

# **A Manual of Mental Health Care** in General Practice

John Davies





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All the information contained within this book is intended as a guide only and will be altered in the face of future advances in knowledge, in particular, with regard to pharmacological treatments. Responsibility for treatment, including drug prescribing, resides with the individual doctor. The views expressed within the book are those of the author and are not those of any of the agencies, departments or funding bodies that have provided financial or practical support for its production and/or distribution.



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the Primary Mental Health Care Development Liaison Officers (DLOs) in each state and territory Division of General Practice State Based Organisation (SBO).

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National Mental Health Strategy, Primary Mental Health Care Initiative, Divisions of General Practice, Primary Care Psychiatry: The Last Frontier, Joint Consultative Committee, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, February 2000

## Foreword to revised edition

As expected, the first edition of the manual met with great acclaim. It fulfilled the promise of relevance and utility to general practitioners and was eagerly sought after by many other health professionals. There is a huge waiting list for the revised edition.

The revised edition has been extensively updated in the area of pharmacology and an entirely new chapter on sexual dysfunction has been added. This new chapter maintains the standard set in the previous edition—John again demonstrates his ability to condense and clarify vast amounts of material, making it accessible and immediately useful.

Once more, I commend to you this excellent book in the expectation that it will significantly assist you in the relief of suffering of those who seek your help.

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## Preface to revised edition

I have made a number of changes to the book, some in response to comments from readers, others to keep the book up-to-date. The major changes are a new chapter on sexual dysfunction and a revision of the chapter on pharmacological treatments. Over the 18 months since the first printing, the use of thioridazine has been tightly restricted, and new antidepressants, antipsychotics and hypnotics have become available.

The Commonwealth budget of 2001 set aside \$120.4 million for the 'Better outcomes in mental health care' initiative. This includes around \$10 million to provide education and training to general practitioners. Those who have undergone approved skill-based training (including two hours of familiarisation and six hours of clinical training) will be able to apply for incentive payments for the delivery of packages of care that include an assessment, the development of a treatment plan and a review. Those who have undertaken 20 hours of approved skill-based training in focused psychological strategies will gain access to higher rebates for the delivery of six sessions of therapy, extendable to a maximum of 12 per year.

A point that needs to be made is that reading this book will not in itself necessarily translate into improved clinical skills and the delivery of better treatment—these require participation in a skills-based training program as well as supervision of actual clinical work. Skills-based training programs such as the SPHERE program use modelling, role-playing and the review of videotaped trainee interviews<sup>1</sup>. I hope this book will be a useful resource for those undertaking such training.

I want to express my gratitude to Anthony Bell, Simon Burton, Brian Kelly, John McGrath, Michael Robertson, Jim Rodney and Josie Sundin for their comments on earlier drafts. Thanks also to the Department of Health and Ageing, to Dermot Casey for his support, and to Susan Staruszkiewicz for her patience in preparing the manuscript for print.

**John Davies**

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<sup>1</sup>Hickie I, Scott E, Morgan H, Sumich H, Naismith S, Davenport T, Hadzi-Pavlovic D, Gander J. *A Depression Management Program: Incorporating Cognitive-Behavioural Strategies*. Box Hill: Educational Health Solutions, 2000.



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Most of all, I thank Grace Groom, Director of the Queensland Divisions of General Practice Mental Health Support Strategy, without whose drive, support and humour the book would never have been written.

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## Introduction

This book grew out of the collaboration between the Logan-Beautesert Mental Health Service and the Logan Area Division of General Practice on the case-conferencing project, a series of eight seminars that aim to improve general practitioners' knowledge of the mental disorders that they commonly treat and to increase their familiarity with how the service functions. I hope that it is a useful resource for similar projects.

In writing the book I have tried to combine the advantages of a manual and a textbook. I hope that it provides easily accessible information on the assessment and treatment of the mental disorders that general practitioners see, but in more depth than might usually be found in a manual.

One of the challenges of treating mental health problems in general practice is that as many as 50 per cent of them do not meet the criteria for any specific diagnosis. Moreover, people often present with a complex combination of physical and mental health problems. I believe that a solution to these problems is for general practitioners to develop skills in making both a diagnosis and a formulation. While a diagnosis is made on the basis of features that the individual shares with others who have similar problems, the formulation also includes features specific to that individual. It brings together all of the salient factors in the person's history that have a bearing on the development and continuation of the problem. While the diagnosis is a useful guide to treatment, the formulation allows treatment to be tailored to the specific needs of the individual.

The book begins with an overview of mental health care in general practice and of the relationship between general practitioners and district mental health services. In Chapters 2 to 13, I discuss some principles of psychiatric assessment and treatment. Since much of the material in the rest of the book assumes an understanding of issues covered here, I recommend reading these chapters first. In the following eleven chapters, I describe the treatment of specific disorders. Chapter 25 deals with the issue of doctors' own mental health. The final chapter was written by consumers and carers of the Logan-Beautesert Mental Health Service as a letter to general practitioners.

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# Chapter I

## Working with district mental health services

Mental disorders are prevalent in the community. They produce high levels of disability and handicap and place a large burden on society. While specialist mental health services will never be able to meet the demand for treatment on their own, general practitioners are well placed to provide mental health care to the majority of those suffering a mental disorder. Indeed, most people who seek help for their mental health problems do so from their general practitioner. General practitioners will be assisted in this task through close collaboration with specialist mental health services.

### The burden of mental illness

In 1996 the Harvard School of Medicine, the World Bank and the World Health Organization published their report on the Global Burden of Disease project<sup>1</sup>. This project calculated disease burden by adding together years of life lost through premature mortality and years lived with a disability to form a new measure of burden, the Disability Adjusted Life Years lost (DALY). The results were quite different from those of previous studies because of the inclusion of a measure of disability in addition to one of mortality.

The study had salutary results with respect to the burden of mental illness. Worldwide, mental illnesses account for 10.5 per cent of the total burden of disease. In established market economies like Australia, they account for 22 per cent of all DALYs. The top ten conditions worldwide include four psychiatric syndromes: unipolar depression, alcoholism, schizophrenia and obsessive-compulsive disorder. It was calculated that by 2020 depression will be the second highest cause of disease burden worldwide, exceeded only by ischaemic heart disease, and that mental illness as a whole will account for 15 per cent of the total burden of disease worldwide.

The *National Survey of Mental Health and Wellbeing* (1999) found that over the year of the study more than 20 per cent of the adults surveyed suffered a mental illness<sup>2</sup>. The commonest illnesses were anxiety disorders (9.7 per cent), substance abuse (7.7 per cent) and affective disorders (5.8 per cent). There were differences in the prevalence of disorders between the sexes with substance abuse more common amongst males, and anxiety and affective disorders more common amongst females. Around one person in four suffering one mental disorder also suffered another. High levels of disability accompany these disorders. For example, people with anxiety disorders have an average of 2.1 days out of role every month. A disturbing finding of the survey was that only about one-third of those suffering a mental disorder seek treatment. Most of these people seek help from their general practitioner.

### Mental health care in general practice

Around one-third of people presenting to general practitioners suffer a diagnosable mental disorder. A further one-third suffer significant psychological symptoms that do not meet the criteria for any specific disorder. Of those with a mental disorder, only half receive a diagnosis and, of these, only half receive specific drug treatment<sup>3</sup> (see Figure 1-1). The commonest

<sup>1</sup> Murray CJL, Lopez AD, Eds. *Summary: The Global Burden of Disease*. Harvard: World Health Organisation, 1996.

<sup>2</sup> Andrews G, Hall W, Teesson M, Henderson S. *The Mental Health of Australians*. Canberra: Commonwealth Department of Health and Aged Care, 1999.

<sup>3</sup> Harris MF, Silove D, Kehag E, et al. Anxiety and depression in general practice patients: prevalence and management. *Medical Journal of Australia* 1996; 164: 526-529.

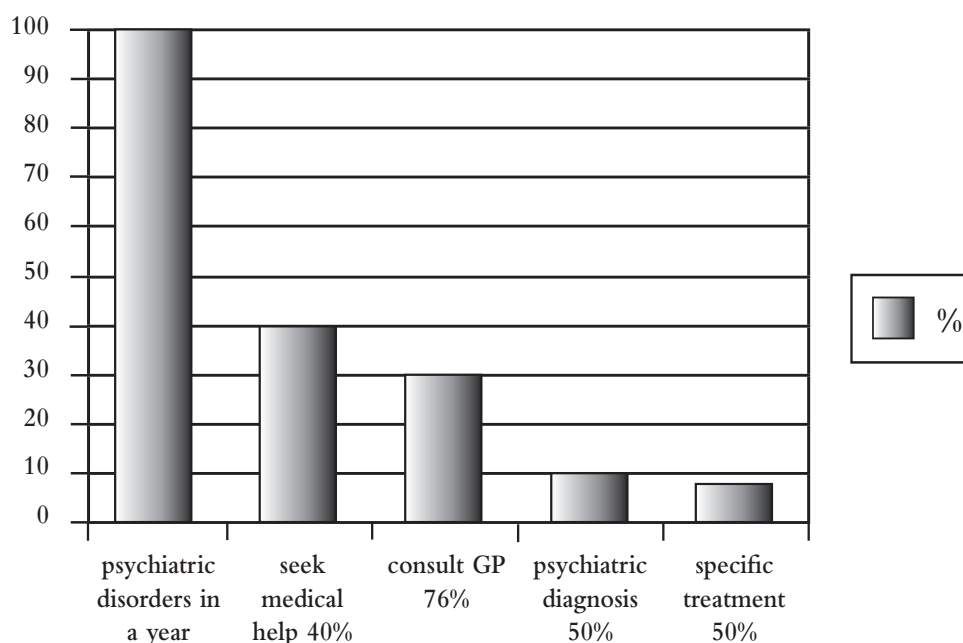
problems are depression and anxiety, most often occurring together and frequently presenting with physical symptoms. While these conditions often do not present with florid symptoms, they are associated with high levels of disability and handicap. One study found that, of a group of chronic physical illnesses, only ischaemic heart disease produced levels of disability comparable with depression<sup>1</sup>. The National Survey of Mental Health and Well Being confirmed the high levels of disability associated with these disorders. Because of their high prevalence, the overall burden of these disorders is substantial.

The assessment and treatment of people with mental health problems in general practice presents a number of difficulties. Since the system of Medicare rebates favours short consultations, it is often difficult to find the time to perform thorough assessments or any sort of psychotherapy. People often present their mental health problems with physical rather than psychological symptoms. In many cases, both mental and physical disorders are present. The cause of patients' problems is often a complex combination of biological, psychological and social factors. The conditions seen in general practice often do not fit neatly into established diagnostic categories, and the effectiveness of drugs in their treatment is not always known.

General practitioners may also have difficulties working with their local mental health service. They may be unaware of referral procedures and of the way that the mental health service functions. They may be reluctant to refer patients because of concerns that the specialist service will take over primary care of their mental health problems. They may feel that mental health services have little to offer in the treatment of people with some of their most challenging problems, such as 'heartsink patients' or those with personality disorders.

Hospital staff may not involve general practitioners sufficiently in discharge planning. Discharge summaries, if they are sent, may arrive late and not readily provide the information that the general practitioner needs to know. Mental health staff may be reluctant to discharge patients whom they know well and whose conditions are stable because of the work involved in arranging discharge and then getting to know a new patient. They may be unfamiliar with the way general practitioners run their practices and uncertain of their willingness to accept referrals for continuing care.

**Figure 1-1: Filters to mental health care in general practice**



<sup>1</sup> Wells KB, Stewart A, Hays RD et al. The functioning and well-being of depressed patients: results from the medical outcomes study. *Journal of the American Medical Association* 1989; 262: 914-919.

## 2 Working with district mental health services

## District mental health services

Over recent years, there have been significant changes in the way that mental health care is delivered in Australia. The agenda for these changes was set in 1992 when the state and Commonwealth health ministers agreed to the implementation of the National Mental Health Plan. The major change has been the shift in the delivery of care from large stand-alone psychiatric institutions to the community. As a consequence, families and other carers now take greater responsibility for the support and care of people with mental illnesses. Disability support and rehabilitation services are now provided by mainstream agencies and non-government organisations, in many cases the same that provide services to people with physical disabilities. Ultimately, the treatment of mental disorders should parallel that of physical conditions, with general practitioners providing most of the ongoing care, supported by specialist mental health services.

### Target population

The priority for district mental health services is to provide mental health care to people living in their catchment area who suffer serious mental disorders and other serious mental health problems. The target population includes people with psychotic and severe neurotic disorders, for example, those with schizophrenia, delusional disorder, bipolar mood disorder, major depression and severe obsessive-compulsive disorder. However, the seriousness of a disorder often has more to do with the level of disability and handicap than with the diagnosis or level of impairment. For example, a person with panic disorder and agoraphobia may suffer more disability and handicap than someone with schizophrenia. It should be noted that district mental health services are not funded to provide treatment to people whose primary problem is substance abuse, a marital or legal problem, or intellectual disability.

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**The target population for district mental health services includes people with serious mental disorders and other serious mental health problems.**

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General practitioners should get to know the private psychiatrists in their area, and their billing practices. You may wish to refer a person to a private psychologist for counselling, cognitive behavioural or behavioural treatments. Updated lists of local rehabilitation and disability support agencies, counselling services and relevant non-government organisations should be available from your local district mental health service or division of general practice. The following section describes the way the Logan Beaudesert Mental Health Service functions. While most services in Australia operate along similar lines, you will need to get to know how your local service operates.

### Referral procedures

Within office hours, you should direct referrals to the community mental health service. Most district mental health services no longer accept outside referrals to hospital outpatients. You can make the referral over the phone or by writing a short note.

An intake officer, a psychiatric nurse or allied health professional who has been trained in mental health assessment, will accept the referral. Since it is not a medical officer who performs the first assessment, the referral letter should be addressed to the intake officer, not the doctor.

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**Referral letters to district mental health services should be addressed to the intake officer.**

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All referrals are discussed the following weekday in a multi-disciplinary staff meeting when the final decision about the person's treatment plan is made. If the service accepts the person for ongoing treatment, he or she is assigned a medical officer (psychiatrist or psychiatric registrar)

and, usually, a case-manager.

People needing urgent assessment out-of-hours are generally seen in the hospital emergency department. However, most services have some form of extended hours service (see below).

### **The role of the case-manager**

The case-manager (sometimes called key worker) is a mental health nurse or allied health professional (psychologist, social worker or occupational therapist) whose principal role is to coordinate the different aspects of a person's care. This often involves linking the person with a range of accommodation, social security, disability support and rehabilitation agencies. The case manager is also responsible for monitoring patients' mental states, their clinic attendance, and their adherence to medication and follow-up—and for supporting their families and other carers. The case-manager is the person you should contact when you require information about a current client of a district mental health service.

### **Recent developments**

#### *The mobile intensive treatment team*

Over the past five years, a number of services have been evaluating the role of mobile intensive treatment teams. These comprise a specialised group of staff who provide intensive case management to a small group of the most disabled consumers. Caseloads are kept small in order to permit high levels of care. The evaluation of this mode of service delivery has presented some methodological difficulties, but preliminary results suggest that mobile intensive treatment teams reduce hospital bed-days, produce high levels of consumer and carer satisfaction, and lead to better patient outcomes in terms of reduced impairment, disability and handicap.

#### *The extended hours service*

The National Standards for Mental Health Services include the provision of services 24-hours a day. Most services throughout Australia now have at least some limited after-hours capacity. For example, the Logan-Beaudesert Mental Health Service has an extended hours service that provides assessment and ongoing case management between 5pm and 9pm on weekday evenings, and between 10am and 6pm on weekends and public holidays. At other times, a phone advisory service is provided and assessments are available through the Logan Hospital Emergency Department.

#### *Community Assessment and Treatment teams*

In some states, Community Assessment and Treatment (CAT) teams have been established that provide assessments, intensive treatment and support, often in the person's home. In some services they act as gatekeepers to the inpatient units and also have access to alternatives to hospital accommodation such as motels or home care.

### **Partnerships in mental health care**

The establishment of effective working partnerships between general practitioners and mental health services is one of the key aims of the second National Mental Health Plan, released in July 1998. The advantages of providing mental health care in general practice are clear. It normalises mental health treatment, putting it on a par with the treatment of physical illness. There is less stigma attached to attending a general practitioner than attending a specialist mental health service. Patients can have both their physical and mental health needs met by the same person. Improving mental health care in general practice will help address the large unmet need for the treatment of the high prevalence depressive, anxiety and somatoform disorders. The ability of general practitioners to treat most of the mental health problems that they see will allow the specialist mental health services to concentrate on treating people with more severe disorders. General practitioners will gain greater job satisfaction if they are able to more effectively diagnose

and treat the large number of their patients who suffer mental health problems.

In March 1999, three million dollars was set aside from the budget of the Second National Mental Health Plan for a national initiative in primary mental health care, the aims of which are to provide education and support to general practitioners in mental health care, and to promote partnerships between general practitioners and public and private mental health services. Some of the strategies used to meet these goals include the development of educational packages on the treatment of the sorts of mental illness commonly seen by general practitioners, and programs aimed at familiarising general practitioners with the way mental health services function. A number of models of cooperation between general practitioners and mental health services have been developed. The essential prerequisite is effective communication—between generalist and specialist, private and public systems, and between medical and non-medical practitioners. The divisions of general practice are ideally placed to coordinate these partnerships with district mental health services\*.

Since November 1999 new Medicare Schedule items have been available for general practitioners to bill for care planning and case conferencing with other health professionals, without the patient being present. Items are available for the preparation and review of care plans for patients who have one or more chronic conditions with complex multidisciplinary care needs. The plan may be made on discharge from an inpatient facility or during community care. It requires informed consent from the patient. It must be documented and include jointly formulated management goals that the patient and carer agree to. It must involve the general practitioner together with two other health care providers from different clinical disciplines who are involved in the person's ongoing care and agree to work with the general practitioner to achieve the set goals. Additional items are available for case conferences. These also require the involvement of at least two other health care providers involved in the ongoing care of a person with one or more chronic conditions and complex multidisciplinary care needs. Documentation includes a list of participants, times, problems, goals, strategies discussed and a summary of outcomes. Prior consent must be obtained. The patient and the other health care providers are given a copy of the summary.

The 'Better outcomes in mental health care' initiative announced in the 2001 Commonwealth Budget has five major components: incentive payments for general practitioners to provide assessment, care planning and review of people with mental health problems; education and training of general practitioners; new Medicare Benefits Schedule items for focused psychological strategies provided by appropriately trained general practitioners; access to allied health services through funds held by divisions of general practice; and improved access to psychiatrists through a new Medicare Benefit Schedule item for psychiatrist case conferencing involving the general practitioner, a psychiatrist and one other professional with or without the patient, and provision for consultation between the general practitioner and a psychiatrist in emergency situations.

The 'beyondblue' initiative is a \$35 million commitment over five years from state, territory and federal governments, lead by Victoria and the Commonwealth, to optimise the care of people with depression and related disorders<sup>1</sup>. The five priority areas are the promotion of community awareness and literacy, consumer and carer input, prevention and early intervention, applied research, and primary care training and support. The latter includes projects to improve the delivery and quality care for depression in general practice.

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<sup>1</sup> See beyondblue website: [www.beyondblue.org.au](http://www.beyondblue.org.au).

\* Information about the primary mental health care initiative in Australia can be accessed from the project officer of the Primary Mental Health Care Australian Resource Centre (PARC) at [parc@flinders.edu.au](mailto:parc@flinders.edu.au).

## **An example of collaboration between general practitioners and a district mental health service**

The Logan Area Division of General Practice provides support to general practitioners working in an area situated about halfway between Brisbane and the Gold Coast. The Logan Beaudesert Mental Health Service provides mental health care to residents in the Logan Beaudesert Health District, which includes the area covered by the Division, but also extends south, around the western boundary of the Gold Coast District, to the New South Wales border.

The Division and the Service have collaborated on a number of projects over the past six years. The case-conferencing project comprises eight two-hour sessions in which general practitioners meet with two psychiatrists from the Service. In the first hour, there is discussion on a focus topic taken from this book. In the second hour, a psychiatrist interviews a patient of one of the general practitioners in front of the group. A discussion of issues raised by the case then follows. The project has succeeded in increasing general practitioners knowledge of the sorts of mental health problems that they commonly see and their familiarity with the Service<sup>1</sup>.

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### **The case-conferencing project and the SPHERE program aim to improve the skills of general practitioners in treating the mental health problems that they commonly see.**

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General practitioners in the Division have also undergone training in the SPHERE program, which takes its name from the Somatic and Psychological Health Report (SPHERE), a self-report instrument developed for the detection of psychological problems in general practice populations<sup>2</sup>. The program comprises four components: a case-identification system for psychological disorders; a four-seminar training program for the management of depression and anxiety by general practitioners; a 12-month disease management program for use by general practitioners; and ongoing doctor support through the provision of clinical and educational materials and further educational activities. More extended programs are being developed to cover cognitive behavioural therapy, chronic fatigue and chronic pain, geriatric depression and adolescent mental health problems.

The Logan Area Division of General Practice has recently been chosen to be one of the metropolitan sites for the General Practice and Psychiatrists Partnership program (GPAPP), an initiative coordinated by the Queensland Divisions of General Practice (QDGP) and funded by the National Mental Health Strategy through Queensland Health. It is based on the Consultation-Liaison in Primary Care Psychiatry Project (CLIPP), which was pioneered in Melbourne<sup>3</sup>. Psychiatrists from the District Mental Health Service visit group practices once a fortnight to provide on-site consultation on the management of difficult cases. In Melbourne, the project has facilitated the transfer of patients' care from district mental health services back to primary care.

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<sup>1</sup> Davies J, Ward W, Groom G, Wild A, Wild S. The case-conferencing project: a first step towards shared care between general practitioners and a mental health service. *Australian and New Zealand Journal of Psychiatry* 1997; 31: 751-755.

<sup>2</sup> Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T and Naismith S, Koschera A. *The SPHERE Program: A training manual for treating depression and anxiety in general practice*. Kogarah: Educational Health Solutions, 1998.

<sup>3</sup> Meadows GN. Establishing a collaborative service model for primary mental health care. *Medical Journal of Australia* 1998; 168: 162-165.

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**The metropolitan pilot of the GPAPP program aims to provide on-site consultations to general practitioners on the treatment of people with mental disorders.**

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Over the past year, the Division and the Service have collaborated on the shared care project. This involves a case manager from the Service working with a group of general practitioners who have completed the case-conferencing project in the management of around twenty people with schizophrenia. The general practitioners meet with a psychiatrist once a month to review patient care and for ongoing education. Preliminary results show high levels of satisfaction amongst all participants. There were no significant changes in mental health outcome, though an unexpected result was a reduction in occupied bed days in hospital. A number of physical disorders were diagnosed and treated. The project has subsequently been extended to include 20 general practitioners in the Division and all case managers of the Service.

These projects constitute changes in the culture of mental health service delivery towards greater cooperation between public and private sectors and specifically between mental health services and general practitioners. The aims are improved patient outcomes, more efficient service delivery and a lessening of psychiatric morbidity in the community.

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**The aim of educational and shared care projects is to improve health outcomes in the population by changing the culture of mental health care delivery towards greater cooperation between the public and private sectors.**

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# Chapter 2

## Mental health assessments

This chapter begins with a discussion of eight principles of the psychiatric interview. An outline of the psychiatric history and mental state examination follows. In the final section, I discuss the differences between a diagnosis and a formulation and provide several sample formulations.

### Eight principles of the psychiatric interview

#### 1. Time

Psychiatric assessment and psychological treatments take time. Spending time listening to and clarifying patients' problems, and making an attempt to understand how they feel and why they feel that way, is therapeutic in itself. Unfortunately, the pressure of work in general practice makes it difficult to find this time. Moreover, the financial incentives of Medicare are towards shorter, not longer, consultations. One solution is to spread the assessment out over several sessions. The use of self-report questionnaires such as the General Health Questionnaire (GHQ)<sup>1</sup> or the SPHERE-GP instrument will also save time in the consultation<sup>2</sup> (see also Appendix 1).

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**The use of self-report questionnaires, such as the SPHERE-GP, can save time in the consultation.**

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#### 2. Reassurance

As a rule, it is better to try to understand a person's experience more clearly than to give bland reassurance. Although you may mean well, he or she may perceive a reassuring comment as presumptuous or rejecting. However, reassurance does have a place when it is true and does not dismiss the person's experience. It may then instil hope. Some examples are given in Box 2-1.

##### Box 2-1: Reassurance

###### *Unhelpful comments:*

'I'm sure things can't be as bad as you say.'

'But there is no reason for you to feel that way.'

'I understand how you feel, but...'

###### *Helpful comment:*

(To a depressed man) 'When people are depressed, they often feel that nothing can be done to help. There are effective treatments for depression and I know that I can help you.'

#### 3. Interview technique

The following characteristics of interview style improve the likelihood of detecting mental illness:

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<sup>1</sup> Goldberg DP, Williams P. *A User's Guide to the General Health Questionnaire* Windsor: NFER-Nelson 1988.

<sup>2</sup> Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T and Naismith S, Koschera A. *The SPHERE Program: A training manual for treating depression and anxiety in general practice*. Kogarah: Education Health Solutions, 1998.

- listening, clarifying and asking for an example
- not interrupting, especially at the beginning of the interview
- asking open-ended questions, especially at the beginning of the interview
- asking directive psychological questions
- an empathic style – This involves putting yourself in the other person's position so as to understand how he or she feels, thinks and behaves, and why he or she feels that way. However, empathy is not simply an uncritical acceptance of a person's ideas and impulses (see the note on pseudoempathy in Box 12-3).
- picking up and responding to verbal and non-verbal cues
- maintaining control of the interview.

Examples are given in Box 2-2.

#### 4. Transference and countertransference

Transference can be broadly defined as the feelings that the patient has for you. Some of these

##### **Box 2-2: Examples of effective interview techniques**

###### *Clarification*

You ask a man to give you an example of what he means when he says he has suffered a panic attack.

You summarise the person's complaints, their time course and the events happening at the time.

###### *Asking open-ended questions*

At the beginning of the interview, you ask, 'How are you feeling?'

###### *Directive psychological questions*

You ask a man who presents with fatigue and insomnia if he has been feeling down or depressed. Later, you ask him about anhedonia, vegetative function change and suicidality.

###### *Response to a verbal cue*

A 47-year-old man complains of a number of vague physical symptoms including fatigue, abdominal discomfort and headaches. He says that he cannot even be bothered playing indoor cricket any more. You ask, 'When did you last do something that you really did enjoy?' He takes some time responding, and then says, 'It seems ages. I suppose I enjoyed the trip to Caloundra last Christmas'. Then you ask if he has been feeling depressed. You pick up the man's cue about anhedonia and follow it up with direct questions about depression.

###### *Response to a non-verbal cue*

A woman who has been attending your practice over the past five years is not herself. She looks tired and depressed and sits slumped in the chair. Usually well groomed, today her hair is untidy and her clothes rumpled. Her affect is flat and she speaks in a soft voice giving unelaborated responses to your questions. You say, 'You look tired today. How are you feeling?' Later you ask if she has been feeling depressed.

###### *Empathic style*

A middle-aged man becomes depressed after being overlooked for a promotion at work. You ask about his prospects for promotion in the future. This uncovers his fear that, at 52, he is unlikely ever to be promoted. The question that you ask leads the man to elaborate his concerns. Further questions may address the other developmental challenges of middle age that he is presently facing.

###### *Maintaining control*

An elderly man speaks at length about how unjustly he is treated by his neighbours. You say, 'I am sorry to hear that you are so upset by your neighbours, but could I take you back to what you were saying about feeling depressed'.

feelings are reality-based, for example, respect for your expertise in medicine. Others have unconscious origins and arise from the transference on to you of feelings that are held towards others who are significant in the person's past or present. For example, being perceived by a young man as an authority figure, you may elicit transference feelings that he has towards his parents, teachers and other authority figures in his life.

Countertransference refers to the feelings that you have towards the patient. Again, these will, in part, be reality-based. Some will arise in response to the transference. Some will be similar to feelings that are elicited in other people who deal with that person, while others will reflect aspects of your own past and present relationships transferred on to the patient. Most will be a combination of all of these. It is normal, of course, that you should experience these feelings. The important thing is to be aware of them and to acknowledge them to yourself, even if they seem unacceptable—for example, feeling angry or bored with a person, feeling overly concerned about or even feeling attracted to him or her. By acknowledging these feelings to yourself and making them conscious you are much less likely to act inappropriately upon them. For example, it is quite normal to feel angry with certain people, but it is likely to be damaging and unprofessional to act out this anger.

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**By acknowledging to yourself your countertransference responses, you lessen the likelihood of acting out upon them.**

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Monitoring your countertransference responses can provide you with valuable information about a person. For example, when seeing a young woman who repeatedly self-harms, you may feel frustrated and angry and you may even imagine being cruel to her. Recognising these feelings and impulses, you take care not to act out upon them. Reflecting upon them, you recognise their origin in the physical and sexual abuse that she suffered at the hands of her foster father. You gain a deeper understanding of her and the way people react towards her. By containing the impulse to act out, you avoid repeating and reinforcing the abusive patterns of her previous relationships. At the same time, you take care not to act upon unrealistic fantasies of 'rescuing' her (see also Chapter 22).

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**Monitoring the countertransference can improve your understanding of the patient.**

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## **5. Boundary issues**

Doctors are sanctioned to ask about private and intimate aspects of their patients' lives and to conduct physical examinations. There is a clear power differential in the relationship between patient and doctor. In particular, people presenting for counselling or any type of psychological therapy are often at their most vulnerable. The transference of flattering feelings and impulses onto the doctor—respect for authority, attraction to power and success, desire for approval—may tempt the doctor into abusing his or her power. To exploit such a position to fulfil one's own needs is unethical and potentially damaging to patients.

It is essential to be clear about your role as a professional. You are not a friend of the patient. Indeed, it is wise to avoid, if possible, treating your friends. It is always unethical to have sexual relations with a patient. For professional therapists, it is prohibited to have intimate relations even after therapy has finished.

Monitor your countertransference feelings and impulses and take care not to act out in ways that breach professional boundaries. Transgressions of these boundaries typically occur in a stepwise progression. They may begin with the acceptance of expensive gifts, financial or stock-broking advice, or even betting tips. There may be a temptation to disclose and discuss one's own problems. Appointments may be made that are longer than usual, or regularly scheduled

at the end of the day when other staff members have left the practice. Fees may be waived. Unnecessary home visits may be made. This may progress to the performance of unnecessary physical examinations, meeting patients outside the consulting room, and to involvement in social situations and sexual relations.

Doctors who are vulnerable to boundary transgressions include those experiencing life crises, in particular those with problems in their own marriages or personal relationships<sup>1</sup>. Perfectionists who are excessively self-sacrificing and work unnecessarily long hours may have difficulty setting limits on the demands of certain patients and begin taking extraordinary measures in attempt to rescue them. Patients with histories of sexual abuse may be particularly prone to evoke such countertransference responses, especially when they express recurrent suicidal ideation. Doctors who deny their dependency needs and give the appearance of being self-contained may be prone to seeking gratification for their needs for love and nurturance through their patients: while denying their own dependency needs, they may perceive others as being dependent on and needy of them. A doctor suffering a psychosis might violate professional boundaries as a consequence of the illness. Psychopathic doctors who wilfully exploit patients for the gratification of their own needs have no place in the medical profession.

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**Boundary transgressions typically occur in a stepwise progression.**

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## **6. Understanding versus explanation**

In formulating a person's problems, we seek to answer the question, 'Why does this individual feel, think and act this way at this time?' The method of understanding helps us find reasons for his or her experience; the method of explanation seeks causes.

We understand a person's experience when, through listening to his or her story and clarifying the experience, we are able to empathise with him or her and to imagine how we might feel under similar circumstances. We can understand experiences in the mind of another. For example, we understand the grief of the bereaved, the anger of someone who is frustrated, the guilt of the person who has hurt another and the shame of someone who has done something foolish. We can also understand the meaning of an event for that person, and we can look for reasons why he or she feels that way.

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**We can understand the grief of the bereaved, the anger of someone who has been frustrated, the guilt of the person who has hurt someone else, and the shame of someone who has done something foolish.**

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By contrast, aspects of some mental states are not understandable in this way. For example, there is no understandable reason for the memory loss of someone with dementia. We cannot empathise with changes in another person's brain. Instead, we seek an explanation in terms of a cause—in this case, a disruption in brain physiology and a loss of brain substance. Similarly, we cannot understand how a person with schizophrenia starts hearing voices. There is no meaningful reason for this reaction and we cannot empathise with it. Instead, we seek explanations in terms of neurotransmitters, abnormalities in information processing and other physical causes.

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<sup>1</sup> Gabbard GO. 'Psychodynamic approaches to physician sexual misconduct' in *Physician Sexual Misconduct*, Eds Bloom JD, Nadelson CC, Notman MT. Washington DC, American Psychiatric Press, 205-223.

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**The memory loss of someone with dementia or the hallucinations of someone with schizophrenia are not understandable. There is no reason for them. Instead, they require an explanation—a cause.**

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An understandable reaction is not necessarily a normal one. For example, you might understand why a high-achieving man becomes depressed following a myocardial infarction. However, this should not stop you from diagnosing major depression if his depressed mood persists and he expresses feelings of worthlessness and guilt, and suicidal ideation. While the understandable aspects of a condition may be amenable to some form of psychotherapy, the condition may also require some pharmacological intervention or even ECT.

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**Although a problem may be understandable, its treatment may require pharmacological or other physical interventions.**

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Since all mental disorder is both a disorder of mind and of the brain, it is always possible to both understand and explain different aspects of the same problem. The grief of a bereaved woman will be reflected in biochemical and other events in her brain. However, the fact that her reaction is clearly understandable indicates that our initial treatment would be through grief counselling. If her grief is prolonged, and she begins to suffer prominent and distressing feelings of guilt, and is contemplating suicide, we would use an anti-depressant drug as an adjunct to the grief work. Similarly, in the case of a man with schizophrenia, although we may not be able to understand the evolution of his auditory hallucinations (the form of his experience), we may be able to empathise with their content. We can also empathise with his reactions to the disability and handicap that he suffers as a consequence of the illness. For the person with dementia, the feelings of loss, fears about the future, and the change to a more dependent role are all issues that are understandable and amenable to psychotherapy and counselling.

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**While the form of a delusion proper is not understandable, it is often possible to empathise with its content.**

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## **7. The dialectical principle**

In the philosophy of Hegel, dialectics is a process in which a proposition is made (thesis), then negated (antithesis), and finally replaced by a new proposition that resolves the conflict between the two (synthesis)<sup>1</sup>. Although this may seem a little obscure, this way of thinking is common in making decisions about mental health problems. You will often have to make choices between apparently contradictory propositions. Always consider the possibility that the best course of action lies in a synthesis of the two. There are very few propositions in psychiatry that hold true in every case. Some examples of these dialectical dilemmas are given in Box 2-3.

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**In psychiatry, the best solution to a problem is often a synthesis of two apparently contradictory possibilities.**

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## **8. Impairment, disability and handicap**

When assessing people with mental health problems, it is useful to classify their complaints as impairments, disabilities or handicaps. Mental impairment is any loss or abnormality in psychological functioning. It includes the signs and symptoms of mental illness. Disability is any restriction or lack in ability to perform an activity normal for a human being. Handicap is a disadvantage, resulting from impairment or disability, that limits or prevents the fulfilment of a

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<sup>1</sup> Brown L, Ed. *The New Shorter Oxford English Dictionary*. Oxford: Clarendon Press, 1993.

### Box 2-3: Some dialectical dilemmas

*Since she has a terminal illness, it is understandable that she is depressed, so I should not prescribe medication.*

Wrong: although her depression is understandable, if her symptoms persist and include feelings of worthlessness and guilt, suicidality or psychotic symptoms, she should be treated with an antidepressant (and possibly an antipsychotic or ECT) in addition to some form of psychotherapy to deal with her grief.

*Should I make a formulation specific to this woman's problems or should I make a diagnosis and treat the condition from which she suffers?* Do both.

*Is substance abuse or an underlying psychosis causing his psychotic symptoms?* It could be a combination of the two.

*Are his cognitive deficits due to dementia or major depression?* A third possibility is that he suffers both conditions.

*Her panic attacks are probably just secondary to her depression so if I treat the depression they should also improve.* Isolated panic attacks can occur in major depression, but if they are recurrent and accompanied by persistent concern about having more attacks, worry about the implications of the attacks, or significant behaviour change, then both diagnoses should be made. In general practice settings, mixed anxiety/depression is more common than either one alone. Treat both.

*I should strive to be decisive and make the final diagnosis in the first session.* Make a working diagnosis in the first session, but be prepared to tolerate some uncertainty about the final diagnosis. The formulation will continue to evolve and deepen so long as you continue to see the person.

*I must never breach a patient's confidentiality.* There are exceptions. For example, if the person makes a direct threat against someone else, you may be obliged to contact the police or to warn the intended victim. With most mental health treatment now being delivered in the community, a larger responsibility for care now falls on the family or other carers. Unless expressly forbidden to do so by the individual, carers should, whenever possible, be involved in treatment. Ask the person if you can meet his or her spouse and family at the next consultation.

**Note:** Like the other propositions in psychiatry, the dialectical principle itself does not always apply. For example:

*During an exacerbation of his psychosis, a man with schizophrenia develops obsessive-compulsive symptoms. Should I diagnose obsessive-compulsive disorder?* Here, the hierarchical principle of diagnosis applies. The neurotic symptoms are subsumed under the diagnosis of a psychotic disorder.

*An elderly woman becomes delirious post-operatively and experiences hallucinations and persecutory delusions. Should an additional diagnosis of schizophrenia be made?* No. Organic disorders stand at the top of the diagnostic hierarchy and may be manifest by any neurotic or psychotic symptoms.

*A Vietnam veteran presents with a number of anxiety and depressive symptoms in addition to re-experiencing a traumatic battle scene. Should I diagnose depression, generalised anxiety and agoraphobia?* The most parsimonious explanation is post-traumatic stress disorder, though this disorder may be complicated by major depression or an anxiety disorder.

social role that is normal for that individual, given his or her age, sex and cultural expectations.

It is helpful to make this distinction when planning management. In general, the alleviation of impairments is the focus of treatment, while the prevention and minimisation of disabilities and handicaps constitutes disability support and rehabilitation. As a general practitioner, you will mainly be involved in the delivery of treatment. However, you need to be familiar with the rehabilitation services in your area, to know the appropriate referral procedures and to be able to work in partnership with them. Some examples of impairment, disability and handicap are shown in Box 2-4.

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**General practitioners treat patients' impairments and coordinate their rehabilitation to minimise disability and handicap.**

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**Box 2-4: Examples of impairment, disability and handicap**

- A woman with schizophrenia hears her thoughts spoken out loud (thought broadcast, an impairment). As a consequence, she withdraws, spending much of her time at home, and she no longer goes shopping (agoraphobia, a disability). She has not managed to work since the onset of her illness five years before, she has no social contacts outside her immediate family and she depends on her husband to do all of her shopping (handicap).
- A man has developed agoraphobia (disability) after having a panic attack (impairment) in a bank three months before. He remains on sickness allowance and sees little of his friends. His wife is becoming increasingly exasperated by his dependence on her (handicap).
- A man with early dementia suffers memory deficits, disorientation in place and mild agnosia (impairments). He has left the gas on twice after heating the kettle, he got lost on the way back from the shops and his wife has to remind him to attend to his personal hygiene (disabilities). He had to give up his job as an architect a year ago and is now becoming increasingly dependent on his wife for care and supervision (handicap).

**The psychiatric assessment**

The aim of the assessment is to answer the following questions, 'How is this person feeling, thinking and acting at this time? How did he or she come to be this way? What resources are available that will assist treatment? What are the potential barriers to treatment?'

What follows is a comprehensive description of the history and mental state examination. The weight placed on the different parts of the assessment will vary from individual to individual. For example, the past medical history of a 60-year-old man presenting for the first time with depression is a vital part of the assessment, while in the case of a fit young man presenting with an adjustment disorder it is much less likely to contribute to the formulation. Similarly, the assessment of cognitive functioning is essential in the assessment of someone with dementia, but will not usually be a significant factor in assessing a young man presenting with depression. The sort of therapy that you will be using will also influence the nature of the assessment. For example, if you are offering cognitive behavioural treatment (CBT), you will seek information about the person's automatic thoughts (see Chapter 10). If you use interpersonal psychotherapy (IPT), you will need to take an interpersonal inventory (see Chapter 1). The presenting complaint and the mental state examination are the most important parts of the assessment.

General practitioners will rarely have time to take a detailed history in a single consultation. However, they often have the advantage of already knowing much of their patients' personal and family histories, and of being familiar with their normal mental states. In some cases, it may be necessary to spread the assessment out over two or more sessions with the first session concentrating on the presenting complaint and a risk assessment. Whenever possible, families and other carers should be involved in the assessment and treatment from the outset. Time may be saved by using the SPHERE-GP<sup>1</sup>, a self-report screening instrument that identifies people with psychological distress who need a thorough diagnostic assessment (see Appendix 1).

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**The presenting complaint and mental state examination are the most important parts of the psychiatric assessment.**

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<sup>1</sup> Hadzi-Pavlovic D, Hickie I, Ricci C. *Somatic and Psychological Health Report: development and initial evaluation*. Technical Report TR-97-002, School of Psychiatry, University of New South Wales, Academic Department of Psychiatry, the St George Hospital and Community Health Service, 1997.



## Psychiatric history

### Identification data

Most of the person's identification data is probably obtained when he or she registers to see you. As well as name, age and address, it is also useful to know whom patients live with, the type of accommodation they occupy, their occupational status and their means of support. In discussing a patient with a colleague, it is useful to state these facts at the outset.

### The presenting complaint

The presenting complaint and the mental state examination are the most important parts of the assessment. A list of the steps taken when eliciting the presenting complaint and some useful questions are shown in Box 2-5.

#### Box 2-5: The presenting complaint

1. Listen and list the complaints. 'What are the problems?'
2. Clarify the complaints. 'What was running through your mind at the time? What were you afraid might happen? How did that make you feel? What did you do then?'
3. Clarify the time course and any precipitants. 'When did you last feel well—your usual self? What was happening around that time?'
4. Summarise. 'Am I right to say that you have been feeling down in the dumps, tired and on edge for the past six months, and that last week you got so frightened in the cinema that you thought were going to die and you had to leave immediately and go home?'
5. Ask about other symptoms. For example, assess anhedonia in a depressed person by asking, 'What do you like doing? When did you last do something you really enjoyed? Do you like watching TV?' Assess suicidality by asking, 'Do you ever feel life is not worth living? Have you ever had thoughts of ending your life?'
6. Assess the level of disability and handicap by asking about their work, hobbies, interests and how they spend their time; and about the quality of their personal relationships. 'How are you coping at work? How are things at home? Are you still seeing your friends?'
7. Investigate the social context. 'How is this affecting the other members of the family? How are your children getting on at school? How does your wife respond to your problems? How are you getting on with her? Can I speak to her about it?' Obtain collateral history from the person's carers, family or other acquaintances. This is especially important if the person has a severe acute mental disorder that prevents him or her from giving a full and reliable history.
8. Ask about the effectiveness of previous treatments. 'Have you ever felt this way before? What did you do about it? What helped?'

### Assessment of suicidality and dangerousness

Any person presenting with psychiatric symptoms should be asked about suicidality and dangerousness. However, you should be ready to use the structured problem solving techniques described in Chapter 6 to help find alternative ways of dealing with life stressors if the person does suffer suicidal ideation. You should also seek an agreement that if the suicidal ideas recur, he or she will seek help before acting upon them. See Chapter 3 for a detailed discussion of these issues.

### Past psychiatric history

Details of a person's past psychiatric history should be sought:

- time and nature of the first presentation
- past and current treatments and their effectiveness



- names of previous therapists
- past admissions – number, length, place and treatment, especially the first and the most recent admission.

### **Past medical history**

The relationship between physical and mental illness is discussed in greater detail in Chapters 16 to 19. Physical illnesses can cause mental illness, (e.g. hypothyroidism complicated by depression) or precipitate mental illness (e.g. depression in response to suffering a myocardial infarction). In general practice, people with mental illnesses commonly present with physical symptoms. Mental illness can lead to an exacerbation of concurrent medical conditions, (e.g. a man with schizophrenia who fails to adhere to his diabetic treatment). When both mental and physical disorders are present, the prognosis for both conditions is worse. The presence of a physical illness may influence your choice of medication.

### **Current medication**

Record drug names and doses for both physical and mental illnesses. Are there any that might be affecting the person's mental state? Are there potential interactions with the drugs used to treat the mental disorder?

### **Alcohol and other substance abuse (see also Chapter 18)**

Document the following:

- the amount consumed and the period and pattern of abuse
- tolerance – increasing amounts required to achieve the same effect
- withdrawal symptoms
- unsuccessful efforts to cut down
- the salience of the abuse – large amounts of time spent obtaining, using or recovering from the effects of the substance
- complications – physical (e.g. liver disease, peptic ulcer in the person with alcohol abuse), psychological (e.g. cocaine-induced depression)
- disability and handicap – loss of job, legal (e.g. driving under the influence), social (e.g. neglect of children, marital breakdown).

### **Forensic history**

Note any serious offences, especially those leading to imprisonment. Is there a history of violence towards others? Is the person facing any current charges?

### **Family psychiatric history**

Document the family tree and note any relatives with mental illness. Ask about the person's relationships with other family members—these often have a strong influence on the quality of his or her current close relationships. Ask about the reactions of family members to the person's problems and the level of support that they provide. Ask if you can meet the person's family or other carers to discuss the problems with them and to involve them in treatment.

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**Ask if you can speak to the person's spouse, family or other carers in order to gain collateral information and to involve them in treatment.**

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## Personal history

As the person's general practitioner, you may already know much of his or her personal history:

- circumstances of birth
- developmental milestones
- relationship with parents and siblings
- schooling
- childhood neglect, abuse or trauma
- work history
- marital/relationship history
- current interests.

Schooling, work history and the quality of a person's relationships are important guides to the stability of his or her personality. For example, the fact that a woman has been happily married for 15 years and has been content and settled in the same job for the past 10 years suggests that she has a strong and stable personality. These are important protecting factors that indicate a good prognosis. The precipitants of current problems may have significance in terms of a person's developmental history Box 2-6.

### **Box 2-6: The meaning of precipitating events**

A woman becomes depressed around the time of her daughter's seventh birthday. On taking the personal history, you discover that her own mother died shortly after she turned seven.

## Pre-morbid personality

A person's pre-morbid personality may predispose to the development of mental disorder. For example, a person with dependent traits may be vulnerable to depression following a separation. Be careful not to confuse a person's current mental state with his or her normal way of behaving. For example, during a manic episode, a man may appear 'histrionic', but this may be quite unlike his normal personality.

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### **Schooling, work history and the pattern of a person's relationships are important guides to the stability of his or her personality.**

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See Chapter 12 for a discussion of the following core psychodynamic issues. Their assessment will often enhance the formulation.

1. impulse control
2. self-esteem
3. shame and guilt
4. quality of relationships
5. defence mechanisms
6. developmental challenges

## Mental state examination

**Appearance** – Observe the person's self-care, grooming, general physical health and dress. For example, a man who is depressed may neglect his self-care. A person with schizophrenia may dress bizarrely. A person with obsessive–compulsive personality traits may dress with excessive conformity, while one with histrionic traits may dress flamboyantly.

**Behaviour** – Note how the person acts during the interview. A depressed person may exhibit psychomotor agitation or retardation. An anxious person may sweat, have a tremor and startle easily. A person on antipsychotic medication may have akathisia or exhibit Parkinsonian side effects. People with depression, schizophrenia or organic psychoses may exhibit signs of catatonia.

**Conversation** – Document the volume and rate of speech, and the command of grammar and vocabulary. A person with negative symptoms of schizophrenia may exhibit a poverty of speech or a lack of spontaneous speech. A depressed person may be electively mute. A person suffering mania may exhibit pressure of speech. A person with intellectual disability may mispronounce words, have limited vocabulary and make grammatical errors. A person who has suffered a cerebro-vascular accident may be dysphasic.

**Mood/affect** – Mood refers to the sustained emotional tone that is reported by the individual. Some words commonly used to describe mood include euthymic, depressed, angry, elated, elevated, irritable or anxious. Affect refers to the varying emotional response witnessed during the interview. Some terms used to describe this include appropriate, inappropriate, fatuous, blunted, restricted, flat or labile.

**Perception** – Patients may suffer hallucinations. Those with schizophrenia may experience hallucinations in any sensory modality (i.e. visual, gustatory, olfactory, kinaesthetic or auditory). However, auditory hallucinations are the most common. In delusional disorder, there may be kinaesthetic or olfactory hallucinations related to the delusional theme. In organic psychoses, hallucinations may occur in any sensory modality. Illusions are most often experienced by persons who are intoxicated or delirious.

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### The most common perceptual abnormalities in schizophrenia are auditory hallucinations.

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#### Thought disorder

- a) **Thought form** – People with schizophrenia may show evidence of formal thought disorder ranging from mild loosening of associations to incoherence. They may also exhibit concrete thinking—that is, having only a literal understanding of language without an appreciation of the abstract meanings conveyed, for example, through metaphor and humour.
- b) **Thought content** – Delusions are features of psychotic illnesses. They may be persecutory, grandiose, nihilistic, bizarre, etc. People with neurotic disorders such as hypochondriasis may have overvalued ideas. Those with anxiety disorders may suffer phobias, obsessions or compulsions.
- c) **Thought possession** – A person with schizophrenia may experience thought insertion, thought withdrawal, thought broadcast or thought block. She or he may also experience other passivity phenomena (i.e. somatic passivity or passivity of emotion, impulse or volition). See Chapter 22 for a more detailed discussion of these phenomena.
- d) **Thought stream** – A person with mania may exhibit flight of ideas. Someone with depression may be psychomotor retarded. The thinking of people with organic disorders or certain personality disorders may be circumstantial.

**Cognition** – In an acute brain syndrome (delirium) the onset is usually rapid, and the level of consciousness, orientation, concentration and attention span, as well as memory and other areas of cognitive function are impaired. Delirium frequently presents with a variety of other abnormalities on the mental state examination, including perceptual abnormalities (e.g. hallucinations and illusions) and delusions.

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**A rapid onset of symptoms that include an altered level of consciousness, disorientation, and impaired attention and concentration suggests a diagnosis of delirium.**

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People with chronic brain syndromes, such as dementia, usually suffer an insidious onset of the illness. They are usually alert, (i.e. have a normal level of consciousness) and sometimes oriented with normal attention, but have deficits in memory, especially short-term memory, and in other areas of cognitive function—abstraction, judgment, and higher cortical functioning. They may also undergo a change in personality (see Chapter 17).

People with severe functional disorders, such as major depression, may exhibit pseudodementia—that is, despite having normal cognitive capacity, they perform poorly on tests of cognitive function because of the severity of their mental disorder.

The principal components of the assessment of cognitive function are listed below. A useful screening test is the mini-mental status examination (see Appendix 2).

- a) Level of consciousness – This ranges from alert through clouded to comatose.
- b) Orientation – Test orientation in person, place and time.
- c) Attention – This may be tested using serial 7s, serial 3s, by spelling ‘world’ backwards or by asking the person to recite the months of the year backwards.
- d) Memory – Any person with dementia will have some degree of amnesia. Confabulation is a feature of Korsakoff’s psychosis, but can occur in any disorder in which memory is impaired. Test immediate recall by asking the person to repeat a name and address or three objects. Short-term memory can be tested by recall of the name and address (or the objects) after five minutes. You can usually test long-term memory during the clinical interview. You can test it formally by asking questions about past world events.
- e) Other tests – General knowledge can be tested by asking about current world events. Remember to take into account a person’s education and cultural background when selecting suitable questions. Tests of abstract thinking include asking the person the interpretation of a proverb, or asking differences (e.g. between ice and glass, or between a dwarf and a child). Judgement—the ability of a person to make rational plans of action—is usually assessed while taking the history, but can be tested formally by asking what the person would do if she or he found a stamped, addressed envelope.
- f) Intelligence – The assessment of a person’s current functioning in the light of his or her educational and occupational background is required in the diagnosis of dementia. Neuropsychological assessment provides more detailed information. A high IQ is sometimes a protecting factor for someone with a mental disorder, but on the other hand, intelligent people may be acutely aware of losses they suffer as a consequence of illness.

**Insight** – Insight refers to the ability of a person to understand his or her problems, their origin and what can be done to overcome them. It is rarely an all-or-none phenomenon. For example, a man with schizophrenia may deny that he has the illness and still believe in the reality of his delusions, yet at the same time regularly attend appointments and adhere to prescribed medication. What is important for the person to understand depends on the condition from which he or she suffers and the treatments available. For a person with a psychotic illness, an

acceptance of the need for treatment and monitoring is often the most critical issue. By contrast, a man with personality disorder needs to understand how certain of his habitual ways of dealing with other people and with life events cause him and others distress. For a man undergoing a course of behaviour therapy, understanding the origin of his problems is less important than having the motivation to change and persist with therapy. In psychodynamic psychotherapy, the emphasis is on understanding one's habitual ego defences and ways of responding that have led to problems in the past. Change occurs through the repeated working through of solutions that have led to maladaptive responses in the past in order to learn and consolidate new responses.

## Diagnosis and formulation

Diagnoses are made according to criteria defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)<sup>1</sup> or the International Classification of Diseases (ICD 10)<sup>2</sup>. By contrast, a formulation is a narrative that brings together salient facts from a person's life story in order to make sense of his or her current problems. These include biological, psychological and social factors that may predispose to, precipitate, perpetuate or protect against mental illness. Both a diagnosis and a formulation are required in the comprehensive assessment of a person suffering mental health problems. Differences between a diagnosis and a formulation are summarised in Table 2-1.

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**Both a formulation and a diagnosis are required in the comprehensive assessment of a person suffering mental health problems.**

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**Table 2-1: Differences between a diagnosis and a formulation**

Diagnosis	Formulation
Nomothetic (i.e. assigns individuals to groups with shared characteristics)	Ideographic (i.e. focuses on the uniqueness and complexity of the individual)
Validity tested using scientific methods	Validity judged on the basis of the reliability and salience of the data used and the plausibility of the interpretations made
Summary label, for example, 'depression' or 'schizophrenia'	Narrative that answers the question, 'Why is this individual suffering these problems at this time?'
Precedes search for causes of disorders (i.e. an explanation for it)	Seeks reasons for a person's problems (i.e. an understanding of it)

## Formulation

The different factors that make up a formulation are shown in Table 2-2.

### *Biological factors*

Any physical disorder that directly or indirectly affects the central nervous system can influence a person's mental state. Similarly, drugs and other substances that gain access to the brain, or that indirectly affect brain function, can cause mental symptoms. Mental symptoms commonly arise as a psychological response to having a physical disorder. Genetic factors contribute to the development of the psychoses, but also to disorders such as personality disorders and substance abuse.

