and clearly concluded that ECT is more effective than psychotropic drugs in the treatment of depression⁴.

NICE also says that ECT should not be used as a first line treatment. Instead, one should try pharmacological and psycho-social interventions first and only consider ECT when those interventions have failed. In some cases, however, such as patients who are not eating and drinking, and whose disorders are therefore life-threatening or those who are already known to respond much better to ECT than to any other interventions, it would be reasonable – perhaps even necessary – to consider ECT as a first line treatment.

ECT is a very powerful and effective antidepressant treatment, but it does not always produce a sustained improvement by itself. After the course of ECT, the patient's mood will need to be maintained with the help of antidepressants and whatever psychosocial interventions may be appropriate in the case. This will reduce the likelihood of relapse very significantly.



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Technique and administration

ECT is “modified” by the use of a short-acting anaesthetic agent, such as propofol, and a muscle relaxant, like suxamethonium. The result is a seizure with a much reduced motor component, so the risk of fractures and trauma is greatly minimised. It is important, of course, to ensure that the anaesthesia is given before the muscle relaxant, as otherwise the patient would be conscious but paralysed, which is a terrifying experience. A modern ECT machine delivers with each stimulus between 50 and 750 millicoulombs approximately in electrical energy, in the form of brief electric pulses. We can control the amount of energy we give to the patient with the help of a dose dial, but the length of the stimulus is automatic and only lasts for a few seconds. The dose dial in a modern ECT machine controls the percentage of energy to be delivered, from 10% of the machine power output, to a maximum of 100%. Normally, the machine also has an EEG component that is able to tell us the actual length of the EEG seizure, after the clinical motor seizure ends. The EEG component of the machine has a number of electrodes that are applied to the patient’s head, whereas the ECT machine itself has two electrodes, that can be applied bilaterally or unilaterally. Most frequently, ECT is given bilaterally, by positioning each electrode in either temple, roughly between the external angle of the eye and the ear. When there are concerns about the possibility of inducing memory side effects, Unilateral ECT is thought to be a better alternative to Bilateral ECT. Unilateral ECT is normally given to the right cerebral hemisphere (non-dominant), by applying one electrode in the usual position in the right temple and the other in the temporal vertex. Before delivering the stimulus, we check the impedance to the passage of the electricity through the electrodes (measured in Ohms) by applying them to the patient’s head and then pressing the *impedance* button in the machine. We want the impedance to be below a certain number; or otherwise we will need to try to achieve better contact by withdrawing the electrodes and applying them again.

During the delivery of the stimulus, it is important to maintain good contact between the electrodes and the patient’s skin. This good contact is facilitated by either dipping the electrodes in an electrolyte solution beforehand or otherwise by applying a conducting gel to the surface of the electrodes. After the stimulus is delivered, the patient will have a generalised tonic-clonic seizure, which will last for about 10 or 20 seconds or so. The EEG recording will be able to tell us the actual length of the seizure in the patient’s brain, which is often longer than the motor seizure.



Deciding the dose of electricity to be delivered is one aspect of the treatment that requires some consideration. Some ECT machine manufacturers simply recommend that the patient’s age is directly translated into the dose (in percentage) in the first session; in other words, if the patient is 35, one should give him 35%, whereas if he or she is 70, they should receive 70%. However, many patients would receive excessive doses of electricity if this system was applied universally. Instead, we titrate the dose from an initial stimulation in the first session of 10 or 20% and restimulate – still in the first session – up to a maximum of three stimuli, until we achieve a response. We now know that the dose at which the patient responded with a tonic-clonic seizure is the dose that reaches his own personal epileptic threshold. We believe that in the case of Bilateral ECT the dose necessary to reach the therapeutic threshold – that is, the dose needed to produce an improvement in the patient’s psychological state – exceeds the epileptic threshold at least by half, so the dose we will deliver in session number two will be the dose at which we reached the epileptic threshold in session number one plus half. Therefore, if the epileptic threshold in a given patient was found to be 30% in the first session, we will then give him 45% in session number two (30% + half of 30%). In the case of Unilateral ECT, the dose used will be three to six times the dose necessary to reach the epileptic threshold.

The epileptic threshold is affected by a variety of factors, such as age, gender or medication. Antipsychotics and SSRI antidepressants lower the epileptic threshold, whereas anticonvulsants, which sometimes are used as mood stabilisers in some psychiatric patients, obviously increase it. Benzodiazepines also increase the threshold.

After the treatment, the patient is taken to the recovery room, where they will be looked after by the recovery nurse until he or she is ready to return to the ward. This normally only takes a few minutes.

An average course of ECT will consist of six to twelve treatment sessions, two sessions a week. In some rare cases, ECT is continued indefinitely as a maintenance treatment, perhaps at a rate of one treatment fortnightly, but this is discouraged by NICE.

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Risks

ECT should not be used when there is a raised intracranial pressure or when the patient has suffered a brain vascular event, or an MI recently. Most other contraindications or reasons for caution are specifically related to the general anaesthesia. Rarely, ECT can induce a prolonged fit or a status epilepticus, which the anaesthetist will need to terminate. The risk of death is quite low, and in fact it has been pointed out that the death rate associated with ECT is comparable to the spontaneous death rate in the general population. ECT is sometimes capable of inducing manic rebounds, particularly if the patient has a Bipolar Affective Disorder. In these cases, it is probably better to avoid ECT altogether or otherwise to observe the patient carefully after each treatment and to stop the course immediately if he or she starts to show signs of a rebound, such as disinhibition, or an excessively expansive affect.

Side effects

The most frequent side effect are transient and generally tolerable. They include headaches, muscle aches, nausea and fatigue. Post-treatment confusion may also be a problem for some.

It is very common to have a partial amnesia for the treatment period. This means that patients often remember very little about the month when they had ECT, both during the treatment period and after it finishes. It is important to reassure them that this is a frequent side effect and that, in most cases, patients recover their ability to register and recall memories after the treatment ceases. However, when memory impairment is a significant concern, it is advisable to review the need for ECT in that particular patient, or otherwise to consider Unilateral ECT, which is less likely to affect memory than Bilateral ECT. Rarely, ECT can impair the patient's retrograde biographical memory (the ability to remember episodes in one's own life). This has been a controversial matter for some time, but it is now generally agreed that a small minority of patients may suffer a permanent memory impairment following ECT.

A significant proportion of electro-convulsive treatments are given to elderly patients. Opponents of ECT argue that this is an expression of authoritarian psychiatrists making inappropriate or excessive use of this invasive treatment against those who are least able to resist it. However, there is a much more benign explanation for this excess of elderly recipients of ECT: it is thought that elderly people are more likely to develop the type of depressive illnesses that will require ECT, such as depressions presenting with psychomotor changes, stupor or psychosis, as well as instances in which the individual has stopped eating and drinking. As we pointed out above, it is precisely in this type of clinical presentation that ECT is particularly likely to be effective.



However, it is evident that an elderly person will also be more at risk of developing side effects from both ECT and the anaesthetic procedure and that the general risk of complications will be higher for an elderly person, compared to other age groups. The rate of cognitive side effects, in particular, is especially prominent among old patients. It is therefore particularly important to ensure that elderly ECT patients are carefully examined before the beginning of the course to check that they will be able to tolerate the treatment (this in fact applies to patients of all ages), together with a full set of blood investigations, ECG and chest X-rays, and that any side effects (including cognitive adverse effects and post-ictal confusion) are recorded and considered.

Legal aspects⁵ and consent

ECT requires informed and explicit consent. The recent amendment to the 1983 Mental Health Act stipulates that we cannot give ECT to a person who refuses it, as long as this person has the mental capacity to refuse it. In other words, the Mental Health Act cannot be applied to a person with mental capacity who refuses ECT. However, if a patient is already detained under the Mental Health Act and lacks mental capacity, then this patient may be given ECT under the Act, with the help of a specially appointed second opinion doctor, who will also need to declare formally that ECT is necessary for that patient. This second opinion doctor will not be able to sign the papers authorising the treatment if the patient in question had completed a valid "advance directive" saying that he or she did not wish to be given ECT in the future, or if the entities recognised under the Mental Capacity Act as having the power to intervene in this type of situation – such as the new Court of Protection – had any objection against the treatment.

Perhaps more important than these complex legal considerations is the principle that no one should be coerced to receive ECT or threatened that they "will be sectioned" if they refuse to have it. Every patient should receive oral and written detailed information on the expected benefits and possible side effects of the treatment, including the possibility of persistent amnesia. They should also be made aware of the fact that they have the right to withdraw consent at any point during the treatment course and that this would not affect their right to receive an alternative treatment for their psychological complaint. Only a doctor that is competent in delivering the treatment should undertake the task of seeking consent for it.

ECTAS

The Royal College of Psychiatrists has set up an ECT Accreditation Service (ECTAS) that inspects ECT clinics and awards accreditation to those clinics that fulfil a comprehensive set of criteria, designed to ensure that ECT is given by competent practitioners in adequate facilities, following safe and appropriate procedures.

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Mrs Ks case

Mrs Ks antidepressant was changed, but she also had a full course of ECT, which in this case consisted of eight individual treatments. She started to show some improvement after the second treatment; by that time, she had started to eat and drink spontaneously and without prompting. Her psychomotor retardation also subsided at about the same time. After two or three more ECTs, her mood had lifted very substantially and she was fully recovered by the end of the ECT course. On discharge from hospital, her mood was normal, her abnormal thoughts and voices had disappeared completely and she certainly did not have any ideas of self-harm. Obviously, she will need to be followed-up closely by the community team and her psychiatrist, who hopes that the support of the team, together with the protective effect of the full dose of her new antidepressant, will keep her well and away from hospital.

Questions

Choose the best answer in each MCQ.

1. Which of the following are possible indications for ECT?

- a. Severe depression.
- b. Mania that has not responded to adequate pharmacological treatment.
- c. Catatonic schizophrenia.
- d. All the above.
- e. None of the above.

2. ECT:

- a. Does not need explicit consent.
- b. It can be given even if a patient with mental capacity refuses to have it.
- c. It cannot be given under the Mental Health Act.
- d. It can be used as a punishment.
- e. It needs informed consent and the expected benefits and risks need to be explained carefully to the patient.

3. ECT:

- a. Is given with a general anaesthetic and a muscle relaxant.
- b. The muscle relaxant is given first and then the anaesthetic.
- c. The patient experiences pain during the treatment.
- d. Is given everyday for a week.
- e. Is normally given four times a week.

4. The possible side effects of ECT may include:

- a. Headaches.
- b. Post-ictal confusion.
- c. Memory problems.
- d. Nausea.
- e. All the above.

5. Elderly patients:

- a. Should never have ECT.
- b. Are less likely to be treated with ECT than younger patients.
- c. May have ECT, but they need to be carefully assessed physically before the treatment.
- d. Are less likely to respond to ECT.
- e. Are less likely to have memory problems after ECT.



Mrs Ks antidepressant was changed, but she also had a full course of ECT, which in this case consisted of eight individual treatments. She started to show some improvement after the second treatment; by that time, she had started to eat and drink spontaneously and without prompting.
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The main indications for ECT are: severe depression, catatonic schizophrenia and mania that has not responded to adequate pharmacological interventions.
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Answers

1. d.

The main indications for ECT are: severe depression, catatonic schizophrenia and mania that has not responded to adequate pharmacological interventions.

2. e.

ECT cannot be given if a person with mental capacity refuses to have it. It needs informed and explicit consent. ECT can be given under the Mental Health Act in certain circumstances, if the patient lacks mental capacity. It is never used as a punishment.

3. a.

ECT is given with a general anaesthetic and a muscle relaxant. The anaesthetic is given first and the muscle relaxant later, otherwise the patient would be paralysed and awake. ECT is normally administered twice a week. There is no therapeutic advantage in doing it any more frequently and this would increase the likelihood of side effects.

4. e.

Headaches are probably the most common side effect. A memory impairment for the period of the treatment course is very common and normally well tolerated. A deficit in biographical memory (memory for events in one's life) is a rare but distressing adverse effect.

5. c.

Elderly patients are in fact comparatively more likely to have ECT than younger patients. They are also comparatively more likely to present with the type of depressive disorder that responds well to ECT (hence the higher numbers of elderly patients in ECT clinics). However, they need to be carefully assessed before the treatment and their cognitive function needs to be monitored closely, as they are more vulnerable to the risk of developing memory problems after ECT. When this is a concern, a switch to Unilateral ECT should be considered.

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IS PSYCHIATRY FOR YOU?

Ankush Singhal and Chinedu Onwuemena

Psychiatrists are doctors who look after patients with mental health problems, such as schizophrenia, mood disorders, anxiety disorders, personality disorders, eating disorders, learning disabilities, dementia and substance misuse.
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Introduction

Psychiatry is one of the most amazing disciplines in medicine. It offers lots of opportunities to work in a variety of settings including community, hospital wards, patients' own homes, residential and nursing homes, etc. As a psychiatrist, you will work with different professionals in a multidisciplinary team in a bio-psychosocial approach. It has many attractive attributes as a career; however, there have been lots of myths, misconceptions and stigma about this specialty. Traditionally, psychiatry has never been a specialty of choice for majority of medical graduates across the world for various reasons, resulting in high number of foreign medical graduates joining psychiatry. The purpose of this article is to help new graduates to take an informed decision about choosing psychiatry as a long-term career.

What do psychiatrists do?