<sup>1</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4<sup>th</sup> Ed. Washington DC: American Psychiatric Association, 1994.

<sup>2</sup> World Health Organisation. *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organisation, 1992.

### *Psychological factors*

A person's personality, its strengths and vulnerabilities, can either predispose to mental illness or protect against it. The 10 personality disorders described in the DSM-IV are discussed in Chapter 23. The psychodynamic assessment of personality covers patients' characteristic defences, their ability to control impulses, their ability to maintain self-esteem, the quality of their relationships, and their capacity for shame and guilt (see Chapter 12).

Mental disorders are often precipitated by stress. The stressor may be an adverse event such as a loss or a desirable one such as marriage. It could be a normal developmental challenge, for example, an adolescent leaving home or a 65-year-old facing retirement. In general practice populations, mental disorders commonly occur as a psychological response to having a physical disorder. The stressor may have special significance for that individual in terms of his or her history: for example, a relationship breakdown would be particularly stressful to a woman who lost her parents during her childhood.

### *Social factors*

Strong social supports are protective against mental illness and ensure a better prognosis. Limited social support is a vulnerability. Stressful patterns of social interaction tend to perpetuate mental illness. For example, a high level of expressed emotion (hostility, critical comments and enmeshment) increases relapse rates in schizophrenia and depression. Unemployment is associated with increased levels of both mental and physical morbidity. A person's ethnic and cultural background may predispose to the development of mental disorder and influence the way in which symptoms are presented (see Chapter 4).

**Table 2-2: The different factors that make up a formulation**

	Predisposing	Precipitating	Perpetuating	Protecting
<i>Biological</i>	1	2	3	4
<i>Psychological/ behavioural</i>	5	6	7	8
<i>Social</i>	9	10	11	12

The following vignettes illustrate the different factors that make up a formulation. The numbers refer to the boxes in Table 2-2. Most of these examples are best regarded as partial formulations because they do not attempt to bring together all of the elements in a person's history. However, to avoid artificiality, some include more than the just the factor being illustrated.

1. Both parents of a 45-year-old man with schizophrenia were treated for the same condition.  
*Comment:* He had a biological (genetic) predisposition to the development of schizophrenia. With both parents suffering the condition, his lifetime risk at birth was around 45 per cent. Note, however, that his identical twin brother, who has never suffered psychotic symptoms, now has only a small risk of developing the illness because the onset almost always occurs before the age of 40.
- 2a. A 60-year-old man who is alcohol dependent develops alcohol withdrawal delirium three days after admission to hospital for repair of a fractured neck of femur.  
*Comment:* The precipitant is the withdrawal from alcohol in a man who is alcohol dependent. Other factors, including post-operative complications, could also be playing a part.
- 2b. A 65-year-old woman is admitted to a psychiatric ward with a diagnosis of depression. In addition to her low mood, she describes loss of appetite, a three-kilogram weight loss over the past two months and a loss of energy. She is convinced she has cancer. On physical examination, she looks unwell. Her skin is sallow and

she appears jaundiced. Subsequent investigation reveals carcinoma of the pancreas. *Comment:* Depression is commonly associated with a number of medical conditions, including carcinoma of the pancreas, Parkinson's disease, Huntington's disease, stroke, hypo- and hyper-thyroidism, hypo- and hyper-parathyroidism, SLE, hepatitis, infectious mononucleosis and HIV. It is always important to consider an underlying physical illness as the cause of psychiatric symptoms. Physical illnesses remain at the top of the diagnostic hierarchy. There is always the danger of coming up with a plausible psychosocial formulation for symptoms and missing the underlying physical condition.

3. A young man with schizophrenia is admitted to hospital with an exacerbation of his psychotic symptoms (derogatory voices, delusions that he is being chased). He has been smoking marijuana every day over the past three weeks and he has used intravenous amphetamines three times over the past week. *Comment:* The marijuana and amphetamines are likely to have precipitated his relapse. His continued use will perpetuate the illness.
4. A 70-year-old widower is treated for an episode of major depression. Since his wife's death two years before, he has become socially isolated. As part of his rehabilitation, he is encouraged to join a local bowls club. He also begins working as a volunteer for Meals on Wheels. *Comment:* This vignette is given as an example of a biological protecting factor. His good physical health enables him to play bowls and to participate actively in delivering Meals on Wheels.
5. A 50-year-old violinist with the Queensland Symphony Orchestra presents with anxiety, depression and agoraphobia. She has been unable to return to work since suffering an epileptic seizure four months ago while on stage in the Performing Arts Complex. Thorough neurological investigation has failed to reveal any abnormality. The precipitant appears to have been fatigue coupled with withdrawal from benzodiazepines. She is described pre-morbidly as being a perfectionistic, conscientious, hardworking, and strong-minded person who is a capable and willing organiser. *Comment:* Pre-morbidly, she demonstrates a number of obsessive-compulsive personality traits (see Chapter 23). An important dynamic in people with these traits is the need to feel in control. Her epileptic seizure, which occurred in public and involved incontinence, represents an extreme loss of control for her. The blow to her self-esteem has resulted in depressive symptoms. The fear of having another fit has led to avoidance and agoraphobia.
6. and 7. A 50-year-old woman is brought to see you by her daughter. She has been unable to leave the house unless accompanied by her daughter or her husband since having a panic attack two months ago in the entrance to the Logan Plaza shopping centre. Her daughter has been doing all the shopping recently and has been taking meals to her parents every evening. She is beginning to feel tired and exasperated by the situation. The patient's husband is reportedly less concerned and, in fact, feels that his daughter is exaggerating the problems. He has refused to see you. He works as a taxi driver and has over recent years become suspicious that his wife is having an affair. Not a day goes by when he does not interrogate her and he frequently drops home to check up on her during the day. *Comment:* Her fear of having another panic attack has led to avoidance behaviour (agoraphobia). This is reinforced by her husband's suspiciousness and intimidation, and also by the secondary gains of bringing her daughter closer and of being cared for by her.
8. A man with paranoid schizophrenia is an excellent chess player. Although unemployed, he attends a chess club three times a week where he continues to perform well. *Comment:* Although he suffers from schizophrenia, he is an intelligent man who is gifted at chess. Playing and studying the game is largely a solitary occupation that presents few threats to him. Indeed, the determination and single-mindedness that are features of his game



reflect a positive side of his paranoia.

9. A 13-year-old girl suffers from anorexia nervosa. Her father is an advertising executive whose work often takes him interstate or overseas. He and his wife often entertain business associates at home—she has a reputation as an excellent cook. She herself has struggled with her weight over the years and is currently attending a weight loss centre. The girl attends a private girls' school where she is described as a good student who is always well behaved. She also studies ballet. She has been on diets before, sometimes together with a school friend, but these have never lasted longer than a few weeks. She has been dieting now for three months. Her mother remembers her being upset at a family barbecue around the time of onset when her paternal grandmother commented that she was looking fat.  
*Comment:* The vignette is given to illustrate how social factors can predispose to the development of mental illness. Certain societal forces, derived especially from advertising and the popular press, dictate that women should be thin. This view is particularly prevalent in the worlds of gymnastics, ballet, modelling and athletics. The complete formulation would also include a number of other factors. Her mother's preoccupation with dieting suggests a possible genetic and/or learned component. Food often plays an important role in communication within the families of anorexics. Such families may exhibit an orientation towards success that limits the free expression of feelings, the respect for each individual's autonomy and the resolution of conflict. The precipitant appears to have been the critical remark made by her grandmother. Pre-morbidly, she had several obsessive-compulsive personality traits (perfectionism and conscientiousness). The anorexic symptoms can be seen as an attempt by a girl with a fragile self-esteem to gain control at a time when she is undergoing the physical and social role changes of adolescence. Moreover, the dieting itself will interrupt her physical, social and cognitive development.
10. A 60-year-old widow presents with major depression. The precipitant was the anniversary of the death of her husband a year ago. She had an ambivalent relationship with him. He was an alcoholic and was both verbally and physically aggressive towards her and her children, especially when he was intoxicated. A number of people commented on how well she seemed to cope after the funeral. She had not cried and was soon back engaged in her usual activities. Her father too was a violent man—the patient's mother left him, taking the three children with her when she was eight years old. The family had no subsequent contact with him. They were notified five years later that he had died in a motor vehicle accident some months before.  
*Comment:* Her depression has been precipitated by the anniversary of the death of her husband, a man towards whom she has ambivalent feelings. On one hand, she is angry because of the years of abuse she and her children suffered at his hands, and now, because of his abandonment of her. She also feels guilty because she had often wished him dead. On the other hand, she remains sad at the loss of her marital partner. The loss also re-kindles unresolved issues over the loss of her father. Grief counselling will aim to help her acknowledge, experience and work through these ambivalent feelings.
11. A young man with schizophrenia is admitted to hospital with his third exacerbation of psychosis in the past six months. His mother describes considerable conflict at home. The father has never been able to accept his illness, sees him as lazy and frequently criticises him for not going out and getting a job. There is also marital conflict, frequently over the patient. On a number of occasions, the young man's father has given his wife the ultimatum that either his son moves out of the house or he will. Several attempts have been made to accommodate the young man away from home, but his mother remains convinced that he is unable to look after himself and these attempts have generally only lasted for about two weeks. He has usually run out of money and phoned his parents. His father has driven around, collected all his belongings and taken him back home.  
*Comment:* An important perpetuating factor in his illness is the high 'expressed emotion' (EE) at home. The three components are hostility, critical comments and enmeshment.



12. A 33-year-old man presents with his girlfriend of eight years and describes a 10-year history of paranoid delusions that the members of a bikie gang are chasing him. His girlfriend has managed to look after him and reassure him over this period. He has never previously sought psychiatric help. He has managed to do some casual work over the years as a painter, employed by his girlfriend's brother. On this occasion, she brought him to hospital because, for the first time, he had been talking about suicide.  
*Comment:* The strong support he receives from his girlfriend is an important protecting factor. On the other hand, this support may have prevented earlier treatment and so worsened his prognosis.



# Chapter 3

## Suicidality and dangerousness

Around one in every 100 deaths in Australia is by suicide. The rate among people who have had at least one admission to hospital for a depressive illness is five times that in the general population. Men complete suicide at twice the rate of women. Of particular concern over the past decade has been the alarming increase in the rate of suicide among young people, especially young men living in rural areas. The rate in this group is around 36/100,000 per year.

### Assessment of suicidality

#### Risk factors

Population studies reveal a number of risk factors for suicide.

1. Demographic factors
  - a) Age: In general, suicide risk increases with age. However, there is a peak for young men between the ages of 15 and 24. For older women the risk actually falls.
  - b) Sex: Males complete suicide at rates around twice those for women. Young women are at higher risk of self-harm.
  - c) People who are separated, divorced, widowed, single or living alone have an increased risk. Caring for a child is protective.
2. Unemployment, retirement or a fall in socio-economic status
3. Previous attempts: A history of previous attempts increases the risk of completed suicide. Be careful not to fall into the trap of thinking that because a person has repeatedly self-harmed in the past that he or she will not complete suicide in the future. The risk increases with the lethality of previous attempts. Knowing someone who has committed suicide, or having a family history of suicide, increases risk. Copycat suicides may follow media coverage of the suicide of high profile people or others with whom they identify. Previous attempts that occurred in the absence of any clear precipitant indicate high risk.
4. Physical illness: especially chronic, severe, disabling or terminal illness

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#### **Physical illness that is chronic, severe, disabling or terminal is associated with an increased risk of depression and suicide.**

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5. Mental disorder: especially major depression, bipolar disorder, schizophrenia, borderline and antisocial personality disorder and substance abuse. A history of impulsive behaviour increases risk. Repeated deliberate self-harm is often associated with a history of childhood abuse.
6. Symptoms: Hopelessness (the belief that things are not going to change, but stay bleak into the future), anxious ruminations, severe psychic anxiety, global insomnia, psychotic symptoms (especially delusions of poverty or doom) and recent alcohol abuse are predictors of suicide. One study has calculated that 72 per cent of those with a suicide plan go on to make a suicide attempt<sup>1</sup>.

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<sup>1</sup> Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Co-morbidity Survey. *Archives of General Psychiatry* 1999; 56:617–626.

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**Hopelessness, anxious ruminations, severe psychic anxiety, global insomnia, delusions of poverty or doom, recent alcohol abuse and having a suicide plan are associated with later suicidal behaviour.**

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7. Availability of means: Access to lethal means such as firearms increases risk.
8. Risk periods: early in treatment or soon after hospital discharge. A sudden unexplained improvement can be a danger sign. The person may have decided to commit suicide. Suicide attempts may occur on the anniversary of important losses.

### **The interview**

The assessment of suicidality is summarised in Table 3-1.

1. Consider the person's risk factors (as above).
2. Ask about suicidality. Begin by asking general questions (e.g. 'Does it ever seem that life is not worth living?'). Then proceed to more direct questions (e.g. 'Have you thought of harming yourself or even killing yourself?'). Clarify if the person has a suicide plan, how specific it is, the lethality of means, whether it has been rehearsed and whether preparations have been made for the person's death (e.g. arranging insurance, finalising a will). There is some evidence that asking about suicide may suggest it as a possible solution to life problems, especially in adolescents who had not previously considered it as an option. Make sure that you follow up the question with a discussion about alternative strategies for solving the person's problems, and seek an agreement that if ideas of suicide recur in the future, the person will first seek help.

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**Ask about suicidality, but always be prepared to follow up the question with a discussion about alternative solutions to the person's problems.**

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3. Assess the suicidal act or intention. It is often useful to ask the person to describe what happened in the days leading up to a suicide attempt. You will then understand the context in which the attempt occurred and the meaning of the act. Was the act planned or done on impulse? Was alcohol involved? Did the person expect to die or was another outcome intended? Some people may take an overdose, for example, simply to get away from their problems and to sleep. Others may expect to be rescued. Writing a note may demonstrate a high level of intent.

Assess the lethality of the act by noting the means, the situation in which it occurred and whether others were nearby. Ask about access to firearms and other means. The lethality of the act may not correlate with the intent. For example, many people are unaware of the potential fatal consequences of paracetamol overdose. Others may have truly expected a minor overdose to have been fatal.

4. Assess the meaning of the act or intention. Assess the person's reasons to die versus (his) reasons to live. Assess the meaning to (him) of suicide and death. Risk is increased when this takes on a positive meaning (e.g. identification or reunion with a loved one, or fantasies of rebirth).
5. Assess the problem. Suicidal acts are attempts at solving problems in a person's life. They often occur in response to relationship difficulties. People who self-harm may do so in the belief that they will elicit sympathy and restore threatened relationships. In reality, they more often induce guilt and anger in others, and tend to drive people away rather than bring them closer, especially when repeated suicide attempts are made. Clarifying the precipitating problem is the first step in trying to resolve it. Listening to a person describe his or her problem will itself provide some relief. You may be the first person who has taken the time to do this. Then

use the counselling and structured problem solving techniques described in Chapter 6 to help the person resolve the crisis.

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**Suicidal acts are attempts at solving problems in the person's life.**

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6. Assess any underlying mental disorder. Disorders associated with an increased risk of suicide include major depression, bipolar disorder (especially during depressed or mixed episodes), psychotic depression (especially with mood-congruent delusions), depression associated with anxiety symptoms, panic disorder, schizophrenia, borderline personality disorder, antisocial personality disorder and alcohol abuse. The risk is increased when two or more disorders coexist (e.g. depression and alcohol abuse). People in the early stages of recovery from depression are at high risk. The person who was psychomotor retarded may find the energy and motivation to complete suicide at this time. Repeated self-harm is often associated with a history of childhood abuse. The impaired judgement of people who are intoxicated, delirious or acutely psychotic places them at high risk. These people almost always require hospital admission, often under regulation.

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**Disorders commonly associated with suicide include depression, panic disorder, alcohol and substance abuse, and schizophrenia.**

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7. Is there an underlying physical disorder? People with severe physical illness, especially the elderly, have an increased risk of suicide.
8. Ask about previous suicide attempts or self-harming behaviour. The frequency and seriousness of these give an indication of current suicide risk.
9. Assess protective factors. Those with limited social supports are at high risk. On the other hand, strong social supports are protective. The ability to mobilise supports is an important factor in treatment. Assess other protective factors: guilt about the impact of suicide on the person's family (especially their children), fears of death and of the unknown, social stigma, and religious proscriptions against suicide.

**Table 3-1: Assessment of suicidality**

- Consider the person's risk factors.
- Ask about feeling of hopelessness.
- Ask about any plans for suicide.
- Evaluate the context of any suicidal act and its meaning to the individual.
- Assess the means used, and the lethality and intent of the act.
- Ask about access to firearms and other means.
- Clarify the problem that the suicidal act attempts to solve.
- Diagnose underlying mental disorder.
- Diagnose physical disorder.
- Document past suicidal behaviour.
- Assess the extent of social supports.

**Management**

1. Treat the physical sequelae of the suicide attempt. You may need to refer the person to hospital for inpatient treatment.
2. Document the suicide risk assessment and the reasons for your actions.
3. Establish a therapeutic alliance. Listening to the person, being sensitive to verbal and non-verbal cues, and having an empathic style will promote open communication. Note, however,

that once a person has decided to commit suicide, you will be seen as an adversary rather than an ally. For this reason, it is important not to place too much reliance on a simple denial of suicidal intent. A majority of people who complete suicide have not mentioned their intention to their therapist, or have denied such an intention. On the other hand, people often communicate their intentions to spouses or family, a fact that underlines the importance of interviewing family members.

4. Ensure the person's safety. Before sending a (man) home, you should aim to reach an agreement that he is no longer suicidal and that if suicidal thoughts recur, he has a plan for getting help before self-harming (see Table 3-2). The plan may involve telling a family member of any suicidal thoughts, or of contacting you or the district mental health service. When he cannot give such an assurance, or when his judgement is so poor that he is not in a position to make such an agreement, it may be necessary to hospitalise him. You may need to do this under the provisions of the Mental Health Act (see Chapter 22). Note that a simple agreement not to commit suicide is of little value in itself, though a refusal to ensure one's own safety constitutes a significant risk.
5. Mobilise social supports. The safety agreement will usually require the cooperation of family members or other close supports. The precipitating problem usually involves those who are close to the person. A plan that has the agreement of everyone concerned is more likely to succeed and all participants will share some responsibility for its implementation.
6. Diagnose and treat the underlying mental disorder. In the immediate aftermath of a suicide attempt, explain the nature, causes, treatment and prognosis of the underlying condition to the person and his or her carers. This will give the person a sense of control and help restore hope.
7. Deal with your own and others' emotional reactions. Suicidal behaviour evokes strong feelings in those close to patients and in those who treat them. Monitor your countertransference to ensure that these feelings do not distort your judgement. Common reactions include:
  - denial – for example, you may find yourself colluding with the person who says that an obviously serious suicide attempt was just an accident
  - anger and distancing – you may, for example, dismiss a person's suicidal thoughts as merely manipulative or attention-seeking
  - rescue fantasies – these might arise, for example, in response to a young woman who repeatedly self-harms. Despite the inability of all her previous therapists to prevent these distressing behaviours, you may be tempted to believe that you, and only you, can save her. This may lead you to denigrate her other therapists and to take extraordinary measures to save her, which may in turn lead to burnout and boundary violations. Taking desperate measures to prevent a person from self-harming may only reinforce his or her feelings of helplessness.

**Table 3-2: Criteria for allowing a suicidal person to go home**

- The person no longer feels suicidal.
- His or her medical condition is stable.
- The person is able to promise to seek help before self-harming if suicidal ideas recur.
- The person is not intoxicated, delirious or psychotic.
- Firearms have been removed from the home.
- Acute problems have been identified, and steps taken to begin to address them.
- Treatment has been arranged for underlying psychiatric problems.
- You feel confident that the person will follow through with the plan.
- Social supports have been contacted and they agree with the plan.

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**People who deliberately self-harm, or who threaten or attempt suicide, evoke strong countertransference responses that can both inform and obstruct treatment. These include denial, anger and impulses to rescue the person.**

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### **Some guidelines for the management of the person who repeatedly self-harms**

As a group, these are among the most difficult people to treat. They evoke strong countertransference responses that can both inform and obstruct treatment. Often these people have been the victims of childhood abuse. A more detailed discussion of management issues can be found in Chapter 23 in the section on borderline personality disorder. Below are some suggestions about how you might approach the management of a young woman who repeatedly presents to you with ideas or acts of self-harm.

1. Focus on the here-and-now issues surrounding the current crisis rather than going over past problems, including those of past abuse. Leave dealing with those issues to her psychotherapist. Try to identify the precipitating problem and use structured problem solving techniques to resolve it. Sometimes the precipitant may not be an event, but rather an unpleasant affective state, for example, a feeling of emptiness or boredom. She may have great difficulty accounting for her actions. Nevertheless, persist in seeking to understand what the act means to her. The initial goal of therapy is to find alternative ways of dealing with such crises.
2. Reach an agreement about ensuring her safety using the principles outlined above. If the plan breaks down, use structured problem solving techniques to revise and improve it.
3. Set explicit limits about what you can and cannot do. Acknowledge that while you are concerned about her self-harming behaviour and wish to help her, her safety is ultimately in her own hands.
4. As a corollary, do not be drawn into desperate attempts at rescue. You may only reinforce the young woman's feelings that she is helpless and cannot take responsibility for her own safety. You run the risk of becoming burnt out or of being drawn into desperate attempts at treatment that may only worsen the problems.
5. Do not be too critical of others involved in her treatment. Talk to them and work together with them towards common goals.
6. Monitor your countertransference and acknowledge negative feelings and impulses. By doing so, you will be less likely to act out upon them.
7. She may at times present a paradox. After just having harmed herself, she may present with a bland, even smiling affect. Do not collude with this denial. Always remain serious and realistically concerned about her dangerous behaviour. Do not joke with her about her self-harming behaviour.

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### **Always remain serious and realistically concerned about a person's suicidal behaviour.**

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#### **When a patient commits suicide**

Sadly, despite our best efforts at prevention, there are some people who will commit suicide. It has been estimated that, on average, general practitioners will lose a patient by suicide around once every six years<sup>1</sup>. Note, however, that this figure varies from one practice to another. In the aftermath of the suicide of a patient under your care, it is advisable to contact the family

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<sup>1</sup> Office of Health Economics. *Suicide and deliberate self-harm*. London: Office of Health Economics, 1981.

and offer to meet with them. Encourage discussion and ventilation of feelings. Acknowledge that the grieving process after a suicide may be particularly painful, with conflicting emotions of sadness, guilt, shame and anger (see Chapter 7). Consider attending the funeral. Contrary to what you might expect, families are generally grateful for your attendance and are unlikely to criticise you.

An audit of the case should be conducted with a group of colleagues. The focus should be on a supportive review and what can be learned rather than on 'what went wrong'. It is essential to seek the support of a colleague at this time (see Chapter 25).

## **Dangerousness**

One of the reasons for the stigma of mental illness is the commonly held belief that people with mental disorders are dangerous. In fact, most individuals with mental disorders are not violent and present no threat to others. In particular, the depressed and anxious people who are commonly seen in general practice are probably less dangerous than people in the community at large. However, it is true that, as a group, people with mental illnesses are around three to five times more likely to commit acts of violence than the rest of the population<sup>1</sup>. This increased risk should be understood in context—it is about the same as that for young men. Moreover, what is true for a group does not necessarily pertain to an individual member of that group. For example, a young, isolated and unemployed man with schizophrenia who has a history of violence and substance abuse and is currently delusionally jealous presents a relatively high risk. By contrast, an elderly woman with well-controlled schizophrenia, who has strong social supports and no history of violence, presents a minimal risk of dangerous behaviour.

With potentially dangerous or violent persons, the main goals, in order of priority, are:

1. self-protection
2. prevention of immediate violence
3. diagnosis and assessment of the risk of dangerousness
4. development of a treatment plan that includes measures to minimise the likelihood of future violence.

## **Self-protection**

Assume that violence is always a possibility and never allow yourself to be surprised by a sudden, violent act. Know as much as possible about a person before seeing him or her. It is especially important to know if the person has a past history of violence, and whether the person has access to firearms or other weapons. Never interview an armed person. Never interview a potentially violent person alone or in a room with the door closed. Never use a room with an internal manually operated lock. Consider removing neckties, necklaces or other articles of clothing or jewellery that the person can grab or pull. Stay within sight of other staff members.

Do not attempt physical restraint yourself. Do not give the person access to areas where weapons may be available (e.g. syringes, furniture). A paranoid person may feel threatened if you sit too close. Keep yourself at least at arm's length from any potentially violent patient. Do not challenge or confront a psychotic patient. Be alert to any signs of impending violence. In the face of impending violence, leave the room. Trust your own instinct about this. If you feel afraid, then leave. Always leave yourself a route for rapid escape in case the person attacks you. Never turn your back on the patient. A common response of people who are angry is to walk out. Do not obstruct their passage.

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<sup>1</sup> Borum R, Swartz M, Swanson J. Assessing and managing violence risk in clinical practice. *Journal of Practical Psychiatry and Behavioural Health*, 1996, 205–215.



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**If you feel afraid during the interview, leave the room.**

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### **Prevention of immediate violence**

The key to prevention is early detection and preventive action. Signs of impending violence include recent violence against people or property, clenched teeth and fists, verbal threats or menacing, wielding weapons or objects potentially useable as weapons, agitation, alcohol or drug intoxication, paranoid delusions and command hallucinations.

Be supportive and non-threatening to potentially violent patients. Set limits by offering choices (e.g. medication by alternative routes) instead of provocative directives (e.g. 'Take this medicine now.'). Tell them directly that violence is not acceptable. Reassure them that they are safe. Convey an attitude of calm and control. If medication is offered, the person should be told that the aim is to help him or her relax and gain more self-control. If medication is needed, choose the least invasive route that is practical.

### **Diagnosis and assessment of the risk of dangerousness**

Risk factors for violence include a statement of intent, a specific plan, the availability of means (especially firearms), male sex, youth (15–24 years), a history of violence and other antisocial acts, poor impulse control, abuse of substances (especially alcohol and amphetamines), low IQ, family history of violence, history of childhood abuse, low socio-economic status, poor social supports, history of suicide attempts and recent psychosocial stressors.

Psychiatric diagnosis on its own is a poor predictor of violence. Most people with mental disorders are not violent. The associations of some mental disorders with an increased risk of violence are listed in Table 3-3.

**Table 3-3: Mental disorders associated with an increased risk of violence**

- substance abuse (especially alcohol and amphetamines)
- withdrawal from alcohol and sedative hypnotics
- psychotic disorders (e.g. schizophrenia and delusional disorder), especially if the person has persecutory delusions, command hallucinations to harm others<sup>1</sup>, delusions or hallucinations that cause unpleasant affects (e.g. anxiety, anger or sadness)<sup>2</sup>, or delusions of infidelity
- depression, especially if associated with psychotic symptoms
- mania is associated with assaultive or threatening behaviour though rarely with serious violence
- personality disorders characterised by rage and poor impulse control (e.g. borderline and antisocial personality disorders)
- organic mental disorders (especially delirium, and frontal and temporal lobe disorders)

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**Psychiatric diagnosis alone is a poor predictor of violence. Risk factors include a statement of intent, a specific plan, the availability of means (especially firearms), male sex, youth (15–24 years), a history of violence and other antisocial acts, poor impulse control, abuse of substances (especially alcohol and amphetamines), low IQ, family history of violence, history of childhood abuse, low socio-economic status, poor social supports, history of suicide attempts and recent psychosocial stressors.**

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<sup>1</sup> McNeil DE, Eisner JP, Binder RL. Relationship between command hallucinations and violence. *Psychiatric Services*, 2000, 51:1288–1292.

<sup>2</sup> Cheung P, Schweitzer I, Crowley K, Tuckwell V. Violence in schizophrenia: role of hallucinations and delusions. *Schizophrenia Research*, 1997, 26:181–190.

## **Treatment plan**

Treat the underlying mental disorder and take steps to reduce the risk of future violence.

1. Warn the intended victim of any violent threat. Phone the police, the person under threat, or his or her family or friends. The duty to warn takes priority over patient confidentiality.
2. Restrict the person's access to weapons (especially firearms). A firearm prohibition order can be arranged by writing to the police.
3. Treat any underlying mental disorder, if necessary, in hospital, under regulation.
4. If violence is related to a specific situation or person, try to separate the two.
5. If there is no evidence of a mental disorder, ask the person to leave and, if necessary, contact the police.

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**If a person makes a direct threat against another, the duty to warn overrides the need to maintain confidentiality.**

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# Chapter 4

## Transcultural mental health issues

### Culture and mental illness

Helman defines culture as a 'set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment'.<sup>1</sup>

Different cultures have different views on what constitutes mental illness. The definition depends on what is regarded as normal and abnormal, and whether or not behaviours are within the norms of the particular society. Mental illness is applied to those behaviours that are both abnormal and outside these norms. Criminal behaviour is viewed as 'normal', but against the norms of society. Certain abnormal behaviours are sanctioned in specific circumstances (e.g. speaking in tongues or, in our society, the behaviour of footballers after winning a game).

The Western concept of mental illness tends to locate the problem within the individual sufferer, whilst in many non-Western cultures, the problem is seen as belonging to the community as a whole. There is a tendency within Western medicine to attempt to reduce illness to a single, often physical cause. Psychoanalysis tends to reduce illness to experiences in the mind of the individual. A theme of this book is to avoid such reductionism and to consider the range of biological, psychological and social factors in the formulation of mental disorders. In many societies, the spiritual dimension is of central importance.

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**The Western concept of mental illness tends to locate the problem within the individual whilst in many non-Western cultures, the problem is seen to be one of the community as a whole.**

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The ways that different cultures view mental illness influence their diagnostic systems. While there are similarities in the forms of illnesses across different societies, the content of symptoms and signs are specific to the society. For example, delusions and hallucinations occur in all cultures but their contents differ. An Australian man with schizophrenia may complain that his thoughts are being influenced by laser beams, while a man from Fiji may complain of black magic interfering with his thoughts.

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**The forms of mental phenomena are similar in different societies, but their content is specific to each.**

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A person's culture also influences the manner in which he or she presents mental health problems. In some cultures, psychological distress is more commonly expressed through somatic complaints than through mental symptoms. Some languages have a paucity of words to describe emotions and other subjective experience. The way that people present their problems and seek treatment is shaped by their culture, and the symptoms and signs tend to fall into patterns recognised within it. The sick role is defined by a number of culturally specific entitlements and obligations of the person who is ill.

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<sup>1</sup> Helman C. *Culture, Health and Illness*. 2<sup>nd</sup> Edition, London: Wright, 1990.

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**In some cultures, psychological distress is usually expressed through somatic complaints.**

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Just as the formulations of people's problems in non-Western societies involve the whole community, so do the prescribed treatments. An unfortunate consequence of Western societies' focus on the individual is the tendency to treat a person in isolation from his or her community. The high priority placed on confidentiality and the right to privacy reflects core values in Western society. A corollary of this attitude is the stigma of mental illness in Western societies.

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**In Western societies, a high priority is placed on confidentiality. As a corollary, people with mental health problems are often stigmatised and treated in isolation from the rest of their community.**

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By contrast, the involvement of the community in both the formulation of the problem and in its treatment in non-Western societies means that the person, rather than being excluded from society, becomes instead a focus of community attention and support. Indeed, the process of healing is often a powerful cohesive force within these societies. This may, in part, explain why people in non-Western societies who suffer psychotic illnesses have a better prognosis than people in the West. Treatments in non-Western societies usually involve the family. In the West, deinstitutionalisation has meant that a greater responsibility for care falls on families who are now routinely involved in treatment.

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**The better prognosis of psychosis in non-Western societies may in part be due to the involvement of the community in both the formulation of the problem and its treatment.**

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There are certain common features of non-pharmacological treatments across different cultures. All involve a mythic belief system that the healer communicates to the sufferer. The healer makes links between the myth and the problems of the individual. The individual is engaged emotionally in the treatment. Therapeutic change is achieved by reframing the problem in terms of the myth. The person gains a sense of mastery and a new explanatory narrative of his or her experience. This is as true of psychoanalysis as it is of various forms of spiritual healing in non-Western societies.

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**There are features common to all effective forms of psychotherapy.**

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When people move from one culture to another they suffer a variety of stressors and their rates of mental illness are higher than for people in the host society and in their society of origin. To some extent, this may be explained by the fact that people with a history of mental illness seem to be more likely to migrate, but it also has to do with the stresses of migration. Refugees are at higher risk than voluntary migrants, especially those who have been traumatised by war or experiences of torture. The change of culture, including language, is a significant stressor. Immigrants often suffer a loss in social and occupational status if their qualifications are not recognised. Family incomes are often low and unemployment levels high. People may be forced to live in overcrowded conditions with few amenities. Immigrants may suffer racial discrimination. Conflict may arise between parents and their locally born children.

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**Migration is a stressful event that can precipitate mental illness.**

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Consider the guidelines in Table 4-1 when interviewing a person from a non-English cultural background.

**Table 4-1: Assessing the person from a non-English cultural background**

- Ask the person his or her preferred form of address. Do your best to pronounce the name correctly.
- Where possible, involve the family in treatment, but not as interpreters.
- Be informed by what you know about disease process, but do not neglect to try to understand the person's experience and the illness.
- The focus is often on healing (or coping, rehabilitation and disability support) rather than cure.
- Set aside at least twice the usual time. If you use an interpreter, the consultation will always take longer.
- You will often have to work slowly from first principles in making a diagnosis, rather than relying on your skills in pattern recognition.
- Whenever there are language difficulties, use an interpreter.
- Ask the person and his or her family about the meaning of the symptoms and signs within their culture of origin, and their understanding of the diagnosis and treatment.
- Be careful not to ascribe psychopathology to symptoms and signs that are not abnormal with the person's culture of origin.
- On the other hand, do not dismiss complaints as just normal cultural variants.

## **The interpreted interview**

When a person cannot communicate fluently with you in English you should use a professional interpreter. This will not interfere with the doctor–patient relationship. On the contrary, by ensuring that you understand the person's complaint, and that he or she understands your explanations and instructions, you will deliver better care. Both on-site and telephone interpreting can be organised through the Translating and Interpreting Service (TIS) in each state and territory.

It is generally not advisable to use other staff (for example a secretary) or other family members to interpret. Messages may be altered, censored, distorted, normalised or presented in a highly subjective way. There may be a lack of knowledge of specific medical terminology. There may also be a lack of awareness of such ethical issues as confidentiality. The use of a child as interpreter for his or her parents may distort the authority relationships within the family and can be embarrassing to both child and parent. Important information may be withheld.

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### **It is generally inadvisable for staff or family members to act as interpreters.**

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In certain situations, the use of an interpreter is mandatory:

- seeking informed consent
- communicating the results of diagnostic tests
- giving pre- or post-operative instructions
- discussing the diagnosis of a terminal illness
- dealing with situations that involve domestic violence
- treating mental illness
- breaking bad news (see also Chapter 7).

## **On-site interpreting**

Before the interview, make sure that extra time has been set aside for the consultation with the interpreter. When complex information needs to be communicated, it is wise to brief the interpreter before the interview. During the interview, always speak directly to the person, addressing him or her in the second person. Avoid having the conversation with the interpreter. At the beginning of the interview, introduce yourself and the interpreter and explain your roles. Explain that the interview will remain confidential. During the interview, speak slowly and

use short sentences in plain English. Pause after two or three sentences to allow the interpreter to communicate what you have said. Summarise the discussion periodically throughout the interview. At the end of the interview, ask the person if he or she has any questions. Consider debriefing the interpreter after the interview.

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**Set aside extra time for an interpreted interview.**

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### **Telephone interpreting**

This form of interpreting is not suitable for complex interviews. If using dual handsets, speak a little softer than usual. When using a conference phone, you and the patient may need to speak a little louder in order for the interpreter to hear you both.

### **Consent for procedures**

When obtaining consent for surgical or other procedures, always ask an interpreter to be present in a face-to-face interview. On the consent form, include a statement signed by the interpreter indicating that he or she has translated all of the necessary details for the person.

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**Always use an interpreter in a face-to-face interview when gaining consent for surgical or other procedures.**

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### **Indigenous mental health issues**

The standards of physical and mental health among indigenous people in Australia are poor in comparison with the wider community. Life expectancy is 20 years less than for non-indigenous people. The main causes of this excess morbidity are diabetes, cardiovascular disease, peripheral vascular disease, lung disease, kidney disease and accidents. It has been estimated that alcohol is a contributing factor in as many as 50 per cent of premature deaths<sup>1</sup>.

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**Alcohol is a contributing factor to the low life expectancy of indigenous Australians.**

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Knowledge of the epidemiology of mental disorders among indigenous people is limited. Early studies were flawed, because they relied on information from non-indigenous sources and used Western diagnostic instruments. More recent studies estimate the prevalence of mental disorders in indigenous people to be between 35 per cent<sup>2</sup> and 54 per cent<sup>3</sup>. Indigenous Queenslanders are more than twice as likely as other Queenslanders to be admitted to an inpatient psychiatric facility. However, indigenous people are thought to be under-represented among those attending community mental health services<sup>4</sup>.

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<sup>1</sup> Mathews JD. *Aboriginal Health Issues. Report to Senator Graham Richardson from the Menzies school of health research*, Darwin, Northern Territory: 1993.

<sup>2</sup> Clayer JR, Divakaran-Brown CS. *Mental Health and behavioural problems in the urban Aboriginal population*. Report of a study conducted by the Aboriginal Health Organisation and the mental health evaluation centre of the South Australian Health Commission, 1991.

<sup>3</sup> McKendrick JH. *Patterns of psychological distress and implications for mental health service delivery in an urban Aboriginal general practice population*. Thesis: Doctor of Medicine. University of Melbourne.

<sup>4</sup> Queensland Health. *Queensland Mental Health Policy Statement for Aboriginal and Torres Strait Islander people*. Brisbane: Queensland Health, 1996.

There is a high prevalence of depression and anxiety. In a study of one community in Adelaide, 25 per cent of Aboriginal adults had attempted suicide at some time in their lives<sup>1</sup>. The rate of suicide for indigenous young men between the ages of 15 and 24 is three and a half times higher than for other Queensland men in this age group<sup>2</sup>. Rates of alcoholism are high with levels between 32 per cent and 65 per cent reported in men, and between 3 per cent and 51 per cent in women, in different communities<sup>3</sup>. Among children and young people, there is a high prevalence of conduct disorder. The rate of incarceration among 15 to 19 year old boys is 25 times that of non-indigenous youth. There are also high rates of alcohol and substance use (including marijuana and petrol sniffing) among indigenous youth.

The severe social disadvantage under which many indigenous Australians live may partly explain these high rates of mental disorders. As a group, indigenous people are poorly educated, live in overcrowded conditions, suffer a low standard of housing, and have high levels of poverty and unemployment. Their physical health is poor. Families are disrupted with high rates of parental discord, domestic violence and substance abuse. Children frequently suffer neglect and abuse.

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**Severe social disadvantage may partly explain the high rates of mental disorders amongst indigenous people.**

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The current social situation of indigenous Australians can be understood in terms of the history since white settlement. Throughout the world, the worst outcomes for indigenous peoples following colonisation have occurred when there has been no formal treaty or settlement regarding the transfer of lands, and where the national government has not been in control of indigenous affairs. In Australia, there were no treaties, and the Federal Government only took over responsibility for indigenous affairs after the referendum in 1967.

In the early days of white settlement, Aboriginal families were forced to move away from their traditional lands to make way for farmers and other settlers. They were often resettled on land that was far from their homelands, in places where they could not practice their traditional ways of life. In the process, extended family groups, fundamental to indigenous culture were often broken up. Government and church agencies took over many of the traditional roles of people in these communities and so further contributed to the loss of identity suffered by these displaced people. Up until the mid 1960s many indigenous children, especially young girls, were taken from their families and brought up in orphanages or within non-indigenous households. The separation of young people from their families continues to this day with many young men being incarcerated in juvenile justice facilities. In a recent Victorian study, 49 per cent of respondents had been separated from both of their parents for significant periods of time before they were 14 years old<sup>4</sup>.

The impact of these events is evident today. The multiple losses suffered as a consequence of colonisation—the loss of land, family connections, culture and health—has had a profound effect on the identity and consequently on the health of indigenous Australians. The anger of many young Aboriginal men can be seen as a response to these events. In the face of this loss of identity, many turn to alcohol.

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<sup>1</sup> Radford AJ, Harris RD, van der Byl M, et al. *Taking control: a joint study of Aboriginal social health in Adelaide with particular reference to stress and destructive behaviours*, Monograph 7, Department of Primary Health Care, Flinders University of South Australia, Adelaide, South Australia, 1991.

<sup>2</sup> Baume PJM, Cantor CH, Mc Taggart PG. *Suicides in Queensland: a comprehensive study, 1990-1995*. Brisbane: Australian Institute for Suicide Research and Prevention, 1998.

<sup>3</sup> Hunter EM. *Aboriginal Health and History: Power and Prejudice in Remote Australia*. Melbourne: Cambridge University Press, 1993.

<sup>4</sup> McKendrick J, Cutter T, Mackenzie A, Chiu E. The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population. *Australian and New Zealand Journal of Psychiatry* 1992; 26:40-47.



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**The multiple losses suffered by indigenous people as a result of colonisation have had a profound effect on Aboriginal identity.**

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Indigenous cultures' recognition of mental illness is demonstrated in language. There are many Aboriginal words to describe abnormal mental states and behaviours (e.g. 'womba' and 'wangi wangi'). Moreover, there appears to be a high tolerance of abnormal behaviour. Disturbed people are usually cared for by their families with women often having to carry the main burden of care. Aboriginal and Torres Strait culture has a holistic concept of health, embracing not just physical and mental health, but also cultural and spiritual well being. Disturbance in an individual is viewed as reflecting a community problem. Mental disturbance, especially when severe, is often seen as a spiritual problem and spiritual treatments may be used. Traditional healers play a vital role in the care of indigenous people with mental health problems.

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**Aboriginal culture has a holistic concept of health, embracing not just physical and mental health, but also cultural and spiritual well being.**

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When treating an indigenous person with a mental health problem, be mindful of cultural differences. A failure to do so may lead to misdiagnosis. Culturally normal behaviours may be mistaken for psychotic symptoms and be treated inappropriately with antipsychotic medications. On the other hand, important symptoms of distress may be mislabelled as normal cultural variants. If possible, engage the services of a local indigenous community member or health professional to assist the assessment and ongoing care.

There are no formal guidelines or protocols put forward by Queensland Health for the assessment and treatment of an indigenous person who is suffering a mental health problem. However, consider the following suggestions that are taken from a training video<sup>1</sup>.

1. Set aside extra time. The interview is likely to take longer than usual.
2. Explain your role and the sort of things you are going to ask.
3. Remember that you may be viewed as a member of a culture that has caused damage to indigenous culture—anticipate some anger, resentment or suspicion.
4. Be careful about using direct questions. They may be perceived as threatening and intrusive and be met by a hostile response.
5. Avoid using medical and other technical jargon.
6. Recognise that vague and non-specific answers may reflect the discomfort of the person being interviewed.
7. Indigenous people may avoid direct eye contact. This is regarded as polite within indigenous culture.
8. Be aware of the following cultural prohibitions:
  - referring to a dead person by name
  - referring to certain close relatives by name (for example, a Torres Strait Islander male may not refer to his brother-in-law by name)
  - criticising an elder (older people are treated with great respect within traditional cultures)
  - confiding certain personal information to a member of the opposite sex (men's and women's business are usually kept separate)
  - criticising members of the extended family (family loyalties are strong).

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<sup>1</sup> Audiovisual services. *Last night I heard a voice: Working with Indigenous Mental Health Clients*. Queensland Government, 1996.



9. In assessing the mental state of an indigenous person remember the following:
- Hallucinations may not necessarily be psychotic phenomena. For example, it is normal for the bereaved to see and hear the voice of a deceased family member. Other family members are also likely to share the experience, which is usually perceived as reassuring. These phenomena usually do not persist longer than a month after the relative's death.
  - Limited eye contact, and softly spoken and brief answers may merely indicate that the person is shy or being polite.
  - Anger and obscene language directed at you may reflect past experience by that person, or his or her family, of exploitation and hardship inflicted by members of your own culture.
10. Consider carefully the appropriateness of any cognitive tests that you use. Take into account the education and living situation of the person being tested. Tests such as counting backwards, spelling and remembering a sentence may be perceived as demeaning and precipitate a hostile response.



# Chapter 5

## Family and marital problems

Many of the mental health problems seen in general practice are problems in couples, or in families, rather than in an individual. In cases where an individual suffers a mental illness, the impact of the illness on the family, and the way that family factors affect the person with the illness, are important components in the assessment and treatment.

General practitioners are not expected to provide formal family therapy or relationship counselling. However, they need to be confident in assessing and formulating family and marital problems, and in providing basic counselling and appropriate referral.

### Family problems

#### Family perspective

Family assessment requires a change in perspective from viewing an individual with a mental disorder to viewing the interactions within a social system in which difficulties exist. When one member of a family does suffer a mental (or physical) illness, this wider perspective encompasses not only the way that the illness affects the individual, but also the meanings that other members of the person's family ascribe to his or her behaviour, how they respond, how their behaviour feeds back on to the individual and on other family members, and the impact of the family's response on the person's illness. One looks for circular patterns of causality ( $a \rightarrow b \rightarrow c \rightarrow a$ ), rather than simple linear causality ( $a \rightarrow b$ ).

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**In assessing a family system, look for patterns of circular rather than linear causality.**

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#### Family functioning

Individuals are members of a wide variety of social systems—at school, at work, and in recreation and sporting clubs. People with chronic mental disorders belong to systems of mental health care that include mental health staff, rehabilitation agencies and general practitioners. The most fundamental social system to which we belong is the family. There are a number of ways of viewing the structure and function of families:

- The commonest structure in our society is the nuclear family. However, a large number of variants exist, including the single-parent family, the extended family and the blended family.
- Like individuals, families undergo developmental changes throughout their life cycle. There are wide variations, but some of these are as follows: two young people leave their families of origin, meet, become engaged and marry; the first child is born, and second and subsequent births follow; the first child starts pre-school and then moves on to primary school; the youngest child starts school, leaving no children at home during school hours; the children pass through adolescence, develop greater autonomy, form intimate relationships outside the family of origin and leave home; and the final period between the parents' retirement and their death. Each of these transitions requires individual family members and the system as a whole to change. Illness and other significant stressors can interfere with this developmental process. On the other hand, developmental changes may precipitate mental illness in an individual.

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**A family, like an individual, undergoes developmental changes throughout its life cycle.**

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- A family's cohesiveness is evident in the loyalty of individual members to each other and their ability to work together. It is compromised when there is severe conflict between family members, when opposing alliances form or when one member is made a scapegoat.
- Each generation influences subsequent generations. The way that a man is reared affects the way he rears his own children. Aspects of the identity of a family as a whole are also passed on to the next generation. In some families, a 'myth' about the family is handed down from one generation to the next—for example, that 'The Smiths are a stubborn lot.'
- Within the family system are a variety of subsystems. In well-functioning families, the strongest bond is that between the parents. Other subsystems include those between the children, between members of the same sex, and between those sharing common interests. Problems can arise when one subsystem is in conflict with another, for example, when a mother and her daughter begin making family decisions more appropriately the responsibility of the parents.
- Boundaries between subsystems need to be both clear and flexible. Patterns of diffuse boundaries, typical of enmeshed families, may produce highly cohesive family units but at the expense of the autonomy of the individual members. On the other hand, families with excessively rigid boundaries may promote individual autonomy but leave the members isolated and unsupported in times of stress.

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**Boundaries between family subsystems need to be clear, but flexible.**

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- Different patterns of communication exist between individuals in the family and between the different subsystems of the family. Certain patterns may characterise the family as a whole. Styles of communication vary in amount, clarity and the way people respond. Conflict between verbal and nonverbal communications can lead to misunderstandings, uncertainty and anxiety.
- Families often have a pervasive atmosphere that can be described, for example, as lively, critical, suspicious, earnest, chaotic, good-humoured or tense. The range of emotional expression may be limited to one predominant affect, such as anger. In other cases, there may be an absence of emotional expression. In families with a limited range of emotional expression, emotional distress may be communicated through somatic symptoms or aberrant behaviours.

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**In families with a limited range of emotional expression, distress may be expressed through the development of somatic symptoms or behaviour problems.**

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- Families differ in how effectively they deal with stressors, whether meeting the normal developmental challenges of their members or coping with other life events. Following a stress to a social system, such as a family member developing a mental illness, the system changes and eventually reaches a new equilibrium, a process analogous to the functioning of physiological systems in maintaining homeostasis. Stressors may be external to the family (e.g. financial difficulties or unemployment of a principal breadwinner) or internal (e.g. the developmental challenges of individuals or of the family as a whole, or illness of a family member). Stressors may be adverse (e.g. the death of a family member) or benign events (e.g. the birth of a child). Families may grow in response to a challenge or be set back.

## **The well-functioning family**

Some characteristics of the well-functioning family are listed below:

- The members of the family like each other.
- There are clear boundaries between subsystems with well-understood rules about their different roles. In particular, the parental bond is the strongest in the family and its role in making major decisions about the family and the children is acknowledged.
- Communication is clear and unambiguous.
- The family as a whole and the individual members respond to stressors effectively and cooperatively.
- The family is able to provide for the normal dependency needs of its members (by, for example, providing support and nurturance during illness), while at the same time promoting each individual's autonomy and development.

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**A well-functioning family meets the normal dependency needs of its members while, at the same time, promoting each individual's autonomy.**

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- The family provides a model of socialisation that can be transferred to relationships in the outside world. Specifically, the parents provide models for identification by the same-sex offspring.

## **Mental illness and the family**

The relationship between mental illness and the family is complex (see example in Box 5-1).

### **Techniques for interviewing families**

As a general practitioner, you are not expected to deliver formal family therapy. Moreover, since you will often be treating individual family members, it may be difficult, if not impossible, not to take sides. It may also be difficult to maintain confidentiality when some information has been given to you in confidence by individuals, and other information has been shared with the family as a whole.

Different schools of family therapy advocate different techniques: structural, strategic, the Milan school and psycho-educational. In general practice the techniques for interviewing the individual patient are applicable—listening, clarifying, using an empathic approach, asking directive psychological questions, and responding to verbal and non-verbal cues. The techniques of counselling, structured problem solving and supportive psychotherapy are also used (see Chapters 6 and 8).

Psycho-education is an important component of the treatment of all mental disorders. Families need to know about the symptoms, signs, relapse signatures, treatments and prognosis of illnesses suffered by their members, and where they can get help in an emergency. With the move from institutional to community care for people suffering a mental disorder, much of the responsibility for care now falls on families.

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**Family psycho-education is an important component of the treatment of all mental disorders.**

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### Box 5-1: Mental illness and the family

*In a well-functioning family, a person with an illness is supported by the other family members.*

Russell, who suffers from schizophrenia, lives in a granny flat at the back of his mother's house. She knows his general practitioner and psychiatrist well and contacts them if she sees signs of relapse or any other deterioration in his condition. His brothers take him on holidays with their families and are able to offer him work from time to time.

*The illness of one individual causes another to become symptomatic.*

- A woman with delusional disorder believes that the neighbours are involved a criminal group that facilitates illegal migration to Australia. Since giving information to the police, she is convinced that her own life is at risk. She insists that her 10-year-old son stay home from school in case he is abducted. The boy has also begun to believe that the neighbours are a threat to him.
- In the face of caring for his wife who suffers dementia, a man develops major depression.

*A problem in the family causes an individual to be labelled as unwell.*

A couple bring their 11-year-old son to see you because of behaviour problems at home. There are no complaints of behaviour problems at school. Over the last two years, there have been increasing marital problems and both parents have confided their difficulties in the boy.

*A problem in the family is manifest by an individual becoming symptomatic.*

A man becomes depressed in the face of worsening marital conflict.

*A person's illness is exacerbated by problems in the family system.*

Louise has frequent admissions to hospital following exacerbations of her schizophrenic illness. Her symptoms usually improve dramatically shortly after admission. She lives with her parents who, since neither is employed, spend most of their time home. There is conflict over her illness, her mother spending a lot of time supporting her, and her father often critical, insisting she is lazy and should be working.

*A person's illness causes problems in the family system.*

- A woman with obsessive-compulsive disorder insists that her husband assist her in her rituals. At times, he is up until 1.00am as she completes her showering and cleaning rituals before going to bed.
- Since the onset of Steven's schizophrenic illness, his mother has become his principal support. His 16-year-old brother has been increasingly resentful of the attention that Steven receives and he complains that nobody is interested in anything that he does. He is threatened with suspension from school because of rudeness to teachers and fighting.

*A person's illness is a 'solution' to problems in the family.*

Following the onset of Tracey's schizophrenic illness, her mother devotes an increasing amount of time to supporting her. She always attends appointments, asking to be present even when Tracey has Modecate injections. Meanwhile, Tracey's father spends more time at work and the local bowls club, and less time at home. Tracey's mother confides in her about the marital problems.

*Physical illness can also interfere with normal developmental tasks of individuals within a family.*

Andrew is a 15-year-old young man whose diabetic illness has been poorly controlled recently. His parents are anxious and upset. Until recently, they carefully monitored his blood sugar and insulin dose. However, over the past three months, he has resisted their involvement, insisting he will manage his insulin himself.

Comment: Andrew's developmental demands for greater autonomy are in conflict with the limitations placed on him by the illness and by his parents' desire to maintain some surveillance and control over the treatment. His distress is expressed through his poor compliance. Treatment would involve seeking an agreement with his parents that he will take greater control of his treatment, and to help Andrew grieve the losses and the limitations associated with having the illness, to gain a greater acceptance of it and to improve his compliance with treatment.

In interviewing families, it is important to respect the existing power structures within the family, but at the same time to facilitate each individual having his or her say. A useful technique is circular questioning in which each individual is asked in turn his or her opinion on the particular matter in question, and then to respond to what the others have said

### **Transference and countertransference**

Unless recognised, certain common patterns of countertransference can interfere with therapy. Acknowledge to yourself if you do not like an individual family member and take care that this does not bias your interventions. Having a particular liking for one individual can also interfere with therapy. Your judgement may also be distorted if the problems in the family are similar to problems in your own family. The best solution in such cases may be to refer the family elsewhere.

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### **Having a strong liking or dislike for a family member can interfere with therapy.**

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### **Indications for family therapy**

- child and adolescent emotional or behaviour problems
- family member with a serious mental disorder—in particular, a person with schizophrenia living in a family with high levels of expressed emotion, or a girl with a recent onset of anorexia nervosa
- families in crisis
- families in which the developmental tasks of its members are delayed
- when family factors are causing, maintaining or exacerbating an individual's mental illness
- families with boundary problems—for example, enmeshment or isolation
- families with serious communication problems.