Psychiatrists are doctors who look after patients with mental health problems, such as schizophrenia, mood disorders, anxiety disorders, personality disorders, eating disorders, learning disabilities, dementia and substance misuse. As opposed to most of the other medical specialties, there is a limited use of laboratory or radiological investigations, rather diagnosis is mainly based on a good history and mental state examination. A psychosocial assessment is equally important for management. Management options include a variety of psychotropic medications (including antipsychotics, antidepressants, anxiolytics, mood stabilisers, hypnotics, etc.), electroconvulsive therapy (ECT), psychotherapeutic measures (ranging from counselling to more structured cognitive behavioural therapies) and help with social circumstances. Therefore, for a comprehensive assessment and management, psychiatrists work with social workers, community psychiatric nurses, clinical psychologists and occupational therapists, etc. and consultants often have to lead such a team.

Sometimes patients have no insight about their illness. These patients can be assessed under Mental Health Act and can be treated against their will if they meet the criteria.

Day to day duties may vary with the grade of the psychiatrist, subspecialty of psychiatry and setting. Typically, clinical duties of core trainees (CT1-3) in psychiatry include clerking; seeing patients in outpatient clinics; assessment of new admissions; management of inpatients; attending ward rounds; discharges; communication with GPs and other professionals; participating in multidisciplinary community team meetings; and occasional home visits.

On-call duties: on-call duties mainly include management of inpatients (e.g. a suicidal patient, an aggressive patient, etc.) and patients presenting with mental health symptoms out of hours (including A&E) while working closely with other professionals, such as crisis and home treatment team; mental health liaison nurses; and social workers. A significant proportion of on-call duties consist of assessment and management of suicidal patients including those presenting with deliberate self-harm or overdose. Most of the NHS trusts have teams of nurses trained to deal with deliberate self-harm assessments and patients who present in crisis. Consequently, on-call duties are usually less hectic than acute specialties and many rotas allow you to be on-call from home (non-residential on-calls).

Trainees also need to attend weekly MRCPsych course and are encouraged to do clinical audits. They get regular weekly supervision from their supervisor.

In higher specialist training (ST4-6 trainees), in addition to routine clinical work, trainees need to enhance other skills also including management and leadership; supervising juniors; teaching skills; application of Mental Health Act; report writing; etc. They are given more independence in clinical work and decision-making, participate in second on-call rota (from home) and are expected to lead the team in absence of their consultants. They also get one session each for research and special interest every week. As a psychiatrist, you work in different teams and setting. Your job may be a predominantly community-based, inpatient-based or a mixed one.

Career progression

Psychiatry offers a relatively rapid career progression. Psychiatry is one of the medical specialties with the highest number of flexible trainees. Flexible training in psychiatry allows you to combine a fascinating and rewarding career with other commitments or interests.

After your graduation, it is not mandatory to have done any psychiatry training in your Foundation programme, though it is invaluable to demonstrate your commitment to the specialty at the application stage. It also helps you to decide whether this is the specialty you want to devote rest of your life to. If you have no such exposure, a clinical attachment in psychiatry may be quite useful.

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Specialist training in psychiatry is 6 years, divided into 3 years of core training (CT1–3) and 3 years of higher training (ST4–6). Trainees are called “core trainees” and “specialty registrars” respectively. In the first 3 years, trainees are rotated through various subspecialty posts for 6 months each to build basic competencies in various aspects of psychiatry.

They need to pass three written parts of MRCPsych exams followed by a CASC exam before they can apply for higher training in one of the six subspecialties mentioned below. These ST4–6 trainees are rotated in three posts of 1 year each. At the end of the training, they are awarded “certificate of completion of training” (CCT) in that subspecialty, following which they can apply for consultant posts.

Options for non-training grades include locum appointment for service (LAS) and staff grade psychiatrists (at middle grade level) and alternative for consultant grade is position at associate specialist level. Historically, psychiatry in UK has been dependent on doctors qualified overseas more than other specialties. With the reduction in number of doctors coming from overseas (due to many reasons including recent changes in immigration laws), the prospects of career as a consultant psychiatrist are going to be even better.

Subspecialties within psychiatry¹

1. General adult psychiatry: you will deal with a wide range of mental health conditions including depression, bipolar affective disorder, psychotic illnesses, anxiety disorders, personality disorders, substance misuse disorders, eating disorders, etc. in patients in the age range of 16–65 years. There is a scope of further specialisation in disciplines of:

- Neuropsychiatry (managing psychiatric and behavioural presentations of neurological disorders like epilepsy, brain injury or neuropsychiatric disorders, e.g. Huntington’s disease).
- Eating disorders (e.g. anorexia and bulimia nervosa).
- Substance misuse (abuse or dependence on alcohol and other substances).
- Social and rehabilitation psychiatry (promoting the recovery of people with long-term serious and complex mental health problems).
- Liaison psychiatry (working closely with other medical specialties to manage interaction between mental and physical health including psychosomatic disorders, medically unexplained symptoms, self-harm behaviour, etc.).
- Perinatal psychiatry (managing mental illnesses related to delivery and puerperium).

2. Old age psychiatry: in this specialty, psychiatrists assess and manage similar range of mental disorders as general adult psychiatry, but in patients above 65 years of age. A significant proportion of workload includes managing patients with dementias, many of whom may lack mental capacity to decide about their management. It offers opportunity of working closely with geriatric medicine because of higher rates of physical co-morbidities in elderly patients. They have to make frequent domiciliary visits and visits to residential and nursing homes.



3. Forensic psychiatry: forensic psychiatrists are expert in assessment and management of mental illnesses in mentally disordered offenders, patients with significant forensic history and those who pose a very high risk to others and need to be managed in secure units. They work in liaison with legal agencies like courts, probation services and prisons. Their duties also include giving opinion about criminal responsibility, fitness to plead and stand trial, preparing reports and giving evidence in court of law.

4. Child and adolescent mental health services (CAMHS): this specialty deals with patients younger than 16 years of age. Common problems include emotional and behavioural problems besides others (e.g. attention deficit hyperkinetic disorder). There is more emphasis on non-pharmacological management including behavioural and family therapy. Psychiatrists work closely with other agencies like school, parents, social services and educational psychologists.

5. Psychiatry of learning disability (LD): LD consultants are expert in managing a wide range of psychiatric conditions, emotional and behavioural problems in patients with low intelligence levels including autistic disorders and mental retardation. They work closely with residential homes, where many of these patients stay.

6. Psychotherapy: it mainly includes using variety of psychotherapeutic approaches like psychodynamic therapies, family therapies, cognitive behavioural therapies, etc. in conditions like mood and anxiety disorders, interpersonal problems, personality disorders, psychosomatic disorders and in CAMHS.

Academic and research careers: there is a good scope of entering an academic career and there are lots of research opportunities as well. There are some posts for academic clinical fellowship at junior trainee level, which are highly competitive. You can get a post based in a University hospital and be actively involved in research and teaching. London, Cambridge, Oxford, Birmingham, Leeds, Manchester and Newcastle-upon-Tyne are some of those centres which particularly offer excellent research opportunities.

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Psychiatry as a career choice: past and present

"Most Important" Factors Influencing The Choice Of Psychiatry	Participants N (%)
Psychiatric teaching received as a medical student	14 (19.4)
Exposure to psychiatry as a house officer	2 (2.8)
Psychiatrists met during medical training	10 (13.9)
Members of family working in psychiatry	2 (2.8)
Patients met during medical training (who were neither family or friends)	8 (11.1)
Empathy for patients with a mental disorder	26 (36.1)
Personal experience of mental disorder in yourself, family or friends	4 (5.6)
Desire to understand yourself better	5 (6.9)
Better working conditions expected in psychiatry (e.g. easier progress to consultant jobs and the working hours more compatible with a family)	15 (20.8)
Possibility of treating mental disorder through alternative approaches (e.g. psychotherapy, an anthropological understanding)	4 (5.6)
Interface of psychiatry with the social sciences (e.g. philosophy, anthropology or law)	10 (13.9)
Interface of psychiatry with the neurosciences	18 (25)
Disenchantment with other medical specialties	7 (9.7)
Sense of fulfilment expected from seeing patients improve	11 (15.3)

Table 1: "Most important" reasons for choosing psychiatry³.

Traditionally, medical students' attitude towards psychiatry has been negative. They perceived psychiatry as the specialty of lowest status and psychiatrists to be lower in competence than surgeons and physicians. Several studies have considered factors that lead to the choice of psychiatry as a specialty. In a study² of undergraduate students in London (n=301), psychiatry was the least popular clinical specialty. Only nine students (3%) expressed a preference for a career in psychiatry. The reasons for not choosing psychiatry, included "boring", "unscientific", "depressing", "stressful", "frustrating" and "did not enjoy rotation" (in that order). A family history of mental illness was significantly associated with choosing psychiatry. In another survey³ of consultant psychiatrists (n=72), most important reasons for choosing psychiatry were identified as given in Table 1.



The UK Medical Careers Research Group⁴ surveyed the UK medical graduates of 1974, 1977, 1980, 1983, 1993, 1996, 1999 and 2000. Psychiatry was their first choice of long-term career in the first year after qualification for 4.3% and at the end of the third year after qualification for 4.9% of all respondents. Between 1974 and 2000, there was little evidence of change in the percentages of medical graduates who chose careers in psychiatry. Most important factors to have a great influence on choice for psychiatry were its experience as a student, their own assessment of their skills and aptitudes, the anticipated hours and working conditions and their enthusiasm and commitment to the specialty.

Choosing a specialty after graduation is indeed a difficult and one of the most important decisions of your life. You need to think about your personal attributes (see Box 1) and consider all possible pros and cons (see Box 2) before entering this specialty.

IS PSYCHIATRY FOR YOU?

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Box 1 - Personal attributes: essential for a psychiatrist

- patience
- empathy
- communication skills
- holistic approach
- team working
- flexible
- listening skills
- ability to tolerate uncertainty
- willingness and ability to respect the views of other disciplines

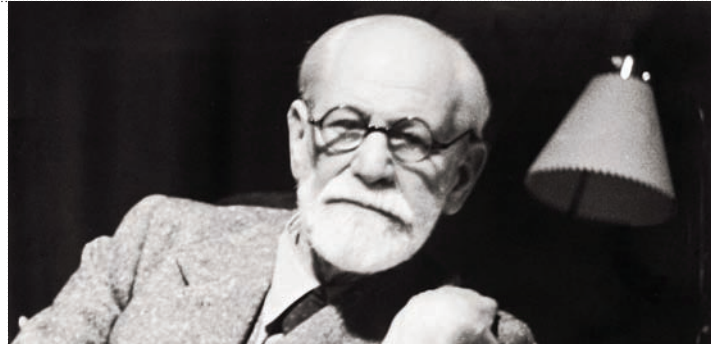
Box 2 - Pros and cons of choosing psychiatry as a long-term career⁵

PROS

- Very good career prospects.
- Less intensive on call duties compared with other acute specialties.
- Combines medical sciences and psychology.
- Relatively high pass rate in postgraduate examinations.
- Higher degrees (e.g. PhD, MD) are not essential for career progression.
- Relatively short training time.
- Early specialisation.
- Satisfaction in helping patients with disabling diseases.

CONS

- Higher risk of violence and aggression from patients.
- Often involves treating patients against their will.
- Not highly regarded by some doctors or the public or media.
- Frustrating managing conditions for which psychiatrists may have little to offer.
- Can be isolating if working with a few colleagues.
- Few psychiatrists do significant private practice.



Myths and challenges

Last year, psychiatry celebrated its 200th birthday. Professor Johann Christian Reil of Halle, Germany, first introduced the term “psychiatry” in 1808. He argued that psychiatry required the very best medical practitioners. However, even after 200 years, psychiatry appears to be still struggling.

Contrary to popular belief, most psychiatrists are “normal” people who generally do not have beards and do not always want to know about your childhood. Until recently, psychiatry was often regarded as a “Cinderella” specialty as it does not share the adrenaline fuelled excitement of emergency medicine or the glamour of other acute specialties, such as general medicine and surgery⁵. Often psychiatry is perceived as a “different” specialty because it lacks “decisiveness” and is not about curing people like other specialties. Little exposure to psychiatry during undergraduate curriculum adds to the problems. Other medics often perceive psychiatry as an easy option for those who fail to progress in other acute specialties. This is certainly not the case and a career in psychiatry has a great deal to offer in its own right. Now the specialty is also facing a lack of confidence resulting from a lack of funding, and in many cases mental health trusts have been raided for money to support acute trusts. Negative public perceptions of patients, fuelled by the media, have contributed to the stigma associated with psychiatry and psychiatrists may also suffer from the same stigma that affects their patients⁶.

Recruitment and retention of psychiatrists continue to be a major problem in the UK. 11% of consultant posts and 7% of national training numbers in psychiatry were vacant in 2002. In 2005, 2% of consultant posts in psychiatry in England were unfilled, with a further 15% of posts filled by locums⁷. In 2003 psychiatry accounted for 29% of all consultant vacancies in all specialties in England (364 out of 1,264)⁸. According to the Royal College of Psychiatrists, only 6% of people who took the exam for membership of the college (MRCPsych) were UK graduates¹. Overseas recruitment continues to mask the long-standing under-recruitment of British medical graduates into psychiatry. Brockington and Mumford, reviewing the issue of recruitment in psychiatry, estimated that 250–300 consultant psychiatrists are required annually, including replacements and new posts⁹.

IS PSYCHIATRY FOR YOU?

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“To anyone thinking of doing this specialty, I would advise them to get more experience of it. Psychiatry doesn’t suit everyone - you need particular skills in speaking and listening to patients. But if you are interested, don’t be put off by its negative image, just give it a go.”
Good Medical Practice.



Conclusion

Psychiatry is indeed a unique specialty which has its own advantages, disadvantages and challenges. It is very important to assess your own skills and interests. Ollie White, a specialist registrar in child and adolescent forensic psychiatry, sums it precisely – “To anyone thinking of doing this specialty, I would advise them to get more experience of it. Psychiatry doesn’t suit everyone – you need particular skills in speaking and listening to patients. But if you are interested, don’t be put off by its negative image, just give it a go.”⁶

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FACTITIOUS DISORDER

Alok Kumar Rana and Ankush Singhal



"Factitious disorder refers to the conditions consisting of intentional production or feigning of signs of medical or mental disorder along with misrepresentation of history and symptoms in order to assume the sick role without any external incentive"¹.