### **Contraindications**

- where there are cultural prohibitions
- child sexual or physical abuse – In such cases the priority is to ensure the safety of the victim. Confronting the perpetrator in family therapy mislabels the problem as a family problem and may lead him or her to retaliate against the person who discloses the abuse.

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### **Family therapy is contraindicated in families in which there is child abuse.**

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- families with paranoid individuals who oppose therapy
- when destructive marital secrets may be revealed
- when addressing the problems of a late adolescent within the family as a whole risks compromising his or her growing autonomy – While some family intervention may be indicated, it is essential to see the adolescent on his or her own and to respect the confidentiality of the consultation.

### **Marital counselling**

Around 40 per cent of marriages in Australia end in divorce. The break-up of a marriage is one of life's most stressful events. The annual cost of marital difficulties in Australia has been

estimated to be two billion dollars a year<sup>1</sup>. Twenty per cent of assaults reported to the police and twenty-five per cent of murders occur between spouses. People suffering marital distress pay more frequent visits to their general practitioners, sometimes with ill-defined somatic complaints. Marital distress is associated with higher rates of depression, substance abuse, sexual dysfunction, marital violence, accidents, heart disease and cancer. The children of couples with marital problems are prone to behaviour problems, school problems and depression. Children who witness parental violence are at risk of entering abusive relationships later in life, as victim or abuser.

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**Marital distress is associated with higher rates of depression, substance abuse, sexual dysfunction, marital violence, accidents, heart disease and cancer.**

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### **Presentation**

One or other partner may present to you because of the marital problem. However, in many cases he or she will present with some other problem—ill-defined physical symptoms (headaches, gastro-intestinal symptoms), substance abuse, injuries, depression or sexual problems. Children of troubled couples may be brought to see you because of depression or behaviour problems.

### **Formulation**

Problems in marriages can be viewed from a number of perspectives. Using a systems approach, one considers the interactions between the couple rather than looking for a problem in one or other individual. Instead of seeking a single cause of the problem, one looks for circular patterns of causality in which one event triggers others that eventually feed back on the original event.

Individuals may have different expectations of their relationship. For example, a man may be distressed because his wife does not share aspects of her life with him—her work, the time she spends with her female friends and her sporting activities. There may be communication problems. Partners may be unable to discuss their difficulties.

Marital problems may arise in the face of stress—when both partners are unemployed, when a member of the family suffers an illness, or at times of developmental change within the family, such as the birth of a child.

From a psychodynamic perspective, one may see patterns in relationships that cross generations. For example, the man who has a conflicted relationship with his mother may unconsciously behave towards his wife in the same way as he does towards his mother. Here, the image he has of his wife is in conflict with her real identity. Instead of recognising and confirming her identity, he coerces her to conform to his image of her.

### **Marital therapy**

One of the prerequisites for performing marital therapy is that the therapist is disinterested, taking sides with neither partner. For the general practitioner, this is often impossible as he or she is already treating one or both partners for individual problems and is a confidante of each. In such cases, referral should be made for marital therapy. Organisations offering this service include Relationships Australia, Lifeline, Catholic Family Services and other counselling centres.

The main role of the general practitioner is in the detection of marital problems. You may also provide information to the couple about the resources available to help them, including written material<sup>2</sup>. Use counselling and structured problem solving to help deal with crises. In cases of

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<sup>1</sup>Wolcott I, Glazer H. *Marriage Counselling in Australia: An Evaluation*. Melbourne: Institute of Family Studies, 1989.

<sup>2</sup> Montgomery B, Evans L. *Living and Loving Together*. Melbourne: Viking O' Neill, 1983.



marital violence, provide information about crisis support and accommodation, social security and legal sanctions.

Indications for referral for marital therapy include chronic, multiple and severe problems, limited problem solving capacity, and associated mental disorder (depression, substance abuse) in one or other partner. Some techniques used by marital therapists are listed below.

- The focus is generally on the relationship and interactions between the partners rather than on one individual's problems.
- The couple are often asked to sit facing each other rather than the therapist. This facilitates direct communication.
- Circular questioning involves the therapist asking one person a question about the other, and then asking the other to respond.
- In reciprocal negotiation, a complaint of one partner is re-formulated as a wish. A task that fulfils this wish is then negotiated between the two. The other person is also given the opportunity to express a wish, and a task is then agreed upon to realise it.
- The therapist carefully observes the way that the couple communicate, noting problems such as those listed below:
  1. expressing thoughts in an intellectual, debating style, but without the expression of emotion
  2. a lack of empathy for the other
  3. failing to listen
  4. monologues in which one partner acts as spokesperson while the other submits
  5. one partner stating how the other feels instead of allowing the other to state this for him/herself
  6. wandering off the topic
  7. constant criticism with little positive reinforcement.

Generally, the therapist will interpret the communication problem and then ask the couple to rehearse a different style.

- The therapist may ask the couple to have an argument over some real, though minor, problem. This is a useful way of getting the subservient partner in a relationship to rehearse expressing his or her views and being more assertive.
- Another technique is for the therapist to ask each partner to role-play the response of the other to a given situation. This enhances empathy.
- The couple may be asked to set aside time for pleasurable activities or for tasks agreed to in a reciprocal negotiation. Time may be set aside to discuss a particular problem.



## Chapter 6

### Crisis intervention, counselling and structured problem solving

Crisis intervention, counselling and structured problem solving are techniques used to help people who are under stress. Stress is a person's response to an event that requires him or her to change. A stressor may be either an adverse event, such as bereavement, or a desirable one, such as a promotion. Likewise, the outcome of facing a stressor can be positive or negative. A person under stress may or may not have an intercurrent mental illness. People with personality disorders are especially prone to stress. Their lives are frequently chaotic, and their maladaptive coping mechanisms mean that they often exacerbate or avoid their problems rather than find effective solutions to them. Some common stressors are listed in Table 6-1.

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**Stressors include both adverse and desirable events.**

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**Table 6-1: Common stressors**

- |                          |  |
|--------------------------|--|
| 1. losses                | – bereavement  |
|                          | – separation/divorce                                 |
|                          | – response to major surgery or medical illness       |
|                          | – financial loss                                     |
| 2. life changes          | – new job  |
|                          | – marriage   |
|                          | – retirement   |
|                          | – developmental stage – e.g. adolescence, retirement |
| 3. relationship problems |  |
| 4. others                | – housing  |
|                          | – work problems                                      |
|                          | – financial problems                                 |
|                          | – problems with neighbours                           |

Elevated levels of arousal caused by a stressor initially lead to improved coping. However, when the levels of arousal rise above a certain point, coping deteriorates and can lead to decompensation (see Figure 6-1).

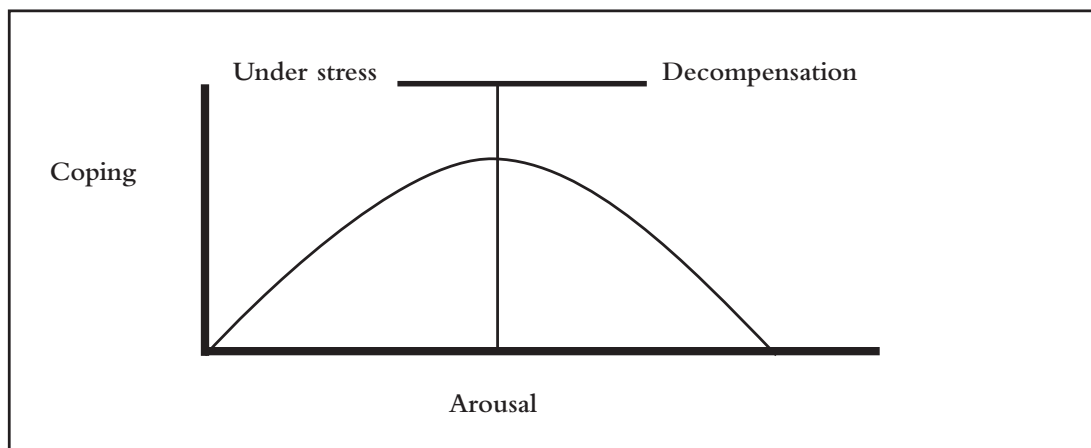
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**Increased arousal initially improves coping, but excessive arousal can lead to decompensation.**

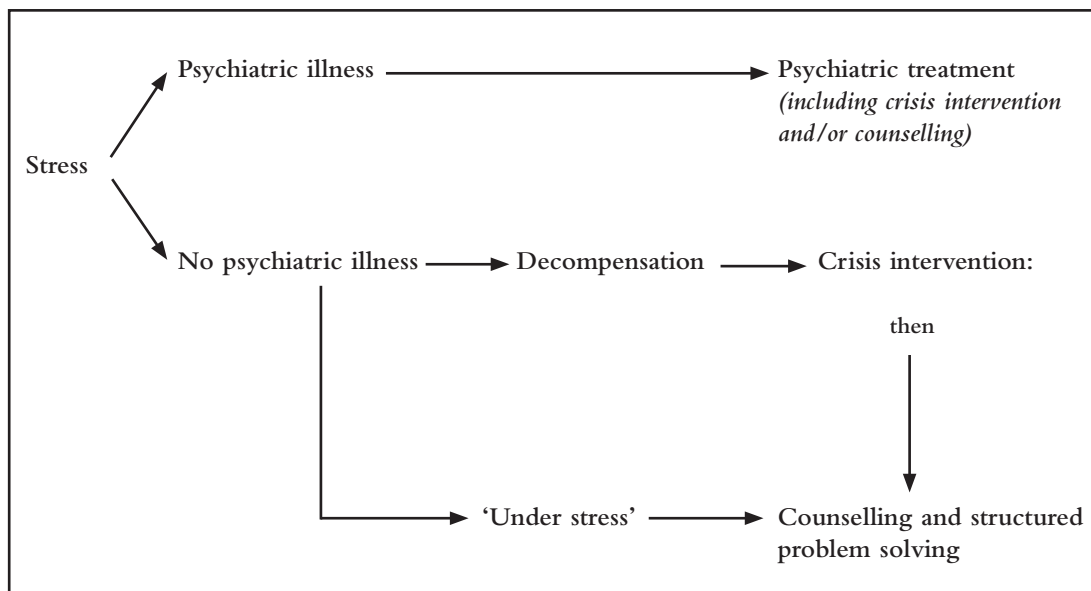
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The ways of dealing with these two situations are quite different. The person who is under stress receives counselling and is taught structured problem solving (see Figure 6-2), while the person who is decompensated first undergoes crisis intervention.

**Figure 6-1: The relationship between coping and level of arousal**



**Figure 6-2: Pathways of treatment of people under stress**



## Crisis intervention

The aim is to decrease the level of arousal until the person in crisis can return to his or her normal level of coping. As soon as this is achieved, responsibility for the problems is handed back to him or her, and counselling and problem solving can begin. Some of the steps used in crisis intervention are listed below. An example is given in Box 6-1.

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**Crisis intervention aims to decrease the decompensated person's level of arousal so that he or she can begin to cope effectively with his or her problems.**

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- Temporarily take over responsibility for the problems.
- Remove the person from the stressful situation. In some cases, it may even be necessary to arrange a brief admission to hospital.
- Lower the person's level of arousal by listening, encouraging the person to ventilate his or her feelings and providing reassurance. A brief course of a benzodiazepine may sometimes be appropriate.

- Diagnose and treat any mental disorder.
- When the person's judgement has returned to normal, offer counselling and structured problem solving.

### **Box 6-1: Example of crisis intervention**

A 35-year-old single man is involved in a car accident in which he is uninjured, but the young woman driving the other vehicle is killed. He presents to you two days after the accident complaining of insomnia, poor concentration and constantly experiencing vivid images of the accident. He has been chain smoking and drinking heavily since the accident.

You advise him that he should not be alone while he is in crisis. He contacts his sister who is happy for him to stay for a week with her. You recommend that he takes a week off work and does not drive. You give him a sickness certificate. You advise him to reduce his smoking and drinking, pointing out that the drinking will only exacerbate the sleeping problem. You give him seven temazepam 10mg tablets to help him sleep and make an appointment to see him the following week. Over the following weeks, you monitor for the development of post-traumatic stress disorder, depression or an anxiety disorder. You listen as he describes his experience and encourage him to ventilate his feelings and discuss what the event means to him.

## **Counselling**

The aim is for the person to cope as well as possible with the stressor. The problem is not treated as an illness. The person is not treated as being 'sick' but rather as a coping adult. The theory of counselling is that through facilitating the expression of feelings about the stressor in the context of a good therapeutic alliance, the person will be able to clarify and understand his or her problems better and solve them rationally to the best of his or her ability.

---

### **Counselling and structured problem solving aim to help people cope to the best of their ability with their problems.**

---

Counselling begins by understanding and clarifying the problem. Some steps you might take in counselling (a woman) are listed below:

- Listen as she describes the stressful situation or event.
- Reflect back what she says and clarify her account of what has happened.
- Allow her to ventilate her feelings.
- Empathise with how she feels.
- Try to make sense of any precipitants. These may have special meaning in terms of her past history. For example, the loss of a loved one may rekindle grief over past losses.
- Take note of any dysfunctional ways of coping, for example alcohol or other substance abuse, aggression or violence.
- Ask how she has dealt with similar problems in the past.
- Ask how she has dealt with other stressful events.

## **Structured problem solving**

The next step is to help her use structured problem solving to deal with the stressor (see Table 6-2). This Table is reproduced as a handout for patients in Appendix 3.

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### **Structured problem solving helps people find effective and rational solutions to their problems.**

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### Table 6-2: Structured problem solving

Use this chart to help solve problems that are causing you stress. If problems are not dealt with, they often worsen and cause more stress.

1. Make a list of the things that are worrying you.
2. Choose the problem that you want to deal with first and write it down as a need or a goal (e.g. 'I need to find a job', rather than, 'I don't know what to do with myself'. Or, 'I need to have more money in the bank', rather than, 'I haven't got enough money').
3. Write down all the possible solutions you can think of. List all solutions, including bad or silly ones. The aim at this stage is not to decide if a solution is good or bad. You might want to ask other people whom you trust to suggest some other possible solutions.
4. Beside a list of the possible solutions, draw two columns and write in them the advantages and disadvantages of each. Your GP or another person you trust may be able to help you with this.
5. Choose the best solution. It does not have to be the perfect solution. There rarely is such a thing. But it is better to try some solution than to do nothing at all.
6. Write down the steps needed to carry it out. Include the things you need to do, the resources that you require (e.g. a car or a day off work), the hurdles you need to overcome and the time you anticipate that it will take. You may need to rehearse some of the steps (e.g. a difficult interview or phone call). Decide on your goals so that after you have put the plan into action, you can assess how well it worked. For example, the goal might be having more money in the bank, going out with friends once a week or having fewer arguments with your spouse.
7. Put the plan into action.
8. Review how effective the solution was. First of all, congratulate yourself on trying to solve the problem rather than doing nothing. What have you achieved? What problems remain? Should you continue with the current solution, modify it or try a different approach?
9. Repeat the process for the remaining problems.

**Note:** When you are under severe stress, your ability to solve problems is often impaired. Avoid making major life decisions in the midst of a crisis.

You will need to set aside two or three longer consultations (e.g. 25 minutes) in the counselling phase as you assess and define the problems. The other steps can usually be spread over about five 15 minute sessions. However, new problems may then need to be addressed. Most of the work is done by the person (him or herself) at home.

Some steps that you might take in assisting a woman with structured problem solving are listed below:

- Explain the approach described in Table 6-2 and give her a copy of it (Appendix 3).
- Help to clarify the problem. The problem should be formulated as a specific goal or need.
- Suggest other possible solutions.
- Remind her of her strengths and weaknesses.
- Ensure that she is realistically appraising the different possible solutions.
- Make sure that she does not rush into action.
- Help her break down the plan into discrete steps.
- Help her to check the effectiveness of the action taken and identify any remaining problems.

An example of counselling and structured problem solving is given in Box 6-2.

### **Box 6-2: Example of counselling and problem solving**

A 47-year-old man recently diagnosed with angina has been advised to have a coronary artery bypass graft. He has always been a capable sportsman and has prided himself on his physical strength and agility. He is upset and angry about how the illness will limit his activities. Since being given the diagnosis, he has increased his cigarette and alcohol consumption. His only significant past medical problem was a fractured hip that he suffered in a motorbike accident when he was in his twenties. He was counselled for depression during the rehabilitation from this injury.

He initially states that he is not going to have the operation, but instead intends to give up his job, leave home and travel Australia on a motorbike. You advise him not to make hasty decisions while he is in crisis. You listen to him and empathise with his frustration and sense of loss. You remind him of the damage he is doing with his smoking and excessive drinking. You observe him carefully over the following months for the development of depression.

He later consents to the operation, but he remains angry and despondent about his circumstances. Amongst the specific problems that he identifies is his inability to continue playing competition squash. His problem solving goal is to find alternative activities. His list of possible solutions includes:

- stopping all sporting activity
- aiming to play less physically demanding sports
- carrying on playing squash, regardless of the consequences.

After considering the adverse consequences of giving up all sport (boredom, few other interests and loss of social contacts) and the dangers of continuing playing squash, he chooses the second option. He lists the steps as follows:

- completing the cardiac rehabilitation course
- asking a friend to nominate him for membership of the local bowls club
- enrolling in golf lessons
- asking a friend to nominate him for a position on the sports club committee.

Three months later, he is still engaged in the cardiac rehabilitation. He gave up playing bowls because he did not enjoy the game, but he has joined a golf club and his game is quickly improving. He is treasurer of the sports club. There have been strains on his marriage. You listen as he describes these problems and use a similar approach to help him to deal with them.

### **Non-specific stress reduction techniques**

In addition to the specific techniques discussed above, a number of non-specific techniques can be used to reduce stress. People should be advised to avoid major life changes in the midst of coping with major stressors. They should be reminded of the importance of dealing with problems in their lives rather than ignoring them (e.g. ongoing relationship problems). They may benefit from the controlled breathing, relaxation exercises and self-hypnosis described in Appendices 4, 5 and 6. It may be useful for them to monitor their daily activities and to use a Daily Activity Schedule that includes enjoyable activities and a regular exercise program (see Appendix 7). Advice on avoiding self-medication with alcohol, cigarettes and benzodiazepines and improving sleep habit may also be indicated (see Table 14-3). It may be appropriate to refer people to other specialist agencies that can help with their problems (e.g. for financial counselling).

### **A note on advice**

Rather than help people solve problems themselves, it is often tempting to tell them how to solve their problems. It may save time in the consultation and the 'solution' may seem obvious. However, you should resist this impulse. Telling a man what he should do will reinforce his sense of ineffectiveness and low self-esteem. Since it is the man himself who has to live with the consequences of his actions, he should take responsibility for these decisions himself. If you tell him what to do, he will be less committed to the decision and may blame you if things do not work out well.

There are exceptions to this rule. As an expert in medicine, you will give advice on the diagnosis, treatment and prevention of illness. During the crisis intervention phase, when a person's judgement is severely impaired and his or her ability to cope is overwhelmed, it may be necessary to take control and advise him or her what to do. In particular, it is often wise to advise people who are in the midst of a crisis not to make major life decisions. You should also advise people what to do in situations in which there is danger to themselves or others.

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**Structured problem solving aims to help people find solutions to their problems themselves. It is not about telling people what they should do.**

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Patients often see doctors as authorities, not only on medicine, but on many other matters as well. This attitude may be a manifestation of a paternal or maternal transference. It is flattering to be regarded this way by our patients, but generally inadvisable to act out in the counter-transference by telling people how they should run their lives. Some examples of appropriate and inappropriate advice are given in Box 6-3.

**Box 6-3: Giving advice***Appropriate advice*

- A woman consults you two days after her husband has left her. She is thinking of selling her house and moving interstate. You advise her to delay making such a major decision until the immediate crisis has settled and the advantages and disadvantages of it can be calmly and carefully considered.
- A woman tells you that her husband, who has delusions that she is being unfaithful, has threatened violence against her. You advise her to take the threat seriously and to call the police if there is any immediate threat of violence. You explain how he can get access to treatment. You also explain the legal protection available (protection or restraining order) and how to access safe houses through Crisis Care.

*Inappropriate advice*

- An elderly woman who was widowed two years ago and whose children live overseas often asks you for advice on how she should manage her affairs. One day she asks if you think she should sell her house and move to a home unit. Coincidentally, you recently decided to invest in the float of a public company that is soon to be privatised. You advise her to sell the house, move to a unit and invest her excess capital in the company.

Comment – In the transference, she speaks to you as she might have spoken to her husband or her son. In the counter transference, you make the mistake of acting as if you were her husband or son. The appropriate response would have been to use the structured problem solving approach outlined above. Amongst possible solutions, you would ask what her son suggests she should do.

**A note on 'debriefing'**

Note that 'debriefing' or crisis intervention alone is ineffective in preventing later psychological sequelae following a traumatic event. While those who are exposed to trauma have a high risk of later developing a psychiatric disorder, most who do so do not suffer an acute stress reaction at the time of the event. The key is in long-term observation and early intervention. General practitioners are well placed to do this.



# Chapter 7

## Grief counselling

In the last chapter, I discussed the principles of counselling and structured problem solving. Here, I describe the application of these principles to two specific situations that are common in general practice—counselling the bereaved and giving people bad news. Both involve helping people deal with grief, the response of a person to loss. Bereavement, physical and mental illness, redundancy, unemployment, relationship breakdowns and other stressful life events involve significant losses, including a loss of the ability to carry out valued activities, and losses of earning capacity and independence.

Whereas grief refers to the individual's response to loss, mourning is the process that people go through after a loss. It involves a number of tasks as discussed below. The general practitioner should avoid pathologising what is a normal mourning process. On the other hand, he or she needs to recognise and intervene when the mourning process is abnormal, or when a person develops a mental disorder.

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**Whereas grief refers to the individual's response to loss, mourning is a process involving a number of tasks.**

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## Bereavement

### Normal grief

Normal grief may involve a variety of feelings, thoughts, behaviours and physical symptoms. Some of these are listed in Table 7-1.

### Tasks of mourning

Worden<sup>1</sup> describes the following four tasks of mourning:

1. *Accepting the reality of the loss*

While it is normal for the bereaved to exhibit some denial of the loss, it is abnormal for the denial to persist. Denial may be manifest in a number of ways. The room of the deceased may be left as it was at the time of his or her death. The bereaved may lay out his or her clothes each morning. Alternatively, all reminders of the deceased may be removed from the house. These behaviours will cease when the reality of the loss is accepted.

2. *Experiencing the pain of grief*

Every individual experiences grief in his or her own way, and no individual will experience all of the symptoms and signs listed in Table 7-1. However, in the process of mourning, every individual needs to experience the pain of grief. Grief is often complicated when the relationship with the deceased was characterised by marked ambivalence: the person may feel guilty that they had often wished ill of the deceased. An inability to acknowledge anger with the deceased may result in the anger being displaced onto other family members or yourself.

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<sup>1</sup> Worden JW. *Grief Counselling and Grief Therapy*. London: Tavistock Publications, 1983.

**Table 7-1: Feelings, thoughts and behaviour associated with normal grief**

*Feelings*

- shock and numbness – This commonly occurs immediately after the death and is accompanied by feelings of disbelief.
- sadness
- anger – For example, a man may feel angry with his wife for abandoning her. The developmental origins of the anger of the bereaved can be seen in the protest that a child exhibits when separated from his or her caregiver. The anger may also be understood as an expression of the person's frustration in being unable to prevent the loss.
- guilt – People often feel guilty that at the time of the person's death, they had not done something to save him or her.
- anxiety – The bereaved may fear that they will not be able to cope without the deceased. They may have a heightened awareness of their own mortality.
- loneliness
- yearning – The person longs to be reunited with the deceased.
- relief – People in difficult relationships may experience some relief on the death of their partner. When the deceased suffered a long and distressing death the bereaved may be relieved that his or her suffering is over. There may be also be relief when the deceased suffered a long and burdensome illness such as dementia.

*Thoughts*

- disbelief – This is a common response on hearing of the death.
- poor concentration – The person is preoccupied and distracted.
- preoccupation with the deceased – The person is constantly thinking of the deceased.
- hallucinations – The person may see images of the deceased, especially early in the mourning process.

*Behaviour*

- sighing and crying
- vegetative function change – People who are grieving may suffer some transient sleep and appetite disturbance. Their concentration may be impaired and they may be absent-minded. (Persistent neurovegetative symptoms suggest a diagnosis of major depression).
- interpersonal withdrawal – The person may withdraw from social contacts.
- dreams of deceased
- reminders of the deceased – Some people may avoid reminders of the deceased, while others become particularly attached to photographs, clothes, jewellery and other mementos of him or her. They may visit places of special significance to the deceased.
- searching – They may call out the name of the deceased and search for them.
- activity level – Some people become withdrawn and inactive while others may be restless and overactive.
- culturally specific responses – In Anglo-Saxon cultures, there is generally less emotional display than in southern European cultures. In an Irish wake the bereaved eat and drink, and talk about good and bad memories of the deceased. In traditional Maori cultures, the body is viewed in an open casket in the home of the bereaved. In the Kaluki tribe in New Guinea, feelings of sadness and anger are combined with a feeling that compensation is due for the loss. In Iran, there is often a display of righteous anger, and an identification with the families of religious martyrs<sup>1</sup>.

*Physical symptoms*

- hollowness or churning in the stomach
- tightness in the chest or throat
- depersonalisation
- breathlessness
- weakness and fatigue
- sensitivity to noise; inability to block out background noise

<sup>1</sup>Rapheal B. *The Anatomy of Bereavement*. London: Routledge, 1994.

### 3. *Adjusting to a world without the deceased*

The nature of the adjustment will depend on the role that the deceased played in the person's life. For example, a young widow may have to get used to coming home to an empty house and caring for the children on her own. These issues often come to the fore at around three months after the death. At this time, social supports have often fallen away and the person is facing the task of getting on with life without the deceased.

### 4. *Withdrawing from the deceased and forming new intimate relationships*

The final task is to detach from the deceased and to form a new intimate relationship without feeling that the memory of the deceased is in some way being dishonoured.

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**Four tasks of mourning include accepting the reality of the loss, experiencing the pain of grief, adjusting to a world without the deceased, and withdrawing from the deceased and forming new relationships.**

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The completion of these tasks of mourning usually takes at least a year after the death of a loved one, and sometimes between three and four years.

## **Abnormal grief**

Grief is abnormal when it is chronic, delayed, exaggerated or masked.

1. Chronic grief – The normal mourning process following the bereavement of a loved one commonly lasts at least a year. When it persists too long, the person is likely to present for help or be brought to see you by the family.
2. Delayed grief – A delayed grief reaction occurs when a person has been unable to complete the tasks of mourning following the death, and instead suffers intense feelings of grief some time later.
3. Exaggerated grief – Grief may be exaggerated when the experiences cause intense suffering or become symptomatic of a mental disorder.
4. Masked grief – Rather than present with the normal feelings associated with grief, people may react by developing persistent physical symptoms. These sometimes mirror the symptoms suffered by the deceased. In other cases, the pain may symbolise the grief.

## **Factors predisposing to abnormal grief reactions**

Some characteristics of the bereaved, his or her relationship with the deceased, the manner of the loss and the person's social milieu that may predispose to an abnormal grief reaction are shown in Table 7-2.

## **Signs of abnormal grief**

Some signs of abnormal grief are shown in Table 7-3.

## **Grief and depression**

The distinction between the two is not always clear. The list of the symptoms of normal grief demonstrates the overlap between the two syndromes. A diagnosis of depression is made when the symptoms are prolonged and more severe than would be expected. Features that suggest a diagnosis of depression include severe and prolonged feelings of worthlessness and low self-esteem, suicidal ideation, pervasive feelings of guilt that do not merely relate to the immediate circumstances of the death, prolonged and severe psychomotor agitation or retardation, hopelessness, panic attacks and other anxiety symptoms, and psychotic symptoms. The depressed person typically suffers prolonged disability and handicap.

**Table 7-2: Predisposing factors to abnormal grief**

*The relationship*

Those in ambivalent relationships may have difficulty acknowledging their negative feelings about the loss, especially anger and guilt. The person who saw the bereaved as a narcissistic extension of him or herself will experience a painful sense of personal loss. The person in a dependent relationship will feel helpless and abandoned.

*The nature of the loss*

Those who are bereaved by suicide often suffer shame because of the social stigma, guilt that they had not done something to prevent the suicide, anger at the rejection and the burden that he or she must now live with, and fear that he or she or someone else in the family will commit suicide.

*Past history*

The person with past complicated grief reactions or episodes of depression is at risk.

*Personality factors*

The obsessional person may have difficulty working through the pain of grief and dealing with the loss of control. The narcissistic person who avoids being dependent on others may have difficulty dealing with the pain of grief. The dependent person may be overwhelmed with feelings of helplessness.

*Social factors*

People who perceive that they lack social supports, or whose social supports deny or cannot discuss the loss (e.g. after suicide) may also be at higher risk. Those who experience other significant life events around the time of the death may have difficulty working through the tasks of mourning.

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**Features that suggest a diagnosis of depression include severe and prolonged feelings of worthlessness and low self-esteem, suicidal ideation, pervasive feelings of guilt that do not merely relate to the immediate circumstances of the death, prolonged and severe psychomotor agitation or retardation, hopelessness, panic attacks and other anxiety symptoms, and psychotic symptoms.**

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**Table 7-3: Signs of abnormal grief**

- The person, long after the event, is unable to speak of the loss without experiencing fresh painful feelings.
- The person over-reacts to minor triggers, such as watching a movie.
- The person fails to remove the possessions of the deceased. For example, the widow who, two years after her husband's death, still lays his clothes out for him every morning.
- The person avoids memories of the deceased. For example, the bereaved may not have attended the funeral or have visited the grave.
- The person presents to you with physical symptoms identical to those suffered by the deceased.
- The person continues to suffer considerable disability and handicap for longer than a year after the death.
- Themes of loss constantly crop up in the person's conversation.

## **Grief counselling and therapy**

The tasks of mourning are usually accomplished by people on their own with the support of their friends and families. Nevertheless some will turn to you for help at these times, especially those who lack close social supports. In other cases, you will recognise some of the signs of an abnormal grief reaction or the onset of a mental disorder that has been precipitated by the loss.

Worden makes a distinction between grief counselling, which involves helping the bereaved accomplish the tasks of grief, and grief therapy, which uses specialised techniques to help people with complicated or abnormal grief reactions<sup>1</sup>. For the sake of brevity, I discuss the techniques of both counselling and therapy together.

#### *Education*

People will often be relieved simply to know that their experience of grief is neither abnormal nor evidence of a mental illness.

#### *Assisting people to accomplish the four tasks of mourning*

1. Techniques used to help a person confront the reality of the loss include talking in detail about the events surrounding the person's death and about his or her relationship with the deceased. You might ask the person to bring in mementos of the deceased and discuss their meaning.

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### **Talking in detail about the events surrounding the death and the person's relationship with the deceased helps the bereaved accept the reality of the loss.**

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2. People often have difficulty dealing with anger and guilt associated with grief. Anger is especially prominent when the bereaved was very dependent on the deceased. The person feels anger at his or her abandonment. Explore the nature of the relationship. Encourage them to express their feelings. Help the person problem-solve new ways of coping. Anger is also prominent when there is someone to blame for the death, for example after a vehicle accident.

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### **People often have difficulty dealing with anger and guilt associated with grief.**

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People whose relationship with the deceased was markedly ambivalent often experience painful guilt during their bereavement. At times, they may even have wished the person dead. Help them acknowledge their ambivalent feelings about the deceased. Talk about the death and the person's relationship with the deceased. Encourage the expression of negative affects. Explain that it is normal to have negative as well as positive feelings about people, and that to express one's anger with the person does not diminish the positive feelings one has. A specific technique is to encourage the person to talk about the things they miss, and then the things that they do not miss about the deceased.

In some cases, people feel guilty that they were unable to prevent the death. The person will usually come to realise that, in reality, there was nothing that he or she could do. In cases where there is some real reason for the guilt, it is a question of the person acknowledging what they did or did not do. In some cases, they may benefit from addressing the dead person and apologising for their actions. You might ask the person to address the deceased as if they were in the room. This can be facilitated by asking the person to imagine that the deceased is seated in an empty chair.

3. Use structured problem solving to help the person cope with the practical challenges of living without the deceased (see Chapter 6).
4. Encourage the person to form new relationships.

#### *Anniversary reactions*

Grief may recur at specific times after the death—at three months, when the practical challenges of coping without the deceased are becoming evident; on anniversaries and birthdays; and at holiday times.

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<sup>1</sup> Worden JW. *Grief Counselling and Grief Therapy*. London: Tavistock Publication, 1983.

### *Maladaptive coping*

Take note of any maladaptive ways of coping, such as excessive alcohol consumption or cigarette use.

### *Reassurance*

Avoid bland reassurance (see Chapter 2).

### *Physical examination*

Be aware of the physical symptoms that are a feature of normal grief, but do not disregard the possibility of physical illness.

### *Medication*

A short course of a benzodiazepine may be indicated for insomnia early in the period of mourning. Antidepressants should not be prescribed unless the process is clearly abnormal and the diagnosis of major depression is made.

### *Effect on the family system*

Consider the bereavement not only in terms of the individual who presents to you, but from the perspective of the family as a whole (see Chapter 5).

### *Transference and countertransference*

Feelings that the bereaved holds for the deceased may be displaced onto the therapist. These include anger at being abandoned and guilt at the bereaved person's inability to prevent the death. Within the countertransference you will experience a number of painful feelings—the frustration and helplessness of not being able to cure the person with a terminal illness; the pain of witnessing the suffering of others; the response to negative feelings being displaced onto you by the bereaved. Dealing with losses of others will activate feelings about your own losses and feared losses. You will reflect on your own mortality. You are most vulnerable in the countertransference when the patient is similar to you or shares similar experiences. It is important to recognise your own grief when a patient dies. In some cases, attending the funeral may assist your own mourning.

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## **Grief counselling and therapy often uncover strong transference and countertransference responses.**

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Worden recommends that those who provide grief counselling should take a personal loss inventory. It is important to be aware of one's own limitations and not take on too many patients suffering bereavement. Recognise the sorts of people that you have difficulty dealing with and refer them on. Dealing with death and dying is an exhausting process and can lead to burnout (see Chapter 25). Recognise your own limitations and find out where you can get help if you need it.

## **Breaking bad news**

General practitioners often face the difficult task of breaking bad news. You may have to tell a man that he has a chronic or terminal illness. You may have to inform relatives and friends of the death of a loved one. The following six steps for breaking bad news are from Buckman's book<sup>1</sup>.

### **1. Timing and place**

Wherever possible, bad news should be communicated in person rather than over the phone. If the person has a poor command of English, arrange for a professional interpreter to be present (see Chapter 4). Never use a family member as an interpreter when conveying bad news. Sufficient time should be set aside and interruptions avoided. Find a quiet and private place. If

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<sup>1</sup> Buckman R. *How to break Bad News: A Guide for Health Care Professionals*. Baltimore: John Hopkins University Press, 1992.

there are others with the patient, ask to be introduced and check with the person whether they are to stay—‘Is it OK if I talk freely about your illness while Gary is here?’ Begin the interview with an open question, such as ‘How are you feeling?’

## 2. Find out how much the person knows

Clarify how much the person knows about the illness, its seriousness and the prognosis. Find out how he or she has coped with illness and loss in the past. Note not only the content of what he or she says, but also the language he or she uses. Observe how the person is feeling. Note his or her specific concerns.

## 3. Ask how much the person wants to know

This will be the essential guide to how detailed the information you give should be. You should check how the person is responding throughout the interview. You might say, ‘I’m not sure how much detail you want me to go into. Are you the kind of person who likes to know all about their problem or would you rather have just a broad outline?’

## 4. Provide information

First, clarify the person’s agenda. What are his or her main concerns? Throughout the interview, you will try to align your understanding of the illness, its treatment and prognosis with that of the patient. Early in the interview, it is often useful to signal that you have bad news to impart—‘I’m afraid the situation is more serious than we thought’. Information should be provided in small chunks and you should stop frequently to check that it has been understood. Use plain English and avoid medical jargon. Let the person’s use of language guide yours. Reinforce and clarify what you are saying.

## 5. Acknowledge and respond to the person’s reactions

People react to bad news in a variety of ways (see Table 7-4). In order to respond effectively, first evaluate the acceptability and adaptiveness of the reaction and whether or not change is feasible. Consider also whether the person is suffering a mental disorder.

**Table 7-4: Some responses to bad news**

Feelings	Thoughts	Actions
Fear Anxiety Anger Guilt Despair Hope Relief	Disbelief Denial Why me? Bargaining Humour	Crying Threats Displacement Flattery Dependency

### *Acceptability*

Be tolerant of the person’s reactions. In some cases, the person may be angry or even violent. Try to remain calm. Acknowledge the emotion rather than argue the point at issue—‘You are very upset with this news...’. Set limits—‘I want to discuss this with you, but it is difficult while you are pacing the room’.

### *Maladaptive versus adaptive*

Assess whether a response is adaptive or maladaptive. A degree of denial is almost always present at some stage of the response. It is adaptive in protecting the person from being completely overwhelmed by the news. On the other hand, it is maladaptive if it prevents a person receiving



appropriate treatment or otherwise interferes with his or her ability to cope with the illness. The man who devotes his time to finding a cure for the condition from which he suffers may feel more hopeful, and others may also benefit from his activities. However, the response is maladaptive if it leads him to decline appropriate treatment or if it exhausts him, increases his distress or isolates him from his family and friends.

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**Denial may be adaptive or maladaptive.**

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*Changeable versus unchangeable*

In spite of being maladaptive, some responses are simply not amenable to change. Rather than exhaust yourself and the patient going over the same ground, it is sometimes better to accept that the behaviour will continue, and to provide support. For example, if a person insists on frequent changes of medication with little apparent benefit, it may be best to set aside a certain amount of time at each consultation to listen to the complaints and empathise with his or her anxiety. If you are not sure whether or not a problem can be fixed, refer the patient for a second opinion.

*Diagnose psychiatric illness*

Around 20 per cent of people with cancer or other serious illnesses develop depression. While there is some overlap between the normal responses to loss and depression, a diagnosis of depression is made if the lowered mood is persistent, the symptoms severe and specific symptoms of depression are present (anhedonia, marked vegetative function change that cannot be accounted for by the physical illness, suicidality, psychomotor agitation or retardation, psychosis, prolonged guilt, worthlessness and low self-esteem). If you are not sure, seek a psychiatric opinion.

The following communication techniques are useful when explaining bad news to people. Some of these were discussed in Chapter 2.

*Listening*

Listen and allow the person to ventilate his or her thoughts and feelings.

*Open-ended questions*

Rather than respond directly to a statement of the patient—‘It can’t be true.’ ‘Well, I’m afraid it is.’—it is often better first to deepen your understanding of the way the person feels—‘How are you feeling now? What is running through your head at the moment?’

*Empathic responses*

Rather than respond in a literal way to the content of what a person says, it is often better to respond first to the emotion behind the statement—‘It must be hard to believe you have this illness, especially when you have always been so fit. You feel angry that this was not picked up earlier’.

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**Open-ended and empathic responses are generally more effective than direct or literal responses.**

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*Avoid false reassurance*

As mentioned in Chapter 2, reassurance has its place. For example, you may allay a man’s fears by reassuring him that you can provide pain relief for his symptoms. However, there may be times when, in an attempt to alleviate a man’s immediate distress you are tempted to mislead him. When subsequent events do not go as you predict, the distress will be so much the worse.

*Answering difficult questions*

‘How long have I got?’ First, clarify exactly what the person means. He or she may not be asking how long before they die, but, for example, how long before they leave hospital. Ask what they understand their prognosis to be. Give the person a ballpark figure—‘It will probably be from two to three months to five or six months’. Acknowledge your uncertainty and empathise with



the anxiety that this uncertainty causes.

‘Is it terminal?’ Check what the person means. Ask a man what he understands the prognosis to be. A statement along the following lines may be helpful—‘I have one patient with the same condition who is still doing well and has had no recurrence after three years’.

#### *Transference and countertransference*

Be aware of the transference and countertransference. Communicating bad news is difficult and often painful. Telling a person that they have an incurable illness acknowledges the limitations of medical knowledge. Doctors may have particular difficulty with this task. One of the motivations for entering the medical profession may be a heightened fear of death. You may feel guilty that you neglected something that might have altered the course of the illness. You may resent having to be the messenger of bad news, and the target of the anger and blame that often fall on the messenger. Breaking bad news may not have been included in your medical training.

You may also have to deal with difficult transference responses, including flattery and dependency. It is easy to be flattered when a man says that you are the best doctor he has ever had. However, you may regret this later when you struggle to meet the special expectations the person places upon you. It is best to articulate and correct the perception at the beginning—‘It is nice of you to say that, but, really, this drug is very effective’. It is normal for people in distress and under threat to be more dependent. However, it is important not to begin making decisions for the person that are outside your area of expertise and should really be made by that individual, perhaps with advice from his or her or relatives.

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**Transference responses to receiving bad news include idealisation of the therapist and excessive dependency upon him or her.**

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## **6. Planning**

At the end of the interview, summarise your understanding of the illness, the treatment and the prognosis, and the specific concerns raised by the patient. Give the person time to ask questions. Make a time for the next appointment.



# Chapter 8

## Supportive psychotherapy

For some people with chronic mental disorders, the ability to cope with life challenges is not just temporarily overwhelmed in the face of life stressors, but rather it is chronically impaired. Supportive psychotherapy is indicated for this group of people. Despite the fact that it is a form of therapy that is widely used by psychiatrists, general practitioners and other health professionals, research into it has, until recently, been relatively limited<sup>1</sup>.

### Background

#### Definition

Supportive psychotherapy is a form of long-term psychotherapy that aims to optimise patients' functioning, promote their autonomy, enhance their self-esteem, and lessen their anxiety and distress. Unlike other forms of therapy, supportive psychotherapy does not aim to produce major change in the person. While behavioural treatments aim to alter the way people act, cognitive therapy the way people think, and dynamic therapy the patterns of their defences, supportive psychotherapy aims not to change, but rather to strengthen their existing coping mechanisms.

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**Supportive psychotherapy is a form of long-term psychotherapy that aims to optimise a person's functioning by strengthening rather than changing his or her existing coping style.**

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#### Indications

Supportive psychotherapy is the treatment of choice for people with chronic disabling conditions in whom fundamental personality change is not a realistic goal. These people are often severely handicapped, with a limited range of interests and activities, and impoverished social worlds. They are often isolated and what relationships they have are often fraught with conflict. Their ability to cope with the everyday challenges of life is limited and they have few social and other resources to assist them. Included are people with chronic psychotic disorders (schizophrenia, delusional disorder), severe affective disorders (chronic depression, bipolar disorder), anxiety disorders (post-traumatic stress disorder), somatoform disorders (chronic pain, hypochondriasis, somatisation disorder) and personality disorders. However, not all people with these diagnoses require long-term supportive therapy. Many are able to cope well despite their illnesses, and have strong social supports.

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**Supportive psychotherapy is the treatment of choice for people with chronic disabling conditions in whom fundamental personality change is not a realistic goal.**

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#### Aims

In view of the severe disability and handicap suffered by these people, the goals of treatment are modest. In some cases, merely maintaining the person's level of functioning is the appropriate

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<sup>1</sup> Bloch S. Supportive psychotherapy. In: Bloch S, Ed *An Introduction to the Psychotherapies*. 3<sup>rd</sup> ed. Oxford: Oxford University Press, 1996: 294–319.

goal. The overall aim is to optimise the patients' adaptation to living. Specific aims are to optimise their social and occupational functioning, to help them deal as adaptively as possible with life challenges, to acknowledge and cope with their losses, to boost their self-esteem, to improve their reality testing, to monitor their mental states and prevent relapse of their illnesses, to support their families and other carers, to provide a source of comfort and security, to promote their autonomy, and eventually to transfer support from therapy on to the individual's family and other people in their social milieu.

### **Treatment setting**

Unlike the other therapies described in this book, supportive psychotherapy is not time limited but rather long-term. In general practice, sessions will usually be between 15 and 25 minutes. Regular appointments should be made, usually at two or four weekly intervals. You will need to discuss your own availability out of hours and arrange whom the person should contact in an emergency. Where possible, you will speak to family members and other carers. You will need to liaise with other agencies involved in the person's care that may include the local mental health service, employment and housing agencies, and patient and carer support groups.

### **Techniques of therapy**

A number of methods discussed elsewhere in this book are applicable. Basic interview skills are required—taking a history, listening, clarifying, allowing the expression of feelings, asking directive psychological questions, using an empathic style, and responding to verbal and nonverbal cues (see Chapter 2). Most important is the ability to listen to the patient, to clarify what he or she says, and to be alert to any significant change, whether for better or for worse.

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**Basic interview skills are important in supportive psychotherapy—history taking, listening, clarifying, allowing the expression of feelings, asking directive psychological question, using an empathic style, and responding to verbal and non-verbal cues.**

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Be aware too of the non-specific aspects of the interview that contribute to the efficacy of therapy: the intense, confiding relationship; the setting in your surgery; the acknowledgment of your credentials as a 'healer'; your ability to instil hope; your provision of new information; the person's emotional arousal in discussing personal events; and his or her experience of improvements in symptoms and functioning<sup>1</sup>.

At different times in therapy you will use crisis intervention and structured problem solving to deal with acute stressors. Various behavioural techniques may also be indicated—for example, the use of activity schedules and programs of exposure for the treatment of phobias. Many people will be on drug treatments for their mental disorder. The following techniques are used in supportive psychotherapy. Care needs to be taken in their use. I give examples of their appropriate and inappropriate use.

### **Holding and containment**

The ability of the therapist to be there for the person provides a point of stability and security in his or her otherwise chaotic world. The comfort these people have in knowing that you are there for them can soothe them when they are under stress. In facing a difficult situation, a person may imagine what you might do before he or she acts.

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<sup>1</sup> Frank JD. Common features of psychotherapy. *Australian and New Zealand Journal of Psychiatry* 1972; 6:34–40.

Often in therapy, the best intervention is to listen and do nothing rather than to do something that is ineffective or even destructive. On the other hand, it is important to recognise when a dysfunctional, though stable situation has changed and requires active intervention (see Box 8-1).

### **Box 8-1: Holding and containment**

A 38 year-old woman with chronic schizophrenia complains of ongoing problems in the relationship with her defacto partner. There are no safety issues, but repeated attempts to ameliorate the difficulties through couple counselling have been ineffective in producing change. Nevertheless, the relationship has survived. There have been no recent changes in her mental state. You anticipate that she will continue to discuss these problems with you from time to time. You observe for any significant changes. At the same time, you accept that while there are likely to be continuing difficulties in the relationship, it is presently in a state of equilibrium.

#### *Caveat*

A 45 year-old woman suffers from chronic schizophrenia. She is of borderline intelligence and demonstrates histrionic and obsessional personality traits. There have been long-term difficulties in the relationship with her husband who also suffers from schizophrenia. The conflicts have usually arisen in the context of her need to be in control and to keep their house tidy, while her husband remains unconcerned about these matters and is not always willing to help. She has been more upset over the past three months. She has been sleeping poorly and has lost the energy to do the housework. She takes a minor overdose of temazepam. At this point, it is essential to realise that the situation has changed. She is suffering major depression and requires treatment for it.

## **Genuineness**

In comparison with other forms of psychotherapy, part of the role of the therapist in supportive psychotherapy is to be a model for the patient. Some minimal self-disclosure may even be appropriate. For example, you should give matter-of-fact answers to questions about where you are going on leave. You may give some acknowledgment that your life is not as perfect and ideal as he or she assumes. You may share a joke. On the other hand, it is quite inappropriate to discuss specific aspects of your life or your personal problems. This blurring of boundaries will only confuse the person over your role as a professional or a friend, as helper or helped (see Box 8-2).

### **Box 8-2: Genuineness**

A person says to you, 'Being a doctor and with all your money, you wouldn't have any problems'. Without being specific, you can assure the person that you face problems in your life too.

#### *Caveat*

You do not take this further and begin ventilating your financial problems to the person.

## **Reassurance**

The role of reassurance in therapy was discussed in Chapter 2. Reassurance is used more frequently in supportive psychotherapy than in most other forms of psychotherapy. Make sure that the reassuring statement is true and not merely a bland platitude (see Box 8-3).

### **Box 8-3: Reassurance**

- A man had a panic attack while waiting in line to buy tickets for a concert. He was convinced he was having a heart attack. After taking a history, examining him and performing the necessary investigations, you are able to reassure him that there is no evidence of any heart problems, but that his symptoms are typical of a panic attack. You then explain the treatment of panic attacks.
- A young man with schizophrenia is upset after someone remarks that the job he does in the family fruit and vegetable shop is too easy. He feels he is letting his family down by not contributing more. You ask his mother to come into the consultation. She states that the family is very pleased with his work. Although his duties are somewhat less demanding than those of the others employed in the shop, they recognise his disabilities and note that he has only had one day off work in the last six months when he had the flu. You remind him that many young men of his age, without a disability, have difficulty finding work. Moreover, many with his disabilities do not work at all.

#### *Caveat*

A man with post-traumatic stress disorder complains of disturbing nightmares, often relating to his experience in Vietnam. He wakes around four times every night. Calculating that he nevertheless does get, on average, six hours sleep, you attempt to reassure him that his sleep is quite adequate. He fails to turn up for his next appointment.

### **Positive reframing**

Even adverse events may have some positive aspect (see Box 8-4).

### **Box 8-4: Positive reframing**

A young man with schizophrenia is upset after attending the wedding of an old school friend. He does not have a girlfriend and is aware of how his illness limits his options in life. While acknowledging the man's grief, you add that there may nevertheless be some benefits of suffering the illness. While most of his friends probably have little understanding of what it is like to suffer a chronic illness, mental or physical, he is learning about this at an early age. He can use this knowledge to his advantage by looking after his physical health. At some stage his friends will develop some illness, something that will be new and hard for them to cope with when they are in their middle-age or older.

#### *Caveat*

This must be done sensitively. The statement you make must be true and should not be presented in a way that fails to acknowledge the reality of the losses that he suffers.

### **Explanation**

Education of the person and the family about his or her illness is an essential component of treatment. People with severe disorders may have distorted perceptions of reality that adversely affect their judgement and behaviour. Clarification and explanation of the reality of a situation will help them meet challenges in more adaptive ways (see Box 8-5)

### **Box 8-5: Explanation**

- You explain to a young woman with schizophrenia and her family about the illness, its symptoms, suspected causes, treatment and prognosis. You make yourself available to answer questions and you refer the parents to the family education program at the local mental health service, and the young woman to the patient education program.
- A man with schizophrenia has long standing delusions that he has been chosen by God to perform some important act, the nature of which is not clear to him. He is often frustrated that others do not share his conviction. You acknowledge that you must agree to disagree about the nature of his beliefs. You believe that they are a symptom of his illness. You nevertheless respect the reality of these experiences and their importance to him. You seek common ground in aiming to optimise his work, leisure and social functioning.

#### *Caveat*

In telling a man that he suffers from early dementia, you do not offer unsolicited comments about the worst case outcomes. Nor do you argue strongly about the doubtful scientific efficacy of an inexpensive herbal treatment that he has faith in. Instead you are guided by his questioning (see also Chapter 7). The relatives and family may want more explicit information.

### **Advice**

The use and misuse of advice were discussed in Chapter 6. Because of the person's limited coping skills, you will give advice more frequently in supportive psychotherapy than in other forms of psychotherapy. You will give advice about treatment of the illness and when and how to seek help; about every day problems such as budgeting, diet, good sleep habit and general self-care; and on social and interpersonal skills—for example, being assertive or how to behave on social occasions (see Box 8-6).

### **Box 8-6: Advice**

In treating a young man with schizophrenia, you offer advice on a number of matters in addition to the treatment of his illness. You suggest that he arranges a direct debit from his bank to pay his rent each pension day. You provide him with dietary advice to help prevent excessive weight gain while he is taking antipsychotic medication. When he asks for a prescription for temazepam to help him sleep, you point out that, because he sometimes sleeps 15 hours a night, it is expected that he will have difficulty falling asleep the following night. You advise him to get up at a regular time every morning. You recommend that rather than attempt to return directly to full-time work, it might be better to first seek some part-time work. You suggest that he could meet some people with similar problems at Schizophrenia Fellowship.

#### *Caveat*

A woman has numerous complaints about her husband. Unless there are compelling reasons that she is at risk—for example, if he is violent—it would be quite inappropriate for you to advise her to leave him. She must make such decisions herself.

### **Suggestion**

Whereas advice involves giving a person explicit instructions about what to do in a particular situation, suggestion seeks to modify a person's behaviour by showing or withholding approval for their actions (see Box 8-7).

### **Box 8-7: Suggestion**

The defacto partner of a young woman has assaulted her in the past. Last week when he came in an intoxicated state to visit, she refused to let him in. You congratulate her on her self-assertion.

#### *Caveat*

You take care not to collude with a young man as he laughs about his criminal activity.

### **Encouragement**

By making encouraging statements about a person's actions you enhance his or her self-esteem, reduce his or her sense of ineffectiveness and promote further positive actions. Like reassurance, encouragement must be genuine and realistic if it is to be beneficial. It is important to stay alert to the possibility of change and progress. In view of the long-term nature of therapy and the low expectations of change, there is always the danger of missing or ignoring changes when they do occur (see Box 8-8).

### **Box 8-8: Encouragement**

- When a man with schizophrenia tells you of his plans to spend two weeks in New Zealand with a friend, you congratulate him on his initiative. You ask him to describe the plans in detail and offer any commonsense suggestions. You check that he has a plan for getting help if he needs it. On his return you ask about the trip and congratulate him on doing something so challenging. Later, at times when his confidence is low, you remind him how well he managed on the trip to New Zealand.
- You make a polite comment about a person's appearance—'That new hairstyle suits you'.

#### *Caveat*

A young woman with borderline personality disorder who has not worked for five years intends to return to full-time work. You congratulate her on her initiative, but remind her that she might be better off trying some part-time work initially.

### **Transference and countertransference**

While being informed by the transference, you will generally not interpret it in supportive psychotherapy. It is essential to monitor your countertransference. Because all of the techniques discussed here can have adverse as well as beneficial consequences, you need to be clear about whether an intervention is truly to help the patient or is instead an acting out of your own frustration, boredom, rescue fantasy or other feeling or impulse (see Box 8-9).

### **Box 8-9: Transference**

- A man with severe post-traumatic stress disorder is angry when you are 20 minutes late for his appointment. You recognise his resentment and explain why you were running late.
- You are seeing a 28-year-old woman who has a five-year history of severe disorganised schizophrenia. She first presented during her first year at medical school. You take care to set realistic goals for her treatment and rehabilitation. Otherwise, your identification with her may lead you to entertain unrealistic fantasies about what she can achieve that in the long-run may only lead to disappointment for her and frustration and burnout for you.

#### *Caveat*

You might understand the rage of a woman with borderline personality disorder as a reflection of her identification with her stepfather who abused her as a child. However, an interpretation along these lines is only likely to make her more upset.



## Interpreting defences

Though the interpretation of defences does not play a major role in supportive psychotherapy, there are times when it is useful to clarify how a person feels, and to discuss maladaptive ways that he or she responds to events. A useful technique is to ask a (man) to reflect back on how he reacted to a stressful event, after the event has passed and he is calm—‘Strike while the iron is cold’.<sup>1</sup>

Remember that the ego defences are deployed as a solution to problems. Removing them will, at least initially, lead to an increase in anxiety. In the face of unavoidable external stressors (for example, suffering a severe and chronic illness), some degree of denial is often adaptive (see Box 8-10).

### Box 8-10: Interpreting defences

A middle-aged man states that he has been depressed since taking redundancy from his job two years before. After describing the circumstances of the loss of his job, you are able to clarify that, in addition to feeling depressed at his loss, he is also angry with his former employer and ashamed at his reduced ability to provide for his family.

#### *Caveat*

A 46-year-old woman with schizophrenia is upset and contemplating suicide after repeated arguments with her daughter. After her daughter is diagnosed and treated for post-natal depression, her distress subsides. You are then able to discuss and clarify the cause of her upset.

## Improving social supports

The techniques of interpersonal psychotherapy are applicable here (see Chapter 1). High levels of expressed emotion in the families of people with mental health problems may exacerbate their conditions. On the other hand, strong social supports improve a person’s prognosis and limit his or her disability and handicap (see Box 8-11).

### Box 8-11: Improving social supports

The course of a young man’s schizophrenic illness is complicated by substance abuse. His parents are frustrated at their difficulty getting help and they make written complaints about the care offered by yourself and the local mental health service. You spend several sessions with the parents explaining the facts of the illness and the substance abuse, and answering their questions. You empathise with their feelings of helplessness and attempt to address any shortcomings in his previous management. You discuss, in a matter-of-fact way, the limitations on what you can do, especially about the substance abuse. You later find that the parents remain the young man’s principal supports. They are more readily able to accept the limitations of what they can do, as well as the limitations of what you can do.

#### *Caveat*

A young man with chronic schizophrenia has little social contact outside his immediate family. He is, nevertheless, satisfied with this, as are his parents. While you remind him of the availability of various social activities, you do not press him too hard to engage in these.

## Catharsis

Within a trusting therapeutic relationship, a person may be able to reveal events in their lives that they have been unable to discuss with anyone else (see Box 8-12).

<sup>1</sup> Pine F. Supportive therapy, a psychoanalytic perspective. *Psychiatric Annals* 1986; 16: 526-529.

### **Box 8-12: Catharsis**

After seeing a man for several years for treatment of chronic post-traumatic stress disorder, he weeps as he confides that while serving in Vietnam, he had an illegitimate child whom he has been supporting over the past 25 years.

#### *Caveat*

While respecting a young woman's need to discuss her past sexual abuse, you nevertheless focus on helping her deal more effectively with her current problems.

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**Techniques of supportive psychotherapy include holding and containment, genuineness, reassurance, positive reframing, explanation, advice, suggestion, encouragement, monitoring the transference and countertransference, interpreting defences, improving social supports and allowing catharsis.**

---

### **Problems in supportive psychotherapy**

All of the techniques described above present dialectical dilemmas in their application: how actively to intervene; when and how much to self-disclose, deciding whether or not a reassuring statement is true, how comprehensive an explanation should be; whether to ignore or confront a person's denial; when to give advice what is appropriate encouragement; how actively to embark on a plan of rehabilitation; deciding the appropriate goals of rehabilitation; when it is useful to promote an emotional catharsis versus when to move on; and deciding whether an intervention is for the sake of the patient or to satisfy an impulse of your own.

It is difficult to strike the right balance between providing support to the person while not promoting excessive dependence. Given these patients' levels of disability, some degree of dependency is inevitable. On the other hand, promoting excessive reliance on your guidance may cause the person to regress and act in less adaptive ways. An excessively directive approach may reinforce a person's feelings of helplessness and further compromise his or her ability to act autonomously. Since the people who are offered supportive psychotherapy often have great difficulty in personal relationships, maintaining a therapeutic alliance with these people is often difficult.

Moreover, the limited gains made over long periods of time can be demoralising and frustrating for the therapist. It is essential to monitor your countertransference to prevent acting out in the therapy. It is probably wise to limit the number of severely disabled people that you take on. Countertransference problems are best addressed in supervision and through peer support groups.

In comparison with other forms of therapy, the therapist in supportive psychotherapy reveals more of him or herself to the patient, at times even providing some minimal self-disclosure. It is a constant challenge deciding what, when and how much to self-disclose. Are you disclosing for your own purposes or for the good of the patient? Be careful not to blur the professional boundaries between therapist and patient. Remember that the relationship is different from a friendship. There is not the same expectation of mutuality, since the therapist is there for the patient and not vice versa. A failure to clarify the boundaries will confuse the person and may lead him or her to make excessive demands upon you. Other boundaries may also be breached more easily in supportive psychotherapy. For example, although you will always try to involve family and carers in treatment, you must still respect the person's right of confidentiality.

Finally, there is a danger that in providing support, you may inadvertently perpetuate problems by maintaining equilibrium in a system that removes the impetus for a person to change. For example, regular visits to a therapist may prevent a person from doing something about his or her relationship problems.

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**Beware that therapy is not perpetuating problems by maintaining an equilibrium that removes the impetus for the person to change.**

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# Chapter 9

## Behavioural treatments

Behavioural techniques derive from learning theory, which holds that both adaptive and maladaptive behaviours are learned through our interaction with the environment. Three models of learning are described—classical conditioning, operant conditioning and social learning. A brief overview of behavioural treatments follows together with a case example.

### Classical conditioning (associative learning)

Pavlov performed the classic experiment. A dog salivates when presented with food. A bell is then sounded each time the dog is offered food. After several repetitions, the dog salivates on hearing the bell, even in the absence of any food. The bell has become a conditioned stimulus to produce a response mediated by the dog's autonomic nervous system. The response becomes attenuated if the bell continues to be rung while not paired with the presentation of food.

Watson performed a similar experiment on an infant referred to as 'Albert B'. Albert began the experiment playing happily with a white mouse. A frightening stimulus (a loud noise) was then applied whenever Albert touched the mouse. After several repetitions of the experiment, the boy became upset and fearful when presented with the mouse, even if no noise was made. Stimuli similar to the mouse, for example a white rabbit, also distressed him—that is, the response became generalised.

Two clinical examples of classical conditioning are shown in Box 9-1.

#### Box 9-1: Classical conditioning

- A young boy is bailed up by the neighbour's Alsatian dog. Over the following weeks, he becomes upset and starts crying whenever he sees the dog. Later he becomes frightened even of small dogs and other domestic animals (generalisation).
- A Vietnam veteran who suffers from post-traumatic stress disorder has a panic attack while watching a news item on a battle in Kosovo. Images of battle have become a cue to re-living the anxiety of his combat experience.

**Classical conditioning helps us understand the origin of phobias and the cues to anxiety and other affective states.**

### Operant conditioning

Operant conditioning explains how the frequency of a behaviour is increased or decreased.

#### Positive reinforcement

Skinner performed the following experiment. He placed a rat in a cage in which there was a lever that, when pressed, released a pellet of food. Initially, the rat only pushed the lever by chance. Then, as it learned the consequences of its action, the frequency at which it pushed the lever increased. Eventually, the rat was pushing the lever most of the time, even when it could not eat any more pellets. The pellet of food positively reinforced pushing the lever.

#### Negative reinforcement

Another experiment involved a rat receiving an electric shock whenever it went to one end of its cage. It quickly learnt to escape by running to the other end and staying there. In this case,

relief from an aversive stimulus (the electric shock) is a negative reinforcer of the avoidance behaviour.

## **Punishment**

Finally, the frequency of a particular behaviour can be reduced if an aversive stimulus or punishment follows the behaviour. In contrast to negative reinforcement, which increases the frequency of a behaviour (avoidance), punishment reduces its frequency.

Examples of operant conditioning are shown in Box 9-2.

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### **Operant conditioning explains how the frequency of a behaviour is increased or decreased.**

---

#### **Box 9-2: Operant conditioning**

- *Positive reinforcement*

Adam is the eight-year-old only son of a young professional couple. He sees little of them during the day, and they are usually too tired to spend much time with him when they get home. In response to the tantrums he has been having over the past month, both parents stop whatever they are doing and turn their attention to trying to placate him. The tantrums are becoming more frequent and lasting longer.

- *Negative reinforcement*

Joyce had a panic attack at the supermarket three weeks ago. She ran out of the building, leaving her shopping behind, and she has not returned there since. The relief from anxiety negatively reinforces her avoidance behaviour.

## **Social learning**

Bandura noted that we also learn by observing the behaviour of others and its consequences for them. For example, we learn to speak through imitation of our parents (see clinical example in Box 9-3).

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### **Social learning explains how new behaviours can be learned by observing others.**

---

#### **Box 9-3: Social learning**

During treatment for her needle phobia, Tracey was able to observe her older sister having an injection without getting upset, and then being congratulated by her mother and the doctor.

## **Behavioural approaches to treatment**

In the following sections, I outline the approaches to behavioural assessment, treatment and outcome evaluation. I then provide a case example.

### **Behavioural assessment**

A behavioural assessment begins by operationalising the problem behaviour—that is, by describing the behaviour in a measurable and specific way. The second step is to explore what happened before and after the behaviour in order to identify any reinforcers. The third stage is to set the goals of treatment.

---

### **Behavioural assessment involves operationalising the target behaviour, clarifying its antecedents and consequents, and setting the goals of treatment.**

---

## Treatment

Some behavioural treatment techniques are listed below.

1. *Counselling and problem solving* (see Chapter 6 and Appendix 3)
2. *Methods of arousal reduction* – These include controlled breathing, progressive muscular relaxation and self-hypnosis. They are described in the handouts for patients in Appendices 4, 5 and 6.
3. *Daily activity schedules* (see Appendix 7) – By becoming more active, a person regains access to sources of positive reinforcement. Documenting pleasurable activities will correct the depressed person's perception that he or she is unable to gain any pleasure or satisfaction from life activities. A daily activity schedule can be used to document baseline functioning and the progress of treatment.

It is often useful to suggest that patients incorporate some pleasurable activities, exercise, duties or chores, and social activities in their day. They can then document the actual activities and rate their responses to them using the schedule.

4. *Exposure* – This involves the construction of a hierarchy of feared situations that the person then confronts in order from least fearful to most fearful. The person may first confront his or her fears in imagination before doing so in vivo. It is explained in the patient handout in Appendix 8. The person must stay in the feared situation: if she or he escapes, the relief from anxiety negatively reinforces the avoidance behaviour. Changes in the person's level of anxiety can be documented using the Subjective Units of Distress Scale (SUDS), (see Figure 9-1).

The person can document how the level of anxiety falls when he or she stays in the situation (habituation), (see Figure 9-2). In order to maximise the efficacy of the treatment, patients should not be prescribed a benzodiazepine and should not take any safety devices with them such as mobile phones. The efficacy of the treatment depends on the person confronting his or her anxiety.

By rating the peak level of anxiety experienced at each exposure, the person can also document the lessening of anxiety on each occasion (desensitisation), (see Figure 9-3). To promote desensitisation, the person should confront the feared situations regularly and frequently.

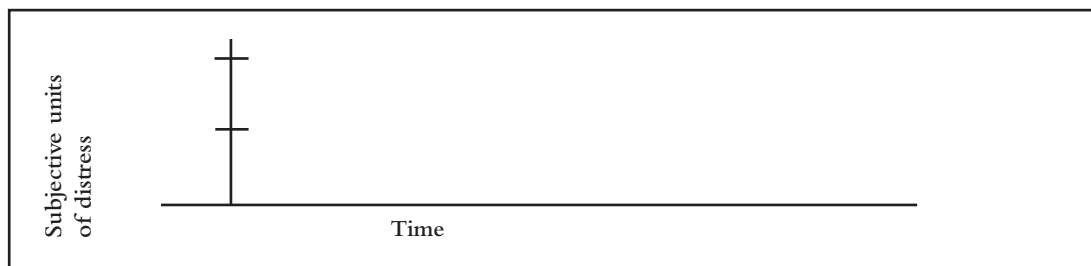
5. *Exposure and response prevention* – This is the treatment of choice for the rituals of obsessive-compulsive disorder. The person is asked to confront his or her fears (exposure) without performing the ritual (response prevention). Instead of using the ritual to decrease the anxiety, the person is asked to wait until his or her anxiety subsides through habituation. For example, a woman with obsessional fears of contamination may be asked to touch a door handle and then go about her usual activities without washing her hands. The person is then asked to work through a hierarchy of feared situations as described above.
6. *Goal setting* – Goal setting is an important part of rehabilitation for chronic mental disorders. The first step is to engage the person in the process of change, discussing the pros and cons of staying the same or moving on. The next step is to identify problem areas and to reformulate these as needs: for example, a man's problem of being bored might be reformulated as, 'I need to become involved in some interesting activities.' A list is then made of his strengths and other resources, including any specific talents (e.g. sporting or musical ability), people who will help, specific interests and past interests. Goals are then set that use the resources available to meet his needs. It is essential that the goals are realistic: if they are too difficult, the man may only be setting himself up for failure. On the other hand, they should be a challenge to him. A goal also needs to be formulated in a specific operationalised form. For example, rather than, 'Going to the movies,' it could be, 'Going to see Titanic on Wednesday

night at the Hyperdome with Richard.’ Long-term goals need to be broken down into small steps. For example, the goal of returning to work might involve an occupational therapy assessment, referral to a job support agency, preparation of a resume, commencing work eight hours a day, then building up over a period of months. Progress should be monitored. People are praised for the goals they fully or partially attain. The assessment of progress determines the next step to be taken.

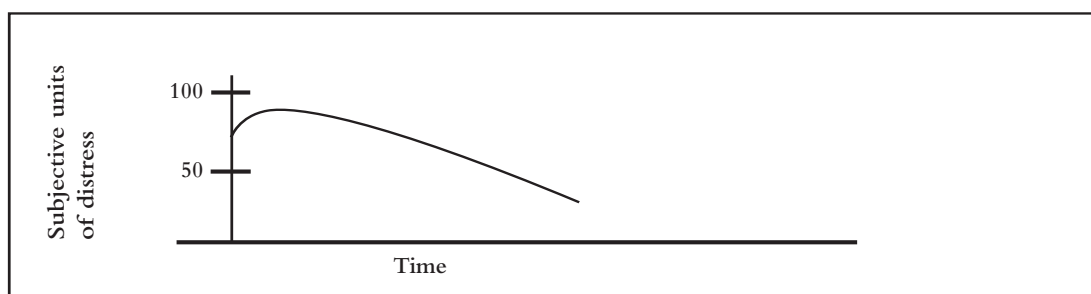
## Outcome evaluation

The SPHERE-GP<sup>1</sup> is a useful tool for assessing the outcomes of treatment (see Appendix 1).

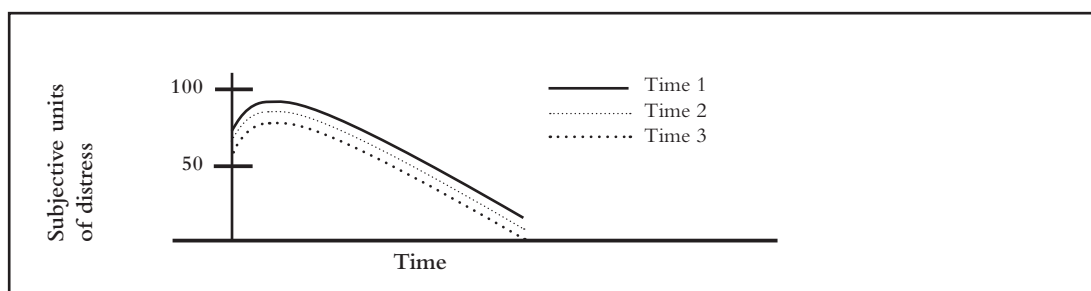
**Figure 9-1: Subjective units of distress scale (SUDS) plotted over time**



**Figure 9-2: Habituation**



**Figure 9-3: Desensitisation**



## Case example

### *Behavioural assessment – operationalised account*

Jane presents to you after suffering a panic attack in a cinema. She begins by saying, ‘I felt terrible’. After further questioning, the operationalised account of what happened might be as follows: ‘I was convinced that I was going to die. My heart was racing and I felt as if I was going to pass out. My fingers were tingling and I was gasping for air because I felt as if I was choking’. A careful history and mental state examination excludes an additional diagnosis of depression.

<sup>1</sup>Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T and Naismith S, Koschera A. *The SPHERE Program: A training manual for treating depression and anxiety in general practice*. Kogarah: Educational Health Solutions, 1998.



*Behavioural assessment – antecedents and consequents of the behaviour*

Jane states that she has been very worried about various financial problems over the past six months. She has been ruminating over them and sometimes feels she will never get on top of them. Last Friday night, she went alone to see a movie, hoping to take her mind off her other worries. Twenty minutes into the movie, she had the panic attack.

During the panic attack she felt that she had to get out of the theatre. Once outside, she felt better. She drove quickly home, buying a packet of cigarettes on the way. She smoked 10 of them and also drank three glasses of wine before going to bed.

*Behavioural assessment – setting the goals of treatment*

Jane and her therapist settle on the following three goals:

1. to develop a plan to deal with her financial problems and to avoid maladaptive patterns of coping such as substance abuse
2. to learn to understand her anxiety symptoms and to control them
3. to be able to go to a movie on her own.

*Counselling and structured problem solving to deal with financial problems*

Counselling begins by clearly defining the problem—her income versus her recurrent costs of living and her debts. Various options are explored: sending back the furniture that she is buying on lay-by; re-financing the loan to pay off her car (or selling the car); reducing her cigarette consumption; getting a part-time job in the evening. Having discussed the pros and cons of each possible solution, she chooses a plan of action. She writes down each step that she needs to take to implement the plan. The plan is then put into action. Later, its effectiveness is assessed and changes made where necessary.

*Treating the anxiety symptoms*

The therapist explains the nature of anxiety; its physical, psychological and behavioural manifestations; the fight and flight response; the relationship between anxiety and performance; and the causes of anxiety.

She is then taught a method of arousal reduction (progressive muscular relaxation) and a breathing control technique. She is encouraged to practice these every day. As well as becoming more proficient in their use, the practice also enables her to experience what it feels like to be relaxed. The breathing control is also used to abort the onset of a panic attack.

A cognitive approach is also used (see Chapter 10). She is asked to keep a diary of the dysfunctional thoughts that she has at times when she is feeling anxious. One entry from this diary is shown in Box 9-4.

**Box 9-4: The five-column technique of cognitive behavioural therapy**

<b>Situation</b>	<b>Emotional response before</b>	<b>Automatic thought</b>	<b>Rational response</b>	<b>Emotional response after</b>
Went to cinema alone	Anxious (rating: 40/100)	I cannot cope. (rating: 60/100)	I have been able to do this in the past. I can use my breathing control technique to control the anxiety. I managed to go to the cinema with Robyn last week.	A little anxious (rating: 15/100) (rating of strength of belief in automatic thought: 15/100)

### *Treating the avoidance behaviour*

Graded exposure is used to attain the third goal—going to the cinema. First, Jane is taught about the theory of exposure. She is told that escaping from the cinema will only worsen the problem, because the avoidance is rewarded by a fall in anxiety. Therefore, she should only expose herself to situations that she is confident she can tolerate. If she stays in a feared situation, her anxiety level will fall. She can prove this by documenting her level of anxiety during exposure (habituation). Each time she enters a particular feared situation, she will experience a little less fear than she did the time before (desensitisation).

She is asked to construct a hierarchy of feared situations from least feared to most feared. She rates the amount of anxiety that she expects to experience at each step on a scale from 0 to 100 where 0 means no anxiety and 100 is maximal anxiety (see Box 9-5).

### **Box 9-5: Hierarchy of feared situations with rating of anticipated anxiety**

<b>Situation</b>	<b>Anxiety rating</b>
Go to cinema alone on a busy Friday night.	85
Go to cinema alone on a quiet day (mid-week afternoon).	70
Go to cinema with Robyn. She leaves me at the door.	60
Go to cinema with Robyn. She moves to another seat after 10 minutes.	45
Go to cinema with Robyn.	30

Having assured herself that she will be able to manage the first step, she puts it into action. As part of her homework, she rates the peak anxiety level during each exposure. When this has fallen to around 50 per cent of the predicted anxiety level, she is ready to proceed to the next step. She will notice that her anxiety levels are lower on each repetition of a step.

### *Documenting the outcomes of treatment*

The SPHERE<sup>1</sup> instrument is used to assess her condition before, during and on completion of the treatment.

## **Training in behavioural treatments**

While many of the techniques described in this chapter may seem straightforward, a common reason for failure of therapy is a haphazard approach to treatment. For example, exposure of a person with agoraphobia to a situation that he or she cannot tolerate will only reinforce his or her avoidance behaviour. If you do not have enough time to perform these techniques, refer the person to a specialist in the area, such as a clinical psychologist. If you are interested in using the more complex techniques, it is advisable to have training and supervision from a specialist in the area.

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<sup>1</sup> Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. *Treating Depression and Anxiety in General Practice: Training Manual*. Kogarah: Educational Health Solutions, 1998.

# Chapter 10

## Cognitive behavioural therapy (CBT)

This type of psychotherapy has proven effectiveness in the treatment of mild and moderate depression, panic disorder, agoraphobia, eating disorders and personality disorders. Its basic premise is that disturbed mood is caused by distorted, negative and maladaptive thinking. Disturbed mood, in turn, produces negative ways of thinking. CBT seeks to improve mood by identifying and challenging negative thoughts and replacing them with more realistic and adaptive ones. Useful references include the books by Hawton et al.<sup>1</sup> and DeRubeis<sup>2</sup>. Self-help books include those by Tanner and Ball<sup>3</sup>, Burns<sup>4</sup> and Beck and Greenberg<sup>5</sup>.

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**CBT is based on the premise that disturbed mood is caused by distorted, negative and maladaptive thinking.**

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The cognitive model described by Aaron Beck puts forward three concepts to explain the origin of depression:

- a) the cognitive triad
- b) schemas
- c) cognitive errors

In reading this chapter, you may recognise a number of techniques that you already use. If so, I hope that the discussion helps you organise your interventions and encourages you to seek further training in CBT.

## Background

### The cognitive triad

The cognitive triad comprises three patterns of thinking that depressed people habitually use. First, a depressed man tends to have a negative view of himself, attributing any negative experiences he has to a fault within himself. Second, he tends to interpret his ongoing experiences in a negative way. He sees the world as making impossible demands upon him, obstacles are constantly being put in his path, and he is constantly being frustrated from realising his goals. Third, he has a negative view of the future, anticipating that his suffering will only worsen and that he will never attain his goals.

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**People with depression have negative views of themselves, the world and the future.**

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<sup>1</sup> Hawton K, Salkovskis PM, Kirk J, Clark DM eds. *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*. Oxford: Oxford University Press, 1989.

<sup>2</sup> DeRubeis RJ, Beck AT. Cognitive Therapy. In: Dobson KS ed. *Handbook of cognitive-behavioural therapies*. New York: Guilford Press, 1988: 273–306

<sup>3</sup> Tanner S, Ball J. *Beating the Blues: a Self-Help Approach to Overcoming Depression* Moorebank: Doubleday, 1989.

<sup>4</sup> Burns DD. *Feeling Good: The New Mood Therapy*. Melbourne: Information Australia Group, 1980.

<sup>5</sup> Beck AT, Greenberg RL. *Coping with Depression*. New York: Institute for Rational Living, 1974.

## Schemas/underlying assumptions/core beliefs

Schemas are relatively stable patterns of thinking that a person habitually uses to interpret his or her experiences. As he or she becomes more depressed, these primitive depressive schemas come to dominate his or her thinking more and more, while other more balanced ways of evaluating events recede. These negative schemas become increasingly independent of events until in severe depression they can become autonomous, with the person unresponsive, or even oblivious, to external events.

## Cognitive errors

People who are depressed make cognitive errors in processing information about their experience. Treatment involves identifying their automatic thoughts, recognising the logical errors in them and replacing them with rational responses to the events. Note, however, that CBT is not just about thinking positively, or eliminating unpleasant feelings altogether. Rather, it is about appraising events realistically. Some common cognitive errors are listed in Box 10-1.

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**CBT aims to uncover the cognitive errors that people make in evaluating events in their lives and to help them make more rational evaluations.**

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### Box 10-1: Common errors in thinking

*Mind reading* – ‘She thinks I’m a fool.’ or ‘They think I’m a bore.’

*Fortune telling* – ‘I’m sure to make a fool of myself.’ or ‘I’m sure to mess it up.’

*Black and white thinking* – Things are seen as either all good or all bad. ‘That is awful.’ or ‘I’ve totally messed it up.’ or ‘Unlike me, he always gets things right.’

*Labelling* – saying ‘I am’ instead of ‘I did’—‘I’m an idiot.’ or ‘I’m a failure.’ instead of ‘I did not win the competition.’

*Overgeneralising* – saying ‘always’, ‘never’, ‘no-one’ or ‘everyone’—‘I will never pass the exam.’ or ‘No-one cares about me.’

*Expecting too much of yourself* – saying ‘should’, ‘must’ or ‘have to’, and so setting unrealistically high standards for yourself—‘I must do this perfectly.’

*Refusing to accept praise* – ‘He is only saying that because...’ or ‘It was only a fluke that...’

*Over-emphasising failure* – ‘Now I’ll never be able to do it.’ or ‘What’s the point of trying again.’ or ‘They will never accept me now.’

*Personalisation* – blaming yourself for things over which you have no control—‘Where did I go wrong that he could do that?’

*Emotional reasoning* – ‘I don’t feel like doing it.’ or ‘Maybe I’ll feel like doing it tomorrow.’

*Not considering the possibilities* – saying ‘I can’t.’ instead of ‘How can I...?’

*Living in the past* – ‘If only I had...’

*Focusing on the negative* – Because of one negative aspect of an event, you assume that it is all bad. ‘He ignored me, so I must be a bore.’

## Treatment techniques

### Introduction to therapy

Since the person is an active collaborator in cognitive behavioural treatments, he or she must first understand and be engaged in the process. He or she may wish to read one of the self-help texts mentioned above. A course of CBT usually requires at least eight weekly sessions, each of about 25 minutes duration.

Over the first week of treatment, it is useful to ask patients to make a record of their activities and their associated moods. They may rate their moods on a scale from 0 to 100, where 0 is the worst possible and 100 is the best. Simply identifying his or her moods may begin to give a person a sense of control over them. The record may later be used to provide evidence to correct cognitive distortions. For example, a man who says he is depressed all the time will realise that, in fact, he is only depressed at certain times of the week. The record also provides the starting point for increasing the range and scope of daily activities.

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**Early in therapy, patients are asked to make a record of their activities and the associated moods.**

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### **Three-column technique**

The next step is to ask people to record their automatic thoughts at times when they are experiencing unpleasant feelings. One way to do this is to ask them to draw three columns on a piece of paper. In the first column, they record the situation in which the unpleasant feeling arose. In the second column, they describe the feeling. In the third column, they record their automatic thoughts. People may often be unaware of their internal dialogue. The ability to reflect on and monitor their thoughts often provides, in itself, a sense of self-efficacy and emotional relief.

The thoughts that need to be recorded are those that reflect on the personal meaning of the event for that individual (e.g. 'I'm a failure.'). A thought may be an inference about what the event means for the person's future (e.g. 'I will never get a job.'). It may reflect on how other people will perceive them (e.g. 'Everybody will think that I am a failure.'). Not all automatic thoughts are negative. Moreover, some negative thoughts are realistic and appropriate to the circumstances (e.g. a man feels guilty after swearing at his wife. He thinks, 'I should not have done that. I must apologise and do my best not to do it again.'). Thoughts that are descriptions of mood should be recorded in the feelings column (e.g. 'I feel sad.'). Thoughts that are descriptions of the event should be recorded in the situation column (e.g. 'I did not get the job.'). What needs to be recorded are the actual thoughts the person had at the time, not a description of them (e.g. 'I will never be able to do this', rather than 'It was terrible. I didn't know what to say.'). The handout in Appendix 9 will help explain this to patients.

### **Five-column technique**

A next step is for patients to complete a daily record of dysfunctional thoughts. They are asked to draw five columns on a piece of paper. In the first column, they record the situation in which an unpleasant emotion was experienced. In the second column, they describe their mood and rate its intensity. In the third column, they record the automatic thoughts that accompany the mood. The strength of belief in these thoughts is rated on a scale of 0 to 100. In the fourth column, they note the cognitive distortion in the automatic thought and write a rational response to it. Patients should be reminded that some unpleasant thoughts are reasonable and contain no cognitive distortion. The aim is to appraise events accurately, not simply to 'think positively'. The ability to correctly classify cognitive distortions is less important than the ability to recognise and challenge them. The following questions are helpful for finding rational responses to automatic thoughts:

1. What is the evidence for and against the belief?
2. What are alternative interpretations of the event or situation?
3. What are the real implications, if the belief is correct?
4. What would you say to a friend who said that?
5. What is the worst thing that could happen if it were true?

6. How likely is this ‘worst case’?
7. How would you deal with this ‘worst case’ if it were true?
8. If the ‘worst case’ came to pass, how would you feel about it tomorrow, next week, next month, in a year, in five years, in ten years?
9. All things considered, how likely is the thought to be true?

Patients also rate the strength of their belief in the response. On completion of the exercise, they complete a repeat rating of their mood and their belief in the automatic thought. An example of a typical entry using the five-column technique is shown in Box 10-2.

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**The five-column technique is used to document unpleasant mood states, the situations in which they arise, the automatic thoughts that accompany them, the cognitive distortions implicit in the automatic thoughts, rational responses to them, and the outcome of the process.**

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#### Box 10-2: The five-column technique

Situation	Mood	Automatic thought	Rational response	Outcome
While I was talking to a group of my friends, Tom got up and left without speaking to me.	Depressed and humiliated (rating of intensity of emotion: 70 per cent)	He ignores me, so I must be boring. (rating of strength of belief: 75 per cent – focusing on the negative)	Although he doesn’t seem to be interested, others are listening attentively, so I cannot be boring them.  (rating of strength of belief: 80 per cent)	(rating of depressed mood: 20 per cent) (rating of belief in automatic thought: 20 per cent)

It is important to distinguish between simple descriptions of how one feels (e.g. ‘I feel guilty,’ or ‘I feel ashamed,’ or ‘I feel terrible.’) from thoughts about the meaning of one’s experiences (e.g. ‘I feel guilty, because I should have been able to stop him drinking,’ or ‘Because I did not win the race, I am a failure.’). It is only the latter that can be challenged. Statements about how one feels are irrefutable. Descriptions of how one feels should be recorded in the mood column. Challenging the way people say they feel is unempathic and will only damage the therapeutic alliance.

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**Only thoughts about the meaning of events can be questioned; descriptions of how one feels cannot be refuted.**

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Later in therapy, the patient may use a simplified version, the two-column technique, which focuses on the automatic thoughts and rational responses. Box 10-3 demonstrates this two-column technique and contains examples of the cognitive distortions.

#### Vertical arrow technique

The vertical arrow technique illustrated in Box 10-4 can be used to dig deeper and uncover a person’s schemata—the assumptions that underlie his or her automatic thoughts. One technique is to write down the automatic thought and then ask the following questions:

- What if that did happen?
- What would this mean to me if it were true?
- What is so bad about that?
- What do I mean by that?

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**The vertical arrow technique is used to elucidate underlying assumptions that may predispose a person to depression.**

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A useful tool for uncovering these schemata is the Dysfunctional Attitudes Schedule<sup>1</sup>. Some of the dysfunctional attitudes that may predispose to depression are shown in Table 10-1.

**Table 10-1: Underlying assumptions that predispose to depression**

- 'I can only feel good if she approves of what I do.' – People whose self-esteem is based on how others judge them are vulnerable to depression and anxiety.
- 'I cannot do without her.' – Those whose self-esteem depends on being loved by someone are vulnerable to depression and anxiety.
- 'I must be the best at work.' – An excessive reliance on productivity and achievement at work predisposes to the development of depression and anxiety.
- 'I must be perfect.' – Only being satisfied if things are done perfectly leads to anxiety and disappointment.
- 'I am entitled to success, love and happiness.' – The belief that you deserve success, love and happiness leads to depression and frustration when things do not all go your way.
- 'It is my fault that he did it.' – People who assume that they are responsible for everything that happens in their world are prone to guilt, blaming themselves for things over which they have no control.

Burns<sup>2</sup> suggests a number of variants of this approach in challenging some underlying assumptions:

1. List the advantages and disadvantages of the assumptions.
2. Compare the predicted satisfaction gained from a particular activity with the actual satisfaction recorded after completing the activity. For example, a woman with underlying assumptions about the need for love and approval may discover that she gains just as much satisfaction from solitary activities as from activities that involve others. The man who is addicted to achievement may find that he gets a lot of enjoyment from activities outside work.
3. For the perfectionist, Burns<sup>3</sup> suggests recording satisfaction with an activity together with a measure of how effectively (percentage of perfection) it was done. people often find that the two are not as closely related as they had assumed.

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<sup>1</sup> Weissman AN. The dysfunctional attitudes scale: a validation study. *Dissertation Abstracts International* 1979; 40: 1389-1390.

<sup>2</sup> Burns DD. *Feeling good: The New Mood Therapy*. Melbourne: Information Australia Group, 1980.

<sup>3</sup> *ibid.*

### Box 10-3: The two-column technique

Automatic thought	Cognitive distortion and rational response
She says nothing when I enter the room. Therefore, she dislikes me.	(mind reading) The fact that she says nothing does not mean she dislikes me. She may be listening to someone else. She may prefer to speak to me later.
I think he is wrong, but I won't say anything, because I'm sure to make a fool of myself.	(fortune telling) I think he is wrong and I have good reasons for my view. I will tell him.
He ignores what I am saying, so I must be boring.	(focusing on the negative) While it appears that he is ignoring me, others are listening attentively. I am certainly not boring them.
I missed out on getting the job. Therefore, I will never get a job.	(over-generalisation) While it is disappointing that I did not get this job, it does not mean that I will never get another job. I have a good work record and I have always managed to find work before, even when jobs have been scarce.
I have made a mistake. Therefore, I will be sacked.	(over-emphasising failure) Everybody makes mistakes. I can learn from this and do better next time. The problem is easily fixed, so there is no reason for me to be sacked.
The boss complimented me, but he probably just felt sorry for me.	(refusing to accept praise) I did do a good job and it deserves to be recognised.
I didn't vacuum the floor today. Therefore, the house is filthy.	(black and white thinking) The fact that the floor has not been vacuumed today does not make the whole house filthy. Most of my friends only vacuum once a week. Others often remark on how clean the house is.
I do not feel like seeing anyone, so I'll just stay home.	(emotional reasoning) Just because I feel like staying home does not mean that I should do so. Since I have an appointment with the hairdresser and I do need to have my hair cut, I should keep the appointment.
I should always please my boss.	(expecting too much of yourself) I cannot please her all the time. Even if I do everything well, there is no guarantee that she will be pleased. I will, however, continue to work well.
He should be more considerate.	(expecting too much of others) It would be nice if he were more considerate. If I treat him well, he might be more considerate, but I cannot guarantee it.
I did not get into the A Team. I am a failure.	(labelling) While I did not make the team, I still enjoy indoor cricket, I have a good job and a happy marriage, and I enjoy good health.
If only I had worked harder, I would now have a better job.	(living in the past) There are opportunities for promotion in the Company. I will discuss this with my supervisor.
I can't play tennis.	(not considering the possibilities) I could get some coaching and play well enough to join the club.
My son has been found smoking marijuana. Therefore, I am a failure as a mother.	(personalisation). I cannot be monitoring his activities 24-hours a day. He is 18 years old and responsible for himself. What I can do is 1) provide him with the facts about the dangers of the drug, and 2) insist he not smoke at home.



#### Box 10-4: Vertical arrow technique

Automatic thought	Rational response
I am a failure because I only got a 'C' on the test. ↓ Why is this a problem for me?	(labelling, black and white thinking) My academic record is good and, in any case, I passed. I have had successes in a number of areas of my life, including my academic career, so I am not a failure.
Because I should have got an 'A'. ↓ Why do I always have to get 'A's'?	(expecting too much of yourself) A 'C' is still a satisfactory pass.
Because otherwise my unblemished academic record will be ruined. ↓ Why does it matter if my academic record is not perfect?	(black and white thinking) I do not have to be perfect at everything that I do. I will only make myself anxious attempting always to be perfect. The important thing is my training for the job, not my academic record, which, in any case, is rarely taken into account in job interviews.
Because people will think that I am slipping and have no respect for my work. ↓ If people do not respect my work, why would I be upset?	(mind reading, focusing on the negative) In fact, most people are not very interested in my work. My previously 'unblemished' record is as much to blame as my 'C'. It is what I think about myself, not what others think about me, that is important.
People would look down on me and see me as a failure. ↓ If people saw me as a failure, why would this upset me?	(mind reading, focusing on the negative) Why should they look down on me? It is still a very good academic record. I am happily married. I am well liked by my friends at the club.
Nobody would want to know me. ↓ Why would this be a problem?	(mind reading, focusing on the negative) I have several friends outside of work who would not care about my exam results. They might like me better knowing I'm not always 'perfect'.
Then I would be alone. ↓ Why would this be a problem?	(black and white thinking) I would still have my family and friends.
Because life would not be worth living if I were alone.	(black and white thinking) I get a lot of pleasure out of activities that I do alone, e.g. painting, reading and my stamp collection.

#### Behavioural techniques

An inability to act is common among depressed people. Since they are unable to solve their problems, their difficulties tend to escalate and they lose access to sources of positive reinforcement. A number of techniques can be used to assist problem solving and to help people become more active:

1. Counselling and structured problem solving (see Chapter 6)
2. Daily activity schedule (see Appendix 7) – Plan each day's activities hour by hour. The person begins each day by reviewing the activities he or she actually undertook the day before. The advantage of having a schedule is that it removes the need to make a decision about what to do on the day. If the person fails to implement the schedule, the reasons can be explored using the cognitive techniques described above.

3. List the advantages and disadvantages of a particular action, or of doing nothing.
4. Test negative hypotheses. For example, a man who believes that he can only get pleasure doing things with other people could test this by listing the activities for the day, rating the pleasure expected to be experienced doing each, and then reviewing the actual pleasure experienced on completion of each activity. Contrary to expectations, people often find that they got as much, if not more, pleasure from solitary activities than from doing things with others.
5. Break complex tasks down into a series of steps.
6. For people who have difficulty motivating themselves to act, it may be useful to list the thoughts that oppose action and then rebut them with thoughts that promote action.
7. Others are often telling people who are unable to act that they must do something. This may only exacerbate the problem, because being told what to do often removes the pleasure in doing it. People often react to nagging by doing nothing. They may have to learn to do things in spite of the fact that this may please those who are nagging them.

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**People sometimes have to do something, in spite of the fact that it is what other people are nagging them to do.**

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### **Indications for cognitive behaviour therapy**

Cognitive behaviour therapy is an effective form of treatment for people with mild to moderate depression, anxiety disorders and eating disorders. While structured problem solving alone may be indicated for people who are temporarily overwhelmed by their problems, CBT may be a useful adjunct in the treatment of those who have often had difficulty solving their problems in the past. CBT should be combined with antidepressant treatment in those with moderate or severe depression and anxiety. CBT is likely to be more effective than IPT in the treatment of people with few affectively charged precipitants to their depression, but less effective in people with significant cognitive dysfunction.

# Chapter 11

## Interpersonal psychotherapy (IPT)

This form of therapy was originally developed in the USA by Gerald Klerman and Myrna Weissman for the acute treatment of outpatients with non-psychotic depression<sup>1,2</sup>. It has also been used in the maintenance treatment of depression and in the treatment of a number of specific populations of depressed people—adolescents, older people, HIV positive patients and people with dysthymia,<sup>3</sup> bipolar disorder<sup>4</sup> and bulimia nervosa.

### Background

The principal assumption of IPT is that a person's mood, and events in his or her interpersonal world, are interdependent. Interpersonal events—both adverse and favourable—can lead to depressive symptoms, and depression may, in turn, impair a person's interpersonal functioning. By actively intervening to improve a person's interpersonal functioning, his or her mood will also improve. The focus of treatment is on interpersonal problems in one of four areas: grief, role disputes, role transitions or interpersonal deficits.

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**An assumption of interpersonal psychotherapy is that by improving a person's interpersonal functioning, his or her mood will also improve.**

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### General characteristics

The therapy is time-limited. In the original descriptions by Klerman and Weissman, it is spread over 12–16 weekly sessions each of 50 minutes duration. In this form, it is probably not suitable for use in general practice. However, a shorter version comprising six half-hour sessions—interpersonal counselling (IPC)—has been shown to be effective in primary care populations<sup>5</sup>.

### Comparison with other psychotherapies

Although IPT shares many characteristics with other forms of psychotherapy, it is distinguished from these in a number of ways. Its unique feature is the interpersonal focus and, specifically, the focus on one of the four problem areas. Moreover, the focus is on here and now functioning. While information about past relationships, including childhood relationships is sought, this information is only used to cast light on current interpersonal functioning. Unlike dynamic and supportive therapies, it is time-limited, a characteristic it shares with CBT and behavioural therapies. As in CBT, the therapist discusses cognitive distortions that may be contributing to interpersonal difficulties. However, unlike CBT, the therapist does not specifically seek out maladaptive patterns of thinking, nor does he or she set specific homework tasks (see Chapter 14

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<sup>1</sup> Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES. *Interpersonal Psychotherapy of Depression*. New York: Basic Books, 1984.

<sup>2</sup> Robertson M. Interpersonal psychotherapy, an introduction for clinicians. *Australasian Psychiatry* 1999; 7:25–27.

<sup>3</sup> Markowitz JC. *Interpersonal Psychotherapy for Dysthymic Disorder*. Washington DC: American Psychiatric Press, 1998.

<sup>4</sup> Robertson M. Interpersonal psychotherapy for patients recovering from bipolar disorder. *Australasian Psychiatry* 1999; 7: 329–331.

<sup>5</sup> Klerman GL, Budman S, Berwick D, Weissman MM, Damico-White J, Demby A. MSW and Feldstein M. Efficacy of a brief psychosocial intervention for symptoms of stress and distress among patients in primary care. *Medical Care* 1987; 25: 1078–1088.

for a discussion of the relative indications for IPT versus CBT). While dynamic psychotherapy may attempt to change a person's personality, IPT does not set this as a goal. IPT, nevertheless, recognises the influence of personality on the outcome of treatment, on the patient/therapist relationship and on interpersonal functioning.

## **The conduct of IPT**

### **The beginning phase (sessions 1–3)**

In assessing a person for IPT, you need to diagnose the type of depression from which the person suffers, perform a risk assessment, exclude possible medical causes of the symptoms and evaluate the need for medication (see Chapter 14). Educate the person about the nature of depression and its treatment. Explain that depression is a serious medical illness that is not uncommon; that, like a physical illness, it is not the person's fault; and that there are effective treatments that enable depressed people to return to being their usual selves. Rate the severity of the person's depression using the Hamilton Depression Rating Scale (HAM-D)<sup>1</sup> and use the results as a baseline for monitoring the person's progress.

Admit the person to the sick role. Explain that depression is a medical illness that is often attended by considerable disability and handicap. The person is, therefore, entitled to take some time off his or her usual roles and responsibilities. This will help displace any guilt about having the illness away from the person and onto the illness and the interpersonal problem. At the same time, the person is expected to work with the therapist to get better.

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#### **In IPT, the person is explicitly given admission to the sick role.**

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Make an inventory of the person's current interpersonal relationships and note how these are linked to the onset of his or her depressive symptoms. Explore the nature and frequency of the person's interactions with others, the patterns of these relationships and any recurrent problems in them. Within a given relationship, assess the expectations that the patient and the other person have of each other and whether these expectations are being fulfilled. Discuss both the positive and negative aspects of the relationship. Define changes that the person would like, either through changes in his or her own, or the other person's behaviour.

Identify one, or at most two, key problem areas: grief, role dispute, role transition or interpersonal deficits. In interpersonal therapy, grief refers specifically to bereavement. Other losses, such as the loss of a job or a relationship breakdown, are regarded as role transitions. Role transitions include developmental changes (e.g. leaving home, getting married, dealing with ageing), relationship changes (e.g. marriage or divorce), changes in role at work (e.g. promotion, redundancy, retirement) and other significant life events (e.g. the birth of a child, moving house, illness of the person or a family member). Role disputes involve conflict with another person—a spouse, a family member, a colleague at work or some other significant figure in the person's social world. The category of interpersonal deficits is reserved for those who do not have evidence of current problems in any of the other three categories. Many of these people have impoverished social worlds and possess limited social skills. Some are involved in social relationships, but feel dissatisfied with them. Others suffer from chronic depression.

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#### **Therapy concentrates on one (or at most two) of the four problem areas: grief, role dispute, role transition or interpersonal deficits.**

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<sup>1</sup> Hamilton M. Development of a rating scale for primary depressive illness. *British Journal of Clinical Psychology* 1967; 6:278–296.

People often present with problems in several of the key problem areas. Focus on the one that best encapsulates the event that precipitated the depression. Present your formulation to the person (see example in Box 11-1) and seek agreement on the focus of therapy.

#### **Box 11-1: Sample interpersonal formulation**

You are suffering from major depression. This illness is not your fault. Effective treatments are available. One of these is interpersonal psychotherapy, which is based on the idea that our feelings are linked to events in our lives. It seems to me that you have been in conflict with your husband since the birth of your daughter last year. Over the next 12 weeks, I suggest that we work on finding better ways of coping with this dispute with your husband. This will also relieve your depression.

Explain the concepts and process of IPT. He or she may wish to buy the patient's guide to IPT<sup>1</sup>. Tell a (female) patient that IPT focuses on here and now issues, and that she will need to discuss important events in her interpersonal world and describe her feelings about these. Reach an agreement with her about the nature of the therapy and the number, frequency and duration of the sessions.

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**People undergoing IPT need to understand and agree that therapy will focus primarily on here and now issues—in particular, their relationships with significant people in their lives—and that they will be expected to discuss these relationships and their feelings about them.**

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#### **Middle phase (sessions 4–12)**

The middle sessions focus on the key interpersonal problem area. You should generally begin sessions by asking an open-ended question about the past week and any significant events, such as 'How have you been since the last session? What has happened?' Ask the person to describe the events in detail, including the way he or she felt. Make links between the events and the person's mood.

In discussing an interpersonal conflict, it is often useful to ask, 'What did you want?' Ask a (female) patient to consider other ways that she could have dealt with the situation. Explore the positive and negative consequences of the different possibilities. She may benefit from rehearsing more effective ways of coping. Complex tasks may be broken down into a series of more manageable steps. Easy tasks are often best performed before more difficult ones.

#### *Grief*

The aim is to facilitate the mourning process, and to help the person move on and establish new relationships and interests (see also Chapter 7). Grief is abnormal when symptoms are excessively severe or persistent, or when they fail to appear. In the latter case, the person may experience symptoms later, for example, on the anniversary of the death.

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**The goals of grief work are to facilitate the mourning process and to help the person move on and develop new relationships and interests.**

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Review the depressive symptoms and their relationship to the death. The person with unresolved grief often idealises the relationship with the deceased, while refusing to acknowledge anything positive about events following the bereavement. Ask the person to describe both positive and negative aspects of the relationship, and of the future without the deceased—'What do you miss?

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<sup>1</sup> Weissman MM. *Mastering depression: A Patient's Guide to Interpersonal Psychotherapy*. Albany, New York: Graywind Publications Incorporated, 1995.

What don't you miss?' It is particularly important for the person to be able to acknowledge negative aspects of the past relationship and to feel free to experience and express negative affects associated with these. The process of mourning may be facilitated by having the person go through the belongings of the deceased and other mementos such as photographs.

Ask the person to describe in detail the events surrounding the death. Exactly what was he or she doing before, during and after the death? How did he or she feel? Encourage the person to acknowledge both good and bad affects. For example, a man may feel guilty that he could do nothing to save the person, or that he was not present at the moment of death. Was he able to discuss his feelings after the funeral? Did he express his grief or did he cover it over?

Encourage the person to move on. Ask, 'Where do you go from here?' It may be relevant to explore the implications of becoming a 'professional mourner'—people sometimes believe that if they stop grieving, the person will be forgotten. Promote the formation of new relationships and participation in new activities.

#### *Role dispute*

The aim is to clarify the nature of the dispute and to modify expectations and faulty communication in order to bring about a more adaptive resolution of it. The most appropriate action to take will depend on the stage of the dispute. If there is open conflict, the participants will need to calm down before the problems can be renegotiated. If the dispute has reached an impasse (i.e. if communication about the problem has ceased, while an atmosphere of tension and suppressed hostility remains), the level of overt conflict will rise as the issue is brought out into the open. In some cases, the conflict may be irreconcilable with the only solution being to dissolve the relationship. Here, the role of the therapist is to facilitate the mourning process and then to encourage the formation of new relationships.

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### **Role disputes may be at the stage of re-negotiation, impasse or dissolution.**

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The source of role disputes often lies in conflicting expectations of the two participants. For example, a woman may wish to get a job and pay someone to take care of her children, while her husband expects her to stay home and manage the household. Explore the patient's expectations and where they conflict with those of the other person. Do they reflect problems that the person has had in other relationships? What is the person gaining from his or her behaviour? What is perpetuating the conflict? Explore options for the resolution of incompatible expectations. What can the person do to change his or her expectations? What can the other person be expected to do?

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### **The source of role disputes is often found in non-reciprocal expectations of the two protagonists.**

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Depressed people often blame themselves for things over which they have no control, or for failing to meet unreasonable expectations of others. Clarify these issues and, where applicable, normalise forbidden affects: 'If someone treats you like that, you have a right to feel angry. You are entitled to expect things to change.' The person may benefit from rehearsing more assertive behaviour. It may be useful to ask the partner in a marital dispute to attend some of the sessions.

#### *Role transitions*

The aims are to mourn the loss of the old role, to recognise positive aspects of the new role and to restore self-esteem by developing a sense of mastery over the demands of the new role.

Begin by reviewing the depressive symptoms and linking them to the change in role. Giving up an old role is a loss, which the person needs to mourn. Encourage the person to talk about the loss and to express feelings associated with it, including negative feelings such as anger, frustration and guilt. Review the positive and negative aspects of the new role. Even adverse events present

some positive opportunities. Encourage the person to take advantage of these opportunities. Correct false assumptions that he or she has about the new role. Teach structured problem solving to deal with the practical consequences of the role transition. Review opportunities that the person has for making new social relationships.

#### *Interpersonal deficits*

The aims in treating people with these problems are to reduce their loneliness and social isolation, and to encourage the formation of new relationships. Since these problems are often difficult and long standing, the goals of therapy are modest—to start work on alleviating them, rather than completely resolving them. Owing to the absence of significant current relationships, therapy focuses on past relationships, the therapeutic relationship and forming new relationships.

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**People whose primary problems are interpersonal deficits are encouraged to reduce their social isolation and to form new relationships.**

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Review the depressive symptoms and link them to the person's social isolation. Clarify the patterns of significant past relationships and note any recurring problems. Ask the person to consider both positive and negative aspects of these relationships. Use the therapeutic relationship as a model of how the person relates to others—that is, actively discuss the transference. Ask a (female) patient to tell you if there is something you do that upsets her. Ask her to articulate her feelings and discuss her concerns. Use the techniques of communication analysis and role-playing discussed below. Encourage the person to put his or her newly learned skills into practice by getting in touch with old friends, going out with new friends and attending social functions.

#### **Termination phase (sessions 13–16)**

The termination phase begins with a review of the gains that the person has made, the active steps that he or she has taken to overcome the problems and the changes in the severity of symptoms. The patient, not the therapist, is given credit for these gains. Educate the person about the possibility of relapse. After a single episode of major depression, there is a 55 per cent chance of relapse. After three or more episodes, there is a 90 per cent relapse rate. Ask the person to reflect on his or her early symptoms of relapse, and to have a plan to seek help should these symptoms arise.

In interpersonal therapy terms, termination constitutes a role transition. The person experiences normal sadness, but not depression, at the ending of the relationship. Address the issue directly and encourage the expressions of ideas and feelings about termination.

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**The person experiences the termination of therapy as a role transition.**

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For people who fail to respond to IPT, referral should be made for another form of treatment. For those with recurrent depressive episodes, consider maintenance interpersonal therapy<sup>1</sup>. In the form in which it has been evaluated, this involves 50-minute sessions once a month. If you embark on this treatment, a new contract should be made with the patient. Unlike acute treatment, maintenance treatment may require switching the focus over the course of treatment.

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<sup>1</sup> Frank E, Kupfer DJ, Perel JM, Cornes C, Jarrett DB, Mallinger AG, Thase ME, McEachren AB, Grochocinski VJ. Three-year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry* 1990; 47:1093–1099.



## Techniques of therapy

Klerman and Weissman<sup>1</sup> describe the following techniques as applicable (though not unique) to IPT.

### Directive and non-directive exploration

At the beginning of sessions, non-directive techniques are used to gather information. Ask open-ended questions and use verbal and non-verbal communication to encourage the person to continue what he or she is saying. You may repeat what the person has just said or refer back to something said earlier. Later in the session, you may need to use more directive techniques. For example, you might use closed questions to clarify the details of an interpersonal dispute.

### Clarification

You might ask a man to repeat what he just said, or paraphrase his statement and check if that is what he meant. You may wish to clarify how a person felt—‘You felt very frustrated?’ Point out the logical consequences of what the person has said. Draw attention to apparent contradictions to clarify what the person means or feels—‘It is interesting that in the last session you said you had never enjoyed his company, but today you say you did have a good time together last weekend.’ Use cognitive techniques to identify and challenge irrational automatic thoughts and underlying assumptions (see also Chapter 10).

### Encourage the expression of affect

Some patients will benefit from being encouraged to acknowledge and experience negative affects such as guilt, shame or anger, especially in grief work. Promote a detailed discussion of the relationship in question. Ask directly how the person feels. Remind him or her that certain negative feelings are normal—‘Anybody would feel angry if they were treated like that’. People are sometimes afraid to acknowledge unwanted feelings and impulses for fear that they might act upon them. Reassure them about the difference between feeling and acting.

Other patients may need to be taught more effective ways of controlling their moods and impulses. It is sometimes best for the person to avoid situations that arouse painful affect. Conflict is often more effectively resolved after both parties first take some time to calm down and get their feelings under control. Help the person to identify the thoughts that accompany a negative affect. Then use structured problem solving to deal with the underlying stressors. Help patients to identify and question irrational thoughts they have when they feel anxious or depressed (see Chapter 10).