A 30-year-old unmarried Caucasian male presented with a history of having been sexually assaulted 5 days earlier in a nearby city by a group of unknown males. Reportedly they kicked and stamped on him and during the assault a glass bottle was forcibly inserted into his rectum and the bottle neck broke. The patient appeared very agitated and uncooperative. On examination, there was no evidence of external injury to him. His abdomen was soft and showed a well-healed lower midline incision. He attributed this scar to a laparotomy done for abdominal pain in his childhood².

What investigations would you like to do?

A rectal examination on the ward should be followed by a plain X-ray of the abdomen to confirm the presence of the broken off upper part of a glass bottle. A flexible endoscopy can confirm the presence of the broken glass bottle in the sigmoid colon. An endoscopic snare can be used to retrieve the broken glass bottle, if present. Repeat endoscopy may be needed to see any damage to the mucosa.

Patient refused a rectal examination on the ward. On examination under anaesthesia, no evidence of perianal trauma was found. Plain X-ray of his abdomen showed the broken off upper part of a glass bottle. An endoscopic snare was passed and the broken glass bottle along *with paper* retrieved with no damage to mucosa. The patient was reluctant to divulge any personal history. The following morning the patient complained of pain in his abdomen. Due to the possibility of rectal perforation, a CT scan of his abdomen and pelvis was arranged which came back normal².

A rectal examination on the ward should be followed by a plain X-ray of the abdomen to confirm the presence of the broken off upper part of a glass bottle. Good Medical Practice.

What are the important findings to consider to reach a diagnosis?

The examination or investigations may not be helpful to confirm the history. The safe insertion of the broken glass bottle with no perianal trauma or damage to mucosa did not correspond to the gravity of the described incidence. This may prompt you to think beyond the surface. This looks like intentionally produced signs of medical disorder with no apparent external gains/incentives as in factitious disorder (FD).

What else would you like to know to ascertain diagnosis?

Past medical records review is invaluable. If possible, any information on previous admissions to neighbouring hospitals may give definite indications toward diagnosis.

Due to the unusual circumstances, the case was discussed with a second surgical consultant within the same department. Surprisingly, he recognised the patient from a previous post at a nearby hospital. The same man had presented under a similar sounding name with an almost identical history. On that previous occasion he had also claimed to have been sexually and physically assaulted in a car park, during which time a bottle top was reportedly inserted into his rectum. This was removed under general anaesthesia shortly after which he self-discharged, with no follow-up being possible as he had no general practitioner².

Apparently this patient qualifies for the diagnosis of "Munchausen Syndrome" which is a specific subset of factitious disorder. It is discussed in detail later. How can you get more evidence to conclude?

Collateral history from any informant may provide useful clues to diagnosis. During the stay, an attempt to contact any visitors or next of kin may reveal no visitors and a false phone number of the next of kin.

He told the team that he was not registered with a GP and later it was discovered that the home address he gave at registration was a fictitious one. During his stay, he had no visitors. An attempt was made to telephone his next of kin. However, the number proved to be of someone who denied knowing the patient and informed us that he had received a similar enquiry, about a month ago from another hospital².

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What will be your next step?

Either confronting the patient in a non-judgemental manner may reveal the true picture or referral to psychiatric services may be required. An attempt to confirm the personal information may reveal the falsification of information. This may provide an opportunity to explore the intention behind admission and referral to appropriate psychiatric services.

A psychiatric consultation was requested upon which the patient became angry and refused further treatment. However, with the encouragement of a nurse, he later agreed to see the psychiatrist. The psychiatry team did not find any evidence of a mental disorder, other than the possibility of Munchausen’s Syndrome. When the patient was asked about the possible earlier presentation at another hospital, he became very angry and took his own discharge against medical advice².

What are the diagnostic guidelines for factitious disorder?

The ICD-10 (International Statistical Classification of Diseases, 10th revision) diagnostic guidelines for factitious disorder are summarised in Table 1. In ICD-10, factitious disorder is classified under “other disorders of adult personality and behaviour (F68)”³.

F 68.1	Intentional production or feigning of symptoms or disabilities, either physical or psychological (factitious disorder).
A	In the absence of a confirmed physical or mental disorder, disease or disability (which could explain the symptoms), the individual feigns symptoms repeatedly and consistently.
B	The motivation for this behaviour is almost always obscure and presumably internal, and the condition is best interpreted as a disorder of illness behaviour and the sick role.
C	The person usually shows signs of a number of other marked abnormalities of personality and relationships.
D	No evidence can be found for an external motivation (such as financial compensations, escape from danger, more medical care, etc.). If such evidence can be found category Z76.5 should be used (malingering).

Table 1: ICD-10 diagnostic guidelines for factitious disorder³.



The Diagnostic and Statistical Manual of Mental Disorders, fourth edition – text revision (DSM-IV-TR), organises factitious disorder into four types:

1. Factitious disorder with predominantly psychological symptoms.

This subgroup consists of patients who present with feigned psychiatric symptoms. These symptoms include depression, hallucinations, mania, amnesia, posttraumatic disorder, psychosis, dissociative symptoms, etc. These patients therefore do not respond to the routine therapeutic interventions and may unnecessarily receive large amount of psychotropics as well as may receive electroconvulsive treatment.

2. Factitious disorder with mostly physical symptoms.

People with this disorder present with symptoms and signs related to a physical illness, symptoms, such as chest pain, stomach problems or fever. The best known type of this category is Munchausen syndrome. The disorder has received many other names like *Hospital addiction* and *Polysurgical addiction*. Due to multiple surgeries, these patients may present with so-called gridiron or washboard like abdomen. The other known term for these patients is *professional patient syndrome*. The central feature of this disorder is the ability of these patients to present their symptoms so well that they usually achieve to gain the admission in hospital¹.

It is important to note that although the term Munchausen syndrome is sometimes used to refer to factitious disorders in general, but it is a subset of factitious disorder.

3. Factitious disorder with combined psychological and physical symptoms.

People with this disorder report symptoms of both physical and mental illness. This diagnosis is considered if none of the type of symptoms predominates.

4. Factitious disorder not otherwise specified.

The patients with factitious signs and symptoms who do not fit any of above categories should be classified under this category. It includes “factitious disorder by proxy”.

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What is Munchausen syndrome and how is it related to factitious disorder?

"Munchausen Syndrome refers to a syndrome in which patients embellish their personal history, chronically fabricate symptoms to gain hospital admissions and moves from hospital to hospital"¹.

The name "Munchausen Syndrome" was taken from Baron Hieronymus Friedrick Friedrich Freiherr von Munchausen (1720–1791), a German cavalry officer renowned for wandering from city to city and telling dramatic stories about his life¹. The term Munchausen Syndrome was first described by Richard Asher in 1951⁴. Original Munchausen Syndrome as described by Asher, consists of a triad of the simulation of disease, *pseudologia fantastica* (habitual or compulsive lying with an elaborate and often fantastic account of untrue exploits) and peregrination (wandering)⁵.

Munchausen Syndrome is a severe (and relatively uncommon) form of factitious disorder and is classified under factitious disorders in ICD-10³. The factitious illness behaviour is particularly chronic and severe and may be practiced to the exclusion of most other activities. The intentionally produced signs and symptoms of illness or injury may include medical manipulation (e.g. self-inflicted infection, superwarfarin ingestion), thereby virtually guaranteeing hospitalisation. These patients often willingly submit to invasive interventions such as surgery. Peregrination, also commonly called itinerancy, is observed. Once their intentions are discovered, these patients may move from place to place to various hospitals in different towns, cities or may be countries to see unknown medical staff in order to get admitted and treated. Some authors invoke additional diagnostic elements like the patient may use different name or may adopt false identities. These patients usually have little or no significant social contacts and so their social contacts are limited to mainly health care professionals⁶.

There are many ways in which people with Munchausen Syndrome can feign or induce illnesses and present to clinicians⁷. They include feigning and dramatising the symptoms which are hard to disprove, presentation to emergency departments at night or on the weekends, tampering with sample/test results (e.g. urine samples are contaminated with blood/faeces), absence of collateral and past medical history due to falsification of the information, self-infliction (e.g. cuts, burns, overdoses or self-poisoning), aggravating pre-existing conditions (e.g. by reopening previously healed wounds or re-infecting wounds with dirt), insisting on surgical procedures even by threatening litigation, travelling from hospital to hospital in different parts of the country, and seeing many different doctors (doctor shopping).

Most of the features described above were also evident in our patient. He gave a dramatic history of a violent sexual and physical assault. A further interesting finding, which does not appear to fit with the history of an assault, is the presence of paper in the neck of the bottle. This begs the question as to why and how the paper came to be present. It may be possible that this paper was packed into the bottle fragment, prior to insertion by the patient, as an attempt to afford him some protection from internal trauma².

What could be the cause of factitious disorder?

The aetiological factors in factitious disorders remain poorly understood. One hypothesis suggests that impaired information processing in the brain contribute to Munchausen patients' *pseudologia fantastica* and aberrant behaviour. However, no genetic patterns have been established¹. Carney and Brown examined 42 factitious disorder patients and found that the vast majority were emotionally deprived in childhood or adulthood. Around two-thirds had attempted suicide or self-harmed, over half had psychopathic personality traits and half had previously been in caring professions. Over a third of cases were wanderers and this subgroup had more admissions, more psychopathic traits, more severe factitious symptoms (i.e. degree of trauma) and was less likely to attend for follow-up appointments⁸.

How common is factitious disorder?

The prevalence of factitious disorders generally, is difficult to ascertain and is likely to be underreported due to their secretive and false identities. Also as soon as they are discovered, they discharge themselves from hospital and move to different areas.

The condition is thought to be most common in white men aged between 30 and 50. It is unclear why this is the case⁶.

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What is the course and prognosis of factitious disorder?

Factitious disorder typically begins in early adulthood but may also start in childhood and adolescence. The onset is usually insidious and may start with an admission for a genuine illness. The onset may be earlier in patients who had an early hospitalisation for actual illness. With the progress of disorder and more involvement with medical personnel their medical knowledge and skills to produce symptoms and signs improves resulting in chronic illness. The course with repeated admissions and long-term hospitalisation reduces the chances of having proper job and is detrimental to sustained long-term relationships. This leads to relatively poor prognosis in people with long history of disorder¹.

In most cases people with Munchausen Syndrome, the disorder is a chronic condition that can be very difficult to treat. The current evidence shows that the prognosis for factitious disorder is fair, but the prognosis for the more chronic and severe Munchausen variant is poor. A positive prognostic sign is the presence of a treatable concurrent mental disorder, such as major depression. The newer technologies like the Internet and inter hospital networking by collecting standardised but anonymous data about such patients could be use to inform such patients general information about treatment, outcome and prognosis⁶.

What other differential diagnoses should you consider in a case of factitious disorder?

The following differentials should be considered before confirming a diagnosis of factitious disorder⁶.

Genuine medical disorder: including non-response to treatment, non-compliance or atypical presentation of related medical conditions.

Genuine psychiatric disorder: including depression, schizophrenia, delusion disorder, etc.

Malingering: when a primary external motive (e.g. to avoid punishment in a court case, for financial gains, etc.) for the deceptive illness behaviour exists, the diagnosis of malingering should be considered.

Hypochondriasis: it refers to an excessive preoccupation or worry about having a serious physical illness. Further examination and investigations completely rule out any such physical problem. These patients are convinced about their belief as a fact and do not hide any personal information in order to get admission and treatment.

Somatisation disorder: it consists of patients who chronically and persistently complain of varied physical symptoms that have no identifiable physical origin.



What are the management options?

Diagnosing factitious disorder is difficult. Its management is even more difficult. No specific drug treatment therapy has been effective¹. Initially the management of these patients should follow the principles of medical care of any other patient. Once diagnosis of factitious disorder is suspected, unnecessary investigation and procedures can be avoided by building a supportive relationship with the patient. At this time, they often disappear to avoid detection and seek help at a different hospital. After a diagnosis of factitious disorder has been established, it may prove more useful to consult mental health professionals. These patients may benefit from management for any underlying mental disorders, such as major depression⁶. If a person can acknowledge they have a problem, the involvement of a psychiatrist or psychologist and social services may be of help. They may also benefit with psychological intervention like psychotherapy for the suspected underlying disorder. Most of these patients refuse to admit that they have a psychological problem and do not co-operate with suggested treatment plans. Also, these patients refuse any meaningful therapy by abruptly leaving the hospital or failing to keep the follow-up appointments.

The management of Munchausen's Syndrome is understandably challenging and Huffman and Stern describe four key principles⁹. These principles basically cover the management of all factitious disorders.

First, the chosen diagnostic tests should depend on objective signs rather than described symptoms, especially if they are invasive tests.

Second, all the team members should follow the consistent approach with the patient. This will reduce opportunities for the patient to split the team and cause disruption.

Third, team should set clear but compassionate boundaries. At the same time acknowledge that the team are aware of the patient's distress and are doing their best to help (albeit with a different view from the patient as to what may be beneficial).

Fourth, the team's frustration with the patient should be refocused on differentiating genuine symptoms from the factitious by direct observation and/or further tests.

Both medical and psychiatric outpatient follow-up should be offered for ongoing support.

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What could be the complications of factitious disorder?

These patients are at high risk of self-harm to feign the symptoms. Once admitted they continue to carry a high risk of iatrogenic complications due to unnecessary investigations and surgical procedures. This may at times lead to drug dependence. If not recognised in time, it may increase morbidity and mortality rates significantly⁵. Munchausen Syndrome although a subset but is itself a complication⁶.