### Communication analysis

The goal is to identify communication failures and to learn new and more effective skills. Sometimes, conflicts arise simply through a lack of communication. Identify and modify the following unhelpful communication styles: using ambiguous non-verbal communications, such as sulking, remaining silent or self-harming; assuming that others know how one thinks or feels without being told; not checking the veracity of a one’s assumptions (‘He thinks I’m a fool’); or being unable to assert oneself or criticise another person because of exaggerated fears of the consequences.

### The therapeutic relationship

The way that people communicate with you can be taken as a model of how they relate to others in their lives. It is useful to reflect on this interaction, especially when treating people with

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<sup>1</sup> Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES. *Interpersonal Psychotherapy of Depression*. New York: Basic Books, 1984.



interpersonal deficits who have few other significant relationships. Ask patients to tell you if you do something that upsets them. They then have the opportunity to rehearse being more assertive and you have the opportunity to correct faulty assumptions that they make.

### **Behaviour change techniques**

Use structured problem solving to help the person find workable solutions to their problems. At times, it may be appropriate to give the person advice (see Chapter 6). Education plays an important part in IPT—explaining the symptoms and treatment of depression, the relationship of events in the person's interpersonal life to the depressive symptoms, and the process of IPT. In role-play, a (female) patient is asked to speak to the therapist as she would to the other person. This will clarify her feelings about the person, demonstrate the effectiveness of her communications and provide her with an opportunity to rehearse new ways of communicating.

### **Dealing with resistance in therapy**

Patients may behave in ways that interfere with the process of therapy. They may, for example, arrive late, miss appointments, remain silent or persist in discussing irrelevant material. Do not ignore these behaviours, but rather discuss them openly and matter-of-factly. Sometimes, there will be a simple reason for the behaviour, unrelated to the process of therapy. For example, a person may consistently arrive late because the appointments are scheduled at an inconvenient time. However, in other cases, the behaviour may be a manifestation of the person acting out—that is, acting on an impulse to avoid a problem, rather than thinking about it and seeking a rational solution to it. In such cases, it is important to bring the behaviour to the person's attention—discuss it, seek to understand its meaning, and help him or her find more effective solutions to the underlying problems and more effective ways of communicating.

In IPT terms, resistance in therapy is an example of a role dispute in which the expectations of the patient and the therapist are at odds. Discuss the behaviour and the way that it is interfering with therapy. For example, the person who arrives late will not have sufficient time to deal adequately with the material to be covered each week. Help the person recognise that these behaviours represent indirect and inefficient ways of communicating. By openly discussing these difficulties, the person is able to allay their fears about the direct discussion of problems and experience how much more effective direct communication is in solving problems. The way the problem is dealt with in therapy becomes a model for how the person can more effectively deal with problems outside therapy.

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### **In IPT terms, resistance in therapy is an example of a role dispute.**

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Behaviours that sabotage therapy often serve to avoid discussion of painful topics. Note the context in which the avoidance behaviours occur. For example, a person may always change the topic of discussion when a particularly painful issue is being discussed. The person may fear your reaction to the problem. Try to engender a feeling of trust in the patient. Accept and normalise unwanted feelings. Patients may fear that if they articulate unacceptable impulses, they will lose control and act upon them. Emphasise the difference between feelings and impulses, which are not under the person's conscious control, and actions, which are.

In all forms of psychotherapy, it is important to monitor the transference and counter-transference. Resist the temptation to advise dependent people on how they should solve their problems. Instead, use counselling and structured problem solving to help deal with their problems themselves. Discuss the differences between a therapeutic relationship and a friendship. Do not self-disclose to patients and do not socialise with them. Monitor your own feelings about patients: by acknowledging unacceptable impulses—you will be less likely to act out upon them.

## Combining IPT with pharmacotherapy

Like other forms of psychotherapy, IPT can and, in many cases, should be combined with drug treatment for depression (see Chapter 14). Several studies suggest an additive effect of combined therapy, especially in the treatment of severe depression. In particular, patients who have evidence of neurovegetative function change (sleep, appetite and weight disturbance; psychomotor agitation or retardation; anhedonia; and loss of libido) will benefit from medication in addition to IPT. Individuals may have a particular preference for one or other form of treatment.

## Training in IPT

You will need to read the text by Klerman and Weissman<sup>1</sup>. The Hamilton Depression Rating Scale (HAM-D) is the instrument that has been used to assess outcome in the major trials of the efficacy of IPT<sup>2</sup>.

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**Those wishing to practise IPT should read the text by Klerman and Weissman, and video or audiotape at least one course of therapy.**

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To gain competence in IPT, you need to complete three supervised cases that are certified by an IPT expert. It is useful to video or audiotape at least one course of treatment and discuss this, session by session, within a group of your peers who are interested in IPT. Like the techniques of CBT, there are probably several IPT techniques that you already use. I hope that this discussion will encourage you to embark on further training.

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<sup>1</sup> Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES. *Interpersonal Psychotherapy of Depression*. New York: Basic Books, 1984.

<sup>2</sup> Hamilton M. Development of a rating scale for primary depressive illness. *British Journal of Clinical Psychology* 1967; 6 :278-296.

# Chapter 12

## Dynamically informed therapy

Psychodynamic treatments range across a broad spectrum from expressive therapies, including psychoanalysis, which aims to produce personality change, to supportive therapies that aim to improve coping by bolstering a person's existing personality structures, including his or her habitual coping styles and defences (see Chapter 8). The three main theoretical schools are ego-psychology (Freud et al.), object relations (Klein, Mahler et al.) and self-psychology (Kohut, Kernberg et al.).

In this chapter, I discuss eight dimensions of the psychodynamic assessment of personality that are useful in formulating the psychological components of patients' problems. I also describe two psychodynamic interventions that can be used in general practice—empathic responses and interpretation. I refer readers to Gabbard's book for a detailed description of the different psychodynamic theories and their application in therapy<sup>1</sup>.

### Impulse control

An impaired ability to delay the gratification of drives and desires may be manifest in substance abuse, sexual promiscuity, paraphilias, binge-eating or a pattern of repeated violent or self-harming behaviour. The characteristic defence is 'acting out' (see page 102).

### The characteristic defence of people with impaired impulse control is 'acting out'.

Impaired impulse control is a feature of the Cluster B personality disorders—borderline, antisocial and histrionic (see Chapter 23). People with psychotic illnesses or depression may also exhibit impaired impulse control. Biological factors that predispose to poor impulse control include genetic factors, brain damage (especially to the frontal lobes), dementia, delirium, and the abuse of alcohol and stimulants. Abused children who have been the victims of adults with poor impulse control may be at risk of developing problems with impulse control themselves. Some examples are shown in Box 12-1.

#### Box 12-1: Examples of impaired impulse control

##### *Antisocial personality disorder*

A man with antisocial personality disorder has a long history of violent behaviour and substance abuse. He tells you that on weekends he and his brother go to places frequented by homosexual men and assault anyone who approaches them.

##### *Psychosis*

A man with schizophrenia sets fires in response to commands of the voices that he hears.

##### *Depression*

A depressed woman with no previous criminal history shoplifts some relatively inexpensive articles that she could easily have afforded to buy. She cannot explain why she did it, but expresses how ashamed she feels and her belief that she should be punished like any other criminal.

##### *Borderline personality disorder*

A woman who was sexually abused as a child has difficulty controlling her impulses to self-harm.

<sup>1</sup> Gabbard GO. *Psychodynamic Psychiatry in Clinical Practice, DSM-IV Edition*. Washington DC: American Psychiatric Press, 1994.

## Self-esteem

A person's perception of him or herself as a good person, worthy of the affection of others, is impaired in depression. In 'Mourning and Melancholia', Freud described a loss of self-esteem as one of the principal features of depression and one that distinguishes it from normal mourning<sup>1</sup>. People with personality disorders are predisposed to depression because of their low self-esteem. In particular, child abuse may damage self-esteem (see Box 12-2).

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### People with a low self-esteem are vulnerable to depression.

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#### Box 12-2: Examples of low self-esteem

##### *Dependent personality disorder*

A woman with a dependent personality disorder has a low self-esteem that is evident in her inability to make decisions for herself. She has suffered recurrent bouts of depression.

##### *Narcissistic personality disorder*

A man with narcissistic personality disorder defends against his low self-esteem by his grandiosity, his demands for constant praise and his rejection of any criticism. He used to be very proud of his sporting prowess. He attended a gymnasium and was a member of the local lifesaving association. He becomes depressed after suffering a myocardial infarction that will curtail his sporting activities.

## Shame and guilt

Shame is the emotion that we experience when we fail to live up to our conception of how we should behave. We feel ashamed when we do something embarrassing in front of other people. How ashamed we feel will depend on what we actually do, the situation in which we do it and the standards that we set for ourselves. One person may be mortified after making some minor faux pas, while another is quite shameless about behaving in a manner repugnant to everyone in his company. A man with an exacting and rigid idea of how he should behave will be vulnerable to depression and anxiety.

By contrast, guilt is the emotion that we experience when we do something wrong that hurts another person. It is associated with an expectation of punishment. The extent to which we feel guilty depends on what we have done, as well as the strictures of our conscience. People with rigid and punitive consciences may feel guilty over relatively minor perceived infractions and be predisposed to depression. By contrast, those with little concern for the rights of others may fail to experience guilt after seriously infringing the rights of others. Such people are prone to anti-social activity. Examples are given in Box 12-3.

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**Shame is the emotion that we experience when we fail to live up to the image we have of how we should behave. Guilt is the emotion that we experience when we do something wrong that hurts another person.**

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<sup>1</sup> Freud S. 'Mourning and Melancholia' in *The Pelican Freud Library, Volume 11: On meta psychology: the theory of psychoanalysis*. Ed. Angela Richards. Ringwood, Victoria, Penguin, 1984.

### **Box 12-3: Examples of shame and guilt**

- A man with narcissistic traits is especially prone to feeling ashamed, because his extreme sensitivity to criticism and rejection is coupled with an equally strong need to show off and impress others, something that often backfires and turns people against him.
- A man convicted of assault fails to feel any remorse. He is furious with the woman he assaulted, because if it were not for her, he would not be in jail.
- A young woman suffering from post-partum depression feels guilty because of angry thoughts she has about her baby's demands. She also feels ashamed that she has failed to be the kind of mother she had wanted to be. She is described pre-morbidly as a perfectionist who is serious and conscientious at work and rarely expresses anger.

## **Quality of relationships**

The ability of a person to form enduring close relationships with others, including intimate relationships, is an important measure of his or her psychological health. The quality of a person's relationships is an important factor in the prognosis of his or her mental disorder. The patterns of relationships formed throughout life often reflect early bonds with parents and siblings. These recurring patterns become evident during therapy in the transference and counter-transference.

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### **The patterns of relationships formed throughout life often reflect early bonds with caregivers.**

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Bowlby writes that the presence of strong and stable attachments in early childhood permits the child to begin to explore the world from a secure base and, in adulthood, to form intimate relationships, and to be resilient in the face of stressful life-events. By contrast, children who form anxious attachments are less well adapted and, in adulthood, have difficulty forming intimate relationships, are vulnerable in the face of stressful life-events, and are prone to depression and anxiety.

## **Defence mechanisms**

Freud postulated that unconscious sexual and aggressive drives are prevented from reaching consciousness by unconscious ego defence mechanisms. The primary defences are repression and denial. Repression is the shutting out from consciousness of an unacceptable drive, wish or other aspect of internal reality. Denial is the disavowal of unacceptable or threatening aspects of external reality. Examples of repression and denial are given in Box 12-4.

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### **The primary defences are repression and denial.**

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The maturity of the defence mechanisms that a person habitually uses is a useful indicator of his or her psychological health and success in adaptation to life. The following hierarchy of defences, from primitive to mature, is taken from Vaillant<sup>1</sup>. Examples are shown in Box 12-5.

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### **The maturity of defences that a person habitually uses is an indicator of his or her psychological health.**

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<sup>1</sup> Vaillant GE. Theoretical hierarchy of adaptive ego mechanisms. *Archives of General Psychiatry* 1971; 24: 107-116.

#### **Box 12-4: Examples of the primary defences – repression and denial**

- *Repression*

A woman becomes depressed on the anniversary of her husband's death. Her husband was an alcoholic who abused her verbally and physically throughout the marriage, and prevented her developing her own social networks.

*Comment:* She has repressed the anger she has towards her husband over his abuse, and now, his abandonment of her. Her inability to acknowledge and work through her ambivalent feelings has inhibited the mourning process.

- *Denial*

A man with schizophrenia denies that he has a mental illness and criticises his general practitioner for forcing him to take medication. He nevertheless attends his appointments regularly and is adherent to medication.

*Comment:* The man's denial of the illness helps him cope. Displacement of the problem on to the doctor and the medication allows him to vent his frustration externally rather than with himself or with an illness that he cannot escape.

- *Denial*

A woman retains hope in spite of being told that her bowel cancer is inoperable, believing that the diet she is on and the herbal remedies she takes will cure it.

*Comment:* A degree of denial is adaptive in any grief reaction. Unless she is being exploited by someone promising a cure, it is probably best not to challenge her denial.

#### **Narcissistic defences**

These are features of psychotic illnesses, but may also be evident in children before the age of five and in adult dreams and fantasy. They include delusional projection, psychotic denial and distortion.

#### **Immature defences**

These may be seen in normal children and young people between the ages of three and 16. Adults with personality disorders also use these defences.

- Projection – the attribution of one's own unacknowledged feelings to others. Its use is a feature of paranoid personality disorder.
- Passive-aggression – the turning against oneself of hostile feelings towards others by procrastinating, forgetting, being late for appointments, doing things deliberately slowly or clowning around instead of completing a task
- Acting out – acting on an impulse without reflection in order to avoid experiencing a painful affect and the thought that accompanies it

#### **Neurotic defences**

- Displacement – shifting an unacceptable feeling about an important and powerful person in one's life on to someone less powerful
- Intellectualisation – the excessive use of intellectual processes as a means of avoiding the experience of distressing feelings
- Reaction formation – warding off an unconscious wish or impulse by adopting a characteristic trait that is diametrically opposed to it
- Dissociation – the compartmentalisation of one's identity to avoid emotional distress (see also Chapter 21). A person may be amnesic for a traumatic event, but suffer flashbacks of it. Counterphobic behaviour may defend against feelings of inadequacy and fear. An actor is able to dissociate into the character that he portrays. Members of a fundamentalist church

dissociate when they speak in tongues. Like all of the secondary defences, dissociation is preceded by repression or denial. It is distinguished from repression by being a vertical split in which mental contents are stored in a parallel consciousness; in repression, there is a horizontal split with material being transferred to the unconscious.

### **Mature defences**

These include humour, anticipation, sublimation and altruism.

#### **Box 12-5: Examples of ego defence mechanisms**

##### *Projection*

A man defends against an unacknowledged and unacceptable desire for sexual relations with a family friend by repression of the impulse and projection of it on to his wife, whom he begins to accuse of infidelity.

##### *Passive-aggression*

You are seeing a couple for marital counselling. The husband arrives 15 minutes late for the appointment. His wife says that this is typical of him—he is never on time. He gave up his middle management position in the public service three years ago to enrol in post-graduate studies in philosophy. He receives a small allowance from the government, but his wife has been largely responsible for supporting the family over this period. He is having difficulty completing his thesis and has already had two extensions of the date it is due. Last weekend, he ‘forgot’ that his wife’s parents were coming to dinner and arrived home just as they were leaving having spent the evening in the library working with newfound enthusiasm on the thesis.

##### *Acting out*

A young woman with borderline personality disorder cuts herself with a razor blade. When asked what she was thinking about at the time, she states that she cannot remember. Nor can she describe how she was feeling; and she cannot identify any precipitant for her action.

##### *Displacement*

A man is under financial pressure having to support his wife and five children and pay off a home mortgage from the living he makes as a salesman. His boss is constantly reminding him of the need to meet the monthly sales targets—a failure to do so is met by veiled threats about job security. The man’s wife is upset and embarrassed by his increasingly extreme views about Aborigines and migrants that he angrily propounds whenever they have friends over.

##### *Intellectualisation*

A woman consults you four months after the death of her 15-year-old son from leukaemia. She is exasperated because her husband is spending more and more of his time researching alternative medical treatments for cancer. He spends most evenings scanning the Internet for new information. She feels she can discuss nothing else with him, including their son’s death.

##### *Reaction formation*

A young woman presents to you depressed. She is married with three children, aged one, three, and five years. She has always appeared anxious to do the best for her children. She says that her husband and mother both say that she ‘spoils’ them, but she cannot help it. She brings the children to see you frequently, often with relatively minor problems. Despite having some family supports, she has never used a baby-sitter, always insisting she should look after the children herself.

In the context of a strong therapeutic relationship with you, she begins to be able to recognise and accept as normal, her occasional frustration and anger at the demands placed upon her by her children. She may later begin to be able to deal with her feelings by using more mature defences, such as humour and sublimation.

##### *Dissociation*

A young woman is amnesic for a vehicle accident in which her boyfriend was killed. Despite suffering no serious injury herself in the accident, she continues to suffer frightening nightmares, she feels constantly tense and irritable, and she has withdrawn from most of her usual social activities.

## Developmental stages

A number of writers have described sequences of stages in human psychological development. Unlike the psychosexual stages described by Freud that focus on early development, the stages in psychosocial development described by Erikson cover the whole of the life cycle. Each stage is characterised by a core conflict (see Table 12-1)<sup>1</sup>. Coping with normal developmental tasks is stressful and can precipitate mental health problems (Box 12-6).

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**Coping with normal developmental tasks is stressful and can precipitate mental health problems.**

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**Table 12-1. Eight Ages of Man<sup>2</sup>**

Age	Core conflict
0–1	trust <i>vs.</i> mistrust
1–3	autonomy <i>vs.</i> shame and doubt
3–6	initiative <i>vs.</i> guilt
6–12	industry <i>vs.</i> inferiority
12–18	identity <i>vs.</i> role diffusion
18–30	intimacy <i>vs.</i> isolation
30–60	generativity <i>vs.</i> stagnation
60 >	ego-integrity <i>vs.</i> despair

### **Box 12-6: Examples of Erickson's developmental stages**

#### *Identity versus role diffusion*

A rebellious adolescent girl has recently been discovered with a small quantity of marijuana. She belongs to a peer group who dress exclusively in black, wear nose-rings and are obsessed with the music of Nirvana.

#### *Intimacy versus isolation*

A 30-year-old single man presents lonely and depressed. He has never managed to sustain an intimate relationship for longer than six months.

#### *Generativity versus stagnation*

A 45-year-old man is going through a 'mid-life crisis'. He is dissatisfied with his work where he realises he will never progress. He is separated from his wife, who has custody of their two children. He has been living alone since the brief affair that he had with a colleague at work finished six months ago.

#### *Ego-integrity versus despair*

A 66-year-old man becomes depressed nine months after retiring from the staff of the school where he had taught over the past 25 years.

## Regression

Regression is a common sign of mental distress, especially in children. People who have not resolved early developmental conflicts are prone to regression when under stress. This is particularly likely to occur when a stressor reactivates earlier conflicts (see Box 12-7).

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<sup>1</sup> Erikson EH. *Childhood and Society*, 2<sup>nd</sup> Edition. New York:VW Norton, 1963.

<sup>2</sup> *ibid.*



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**Regression is a common sign of mental distress, especially in children and young people.**

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**Box 12-7: Example of regression**

A 24-year-old man consults you about a number of current problems, but his main need seems to be to talk about himself and for you to listen. If you attempt to interrupt, he quickly becomes anxious and agitated, speaking more quickly, often simply ignoring what you have to say. He seems driven to complete what he wishes to say and sometimes brings a list of things he needs to tell you. Just as the session is about to finish he tells you how angry he was with another doctor who, he says, was always rigid about the time, 'throwing' him out when time was up. You know from his background that, as a child, his father would often come home drunk and, after arguing with his wife, come to the boy's room and insist that he get out of bed and listen as he recounted the problems and frustrations of his day.

*Comment:* At an age when he needed support and nurture from his parents, he instead had to provide his father with support and sympathy. Ten years later, he is still seeking the care that he missed as a child. In the transference, he becomes like his father, and you experience, in the counter-transference, how he felt as a child.

## **Repetition compulsion**

The preceding example illustrates how patterns of early attachments often tend to repeat themselves throughout a person's life, even though these patterns may have been painful or even abusive. It seems that any attachment is better than none (see Box 12-8).

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**Patterns of early attachments often repeat themselves throughout a person's life even though these patterns may have been painful or even abusive.**

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**Box 12-8: Example of repetition compulsion**

You see a young man whose wife has recently taken out a restraining order to prevent him visiting her. She recently left him, together with their two young children. On describing his background, he tells you that he hated his father. His earliest memories are of his father coming home drunk and verbally and physically abusing his wife while the children hid under their beds, knowing that they might be the next victims of his rage.

*Comment:* Despite suffering at the hands of his father as a child, he has nevertheless identified with him (identification with the aggressor) and now acts like him.

## **Two interventions derived from dynamic psychotherapy**

In this section, I briefly discuss the use of empathy and interpretation in psychotherapy. Empathy is an essential component in understanding a person's problems and an empathic style is one of the most robust predictors of general practitioners recognising their patients' mental disorders. An empathic approach also plays an important role in therapy. It is central to the self-psychological approaches of Kohut. Interpretation is a cornerstone of all dynamic therapy.

### **Empathy**

Empathy is experiencing *ourselves* what it is like to be in the position of another person. We can feel the sadness of someone who tells of the death of a loved one. We can experience the anger of someone who has been frustrated and deceived. As well as being a tool for understanding patients, empathic responses strengthen the therapeutic alliance and can, themselves, produce change (see Box 12-9).

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**Empathic responses strengthen the therapeutic alliance and can, themselves, produce change.**

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**Box 12-9: Empathic response**

A 63-year-old woman becomes depressed six months after her husband's death from complications of alcoholic liver disease. You know that she had to tolerate both verbal and physical abuse over the years of their marriage. After he died, others reported that she 'coped very well'. She reports that she has never cried over his death.

You can empathise with the ambivalent feelings she has towards her husband. These make it difficult for her to mourn his death. In the context of a trusting relationship with you, she begins to acknowledge her anger towards him, as well as her guilt that she had sometimes wished he were dead. Acknowledging these negative affects within the therapeutic alliance will allow her to experience her sadness and to mourn her loss. (If her symptoms of depression persist, she may also require treatment with antidepressants).

Repeated empathic failures by caretakers during infancy and early childhood are thought to predispose to problems in self-esteem, and in one's sense of identity and personal coherence in adulthood. A consequence of the low self-regard of people with narcissistic personalities is an extreme sensitivity to any minor sleight or perceived insult. Empathic responses during therapy can, over a period of time, ameliorate these traits (see Box 12-10).

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**Repeated empathic failures in infancy are thought to contribute to the development of narcissistic personality disorder.**

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**Box 12-10: Example of empathic failures in childhood**

A 28-year-old man is furious with you because you are late for his appointment. You feel angry at such entitled and demanding behaviour, but recognising these feelings, you take care not to act it out. When he settles down, you acknowledge his feeling of hurt and explain why you were running late. It might then be appropriate to make an interpretation. For example, 'You get very upset when people do not meet their commitments to you'.

Be careful that by being empathic you do not collude with the person's problems and make them worse. Reflect on the transference and countertransference in order to avoid pseudoempathic responses (see Box 12-11).

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**Be careful that by empathising with a person's experience you do not reinforce his or her maladaptive behaviour patterns.**

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**Interpretation**

Interpretation covers a wide range of interventions. It may simply involve a clarification of what a person says or how that person feels. For example, when an elderly man says that his daughter failed to visit him over the weekend, you might say, 'You would have felt let down...angry with her'.

You might interpret a defence. For example, when a woman whose mother recently died talks at length about current problems with the local council, and the weather, you might interpret her denial by saying, 'It is too painful for you to talk about your mother's death'.

Defence mechanisms are deployed in order to solve some intrapsychic conflict. The equilibrium that they provide may be the most adaptive solution to a person's problems at that time. For

### Box 12-11: Pseudoempathy

- A 42-year-old woman seeks your advice in solving a large number of domestic problems. She presents herself as helpless. She needs you to tell her what to do.

*Comment:* You may empathise with her feelings of dependency and her wish for others to make decisions for her, but it would be a mistake to respond to this by telling her how she should organise her domestic affairs. Be aware of the transference and counter-transference—in this case a child-like dependent transference that evokes in you a paternal/maternal countertransference to take care of her.

- A young man with antisocial personality disorder describes the pleasure he takes in his criminal activity.

*Comment:* You should take care not to empathise with his excitement and enjoyment, his sense of entitlement and self-justification, and his lack of responsibility. Such collusion will only reinforce his antisocial behaviour. You might instead make it clear that while you will listen to him, you do not approve of his behaviour. If, for example, he boasts, 'If some guy gets in my way there will only be one of us left standing', you might say, 'You mean you would assault him'. Or, if he gloats over taking advantage of someone, 'So you mean you sold him something worthless'. Or if he says, 'I will finish him if I see him', you might ask, 'Are you threatening to commit murder?' You might add, 'I have to tell you that there is nothing I can do in your defence as a doctor if you commit a crime'. If he persists with his threats, you should alert the police and the person under threat.

example, the numbing that is evident in people who have recently been exposed to a severe trauma is, at least initially, adaptive because it prevents the person from being overwhelmed. Two years after the event, however, such denial is not adaptive and may lead to severe handicap—withdrawal from social supports and a loss of access to pleasurable activities. It is a matter of judgment when to interpret a defence. In the midst of a crisis it is often better to bolster a person's defences, but once the crisis is over it may be helpful to interpret and try to change them. Removing a defence will always cause some anxiety. It should be remembered that the development of psychotic symptoms is one of the recognised complications of psychoanalysis.

You might make an interpretation within the transference (see Box 12-12)

### Box 12-12: Interpretation within the transference

A young man who has problems with authority figures arrives late for his appointment. He is sullen and curt in his responses and avoids eye contact with you. You might say, 'You feel angry with me'. He might then make an association. For example, 'Yes, you remind me of this teacher who always put me down...' Later, he makes a link to his father who was always critical of him and seemed impossible to please.

For the most part, the interpretations that you make in general practice will be clarifications.

Making interpretations at deeper levels can be problematic. Even though an interpretation may be correct, it is not necessarily helpful and may even be damaging. For example, a 14-year-old boy who lives with his mother and stepfather is having problems at school. The following might be true, but it would certainly be inappropriate—'You are displacing the anger with your oedipal rival on to your teachers'. As a rule, the patient makes the most effective interpretations him or herself, with you providing the trusting and empathic relationship that allows such self-reflection.

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**In general practice, the commonest interpretations are clarifications.**

**Interpretations at deeper levels can be problematic.**

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The correct timing of an interpretation is vital, and your empathy with a patient will be a good guide. For example, in the case of the old man mentioned previously, you might realise that he was neither sad nor angry that his daughter did not visit him. He was pleased, because it meant he could go fishing with the man next door.

Reflect on the countertransference and ensure that you are not acting out when making an interpretation. For example, a young woman with borderline personality disorder may evoke in you intense feelings of anger. If you do not recognise this, you may act out by making a cruel statement to her masked as an interpretation.

Finally, there is always the danger of wanting to be clever. The elegance of an insight can sometimes tempt us to make an interpretation that is either wrong or mistimed. As a rule, it is better to say nothing—to listen and clarify, rather than risk making an interpretation that may be perceived by the patient as unempathic, demeaning or even insulting.

## **Training**

The aim of this chapter was to acquaint you with some of the principles of dynamic psychotherapy that may help improve your understanding of patients and deepen your formulations of their problems. If you wish to perform short-term dynamic psychotherapy, you should first undergo a period of training and supervision.

# Chapter 13

## Pharmacological treatments

This chapter contains brief descriptions of the classes of drugs that are most commonly used in the treatment of mental disorders. The recommended doses are for physically healthy adults of average weight. Adjustments need to be made for elderly people, children, young people and those with physical illnesses. Drug treatments for mental disorders are changing rapidly. I therefore, recommend that you obtain each new edition of *Therapeutic Guidelines*, as it becomes available<sup>1</sup>.

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**General practitioners are advised to obtain a copy of each new edition of *Therapeutic Guidelines* as it becomes available.<sup>2</sup>**

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### Antipsychotics

Traditional antipsychotics have been used in the treatment of psychosis since the 1950s. Recently, five new drugs have become available in Australia—clozapine, risperidone, quetiapine, olanzapine and amisulpride. These have different mechanisms of action, side effect profiles and therapeutic responses from conventional antipsychotics. See also Chapter 22 for practical tips on the prescription of these drugs.

#### Traditional antipsychotics

These drugs are thought to exert their therapeutic effects through the blockade of D2 dopamine receptors in mesolimbic and mesocortical systems. The main indication is the treatment of positive symptoms of psychosis (i.e. hallucinations, delusions and formal thought disorder) and the prevention of relapse in schizophrenia. They are less effective and slower to act in the alleviation of negative symptoms. In fact, they may worsen negative symptoms when used in high doses. They are also used in the treatment of other acutely disturbed people, for example, the delirious patient.

There is no evidence that any one traditional antipsychotic is more effective than another. The differences are in the side effect profiles. In general, low potency drugs, such as chlorpromazine, cause more sedation and anticholinergic side effects, but only moderate extrapyramidal side effects, while high potency compounds, such as fluphenazine, trifluoperazine, haloperidol and thiothixene, have more extrapyramidal effects, but cause less sedation and fewer anticholinergic effects.

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**Low potency antipsychotics cause more sedation and anticholinergic side effects. High potency drugs cause more extrapyramidal side effects.**

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Depot preparations of fluphenazine (Modectate), haloperidol (Haldol), flupenthixol (Fluanxol), risperidone (Risperdal Consta) and zuclopenthixol (Clopixol) may be prescribed when adherence to oral medication is in doubt. Note that the depot medication is zuclopenthixol decanoate (Clopixol Depot). Zuclopenthixol acetate (Clopixol Acuphase) is used for the management of psychiatric emergencies and can cause marked sedation for around three days.

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<sup>1</sup> The Writing Group. *Therapeutic Guidelines: Psychotropic Version 4, 2000*. North Melbourne, Therapeutic Guidelines Ltd: 2000

<sup>2</sup> *ibid.*

Recommended doses of antipsychotics are lower than those used in the past. Doses above 15mg equivalent of haloperidol have no additional antipsychotic effect, but certainly increase the incidence of adverse effects. Antipsychotics take at least two weeks to begin to produce their therapeutic effect. In the treatment of first episodes of psychosis, they may take as long as 11 weeks to act. Therefore, it is important to be patient and not increase doses prematurely in the early phases of treatment.

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**Doses above 15mg equivalent of haloperidol produce more side effects, but no additional antipsychotic effect.**

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In acute psychosis, control of disturbed behaviour can be gained through adjunctive treatment with a benzodiazepine. Antipsychotics are usually continued for at least 12 months following a first episode of psychosis. If the person remains symptom free, the dose may then be gradually lowered and then ceased. It is wise to follow up patients for at least 12 months after ceasing an antipsychotic.

Use anticholinergics to avoid dystonic reactions early in treatment or when the dose changes. Young men are particularly prone to suffering dystonic reactions, especially when administered potent antipsychotics. Once a steady dose has been established, the anticholinergic can usually be withdrawn. Anticholinergics have significant side effects of their own—dry mouth, constipation, blurred vision, worsening of glaucoma, urinary obstruction and confusion. In the elderly, they can cause delirium. Moreover, with the exception of Parkinsonism, they are of limited value in treating the other extra-pyramidal syndromes. For persistent extrapyramidal symptoms, consider dose reduction or switching to one of the newer antipsychotics.

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**Once a steady dose of antipsychotic has been established, anticholinergic agents can usually be withdrawn.**

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*Adverse effects*

1. Extrapyramidal effects – These are caused by dopamine blockade in nigrostriatal pathways.
  - a) Acute dystonia involves muscular spasm of the extra-ocular muscles (oculogyric crisis), the neck, trunk or hands. Young males are particularly at risk, especially early in treatment. Laryngeal dystonia can be fatal. Always warn patients and their carers about dystonic reactions. Laryngeal dystonia can be accompanied by a feeling of tongue swelling. Be careful not to mistake this for an allergic reaction. Consider the use of an anticholinergic agent, especially when commencing treatment with one of the potent antipsychotics.
  - b) Akathisia is a feeling of agitation usually accompanied by restless legs. It is a particularly unpleasant side effect. Since people often do not recognise that it is a drug side effect, you should inquire about it. It is generally less responsive to anticholinergic treatment than dystonias and Parkinsonian side effects. Treat it by reducing the dose or by changing to one of the newer antipsychotics. Diazepam and propranolol may help some people cope with this side effect.

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**Akathisia tends to respond poorly to anticholinergics. Treat it by reducing the antipsychotic dose or changing to one of the newer atypical agents.**

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- c) Parkinsonian side effects include rigidity, bradykinesia and a fine tremor. On examination, cogwheeling may be present. Parkinsonian side effects may be complicated by falls, especially in the elderly. They may be mistaken for signs of a depressive syndrome. Anticholinergics may reduce acute Parkinsonian symptoms, but dose reduction or changing to a newer antipsychotic are better long-term strategies.

d) Tardive Dyskinesia is a potentially permanent adverse effect of antipsychotics involving abnormal choreoathetoid movements, especially of the tongue, mouth, lips and jaw. It may also affect muscles of the limbs and trunk. Tardive Dystonia involves mass involuntary contractions of muscles of the tongue, face, neck and back. The risk of developing these side effects increases with increasing exposure to traditional antipsychotics. However, they can occur after only limited exposure. The elderly (especially older women) and people with brain damage are at higher risk of developing the tardive syndromes. Remember that antipsychotics, while causing these adverse effects, also suppress their manifestations. As a consequence, they may first become evident after dose reduction. Since there is no known treatment, it is important to minimise the risk of its development by using the lowest effective dose of antipsychotic.

With the advent of the atypical antipsychotics, which appear to have a lower propensity to cause these adverse effects, it is essential to carefully monitor for the development of tardive dyskinesia and tardive dystonia. I recommend that screening should be performed and documented at least once a year for people on long-term treatment (see Abnormal Involuntary Movements Scale (AIMS), Appendix 10).

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**Use the AIMS instrument to screen for the presence of tardive dyskinesia at least once a year.**

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2. Anticholinergic effects – These include dry mouth, constipation, blurred vision and urinary retention. In the elderly, antipsychotics can cause delirium, especially when used together with other drugs with anticholinergic effects (for example, antiparkinsonians or tricyclics). They may precipitate narrow angle glaucoma. Low potency agents such as chlorpromazine have the most pronounced anticholinergic effects, risperidone the least.
3. Sedation is thought to be due to histamine receptor blockade. Always advise patients of possible effects on driving, and the interaction with alcohol.
4. Postural hypotension – Adrenoceptor blockade leads to a failure of the reflex constriction of veins in the lower limbs that normally occurs on standing. Patients should be advised to take care when rising, to sit on the edge of the bed before getting up, and to sit down if they feel faint or dizzy. This side effect is most pronounced with low potency antipsychotics such as chlorpromazine.
5. Sexual dysfunction – Antipsychotics can cause erectile dysfunction and ejaculatory dysfunction. These effects are most pronounced with thioridazine and least with olanzapine and quetiapine.
6. Neuroleptic malignant syndrome – This is a rare syndrome, but has a mortality rate of between five and 10 per cent. It presents with fever, muscular rigidity, autonomic instability (fluctuating pulse rate, blood pressure and respiratory rate) and delirium. Electrolytes, liver function and creatinine phosphokinase are elevated. It is a medical emergency, often requiring admission to an intensive care unit for supportive measures to lower temperature and to maintain blood pressure and hydration. Dantrolene is sometimes used to lessen muscle rigidity.

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**Neuroleptic malignant syndrome is a medical emergency that presents with fever, muscular rigidity, autonomic instability and delirium.**

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7. Retinal pigmentation, caused by the deposition of pigmented granules, can lead to decreased acuity, poor night vision and 'browning' of vision. Those on thioridazine are most at risk. Any person on long-term thioridazine should have an annual ophthalmological examination.



8. Photosensitivity – People prescribed chlorpromazine are most at risk. They should be advised to wear a hat when out of doors and to use a blockout sunscreen. Yearly ophthalmological examinations for lens opacities are advisable for those on long-term treatment.
9. All of these drugs can cause ECG changes. Thioridazine can now only be prescribed to people with schizophrenia who have failed to respond to treatment with at least two other antipsychotic drugs. It is contraindicated in combination with other drugs that inhibit cytochrome P450 2D6 and drugs that prolong the QTc interval. It is also contraindicated in people with a history of cardiac arrhythmias or congenital long QT syndrome. Periodic monitoring of the QTc interval and serum potassium are required. People with a pre-treatment QTc interval greater than 450 msec should not receive the drug. It should be discontinued in patients with QTc greater than 500 msec.

Instances of sudden death have occurred with pimozide.

10. Hyperprolactinaemia is caused by dopamine receptor blockade in the tubuloinfundibular pathways. It may be manifest by galactorrhoea, amenorrhoea and reduced libido.

### Atypical antipsychotics

These include risperidone, olanzapine, quetiapine, amisulpride and clozapine. They are thought to exert their action through the blockade of dopamine, and serotonin receptors. Clozapine is effective in 10–20 per cent of cases resistant to treatment with other antipsychotics. All have a lower propensity to cause extrapyramidal effects. They are effective in reducing both negative and positive symptoms. Risperidone, quetiapine, olanzapine and amisulpride are presently only available on authority prescription for people with schizophrenia. Clozapine can cause neutropaenia in 5–10 per cent of people and agranulocytosis in 0.5–1 per cent. It has also been associated with potentially fatal myocarditis and cardiomyopathy. Side effects include weight gain, sedation, postural hypertension, hypersalivation, constipation and a decrease in seizure threshold. Consequently, it can only be prescribed at sites registered with the Clozaril Patient Monitoring System.

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**The newer antipsychotics cause fewer extrapyramidal side effects and are associated with fewer negative symptoms. Clozapine is effective in some cases that are resistant to other antipsychotics.**

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The atypical antipsychotics are generally better tolerated than conventional antipsychotics, however, they are not free of adverse effects (see Table 13-1). Atypical antipsychotics, especially clozapine and olanzapine, have been linked to impaired glucose metabolism, weight gain, raised lipid levels and an increased risk of developing diabetes mellitus. Of particular concern are reports of patients treated with clozapine and olanzapine developing diabetic ketoacidosis shortly after initiation of the drug. Patients treated with these agents should be routinely screened for diabetes and other metabolic abnormalities, including raised lipid levels. Patients with other risk factors for diabetes should be monitored more closely.<sup>1</sup>

### Antidepressants

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**The newer antidepressants are safer in overdose than tricyclics.**

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There are eight classes of antidepressants currently available in Australia—tricyclics, tetracyclics, monoamine oxidase inhibitors (MAOIs), specific serotonin reuptake inhibitors (SSRIs), reversible

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<sup>1</sup> Henderson DC. Atypical antipsychotic-induced diabetes mellitus: how strong is the evidence? *CNS Drugs* 2002; 16:77–89.



inhibitors of monoamine oxidase (RIMAs), serotonin receptor antagonists, selective inhibitors of noradrenaline reuptake (SNRIs) and noradrenergic and specific serotonergic antidepressants (NaSSAs). For a list of the advantages and disadvantages of the different classes of antidepressants, see Table 13-3. Drug interactions with the newer antidepressants are shown in Table 13-2, and recommendations for changing antidepressants are given in Table 13-4.

Antidepressants are used not only in the treatment of depression, but also in anxiety disorders such as panic disorder, and in chronic pain. Clomipramine and the SSRIs have been shown to be effective in the treatment of obsessions. All antidepressants can precipitate mania in people with bipolar mood disorder, but there is some evidence that this is less likely with SSRIs<sup>1</sup>. The concurrent administration of lithium or an anticonvulsant mood stabiliser lessens the likelihood of this occurring.

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**The concurrent administration of a mood stabilising drug together with an antidepressant can prevent the development of mania in people with bipolar disorder.**

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Patients need to be informed that these drugs take two to four weeks to begin to have their antidepressant effect. To prevent relapse after a first episode of major depression, they should be continued for at least six to 12 months.

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**There is a delay of between two and four weeks before antidepressants begin to have their antidepressant effect.**

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### Tricyclic antidepressants

These drugs have been available for some years and have proven efficacy, but they have a higher side effect burden than the newer antidepressants. They are thought to exert their antidepressant effect through inhibition of the reuptake of serotonin and noradrenaline into presynaptic neurones.

Half-lives are between 15 and 30 hours, allowing a single dose, usually at night. The drugs should be started at a low dose, for example, 50mg at night, and then gradually increased over one to two weeks up to 150mg a day. Lower doses should be used in elderly people.

Tricyclics are dangerous in overdose and can be fatal because of their effects on cardiac conduction and their propensity to lower seizure threshold. They may cause a variety of arrhythmias, including ventricular tachycardia, and complete heart block. Patients should be asked about any suicide plans. It is often advisable to prescribe only a week's supply of the drug at a time.

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**Tricyclics can cause death in overdose through cardiac conduction abnormalities, seizures or respiratory arrest.**

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#### *Adverse effects*

Tricyclics have a wide range of potential adverse effects. Patients should be informed of these before commencing treatment.

1. Anticholinergic effects include dry mouth, blurred vision, constipation, urinary retention and tachycardia. Tricyclics can cause an anticholinergic delirium, especially in the elderly. Amitriptyline and clomipramine are strong anticholinergics, whereas desipramine is relatively weak.
2. Sedation is thought to be due to histamine and alpha-adrenergic blockade. Amitriptyline and

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<sup>1</sup> Bazire S. *Psychotropic Drug Directory 2001-2002: the Professionals' Pocket Handbook and Aide Memoire*. Bath, Bath Press, 2001.

Table 13-1: Selected features of the newer antipsychotics

Medication	Dose	Indication for use	Evidence for efficacy	Side effects (selection only)	Comments
<b>Clozapine</b>	200–800mg/day (Therapeutic range: 400–1000µg/L)	for those patients who have not responded to other antipsychotic medications (including risperidone and olanzapine)	Cochrane review <sup>1</sup> 29 studies based on 2490 participants. Clozapine (versus typical antipsychotics) • fewer relapses • greater reduction in symptoms • fewer drop-outs • greater consumer satisfaction	<ul style="list-style-type: none"> <li>• sedation</li> <li>• hypersalivation</li> <li>• weight gain</li> <li>• hyperglycaemia</li> <li>• diabetes mellitus</li> <li>• abnormal lipid levels</li> <li>• ketoacidosis</li> <li>• postural hypotension</li> <li>• higher doses increase the risk of convulsions</li> <li>• 1 per cent risk of agranulocytosis</li> </ul>	<ul style="list-style-type: none"> <li>• requires regular haematological monitoring</li> <li>• 31 per cent of treatment resistant patients have clinical improvement</li> </ul>
<b>Risperidone</b>	<b>1–6mg/day</b>	<ul style="list-style-type: none"> <li>• first admission patients with schizophrenia</li> <li>• patients with sub-optimal symptom management on traditional antipsychotics</li> </ul>	Cochrane review <sup>2</sup> 14 studies based on 3401 participants. Risperidone (versus typical antipsychotics) • greater clinical improvement • little or no additional effect on positive or negative symptoms • fewer drop outs	<ul style="list-style-type: none"> <li>• insomnia</li> <li>• headache</li> <li>• nausea</li> <li>• blocked nose</li> <li>• mild extrapyramidal side effects</li> <li>• weight gain</li> <li>• hyperglycaemia</li> <li>• diabetes mellitus</li> <li>• abnormal lipid levels</li> <li>• hyperprolactinaemia (leading to amenorrhoea, galactorrhea, impotence)</li> <li>• postural hypotension</li> </ul>	<ul style="list-style-type: none"> <li>• risperidone lacks anticholinergic properties.</li> <li>• patients switched from older antipsychotics (which often required the co-prescription of anticholinergics to reduce extrapyramidal side effects) to risperidone can suffer cholinergic rebound (flu-like symptoms)</li> </ul>
<b>Olanzapine</b>	<b>5–20mg/day</b>	<ul style="list-style-type: none"> <li>• first admission patients with schizophrenia</li> <li>• patients with extrapyramidal side effects on traditional antipsychotics</li> <li>• patients with sub-optimal symptom management on traditional antipsychotics</li> </ul>	Cochrane review <sup>3</sup> 5 studies based on 2911 participants. Olanzapine (vs. typical antipsychotics) • effective antipsychotic • fewer drop-outs • lower depression scores • fewer extrapyramidal side effects	<ul style="list-style-type: none"> <li>• sedation</li> <li>• weight gain</li> <li>• hyperglycaemia</li> <li>• diabetes mellitus</li> <li>• abnormal lipid levels</li> <li>• ketoacidosis</li> <li>• dizziness</li> <li>• postural hypotension</li> <li>• mild anticholinergic effects</li> </ul>	<ul style="list-style-type: none"> <li>• transient elevation of liver enzymes</li> <li>• lower incidence of tardive dyskinesia compared to haloperidol</li> </ul>

(Table 13-1 continued next page)

**Table 13-1: Selected features of the newer antipsychotics (continued)**

Medication	Dose	Indication for use	Evidence for efficacy	Side effects (selection only)	Comments
<b>Quetiapine</b>	<b>150–750 mg/day</b>	<ul style="list-style-type: none"> <li>• first admission patients with schizophrenia</li> <li>• patients with extrapyramidal side effects on traditional antipsychotics</li> </ul>	Cochrane review <sup>4</sup> 11 studies Quetiapine (vs. typical antipsychotics) <ul style="list-style-type: none"> <li>• effective antipsychotic</li> <li>• fewer drop-outs</li> <li>• fewer extrapyramidal side effects</li> </ul>	<ul style="list-style-type: none"> <li>• somnolence</li> <li>• fatigue</li> <li>• postural hypotension</li> <li>• dry mouth</li> <li>• dyspepsia</li> <li>• constipation</li> <li>• dizziness</li> <li>• rhinitis</li> <li>• weight gain</li> <li>• hyperglycaemia</li> <li>• diabetes mellitus</li> <li>• abnormal lipid levels</li> </ul>	<ul style="list-style-type: none"> <li>• incidence of EPS similar to placebo</li> <li>• somnolence is major side effect</li> </ul>
<b>Amisulpride</b>	<b>50–800 mg/day (Divided doses above 400mg/day)</b>	treatment of acute and chronic schizophrenic disorders in which positive and/or negative symptoms are prominent	Cochrane review <sup>5</sup> 19 studies based on 2443 participants Amisulpride (versus typical antipsychotics) <ul style="list-style-type: none"> <li>• more effective in improving global state, general mental state and negative symptoms</li> <li>• as effective for positive symptoms</li> <li>• fewer extrapyramidal side-effects</li> </ul>	<ul style="list-style-type: none"> <li>• insomnia</li> <li>• anxiety</li> <li>• agitation</li> <li>• tremor</li> <li>• somnolence</li> <li>• headache</li> <li>• hypersalivation</li> <li>• constipation</li> <li>• nausea</li> <li>• weight gain</li> <li>• amenorrhoea</li> <li>• galactorrhea</li> <li>• hyperglycaemia</li> <li>• diabetes mellitus</li> <li>• abnormal lipid levels</li> <li>• prolonged QT</li> <li>• extrapyramidal side effects</li> </ul>	<ul style="list-style-type: none"> <li>• dose for acute psychosis: 40–800mg/day</li> <li>• dose for predominantly negative symptoms: 50–300mg/day</li> <li>• contraindicated in combination with other drugs that cause QT prolongation, and care with drugs that can cause hypokalaemia</li> </ul>

<sup>1,2,3,4&5</sup> Cochrane Library: <http://som.flinders.edu.au/FUSA/COCHRANE/cochrane/health.htm>.

doxepin are quite sedating, desipramine less so. Patients should be advised not to drive until tolerance to this side effect has developed. They should also be advised of the potentiation of sedation by alcohol.

3. Postural hypotension, sexual dysfunction and weight gain are caused by alpha-adrenergic blockade.
4. Cardiac conduction abnormalities – Tricyclics have a quinidine-like anti-arrhythmic action as well as antimuscarinic effects. They are contraindicated in people with severe conduction abnormalities (e.g. second or third degree atrioventricular block or right bundle branch block,) or within two months of a myocardial infarction. They should be used with caution in patients with ischaemic heart disease or ventricular arrhythmias.<sup>1</sup> People over 40 years old or otherwise at risk should have a cardiovascular system examination and an ECG before commencing treatment with a tricyclic. These drugs can cause sudden death in children and young people.
5. Seizures – Tricyclics lower the seizure threshold and should be used with care in people with a history of epilepsy.
6. Precipitation of mania.

### **Selective serotonin reuptake inhibitors**

The SSRIs are as effective as tricyclics in the treatment of depression. They have fewer side effects because of their lower affinity for acetylcholine, dopamine, histamine and adrenoceptors. They are much safer drugs with minimal effects on cardiac conduction. SSRIs currently available in Australia include fluoxetine, paroxetine, sertraline, fluvoxamine and citalopram.

The effective half-life of fluoxetine is long (between one and two weeks) because of its active metabolite, norfluoxetine. Therefore, it takes over a month to reach steady state levels. It also inhibits liver metabolism and so increases the plasma levels of several drugs, including tricyclics. The half-lives of paroxetine and sertraline are around 24 hours, with steady-state concentrations being reached after about a week. A dose of one tablet taken in the morning is usually adequate (fluoxetine 20mg, paroxetine 20mg, sertraline 50mg, fluvoxamine 50mg or citalopram 20mg).

Adverse reactions include nausea, diarrhoea, headache, tremor, agitation and anxiety. Because of their activating side effects, these drugs are usually taken as a single dose in the morning. A benzodiazepine may be prescribed at night during the first two weeks for insomnia. Unlike tricyclics, the SSRIs do not alter sleep architecture and so usually improve sleep once they are having their antidepressant effect. They cause sexual dysfunction, especially delayed ejaculation.

Although they are relatively free of cardiovascular side effects and have a low lethality in overdose, they must not be taken with MAOIs or RIMAs because of the risk of causing a potentially fatal serotonergic syndrome. A washout period of at least five half-lives is required before changing from an SSRI to a MAOI (i.e. 5 weeks for fluoxetine and 2 weeks for sertraline and paroxetine). SSRIs inhibit the breakdown of tricyclics. Therefore, they should not be prescribed together.

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**SSRIs inhibit the breakdown of tricyclics and so should not be prescribed together with them.**

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<sup>1</sup> Bazire S. *Psychotropic Drug Directory 2001/02: the Professionals' pocket handbook and aide memoire*. Bath, Bath Press: 2000.

**Table 13-2: Drug interactions with the newer antidepressants**

	Cytochrome-P450	Cytochrome-P450
	2D6	3A4
<b>Citalopram</b>	+	-
<b>Fluoxetine</b>	+++	++/+++
<b>Fluvoxamine</b>	-	++
<b>Mirtazapine</b>	-	-
<b>Nefazodone</b>	-	++
<b>Paroxetine</b>	+++	-
<b>Sertraline</b>	+ / ++	-
<b>Venlafaxine</b>	-	-
<b>Potential interactions</b>	<b>neuroleptics</b> <b>tricyclics</b> antiarrhythmics B-blockers phenytoin opiates codeine clozapine risperidone	<b>cisapride</b> <b>alprazolam</b> <b>tricyclics</b> calcium channel blockers benzodiazepines terfenadine astemizole carbamazepine
<b>Strength of interactions: +++potent, ++modest, +weak.</b>		

Adapted from: Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. *Treating depression and anxiety in general practice: training manual*. Kogarah, NSW: Educational Health Solutions, 1998.

### **Irreversible inhibitors of monoamine oxidase (MAOIs)**

Two MAOIs are available in Australia—phenelzine and tranylcypromine. Since these drugs are irreversible inhibitors of MAO, it takes around two weeks before normal levels of the enzyme are restored after cessation of the drug. They are also non-selective, inhibiting both MAO-A and MAO-B. Their use is limited because of their propensity to cause serious adverse reactions, and because of dangerous interactions with foods and other drugs (see Table 13-5). We recommend that they only be prescribed on the advice of a psychiatrist. Doses of phenelzine commence at 15mg morning and midday, increasing to between 45mg and 60mg a day up to a maximum of 45mg bd; tranylcypromine, beginning at 10mg bd increasing to 30–40mg/day with a maximum of 30mg bd.

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**The use of MAOIs is limited because of their propensity to cause serious adverse reactions—in particular, because of their dangerous interactions with other drugs and foods.**

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#### *Hypertensive crisis*

This potentially fatal adverse reaction is caused by an interaction with foods that contain tyramine or other sympathomimetic amines, or with sympathomimetic drugs (e.g. cold remedies that contain phenylephrine and pseudoephedrine). A list of foods and drugs that must be avoided is shown in Table 13-5. Tyramine is usually metabolised by MAO-A present in the bowel wall and the liver. When the action of this enzyme is inhibited, tyramine enters the systemic circulation leading to the release of amines from peripheral nerve endings, which in turn may cause a hypertensive crisis. Symptoms include headache, flushing, photophobia, nausea and vomiting, and palpitations.

#### *Pethidine reaction*

The drug interaction with pethidine can cause fever, labile blood pressure, delirium and coma. MAOIs may need to be ceased before a general anaesthetic.

#### *Reaction with tricyclic antidepressants and SSRIs*

The interaction can cause a serotonergic syndrome with tremor, incoordination, diarrhoea, abdominal cramping, agitation, delirium, tachycardia, hypertension, coma and death.

The common side effects of MAOIs include the following:

- postural hypotension
- dry mouth, blurred vision and constipation (anticholinergic)
- sexual dysfunction – anorgasmia, impotence and ejaculatory failure
- arousal and insomnia – for this reason, the drugs are usually prescribed in divided doses in the morning and at midday
- sedation – some people are sedated rather than aroused.

### **Reversible selective inhibitors of monoamine oxidase**

Moclobemide differs from conventional MAOIs in two ways. First, it is selective, inhibiting the action of MAO-A, but not of MAOI-B. Consequently, it does not produce the tyramine reaction. Second, its action is reversible with normal activity of MAO-A being restored within two to three days of cessation of the drug. Doses usually begin at 150mg bd and are increased to 300–600mg bd (morning and midday) over the following one to two weeks.

Adverse effects include nausea, anxiety, insomnia, headache and dizziness. It should not be prescribed together with pethidine. Cimetidine inhibits its metabolism, so the dose should be halved if used together with this drug.

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### **RIMAs should not be prescribed together with pethidine.**

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#### **Mianserin**

Mianserin has a tetracyclic structure. Its antidepressant action is not well understood. It is an antagonist at presynaptic alpha-2-adrenergic, serotonergic and histaminic receptors. It is strongly sedative. It has fewer cardiotoxic effects and is less lethal in overdose than the tricyclics. Doses begin with 30–60mg at night and are increased over the following week to 90–120mg at night.

It can cause neutropaenia. Therefore, it is advisable to perform a blood count before commencing the drug and then monthly over the first three months. A full blood examination is also advisable if any signs of infection develop, for example, sore throat or fever. The patient should be advised that these symptoms might be early evidence of neutropaenia and to consult a doctor if they develop. Mianserin can also cause polyarthritis.

#### **Nefazodone**

Nefazodone is a serotonin receptor antagonist. Adverse effects include dry mouth, nausea, sedation, dizziness, constipation, fatigue, light-headedness, blurred vision and tinnitus. The incidence of sexual dysfunction is said to be less than with SSRIs.

The manufacturer recommends a gradual increase in dose from 50mg bd in the first week to 200mg bd in the third week. Recommended therapeutic doses are between 300mg and 600mg a day.

**Table 13-3: Which antidepressant?**

<b>Class</b>	<b>Daily dose</b>	<b>Advantages</b>	<b>Disadvantages</b>
Tricyclic antidepressants (amitriptyline, imipramine, dothiepin, doxepin, trimipramine, desipramine, nortriptyline, clomipramine)	<ul style="list-style-type: none"> <li>• 100 – 250mg divided doses with evening preference</li> <li>• low dose (10 – 50mg as evening dose) in treatment of chronic pain and fibromyalgia</li> </ul>	<ul style="list-style-type: none"> <li>• gold standard for treatment of severe depression</li> <li>• clomipramine effective in the treatment of obsessive compulsive disorder</li> </ul>	<ul style="list-style-type: none"> <li>• potential for cardiotoxicity, sudden death in people under 18 years, danger in overdose</li> <li>• wide side effect profile: sedation, anti-cholinergic, postural hypotension</li> </ul>
Selective serotonin reuptake inhibitors (SSRIs) (fluoxetine, sertraline, paroxetine, fluvoxamine and citalopram)	<ul style="list-style-type: none"> <li>• sertraline: 50 – 200mg once daily</li> <li>• fluoxetine: 10 – 40mg once daily</li> <li>• paroxetine: 10 – 40mg once daily</li> <li>• fluvoxamine: 50 – 200mg once daily</li> <li>• citalopram 20 – 60mg once daily</li> </ul>	<ul style="list-style-type: none"> <li>• relative safety in overdose</li> <li>• non-sedating</li> <li>• effective in the treatment of obsessive compulsive disorder</li> </ul>	<ul style="list-style-type: none"> <li>• side effects may include sexual dysfunction, nausea, diarrhoea, agitation, anxiety, sleep disturbance, headache and fatigue, especially early in treatment</li> <li>• drug interactions (see Table 13-2): including inhibition of breakdown of tricyclics</li> </ul>
Serotonin antagonists (nefazodone)	<ul style="list-style-type: none"> <li>• 200 – 600mg in divided doses with evening preference</li> </ul>	<ul style="list-style-type: none"> <li>• no sexual side effects</li> <li>• useful in the treatment of anxiety</li> </ul>	<ul style="list-style-type: none"> <li>• sedation, dry mouth, constipation, blurred vision, nausea, fatigue and tinnitus</li> <li>• drug interactions (P450 – 3A4)</li> </ul>
Serotonin and noradrenaline reuptake inhibitors (venlafaxine)	<ul style="list-style-type: none"> <li>• 75 – 375mg in divided doses with evening preference</li> </ul>	<ul style="list-style-type: none"> <li>• effective in severe depression</li> <li>• few drug interactions</li> <li>• short half-life</li> </ul>	<ul style="list-style-type: none"> <li>• relatively high side effect burden: nausea, anxiety, fatigue, headaches, sexual dysfunction, elevated blood pressure</li> <li>• withdrawal syndrome</li> </ul>
Reversible inhibitors of monoamine oxidase A (RIMAs) (moclobemide)	<ul style="list-style-type: none"> <li>• 450 – 600mg in divided doses with morning preference</li> </ul>	<ul style="list-style-type: none"> <li>• non-sedating</li> <li>• no sexual side effects</li> <li>• few drug interactions</li> <li>• use in depression with fatigue</li> </ul>	<ul style="list-style-type: none"> <li>• side effects: nausea, anxiety, insomnia, headache, agitation and dizziness</li> <li>• interactions with pethidine and cimetidine</li> </ul>
Noradrenergic and Specific Serotonergic Antidepressants (NaSSA) (mirtazapine)	<ul style="list-style-type: none"> <li>• 15-45mg once daily with evening preference</li> </ul>	<ul style="list-style-type: none"> <li>• low incidence of agitation, sexual dysfunction, nausea and vomiting</li> <li>• useful in treatment of anxiety symptoms and insomnia</li> <li>• little effect on cytochrome P450</li> <li>• few drug interactions</li> <li>• relative safety in overdose</li> </ul>	<ul style="list-style-type: none"> <li>• sedation, weight gain, dry mouth and headache</li> </ul>
Tetracyclic antidepressant (mianserin)	<ul style="list-style-type: none"> <li>• 30 – 90mg in divided doses with evening preference</li> </ul>	<ul style="list-style-type: none"> <li>• relative safety in the elderly and medically ill</li> </ul>	<ul style="list-style-type: none"> <li>• sedation</li> <li>• potential to cause neutropaenia and polyarthrititis (rare)</li> </ul>
Monoamine oxidase inhibitors (MAOIs) (phenelzine, tranylcypromine)	<ul style="list-style-type: none"> <li>• phenelzine: 45 – 90mg a day in divided doses with morning preference</li> <li>• tranylcypromine: 20 – 60mg a day in divided doses with morning preference</li> </ul>	<ul style="list-style-type: none"> <li>• non-sedating</li> <li>• use in atypical depression</li> </ul>	<ul style="list-style-type: none"> <li>• potentially fatal hypertensive crisis as result of tyramine reaction</li> <li>• severe interactions with pethidine, tricyclics and SSRIs</li> <li>• side effects: postural hypotension, insomnia and agitation</li> </ul>

Adapted from: Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. *Treating depression and anxiety in general practice: training manual*. Kogarah, NSW: Educational Health Solutions, 1998.

**Table 13-4: Changing antidepressants<sup>1</sup>**

Changing from:	Changing to:			
	Tricyclic	Mianserin	Fluoxetine	Other SSRIs
Tricyclic	No antidepressant-free interval required	No antidepressant-free interval required	1-week antidepressant-free interval (taper TCA dose in this period) if short-term TCA treatment	1-week antidepressant-free interval (taper TCA dose in this period) if short-term TCA treatment
Mianserin	No antidepressant-free interval required		No antidepressant-free interval required	No antidepressant-free interval required
Fluoxetine	Start TCA at low dose (TCA serum levels may be elevated for several weeks due to persisting SSRI-induced CYP 2D6 inhibition)	Start at low dose		Start at low dose
Other SSRIs	Start TCA at low dose (TCA serum levels may be elevated for several weeks due to persisting SSRI-induced CYP 2D6 inhibition)	Start at low dose	Start at low dose	Start at low dose
Moclobemide	1-day drug-free interval (from high dose of moclobemide). No drug-free interval (i.e. start day after stopping) if moderate doses of both drugs	1-day drug-free interval (from high dose of moclobemide). No drug-free interval (i.e. start day after stopping) if moderate doses of both drugs	1-day drug-free interval (from high dose of moclobemide). No drug-free interval (i.e. start day after stopping) if moderate doses of both drugs	1-day drug-free interval (from high dose of moclobemide). No drug-free interval (i.e. start day after stopping) if moderate doses of both drugs
Venlafaxine (treat as TCA until more information available)	No antidepressant-free interval required	No antidepressant-free interval required	1-week antidepressant-free interval (taper venlafaxine dose in this period) if short term venlafaxine treatment	1-week antidepressant-free interval (taper venlafaxine dose in this period) if short term venlafaxine treatment
Nefazodone	No antidepressant-free interval required	No antidepressant-free interval required	Start at low dose until more information available	Start at low dose until more information available
Irreversible MAOIs	2-week antidepressant-free interval	2-week antidepressant-free interval	2-week antidepressant-free interval	2-week antidepressant-free interval
Mirtazapine	Careful cross taper	Careful cross taper	Careful cross taper	Careful cross taper

<sup>1</sup>Adapted from Stuart Baker. Changing from one antidepressant to another. *Drug Wise* 1997; 21:46



<b>Changing to:</b>				
<b>Moclobemide</b>	<b>Venlafaxine</b>	<b>Nefazodone</b>	<b>Irreversible MAOI</b>	<b>Mirtazapine</b>
No antidepressant-free interval required (i.e. start day after stopping) if moderate doses of both drugs. 1-week antidepressant-free interval for clomipramine	Reduce gradually then wait for 4 days	Taper TCA gradually, cease, then wait 3–4 days. Start nefazodone at 50mg twice daily	1-week antidepressant-free interval	Careful cross taper
No antidepressant-free interval required if moderate doses of both drugs	Reduce gradually then wait for 4 days	Taper TCA gradually, cease, then wait 3–4 days. Start nefazodone at 50mg twice daily	1-week antidepressant-free interval	Careful cross taper
Taper high dose fluoxetine, cease before starting moclobemide. From low-moderate fluoxetine doses, no antidepressant-free period needed*	2-week antidepressant-free interval. Start venlafaxine at low dose	1–2 week antidepressant-free interval. Start nefazodone at 50mg twice daily	5-week antidepressant-free interval	Careful cross taper
Taper high dose SSRI gradually and cease before starting moclobemide. From low-moderate SSRI doses, no antidepressant-free period needed*	3-day antidepressant-free interval. Start venlafaxine at low dose	3–7 day antidepressant-free interval. Start nefazodone at 50mg twice daily	2-week antidepressant-free interval	Careful cross taper
	1-day drug-free interval (from high dose of moclobemide). No drug-free interval (i.e. start day after stopping) if moderate doses of both drugs	2–3 day antidepressant-free interval. Start nefazodone at 50mg twice daily	1-day drug-free interval (from high dose of moclobemide). No drug-free interval (i.e. start day after stopping) if moderate doses of both drugs	Careful cross taper
Taper high dose venlafaxine gradually and cease before starting moclobemide. From low-moderate venlafaxine doses, no anti-depressant-free period needed*		3–7 day antidepressant-free interval. Start nefazodone at 50mg twice daily	1-week antidepressant-free interval	Careful cross taper
Start at low dose until more information available, or if cautious a 1-week antidepressant-free interval	Suggest a 3-day antidepressant-free interval and start at low dose until more information available		1-week antidepressant-free interval	4 days antidepressant-free interval
No drug-free interval if moderate doses of both drugs but continue dietary restrictions for 2 weeks	2-week antidepressant-free interval	2-week antidepressant-free interval	2-week antidepressant-free interval (rare reports of sudden death with abrupt switch)	2-week antidepressant-free interval
Careful cross taper	Careful cross taper	4 days antidepressant-free interval	2 weeks antidepressant-free interval	

\*Start moclobemide at 150mg/day; after 2 days can increase to 300mg/day

## Venlafaxine

Venlafaxine is an inhibitor of the reuptake of serotonin and noradrenaline (SNRI). It has proven efficacy in severe depression. However, its use is limited by a relatively high side effect burden and discontinuation symptoms. Adverse effects include nausea, decreased appetite, fatigue, anxiety, headache, dizziness, insomnia or somnolence, increased sweating, sexual dysfunction and increased blood pressure. Discontinuation symptoms include headache, nausea, fatigue, dizziness and dysphoria. Recommended doses are between 75 and 375mg a day in divided doses.

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**Venlafaxine is a potent antidepressant. Its use is sometimes limited by its side effects and withdrawal effects.**

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## Mirtazapine

Mirtazapine is a Noradrenergic and Specific Serotonergic Antidepressant (NaSSA). It enhances both noradrenergic and serotonergic transmission while at the same time blocking 5HT<sub>2</sub> and 5HT<sub>3</sub> receptors. The blocking action permits selective 5HT<sub>1</sub> stimulation and, as a consequence, limits the occurrence of troublesome serotonergic side effects such as insomnia, sexual dysfunction, anxiety, agitation and headache, nausea and vomiting. The principal side effects are sedation (due to its antihistaminic action), weight gain, dry mouth (an adrenergic effect) and headache. It has a low propensity for drug interactions and generally, no withdrawal symptoms. Recommended doses are between 15 and 45 mg/day, given as a once daily dose at night. Paradoxically, sedation may be more pronounced at low compared to high doses.

## Antimanic drugs

### Lithium

Lithium is the treatment of choice for mania, both in the acute phase and in its prevention. The half-life is between 10 and 40 hours. Therefore, it takes between 2 and 10 days to reach a steady-state concentration. It is eliminated through renal excretion and so must be prescribed with care in people who suffer renal impairment, including those with congestive cardiac failure.

Its therapeutic range is between 0.5 and 1.2mmol/L, but higher levels (up to 1.4mmol/L) may be needed in the treatment of acute mania. Levels between 0.6 and 0.8mmol/L are usually adequate for prophylaxis. Lithium is usually started at a dose of around 250–500mg bd with the serum level being checked after five days and necessary adjustments then being made to the dose.

Before commencing lithium, tests of renal function and thyroid function should be performed. We recommend the following monitoring regime for those on long-term lithium: serum lithium every 3/12, renal function (electrolytes, creatinine and urea) every 6/12, and thyroid function annually.

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**Serum lithium should be checked every 3/12, renal function every 6/12 and thyroid function every 12/12.**

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At therapeutic levels, lithium can cause a fine tremor, muscle weakness, problems with memory and concentration, weight gain, polydipsia and polyuria (in 15–30 per cent of people), and rarely, extrapyramidal effects. Long-term adverse effects include hypothyroidism and euthyroid goitre. These can be treated with thyroxine replacement.

**Table 13-5: Irreversible monoamine oxidase inhibitor (MAOI) diet sheet**

<b>Foods</b>	<b>Permitted</b>	<b>Permitted in other quantities</b>	<b>To be avoided</b>
Bread/cereals	All permitted including yeast breads		
Fruit	All permitted except banana peel	Raspberries	Banana peel
Vegetables	All vegetables except broad bean pods and sauerkraut	Avocado	Broad bean pods, sauerkraut
Milk and milk products	Milk: full, reduced fat, skim, condensed, evaporated, powdered; pasteurised milk products including yoghurt, cottage, cream and ricotta cheeses; processed cheese slices; custard, ice-cream; junket.	Products home-made from unpasteurised milk e.g. yoghurt from unpasteurised milk	All matured or aged cheeses
Meat/fish/poultry/eggs/and other proteins	All meat, poultry and eggs if not aged, stale or spoiled. All fish except smoked or pickled fish. All vegetarian protein foods except aged or fermented soy products.	Soy sauce ( a dash or sprinkle is OK)	Aged meat or liver products (e.g. pate), dry sausage (e.g. salami); smoked or pickled fish (e.g. rollmops); soy products like miso and fermented soybean, curd or paste.
Fats and oils	All permitted including cream and sour cream (use before expiry date)	Cream made from unpasteurised milk	Expired (out of date) cream
Desserts	All permitted except banana chips and peel		Banana chips and banana flavoured dessert (banana peel is used in flavouring)
Soups	Fresh home-made permitted	Commercial soup bases, packet soups, tinned soups (use before expiry date)	
Drinks	All permitted except some alcoholic beverages, beef and yeast extracts	Coffee substitutes (e.g. Ecco) and up to a total of two standard glasses of red wines, white wines, port or manufactured beer	Bonox, Bovril, aged non-alcoholic beer (check expiry date) home-brewed beer, protein drink
Miscellaneous	Sugar, jam, honey, marmalade, salt, pepper, herbs, spices, vinegar, essences, flavouring syrups, sauces, confectionery (lollies)	Raspberry jam, chocolate	Vegemite, Marmite, Promite, brewer's yeast

Reproduced from:Victorian Drug Usage Advisory Committee. *Psychotropic Drug Guidelines*, 3<sup>rd</sup> edition, North Melbourne,Victoria,Victorian Medical Postgraduate Foundation Therapeutics Committee, 1995.

Toxic effects occur typically at levels above 2 mmol/L, but can occur at around 1.2 mmol/L. They include coarse tremor, nausea and vomiting, polydipsia and polyuria, dysarthria and ataxia, confusion, disorientation and delirium. Patients must be informed about these effects and the possible causes, including: dehydration secondary to diarrhoea, vomiting and excessive sweating (in fever or hot weather); interaction with thiazide and loop-acting diuretics, nonsteroidal anti-inflammatory drugs, and ACE inhibitors; and overdose.

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**Patients must be informed about the signs of lithium toxicity: tremor, nausea and vomiting, polyuria, polydipsia, slurred speech, ataxia and delirium.**

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Treatment of toxicity involves cessation of lithium and the restoration of fluid balance. Toxicity can cause irreversible brain damage and impaired renal concentrating ability.

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**Treatment of lithium toxicity involves cessation of lithium and restoration of fluid balance.**

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Lithium can cause congenital malformations, in particular, the cardiac Ebstein anomaly. Therefore, it is usually contraindicated during pregnancy, especially in the first trimester. Young women of childbearing age must be informed of this risk and given contraceptive advice. Lithium is excreted in breast milk, attaining concentrations in the infant between 0.1 and 0.5 those in the mother.

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**Lithium is contraindicated in pregnancy, especially during the first trimester.**

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### **Carbamazepine**

It is thought that carbamazepine exerts its therapeutic effect through the inhibition of kindling, a process whereby repeated stimuli to certain areas of the brain can cause a fall in the threshold for response and eventually to spontaneous discharge. The drug may be prescribed to those who cannot tolerate lithium, and in people with rapid-cycling bipolar disorder who fail to respond to lithium.

The drug is metabolised in the liver and has a half-life of 12–24 hours. It induces its own metabolism, so doses usually need to be increased after 2–4 weeks. Doses usually begin at 200mg at night or 200mg twice a day and are then increased until the plasma levels recommended for its use as an anticonvulsant are reached.

#### *Adverse reactions*

Dangerous adverse reactions are listed below.

1. Hypersensitivity reaction – This appears over the first two weeks of treatment, usually as a rash. The drug must be ceased.
2. Bone marrow toxicity – Monitoring of the full blood picture is advisable during the first few months of treatment.
3. Hepatic toxicity – Liver function should also be monitored. While a slight elevation in GGT is common due to hepatic enzyme induction, the drug should be ceased if there is a persistent elevation of liver enzymes.

At toxic levels, the drug can cause nausea, dizziness, dysarthria, diplopia and ataxia. At therapeutic levels, sedation may be a problem, but usually wears off after a few weeks. Other side effects include weight gain. There is an increased incidence of spina bifida if used in the first trimester of pregnancy (incidence around 0.5 per cent). This is lower than the risk associated with sodium valproate (incidence around 1.5 per cent).

Drug interactions limit the use of carbamazepine with many other medications. The following drugs inhibit the metabolism of carbamazepine: cimetidine, erythromycin, isoniazid, verapamil, dextro-propoxyphene and diltiazem. Since carbamazepine can enhance its own metabolism, levels should be checked periodically to maintain a therapeutic dose. It also increases the metabolism and so lowers the plasma levels of oral contraceptives (leading to contraceptive failure), other steroids, phenytoin, theophylline, warfarin, tricyclic antidepressants and antipsychotics.

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**The large number of potential drug interactions limits the use of carbamazepine**

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### **Sodium valproate**

The mode of action of sodium valproate in the treatment of mania is not known.

Valproate has a half-life of between 8 and 20 hours and so takes between two and five days to reach steady state. Doses usually begin at 200mg bd. The anticonvulsant levels are used as a guide to monitoring dose. There is some evidence that the use of a loading dose of valproate in the treatment of mania reduces the amount of antipsychotic required, and may shorten the length of the episode.

Adverse effects include nausea and vomiting, weight gain, thinning of hair, ankle swelling and sedation. More serious adverse reactions include hepatotoxicity, pancreatitis and thrombocytopenia. Periodic checks of liver function and blood count are therefore recommended.

Sodium valproate should not be prescribed during pregnancy, especially in the first trimester, because of the risk of it causing spina bifida.

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**Sodium valproate should not be prescribed during pregnancy, especially during the first trimester.**

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## **Anxiolytics and hypnotics**

### **Benzodiazepines**

Benzodiazepines are used in the treatment of anxiety disorders, as hypnotics and as adjuncts to antipsychotics in the treatment of agitated psychotic patients. They are also effective anticonvulsants and muscle relaxants. Recognition of their propensity for tolerance and dependence has led to greater care being taken in their prescription over recent years.

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**Benzodiazepines are useful adjuncts to antipsychotics in the treatment of agitated psychotic patients.**

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They have their effect through increasing the inhibitory effect of gamma amino butyric acid (GABA) on receptors in the central nervous system.

The fall in blood level and termination of action after a dose of diazepam is initially through redistribution to fat stores. However, if the drug is taken regularly over a few weeks, removal of the drug is by metabolism, a much slower process. Longer acting benzodiazepines include diazepam (half-life 20–100 hours) and clonazepam. Shorter acting drugs include temazepam, alprazolam and oxazepam. The long half-life of diazepam is due to its active metabolites.

Pharmacodynamic tolerance to the sedative effects of the drug develops within weeks. However, tolerance to the anxiolytic effects does not seem to occur. Sudden withdrawal can lead to agitation, anxiety, insomnia, nausea, hallucinations, delirium and seizures. Interactions occur

with other CNS depressants. Adverse effects include sedation, impaired fine motor coordination, dysarthria, nystagmus, ataxia and memory problems. In the elderly, ataxia can lead to falls and serious injury. Cognitive impairment may also be more severe in this group. The benzodiazepines are much safer than the barbiturate hypno-sedatives that they replaced. However, in overdose, death can result from respiratory depression, asphyxiation or inhalational pneumonia.

These drugs should not be prescribed to people with myasthenia gravis or severe respiratory depression.

Indications for the use of benzodiazepines include:

- the short-term treatment of insomnia
- the treatment of insomnia over the first two weeks of treatment with an SSRI
- as an adjunct to antipsychotics in the treatment of an agitated psychotic patient
- the treatment of akathisia
- the treatment of alcohol withdrawal
- as a preanaesthetic.

Although antidepressants and benzodiazepines are effective anxiolytics, I recommend cognitive behavioural therapy as the first line treatment of anxiety disorders (see Chapter 15). Cognitive behavioural therapy is at least as effective as pharmacotherapy; it is non-toxic, non-addictive and is associated with lower relapse rates than pharmacotherapy. However, at times, a combination of both approaches is required.

## **Zolpidem**

Zolpidem is an imidazopyridine that is used for the short-term treatment of insomnia in adults. It selectively binds to the omega-1 (benzodiazepine-1) receptor, part of the GABA<sub>A</sub> receptor complex, but is chemically unrelated to benzodiazepines. The usual dose is 10mg at night; 5 mg in elderly debilitated patients and those with hepatic impairment. The most common adverse effects are dizziness, nausea, drowsiness and diarrhoea. It has a short elimination half-life of around 2.4 hours with a duration of action up to six hours<sup>1</sup>.

## **Zopiclone**

Zopiclone is a cyclopyrrolone agent that is an agonist at GABA<sub>A</sub> receptors. It is used for the short-term treatment of insomnia. Usual doses are between 7.5mg and 15mg at night; 3.75 mg in the elderly and those with hepatic impairment. Side effects include bitter aftertaste and, more rarely, dry mouth, daytime sleepiness and nightmares<sup>2</sup>.

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<sup>1</sup> Adis editors. *Drug of the month* Stilnox. Generic Name: Zolpidem Tartrate *Current Therapeutics*. 2001; 42:79-81.

<sup>2</sup> Noble S, Langtry HD, Lamb HM. Zopiclone: an update of its pharmacology, clinical efficacy and tolerability in the treatment of insomnia. *Drugs*. 1998, 55: 277-302.

# Chapter 14

## Depression

Around 10 per cent of people presenting to general practitioners suffer from depression. Making a diagnosis is often difficult because mixed depression and anxiety occurs more frequently than depression or anxiety alone, and people often present with somatic rather than psychological symptoms. General practitioners see people with disorders across the broad spectrum of depressive illness from the milder forms through to severe melancholia and psychotic depression. The high prevalence 'minor' depressive syndromes, though not containing florid symptoms, are nevertheless associated with substantial disability and handicap, higher than that associated with most physical disorders<sup>1</sup>. Moreover, because of their high prevalence, the overall economic burden of these disorders on the community is substantial.

This chapter covers the assessment and treatment of depression and post-partum disorders. Chapter 15 deals with the treatment of anxiety disorders. See Appendix 11 for a discussion of sleep disturbance, a common presentation in general practice.

## Assessment

People use a variety of words to describe depression—feeling down in the dumps, sad, despondent, gloomy, bored or out of sorts. In some, especially adolescents and children, the predominant mood is irritability. An essential feature of the more serious depressive syndromes is anhedonia, the loss of pleasure or interest in almost all activities. Assess anhedonia by first asking a (man) about his usual interests and activities. Then ask if he is getting as much pleasure as usual from them. Ask him when he last did something he really enjoyed.

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**An essential feature of serious depression is anhedonia, the loss of pleasure or interest in almost all activities.**

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Neurovegetative symptoms of depression include loss of appetite, insomnia (especially early morning wakening), diurnal mood variation (in which the person feels most depressed in the morning with improvement in mood as the day progresses), loss of energy and motivation, reduced libido, difficulties with concentration and memory, and psychomotor retardation or agitation. Older sufferers may present with depressive pseudodementia.

Depressed people often experience feelings of hopelessness, i.e. that they have no future. Ask about future plans and goals. This symptom is a stronger predictor of suicide than depressed mood. Helplessness, the feeling that nothing and nobody can alleviate a person's suffering, may also be present. A person's self esteem is lowered in depression. Depressed people are often plagued by feelings of worthlessness and guilt. They may be preoccupied with thoughts of death and dying. Always ask direct questions about any suicidal thoughts, intentions and plans (see Chapter 3 for a discussion of the assessment of suicidality). In view of the frequent co-morbidity with anxiety disorders, it is important to note the presence of panic attacks, obsessive-compulsive symptoms and phobias.

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<sup>1</sup> Wells KB, Stewart A, Hays RD et al. The functioning and well-being of depressed patients: results from the medical outcomes study. *Journal of the American Medical Association* 1989; 262: 914-919.

## Depression presenting with physical symptoms

Between 50 per cent and 95 per cent of those who present to their general practitioners with depression do so with somatic rather than psychological symptoms. Common presenting symptoms include fatigue, headache, joint pain, chest pain, myalgia, gastro-intestinal disturbance, dizziness and weight loss.

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### **The commonest conditions seen in general practice are mixed anxiety/depressive disorders, often presenting with physical symptoms.**

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There are several possible reasons why people present in this way. Physical symptoms are features of both depression and anxiety. People may be better able to recognise and articulate their physical symptoms than their mental symptoms. They may believe that doctors are primarily skilled in the treatment of physical disorders. Doctors who are uncomfortable dealing with emotional issues, or who are pressed for time, may reinforce these attitudes. People may be reluctant to acknowledge mental symptoms because of the stigma of mental illness. They may be unaware that effective treatments exist for these conditions.

The SPHERE-GP is a self-report questionnaire that is useful in the assessment of people presenting with a combination of somatic and psychological symptoms (see example in Appendix 1). The CES-D scale is a self-report depression scale for use in the general population<sup>1</sup>.

## Depression as a response to physical illness

Between 20 and 30 per cent of people with chronic medical conditions will suffer major depression at some time during the course of the illness. When depression and physical illness occur together, the prognosis for both conditions is worse. For example, depressed patients have three and a half times the mortality of non-depressed patients in the six months following a myocardial infarction. Depression is most likely to occur in response to the diagnosis of chronic or life threatening disorders, or in disorders with distressing symptoms such as chronic pain or dyspnoea. Although painful psychological responses to having a physical illness are understandable, they need to be distinguished from major depression. In general, consider a diagnosis of depression if symptoms are more severe or persistent than expected in a normal grief reaction (see Chapter 7). The persistence of any of the following suggests the presence of depression: feelings of guilt and worthlessness, anhedonia, suicidality, poor concentration, psychomotor retardation or agitation, panic attacks, or psychotic symptoms. Be alert to somatic symptoms that cannot be accounted for by the physical illness.

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### **When depression and physical illness occur together, the prognosis for both conditions is worse.**

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Lists of physical disorders and drugs that can cause depression can be found in Tables 17-5 and 17-7.

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<sup>1</sup> Radloff LS. The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1977; 1:385-401.



## People at risk of depression

Table 14-1 lists some groups of people who are at increased risk of depression.

**Table 14-1: People at risk of depression**

- people with chronic, life-threatening physical illness, or with severe or disabling symptoms
- people with illnesses affecting the central nervous system (e.g. stroke, Parkinson's disease)
- sufferers of unexplained pain, hypochondriasis or prolonged fatigue
- elderly people, living alone
- people who abuse substances, especially alcohol and amphetamines
- women in the post-partum period
- people who have suffered recent significant losses
- people undergoing developmental changes or role transitions such as retirement
- children with chronic, mild dysphoria or irritability, and deteriorating school performance, who state that they feel unloved
- adolescents presenting with irritability, behaviour change or a deterioration in school or work performance

## Diagnosis

The main depressive syndromes seen in general practice are adjustment disorders, dysthymia and major depression. The prototype for these disorders, major depression, will be discussed first. However, this is not the most prevalent condition in general practice settings. Disorders with milder symptoms are more common. Moreover, as many as 50 per cent of people who present to general practitioners feeling depressed have symptoms that do not meet the criteria for any of these disorders.

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**As many as 50 per cent of people who present to general practitioners with depression have symptoms that do not meet the criteria for a specific disorder.**

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### *Major depression*

The essential features are persistent symptoms over at least two weeks of depressed mood or loss of pleasure or interest (anhedonia) together with at least four of the following: change in appetite, weight loss or weight gain, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness or guilt, poor concentration or indecisiveness, recurrent thoughts of death or suicidal thoughts, plans or acts<sup>1</sup>. In adolescents and children the mood may be predominantly irritable.

### *Dysthymic disorder*

This refers to a chronic low-grade depressive syndrome. The DSM-IV requires a duration of at least two years in adults, and at least one year in children and adolescents. The symptoms are not as severe as in major depression and, although persisting for years, may not be present every day over that period. In particular, persistent anhedonia is not a feature. However, because of its chronicity, high levels of disability and handicap may accompany the symptoms. It is the commonest depressive diagnosis in children who present with chronically depressed or irritable mood, low self-esteem and a perception of being unloved.

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<sup>1</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4<sup>th</sup> Ed. Washington DC: American Psychiatric Association, 1994.

### *Adjustment disorder*

Adjustment disorders are reactions that occur within three months of the onset of a stressor, involving symptoms and levels of disability and handicap that are more than would normally be expected. Symptoms may include marked distress, depressed mood, tearfulness, anxiety, irritability or multiple physical complaints. Disabilities and handicaps include interpersonal withdrawal, conduct disturbance (for example, reckless driving, fighting or truancy) and poor work or academic performance.

### *Psychotic depression*

Depressed people often become preoccupied with concerns about their physical health, their finances and feelings of worthlessness and guilt. In some cases, these beliefs are delusional. There may be nihilistic delusions (e.g. the belief that one's internal organs are rotting or no longer exist, or that the world is going to end), delusions of poverty, hypochondriacal delusions (e.g. that one has cancer) or delusions of guilt. The depressed person may suffer hallucinations (e.g. voices saying that he or she is worthless and evil). The diagnosis of psychotic depression indicates the need for specialist referral, hospitalisation, drug treatment and often, ECT.

### *Bipolar disorder (manic depression)*

Episodes of depression may alternate with episodes of mania. The symptoms and signs of mania include elevated mood, grandiosity, a decreased need for sleep, pressure of speech, flight of ideas, increased energy and activity levels, and impaired judgement. Lithium is the mainstay of treatment. Inpatient care is usually required for the treatment of manic episodes. Psychiatric referral is recommended. Please refer to Chapter 22 for a more detailed discussion of treatment of psychotic illnesses.

## **Differential diagnosis**

See Tables 17-5 and 17-7 for lists of physical disorders and substances that can cause depression. While the apathy and poor concentration of the person with dementia may be mistaken for depression, the two syndromes frequently co-exist, especially early in the course of dementia. As mentioned above, depression is often co-morbid with anxiety disorders. The negative symptoms of people with schizophrenia may be mistaken for depression. However, these people are also prone to developing depression (see Chapter 22).

## **Formulation**

The formulation of depression always involves contributions of biological and psychosocial factors. While the diagnosis is an essential guide to treatment, a formulation is required for the development of a comprehensive treatment plan. In particular, for the 50 per cent of people whose symptoms fail to fit any of the recognised syndromes, the formulation is the principal guide to treatment.

### *Biological factors*

As discussed above, depression often arises in response to the stress of having a physical illness, especially life threatening and chronic disorders, illnesses with distressing symptoms, and conditions associated with high levels of disability and handicap. Alternatively, physical disorders and drugs can cause depression (see Table 17-5 and Table 17-7). Have a high index of suspicion about an organic cause of depression in an elderly person presenting for the first time with depression. A family history of depression may suggest that genetic factors are playing a part in the inheritance of a primary depressive disorder, especially bipolar disorder.

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**Life threatening and chronic disorders, illnesses with distressing symptoms, and conditions associated with high levels of disability and handicap are often complicated by the development of depression.**

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### *Psychosocial factors*

Depression may complicate other mental disorders. The frequent co-morbidity with anxiety disorders has already been mentioned. Between 30 and 40 per cent of people with panic disorder or obsessive-compulsive disorder also suffer from depression. Depression may also complicate schizophrenia, alcohol and substance abuse, dementia, somatisation disorder, chronic pain, anorexia nervosa and bulimia. People with personality disorders are vulnerable to depression, especially those with dependent, obsessional and narcissistic traits (see Chapter 23).

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### **Between 30 and 40 per cent of people with panic disorder also suffer from depression.**

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Psychodynamic theories may offer insight into the meaning of an individual's response to loss. In 'Mourning and Melancholia', Freud<sup>1</sup> observed that, unlike the person going through a normal mourning process, the person who becomes depressed following a loss suffers a critical fall in self-esteem. The depressed person is excessively self-critical and suffers feelings of worthlessness and guilt. In the same essay, Freud concluded that the depressed person's anger towards a lost person is often directed against the self.

Other psychodynamic theorists view depression as being caused by a narcissistic injury. That is, depression occurs as a result of people not living up to the high expectations they have of themselves. It is the difference between ideals and reality that leads to depression and the attendant low self-esteem and feelings of worthlessness (see example in Box 14-1).

#### **Box 14-1: Psychodynamic formulation of a man with depression**

A 35-year-old man had for some months been warning other residents of the block of flats where he lived about the poor security. After a fire broke out in his flat, his fears initially seemed to have been vindicated. Two months later, he was charged with starting the fire himself. He subsequently became depressed. Far from being a criminal, his aim in life had always been to be on the side of law enforcement and protection. After leaving school, he had joined the army, but was discharged after taking an overdose of paracetamol. He later attempted unsuccessfully to join the police force. He worked for a security firm for 18 months before a back injury forced him from the job. He had a collection of military insignia and badges, and was proud of his acquaintance with some serving police officers. A tragic event in his personal history was the death of his father in a car accident two weeks before he was born.

*Comment:* The man's depression results from his failure to live up to the high ideals he set for himself to be a strong man, protector and even a hero. The origin of his high aspirations is the idealised image he has of the father he never knew. Ironically, a desperate bid to prove himself a hero involved performing the very sort of act that he was committed to fighting against, and has led to shame, humiliation and guilt.

Arieti<sup>2</sup> postulated that people prone to depression tend to subjugate their own needs and wishes to those of another person (the dominant other) in order to gain his or her affection, attention or approval. In other cases, a man may invest all his energies in the goals of some ideology or organisation.

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### **Common precipitants of depression include loss, or a failure to live up to expectations of oneself.**

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<sup>1</sup> Freud S. Mourning and Melancholia. In *On Metapsychology: The theory of psychoanalysis*. Pelican Freud Library. 1917 11:245-268.

<sup>2</sup> Arieti SS. Suicide and the hidden executioner. *International Review of Psychoanalysis*. 1980 7: 57-60.

### *Social factors*

Around 40 per cent of acute episodes of mood disorder are precipitated by stressful events. Stress is a commoner precipitant of depression than non-adherence to medication. Perceived criticism from a spouse is a high predictor of relapse in depression. Similarly, a high expressed emotion (EE) at home (hostility, critical comments and enmeshment) increases the risk of relapse. A common precipitant is loss, especially of a close relationship. A recent loss may reawaken unresolved losses from a person's past. The anniversary of the loss of a close relationship may precipitate depression.

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**Around 40 per cent of episodes of depression have understandable precipitants.**

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## **Treatment**

### **General principles**

As a rule, the most effective treatments of depression involve a combination of pharmacological and non-pharmacological interventions. An exception is the treatment of people with psychotic depression or catatonia who will require drugs and possibly ECT before being accessible to psychotherapy. At the other extreme are people with minor depression or an adjustment disorder in whom the efficacy of drug treatments is uncertain.

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**The most effective treatment of depression usually involves both pharmacological and non-pharmacological interventions.**

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The two forms of treatment work together synergistically. For example, psychotherapy may enhance the efficacy of drug treatments by addressing the meaning of a person's non-adherence. A depressed man may refuse to take his medication, because he believes that nothing can help him. Another may believe that he does not deserve to get better. A third may feel too ashamed to take medication because of the stigma of mental illness. In the following discussion, three arms of treatment are discussed—non-specific interventions, drugs and psychotherapy.

### **Treatment setting**

Most people suffering depression prefer to be treated at home rather than in hospital. Indications for hospitalisation include danger to self or others, social isolation, limited social supports, poor self-care, severe co-morbid substance abuse, psychotic symptoms and the requirement for ECT.

### **Non-specific interventions**

The following non-specific interventions are applicable to the treatment of depression as well as anxiety and somatoform disorders with which it is commonly associated.

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**Non-specific treatments of depression are also applicable to the treatment of anxiety disorders and somatoform disorders. They include engagement in treatment, illness education, increasing daily activities, exercise programs, limiting excessive substance use and improving sleep habit.**

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### *Engagement in treatment*

It is essential to engage the patient in the treatment plan. Summarise the person's problems and note that they are characteristic of the syndrome of depression. Discuss the formulation and explain how this will guide treatment for that individual. Link the different treatment approaches to specific aspects of the problem—the efficacy of medication in relieving some of the symptoms; counselling and structured problem solving to address specific stressors; cognitive-behavioural approaches to change habitual negative ways of thinking about oneself, the future and the world;

interpersonal therapy to improve social functioning; grief work to deal with losses; and marital or family therapy to deal with relationship problems.

#### *Illness education*

Educating people about depression promotes their active involvement in treatment and addresses any misconceptions they have about the illness. Because of the stigma attached to mental illness, patients' knowledge of depression is often limited and they are often reluctant to accept the diagnosis or adhere to treatment. Some guidelines for educating the depressed patient about depression are shown in Table 14-2.

The 'beyondblue' website, [www.beyondblue.org.au](http://www.beyondblue.org.au), contains useful resources, including accounts of personal experiences of depression, patient information leaflets, a multimedia library with video clips, research reports and discussion-room transcripts.

**Table 14-2: Educating people about depression**

- Symptoms – Explain the frequent occurrence of physical and anxiety symptoms.
- Prevalence – The disorder is not due to some weakness of character. It has a wide prevalence in the community.
- Diagnosis – Explain the difference between normal sadness and depression. Depression is persistent and includes symptoms such as anhedonia that are not normal responses to stress. Depression impairs one's ability to solve problems, and so may lead to an exacerbation of the stress that precipitated it.
- Causes – Explain both the biological and psychosocial determinants of the illness. It may be useful to explain neurotransmitter dysfunction and the role of genetics, physical illness and substance abuse, as well as the impact of stress and personality styles.
- Treatment – Emphasise the need for both pharmacological and non-pharmacological treatments. When using drug treatments, explain their mode of action, the delayed onset of action (2–8 weeks), the need to take the medication for 6–12 months to prevent relapse, and the side effects, toxicity and potential drug interactions. Emphasise that antidepressants are not hypnotics and are not addictive.
- Relapse prevention – Ask the person to monitor his or her symptoms. Clarify the early signs of relapse in that individual.
- Provide the person with pamphlets on depression and recommend self-help books.<sup>1, 2</sup>

#### *Increasing daily activities*

As a consequence of their loss of interest and pleasure, depressed people often withdraw from their usual work, leisure and social activities. They often lose confidence and feel that they can no longer do the things they used to do, or that others will not want to see them. They become avoidant because of co-morbid anxiety symptoms. Through inactivity, they lose access to sources of pleasure and self-esteem. A vicious cycle is created in which depression leads to avoidance, which in turn reinforces depression. Conversely, having a wide range of interests and social contacts helps prevent relapse.

Explain this to the patient. Ask him or her to make out a daily activity schedule for the week that includes some pleasant activities, some duties and some social activities (see Appendix 7). Involve the family in widening the person's range of activities.

<sup>1</sup> Tanner S, Ball J. *Beating the Blues: a Self-help Approach to Overcoming Depression*. Moorebank: Doubleday, 1989.

<sup>2</sup> Burns DD. *Feeling Good: The New Mood Therapy*. Melbourne: Information Australia Group, 1980.

### *Exercise*

A daily exercise program will reduce anxiety and improve physical health and the sleep/wake cycle. A regular hour a day of gentle exercise, such as walking, is preferable to brief irregular bursts of strenuous exercise.

### *Alcohol and drugs*

Depressed and anxious people often turn to recreational drugs to alleviate their symptoms. Explain that while rising alcohol levels may briefly improve mood, falling levels cause depression and anxiety. Remind patients of the physical consequences of cigarette consumption and alcohol abuse.

### *Sleep/wake cycle*

The sleep/wake cycle is frequently disrupted in depression with initial insomnia, early morning wakening, poor quality of sleep, and daytime fatigue and irritability. Table 14-3 contains guidelines for improving the sleep habit.

**Table 14-3: Guidelines for improving sleep habit**

- Establish a regular routine before going to bed (for example, use the toilet, have a shower, brush teeth and listen to some music).
- Go to bed at the same time every night.
- Get up at the same time every morning. Sleeping in will only disrupt the sleep habit and make it harder to get to sleep that night. One reason children rarely suffer sleep problems is that a regular sleep routine is enforced by their parents.
- Do not take naps during the day.
- In the evening, avoid alcohol, cigarettes and other stimulants such as coffee, tea and Coca Cola.
- Avoid using sleeping tablets. All hypnotics disrupt sleep architecture and can cause rebound insomnia and anxiety upon withdrawal. Tolerance to benzodiazepines develops within two to three weeks.
- Set aside time for regular exercise, but avoid exercising in the evening.
- Set aside time for problem solving during the day in order to avoid ruminating over problems through the night.
- Take steps to promote a comfortable, quiet and undisturbed sleep environment.
- If you cannot get to sleep after 30 minutes, get up and leave the bedroom and do something pleasant and relaxing, such as listening to music. Only go back to bed when you feel sleepy
- Only use the bed for sleeping. The only exception is sexual activity.

## **Pharmacological treatment**

Drugs are particularly effective in the treatment of neurovegetative symptoms, anhedonia, psychomotor retardation, and psychotic phenomena such as delusions and hallucinations. They are less effective than psychotherapy in dealing with low self-esteem, guilt, hopelessness, social withdrawal and loss of motivation.

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**Drug treatments are most effective for the treatment of neurovegetative disturbance, anhedonia, psychomotor retardation and psychotic symptoms.**

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There are presently seven classes of antidepressants available. All share similar efficacy, but have different side effect profiles. See Table 13-3 for a summary of their relative advantages and disadvantages. As a first line of treatment, I recommend one of the following classes of drugs:

- selective serotonin reuptake inhibitors (SSRIs), i.e. fluoxetine, paroxetine, sertraline, citalopram or fluvoxamine
- serotonin receptor antagonists, i.e. nefazodone
- selective noradrenaline reuptake inhibitors (SNRIs), i.e. venlafaxine
- reversible inhibitors of monoamine oxidase A (RIMAs), i.e. moclobemide
- tetracyclic antidepressants, e.g. mianserin

As a second line:

- tricyclic antidepressants, i.e. desipramine, nortriptyline, imipramine, dothiepin, amitriptyline, doxepin

I would only recommend the use of irreversible inhibitors of a monoamine oxidase (i.e. phenelzine or tranylcypromine) as a third line. It is probably best only to prescribe these drugs on the advice of a psychiatrist.

It usually takes around two weeks before a therapeutic effect is evident. If there has been no effect after six weeks, consider the possible reasons listed in Table 14-4. If a change of drug is indicated, it is best to change to a member of a different class of antidepressant. Guidelines for changing antidepressants are shown in Table 13-4. Augmentation with lithium or thyroxine may be of benefit in treatment resistant cases. This is probably best done after consultation with a psychiatrist.

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**Explain to patients that their mood symptoms will only begin to improve after about two weeks, and that the antidepressant will need to be taken for six to twelve months in order to prevent relapse.**

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Antidepressant therapy should be continued for at least 6 months, and usually 12 months, in order to prevent relapse. Maintenance therapy may be indicated for people who have suffered three or more episodes of depression, two episodes within five years, or severe illness.

Lithium carbonate is the drug of choice for bipolar depression and may be a useful adjuvant in treatment-resistant unipolar depression. Electroconvulsive therapy remains the most effective treatment for severe depressive illness and is especially effective in psychotic depression.

It is essential to educate the patient about the use of these drugs (see Table 14-2).

**Table 14-4: Reasons for failure to respond to antidepressant medication**

non-adherence
inadequate dose – especially of tricyclics
inadequate duration of therapy – may need up to eight weeks to have therapeutic effect
continuing psychosocial stressors
personality disorder
incorrect diagnosis
undiagnosed medical disorder
continued substance abuse
non-response to particular class of antidepressant



## Electroconvulsive Treatment (ECT)

ECT is the most effective in the treatment for depression with psychotic symptoms and psychomotor changes (psychomotor retardation or agitation). Indications are summarised in Table 14-5. Pharmacological treatment is continued after the course of ECT.

**Table 14-5: Indications for ECT**

psychotic depression  
melancholic features, especially psychomotor retardation or agitation  
previous good response to ECT  
failure of pharmacological and psychological treatments  
severe suicidality  
refusal to eat  
medical contraindications to pharmacological treatment

## Psychotherapeutic approaches to treatment

Psychotherapy for people with depression needs to be flexible, taking into account characteristics of the individual, the formulation of the depression and the stage of the illness.

### 1. *Crisis intervention, counselling and structured problem solving*

These techniques are described in detail in Chapter 6. They are the mainstays in the treatment of adjustment disorders. They are also used in dealing with the precipitants of depressive disorders generally, and with crises as they occur in the lives of people with chronic depression.

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## Use counselling and structured problem solving to help people deal with stressors associated with the onset of depression.

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### 2. *Cognitive Behavioural Therapy (CBT)*

This form of psychotherapy has proven efficacy in the treatment of mild and moderate depression. See Chapter 10 for a more detailed description of CBT. Prefer CBT over IPT in the treatment of people with few affectively charged events associated with the onset of their depression. CBT is less effective in people with significant cognitive dysfunction.

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## CBT has proven efficacy in the treatment of mild to moderate depression.

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### 3. *Interpersonal Psychotherapy (IPT)*

IPT is discussed in Chapter 11. Indications for IPT include the presence of mild, moderate or severe depression (i.e. Hamilton Depression Scale score > 20); the presence of clear life events around the onset of the depression; and the possession of reasonable social skills. IPT is an effective adjunct to pharmacotherapy in the treatment of people with severe depression. It is less effective in people who possess only limited social skills.

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## IPT is an effective adjunct to pharmacotherapy in the treatment of severe depression.

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### 4. *Grief work*

Grief is discussed in detail in Chapter 7. Depression is frequently precipitated by loss and perpetuated by unresolved feelings about loss. In grief work, you encourage the expression of thoughts and feelings toward the lost person or thing (e.g. a job) within a supportive non-judgmental therapeutic relationship. It is especially important to identify any negative emotions and ideas and to give the person permission to express these (e.g. anger towards the deceased).



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## **Grief work helps people deal with loss.**

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People with severe mental or physical illnesses need to mourn the losses that they suffer as a consequence of the disorder. Depression is common after any psychotic episode. After a manic episode a man may feel ashamed of his behaviour and have to mourn other losses (e.g. financial) incurred as a result of impaired judgement. Also at risk are people suffering terminal illness (e.g. HIV infection and cancer), severe disability (e.g. quadriplegia), disorders with frightening symptoms (e.g. dyspnoea in chronic airway disease) or conditions that require complex ongoing medical treatment (e.g. renal dialysis). A prolonged physical or mental illness may lead to the loss of work or friends, and even family breakdown.

Grief work is an important component of interpersonal psychotherapy (IPT). Note, however, that in IPT terms only bereavement is classified as grief, while other losses are seen as role transitions (see Chapter 11).

### **5. Marital/family therapy**

Perceived criticism by a spouse increases the risk of relapse in depression. A high level of expressed emotion (hostility, critical comments and enmeshment) is also a predictor of relapse. Marital conflict or the loss of a close relationship may be the precipitant of a person's depression. The pattern of a maladaptive relationship from the past may re-emerge in a person's current marital relationship. These issues can be dealt with in therapy.

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## **Address family and marital problems in joint therapy with the person's spouse or other intimate.**

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However, you should be cautious when dealing with long standing patterns of interaction within families. In some cases, a person's symptoms and disabilities may come to play a part in maintaining equilibrium in the family system. A sudden change will have an impact on other members of the family and on the family system as a whole. An example of depression occurring in the context of marital problems is given in Box 14-2.

### **Box 14-2: Depression in the context of marital problems**

*Example:* A 60-year-old man presents to you with a three-month history of depression. Last year, he retired from his job as a ship's engineer. You have been treating him for the past month with sertraline 100mg in the morning, but he has shown little improvement. He has been contemplating suicide since his wife announced last week that she wants a trial separation. She has become exasperated with his constant need for reassurance, and feels manipulated by his recent talk about suicide. She also feels guilty about wanting to leave him, but sees no other option at the moment. You have also begun to feel frustrated by his failure to get better.

*Comment:* Reflecting on your countertransference, you gain some understanding of how his wife must be feeling. In particular, you can understand some of the negative reactions. These may, in turn, be exacerbating the problem. You arrange to see the couple together.

The precipitant seems to be the marital problems that have emerged since he retired last year. His job used to take him away from home for around six months of the year—now, he spends all of his time at home. His retirement, though a normal developmental step, is itself a significant stressor.

You encourage him to find new interests outside the home, educate his wife about the nature of his illness, and help them both understand the consequences of some of the maladaptive patterns of behaviour that are associated with his illness. While being concerned for his safety, his wife cannot be totally responsible for him and should not feel guilty about this. He needs to understand how his behaviour, though motivated by a desire to keep her close, may be having the opposite effect.

#### 6. *Dynamically-informed treatment*

The success of any therapy will depend on the establishment of a therapeutic alliance. Listen to the person and empathise with how he or she feels. Acknowledge his or her suffering. Avoid bland reassurance, such as saying, 'But you have no reason to feel depressed'. This may be perceived as unempathic and rejecting. Empathy will also help you to work with the person in formulating the reasons why he or she has developed depression and what steps need to be taken to overcome it.

Having established a therapeutic alliance, the person will begin to transfer on to you feelings and attitudes held towards significant others in his or her life. For example, a dependent man may expect you to give him advice about how to solve his problems. Avoid repeating the patterns of his previous relationships. Instead, use the principles of counselling and structured problem solving to help him make decisions for himself.

Other countertransference responses that are commonly experienced when treating people with depression include frustration and anger when a person fails to improve, boredom with a person's many complaints, guilt and helplessness that you cannot solve the problem, denial of the seriousness of suicidal behaviour, or an impulse to rescue them (see example in Box 14- 3). These reactions give you insight into how others in the person's life feel. In some cases, the responses of others may be exacerbating the depression. For example, some people who fail to improve seem to get a perverse pleasure out of your and their families' inability to help. The sadistic wish to hurt others by making them feel anxious, guilty and de-skilled is sometimes the other side of masochistic self-denigration. In such a case, the limits of what you and the person's carers can do should also be acknowledged.

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**Countertransference reactions that can interfere with the treatment of depression include frustration, boredom, guilt, helplessness and impulses to rescue or to give inappropriate advice.**

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#### **Box 14-3: Transference and countertransference in depression**

A 40-year-old man becomes depressed after his wife leaves him, taking their children with her. She has always been responsible for making the major family decisions. He would never state his views directly, even when he was against a particular decision. Despite several attempts, he has never managed to get his motor vehicle licence. His wife was scornful of his failure and eventually decided that they could not afford to pay for any more driving lessons or tests. In therapy, he expresses his helplessness and wish for you to tell him what to do.

*Comment:* You resist the pressure to give him advice on what he should do. In doing so you avoid repeating the pattern of the relationship with his wife, the 'dominant other'. Instead, you teach him structured problem solving strategies to help him find solutions to his problems himself

#### **Monitoring progress**

Ask the person to monitor changes in his or her symptoms and any side effects of medication over the course of treatment. The SPHERE Patient Treatment Pack<sup>1</sup> contains forms for this purpose. The SPHERE-GP<sup>2</sup> instrument can be used to monitor progress weekly over the first four weeks and then at 6, 12, 26 and 52 weeks (see Appendix 1).

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<sup>1</sup> Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. *Treating Depression and Anxiety in General Practice: Training Manual*. Kogarah: Educational Health Solutions, 1998.

<sup>2</sup> Hadzi-Pavlovic D, Hickie I, Ricci C. *Somatic and Psychological Health Report: development and initial evaluation*. Technical Report TR-97-002, School of Psychiatry, University of New South Wales, Academic Department of Psychiatry, The St George Hospital and Community Health Service, 1997.

## Indications for specialist referral

Some indications for referral to a psychiatrist are shown in Table 14-6. Referral to a psychologist or other expert in CBT may be indicated for persistent mild to moderate depression.

**Table 14-6: Indications for referral to a psychiatrist**

- psychotic depression
- bipolar disorder
- suicidality
- severe post-partum disorder
- severe personality disorder
- complex drug therapy
- poor response to treatment
- if, for any other reason, you lack confidence in treating a particular individual

## Post-partum disorders

The three main syndromes are post-partum blues, postnatal depression and puerperal psychosis. Post-partum blues is a transient, self-limiting condition lasting hours to days. It is a common problem with a prevalence estimated at between 50 per cent and 70 per cent. It will not be discussed further here. Postnatal depression is a depressive syndrome with an onset in the postnatal period, that is, up to six months following childbirth. A depressive illness with an onset later than six months is best described simply as major depression. Puerperal psychosis is a psychiatric emergency with an onset during the first month after childbirth. It is rare with a prevalence of around 0.1 per cent.