What is factitious disorder by proxy?

"Factitious disorder by proxy" is not the same as "factitious disorder". The term "by proxy" means "through a substitute". People with this disorder (usually a parent/carer) produce or fabricate symptoms of illness in another person under their care, typically a child¹⁰ and thus indirectly assume a sick role. It most often occurs in mothers who intentionally harm their children in order to receive medical attention. In ICD-10¹⁰ this is classified under child abuse³ and is not considered a factitious disorder, though it is included under factitious disorders in DSM-IV-TR. The DSM-IV-TR criteria for factitious disorder by proxy are presented in Table 2¹.

"Munchausen Syndrome by Proxy" is a similar subset of factitious disorder by proxy.

A	Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.
B	The motivation for the perpetrator's behaviour is to assume the sick role by proxy.
C	External incentives for the behaviour (such as economic gain) are absent.
D	The behaviour is not better accounted for by another mental disorder.

Table 2: DSM-IV-TR research criteria for factitious disorder by proxy.

Conclusion

Factitious disorders refer to the conditions in which patients attend hospital with a false but plausible and often dramatic history with feigned signs and symptoms suggesting acute illness. Often the person is found to have attended many other hospitals under several false names to avoid any communication among different doctors and health-care staff. They usually provide incorrect information about next of kin in an attempt to prevent staff from obtaining any information and may interfere with the diagnostic investigations. Once correct diagnosis is suspected, they often leave the hospital. Consistent approach with firm boundaries is the key to management¹⁰.

Questions: choose the best out of four.

1. Factitious disorder is classified into four subcategories based on types of presenting symptoms like physical or psychological symptoms in:

- ICD-10.
- DSM-IV.
- Both of these.
- None of these.

2. Munchausen syndrome is named after:

- A clinician.
- A patient.
- A place.
- Another related disorder "Munchausen syndrome by proxy".

3. Original Munchausen syndrome as described by Asher, consists of a triad of the simulation of disease, pseudologia fantastica and

- Doctor shopping.
- Child abuse.
- Tampering with results.
- Peregrination (wandering).

4. Factitious disorder by proxy is classified under "child abuse" in

- ICD-10.
- DSM-IV.
- Both of these.
- None of these.

5. Which is not true with respect to Munchausen syndrome

- These patient self-inflict signs of medical disorder.
- They usually present in emergencies to out of hour staff,
- They often dramatise their story.
- They are usually surrounded by lot of visitor and relatives in the hospital.

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Answers

1. b.

The Diagnostic and Statistical Manual of Mental Disorders, 4th edn. – text revision (DSM-IV-TR), organises factitious disorders into four main types:

1. Factitious disorder with mostly psychological symptoms.
2. Factitious disorder with mostly physical symptoms.
3. Factitious disorder with combined psychological and physical symptoms.
4. Factitious disorder not otherwise specified (includes factitious disorder by proxy).

2. b.

The name “Munchausen syndrome” was taken from Baron Hieronymus Friedrick Friedrich Freiherr von Munchausen (1720–1791), a German cavalry officer renowned for wandering from city to city and telling dramatic stories about his life.

3. d.

Original Munchausen syndrome as described by Asher, consists of a triad of the simulation of disease, pseudologia fantastica (habitual or compulsive lying with an elaborate and often fantastic account of untrue exploits) and peregrination (wandering).

4. a.

In ICD-10, factitious disorder by proxy is classified under *child abuse* and is not considered a factitious disorder, though it is included under factitious disorders in DSM-IV-TR.

5. d.

These patients usually have little or no significant social contacts and so their social contacts are limited to mainly health care professionals. People with Munchausen’s syndrome can feign or induce illnesses which are hard to disprove and typically present to emergency departments at night or on the weekends.

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MUNCHAUSEN'S SYNDROME (FACTITIOUS DISORDER)

Dr Cosmo Hallström



Munchausen's syndrome is a condition characterised by deliberately produced plausible symptoms and often signs of illness, presented for the sole purpose of assuming the sick role and gaining admission to hospital¹.

Good Medical Practice.

Munchausen's syndrome is a condition characterised by deliberately produced plausible symptoms and often signs of illness, presented for the sole purpose of assuming the sick role and gaining admission to hospital¹.

Incidence

It is hard to study the condition in a structured manner and most of the evidence about it is anecdotal and clinical². Doctors may encounter several patients during their professional lifetime. The true incidence remains uncertain and there are wide variations quoted in the literature³, which range from 0.8–9% of outpatients, but this must represent the broad concept of the condition (abnormal illness behaviour or psychosomatic complaints), as opposed to patients with factitious illness. True Munchausen's syndrome must be very rare, but under-diagnosed.

Causes

The reasons for patients developing this unusual condition are obscure. The patients do not usually have a formal mental illness, although often have personality disorders, and many have been brought up in institutions. They like to be the centre of attention and often make their condition central to their life. They may like to feel superior to professionals. Some appear to be opiate addicts and use their symptoms to get opiates. Some have medical backgrounds. The patients are difficult to evaluate psychologically, as they rarely engage with therapy for long enough to reveal their mental mechanisms, and so the causes of the condition are really speculative.

Case Vignette

A commercial traveller presented at A&E in a Midlands hospital on a hot summer's day, claiming to have inadvertently drunk two gulps of turpentine, kept in a plastic bottle under the dashboard of his car, thinking it was drinking water.

The patient was admitted on a Friday to a medical ward because of the possible late complications from ingesting turpentine of organ failure, for observation. The medical registrar, on rotation, went back to his flat in London over the weekend that he shared with another colleague and in conversation discussed this unusual case with his friend. The colleague remembered having seen a similar case at a hospital on the south coast a few weeks previously. On his return to the ward, the registrar confronted the patient asking him if he had been in any other hospitals recently with similar complaints. He absolutely denied having had any recent admissions. The patient discharged himself shortly afterwards, having removed his drip and without being seen to leave the ward. No more was heard of him.

What are the features in this case that arouse your suspicions?

The initial presentation is unusual; the idea that someone should knowingly drink turpentine, not only one gulp but two! The absence of any obvious pathology and the patient's willingness to come into hospital. The fact that he travels around and has no local address. The way the patient behaved around the time of confrontation and the fact that he removed his own IV cannula and disappeared.

Background literature

The literature on the condition is confused as estimates vary and even the existence of Baron Von Munchausen himself is questioned, some authorities claim that he was not a real person.

The stories about him typify the characteristics of Munchausen's syndrome, namely fantastic lying and fabricated signs and symptoms of illness.

The condition was first described and named by Richard Asher in 1951.

Baron Von Munchausen (1720–1797) was supposedly a distinguished German Cavalry Officer and an engaging raconteur. He had a habit of telling fantastic stories, such as he was walking with his horse 1 night in deep snow, until they were both exhausted. In the end he tied his horse to a little twig poking above the snow and fell asleep next to the horse. In the morning he woke up and the horse was tied to the lightning conductor at the top of a church tower, the snow had melted and he was now sleeping on the ground. These fantastic lies are known as "pseudo-logica fantastica". He also had a large, apparently, irreducible inguinal hernia, and while at his hosts dining table, would fall to the ground writhing in agony. The local doctor was called, who would try and reduce the hernia. When he was unable to do so, Munchausen would jump onto the table, leap in the air, reduce the hernia himself in mid-flight and land on the ground, thus adding to the doctor's humiliation. This was an example of the ability to produce physical signs at will.

MUNCHAUSEN'S SYNDROME (FACTITIOUS DISORDER)

Dr Cosmo Hallström

Other common features of Munchausen's

Patients often have a dramatic or atypical presentation. The story can be vague and inconsistent. A long medical history with multiple admissions to hospitals in different cities may emerge. Patients often have an unusual knowledge of medical matters, hospital routine and jargon, and often have some personal medical background. They often have, or can fabricate some physical signs related to their complaint, such as bleeding, scars or hypoglycaemia. Pathological lying is a feature of the condition. They willingly accept unpleasant investigations. They often crave pain relief but seem relatively unperturbed by their symptoms, and delight in the puzzlement or incompetence of their doctors. Their complaints vary, as to whether they are being observed or not. They can become angry and abusive when confronted, and often disappear from the hospital just at the point of discovery.

Patients often have some minor genuine pathology or physical signs (scars or a hernia), which can be the basis to the complaint or add some validity to the condition.

Subtypes of Munchausen's syndrome

The condition can present in many different ways. Common presentations include abdominal signs and symptoms, where the patient has multiple abdominal scars (the grid iron stomach). They may present with (self-induced) bleeding (a match stick inserted into the urethra or blood obtained from the nose). There may be neurological symptoms, such as paralysis or fluctuating consciousness. Psychiatric symptoms, such as catastrophic bereavements may occur ("all of my family were killed in a car crash"). Patients may have pyrexia, possibly induced by injection of faecal matter or hypoglycaemia, caused by self-administration of insulin, self-induced skin complaints (dermatitis artefacta) occur. The patients can be very ingenious in their endeavours to fool the doctors.

A sinister variation is Munchausen's by proxy⁴, where (usually) the mother produces signs and symptoms in her child to make it the focus of medical attention. This can have serious implications for the welfare of the child and can result in death in some tragic cases. Mother's may claim to have a sick child and organise fundraising events for charity and become part of the hospital community.

Abnormal illness behaviour

The spectrum "abnormal illness behaviour" where psychological factors are important in understanding the condition, of which Munchausen's is an extreme example, is common and clinically important. Other conditions within the spectrum include:

- **Malingering** – where patients consciously exaggerates their symptoms for financial or other gain, such as to gain compensation for an injury or to take a day off work.
- **Hysteria** – patients present with signs and symptoms, which they genuinely believe to be true. They result from "unconscious mental mechanisms", developed in order to escape psychologically from a major mental trauma. They project their mental anguish into physical complaints. These patients are often unperturbed by their condition and have a serene acceptance (la belle indifférence) of their overt disability.
- **Hypochondria** – is a fear that some minor symptom is a sign of a serious illness and seek repeated investigations and reassurance. They have frequent and multiple medical contacts, and are high users of medical resources and use up expensive medical investigations and time. They have health anxieties and are difficult to reassure.
- **Chronic pain syndromes** – occur when patients become fixated on their symptoms and pains. Their symptoms of pain and disability are in excess of what would be expected from the underlying pathology, as a consequence of underlying anxieties and depression. These patients frequent pain clinics and can be treated inappropriately with nerve blocks and other specific physical treatments to ease the exaggerated pain.
- **Somatic anxiety** – patients develop muscle pains, headaches and palpitations or breathlessness as a result of the physical manifestations of anxiety and panic. These can present in rheumatology, cardiology or gastroenterology clinics.
- **Psychosomatic complaints** – have a strong emotional component to the expression of the illness, such as asthma, migraine and psoriasis. Stress can bring about an exacerbation of the condition. The condition is genuine, but cannot be properly managed and understood without taking into account the psychological dimension. The treatment of diabetes, in young people, needs an awareness of the psychological impact of the condition on compliance and functioning, for optimal disease control. When rehabilitating patients with chronic disabilities, it is important to be aware of the deal with the psychological aspect of the condition, the change of lifestyle and status that will have a bearing on function and recovery.

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• **Somatisation syndromes** – are conditions where patients have multiple symptoms and complaints in several different organ systems without sufficient pathology to explain them. They presumably deal with their inner distress by focusing on their bodily function. The patients are preoccupied by minor symptoms and complaints, which take on major proportions in their opinion. The patients are often subjected to numerous unnecessary investigations.

• **Compensation Neurosis** – follows on when individuals are involved in an accident. They can either concentrate on getting well or seek regress through lawyers and claim compensation. At this point, they develop a vested interest in promoting their illness and will, understandably, capitalise on any symptoms and disability when seeing their doctors. They make sure that every problem is documented. They will understandably use their symptoms to their advantage, even if they do not exaggerate them, they won't let them fade away. In time their condition and claim may begin to dominate their lives, especially if the injury occurs at work. They may even begin to believe they have symptoms suggested to them by doctors, such as possible memory problems following a minor head injury. They may misattribute everyday symptoms to the accident, when they are just everyday commonplace symptoms.

• **Work-related stress** – some people willingly take time off work, if they have a generous sickness allowance, others are keen to get back to work. Injuries that occur in the workplace are more likely to result in time off work and long-term disability, especially if there is a compensation element involved. An awareness of the meaning of the illness to the patient and their relationship with their employer is important in helping them to recover, especially from chronic illnesses. When a patient has been off work for a psychiatric disorder for 6 months, the chances of them going back to full-time work are about 50%.

• **Untreated depression and anxiety** – especially from life altering illnesses, such as strokes, heart attacks or cancer needs to be recognised and treated appropriately, either through sensitive counselling, specific psychological treatment, possibly medication or self-help from fellow sufferers⁵. Dealing with the emotional aspects of an illness may not affect life expectancy, but will have a profound effect on the quality of life and the functional recovery. The medical model that we pursue tends to overlook this important aspect of the treatment of the total patient. We need to adopt a holistic approach to the assessment and treatment of our patients.

• **Personal Constitution** – all know that some people will take a week off if they have a cold, while others battle through despite having an illness of equal severity, and this depends on the individuals attitude and response to ill health.



Management of Munchausen's

It is important not to miss any treatable physical condition, but also important not to over investigate questionable symptoms, and this requires sound clinical experience and judgement. Many patients will never be diagnosed correctly and will be discharged with their condition unrecognised and move on to the next hospital. The best diagnostic instrument is the telephone and enquiries can be made from a GP and other reliable informants (if available), whereupon the story will gradually begin to unravel.