### Postnatal depression

#### *Diagnostic assessment*

Most general practitioners will routinely screen for depression in all new mothers. A useful instrument is the Edinburgh Postnatal Depression Scale (Appendix 11). In the clinical assessment, ask about the symptoms of depression—depressed or irritable mood, anhedonia, vegetative function change, anxiety symptoms, suicidality, helplessness and hopelessness. Note any persistence of symptoms of the ‘blues’. Observe any problems the mother has dealing with the baby—for example, not wanting to hold the child, feeling detached from or irritable with the child, or having persistent difficulties feeding him or her. Frequent attendance at the practice may indicate that the mother is having difficulty coping. Consider maternal depression if the baby has a difficult temperament, or has bad colic or reflux. Having made a diagnosis, make a formulation.

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**Indicators of postnatal depression include depressed or irritable mood, neurovegetative function change, persistence of the ‘blues’, problems coping with the baby and frequent medical consultations.**

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#### *Formulation*

Biological factors predisposing to postnatal depression include a family history of mood disorder, a past history of mood disorder, a history of pre-menstrual syndrome, previous birth related crises, and complications of the birth or of drug treatments.

Psychological factors include a vulnerable personality, the presence of depression during pregnancy and a past history of postnatal depression or anxiety. Social factors include relationship problems with the husband or the mother’s parents. Assess the level of social support. Note any associated stressful life events (e.g. the need to give up a job, moving house or illness in the family).

Take note, also, of factors relating to the pregnancy itself. These include depression, unplanned or unwanted pregnancy, obstetric complications, birth of a handicapped child or the birth process not proceeding according to expectations.

#### *Treatment*

##### Education

Education about post-partum disorders before childbirth is a useful preventive strategy. For the woman who is suffering from postnatal depression, explanation about the disorder will provide relief in itself. Cognitive distortions typical of depression should also be corrected. For example, the mother may feel that she is a bad mother, that she is a failure, or that she is going insane. It is important to inform women who are suffering postnatal depression that the condition is not uncommon, that they are not alone in feeling this way and that it is not due to a failure on their part. Making it clear that the condition is understood and that effective treatments are available will reduce anxiety and helplessness.

##### Psychotherapeutic approaches

General supportive measures should be used. Allow her to ventilate her feelings. In particular, help her to acknowledge negative feelings about the birth of the baby. Point out that these negative feelings are not uncommon. Be careful, however, not to underrate her suffering and assess any potential for abuse of the child. Also, allow her to discuss any problems in the marriage or in the relationship with her parents. The birth may have necessitated role changes or a loss of work. In helping her to deal with practical issues, use structured problem solving rather than giving her advice on what she should do. Consider the use of specific techniques, such as cognitive behavioural therapy (see Chapter 10).

##### Medication

Indications for the use of medication include severe depression, vegetative function disturbance, psychomotor agitation or retardation, and co-morbid panic disorder. In choosing an antidepressant drug remember that there is little information presently about the safety of the newer drugs (SSRIs and RIMAs) for mothers who are breast-feeding. However, at the time of writing, a number of specialists in the area are prescribing sertraline to breast-feeding mothers with post-partum depression. The amount of tricyclics that appear in breast milk is not harmful.

##### Referral

Consider referral to appropriate community agencies. These might include Relationships Australia, Family Day Care and Community Child Health Nurses. Indications for referral to a psychiatrist include persistent suicidal ideation, poor response to treatment and severe personality problems.

### **Puerperal psychosis**

This is a psychiatric emergency and requires specialist inpatient psychiatric care, preferably in a unit that will house both mother and baby. The disorder may present with psychotic symptoms (auditory hallucinations and delusions), mood lability (between depression, elation and irritability) or features suggestive of an organic disorder (confusion, incoherence). Suicidal ideation and ideas of harming the baby are not uncommon. In one study, five per cent of patients ultimately committed suicide, and there was a probable infanticide rate of four per cent<sup>1</sup>. Women who suffer the disorder may go on to develop schizophrenia or bipolar mood disorder. Consider medical conditions in the differential diagnosis (e.g. septicaemia, toxæmia, hypothyroidism, Cushing's Disease or neoplasm).

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<sup>1</sup> Kaplan HI, Sadock BJ eds. *Comprehensive Textbook of Psychiatry*, fifth edition. Baltimore: Williams and Wilkins, 1989: 856.

# Chapter 15

## Anxiety disorders

In contrast to fear, which is the response to a realistic and immediate danger, anxiety is a fearful response occurring in the absence of a specific danger, or in anticipation of imminent problems or challenges. In the face of an imminent threat to life, fear is adaptive and prepares us for 'fight or flight'. A degree of arousal and anxiety improves performance, but high levels of anxiety diminish performance and can lead to decompensation (see Figure 6-1). Anxiety is only pathological when it is excessive in relation to the threat, persistent, and causes significant disability and handicap.

The National Survey of Mental Health and Wellbeing found that anxiety disorders were the most common form of mental disorder in the population with a one-year prevalence of 9.7 per cent<sup>1</sup>. Mixed anxiety and depression is more common than any specific disorder alone. Table 15-1 lists some of the symptoms of anxiety. Between 50 and 95 per cent of people with anxiety disorders present with physical symptoms.

### Assessment

Many of the physical symptoms of anxiety are caused by hyperventilation. Over-breathing causes a lowering of pCO<sub>2</sub>, which in turn produces an increase in pH. The elevated pH causes vasoconstriction in cerebral arteries and increased binding of oxygen to haemoglobin, which in turn leads to cerebral hypoxia.

**Table 15-1: Symptoms of anxiety disorders**

#### *Fears*

- panic disorder – fear of dying, going mad or suffering some other personal catastrophe
- social phobia – fear of making a fool of oneself
- obsessive-compulsive disorder – fear of contamination, of having harmed others, of doing something terrible
- agoraphobia – fear of being in a place from which escape is difficult
- post-traumatic stress disorder – fear of re-experiencing the traumatic event

#### *Cognitions*

- worry about the future, one's health, or one's relationships

#### *Behaviours*

- avoidance
- withdrawal
- self-medication with alcohol or sedatives

#### *Physical symptoms*

- fatigue, chest pain, headache, nausea and joint pain

#### *Symptoms secondary to hyperventilation*

- light-headedness, dizziness, choking, derealisation and depersonalisation, tachycardia, paraesthesia, cold sweats, muscle tightness, tiredness, and nausea

<sup>1</sup> Andrews G, Hall W, Teeson M, Henderson S. *The Mental Health of Australians*, Mental Health Branch, Commonwealth Department of Health and Aged Care, 1999.

The non-specific approaches used in the treatment of depression are also applicable to the treatment of anxiety disorders. They include education, the use of daily activity schedules, taking regular exercise, limiting the consumption of cigarettes and alcohol and improving the sleep/wake cycle (see Chapter 14). Cognitive and behavioural therapies are the mainstays of treatment. Benzodiazepines are effective anxiolytics, but impair performance and can lead to dependence.

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**The non-specific approaches used in the treatment of depression are also important elements in the treatment of anxiety disorders—patient education, daily activity schedules, exercise programs, limiting cigarette and alcohol consumption and improving sleep habit.**

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An excellent reference for the treatment of anxiety disorders is 'Management of Mental Disorders, Volume 1'<sup>1</sup>. This volume contains detailed descriptions of treatments, as well as handouts for patients. See Appendix 11 for a discussion of the management of sleep disturbance, a common presentation in general practice.

### Differential diagnosis

Some physical disorders and substances that can cause anxiety are listed in Tables 17-6 and 17-8. Anxiety symptoms, including panic attacks, phobias, obsessions and compulsions commonly occur in major depression. People with psychotic disorders may suffer anxiety symptoms as part of their disorder (e.g. obsessive-compulsive symptoms in a man with schizophrenia), in which case the diagnosis of psychosis subsumes the diagnosis of an anxiety disorder. However, people with psychosis may also develop anxiety symptoms secondary to their psychosis (e.g. the man who develops agoraphobia in response to his persecutory delusions).

### Formulation

#### *Biological factors*

There is an increased incidence of panic disorder and obsessive-compulsive disorder among first-degree relatives of sufferers, and concordance rates for monozygotic twins are higher than for dizygotic twins. Some physical disorders and drugs that can cause anxiety are listed in Tables 17-6 and 17-8.

#### *Behavioural theories*

Classical conditioning may explain the development of phobias and obsessions. Operant conditioning may account for phobic avoidance and compulsions (see Box 15-1). Children may learn anxiety by modelling their behaviour on that of a parent.

#### *Psychodynamic theories*

Psychodynamic theories are often useful in understanding the meaning of anxiety to an individual. In his later theories, Freud understood anxiety as a signal of danger when unconscious sexual and aggressive drives that are in conflict with the dictates of the superego threaten to overcome the repression imposed by the ego and enter consciousness. In some cases, secondary defences are then mobilised, which lead to the development of characteristic neurotic symptoms. Freud described four types of anxiety, classified according to their developmental origins. Superego anxiety is a fear of feeling guilty or ashamed. Castration anxiety, which is manifest by fears of retribution, is thought to arise from unresolved conflict during the Oedipal stage of development. Separation anxiety is the fear of losing the love and care of important other people. The most primitive form of anxiety is id anxiety, a fear of disintegration or persecution.

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<sup>1</sup> Treatment Protocol Project. *Management of Mental Disorders*, 2<sup>nd</sup> Ed. World Health Organisation Collaborating Centre for Mental Health and Substance Abuse, 1997.

### **Box 15-1: Learning theory and the causes of anxiety disorders**

#### *Classical conditioning*

- Sam, an eight-year-old boy develops a phobia of dogs after being bailed up by the neighbours' Alsatian.
- Judith suffered an embarrassing incident when her mind went blank and she froze while giving a thank you speech at her local church. Since then, she has been increasingly anxious at social functions.

#### *Operant conditioning*

- Judith has begun to avoid social functions. By preventing exposure to anxious social situations, her avoidance behaviour is negatively reinforced.
- Vera gains relief from her obsessive fears of contamination by repeatedly washing her hands. The relief from anxiety reinforces her compulsive behaviour.

#### *Other psychosocial factors*

Anxiety is frequently co-morbid with other mental disorders. Anxiety symptoms commonly occur in combination with depression. For example, between 30 per cent and 40 per cent of people with panic disorder or obsessive-compulsive disorder also suffer depression. Anxiety symptoms may also complicate schizophrenia, somatoform disorders, dementia and delirium. Anxiety disorders are often complicated by self-medication with alcohol and other substances. Conversely, substance abuse may be complicated by the development of anxiety symptoms.

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### **Anxiety disorders are often co-morbid with depression and substance abuse.**

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Dependent, avoidant and obsessive-compulsive personality traits predispose to the development of anxiety disorders. A history of school refusal may indicate a predisposition to anxiety. As with other mental disorders, the onset of an anxiety disorder is often precipitated by life events. The precipitant may have particular meaning for the person in terms of his or her history. A failure to formulate a case may lead to inadequate treatment (see Box 15-2).

### **Box 15-2: Do not neglect the formulation**

A young woman remains severely disabled by her obsessive-compulsive symptoms despite six months of pharmacological treatment and a course of exposure with response prevention. Her symptoms improve after her general practitioner takes a careful history and arranges counselling to address her marital problems.

## **Generalised anxiety disorder**

Generalised anxiety disorder was first defined as a residual entity in the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1980. Since then, the criteria have been refined and field studies have demonstrated the validity of the category. In the recent National Survey of Mental Health and Wellbeing, it had a prevalence of 3.1 per cent in the adult population, second only in frequency to post-traumatic stress disorder<sup>1</sup>. It is frequently co-morbid with depression and other anxiety disorders.

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### **Generalised anxiety disorder is a common presentation in general practice.**

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<sup>1</sup> Andrews G, Hall W, Teeson M, Henderson S. *The Mental Health of Australians* Canberra: Mental Health Branch, Commonwealth Department of Health and Aged Care, 1999.



The main feature is excessive anxiety and worry for most days over a period of at least six months. Associated symptoms include restlessness, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension and sleep disturbance.

### Differential diagnosis

Generalised anxiety disorder is the closest disorder to normal anxiety, from which it is distinguished by the following: the worries in GAD are difficult to control and cause significant disability and handicap; they are more pervasive, severe and chronic, and may occur without any precipitant; and they are accompanied by a variety of physical symptoms (fatigue, irritability, restlessness and feeling on edge). Physical disorders and substances that can cause anxiety are listed in Tables 17-6 and 17-8. Especially common are caffeine intoxication, sedative and alcohol withdrawal, and stimulant abuse. Anxiety symptoms are common in depression, and may also arise in the context of psychotic disorders.

### Treatment

1. Non-specific treatments as for depression – daily activity schedules, exercise program and improving the sleep habit (see Chapter 14)
2. Educate the patient about the following:
  - a) Normal anxiety, the ‘fight or flight’ response, the physical symptoms of anxiety and their relationship to hyperventilation – People with anxiety disorders are not always aware of some of their symptoms. For example, a man may present with fatigue, but only upon reflection and after self-monitoring, recognise his muscle tension. People will be relieved to understand the origins of their symptoms and feel more in control of them. Careful and thorough explanation alone will often lead to symptomatic improvement.
  - b) The need to confront rather than avoid feared situations and so prevent the development of agoraphobia
  - c) The dangers of becoming dependent on alcohol or benzodiazepines
3. Relaxation training:
  - controlled breathing (see Appendix 4)
  - progressive muscular relaxation (see Appendix 5)
  - self-hypnosis (see Appendix 6)
4. Problem solving to deal with current stressors (see Appendix 3)
5. Cognitive-behavioural approaches to self-monitor for symptoms and to identify and challenge automatic thoughts (see Chapter 10)
6. Referral is indicated for people with severe and chronic symptoms that do not respond to the above psychological treatments. In some, medication may be indicated. Benzodiazepines may be used for the short-term treatment of symptoms, antidepressants (and occasionally benzodiazepines) for chronic symptoms. Patients prescribed benzodiazepines must be informed about side effects and the dangers of developing tolerance, dependence and withdrawal.
7. Evaluation of the outcome of treatment using the Hopkins Symptom Checklist<sup>1</sup>.

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<sup>1</sup> Derogatis LR, Lipman R, Rickels K, Uhlenroth EH, Covi L. The Hopkins Symptom Checklist (HSCL): a self-report symptom inventory. *Behavioural Science*, 1974; 19: 1-15



## Panic disorder

The diagnosis of panic disorder is made when a person suffers recurrent panic attacks that cause significant distress or disability. In a panic attack, there is an abrupt onset of intense fear. The fear may be of losing control, of going mad or of dying. Associated symptoms include palpitations, sweating, shaking, chest discomfort, nausea, dizziness, light-headedness, derealisation, depersonalisation, paraesthesias and hot or cold flushes.

## Differential diagnosis

In the differential diagnosis, it is important to assess whether the panic attacks are occurring in the context of a major depressive disorder. A variety of medical disorders may also cause panic attacks. These include hyperthyroidism, hyperparathyroidism and cardiac arrhythmias. Panic attacks can also be caused by intoxication with amphetamines, cocaine or caffeine. Lists of physical illnesses and drugs that can cause anxiety are provided in Tables 17-6 and 17-8. Other disorders in the differential diagnosis include hypochondriasis, psychotic disorders and other anxiety disorders.

## Treatment

1. Non-specific treatments, as for depression (see Chapter 14)
2. Education about anxiety as above for generalised anxiety disorder
3. Controlled breathing techniques to abort panic attacks (see Appendix 4)
4. Relaxation techniques to prevent panic attacks – Commonly used methods are progressive muscular relaxation (see Appendix 5) and self-hypnosis (see Appendix 6).
5. The use of tricyclic antidepressants or SSRIs when the above measures have not been effective on their own.
6. The avoidance of substance abuse to self-treat symptoms (especially alcohol and benzodiazepines).
7. Evaluation of the outcomes of treatment:
  - a) Ask the person to record the frequency of panic attacks.
  - b) Use the Hopkins Symptom Checklist (HSCL)<sup>1</sup>.

## Agoraphobia

The essential feature of this disorder is a fear of being in places or situations from which escape is difficult. As a consequence, sufferers often avoid the feared situations. Typical agoraphobic fears include being away from home alone, being in a crowd, standing in line or travelling on public transport. Agoraphobia often complicates panic disorder. The avoidance behaviour may constitute a high level of disability.

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### **Agoraphobia commonly complicates panic disorder.**

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## Treatment

1. Non-specific treatments as for depression (see Chapter 14)
2. Education – As in the treatment of generalised anxiety disorder, sufferers of agoraphobia should be taught to recognise and understand their anxiety symptoms. They also need

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<sup>1</sup> Derogatis LR, Lipman R, Rickels K, Uhlenhuth EH and Covil L. The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioural Science*, 1974, 19: 1-15.

to understand how avoidance behaviours can be self-perpetuating. By lowering anxiety levels, avoidance behaviours are negatively reinforced. Avoidance of one situation can lead to avoidance of others with consequent higher levels of disability. A person's tolerance of anxiety will diminish as she or he avoids facing more and more feared situations. He or she should also be advised of the dangers of using alcohol or benzodiazepines to cope with anxiety.

3. Relaxation techniques – controlled breathing, progressive muscular relaxation and self-hypnosis (see Appendices 4, 5 and 6)
4. Graded exposure – This involves graded exposure to a hierarchy of feared situations (see Appendix 8). The two relaxation techniques discussed above should first be mastered. The person is then asked to make a list of feared situations and put them in order from least to most feared. He or she is then encouraged to work step-by-step through the list, confronting the situations using controlled breathing and muscular relaxation before each challenge, and using controlled breathing and selective muscle relaxation to manage anxiety during exposure. It is essential that the person stay in the situation until the anxiety has attenuated (habituation). Escape from the situation will only reinforce the avoidance behaviour. The treatment is time-consuming, often requiring around an hour a day over a month. The Subjective Units of Distress Scale (SUDS) can be used to document habituation of anxiety during exposure (see Figure 9-2) and desensitisation over repeated exposures (see Figure 9-3).
5. Evaluation of the outcome of treatment using the Fear Questionnaire<sup>1</sup> or the Hopkins Symptom Checklist<sup>2</sup>
6. Referral to a psychiatrist, psychologist or specialist anxiety disorders unit if these measures fail.

## Specific phobia

This involves marked and persistent fear when exposed to specific objects or situations—for example, animals, flying, heights, receiving an injection or seeing blood. Avoidance behaviour can lead to significant disability.

### Treatment

This is similar in principle to the treatment of agoraphobia.

1. Education about anxiety (as for panic disorder and agoraphobia, above)
2. Relaxation techniques:
  - controlled breathing (see Appendix 4)
  - progressive muscular relaxation (see Appendix 5)
  - self-hypnosis (see Appendix 6)
3. Graded exposure to the feared object or situation – For example, a person suffering a bird phobia might progress from looking at a picture of a bird, to making a visit to the Currumbin Bird Sanctuary.
4. Avoidance of the use of benzodiazepines and alcohol to cope with feared situations

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<sup>1</sup> Marks IM and Mathews AM. Brief standard self-rating for phobic patients. *Behavioural Research and Therapy*. 1979,17: 263-267.

<sup>2</sup> Derogatis LR, Lipman R, Rickels K, Uhlenhuth EH and Coviell L. The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioural Science*, 1974, 19:1-15.

5. Evaluation of the outcome of treatment by asking the person to rate his or her level of anxiety when exposed to the feared situation using a SUDS score (see Figure 9-1).

People with blood or injection phobias are at risk of fainting during medical procedures. An initial fight or flight response, mediated by the sympathetic nervous system, is followed by an intense parasympathetic discharge, resulting in lowered cerebral perfusion. Make sure the person is lying down before performing any procedures.

## Social phobia

This disorder is characterised by marked and persistent fear when in the presence of unfamiliar people or when under the scrutiny of others. Specifically, the person fears shame or humiliation. Typical feared situations include eating, writing or having to speak in public, or being in a social situation where she or he may do or say something embarrassing. Panic attacks may occur during exposure. Avoidance behaviours can lead to significant disability.

### Treatment

This is similar to the treatment of specific phobia. There is some evidence that antidepressant medication may also help—moclobemide, fluoxetine or phenelzine. Propanolol may be used for symptoms of performance anxiety that suggest sympathetic overactivity (10–40mg taken 30 to 60 minutes prior to the performance). It should not be used in those with asthma<sup>1</sup>.

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**People with social phobia are anxious in the presence of unfamiliar people or when they are under the scrutiny of others.**

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## Obsessive–compulsive disorder

Symptoms include obsessions, that is, persistent and intrusive thoughts, impulses or images that the person attempts to ignore or suppress; and/or compulsions, that is, repetitive behaviours (e.g. hand washing, counting and checking) that are performed either in response to an obsession or according to rigid rules, in order to prevent some dreaded event. Typical obsessions include fears of contamination, doubting (e.g. a fear of having harmed others or of having left an electrical appliance switched on), a need to have things in a particular order (e.g. when hanging out clothes on the washing line) or fears of doing something terrible (e.g. assaulting someone). Compulsive behaviours are recognised, at least initially, to be excessive and not realistically connected with the situation that they are supposed to prevent. Disability results from the time spent on the compulsions, and through their interference with other activities.

### Differential diagnosis

Tourette's disorder and temporal lobe disorders may be complicated by obsessive–compulsive disorder. Obsessive–compulsive symptoms may be the presenting complaint in people with depression. People with schizophrenia may suffer obsessions and compulsions in addition to their psychotic symptoms, or when their psychotic symptoms are in remission.

### Treatment

1. Education
  - a) about the disorder and its symptoms
  - b) about how compulsive rituals are reinforced by causing a reduction in anxiety – For example, a woman who has obsessional fears of contamination experiences mounting

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<sup>1</sup>Victorian Drug Usage Advisory Committee. *Psychotropic Drug Guidelines*, 3rd edition, North Melbourne, Victoria, Victorian Medical Postgraduate Foundation Therapeutics Committee. 1995.

anxiety until she washes her hands 10 times according to her ritual. Performance of the ritual reduces her anxiety and so is negatively reinforced and begins to occur more frequently. Left untreated, the rituals begin to be used to neutralise anxiety in situations in which the possibility of contamination is more and more remote. The rituals become progressively more elaborate, time-consuming and rigid in their application. The increasing demands of performing the rituals lead to considerable disability. Treatment seeks to reverse this process by graded exposure to feared situations as described below.

2. Exposure with response prevention – The person is asked to list situations that trigger the rituals. These situations are then rated according to how much anxiety each produces. The person is then asked to confront each situation in order from least feared to most feared, without performing the ritual. The person is instructed to stay in the situation until the anxiety attenuates (habituation). He or she documents desensitisation by recording levels of anxiety using a SUDS score (see Figure 9-1).

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**A core component of the treatment of obsessive–compulsive disorder is exposure of the person to the feared situation, while preventing the performance of the associated ritual.**

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3. The use of drugs that inhibit the re-uptake of serotonin, i.e. SSRIs or clomipramine.

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**Drugs that inhibit the re-uptake of serotonin are effective in the treatment of obsessive–compulsive disorder.**

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4. Evaluate the outcome of treatment using the Hopkins Symptom Checklist<sup>1</sup> or the Padua Inventory<sup>2</sup>.

Some people will respond well to a detailed explanation of their symptoms alone. It is generally not useful to repeatedly reassure sufferers that their obsessional fears are unrealistic. It is more effective for them to prove this for themselves. Exposure and response prevention is often very time-consuming and may be quite ineffective if performed in a haphazard manner. For example, it may take two hours for the anxiety to attenuate in the first session of exposure. General practitioners are advised to refer people who require complex treatment to a psychiatrist, psychologist or a specialist Anxiety Disorders Unit.

## **Post-traumatic stress disorder (PTSD)**

A surprising finding of the National Survey of Mental Health and Wellbeing was that PTSD was the commonest anxiety disorder, with a prevalence amongst the adult population of 3.3 per cent<sup>3</sup>. PTSD may develop following a horrifying or terrifying event (e.g. rape, assault) and is characterised by intrusive recollections (e.g. nightmares, flashbacks, intrusive thoughts), avoidance of reminders of the event and increased arousal (e.g. insomnia, irritability, jumpiness and anger). The impact of trauma on a person will depend on the vulnerabilities and strengths of the individual concerned. A particular traumatic event may resonate with conflicts from the person's past, some of which may have been repressed (see Box 15-3).

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<sup>1</sup> Derogatis LR, Lipman R, Rickels K, Uhlenhuth EH and Coviell L. The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioural Science*, 1974, 19:1-15.

<sup>2</sup> Sanavio E. Obsessions and compulsions: the Padua Inventory. *Behaviour Research and Therapy*. 1988, 26: 169-177. \*Available from: Educational Health Solutions, Suite 13, 3<sup>rd</sup> Floor, St George Private Hospital and Medical Complex, 1 South Street, Kogarah, NSW 2217.

<sup>3</sup> Andrews G, Hall W, Teesson M, Henderson S. *The Mental Health of Australians*. Mental Health Branch, Commonwealth Department of Health and Aged Care 1999.

**Box 15-3: Post-traumatic stress disorder**

A young woman suffers severe post-traumatic symptoms after being assaulted. The assault rekindles memories of being sexually abused by an uncle when she was a child.

Severe trauma can produce symptoms in the strongest of personalities. Traumatic events can endure and change personality. For instance, abuse suffered as a child may be an important factor in the origin of borderline personality disorder. Even adults who suffer severe trauma can undergo personality change as a result of their chronic post-traumatic symptoms. Treatment involves both drugs (imipramine or SSRIs) and psychotherapy. Specialist referral is indicated for severe or long-standing cases. The essential role of the general practitioner is to be aware of the risk of developing a psychiatric disorder in those who have suffered trauma, to observe them over the long term and to provide early intervention if necessary. (See also Chapter 21 for a more detailed discussion of dissociative disorders and other post-traumatic syndromes, including post-traumatic stress disorder).



# Chapter 16

## The relationship between physical and mental illness

Unravelling the extent to which physical and mental disorders are contributing to a person's presenting problems is a common challenge facing a general practitioner. The SPHERE GP<sup>1</sup> instrument can be of assistance (see Appendix 1). This chapter contains an overview of the relationships that can exist between physical and mental disorders. It concludes with a discussion of the importance of monitoring transference and countertransference responses when treating patients in general medical settings. It serves as an introduction to the following three chapters in which I discuss the assessment and treatment of organic mental disorders, substance abuse and somatoform disorders.

### Psychiatric symptoms that occur in response to having a physical illness

Physical disorders, especially chronic or terminal illnesses and those with severe symptoms and high levels of disability and handicap, may precipitate mental disorder. These physical disorders include HIV infection, cancer, burns, chronic airway disease, chronic renal failure (especially during dialysis), mastectomy and other disfiguring surgery. While the development of depression and anxiety disorders in response to these illnesses may be understandable, these responses are not normal and they require treatment. Initial treatment may involve grief counselling to deal with the issues of loss (see Chapter 7). However, between 20 and 30 per cent of people with chronic physical illnesses develop major depression and require pharmacological treatment.

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**While the development of depression and anxiety disorders in response to suffering a physical illness may be understandable, these responses are not normal and they require treatment.**

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The assessment of depression in the context of a physical disorder is difficult because some of the symptoms could be caused by either condition (e.g. fatigue, loss of appetite, loss of weight and low energy levels). Take note of symptoms that cannot be accounted for by the physical disorder. Remember that people who are depressed may present with an exacerbation of their physical symptoms. Always consider a diagnosis of depression when any of the following symptoms are present: persistent feelings of worthlessness and guilt, anhedonia, hopelessness, suicidality, panic attacks, or psychomotor retardation or agitation.

### Physical disorders that can cause psychological symptoms

Any organic disorder or substance that directly or indirectly affects the central nervous system can cause psychological symptoms (see Chapter 17). These symptoms include not only the cognitive changes of delirium and dementia, but also any of the other abnormalities found on the mental status examination. Organic disorders remain at the top of the diagnostic hierarchy and must be considered in all people who present with psychological symptoms.

You should have an especially high index of suspicion in elderly people who are being treated for physical problems, or who present for the first time with psychiatric symptoms. Perform

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<sup>1</sup> Hadzi-Pavlovic D, Hickie I, Ricci C. *Somatic and Psychological Health Report: development and initial evaluation*. Technical Report TR-97-002, School of Psychiatry, University of New South Wales, Academic Department of Psychiatry, The St George Hospital and Community Health Service, 1997.

a careful mental status examination with particular emphasis on the assessment of cognitive function. Note any physical symptoms, prescribed medications and recreational drug use. Follow up with relevant physical examination and investigations.

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**Have a high index of suspicion about an organic cause in the elderly person who presents for the first time with mental health problems.**

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### **Mental disorders that present with physical symptoms**

In general practice populations, depression and anxiety disorders commonly present with physical symptoms (see Chapters 14 and 15). The primary somatoform disorders include hypochondriasis and the syndromes of unexplained physical complaints—somatisation, pain disorder and the prolonged fatigue syndromes (see Chapter 19). People with psychotic illnesses may also present with physical complaints. For example, a man with psychotic depression may present with hypochondriacal delusions (e.g. the conviction that his bowel is rotting). A man with schizophrenia may suffer somatic passivity (e.g. the belief that his back pain is caused by laser beams from a television station on Mount Coot-tha).

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**In general practice populations, depression and anxiety disorders often present with physical symptoms.**

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### **Physical illness that occurs indirectly as a result of having a mental illness**

People with chronic schizophrenia or alcoholism have an increased risk of various physical disorders associated with poor self-care (e.g. pneumonia, smoking-related diseases, diverticulitis, poor dental health, subdural haematoma and scabies). These people may not bother to present for help. If they do, they may have trouble describing their symptoms and be poorly adherent to treatment. Negative attitudes of medical staff may mean that they receive sub-optimal care.

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**People with chronic mental illnesses often suffer poor physical health.**

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### **Transference and countertransference**

Like the treatment of mental health problems, the treatment of physical illnesses can arouse strong feelings in the doctor—anxiety, frustration, anger, sadness, hopelessness and helplessness<sup>1</sup>. It is normal to experience these emotions. However, in order to prevent acting inappropriately upon them it is essential to monitor and acknowledge them. Inappropriate behaviours include avoiding the patient or his family, making desperate efforts to rescue a patient, failing to convey accurate information about the illness and its prognosis to the patient and his or her family, and getting into conflict with other professionals involved in the person's treatment.

#### **Origin of countertransference responses**

Factors to do with the patient, the doctor and the illness may predispose to difficult countertransference responses.

Coping with chronic, severe or terminal illness places the patient, the family and the treating doctor under stress. The doctor may have difficulty coping with the patient and family's

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<sup>1</sup> Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA* December 19, 2001, 286: 3007-3014.



transference responses. Chronic illnesses, which follow a progressive downhill course, may engender feelings of hopelessness, helplessness and frustration in patients and in those treating them (see also Chapter 7 for a discussion of bereavement and breaking bad news). Illnesses in which the prognosis and treatment options are unclear will test the doctor's ability to tolerate uncertainty and ambiguity.

It is difficult for doctors to maintain a professional distance and think clearly about clinical problems when treating certain individuals—people similar to themselves (especially other doctors), patients who remind them of others who are important in their lives (e.g. their children, spouse or parents), patients they have known for a long time, and people in the public eye. The powerful countertransference reactions engendered by patients with personality disorders may affect the doctor's treatment behaviour (see Chapter 23).

The judgement of doctors who are depressed, abusing substances, under stress or suffering burnout is impaired. Traits that are adaptive in some situations can lead to difficulties in others—a doctor's perfectionist qualities may make it difficult for (him) to acknowledge the limitations of what can be done and lead him to undertake desperate measures in an attempt to rescue patients; he may have difficulty tolerating uncertainty in the prognosis and choice of treatment; he may isolate affect and fail to recognise his emotional reactions and how they are affecting his behaviour. Doctors may resent the demands placed on them by severely ill patients and their families, and have difficulty responding to criticism of their treatment.

### **Dealing with negative feelings**

Monitor your feelings and reflect on your behaviour towards patients, noting especially any tendency to distance oneself from the patient or, on the other hand, to being overly concerned. Acknowledge these feelings. Label them and discuss them with a colleague. This will allow you to take a step back, reflect on how they are affecting your behaviour towards the patient and his or her family, and prevent acting out in the countertransference in ways that are unethical and compromise treatment.



# Chapter 17

## Organic mental disorders

This chapter deals with the assessment and treatment of delirium, dementia and other mental disorders (anxiety, depression, personality change and psychosis) that are caused by physical illnesses or by drugs and other substances.

### Delirium

Delirium is a syndrome caused by a reversible and global derangement of brain metabolism that includes behavioural, psychological and physical symptoms. Any medical condition or substance that directly or indirectly affects the central nervous system can cause delirium. Since delirium can present with any of the abnormalities seen on the mental state examination, it may be mistaken for a functional mental disorder, an error that can result in serious morbidity or even death.

There is usually a relatively rapid onset of symptoms and signs in delirium. The critical clinical feature is an altered level of consciousness that can vary from mild inattention and clouding through to coma, and may fluctuate over time. Monitor your countertransference and be aware of feeling irritated if a person cannot give you a clear history or is otherwise uncooperative. This may be the clue to the diagnosis of delirium. Other signs include poor concentration and attention; disorientation in time, place and person; hallucinations, especially visual and tactile; reversal of the sleep-wake cycle; fleeting persecutory ideation; disorganisation of thinking and behaviour; and either psychomotor agitation or reduced activity and awareness.

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**A person's inability to give you a clear history may be a sign of delirium.**

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The diagnosis of delirium should be suspected in any person with a relatively rapid onset of disorientation and unusual behaviour. A rapid first onset of psychotic symptoms in a person over 50 is likely to be caused by delirium.

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**The sudden onset of psychotic symptoms in a person over the age of 50 is likely to be a sign of delirium.**

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Important causes to keep in mind include alcohol and benzodiazepine withdrawal, infection (e.g. pneumonia, urinary tract infection and meningitis), drug toxicity (e.g. lithium, benzotropine, carbamazepine, digoxin) subdural haematoma, subarachnoid haemorrhage, congestive cardiac failure and Wernicke's encephalopathy. Drugs with anticholinergic side effects are particularly prone to cause delirium. These include tricyclic antidepressants, traditional antipsychotics (especially low potency agents such as chlorpromazine and thioridazine) and anti-Parkinsonian agents. The treatment of delirium involves placing the person in a safe physical environment (e.g. medical ward, nursing home or under close supervision at home); identifying and treating the underlying medical disorder; monitoring food and fluid intake; and providing symptomatic sedation. Suggested drug doses for use in the delirious patient are shown in Table 17-1<sup>1</sup>. Many psychiatrists now prescribe risperidone in preference to haloperidol because of the absence of anticholinergic side effects. Use the least invasive route of administration that is practical—oral before intramuscular before intravenous. Monitor vital signs after administration of a sedative.

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<sup>1</sup> Victorian Medical Postgraduate Foundation Therapeutics Committee. *Psychotropic Drug Guidelines*. North Melbourne: Victorian Medical Postgraduate Foundation Therapeutics Committee, 1995.

Avoid using benzodiazepines in people with respiratory depression. If the cause of the delirium is alcohol or benzodiazepine withdrawal, treatment will include administration of a cross-tolerant benzodiazepine such as diazepam.

**Table 17-1: Drugs used to manage delirium**

Indication	Normal adult	Frail elderly
anxiety agitation	Diazepam 5–10mg orally Midazolam 2.5–5mg intramuscularly Diazepam 5–10mg intravenously	Diazepam 2mg orally Midazolam 1.25mg intramuscularly Diazepam 2mg intravenously
psychotic symptoms (hallucinations or delusions)	Haloperidol 1.5–10mg orally Risperidone 0.5–2mg orally Droperidol 5–10mg intramuscularly, or Haloperidol 5–10mg intramuscularly	Haloperidol 0.5mg orally Risperidone 0.5–1mg orally Droperidol 2mg intramuscularly Haloperidol 0.5–1.5mg intramuscularly

## Dementia

Dementia is characterised by a decline in cognitive functioning that is severe enough to produce significant disability and handicap. In contrast to delirium, which involves an acute derangement of brain function, dementia is associated with progressive neuronal loss.

Dementia always involves some loss of memory (learning new information and recalling previously learned information). Other cognitive disturbances include:

- a) aphasia
- b) apraxia
- c) agnosia
- d) executive function disturbance (planning, organisation, sequencing and abstraction).

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### **Dementia always involves some loss of memory.**

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Associated features include spatial disorientation, impaired judgement and insight, and disinhibition. Dementia may be complicated by the development of depression (especially early in the course when a person retains insight into his or her condition), anxiety, delusions (especially persecutory), hallucinations (most commonly visual) and delirium. The risk of suicide is highest early in the course. People with dementia may occasionally be violent. Dementia is sometimes associated with motor disturbances of gait and slurred speech.

People with early dementia may experience intense anxiety upon having their declining intellectual function made evident (catastrophic reaction).

## Aetiology

The commonest cause is Alzheimer's Disease (65 per cent of cases). Vascular dementia accounts for a further 10 per cent. Note, however, that at autopsy as many as 20 per cent have evidence of both Alzheimer's Disease and vascular dementia. Around 15 per cent of dementias have some reversible component (see Table 17-2).

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### **Fifteen per cent of dementias have a reversible component.**

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**Table 17-2: Reversible causes of dementia**

*Infectious diseases*

- neurosyphilis
- TB
- fungal meningitis
- cryptococcal meningitis
- Creutzfeldt-Jacob disease
- Viral encephalitis
- HIV related disorders

*Neurological*

- Parkinson's Disease
- intracranial tumours
- brain trauma
- hydrocephalus

*Endocrine*

- thyroid disease
- para-thyroid disease
- pituitary/adrenal disorders

*Metabolic*

- hepatic encephalopathy
- uraemic encephalopathy

*Cardio-respiratory*

- cardiac arrhythmias
- cerebral hypoxia
- respiratory encephalopathy

*Autoimmune*

- inflammatory vascular diseases

*Vitamin deficiency*

- B<sub>12</sub> or folate deficiency

*Others*

- drugs and toxins
- sarcoidosis
- hepato-lenticular degeneration

### Taking a history

Both the patient and his or her relatives should be interviewed. Early manifestations of dementia may include changes in behaviour, e.g. excessive orderliness, interpersonal withdrawal, labile mood, sudden outbursts of anger, apathy, deterioration in grooming, telling silly jokes or suspiciousness and paranoia. Sufferers may complain of the problems themselves, or they may deny or try to rationalise them.

### Differential diagnosis

- Exclude any treatable cause of dementia.
- In delirium, there is an altered level of consciousness and a disturbance in attention and concentration. The onset is usually acute and cognitive impairment often fluctuates throughout the day.
- In the elderly, severe mental illness can present with apparent cognitive deficits (e.g. depressive pseudodementia).

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**In contrast to dementia, delirium generally has an acute onset and is characterised by an altered or fluctuating level of consciousness.**

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### Complications

Some complications of dementia are listed in Table 17-3.

### Prognosis

The course depends on the cause. A dementia secondary to neurosyphilis, for example, should gradually improve with treatment. In Alzheimer's Disease there tends to be a steady decline. The course for vascular dementia is sometimes described in textbooks as having a step-wise deterioration, but is in fact quite variable.

**Table 17-3: Complications of dementia**

- danger to self and others as a result of impaired judgement
- depression and suicide, especially early in the course
- motor disturbances, especially in subcortical dementias, such as Huntington's Disease, Parkinson's Disease and vascular dementias
- psychotic symptoms – delusions (especially persecutory) and hallucinations
- delirium – increased susceptibility to physical illness and drug-induced delirium
- vulnerability to stress, both physical (illness and surgery) and psychosocial (any change in environment)

## **Treatment**

### *Family counselling*

The burden of care of people suffering dementia falls largely on the family, especially in the early stages. Emotional reactions include frustration with the person's behaviour, grief and sadness over the loss of the person they knew, anxiety that he or she may come to harm, and conflict among family members over what is best for the person. Educating the family about the nature of the illness, its signs and symptoms, its prognosis, and the available supports will help alleviate some of these reactions and enable the family to make informed decisions about future care. Many of the interventions discussed below require family involvement or are directed at minimising the burden of care. Families and other carers should be made aware of local support groups.

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**It is essential to involve the family in the treatment of a person with dementia.**

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### *Medical treatment*

1. Treat the underlying cause of a reversible dementia.
2. The treatment of co-morbid conditions:
  - physical illnesses, e.g. urinary tract infections, decubitus ulcers, cardiac failure (These may present with delirium.)
  - depression
  - psychotic symptoms
  - drug toxicity.
3. Encourage exercise and good diet. Physiotherapy may be beneficial.

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**Complications of dementia include delirium (including drug-induced delirium), physical illness, depression and psychotic symptoms.**

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4. Psychotropic medication may sometimes be indicated for treating co-morbid illness.
  - Doses of psychotropics should be kept as low as possible (e.g. haloperidol 0.25–0.5mg/day, risperidone 0.5–1mg/day, olanzapine 2.5–5mg/day). However, higher doses are sometimes required. Excessive sedation can exacerbate confusion. Anticholinergic effects can lead to delirium. Parkinsonian side effects can cause falls.
  - Long-acting benzodiazepines should be used with caution because of their tendency to accumulate and affect balance and coordination, leading to falls and fractures.
  - Many psychotropic drugs have significant anticholinergic effects. Particular care is required when such medications are combined. Anticholinergic delirium is a serious complication.

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**Drugs with anti-cholinergic side effects should be used with caution in people with dementia because of the risk of causing delirium.**

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5. Treatment of cognitive impairment

Younger sufferers, who are living at home and suffer mild to moderate symptoms, may benefit from treatment with an anti-cholinesterase inhibitor. Though these drugs do not alter the progression of the disease, in clinical trials people treated with anticholinesterase inhibitors showed less deterioration in cognitive functioning than those on placebo. Two drugs are presently approved for the treatment of the cognitive impairment of dementia—donepezil and tacrine. Since donepezil has little effect on butyrylcholinesterase, it is thought to be selective for CNS sites. Its long half-life permits once daily dosing. Recommended doses are between 5 and 10 mg per day. Unlike tacrine, it is generally well tolerated and does not cause hepatic toxicity. Side effects (including nausea, diarrhoea, insomnia, vomiting and loss of appetite) tend to be mild and often resolve over the first weeks of therapy.

Recommended doses of tacrine (tetrahydroaminoacridine, THA) are between 10 and 40mg a day. The short half-life means that it must be administered four times a day. Fortnightly liver function tests are required over the first four weeks to monitor for elevations in alanine transaminase. Monitoring is then required monthly for three months, and every three months for the duration of treatment. Full blood examinations are required every six weeks for the first six months of treatment, and then every three months. Gastrointestinal side effects (nausea, vomiting and diarrhoea) may be troublesome and often lead to cessation of treatment.

Since there is no evidence for the efficacy of these drugs in severe dementia, they should be ceased when the illness progresses to this stage<sup>1</sup>. Other drugs under investigation include SB 202026 and milameline (muscarinic partial agonists), non-steroidal antiinflammatories, oestrogen, nicotine, Vitamin E and selegiline (a Monoamine Oxidase Type B Inhibitor)<sup>2</sup>.

*Use community supports*

These include the Alzheimer's Association, Dementia Helpline and ARAFMI (Association for the Relatives and Friends of the Mentally Ill). Contact your local community health service for assistance with the following:

- home help
- meals on wheels
- community nursing
- information about other agencies
- respite (including in-home respite, day centres and residential respite for when the family is on holiday)
- assessment by the Aged Care Assessment Team
- information about support groups for carers.

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<sup>1</sup> Victorian Medical Postgraduate Foundation Therapeutics Committee. *Psychotropic Drug Guidelines 3rd ed.* North Melbourne:Victorian Medical Postgraduate Foundation Therapeutics Committee, 1995.

<sup>2</sup> Byrne GJA. Treatment of Cognitive Impairment in Alzheimer's Disease. *The Australian Journal of Hospital Pharmacy* 1998; 28:261-266.

### *Organising finances*

#### Testamentary capacity

While the person still retains testamentary capacity, he or she should be encouraged to make out a will. The assessment of whether a person retains this capacity depends on his or her ability to understand the nature and purpose of a will, to have a broad understanding of his or her financial assets, and to be able to name the people who might legitimately have a claim to assets in the will. He or she must be free of delusions that might directly influence the content of the will and must be under no undue influence from others on the disbursement of his or her assets.

#### Enduring power of attorney

The following discussion refers to current Queensland law. You need to be familiar with the laws in your state/territory. A person must be able to understand the contract granting power of attorney. It enables him or her (the principal) to grant an enduring power of attorney to a named individual or individuals (the attorneys). The date or occasion upon which the power of attorney becomes activated is specified on the form. The power of attorney is enduring because it continues when the person loses the capacity to make decisions. Under the *Queensland Powers of Attorney Act 1998*, an Enduring Power of Attorney can authorise the attorney to make both financial and health care decisions on behalf of the other person. If you become aware of problems in the way an attorney is managing a person's affairs, you should notify the Adult Guardian (phone 07 32340870 or 1300 653 187). Forms are available from newsagencies, GoPrint bookshops, Commonwealth Government Bookshops and legal stationers.

#### The Public Trustee

In Queensland, if a person who has not appointed an enduring power of attorney becomes incapable of managing his or her financial affairs, the Adult Guardian should be contacted. The Adult Guardian will then arrange for the Public Trustee to manage the person's financial affairs.

#### *Consent for medical procedures*

This matter is dealt with by different laws in each state/territory. The *Queensland Powers of Attorney Act of 1998* defines the ways in which health care decisions can be made on behalf of people whose decision-making capacity is impaired.

#### Advance health directive

This document allows the individual to give general instructions about his/her future health care, including end-of-life decisions, such as refusal of life-sustaining medical treatment, if he or she is terminally ill. In Queensland, this does not include instructions for a doctor to help a person die.

#### Enduring power of attorney

As mentioned above, a person (the principal) can appoint another (the attorney) to make future health care decisions on his or her behalf if at some time in the future the principal loses the capacity to make such decisions.

#### Statutory Health Attorney

In the case of a person who develops a decision making disability, but has not appointed an enduring Power of Attorney, the *Queensland Act* makes provision for a close relative or carer who is readily available and could be expected to take responsibility to be able to make health care decisions on his or her behalf. The Statutory Health Attorney is appointed by the Adult Guardian. If no suitable person is available, the Adult Guardian can make these decisions. This replaces the previous informal practice of having the next-of-kin make these decisions.

#### Work

Repetitive tasks may remain within the capacity of someone with early dementia. Jobs that carry responsibility for others, include an element of risk and require clear judgment, must be discontinued.



### *Education*

Explain the prognosis of the condition to patients, their families and other carers. In deciding how explicit to be, it is best to be guided by the individual's questions. Relatives will often want a clear description of the prognosis so that decisions affecting the long-term interests of the family can be made. Families may be reassured to know that a person's distress over his or her impairment tends to lessen with the progress of the condition.

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**Relatives of people with dementia need a clear description of the prognosis so that decisions affecting the long-term interests of the family can be made.**

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### *Disability support*

This involves decreasing the need for functions lost while maximising the use of residual functions. Some advice for carers is contained in Table 17-4.

**Table 17-4: Advice for carers of people with dementia**

- Avoid, where possible, novel or disturbing experiences. Structured activities that take place at regular times each day will minimise disorientation in time. Maintaining a person in familiar surroundings will minimise disorientation in place.
- When frightened by unfamiliar tasks, people with dementia may sometimes be distracted on to familiar subjects with which they are confident and comfortable.
- Set aside extra time for routine tasks, such as eating, dressing and bathing.
- Arrange furniture to minimise disorientation (e.g. place a clock and calendar in a prominent position; keep familiar possessions about; use cues (e.g. a sign on the toilet).
- Recognise that it will often be necessary to repeat instructions and advice (e.g. to remind the person where she or he is). Similarly, carers must tolerate being asked the same questions repeatedly (perseveration).

### *Driving*

Medical practitioners have a responsibility to notify the Department of Transport if, as a consequence of a medical condition, a person may be unfit to drive. Other family members are often good witnesses as to the person's driving ability. If you are unsure, refer the person for a driving test.

### *Living situation*

Plans are best made well in advance if it is anticipated that the person will need to move to a hostel, retirement village or a nursing home. In Queensland, the local Aged Care Assessment Team (ACAT) carries out the assessment of suitable placement.

## **Other mental disorders due to general medical conditions or substance use**

Physical disorders can sometimes lead to psychological symptoms in the absence of dementia or delirium. A list of conditions that can cause depression is given in Table 17-5. Conditions that can cause anxiety are listed in Table 17-6. Conditions that can cause psychosis are listed in Table 21-3. Personality change can result from head trauma, cerebrovascular accident (especially affecting the frontal lobes), epilepsy, HIV infection, hypo- or hyperthyroidism and systemic lupus erythematosus. Psychotic symptoms can be caused by physical disorders affecting the central nervous system, especially subcortical structures or the temporal lobes. These include cerebral neoplasms, cerebrovascular accidents, Huntington's disease, epilepsy, auditory nerve injury, deafness, migraine, central nervous system infections, hypo- or hyperthyroidism, metabolic imbalance and systemic lupus erythematosus.

**Any disease or substance that affects the central nervous system can cause mental symptoms, including depression, anxiety, personality change and psychosis.**

Table 17-5: Physical disorders that can cause depression	
neurological disorders:	Parkinson's disease Huntington's disease dementia cerebrovascular accident epilepsy multiple sclerosis traumatic brain injury
endocrine disease:	hyper- and hypothyroidism hyper- and hypoparathyroidism Cushing's disease Addison's disease
autoimmune disease:	systemic lupus erythematosus rheumatoid arthritis
infectious diseases:	influenza hepatitis infectious mononucleosis HIV infection pneumonia tuberculosis tertiary syphilis
cancer:	especially cancer of the pancreas
vitamin deficiencies:	B12, C, folate, thiamine

Intoxication or withdrawal from a variety of substances can lead to the development of psychological symptoms. A list of drugs that can cause depression is given in Table 17-7. Drugs that can cause anxiety are listed in Table 17-8. Alcohol abuse can be complicated by the development of psychotic symptoms, depression or anxiety during intoxication or withdrawal. Amphetamines and cocaine can cause psychotic symptoms during intoxication, and depression and anxiety during both intoxication and withdrawal. The use of marijuana can cause psychotic symptoms and anxiety during intoxication. Benzodiazepines can cause psychosis and depression during intoxication and anxiety during withdrawal.

**Table 17-6: Physical illnesses that can cause anxiety**

neurological disorders:	neoplasms vestibular dysfunction encephalitis
endocrine disease:	hyper- or hypothyroidism pheochromocytoma hypoglycaemia hyperadrenocorticism
cardiovascular conditions:	congestive cardiac failure pulmonary embolism arrhythmias
respiratory disorders:	chronic airway disease pneumonia hyperventilation
metabolic disorders:	porphyria vitamin B12 deficiency

**Table 17-7: Drugs that can cause depression**

antihypertensives:	alphamethyldopa propranolol reserpine
other cardiac drugs:	digoxin procainamide
anti-inflammatories:	NSAIDs opiates
antibacterial and antifungals:	ampicillin tetracycline sulfonamides
antineoplastics:	azothioprine vincristine
neurological:	levodopa phenytoin
steroids:	oral contraceptives prednisone corticosteroids anabolic steroids
antiulcer:	cimetidine
psychotropics:	benzodiazepines
dermatological:	roaccutane

**Table 17-8: Drugs that can cause anxiety**

recreational drugs:	caffeine intoxication nicotine withdrawal amphetamines cocaine cannabis hallucinogens
corticosteroids	
anticonvulsants	
stimulants:	theophylline ephedrine norepinephrine
sympathomimetics:	bronchodilators
antihypertensives:	captopril
non-steroidal	
anti-inflammatories:	ibuprofen
anti-Parkinsonians:	L Dopa
Insulin	
Thyroxine	
psychotropics:	benzodiazepines (withdrawal)

# Chapter 18

## Substance abuse

Substance abuse is a common presentation in general practice. Around 13 per cent of adults abuse alcohol at some time in their lives with between three and five per cent of men and one per cent of women becoming alcohol dependent. Alcohol is a contributing factor in around 50 per cent of motor vehicle fatalities, 50 per cent of homicides and 25 per cent of suicides. Illicit drug use is most prevalent among young people, especially young men. The assessment of substance abuse is complicated by the fact that few sufferers will present with the problem directly.

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**Alcohol is a contributing factor in around 25 per cent of suicides.**

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### Assessment

#### 1. *Screening*

People with substance abuse often deny their problem. Do not hesitate to ask. A useful screening test for alcohol abuse is the CAGE questionnaire. Two or more positive answers are correlated with alcohol dependence in over 90 per cent of cases.

C – Have you ever thought you should CUT DOWN on your drinking?

A – Have you ever felt ANNOYED by others' criticism of your drinking?

G – Have you ever felt GUILTY about your drinking?

E – Do you have a morning EYE OPENER?

Take particular care in assessing people who do not fit the stereotype of a substance abuser, e.g. a woman with panic disorder and agoraphobia. Substance abuse is common in this group. People may be secretive about their substance abuse.

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**The CAGE questionnaire is a useful screening instrument for detecting alcohol abuse.**

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#### 2. *Reason for presentation*

People commonly present with unrelated problems, or with physical or psychological complications of the substance abuse. They may be motivated to do something about their problems because of the threat of job loss, marital breakdown or legal difficulties.

#### 3. *Extent and pattern of abuse*

Document the amount of the substance consumed, the time course of the problem and the pattern of abuse. For example, the amount of alcohol consumed should be quantified in terms of the number of standard drinks per day. A standard drink is equivalent to a 200ml glass of beer, a 90ml glass of wine or a 30ml glass of spirits. A small bottle of beer is equivalent to 1½ standard drinks, a large bottle to 3½. A bottle of wine is equivalent to eight standard drinks. Recommended safe maximum daily quantities are four standard drinks for men and two for women. Patterns of drinking vary between different populations. For example, Anglo-Saxons typically binge drink, while those from continental Europe more often drink steadily. Ask if the person has suffered any symptoms of withdrawal and whether he or she requires larger amounts to get the same effect (tolerance). Try to uncover the precipitants of the substance abuse. Drinking binges typically occur at times of stress. Identifying the emotional state that leads people to abuse substances is often complicated by their inability to identify and describe feelings (alexithymia). The alexithymic person is prone to act out in

order to modulate unpleasant affects, rather than to recognise and articulate how he or she feels.

4. *Disability and handicap*

Ask about the social consequences of the substance abuse—loss of employment, legal problems (e.g. driving under the influence, charges for possession of illicit substances), marital and family problems and financial problems. Assess the amount of time spent obtaining, taking or recovering from the substances abused (salience), and about activities that have been given up or reduced as a consequence of the abuse.