Suspicious can be raised by the unusual and variable presentation of the patient. They tend not to behave like other patients. They are sometimes recognised by rotating staff from another hospital. Ancillary staff may report inconsistent behaviour. They do not seem to want to get better and seem to enjoy the puzzlement of the doctors over their condition.

On a broader front, the most important aspect for the clinician is to be aware that there is an emotional component to most medical presentations. Patients may exaggerate their symptoms to impress the doctor and to make sure they are taken seriously or they may play down their symptoms as they "don't like to make a fuss". Patients vary in their response to the illness. Some fight to overcome their symptoms, others cave in. For example, I have seen people who cannot work because of the amputation of the tip of their finger, I have seen others who go back to work a week after traumatically losing an arm. A lot depends upon the domestic situation and the mental attitude of the patient.

Although the Munchausen's patient might theoretically benefit from psychotherapy, they tend not to engage. They do not want treatment and do not want to get better, and tend to move on before treatment is arranged. The main principle is "case management" with early diagnosis, sensitive confrontation and notification of the diagnostic suspicions to the GP and other relevant health care agencies. There used to be a fashion for circulating the details of "hospital hoppers" to other hospitals in the area, but that is beset by many ethical difficulties. These patients can use up scarce hospital resources, cost money in unnecessary investigations and may expose themselves to risk from surgery or unnecessary invasive test procedures, especially in the case of Munchausen's by proxy.

The liaison psychiatrist is probably the most appropriate person to explore the patient's problems in a sensitive manner, although it is the treating doctor who has to make the initial diagnosis and referral. Munchausen's syndrome is rare, but psychosomatic complaints and the emotional aspects of physical illnesses are common.

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Multiple choice questions

1. Munchausen's patients are:

- a. Easy to diagnose.
- b. Have no physical signs.
- c. Easy to treat.
- d. Often go undiagnosed.
- e. Only occurs in adults.

2. Which of the following is not a recognised feature of Munchausen's?

- a. A long medical history.
- b. Obvious physical pathology with significant abnormality on investigation.
- c. Gross and pathological lying.
- d. Familiarity with medical and nursing staff.
- e. A variable and inconsistent history.

3. The treatment of Munchausen's is?

- a. Repeated MRI scanning of the relevant organ system.
- b. Cognitive behaviour therapy.
- c. Referral to a pain specialist.
- d. Gentle exploration of the problem under conditions of privacy and trust.
- e. Dramatic confrontation.

4. Munchausen's by Proxy:

- a. A benign condition caused by over protective parents.
- b. Results in unnecessary and intrusive investigations.
- c. Should only be reported to social services if the diagnosis is quite certain.
- d. Is the condition of dubious diagnostic validity.
- e. Runs a benign course.

5. Munchausen's syndrome is otherwise known as:

- a. Hypochondria.
- b. Hysteria.
- c. Factitious disorder.
- d. Malingering.
- e. Somatisation.

6. Abnormal illness behaviour is:

- a. A common manifestation in many medical encounters.
- b. A sign the patient is not genuine.
- c. A waste of doctors time.
- d. A feature of mental instability.
- e. Of dubious clinical significance.

Answers

1. The correct answer is d.

Most cases of Munchausen's are never diagnosed properly and leave the hospital before the diagnosis can be established.

2. The correct answer is b.

Obvious pathology and clear diagnoses are not a feature of Munchausen's. The symptoms do not match up with the signs and the history.

3. The correct answer is d.

If progress is to be made with a Munchausen's patient, the patient must not be confronted, but a therapeutic alliance has to be built based on trust and acceptance, before psychological exploration can be pursued.

4. The correct answer is b.

Munchausen's by proxy results in multiple presentations of a child under unusual circumstances to doctors and can result in ill health and multiple investigations, before the true clinical picture emerges.

5. The correct answer is c.

The modern diagnostic category is Factitious disorder.

6. The correct answer is a.

It is important to be aware that many patients have an emotional aspect to their presentations that needs to be dealt with, if only by humane human management. Dealing with blood test results or other investigations alone may miss the full syndrome and its complex management.

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DELIRIUM

Hilary Gordon and George Ikkos



Three hospital inpatients are referred with very similar presentations. Each has become agitated and distressed, disturbing other patients and causing concern for staff. Patient Management.

Three hospital inpatients are referred with very similar presentations. Each has become agitated and distressed, disturbing other patients and causing concern for staff.

Case 1: Mr A

Mr A is a 64-year-old office manager who was admitted to hospital for back surgery, which took place 48 hours ago. His post-operative recovery was uneventful although he had not slept well since admission. The previous night, Mr A pulled out his IV and NG lines and became angry and confrontational with staff. He phoned the police from his mobile, telling them people were trying to kill him. His shouting woke the whole ward and frightened other patients.

He seems to have settled down this morning and is now sleeping. Staff are concerned that he is having a “nervous breakdown” and want you to transfer him to a psychiatric unit.

How might you proceed?**Gather as much information about the patient as you can:**

- Speak to ward staff to clarify the history. Ask how the patient presented prior to surgery. Look at the nurses’ records to see how the patient presented on previous days/nights.
- Look at the admitting doctor’s clerking records and speak to the patient’s GP or practice manager. You are looking for any history of similar behaviour, mental illness or dementia, history of alcohol or drug dependence (including the possibility of dependence on prescribed drugs, e.g. diazepam or opiates) or any significant medical problems that could be associated with disturbed behaviour.
- Speak to the nearest relative. Obtain background information as above. Ask how they have found their relative since being in hospital. Ask tactfully and non-judgementally about alcohol or drug use.
- Look at hospital notes for evidence of current medical problems (e.g. chest or urinary tract infection).
- Check preoperative and current blood results if available.
- Check the drug chart for polypharmacy or drugs with psychotropic effects.

What emerged with Mr A?

Collateral histories from the admitting doctor, GP and Mr A’s wife confirm that there is no past history of mental illness or memory loss, and no history of alcohol or drug dependence.

Medical examination by the ward doctor conducted during the night was unremarkable.

Mrs A said her husband had been recovering well from surgery until the previous afternoon when he became suspicious of staff and other patients. She had tried to reassure him and he seemed calmer when she left the ward. She had been phoned during the night to come in, as her distressed husband was calling for her.

Mrs A also said that her husband had experienced a similar episode the previous year following surgery to his hip. At that time, he had asked her to stay with him on the ward because he thought people were watching him on CCTV and plotting against him. She had not told staff about her husband’s fears and he seemed to return to normal after a few days.

Preoperative blood results were unremarkable.

Post-operative bloods showed:

- Hb 8.9gm (normal= 11–18)
- Na 130mmol/L (normal= 136–145)
- Albumin 25g/L (normal=35–50)
- GGT and MCV normal.

The drug chart showed regular and PRN opiate analgesia.

On interview

Mr A was seen with his wife. His view of events since admission to hospital was obtained. During interview he was asked about alcohol consumption using the Fast Alcohol Screening Test (FAST) (see Figure 1). Mr A scored 0 on the FAST (i.e. no indication of harmful or dependent alcohol use).

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Mental state examination**Appearance and behaviour**

Mr A appeared drowsy on approach. He shifted restlessly in the bed during interview.

Speech

His speech was difficult to follow at times and his ability to focus, maintain or shift attention was impaired.

Mood

His mood was labile and he became angry during interview.

Thoughts

He said that people had tried to kill him during the night by putting needles into his brain. He said people in black capes and hoods were hiding in his curtains waiting for him to fall asleep. He had tried to stay awake for fear of being killed.

Cognition

Cognitive testing using the 6 Item Cognitive Impairment Test (6CIT) (see Figure 2) revealed a score of 20, with deficits in attention, orientation and memory.

Insight

Regarding insight, he said he was in danger during the night. He only felt safe when his wife was with him.

Assessment using the Confusion Assessment Method (CAM) (see Figure 3), indicated the presence of features a, b and d.

What is the likely diagnosis?

The likely diagnosis in this patient is **Delirium ICD10 F05.0**.

What are the possible causes in Mr A?

Delirium in this patient is probably of multi-factorial aetiology including opiate analgesia; low sodium and albumin levels; slight anaemia; and sleep deprivation.

Predisposing factors include older age group, major surgery and an episode suggestive of delirium in the past.

What is delirium?

Delirium is a state of acute cognitive impairment that can occur in those with medical problems or following surgery. Most forms of delirium are temporary and reversible. The presentation can vary. Symptoms fluctuate and are usually worse at night.

Key features:

- Altered mental state of rapid onset (hours or days).
- Fluctuating levels of consciousness from reduced awareness of surroundings or drowsiness to heightened awareness and agitation.
- Disturbed cognitive function including difficulty with concentration, memory or language. Typically, during interview the patient cannot focus, maintain or shift their attention.

Other symptoms include:

- Delusions: these are usually paranoid thoughts that people are trying to harm them and can lead the patient to pull out drips or catheters, resist or fight with staff or try to get out of bed to “escape”.
- Perceptual abnormalities: these are most commonly visual and include illusions (i.e. misperceptions) or visual hallucinations.
- Increased or decreased levels of activity.
- Reversed sleep/wake cycle.
- Mood changes: emotional lability; anxiety; depression; fear; irritability.

The diagnosis of delirium may be missed because of the variable presentation and the fact that disturbed behaviour noted during the night may be completely absent during the day when the patient is seen by the doctor. Also, delirium has hyperactive or hypoactive forms. The hypoactive form is often undiagnosed or mistakenly diagnosed as an anxiety disorder or depression.

Making the correct diagnosis is important because delirium can lead to:

- Prolonged hospitalisation/bed blocking.
- Risk of accidental self-harm or harm to others while delirious.
- Increased risk of complications/death.
- Psychiatric co-morbidity (e.g. anxiety disorders).
- The need for 1:1 nursing care.
- Increased likelihood of requiring nursing home placement after discharge from hospital.

Causes of delirium:

- Medication (e.g. polypharmacy, treatment with anti-cholinergic drugs, opiate analgesia, antiparkinsonian drugs, tricyclic anti-depressants, lithium, corticosteroids, benzodiazepines).
- Alcohol and substance withdrawal. NB Delirium tremens is treated differently from delirium due to other causes, so asking about alcohol consumption is essential.
- Infection.
- Metabolic/haematological/biochemical/endocrine abnormalities.
- Hypoxia.
- Dehydration.
- Neurological conditions (e.g. subdural haemorrhage, stroke, malignancy, cerebral infection, seizure, non-convulsive status and post-ictal states).
- Severe or acute illness.

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These range from: sleep deprivation; pain; sensory deprivation; major surgery; anaesthesia; malnutrition; constipation; previous episodes of delirium; dementia; and/or older age.
Patient Management.

Predisposing factors to the development of delirium

These range from: sleep deprivation; pain; sensory deprivation; major surgery; anaesthesia; malnutrition; constipation; previous episodes of delirium; dementia; and/or older age.

Pathophysiology

The mechanisms thought to be involved in producing the clinical picture of delirium include disruption in cholinergic and dopaminergic neurotransmitter pathways. Cholinergic underactivity can lead to problems with arousal, learning and short-term memory. Dopaminergic excess can lead to psychotic symptoms.

Prevalence

Most studies have been conducted on inpatients:

- 10–30% of all hospitalised patients (up to 40% in elderly).
- Up to 50% of post-operative patients.
- Up to 70% of patients in intensive care units (irrespective of age).

Those most at risk of developing delirium include patients with significant physical illness; the elderly; those with hearing or visual impairment; the malnourished patient; and those with dementia.

Cardiac or orthopaedic surgery; renal dialysis; burns; and diseases of the central nervous system carry a high risk of developing delirium.

The prevalence of delirium in primary care and the community is little studied. A 2008 study found prevalence in subjects over 69 years to be 0.96%.

Differential diagnosis:

- Dementia: this can coexist with delirium.
- Amnesic syndromes (e.g. Korsakoff's syndrome).
- Psychiatric disorders (e.g. acute and transient psychotic disorders; schizophrenia; mania/hypomania and severe (agitated) depression).

Investigation of suspected delirium:

- Collateral history from staff, GP and nearest relative or friend. This will give you a timeline for the onset and course of symptoms. It may confirm or rule out pre-existing memory problems, drug or alcohol problems, psychiatric problems.
- Full medical examination.
- Assess for the presence of cognitive loss using the 6CIT or MMSE and for delirium using the CAM.
- Blood tests (e.g. Hb; FBC; CRP, U&Es; LFTs; TFTs; calcium; glucose; magnesium; B12 and folate; VDRL; blood cultures(if indicated); oximetry).
- MSU.
- ECG, if indicated.
- Chest X-ray, if indicated.
- CT/MRI brain/LP, if indicated.

Delirium is most commonly multi-factorial in origin and careful evaluation and investigation is required.

How is delirium treated?

Delirium is an organic condition and treatment is primarily directed at identifying and correcting the underlying organic cause(s).

While this process is happening, the patient's distress and disturbed behaviour need to be addressed. The emphasis is on non-pharmacological management, but medication may be required if the patient is significantly disturbed.

One to one nursing may be required to reduce the risk of accidental self-harm or harm to others while delirious.

Several formal instruments can be used to assess and monitor the progress of patients in delirium. These include the Delirium Rating Scale; the Clinical Assessment of Delirium; and the Delirium Symptom Inventory.

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Modification Of Environmental Factors**Providing support and orientation:**

- Offer appropriate and repeated reassurance to the patient, as required.
- Communicate clearly and concisely; give repeated verbal reminders of the day, time, location and identity of key individuals, such as members of the treatment team and relatives.
- Provide a clock, calendar and chart with the day's schedule, all in clear view.
- Have familiar objects from the patient's home in the room.
- Ensure consistency in staff (e.g. a key nurse).
- Use television or radio for relaxation and to help the patient maintain contact with the outside world.
- Involve family and caregivers to encourage feelings of security and orientation.
- Provide family with a copy of RCPsych. information leaflet on delirium for patients and carers.

Providing an unambiguous environment:

- Simplify the care area by removing unnecessary objects; allow adequate space between beds.
- Consider using single rooms to aid rest and avoid extremes of sensory experience.
- Avoid using medical jargon in the patient's presence because it may encourage paranoia.
- Ensure that lighting is adequate; provide a 40–60 watt night light to reduce misperceptions.
- Control sources of excess noise (e.g. staff, equipment, visitors).
- Keep room temperature between 21.1°C to 23.8°C.

Maintaining competence:

- Identify and correct sensory impairments; ensure patients have their glasses, hearing aids, dentures. Consider whether an interpreter is needed.
- Encourage self-care and participation in treatment (e.g. have patient give feedback on pain).
- Arrange treatments to allow maximum periods of uninterrupted sleep.
- Maintain activity levels: ambulatory patients should walk three times each day; non-ambulatory patients should undergo a full range of movements for 15 minutes three times each day.

Pharmacological treatment of delirium

- In many cases identification of delirium, discussion and reassurance of the patients and relatives, and treatment of underlying organic problems will make it unnecessary to prescribe specific treatment for the symptoms of delirium.
- If pharmacological treatment is required, the aim is to normalise the sleep-wake cycle, reduce psychotic symptoms and control agitation/aggression. Haloperidol is the best researched and most commonly used antipsychotic drug used in delirium. Small doses are usually sufficient and oral doses as small as 0.5mg nocte or bd may suffice.
- In more severe cases, intramuscular or intravenous administration of haloperidol may be required. The usual starting dose is 0.5–2.5mg haloperidol IM or IV.

- Following intramuscular or intravenous administration, the patient should be reviewed every 20–30 minutes. If the patient remains unmanageable, but has not had any adverse effects, double the dose and continue monitoring. Continue this cycle until the patient is settled. The aim of administering medication should be to help the patient settle, not to lower their level of consciousness.
- Upper limits on doses of haloperidol have not been clearly established. However, the risk of extra pyramidal side effects is dose-related and doses should be kept as low as possible. Total doses in a 24-hour period are unlikely to exceed 20mg (and in practice, doses over 5–7mg daily are rarely required).
- Patients with delirium who should not be treated with haloperidol include those with delirium tremens (because haloperidol lowers the fit threshold for fits), those with Parkinson's and those with Lewy body dementia (because of the risk of extra-pyramidal side effects). In these patients, treat with benzodiazepines.
- Of the atypical antipsychotics, risperidone (0.5mg orally up to bd), olanzapine (2.5–5 mg orally per day) or quetiapine (25mg bd) can be used. Be aware that olanzapine and risperidone have been associated with increased risk of stroke in older patients with dementia.
- 0.5–1mg of lorazepam may be administered orally, intravenously or intramuscularly bd (maximum qds) and may be beneficial in allowing a lower dose of antipsychotics to be used.
- Medication for delirium needs to be titrated to effect, maintained until delirium is no longer present and then slowly reduced and stopped.

Post-delirium counselling

Delirium can be an unpleasant and frightening experience for patients and their families. Clear explanation, reassurance and support should be offered to families and to the patient either during lucid periods of delirium or once they have recovered. After recovery, provide the patient with the RCPsych information leaflet on delirium.

What happened to Mr A?

Mr A was treated with oral haloperidol 0.5mg mane and 1mg nocte. Nursing staff monitored him carefully and offered regular reassurance and reorientation at times of confusion. A light was left on by his bed at night to reduce the likelihood of Mr A misinterpreting his surroundings (visual illusions).

Anaemia, hypoalbuminaemia and hyponatraemia were gradually corrected. Opiate analgesia was reduced and stopped as soon as feasible.

Mr A slept better and symptoms of delirium gradually receded. Haloperidol was reduced and stopped. By the time Mr A was discharged 2 weeks later, his mental state was normal and he was insightful about the cause of his post-operative distress.

The GP was informed about the episode of delirium and was advised that this could reduce his threshold for recurrence.

DELIRIUM

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Forty-eight hours after admission, Mrs B became extremely agitated and climbed out of bed, dislocating her new hip. She was verbally and physically aggressive towards staff trying to restrain her. Patient Management.

Case study 2: Mrs B

Mrs B (age 63), a retired librarian, was admitted for hip surgery. Surgery was uneventful. Forty-eight hours after admission, Mrs B became extremely agitated and climbed out of bed, dislocating her new hip. She was verbally and physically aggressive towards staff trying to restrain her.

How do you proceed?**As before:**

- Gather as much information about the patient as you can, speaking to ward staff, the GP and nearest relative as a matter of urgency. Look at the admitting doctor's clerking records and current medical notes. Check blood results, if available.
- Interview the patient. Obtain history from nearest relative if patient too unwell to interview. Include tactful questions about alcohol and drugs (however, unlikely you feel the patient is to use them). Be tactful and non-judgemental.
- Assess mental state (including cognitive assessment using 6CIT or MMSE). Complete the CAM as delirium is suspected.
- Full physical examination.

What emerged?

On routine clerking preoperatively, Mrs B gave a history of good general health. She denied past history of mental illness or memory loss. She reported alcohol consumption of 1–2 units daily.

The GP stated that when seen recently, Mrs B reluctantly admitted to drinking up to a bottle of wine a day. She had denied withdrawal symptoms. Recent blood tests at the surgery had revealed a GGT of 82u/L (N= 12–64). Mrs B had been counselled about reducing her alcohol intake.

Mrs B's husband reported that his wife drank daily. She had appeared shaky and sweaty on occasion. She usually took a drink "to steady herself" in the mornings. Sometimes she could not remember what she had done the night before. There was no history of fits.

Ward staff stated that Mrs B appeared anxious on admission but otherwise well until after the surgery when she became agitated. There were no current surgical/medical concerns.

Routine blood tests on admission revealed GGT of 118u/L and MCV of 100.2fL. Other blood tests were normal.

On Interview

History from Mrs B was limited because of her disturbed mental state. Collateral history indicated a FAST score of 4.

Mental State Examination**Appearance and behaviour:**

Thin woman in her 60s. Hyper-vigilant, inattentive, restless, shaky.

Speech:

Pressured, difficult to follow train of thought.

Mood:

Labile, perplexed, anxious, guarded and hostile at times.

Thoughts:

Expressed paranoid delusions that staff had put a snake in her bed (she pointed to the IV line which she had pulled out). She said people were floating around her bed laughing.

Cognition:

Scored 20 on 6CIT.

Further testing:

Positive features a, b and c on the CAM. Score of 20 on CIWA-Ar (see Figure 4).

What is the likely Diagnosis?

Delirium, probably delirium tremens ICD10 F 10.40.

Treatment of alcohol withdrawal**Mild alcohol withdrawal:**

Mild withdrawal (CIWA-Ar score <10) can usually be managed without medication or may require small doses of chlordiazepoxide (e.g. 5mg TDS reduced and stopped within 48 hours).

- Thiamine 100mg bd x 1 month.
- Vitamin B strong 1 bd x 1 month.

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Moderate/Severe Alcohol Withdrawal/Delirium tremens (CIWA-Ar 10-20)**General measures:**

- Nurse in a well-lit area to reduce disorientation and perceptual distortion.

Monitoring:

- Monitor pulse and BP, 4 hourly.
- Monitor for withdrawal symptoms 4 hourly using the CIWA-Ar scale (see appendix).

If score <10 no treatment is usually required.

If score >10, proceed as follows:

- Monitor BMs for hypoglycaemia and treat as required (but only after giving parenteral vitamins).
- Monitor for signs of Wernicke's encephalopathy.
- Monitor for hypomagnesaemia and hypophosphataemia.

Vitamins:

- IM/IV vitamins in the form of Pabrinex 1 pair of vials daily for 3-5 days, to prevent Wernicke's encephalopathy. (NB anaphylaxis can occur).
- Oral thiamine 100mg tds (continue long term if patient malnourished).
- Oral vitamin B strong 1 bd (continue long term if patient malnourished).

Detoxification:

Chlordiazepoxide is the usual drug of choice. Lorazepam or oxazepam can be used in patients with compromised liver function. Lorazepam is useful if parenteral route of administration is required.

- **Day 1:** Chlordiazepoxide 20mg QDS with 20mg QDS PRN, the dose being titrated against withdrawal symptoms.

- **Day 2:** Use the total dose required on day 1 as a baseline dose to be gradually reduced and stopped in 7 days.

Wernicke's encephalopathy (WE):

Wernicke's encephalopathy is an acute condition caused by thiamine deficiency. Failure to treat can lead to permanent memory loss (Korsakoff's syndrome).

The full clinical features of ataxia, ophthalmoplegia, nystagmus and delirium are rarely all present together. If WE is suspected or established, give 1 pair of Pabrinex ampoules IV bd for 2 days, then 1 pair of ampoules daily for 3-5 days.

What happened to Mrs B?

Mrs B was treated as per regime for managing moderate/severe alcohol withdrawal outlined above. One to one nursing was arranged to reduce the risk of further accidental self-harm. She became more settled within a few hours of commencing this regime.

She underwent further surgery to her hip. This time there were no post-operative problems.

At the time of discharge Mrs B had completed alcohol detoxification and was keen to be referred to her local alcohol service for ongoing support.

Case 3: Mr C

Mr C is a 69-year-old retired dentist. He was admitted 2 days ago for treatment of pneumonia. He has been anxious since admission and has required close nursing to offer reassurance. He has not slept well and has appeared drowsy during the day. He has until now, been compliant with nursing and medical management. The previous night, however, he repeatedly removed his nasal oxygen and fought with nurses trying to replace it. He repeatedly pointed to the ceiling and shouted "go away".

How do you proceed?

Gather information and examine the patient as before.

What emerged?

Mr C's wife stated that her husband's memory had been poor for at least a year. He had recently got lost when walking to their local shops and she had been phoned by the newsagent to come and pick him up. There is no previous history of disturbed behaviour such as he exhibited on the ward the previous night.

There is no history of alcohol use. He is receiving antibiotics for the pneumonia, but is still pyrexial and hypoxic (his PO₂ dropped to 79 during the previous night). Routine blood tests show a raised white cell count. Urine testing showed no abnormality. Physical examination revealed a pyrexial man with significant chest problems.

On Interview:

Mr C was rambling and incoherent. No history could be taken. The CAM was positive for features a, b and c.

What is the likely diagnosis?

Delirium superimposed on dementia ICD10 F05.1.

What are the likely causes in Mr C?

Pneumonia leading to hypoxia.

Predisposing factors include dementia and being in unfamiliar surroundings with unfamiliar faces around him and an unfamiliar routine to his day.

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Avoid pharmacological intervention if possible. If required, commence with low dose antipsychotic medication (e.g. haloperidol 0.25–0.5 nocte or quetiapine 12.5–25mg nocte). Patient Management.

How to proceed?

There is no evidence of alcohol misuse, therefore manage as per delirium guidelines (as used with Mr A).

Avoid pharmacological intervention if possible. If required, commence with low dose antipsychotic medication (e.g. haloperidol 0.25–0.5 nocte or quetiapine 12.5–25mg nocte). It is probably best to avoid benzodiazepines for this patient as it may cause respiratory depression. Benzodiazepines can also cause or aggravate confusion particularly in the elderly.

What happened to Mr C?

Treatment for pneumonia was continued. Mr C was managed according to delirium guidelines with emphasis on non-pharmacological interventions. His family tried to be with him as much as possible. Despite this, Mr C became increasingly disturbed and non-compliant, particularly at night. He was prescribed 25mg of quetiapine nocte. It took several weeks for the delirium to recede after the pneumonia cleared and the hospital social worker needed to be involved regarding discharge. Mr C was transferred to a nursing home where he died some months later.

Fast Questionnaire

Questions	0	1	2	3	4	Score
How often do you have 8 (men) 6 (women) drinks on one occasion?	Never	<Monthly	Monthly	Weekly	Daily or almost daily	

If the score is 3 or 4, the patient may be drinking harmfully or may be alcohol dependent. If the score is 1 or 2, continue questioning:

Questions	0	1	2	3	4	Score
How often in the last year have you been unable to remember what happened the night before because you had been drinking?	Never	<Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was normally expected of you because of drink?	Never	<Monthly	Monthly	Weekly	Daily or almost daily	
In the last year, has a relative or friend, doctor or other health care worker been concerned about your drinking or advised you to cut down?	No		Yes, on one occasion		Yes, on one occasion	

Figure 1: Fast questionnaire. Scores of 3 or above suggest harmful or dependent alcohol use.

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6CIT (6-item cognitive impairment test)

1. What year is it?

Correct 0 Incorrect 4

2. What month is it?

Correct 0 Incorrect 3

Remember the following address: John/Brown/42/West Street/Bedford

3. What time is it?

Correct 0 Incorrect 3

4. Count backwards from 20–0

Correct 0 1 error 2 More than 1 error 4

5. Months of the year backwards

Correct 0 1 error 2 More than 1 error 4

6. Repeat the name and address

Correct 0 1 error 2 2 errors 4 3 errors 6
4 errors 8 All incorrect 10

Scores:

0–7 probably not significant

8–9 probably significant

10–28 significant

Figure 2: 6CIT (6-item cognitive impairment test).

The CAM (Confusion Assessment Method)

To have a positive CAM result, the patient must display:

a. Acute onset of symptoms with fluctuating course

AND

b. Inattention (Inability to focus, maintain or shift attention appropriately)

AND EITHER

c. Disorganised thinking (disorganised or incoherent speech)

OR

d. Altered level of consciousness

Figure 3: The CAM (Confusion Assessment Method).

CIWA-Ar

Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol.

<p>NAUSEA AND VOMITING 0 - no nausea or vomiting 1 - mild nausea, no vomiting 2 - 3 - 4 - intermittent nausea with dry heaves 5 - 6 - 7 - constant nausea, frequent dry heaves/vomiting</p>	<p>TACTILE DISTURBANCE (Ask "Have you any itching, pins and needles, burning or do you feel insects crawling on or under your skin?") 0 - none 1 - very mild 2 - mild 3 - moderate 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations</p>
<p>TREMOR (arms extended, fingers spread) 0 - no tremor 1 - not visible, but can be felt fingertip to fingertip 2 3 4 - moderate, with patient's arms extended 5 6 7 - severe, even with arms not extended</p>	<p>AUDITORY DISTURBANCE (Ask "Are you aware of sounds around you? Do they frighten you? Are you hearing things you know are not there?") 0 - not present 1 - very mild harshness or ability to frighten 2 - mild harshness or ability to frighten 3 - moderate harshness or ability to frighten 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations</p>
<p>PAROXYSMAL SWEATS 0 - no visible sweating 1 - barely perceptible sweating, palms moist 2 3 4 - beads of sweat on forehead 5 6 7 - drenching sweats</p>	<p>VISUAL DISTURBANCES (Ask "Does the light appear too bright/hurt your eyes? Is the colour different? Are you seeing anything disturbing? Are you seeing things you know are not there?") 0 - not present 1 - very mild sensitivity 2 - mild sensitivity 3 - moderate sensitivity 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations</p>
<p>ANXIETY (Ask "Do you feel nervous?") 0 - no anxiety, at ease 1 - mildly anxious 2 3 4 - moderately anxious or guarded 5 6 7 - acute panic state</p>	<p>HEADACHE, FULLNESS IN HEAD (Ask "Does your head feel different? Does it feel like a band round your head?" Do not rate for dizziness or light headedness.) 0 - not present 1 - very mild 2 - mild 3 - moderate 4 - moderately severe 5 - severe 6 - very severe 7 - extremely severe</p>
<p>AGITATION 0 - normal activity 1 - somewhat more than normal activity 2 3 4 - moderately fidgety and restless 5 6 7 - paces back and forth or constantly thrashing about.</p>	<p>ORIENTATION/CLOUDING OF SENSORIUM (Ask "What day is this? Where are you? Who am I") 0 - orientated and can do serial additions 1 - cannot do serial additions or uncertain about date 2 - disorientated for date (by 2 days or less) 3 - disorientated for date (by more than 2 days) 4 - disorientated for place and/or person</p>

Figure 4: Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar). Scores between 10 and 20 on CIWA-Ar indicate the need for formal alcohol detoxification.

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Questions

1. What is the prevalence of delirium in general hospital inpatients?

- a. 1–2%.
- b. 5–10%.
- c. 10–30%.

2. Which of the following is true in delirium:

- a. The hypoactive form is often undiagnosed in clinical practice.
- b. Rarely involves mood changes.
- c. The clinical picture is usually worse at night.
- d. Iatrogenic causes are common.

3. In managing patients with delirium which of the following is true?

- a. Involvement of relatives can be helpful.
- b. Nursing in a darkened room reduces the risk of perceptual abnormalities.
- c. Antipsychotic medication is always required.
- d. Treatment is aimed at the organic cause(s).

4. In the pharmacological treatment of delirium, which is true?

- a. Atypical antipsychotic medication is the preferred option.
- b. Benzodiazepines are the drugs of choice in Parkinson's disease.
- c. Antipsychotic drugs are the drugs of choice in delirium tremens.
- d. Pharmacological management can often be avoided with good modification of environmental factors.

5. In delirium assessment which of the following are true:

- a. The CAM covers the core features.
- b. Delirium rating scales can help in the diagnosing and monitoring of delirium.
- c. Collateral history is a vital part of assessment for delirium.
- d. It is not necessary to ask about alcohol consumption in patients over 65.

Answers

1. c.

Most studies of delirium have been conducted on medically ill hospitalised patients. The prevalence in this group is 10–30%.

2. a, c, d

- a: There are three subtypes of delirium. These include hyperactive, hypoactive and mixed forms. The hypoactive form is often missed. Patients present as lethargic and withdrawn and may be misdiagnosed as depressed.
- b: Mood changes commonly occur and include apathy, anxiety, depression, fear, emotional lability and aggression. Aggression is usually related to paranoid thinking and disorientation.
- c: Symptoms of delirium are more prominent at night.
- d: There are many possible causes of delirium. Multi-factorial aetiology is common and include iatrogenic factors (e.g. opiate analgesia, other sedating medication or polypharmacy).

3. a, d

- a: In many cases identification of delirium, discussion and reassurance of the patients and relatives and treatment of underlying organic problems will make it unnecessary to prescribe specific treatment for the symptoms of delirium. If pharmacological treatment is required, the aim is to normalise the sleep-wake cycle, reduce psychotic symptoms and control agitation/aggression.
- b: Perceptual abnormalities are more common in the dark or poor light. Light surroundings during the day plus a night light can be helpful in reducing misperceptions.
- c: Modification of environmental factors can make pharmacological intervention unnecessary.
- d: Treatment is aimed at the organic cause.

4. b, d

- a: Haloperidol is the best researched and most commonly used antipsychotic drug used in delirium. Small doses are usually sufficient and oral doses as small as 0.5mgs nocte or bd may suffice.
- b: Drugs with extra-pyramidal side effects should be avoided in patients with Parkinson's disease. Benzodiazepines may be used (with care as they can make confusion worse and can exacerbate underlying causes, e.g. respiratory problems)
- c: Antipsychotic drugs lower the fit threshold and should therefore be avoided in delirium tremens. Benzodiazepines are the drugs of choice in delirium tremens.
- d: Modification of environmental factors includes the provision of support and orientation, the provision of an unambiguous environment and correcting sensory impairment (provide glasses, hearing aids, etc.).

5. a, b, c

- a: The CAM covers the core features of delirium including acute onset with fluctuating course, inattention and either disorganised thinking or altered level of consciousness.
- b: Delirium rating scales can help both with diagnosing and monitoring of delirium.
- c: Collateral history is an essential element of assessment for delirium.
- d: Tactful questioning about alcohol intake is an essential part of any adult psychiatric assessment. It is particularly important in suspected delirium as the pharmacological management of delirium tremens differs from that of other causes.



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PANIC AND AGORAPHOBIA

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Although this maybe anxiety presenting in the form of a panic attack, it is first important to exclude conditions which could have potentially fatal or damaging outcomes if left untreated. Patient Management.

One evening in A&E you are asked to see a 19-year-old Caucasian woman, Lorraine, who presents with palpitation, breathlessness and numbness in her fingers. It is impossible to obtain any history from her as she is extremely distressed and agitated. On examination, her BP is 140/95 with a pulse rate of 102. Her respiratory rate is 28/minute and she is afebrile with a temperature of 36.2. Her chest is clear on auscultation, she has a normal peak flow and capillary oxygen saturation and her heart sounds are normal. Examination of her nervous system reveals no abnormality. There is no palpable thyroid and no bruit. You suspect that this may be psychogenic in origin but first ask the casualty officer for her opinion. She confirms your findings and asks you to obtain a blood sugar reading but if this is normal to try and calm her down and obtain a history of the presenting complaint.

The initial presentation of this woman could be caused by a number of diagnoses affecting a number of bodily systems. Although this maybe anxiety presenting in the form of a panic attack, it is first important to exclude conditions which could have potentially fatal or damaging outcomes if left untreated. Examples of some of the differential diagnoses to be considered are:

Respiratory system

- **Acute asthmatic attack:**
 - Check Peak Flow.
 - Many asthmatics carry inhalers but asthma can appear dormant for several years and suddenly reoccur.
- **Pneumonia or chest infection:**
 - Check temperature.
 - Check breathing rate.
 - Listen to chest for signs of infection/consolidation.

Substance misuse

- Withdrawal from alcohol.
- Intoxication by stimulants or cannabis.

Cardiovascular system

- Paroxysmal atrial tachycardia or other arrhythmias.
- Myocardial Infarction (although this is unlikely in a previously healthy 19 year old).

Endocrine system

- Hypoglycaemia (most likely in a diabetic patient but can occur for other reasons).
- Thyroid abnormality.

Central nervous system

- Partial seizure.
- Stroke.
- Transient Cerebral Ischemic Attack.

Lorraine is Caucasian but if she was not then the issue of sickle cell trait or disease would be another area to consider. This is, however, less likely in a white girl of British origin.

Once you have established that there is no serious medical condition causing the symptoms, it is necessary to try and calm the patient down. Often being brought to a hospital and receiving reassurance will be sufficient. This reassurance involves explaining to Lorraine how anxiety causes symptoms in all systems of the body. These symptoms can be alarming and sometimes people feel they may be a sign of serious illness. This thought and belief will inevitably increase the anxiety and thus a vicious cycle is created. Speaking quietly and firmly and encouraging the patient to take slow deep breaths may help. Sometimes it is helpful to also ask the patient to breathe in and out into a paper bag. The reason for this is that many of the alarming symptoms of panic are caused by lowered CO₂. This alters the acidity of the blood. Asking the patient to re-breathe their own air or to regulate their breathing returns the chemistry to normal.

At all times while speaking with the patient, it is essential that it is made clear that you realise she is experiencing very real, distressing symptoms. These are not imaginary at all but are caused by psychological factors. A good relationship and good interpersonal skills are therefore, necessary.

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If the patient remains extremely agitated and nothing else is effective, it may be necessary to offer some sedation. However, sedation can cause problems in itself. Benzodiazepines can be used in the acute situation. Although in the long term they run the risk of dependency, this is not relevant in the acute phase. Risks associated with the benzodiazepine drugs include:

- Respiratory depression particularly in those with chronic or acute respiratory disease or who are using other sedative agents including alcohol.
- Drowsiness: the amount of drowsiness which may be caused by the benzodiazepine may place the patient at risk if discharged home without supervision. Therefore in such cases it is safer to admit overnight for observation. In extreme cases this drowsiness and loss of normal gag reflex could place individuals at risk of aspiration if vomiting were to occur.

After sitting quietly in A&E for half an hour, Lorraine, becomes much quieter and is able to talk normally. Her physical examination and blood test results are all normal. When asked to describe what had happened she tells you that earlier in the day she had been travelling home from university on a bus. Suddenly she began to feel extremely anxious. This anxiety manifested itself with her trembling, feeling nauseated, experiencing palpitations and fear that she might lose control. She immediately got off the bus and went into a newsagent, by which time she was also complaining of tingling in the fingers. Although she has had similar episodes like this before, she has never experienced one that is as severe as this. This is the first time she has had paraesthesia of her fingers. She asks you to explain this symptom to her.

During a panic attack hyperventilation is a common symptom and over breathing leads to the disturbances of the chemicals (acid-base balance) in the body leading to alkalosis. This may lead to the symptoms of light headedness, further anxiety and sometimes numbness around the lips and tingling sensation in the fingers and tetany or in other words a spasm of the fingers and hands, which is also known as carpo-pedal spasm.

You then start to question her about her past history. It appears that she has had other episodes over the past 6 months. Lorraine had lived at home in rural Nottinghamshire until 6 months previously when she left the family home to study Economics at University in Liverpool. Since coming to Liverpool, she has found adapting to the noise and pace of the city difficult. She was unused to travelling alone and had previously gone most places in the family car or accompanied by close friends or family. For as long as she could remember, she had been a nervous and shy individual and had had a period when she had avoided going to school at age 11 years when she moved from Primary to Secondary School. At this time she had been seen by the local Child Guidance Clinic and had been helped to return to school. There is no other history of psychiatric disorder and no family history of similar complaints.



Shortly after moving to Liverpool, she became increasingly anxious about crowded places. This has led to her avoiding socialising in the Student Union unless she first has drunk a half bottle of wine. She has also had previous episodes of anxiety symptoms with palpitation and nausea while travelling on buses and subsequently now avoids all public transport. She was unable to face travelling back to Nottinghamshire alone for the Easter Break and asked her mother to collect her by car.

There is no history of any illicit drug use and she says she drinks up to a bottle of wine a week.

You explain to Lorraine that it appears she is suffering from Panic Disorder with Agoraphobia. She asks you what that means.

Panic disorder refers to extreme anxiety which normally occurs in waves and will eventually subside on its own accord. Although it is described as arising “out of the blue” in reality the individual often gives a history of some fears or worries which precede these experiences. Panic may be viewed as an extreme of anxiety. Symptoms of panic may include every system of the body but typical symptoms are:

- palpitation, pounding heart, or accelerated heart rate
- sweating
- trembling or shaking
- sensations of shortness of breath or smothering
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- feeling dizzy, unsteady, light headed or faint
- de-realisation (feelings of unreality) or depersonalisation (being detached from oneself)
- fear of losing control or going crazy
- fear of dying
- paresthesias (numbness or tingling sensations)
- chills or hot flushes.

PANIC AND AGORAPHOBIA

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Mental disorders, which include anxiety disorders, are categorised according to either the World Health Organisations International Classification of Diseases¹⁰. Patient Management.

Mental disorders, which include anxiety disorders, are categorised according to either the World Health Organisations International Classification of Diseases 10 (ICD10)¹, ICD-10, The ICD-10 classification of mental and behaviour and diagnostic guidelines, Geneva, WHO, which is used most commonly in Europe and Commonwealth or the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV)²; Diagnostic and statistical manual of mental disorders DSM IV, Washington DC, American Psychiatric Association, which was developed in North America but is also used widely in other countries. Both of these manuals suggest that when panic disorder exists with another anxiety disorder, then the panic disorder is the first diagnosis.

In this case it appears that Lorraine also suffers from agoraphobia or fear of being in enclosed and crowded places. This condition often first presents in early adult life. Sufferers often have a family history of anxiety disorder and many have a history of being anxious children with a high number having exhibited school refusal or other evidence of anxiety disorders. Agoraphobia can, however, arise without any obvious predisposing factors. The name literally means “fear of the market place” and thus people with agoraphobia often find that places that are difficult to escape from are particularly anxiety provoking. In general agoraphobia sufferers find it easier to travel by car than bus; buses which stop regularly are easier than trains; stopping trains are easier than express trains and underground trains are usually the most fear provoking. Similarly large department stores and supermarkets are usually much more frightening than local shops. People with these fears also usually find it easier if they are accompanied by a trusted companion and find it easier to be near home. Many have also developed an elaborate number of “safety signals” or items which are used as talisman to help reduce the anxiety. Examples of these include carrying reading material to distract from anxiety on journeys; dark glasses to avoid looking around; carrying smelling salts and sometimes carrying alcohol or tablets which are rarely taken but are carried “just in case”.

You explain to Lorraine that you are going to refer her to see her GP with a view to her being referred to her local psychological therapy in Primary Care Service. She is concerned by this as she says she is not keen to take pills and tablets. She asks you what the treatment options are for panic disorder and agoraphobia.

You explain to Lorraine that there are two possible types of treatment but that psychological treatment is the first line approach of choice. The treatment approach, which has been found to be particularly useful for panic symptoms and agoraphobia, is cognitive behavioural therapy (CBT). In this approach the patient will be taught to recognise the thoughts which precipitate the panic. There is a considerable amount of education about anxiety and panic so that the sufferer can understand how the symptoms escalate. For example, if Lorraine is in a situation where she feels anxious, she had reported noticing that her heart beat became very rapid. This increase in heart rate worried her as she became increasingly convinced that this symptom was evidence of a heart abnormality and that she may die. This thought was obviously very anxiety provoking and thus lead to an increase in her anxiety and her heart rate. Thus her thoughts are fuelling the symptoms. This sequence of events was described by Clark (1986) in the UK. Helping the patient to recognise these patterns and to understand them is an important part of CBT for Panic Disorder.

The CBT approach for agoraphobia is based on graded exposure to the feared situation. Firstly the patient needs to understand how avoidance and escape behaviours fuel the problem. In general, when a person is in a fear-provoking situation, they try and escape. This escape reduces the anxiety. Because high anxiety is unpleasant, this reduction in anxiety acts as a reward. Thus the escape behaviour is rewarded and becomes increasingly used as a strategy and leads to more and more restriction of anxiety-provoking activities. In graded exposure treatment, the patient is taught how, although unpleasant, anxiety does no harm and does eventually reduce. In collaboration with the therapist, the patient constructs a hierarchy of increasingly anxiety-provoking situations. A task is then chosen which will cause anxiety but at a level that can be tolerated by the sufferer. They are then asked to go into this situation and remain there until the anxiety consistently reduces by half. This generally takes about an hour. They are then asked to repeat this, preferably two to three times a day. As the task is repeated the anxiety gradually reduces and the time the anxiety takes to come down in the situation also reduces. Once the first step has been mastered, it is time to move onto more challenging steps in the hierarchy (Stern and Drummond 1991, Burke, Drummond and Johnstone. 1997, Drummond and Fineberg, 2007).

PANIC AND AGORAPHOBIA

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Drugs can be used for anxiety disorders and can be prescribed by her general practitioner but do have a number of problems viz:

- Most people developing anxiety disorders are in their teens or early adult life. Anxiety disorders are chronic conditions. Prescription of drugs at a time when young adults are potentially going to start a family is always to be avoided if possible.
- As the conditions are chronic, medication may potentially have to be continued for decades.
- All drugs have the potential for side effects.
- Some drugs cause tolerance and physical addiction but all have the potential for psychological dependence.

If drugs are necessary then the best evidence is for the class of antidepressants known as Selective Serotonin Reuptake Inhibitors (SSRIs) which seem to work in the septo-hippocampal and limbic areas of the brain which are associated with anxiety. These drugs act by increasing the available serotonin in the brain. They have been shown to be effective in a number of controlled studies (reviewed by Ballenger⁷).

In the past other antidepressant drugs known as tri-cyclic antidepressants were used. Although effective these have a large number of unwanted side effects and are not as well tolerated as the SSRIs.

In the past, benzodiazepines, such as diazepam, chlordiazepoxide and alprazolam were used. These drugs are now known to cause considerable problems in long-term use, such as physical and emotional dependency and tolerance, with the need for escalating dosage to achieve the same effect. Other side effects have been listed above. They should only be prescribed to help someone overcome a short-lived problem and never for more than 6 weeks. Anxiety and panic disorders are the subject of NICE guidance⁸.

Self-Assessment Questions

1. Catastrophic misinterpretation of physiological experiences is an important Cognitive element of panic disorders.
2. Agoraphobia frequently occurs with panic attacks.
3. Rotational vertigo is a feature of panic attack.
4. Agoraphobia occurs frequently in fifth decade.
5. Fear of impending loss of control is a psychological feature of panic attack.
6. Agoraphobia is commonly associated with depression.

Self Assessment Answers

1. True

When a patient is anxious they may experience unpleasant bodily symptoms in any part of the body. For example, palpitation or a sensation of breathlessness. If the individual interprets these sensations as being evidence of something seriously wrong with the body, then this leads to increased anxiety and a vicious cycle of escalating symptoms occurs.

2. True

Panic attacks often occur in situations where there are many anxiety provoking stimuli. In agoraphobia, unlike a specific animal phobia, anxiety can be provoked by a large number of situations. There is thus a strong likelihood that extreme anxiety or panic will occur.

3. False

Patients suffering from panic may experience light-headed feelings or dizziness. Rotational vertigo, however, is related to abnormalities in the ear.

4. False

Agoraphobia is a condition which normally arises in early adult life or even in teenage years. If a patient presents with the first onset of agoraphobia in later life, further investigations into possible physical causes of the symptoms are necessary.

5. True

Many patients fear they may “go mad”; lose control and act inappropriately as well as fear of dying during panic.

6. True

Depression and agoraphobia can often occur together. A depressed patient often has heightened arousal and feels anxious in previously non-frightening situations. Depressed patients are also often very restricted and “slowed up” in their activities. This can lead to agoraphobia even when the depressive symptoms lift. Alternatively, some patients with agoraphobia can feel very despondent about their restricted lives which can also lead to depression.

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THE MENTAL HEALTH ACT 1983 A CASE BASED DISCUSSION

Alok Kumar Rana, Ankush Singhal and Richard Eggar



A 23-year-old man, CW, is brought to A&E by two police officers. The police were called because he was shouting at people in the street. Patient Management.

A 23-year-old man, CW, is brought to A&E by two police officers. The police were called because he was shouting at people in the street. When approached by the police he told them that he had recently taken an overdose of paracetamol. They decided to bring him to hospital and chose the general rather than psychiatric hospital because he had taken an overdose.

Which Section of the Mental Health Act has been used?

Section 136. This is a special power under the Act whereby the police can remove someone from a public place if they are in immediate need of care or control and seem to be suffering from a mental disorder. They are removed to a "place of safety" which in this case was the general hospital A&E. (Interestingly an A&E is also a public place for the purpose of Section 136 of the Act). They can be detained for up to 72 hours under Section 136 until they are examined by a doctor and an AMHP (approved mental health professional) and arrangements are made for their care¹.

In A&E he seems perplexed and distracted. Hospital records confirm that he is known to mental health services with a diagnosis of schizophrenia. He says that he has taken an overdose because voices have commanded him to die and that if he does not obey them he believes his family will be murdered by the government.

He agrees to have blood tests but then says that he wants to leave and go home. The duty psychiatrist has been called.

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The psychiatrist arranges for psychiatric nurses to stay with him on the medical ward. He agrees to have treatment with n-acetyl cysteine and to stay in hospital. He also restarts his antipsychotic medication. Patient Management.

What should happen next?

He should be assessed by the duty psychiatrist and they should call a more senior psychiatrist to arrange a Mental Health Act assessment. Once the Mental Health Act assessment is convened it can be decided not to Section him or he could be placed on one of three Sections of the MHA. Section 2 requires recommendations from two doctors (a Section 12 approved doctor, usually an ST4-6 or consultant psychiatrist, and either the GP or an independent Section 12 approved doctor). An application must be made by an Approved Mental Health Professional (usually a social worker) or a nearest relative. This lasts for up to 28 days for assessment and treatment. If the patient is well known to services then the same professionals may instead use a Section 3. This is for treatment and lasts for up to 6 months. It can be difficult in emergency situations to get an independent doctor to come quickly. If that is the case and a delay cannot be justified then a doctor (any doctor post-registration, not necessarily a psychiatrist) and an approved mental health professional can do a Section 4 which is an emergency holding power for 72 hours.

An independent doctor is available and a Mental Health Act assessment is carried out. His parents come to hospital and talk to him first. After speaking to his parents he becomes more co-operative, says that he will agree to stay in hospital and to take medication. His paracetamol levels are slightly above the treatment line and he agrees to stay in hospital and to have treatment with n-acetyl cysteine.

The two doctors and social worker spend some time talking about it and decide not to Section him. The psychiatrist arranges for psychiatric nurses to stay with him on the medical ward. He agrees to have treatment with n-acetyl cysteine and to stay in hospital. He also restarts his antipsychotic medication. However, later that evening the FY1 doctor is called to the ward because he has changed his mind, has decided that the nurses with him are trying to harm him and wants to leave.

What should happen next?

The FY1 doctor talks to the mental health nurses and calls the on call psychiatrist. They advise that he should be assessed for a Section 5(2) of the Mental Health Act. This is a 72-hour holding power for the doctor or clinician in charge of an inpatient's treatment or that doctor's nominated other (this is often a nominated "role" rather than a specific individual). It applies to both psychiatric and general hospitals. In a general hospital it is often the senior medical trainee on call (ST4-6) that has been nominated but this may vary between different hospital trusts. Similarly in psychiatric inpatient settings it is often the junior psychiatric trainee on-call for the wards.

The FY1 asks the psychiatrist to come and assess the patient for a Section 5(2). The psychiatrist explains that it has to be the treating doctor, or their nominated other, but that they will come to the ward to assist if necessary and advises the FY1 to discuss with his or her seniors.

The medical ST4-6 trainee does the Section 5(2) and the patient agrees to take some extra medication. He stops asking to leave and goes to sleep. The next day his n-acetyl cysteine is finished and he is reassessed on the ward by the same two doctors and social worker from the day before. He still tells them that he is willing to accept treatment but they decide that his mental state is too changeable so he is placed on Section 2 and transferred to the local psychiatric hospital.

What treatment can be given under Section 5(2) and Section 2?

Section 5(2) is a holding power and no treatment can be given under the provisions of this Section. If CW were to require treatment against his will, either for his mental disorder or for the overdose, while under Section 5(2) this treatment would have to be given under the provisions of the Mental Capacity Act.

Section 2 is for admission for assessment; however, medical treatment (including medication, nursing care and psychological interventions) for the mental disorder can be given under this Section. Any treatment for medical disorders, such as the overdose, cannot be given under Section 2, or in fact under any Section of the Mental Health Act. If such treatment is required to be given against a patient's will it must again be done using the provisions of the Mental Capacity Act.

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What are the criteria for detention under Section 2?

The patient can only be detained if he has a mental disorder of a nature or degree which warrants detention and he ought to be detained in the interests of his health or safety or for the safety of others. Other alternatives including treatment at home with local Crisis/Home Treatment Services must be considered.

Section	Purpose	Length	Criteria	Application	Recommendations
2	Assessment	28 days (not renewable)	-mental disorder of a nature or degree which warrants detention -ought to be detained in the interests of their health or safety or for protection of others	AMHP or nearest relative	2 doctors -one must be S12 approved and ideally one should have previous acquaintance with patient
3	Treatment	6 months initially (renewable)	-mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital -necessary for their own health or safety or for the protection of others -treatment cannot be provided unless they are detained under S3 -appropriate medical treatment is available	AMHP or nearest relative	2 doctors -one must be S12 approved and ideally one should have previous acquaintance with patient
4	Emergency admission for assessment	72 hours	-urgent necessity -criteria for S2 must also be met	AMHP or nearest relative	1 doctor - can be any doctor but preferably S12 approved or with previous acquaintance
5(4)	Nurse holding power	6 hours	-inpatient -necessary for patients health and safety or for protection of others that patient is immediately restrained from leaving hospital -it is not practicable to secure immediate attendance of a doctor	N/A	Nurse
5(2)	Doctor holding power	72 hours	-inpatient -if an application for admission for assessment or treatment ought to be made	N/A	Doctor in charge of a patient's treatment or nominated other doctor

Table 1: This table outlines the Sections for detention of civil patients in hospital. † AMHP approved mental health professional. ‡ S Section.

While waiting for transport to the psychiatric hospital, CW starts to complain that he has been treated unfairly and should not have been placed under the Mental Health Act as he was agreeing to admission. He asks for advice on how to proceed with this complaint.

What advice should be given to CW?

He should be advised of his rights to appeal against the Section under the Mental Health Act and to have this heard by the hospital managers and by the Mental Health Act Tribunal (both of which have the power to discharge him from the Section). He should also be advised to discuss his concerns with the consultant psychiatrist in charge of his care on the psychiatric ward (responsible clinician according to the Act) who is also able to discharge him from the Section if deemed appropriate. As well as legal advice available, there are Independent Mental Health Advocates that could assist CW to understand his rights under the Mental Health Act.

Reading references

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