5. *Past treatments*

Document previous treatments that were most effective for that individual.

6. *Co-morbidity*

The physical and mental health problems associated with the abuse of specific substances are discussed below.

7. *Mental state examination*

Assess for the substance-specific effects of intoxication and withdrawal and, where applicable, complications of abuse—delirium, dementia, psychosis, anxiety or depression.

8. *Physical examination and investigations*

Assess the substance-specific physical complications discussed below.

## Diagnosis

The DSM-IV criteria for substance dependence include a pattern of substance use that results in significant impairment, disability and handicap, and includes at least three of the following: tolerance (i.e. increased amounts of the substance required to achieve the same effect, or less effect with the same amount); withdrawal, or taking substances to avoid withdrawal symptoms; larger amounts taken than intended; repeated unsuccessful attempts to cut down; a lot of time spent obtaining, using or recovering from the effects of the substance; abandoning important social, occupational, or recreational activities because of the substance abuse; or continued use of the substance despite knowledge of having a persistent physical or psychological illness that is caused or exacerbated by it<sup>1</sup>. The DSM-IV also includes the category, 'substance abuse', for those cases in which problems exist, but the criteria for dependence are not met. This diagnosis requires the continued use of substances in situations that are hazardous (e.g. drink-driving) or that result in significant physical or mental health problems, disability or handicap.

The abuse of substances is associated with specific syndromes of intoxication and withdrawal. Some may cause psychological symptoms—delusions, hallucinations, depression or anxiety. Complications include delirium and dementia. Hallucinogens can cause flashbacks.

## Formulation

The formulation will help you tailor treatment to the individual patient.

### *Biological factors*

Family studies have demonstrated a strong genetic contribution to the development of alcohol abuse. Monozygotic twins have around twice the concordance rate as do dizygotic twins. The offspring of alcoholics have around four times the chance of developing alcoholism as do the children of non-alcoholics, even when raised apart from their families of origin. This biological predisposition provides some evidence for the formulation of alcoholism as a disease, a central tenet of the beliefs underlying Alcoholics Anonymous. However, the incomplete concordance in monozygotic twins is evidence that environmental factors also play a part.

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<sup>1</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington DC: American Psychiatric Association, 1994.

### *Psychological factors*

People may use substances for their pleasurable effects or to avoid some emotional pain. In some cases, people use substances to cope with the psychological symptoms of depression and anxiety. Unfortunately, the use of substances, while alleviating symptoms during intoxication, may worsen them in the long-term.

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**People may abuse substances in an attempt to treat their mental disorders. These often exacerbate the symptoms.**

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Mental disorders associated with substance abuse include anxiety, depression and antisocial personality disorder. The rate of suicide among alcoholics has been estimated to be between 60 and 120 times the rate among non-alcoholics. Alcohol use is a contributing factor in as many as 25 per cent of completed suicides. Co-morbidity rates among the abusers of illicit drugs have been calculated to be 53 per cent, a rate higher than that for alcoholics (37 per cent).

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**Mental disorders that are commonly associated with substance abuse include anxiety, depression and antisocial personality disorder.**

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The psychodynamics of substance abuse suggest that people may abuse drugs to deal with problems in self-esteem and to assist in the modulation of unpleasant affects (anxiety, depression, shame, guilt and rage). These disorders reflect problems in impulse control that may be manifest in other aspects of the person's behaviour such as criminality, self-harm and violence. Substance abuse can be a form of 'acting out'. People may use substances to suppress or remove unpleasant affective states instead of identifying and articulating how they feel, and taking steps to deal with the problems that give rise to these feelings. People sometimes use substances in response to problems in their interpersonal relationships.

### *Social factors*

Substance abuse may occur in response to social stressors. The abuse of illicit drugs is often complicated by criminal behaviour required to obtain the substances. The prevalence of abuse increases with ready access to the drug. Peer pressure is often a factor, especially in young people experimenting with drugs. The use of some substances is glamorised in the media and in advertising.

Certain professions are at high risk. For example, bartenders, journalists, musicians, writers and doctors have higher rates of alcohol abuse than others. Young, single, unemployed youth from socially deprived backgrounds are at relatively high risk of opiate abuse.

## **Treatment**

The principles of treatment include the following:

### 1. *Therapeutic alliance*

Be aware of countertransference responses of anger and helplessness. Substance abusers have often been met by hostility and rejection in the past. Convey your concern about the problem, but be careful neither to judge nor try to take responsibility for it. It is often useful to acknowledge that you are powerless to stop a person abusing substances. You cannot stop a young man who abuses illicit drugs from obtaining the substances, nor can you stop an alcoholic from going to the pub. Within a strong therapeutic alliance, you will be able to confront people about their substance abuse without alienating them.

### 2. *Care in prescribing*

General practitioners often face demands to prescribe or administer therapeutic drugs. For locum doctors attending people in their homes, this can also be dangerous. Have a high index of suspicion of people who ask for opiates or benzodiazepines, especially those who

have not consulted you before. If in doubt, you may prescribe small quantities of the drug. Suspected addicts should be reported to state health authorities. In the absence of legitimate indications, you should calmly, but firmly, refuse to prescribe the drug.

3. *Education*

Educate the person and his or her family about the effects of intoxication and withdrawal, and the physical and mental disorders that may complicate abuse of the substance. Outline the treatment options available, including the relevant drug and alcohol dependency agencies, non-government organisations and self-help groups.

4. *Diagnosis and treatment of co-morbid physical and mental disorders*

The assessment of whether psychological symptoms are caused by the substance abuse or are evidence of a co-morbid condition is often difficult. Consider the symptoms of intoxication and withdrawal for the specific substance involved. Generally, withdrawal symptoms will resolve after two to four weeks. Persistence of symptoms beyond this period suggests the presence of a separate condition.

5. *Treatment of the psychosocial complications of abuse*

Issues that all substance abusers have to face are the losses associated with their habit. These include losses of physical health, work opportunities, family, friends and finances. Unfortunately, identifying the stressors that precipitate abuse is often difficult because of the tendency for substance abusers to deny both their abuse and their other problems. The principles of counselling and structured problem solving described in Chapter 6 can be used to help deal with these losses and with other stressors.

6. *Self-help groups*

Alcoholics Anonymous (AA) is a self-help organisation that was set up in the USA after the lifting of prohibition in 1937. It is based on the belief that alcoholism is a disease over which the sufferer has no control. Members are taught that they need to submit to a higher power in order to maintain abstinence. In the meetings, sufferers give testimonies of their problems and provide mutual support. Although very effective for some, AA tends to have less appeal for young people, women and members of minority groups. Others have difficulty accepting the ideology of the organisation. Ancillary groups exist for the families of sufferers (Al-A-Teen and Al Anon). Similar groups exist for those who abuse other substances (e.g. Narcotics Anonymous). However, these have generally been less successful, in part because of the different age group and subculture affected.

7. *Family work*

Substance abuse invariably affects the spouses, families and others close to the person. The loss of social supports is an important perpetuating factor in the illness. The reactions of family members may inadvertently reinforce the substance abuse. Family members may themselves suffer psychological problems as a result of a person's substance abuse. Both the patient and family members must acknowledge that abstinence is ultimately the responsibility of the patient. No matter how concerned someone else might be, he or she cannot stop another adult from obtaining and abusing drugs (see Box 18-1).

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**Both the patient and family members must acknowledge that abstinence is ultimately the responsibility of the patient.**

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**Box 18-1: Abstinence is the patient's responsibility**

A 55-year-old man who suffers alcohol dependence presents with his wife. He complains that she has not been vigilant enough recently in monitoring his drinking. Last week he went on a three-day drinking binge and she did nothing about it. The man is projecting responsibility for his problem on to his wife. She is made to feel how powerless *he* feels in trying to overcome his problem. In such a case, you would be concerned about her welfare, including her safety.



#### 8. *Abstinence or controlled use*

Whether the goal is abstinence or controlled use will depend on the substance used and the individual concerned. Abstinence is recommended during pregnancy, in cases of polysubstance abuse, when there are serious physical or mental complications of the abuse, when previous attempts at controlled use have failed, or when there is significant disability and handicap.

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**Abstinence, as opposed to controlled use, is advised in the following: during pregnancy, in cases of poly-substance abuse, when there are serious complications of abuse, when previous attempts at controlled use have failed, and when there is significant disability and handicap.**

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### Complications of the abuse of specific substances

In this section, I discuss the assessment and treatment of the complications of the abuse of some common substances.

#### Alcohol

Forty per cent of those who abuse alcohol have a good outcome, 47 per cent continue to abuse and the remainder have a fair to poor outcome. Unfortunately, the impact of treatment is sometimes modest with 19 per cent improving spontaneously over a 12-month period and 26 per cent improving with treatment<sup>1</sup>. Predictors of a good outcome include finding a substitute for the dependency (e.g. devotion to work, a consuming interest or hobby, or membership of a cohesive religious or therapeutic group such as AA); a serious threat to one's physical health, marital and family relationships or career; legal problems; or a new relationship.

Consider the following in the treatment of a person with alcohol withdrawal:

1. Place the person in a well-lit room. Monitoring vital signs and mental status will guide the doses of diazepam administered and the supportive measures required to maintain fluid and electrolyte balance. Investigations may include electrolytes and liver function tests, full blood examination and clotting studies. A chest X-ray may be indicated if there are signs of infection. A CT scan of the head may be needed if there is any evidence of head trauma.
2. Administration of diazepam until calm with a tapering dose over the next seven to 14 days; Thiamine 100mg intramuscularly daily for three to five days, then 100mg orally, daily with vitamin B complex. These are continued over the following months to prevent the development of Wernicke's encephalopathy (see following).

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**During alcohol withdrawal, thiamine and vitamin B complex are given to prevent the development of Wernicke's encephalopathy.**

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3. Supportive measures to maintain fluid and electrolyte balance, to guard against aspiration, and to avoid hypoglycaemia.
4. The treatment of co-morbid conditions, including possible closed head injury, Wernicke's encephalopathy, infections, acute liver and cardiac problems, and seizures.

The physical complications of alcohol abuse include gastritis, peptic ulcer, pancreatitis, liver disease, diarrhoea, hypertension, trauma, impotence, insomnia, peripheral neuropathy, cerebellar degeneration and cardiomyopathy. Alcohol abuse is also associated with a number of mental

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<sup>1</sup> Parloff MB, London P, Wolfe B. Individual psychotherapy and behavior change. *Annual Review of Psychology* 1986; 37: 321-349.

disorders. A failure to diagnose and treat these disorders will prevent adequate treatment of the substance abuse:

1. anxiety disorders – These are the commonest mental disorders found in association with alcohol abuse. The symptoms of alcohol withdrawal include anxiety and panic attacks. People with phobias or post-traumatic stress disorder may self-medicate with alcohol.
2. depression – Alcohol can cause or exacerbate depression. In some cases, a person may drink in order to alleviate symptoms of depression.
3. suicide – The suicide rate among alcoholics is between 50 and 120 times that for the rest of the population. Alcohol is a contributing factor in around 25 per cent of suicides.
4. psychosis – Alcohol may interact with antipsychotic medications and lead to behavioural problems in those with psychotic illnesses. Alcohol hallucinosis usually arises during withdrawal and is characterised by auditory hallucinations that persist after the physical withdrawal. People with alcohol hallucinosis should be carefully assessed for suicidality and dangerousness.
5. neuropsychiatric disorders – Wernicke's encephalopathy is a medical emergency. It is an acute brain syndrome that is characterised by delirium, confusion, ataxia, bilateral symmetrical ophthalmoplegia especially affecting the sixth cranial nerve, and nystagmus. It is caused by thiamine deficiency that is often associated with alcohol abuse. Treatment includes thiamine 100mg intramuscularly and oral vitamin B complex over the following months.

If left untreated, this condition may progress to Korsakoff's Psychosis. The syndrome includes short-term memory deficits, confabulation, polyneuropathy and disturbed eye movements (including lateral nystagmus and paralysis of conjugate gaze). Alcohol abuse can also be associated with the development of dementia.

6. foetal alcohol syndrome – The child may suffer mental retardation and various anatomical abnormalities (cleft palate, microcephaly and hypospadias).

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**Alcohol abuse is associated with anxiety disorders, depression, suicide, psychosis, neuropsychiatric conditions (including Wernicke's encephalopathy, Korsakoff's Psychosis, dementia and foetal alcohol syndrome).**

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Disulfiram is sometimes used as an aversive measure in the treatment of chronic alcoholism. It should be prescribed to physically fit, highly motivated people with a good record of adherence to treatment who are involved in a structured therapeutic program that includes regular checks on adherence. In view of the serious interactions with alcohol, I recommend referral to a specialist unit if this treatment seems indicated.

## **Opiates**

Psychological symptoms of opiate intoxication include euphoria, drowsiness and sometimes, anxiety. Physical signs include pupillary constriction, slurred speech, respiratory depression, hypotension, nausea, vomiting and constipation. Opiate overdose can cause death through respiratory depression and pulmonary oedema. Treatment involves monitoring, support and the administration of intravenous naloxone.

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**The treatment of opiate intoxication includes monitoring, general supportive measures and the administration of naloxone.**

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Opiate withdrawal is usually managed in a specialised inpatient facility. Symptoms of withdrawal include nausea, abdominal cramps, muscle aches, sweating, gooseflesh, restlessness, lacrimation, nasal congestion and tachycardia. Physical complications of chronic opiate use include overdose,

malnutrition, HIV infection, hepatitis and other infections. Associated psychological problems include depression, anxiety and antisocial personality disorder. Efforts to obtain the drugs may lead to criminality and prostitution.

Criteria for methadone maintenance include prolonged physiological dependence on opiates, pregnancy, or failed attempts at drug detoxification. The aim is to reduce the craving for heroin use, prevent the complications of intravenous drug use and permit rehabilitation. It can also limit criminal behaviour associated with drug seeking. Longer-term residential programs provide drug-free environments in which rehabilitation can occur.

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**Criteria for methadone maintenance include prolonged physiological dependence on opiates, pregnancy, or failed attempts at detoxification.**

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### **Cannabis**

Cannabis is used as either leaves (marijuana) or resin (hashish) that are either smoked or eaten. The principal active agent is delta-9-tetrahydrocannabinol (THC). Complications of intoxication with cannabis include anxiety, derealisation and acute paranoid states. It may hasten relapse in people with psychotic disorders. There is no conclusive evidence that it causes psychosis, but there is anecdotal evidence that the use of cannabis can precipitate a first episode and worsen the prognosis.

### **Stimulants**

Amphetamines may be taken orally, intravenously or by nasal ingestion. Cocaine is usually taken nasally or smoked. Intoxication can be complicated by seizures, myocardial infarction, cerebrovascular accident, damage to the foetus and nasal ulceration. Adverse psychological reactions include manic-like symptoms, anxiety, paranoia, aggression and poor judgement. Treatment of intoxication may require antipsychotic medication, support and protection. Withdrawal symptoms include depression, suicidality, fatigue, insomnia and irritability.

### **Hallucinogens**

The common hallucinogens include lysergic acid diethylamide (LSD), psilocybin (in 'magic mushrooms') and methylenedioxymethamphetamine (MDMA, also known as 'ecstasy'). Adverse reactions include anxiety, depersonalisation, derealisation, depression, illusions, hallucinations, delusions, risk-taking behaviour and flashbacks. Treatment involves sedation with diazepam and sometimes haloperidol. Chlorpromazine can sometimes cause a paradoxical reaction with increased anxiety.

### **Solvents**

Common inhaled agents include petrol, glues, lighter fluids and nitrous oxide. The abuse of these substances is most prevalent among young people, especially those in low socioeconomic groups. Adverse effects include confusion, disorientation, impulsive behaviour, ataxia, psychosis, seizures and coma. Death can result from respiratory depression, asphyxiation and cardiac arrest. Long-term use of solvents can cause damage to the cerebellum, liver, kidneys and bone marrow.

### **Hypnotics**

The commonest hypnotics abused these days are benzodiazepines, although barbiturate abuse is still occasionally seen. Among the benzodiazepines, the commonest abused drugs are the more potent ones such as flunitrazepam and alprazolam. The effects of intoxication and withdrawal are similar to those for alcohol. Symptoms and signs of intoxication include drowsiness, confusion, disinhibition, slurred speech, ataxia, poor coordination and nystagmus. Fatalities can occur from respiratory depression or inhalation of gastric contents. Symptoms of withdrawal

include anxiety, tremor, sweating, irritability and insomnia. Delirium can occur with visual hallucinations and formication. Seizures and coma may complicate withdrawal. Prevention is the cornerstone of treatment. Educate patients about the dangers of tolerance, dependence and withdrawal. In particular, advise them of the danger of withdrawal seizures. Prescribe only small quantities over short periods of time. Treatment of withdrawal involves close monitoring of mental state and vital signs while a long-acting benzodiazepine such as diazepam is administered in gradually diminishing doses. For the older person who has been dependent on a small dose of a benzodiazepine or barbiturate for many years, it is sometimes best to continue the drug at the current dose.

# Chapter 19

## Somatoform disorders

People often present to general practitioners with physical symptoms for which no organic cause can be found, or which are in excess of what would be expected from a physical disorder that is present. The prevalence among general practice attendees has been estimated to be between 25 and 50 per cent. The presentations fall into three groups: unexplained physical symptoms, hypochondriasis, and mental disorders presenting with somatic symptoms. In one study, the prevalence of these conditions among general practice attendees was found to be 16.6 per cent, 7.7 per cent and 8 per cent<sup>1</sup> respectively.

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### **Between 20 and 50 per cent of general practice attendees present with physical symptoms for which no organic cause can be found.**

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A failure to diagnose and treat these conditions will have a number of adverse consequences. The person will continue to suffer symptoms, disability and handicap. Treatable mental disorders will be missed. Unnecessary investigations and unwarranted treatments are costly and can lead to further disability. Excessive specialist referrals are expensive and will reinforce the person's conviction that there is something physically treatable that continues to elude diagnosis. The dissatisfied patient is likely to seek help from other doctors. I begin this chapter with a discussion of the assessment of the somatoform disorders in general. I then discuss the treatment of unexplained physical symptoms and hypochondriasis. Although the prolonged fatigue syndromes fall within the category of unexplained physical symptoms, I include a separate discussion of their treatment because of their high prevalence in general practice settings.

### Assessment

People with somatoform disorders are difficult to assess. They are often frustrated with their previous medical advice and unwilling to consider psychological contributions to their suffering. Consider the following steps in the assessment:

#### Review the medical record

These people have often had several consultations with a number of different practitioners. Their records are likely to contain several specialist reports and the results of many investigations. Note the responses to previous treatments and any indications of the attitudes of the person towards the illness, including his or her attitude to the possible contribution of psychological factors.

#### Interview with spouse or other family member

It is useful to seek collateral information about the nature and time course of symptoms, and the levels of disability and handicap. Ask about current psychosocial stressors and any relationship to the onset of the symptoms. Try to engage the family in treatment and rehabilitation.

#### Interview techniques

The approach you take in the interview and in subsequent treatment will depend on the ability of the person to accept the contribution of psychological factors to the problem. Some people

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<sup>1</sup> Kirmayer LJ, Robbins JM. Three forms of somatization in primary care: prevalence, co-occurrence, and sociodemographic characteristics. *The Journal of Nervous and Mental Disease* 1991; 179: 647–655.

will readily do so and engage in psychological treatments. Others will, to varying degrees, resist such an explanation, insisting that you must find and treat a physical cause.

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**Some people readily accept the contribution of psychological factors to their problems. Others resist such an explanation and insist that you find a physical cause.**

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Goldberg and others have proposed a three-stage model for helping people with unexplained physical symptoms to re-attribute their symptoms and relate them to psychosocial problems<sup>1</sup>. The first step involves making the person feel understood. Give the person time to describe his or her complaints. Take a full history of the symptoms, their time course and any precipitants. Ask about the symptom's occurrence over a typical day. Respond to verbal and nonverbal cues by making empathic comments ('The pain sounds very severe', or 'You must get fed up when doctors cannot get rid of the pain'), clarifying ('Tell me when the pain first began') and asking about the mood ('How did that make you feel?'). Establish a picture of the family and social context in which the symptoms have arisen. Ask what the person believes the symptoms mean. Perform a brief physical examination.

The second stage involves changing the agenda to incorporate complaints other than the physical symptoms. Summarise the physical findings. Acknowledge the reality of the symptoms and the distress that they cause. Reframe the problems incorporating other symptoms and relating their onset to stressors in the person's life. It may be useful to ask the patient to record the situations in which symptoms were worse during the week, what they were doing at the time, where and with whom they were.

The final stage involves making an explicit link between the person's emotional state and the physical symptoms. When the symptoms are related to anxiety, explain the pathophysiological process responsible for causing the symptoms, for example, 'When people get very anxious, they often over-breathe. This causes a number of changes in the ability of blood to carry oxygen to the brain that can make you feel dizzy, sweaty and cause tingling in your hands and around your mouth'. A similar approach is used for depression—'When people are depressed their pain threshold is altered so they tend to be more sensitive to pain'. Discuss the other symptoms that the person suffers that are typical of the underlying mental disorder. It may be useful to demonstrate how muscular tension can cause muscle aches and pains by, for example, asking the person to hold a book with his or her arms outstretched. Link the onset and exacerbation of symptoms to stressful events in the person's life. It may be useful to ask the patient to record the situations in which symptoms were worse during the week, what they were doing at the time, and where and with whom they were. Ask how the person is feeling presently, in the consultation, and relate this to his or her worries about what the symptoms mean. Ask if any other family member has suffered similar symptoms and discuss possible psychological contributions to this— it is often easier for the person to see the links between physical symptoms and stressful events or psychological problems in someone else. Having completed the assessment, you should now be in a position to negotiate treatment.

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**A three-stage model for helping patients reattribute their somatic symptoms to psychological as well as physical causes includes making the person feel understood, changing the agenda to incorporate complaints other than physical symptoms, and making explicit links between his or her emotional state and the physical symptoms.**

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<sup>1</sup> Goldberg D, Gask L, O'Dowd T. The treatment of somatization: teaching techniques of reattribution. *Journal of Psychosomatic Research* 1989; 33:689–695.

## Mental state examination

There are certain features on the mental state examination that are specific to somatoform disorders. The person may repeatedly return to complain of their symptoms. The symptoms will sometimes worsen when discussing emotionally painful subjects. The person may have difficulty explaining the nature of the symptoms and have few words to describe emotional reactions. The predominant affect may be anger. In others, there is a lack of affective response. It is useful to note the person's attitude to the symptoms and the strength of his or her conviction that there is some physical cause.

## Unexplained physical symptoms

People often experience psychological distress with physical symptoms. These are often associated with a mental disorder, most commonly depression or anxiety. While physical symptoms can occur in the absence of any physical pathology, more commonly there is some physical disorder present, but the symptoms are in excess of what would be expected.

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**In most cases of unexplained physical symptoms, there is some underlying physical disorder, but the symptoms are in excess of what would be expected.**

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### Presentation

These disorders are characterised by the presence of one or more physical symptoms for which there is either no medical explanation or the amount of impairment, disability and handicap is greater than what would be expected from the physical pathology that is present. Common symptoms include pain (e.g. headaches, abdominal pain), gastrointestinal symptoms (e.g. constipation and diarrhoea), sexual symptoms (e.g. erectile or ejaculatory dysfunction, irregular periods or excessive menstrual bleeding), pseudo-neurological symptoms (e.g. dizziness, incoordination, poor balance, localised weakness, urinary retention, sensory changes, seizures or amnesia) or fatigue. People with unexplained pain tend to make frequent medical consultations, often to different doctors, and fail to be reassured about the nature of their symptoms.

### Diagnosis

Specific disorders include somatisation disorder, conversion disorder, pain disorder and the prolonged fatigue syndromes. Somatisation is a chronic disorder that requires the presence of at least eight symptoms (four of pain, two gastrointestinal, one sexual and one pseudoneurological), beginning before the age of 30 years<sup>1</sup>. While the prevalence of this disorder is low (between 0.2 per cent and 2 per cent), the presentation of a part-syndrome is very common—between 9 and 20 per cent in community samples). The essential feature of conversion disorder is the presence of symptoms or deficits affecting voluntary motor or sensory function that cannot be fully explained by a general medical condition or the effects of a substance. Psychological factors are seen to play a part in the onset or exacerbation of the symptoms. In pain disorder, the predominant complaint is of pain, in which psychological factors are judged to have an important role in the onset, severity, exacerbation or maintenance. The prolonged fatigue syndromes are discussed below.

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**The syndromes of unexplained physical symptoms include somatisation disorder, conversion disorder, chronic pain and the prolonged fatigue syndromes.**

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<sup>1</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th Ed. Washington DC: American Psychiatric Association, 1994.



## Differential diagnosis

Unexplained physical symptoms often arise in the context of other mental disorders. People with depression may suffer fatigue, loss of energy, restlessness, poor appetite and weight loss (see Chapter 14). Anxiety is accompanied by a wide variety of physical symptoms, including muscle tension, fatigue, shortness of breath, palpitations, chest pain, nausea, abdominal distress, dizziness, paraesthesia, derealisation and depersonalisation (see Chapter 15). The perception of physical symptoms is altered in several mental disorders: the anxious or depressed person is likely to focus on the pain, which in turn makes it worse. People suffering from schizophrenia may describe bizarre physical complaints (see Chapter 22).

## Formulation

### *Biological factors*

Unexplained physical symptoms may arise in the absence of any clear physical pathology. However, more often there is an underlying physical problem, but the symptoms are more distressing and produce greater disability than would be expected. Chronic conditions can be complicated by the effects of inactivity, self-medication with alcohol and other substances, and the iatrogenic complications of prescribed medications, multiple investigations and procedures.

The perception of pain depends not only on the extent and site of physical injury, but also on the modulation of neural information by gating mechanisms in the dorsal horns of the spinal cord. Inputs from higher cortical and subcortical areas are integrated with inputs from peripheral afferent fibres to modulate the perception of pain. This may explain the impact of emotional states on pain perception and the efficacy of relaxation techniques, cognitive behavioural approaches, distraction and hypnosis in treatment.

### *Psychosocial factors*

The symptoms can often be understood in terms of the person's past history. For example, a man may identify with a parent who, during his childhood, suffered chronic illness. A woman who was emotionally neglected in childhood may have learnt that the only way she could obtain support and nurturance was through being sick. The person who was traumatised as a child may have an unconscious need to continue suffering and to be punished.

The person's current social milieu may reinforce his or her abnormal illness behaviour. By adopting the sick role, a person is exempted from his or her normal duties and responsibilities and may gain attention and support from family members. In doing so, they reinforce the behaviour. At the same time, the person may covertly express his or her anger with other family members. Compensation and other legal issues may also play a part in reinforcing the abnormal illness behaviour. In some cases, the problem may lie with someone else in the person's social system (see Box 19-1).

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### **The person's social milieu may reinforce his or her abnormal illness behaviour.**

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#### **Box 19-1: When the problem is not with the person who presents**

An 87-year-old woman who suffers from early dementia is brought to you repeatedly by her 90-year-old husband because of abdominal pain. She has been admitted to the local hospital on several occasions, but no physical cause for her symptoms can be found. Her husband is upset that the hospital will not admit her on this occasion, and he asks you to arrange the admission. An exclusive focus on the woman's presenting symptoms may lead you to miss the primary problem—her husband's inability to cope. Treatment will include forming a therapeutic alliance with both the woman and her husband and maximising his social supports to alleviate the burden of care.



## Treatment

It is useful to consider two groups of patients—those who present occasionally with physical symptoms, usually when under stress, and those with chronic unexplained physical symptoms. Members of the first group are often quite willing to acknowledge a psychological cause for their symptoms. They will be reassured by an explanation of how stress can produce the presenting symptoms. Having clarified the stressors facing the individual, structured problem solving can be used to help the person deal with them (see Chapter 6).

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### **Counselling and structured problem solving will assist people to deal effectively with stressful events in their lives.**

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People with chronic unexplained physical symptoms are amongst general practitioners' most challenging patients. Consider the following principles of treatment<sup>1</sup>:

1. Medical examination is required to uncover any physical cause for the symptoms. The results of the examination and any investigations should be carefully explained to the person. The ways in which emotional states can modulate the perception of pain should also be explained. On repeat visits, new symptoms should be noted and a focused physical examination performed.
2. Avoid excessive investigations and procedures. Make regular, time-limited appointments. Dissuade the person from consulting different doctors for the same problems. Only refer to a specialist if there is clear evidence of serious physical disorder.

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### **Avoid excessive investigations, procedures and specialist referrals when treating people with unexplained physical symptoms.**

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3. Diagnose and treat any primary or co-morbid mental disorders, especially depression, anxiety and substance abuse.

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### **People with unexplained physical symptoms are at risk of developing depression, anxiety disorders and substance abuse.**

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4. Acknowledge the pain and explain to the patient that he or she may have to learn to live with some symptoms. Make the aim of treatment to improve the person's ability to cope with the pain, and to have a fulfilling and enjoyable life in spite of it. Concentrate on rehabilitation rather than cure. Rehabilitation activities include a graduated exercise program and setting daily activity schedules that include pleasurable activities (see the non-specific treatments for depression in Chapter 14 and Appendix 7). Teach relaxation techniques (see progressive muscular relaxation in Appendix 5 and self-hypnosis in Appendix 6).

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### **Concentrate on rehabilitation rather than cure.**

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5. Try to uncover the psychosocial precipitants to exacerbations of the symptoms and use the counselling and structured problem solving techniques described in Chapter 6 to help the person cope with these (see Box 19-2).
6. Involve the family in treatment. Explain the nature of the problem. Try to reach an agreement with the family and the patient that they should avoid reinforcing the illness behaviour.

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<sup>1</sup> Bass C, Benjamin S. The management of chronic somatisation. *British Journal of Psychiatry* 1993; 162: 472-480.

### **Box 19-2: Uncovering psychosocial precipitants**

A 50-year-old man presents repeatedly to his general practitioner and to the local hospital complaining of dizziness and loin pain. Thorough examination and appropriate investigation fail to reveal any physical cause.

A brief social history reveals serious marital and family problems. He separated from his wife and three adult children five years before, but he continues to pay his wife's rent as well as maintenance for the children. However, relations between the couple remain acrimonious. The precipitant to a recent hospital admission was an altercation with his oldest son that took place after he refused to let the young man borrow his car. In response, his son shouted abuse at him and broke a pane of glass slamming the door as he left.

*Comment:* The general practitioner focuses on the marital and family problems and attempts to help the man find better solutions to them through counselling and structured problem solving.

Advise family members to acknowledge the person's symptoms, but to avoid constantly responding to them. Instead, they should give as much reinforcement and praise as possible in response to healthy coping and rehabilitation activities.

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### **Encourage family members to avoid responding to pain behaviour but to reinforce coping behaviours.**

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7. Monitor your countertransference. People with unexplained physical symptoms present particular challenges for general practitioners. They will challenge your knowledge and make you feel anxious that you are missing something. You may feel exasperated by the patient's symptoms and his or her failure to get better. Having a clear formulation will organise your thinking and allay your anxiety. Continuing to deepen your understanding of the problems will maintain your interest and increase your confidence in the formulation.
8. Consider referral to a psychiatrist. Be straightforward about who you are asking the person to see.

The formulation and treatment of a man with pain disorder is discussed in Box 19-3.

### Box 19-3: Formulation and treatment of a man with pain disorder

A 37-year-old man consults you regularly for back pain that he has suffered since an injury at work 12 years ago. The pain has been worse since an operation four years ago. Opiate analgesics provide some relief, but he suffers side effects including constipation. He self-medicates with alcohol (average 10 standard drinks a day). He continues to seek compensation for the injury. His wife is exhausted by her attempts to continue to support him. At age seven, he was involved in a car accident in which both of his parents were killed. He is still haunted by images of the car bursting into flames just after he had managed to crawl to safety. He was subsequently brought up in a foster home where he suffered physical abuse. He was often unable to attend school because of illness.

*Comment:* The symptoms can be understood as an unconscious need for punishment in a man who suffers survivor guilt as part of post-traumatic stress disorder. The abuse by his foster father only confirmed his sense of himself as a bad person. The pattern for his illness behaviour was already evident in his youth. The illness is perpetuated by his wife's continued response to his illness behaviour and also by the unresolved issue of compensation. He is at risk of driving his wife away with his demands. His substance abuse will cause secondary impairments and disabilities.

Management of his chronic pain involves treatment of post-traumatic stress disorder with an SSRI or imipramine, education and rehabilitation. His wife is encouraged to take less responsibility for his problems, to try to ignore his illness behaviour, but to respond positively to any progress with his rehabilitation. He is warned about the adverse effects of his alcohol consumption, and referred to the local Alcohol Tobacco and Other Drugs clinic at the local community health service. Rehabilitation will involve a graduated exercise program to increase the flexibility and strength of his back and to improve his general fitness. He is also asked to make a schedule of daily activities that includes at least one pleasurable activity every day.

## Prolonged fatigue syndromes

Around 30 per cent of general practice attendees complain of fatigue<sup>1,2,3,4,5</sup>. Prolonged fatigue presents in several syndrome—chronic fatigue, fibromyalgia and irritable bowel syndrome. All are characterised by fatigue, pain, poor concentration and irritability. In chronic fatigue there is also unexplained, persistent or relapsing fatigue that lasts longer than six months, that is typically worse after activity, and is associated with disturbed sleep, myalgia, and tender lymph nodes. People suffering from fibromyalgia complain of back, joint, muscle and extremity pain. Those with irritable bowel syndrome complain of diarrhoea, constipation, abdominal pain, bloating and nausea. For a diagnosis to be made, there must be a significant level of disability, e.g. a 50 per cent reduction in activity levels over the previous six months.

### Around 30 per cent of general practice attendees complain of fatigue.

In many cases, prolonged fatigue occurs in association with a psychological disorder, most commonly, depression and anxiety. However, in about a third of cases (i.e. around 10 per cent of general practice attendees) there is no significant psychological disorder present.

<sup>1</sup> Hickie IB, Lloyd AR, Wakefield D. Chronic fatigue syndrome: current perspectives on evaluation and management. *The Medical Journal of Australia* 1995; 163:314–318.

<sup>2</sup> Hickie I, Hadzi-Pavlovic D, Ricci C. Editorial: reviving the diagnosis of neurasthenia. *Psychological Medicine* 1997; 27:989–984.

<sup>3</sup> Sharpe M, Hawton K, Simkin S et al. Cognitive behaviour therapy for the chronic fatigue syndrome: a randomised controlled trial. *British Medical Journal* 1996; 312:22–26.

<sup>4</sup> Deale A, Chalder T, Marks I, Wessely S. Cognitive behavior therapy for chronic fatigue syndrome: a randomized controlled trial. *American Journal of Psychiatry* 1997; 154:408–414.

<sup>5</sup> Warwick HMC, Clark DM, Cobb AM, Salkovskis PM. A controlled trial of cognitive-behavioural treatment of hypochondriasis. *British Journal of Psychiatry* 1996; 169:189–195.

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**Fatigue usually occurs in association with a psychological disorder (especially depression or anxiety), but in about a third of cases, there is no significant psychological disorder present.**

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There is unlikely to be a single cause of prolonged fatigue. Possibilities include chronic viral infection, immune dysfunction, neuro-endocrine disturbance and underlying depression or anxiety. What is certain is that disability and handicap may be severe. In particular, a vicious cycle is often established in which fatigue leads to avoidance of exercise and activity, which in turn leads to depression, anxiety and a worsening of the physical symptoms.

### **Assessment**

In assessing the person with fatigue, consider possible physical and psychiatric causes (see Table 19-1). Clarify the pattern of the fatigue, whether the person is tired all of the time or only in certain situations—for example, when at work. Does performing everyday tasks easily tire the person? Inquire about a man's lifestyle. Does he get enough sleep; does he do any regular exercise; is he over-worked; is he bored; are there any current stressors; is he angry about something? Clarify the onset of the problem. Has it been a problem for a long time; were there any precipitants? Explore his or her beliefs about the cause of the illness and try later to incorporate this in a broad, multifactorial formulation of the problem. Assess the person's level of disability and handicap—his or her self-care, family and other personal relationships, work and leisure activities.

### **Investigations**

Investigations that may be useful include:

- urinalysis
- full blood count and differential
- ESR
- electrolytes and liver function tests
- blood glucose
- thyroid function tests
- sleep studies

### **Treatment**

Since much of the disability flows from the avoidance of activity and exercise, an essential component of treatment is to expose the person through a graduated exercise program and increasing daily activities. The recommendations made in the past to rest and avoid activities will only lengthen the duration of the illness and lead to more severe disability and handicap.

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**An essential component of the treatment of prolonged fatigue is to expose the person to a graduated exercise program and to increase his or her daily activities.**

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**Table 19-1: Causes of fatigue**

1. Drugs

- steroids
- tricyclic anti-depressants
- benzodiazepines
- antihistamines
- theophylline
- decongestants
- chemotherapeutic agents
- thyroid replacement hormones
- oral contraceptives
- anti-hypertensives

2. Alcohol abuse

3. Medical causes

- chronic heart disease
- lung disease (asthma, chronic bronchitis, emphysema)
- autoimmune disease (rheumatoid arthritis)
- diabetes mellitus
- anaemia
- hyper- or hypothyroidism
- infection (e.g. UTI)
- neurological disorder

4. Psychiatric causes

- adjustment disorder – Are there current stressors? This may be a common cause of fatigue and sleep problems in people presenting to general practitioners.
- depression – As well as low mood, ask about loss of interest or pleasure and neurovegetative function disturbance.
- anxiety – Ask about panic attacks, avoidance behaviour, tension and worry.
- post-traumatic stress disorder – re-living the event, tension and irritability, withdrawal from usual activities
- somatoform disorders, including chronic pain and somatisation
- alcohol abuse/dependence

5. Primary sleep disorder

1. Perform appropriate medical and psychiatric evaluation to note the presence of any of the aetiological factors mentioned in Table 19-1. Avoid performing investigations and making specialist referrals unless there are clear reasons for doing so. Make regular scheduled appointments and encourage the person to consult only one doctor in order to avoid duplication of investigations, adverse drug reactions and confused communication about the nature of the problem.
2. Ask the patient to record his or her activities over a week using a daily activity schedule. This will often reveal a pattern in which bouts of vigorous or prolonged activity are followed by a worsening of fatigue symptoms, and then periods of rest and recovery. A vicious circle is established in which the link between activity and fatigue is continually reinforced. An important aim of treatment is to break this link. This is done by planning regular small amounts of exercise every day rather than sudden bursts once a week. Patients are encouraged

to perform their planned activity even if they are feeling fatigued. On the other hand, they are advised not to perform any vigorous or more demanding activity, even if they are feeling very well.

3. Use a graduated exercise program to increase the person's exercise tolerance. This part of treatment involves exposing the person to the feared situation—in this case, the normal physiological changes associated with aerobic exercise. The person learns that these changes do not represent warning signs of physical illness. Exercise also has a beneficial effect on mood.
4. Teach the patient response prevention to avoid checking behaviours (e.g. monitoring pulse rate, weight, lymph nodes etc.) and seeking reassurance.
5. Demonstrate to the patient how focusing on a particular body part can induce symptoms.
6. Use structured problem solving to deal as effectively as possible with stressors in relationships and at work (see Appendix 3).
7. Advise the person on good sleep habits (Table 14-3). People with chronic fatigue often have an inconsistent sleep pattern, sleeping during the day and then staying up late. They may stay up late over the weekend and then struggle to go to work on Monday morning. Negotiate regular times for going to bed and rising.
8. Use cognitive behavioural techniques (see Chapter 10). Ask a (female) patient to make a diary, noting the times when her fatigue is worst and recording her automatic thoughts at these times. Help her to refute irrational thoughts and record changes in her symptoms. Uncover underlying assumptions using the vertical arrow technique. These often include traits of perfectionism, low self-esteem, excessive guilt and an excessive reliance on achievement.
9. Moclobemide may be effective in some patients.

## Hypochondriasis

Like the other somatoform disorders, hypochondriasis is treated more often by general practitioners than by psychiatrists. People with hypochondriasis are preoccupied with the belief that they have a serious physical illness. The belief is maintained despite adequate medical evaluation and explanation. Sufferers scan for information about the disorder, check frequently for symptoms and signs, and seek repeated medical reviews. High levels of anxiety are common. While the primary condition is relatively rare, symptoms of hypochondriasis often occur in the context of depressive, anxiety and other mental disorders. In contrast to those suffering unexplained physical symptoms, people with hypochondriasis, instead of being preoccupied with particular somatic symptoms, are worried instead about having a particular illness.

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**Whereas people with unexplained physical symptoms are preoccupied with their symptoms, people with hypochondriasis fear that they have a serious physical illness.**

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## Differential diagnosis

Hypochondriacal symptoms occur in a number of mental disorders. People with depression are often concerned that they have some serious illness. In severe cases, a person may suffer hypochondriacal delusions (e.g. that he or she has cancer or AIDS). Among the many concerns of someone with generalised anxiety disorder are often fears of having a serious illness. During a panic attack, a person may believe that he or she is going to die. Despite recognising the irrationality of their thoughts, people with obsessive-compulsive disorder may be plagued by fears of contracting a serious illness, and they may perform compulsive checking or cleaning

rituals to avoid contamination. People with schizophrenia or delusional disorder may suffer bizarre hypochondriacal delusions.

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**People with depressive and anxiety disorders often suffer hypochondriacal symptoms.**

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### Formulation

#### *Biological factors*

A history of prolonged or severe illness in childhood may be a predisposing factor. Recent severe physical illness may also trigger hypochondriacal fears.

#### *Psychosocial factors*

As mentioned above, hypochondriacal complaints often occur in the context of some other mental disorder, especially depression and anxiety. A parent or other family member with severe illness may provide a model for the person with hypochondriasis. The meaning of the symptoms for an individual may be an unconscious need for punishment, or a means of having dependency needs met. The behaviour tends, on the one hand, to elicit people's concern, but on the other hand to frustrate and annoy them. The symptoms are reinforced by the secondary gains of avoiding one's normal responsibilities and gaining support and care from others. Reassurance seeking behaviour is reinforced by the reduction in anxiety that it causes in the short-term. However, over the long-term it leads to more disability and a need for repeated and more frequent reassurance. A sample formulation is shown in Box 19-4.

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**Hypochondriacal symptoms may express an unconscious need for punishment, a need to be cared for, or anger.**

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#### **Box 19-4: Formulation of hypochondriasis**

A 35-year-old woman presents acutely anxious. She is preoccupied with the fear that she may have contracted AIDS after having an image of a bird tattooed on her shoulder two weeks before. She also has a secret that she cannot tell you. A preliminary test for HIV comes back negative, but she feels that she cannot cope having to wait another three months for a repeat test. Despite her anxiety, she can still enjoy herself when distracted from her preoccupations, and she has not experienced any panic attacks.

She always idolised her father, a large man with tattoos who used to work in the merchant navy. However, she always felt rejected by him and resented the attention he paid to her brother with whom he would go fishing, play cricket, and talk sport. Three months later, after the second HIV test, she reveals the secret—she had been having an affair with a work colleague.

*Comment:* Her anxiety is magnified by the guilt over her marital infidelity. The tattoo was an act of identification with her father. It may also have provided a more acceptable reason for presenting for the HIV test than her sexual behaviour.

### Treatment

1. People with hypochondriacal concerns are often dissatisfied with the medical care that they have received in the past. Work to establish a therapeutic alliance by acknowledging the person's fears and symptoms. Take time to listen to the physical complaints. If the person can learn to trust you, he or she is less likely to consult other doctors, and will avoid having repeated investigations and procedures.
2. When presented with new symptoms, take a relevant history and perform a focused physical examination, but be careful to avoid investigations unless clearly indicated. Similarly, avoid specialist referral unless there are definite concerns about serious illness.

3. Diagnose and treat any primary or co-morbid conditions: depression, anxiety, alcohol and substance abuse.

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**Depression, anxiety, alcohol and substance abuse can complicate hypochondriasis.**

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4. Explain the relationship between mental states and the perception and interpretation of physical symptoms. For example, a persistent preoccupation with having an illness can lead to a focus on physical symptoms, which amplifies the perception of symptoms and in turn leads to greater anxiety about having some serious illness. The vicious cycle can be interrupted by an explanation of the problem, together with the use of relaxation and distraction techniques.
5. Adopt a rehabilitation focus, aiming to help the person cope despite his or her fears. Encourage the person to schedule pleasant activities every day that will distract him or her from being preoccupied with illness. Self-monitoring while performing a graded exercise program will often prove to patients that their disabilities are not as severe as they had feared.
6. People with hypochondriasis generally do not respond well to reassurance. Indeed reassurance-seeking can be seen as a maladaptive response to the fear that one has a serious illness, similar to the rituals of obsessive-compulsive disorder that are used to neutralise anxiety associated with obsessions. Using the principles of exposure and response prevention described in Chapter 9, the person should be exposed to symptoms through bodily focusing or exercise without body checking or seeking reassurance. Family members should be encouraged to minimise their reassuring behaviours and instead to reward healthy and adaptive activities.



## Chapter 20

### Sexual dysfunction

The prevalence of sexual problems in general practice populations has been estimated to be around 15 per cent. The commonest problems amongst women who seek help are hypoactive sexual desire disorder and female orgasmic disorder. Amongst men who present, erectile disorder and premature ejaculation are the most frequent<sup>1</sup>.

### Ethical issues

Because of the intimate nature of sexual problems, those who provide sexual therapy must be clear about relevant ethical and boundary issues.

1. In addition to the rules about not divulging information outside therapy, the therapist needs to negotiate what information from individual therapy can be disclosed in couple therapy. For example, if a (man) discloses that he is having an affair, sexual therapy is contraindicated, and the therapist may find him/herself in the awkward position of having to inform the man's partner of this without stating the actual reason. Some therapists avoid this problem by reaching an agreement that anything discussed in individual therapy can also be raised in couple therapy.
2. It is essential to monitor your countertransference. Because of the intimate nature of sexual therapy, together with the powerful position of the doctor/therapist with respect to the patient, there are particular risks of boundary violations. A failure to acknowledge sexual attraction to a person may lead to unnecessary physical examination. Unless you acknowledge to yourself dislike of a patient, you may behave in a way that makes the person feel rejected or demeaned. Make sure that any intervention you initiate is for sake of the patient(s) and not for your own gratification.
3. Any sexual relationship between a therapist and a client within therapy can severely damage the client. The therapist faces deregistration and possible criminal charges. The ban on sexual relationships applies both during and after therapy.
4. There is no place for the direct observation of sexual behaviour in general practice settings. Similarly, there should be no need for physical contact or demonstration of anatomy or techniques. Written material and—if acceptable to the clients—videotapes can be used for this purpose.
5. Informed consent should be obtained before performing a genital examination of an individual of the opposite sex. The examination should be performed in the presence of a clinician chaperone who is the same sex as the patient.
6. Care must be taken not to impose your values on the patient. For example, while it may be reasonable to discuss a person's aversion to oral sex, there should be no compulsion upon him or her to perform it. If you feel uncomfortable with a couple's values, refer them elsewhere.
7. The therapist should not discuss his or her own sexual behaviour.
8. Before delivering sexual therapy, the therapist should first undergo supervised training. Reading this text does not equip you to practise sexual therapy. However, you should be able to talk about sexual issues with patients, recognise common problems, provide sex education and advice on self-help texts, and make appropriate specialist referrals.

<sup>1</sup> Hawton K. *Sex Therapy: a Practical Guide*. Oxford, Oxford University Press, 1985; 30–50.

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**Any intervention must be for the benefit of the patient, not the therapist. It is essential to monitor countertransference.**

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## **Assessment of sexual problems**

### **Indications and contraindications**

Sexual therapy is contraindicated if there are chronic marital problems with hostility and lack of affection, ongoing infidelity or poor motivation. Couples with chronic marital problems should first undergo marital therapy. Any severe psychiatric disorder will need to be treated before sexual therapy begins. The presence of physical illness is not, in itself, a contraindication to therapy. Sexual therapy is usually delayed until about six months after pregnancy. You need to decide whether the problems reflect a sexual dysfunction or are due instead to unrealistic expectations. Although the same principles apply to both heterosexual and homosexual couples, see pp 199–200 for a discussion of specific issues that apply to homosexual couples.

### **Practical aspects of therapy**

You will generally see the couple together and then separately. Promote a relaxed and trusting atmosphere in which the couple feel comfortable discussing intimate parts of their lives. Monitor the transference and countertransference, in particular, any impulse to avoid discussion of certain topics out of shame or embarrassment. In order to avoid difficulties over confidentiality, it is probably best to ask at the outset that anything said in individual therapy can also be discussed in couple therapy. Reach a consensus on the sort of terminology you are going to use. Avoid performance-based terms, such as ‘achieve’, ‘reach’ and ‘attain’. The interview skills mentioned in Chapter 2, page 10, are applicable.

### **The interview**

To clarify the presenting sexual complaint, you need to assess the associated physiological (e.g. erectile difficulties), cognitive (e.g. negative thoughts, such as ‘I am going to fail again’) and emotional (e.g. feeling anxious and down) components before, during and after having sex. Identify the stage of the sexual response cycle at which problems occur and any relevant medical drug history and past psychiatric history.

Try to answer the question, ‘Why is this couple presenting with these problems at this time?’ There may have been sexual problems for some years—why are they presenting now? Clarify the time course and try to understand any precipitants and perpetuating factors. Ask the question, ‘What was happening around that time?’ rather than, ‘Why did the problems start?’

In addition to the general personal history covering early development, schooling, work, previous relationships, leisure and interests, and religious or specific cultural issues, take a sexual history that includes:

- family, religious and cultural attitudes to sex and sexual problems
- history of abuse or sexual assault
- age of first masturbation and the onset of menarche
- attitude to and feelings about the onset of puberty
- previous sexual relationships
- previous sexual dysfunction
- attitudes to aspects of sexuality such as nudity, masturbation, erotica and sexual fantasy
- sexual orientation

- attitude to pregnancy
- attitude to and fears about sexually transmitted diseases
- level of sexual knowledge and how it was obtained.

Assess general aspects of the current relationship—its length and history, the level of mutual affection, shared interests, communication and relationships with children. Ask also about the sexual relationship—its history, mutual attractiveness, communication about sexual matters and infidelity. Assess each person's motivation for treatment.

Perform a mental state examination, looking particularly for symptoms of depression or anxiety.

Before performing a genital examination of an individual, you should first gain informed consent. It is wise to have a health professional who is the same sex as the client present as a chaperone. Look at the person's general appearance noting particularly any stigmata of an endocrine abnormality. Check blood pressure and peripheral pulses. Perform a genital examination noting any anatomical abnormalities. Perform a vaginal examination.

Consider the following investigations: FSH, LH, prolactin and testosterone, fasting blood sugar, and urine screen. Other tests such as penile plethysmography and vascular studies are left to a specialist.

## **Formulation of sexual problems**

A variety of biological and psychosocial factors can contribute to the development of sexual problems. The formulation in a given individual or couple is never complete; rather, it develops and becomes clearer as therapy progresses.

### **Biological factors**

#### *Neurological disorders*

Sexual functioning involves the interaction of a complex array of cortical, brainstem, parasympathetic (especially in arousal), sympathetic (especially in orgasm) and somatic neural pathways. The impact of a spinal lesion will depend on its level and whether it is partial or complete. Men with high spinal lesions may still have reflex erections. Frontal lobe stroke may lead to sexual inhibition. Temporal lobe damage is usually associated with reduced sexual desire. People with epilepsy, especially if there is involvement of the temporal lobes, may have reduced sexual desire.

#### *Vascular disorders*

Blockage of arteries supplying the genital area leads to erectile dysfunction. Hypertension is associated with erectile dysfunction and ejaculatory failure, problems that may be exacerbated by anti-hypertensive medication. People who have suffered a myocardial infarction may avoid sexual activity for fear of precipitating angina.

#### *Endocrine disorders*

Diabetes mellitus may lead to erectile difficulties due to peripheral neuropathy and vascular abnormalities that worsen with illness duration. These may be exacerbated by psychological reactions to early symptoms of the illness. Both Addison's and Cushing's diseases are associated with reduced sexual desire. Klinefelter's syndrome, cirrhosis, pituitary tumours, testicular tumours, undescended testes and mumps orchitis are associated with loss of sexual desire, erectile problems and ejaculatory failure. Hyperthyroidism is usually associated with reduced desire and erectile problems though hyper-sexuality has been reported. Hypothyroidism is associated with reduced sexual desire that may be partially reversible with treatment.

### *Genital problems*

Vaginitis and venereal disease may cause local burning pain. Pelvic inflammatory disease, endometriosis and ovarian tumours are associated with deep dyspareunia. Curvature of the penis when erect in Peyronie's disease may cause pain. Prostatism and venereal disease may present with pain on ejaculation.

### *Other physical disorders*

Arthritis may lead to sexual problems because of pain. Sjogren's syndrome is associated with dyspareunia due to impaired vaginal lubrication. Serious systemic diseases cause debility and reduced sexual desire. Neoplasm may lead to sexual problems as direct or indirect effects of the illness itself or its treatment, or because of psychological reactions to having the illness.

### *Drugs*

A number of prescribed and recreational drugs can impair sexual functioning (See Table 20-1). Unfortunately, many psychotropic drugs produce significant sexual side effects. Amongst the antidepressants, mirtazapine, moclobemide and nefazodone are generally least likely to cause problems. The effects of SSRIs are dose-related, but resolve in around a third of patients. Olanzapine or quetiapine are said to have few sexual side effects<sup>1</sup>. However, note that responses to specific drugs vary from one individual to another.

While alcohol in low doses decreases anxiety, at high doses it impairs erectile function, retards ejaculation and reduces sexual desire. Cigarette smoking hastens atherosclerosis, which in turn causes sexual dysfunction. There are conflicting reports about the effects of marijuana. Some state that the drug enhances sexual experience; others that it can suppress testosterone levels. Heroin is associated with a loss of sexual interest as well as erectile and ejaculatory impairment.

**Table 20-1: Some drugs that cause sexual problems (especially erectile dysfunction and retarded ejaculation)**

<i>Antidepressants</i>	<i>Antihypertensives</i>
tricyclics	propranolol
SSRIs	clonidine
MAOIs	methyldopa
<i>Mood stabilisers</i>	hydrochlorothiazide
lithium	spironolactone
<i>Antipsychotics</i>	guanethidine
thioridazine, chlorpromazine,	<i>Anticholinergics</i>
haloperidol	benztropine
<i>Hypnotics</i>	<i>Others</i>
benzodiazepines	digoxin
barbiturates	indomethacin
	<i>Drugs of abuse</i>
	alcohol
	heroin
	methadone

<sup>1</sup> Bazire S. *Psychotropic Drug Directory 2001-2002: the Professionals' Pocket Handbook and Aide Memoire*. Bath, Bath Press, 2001.

## Psychosocial causes

### *Predisposing factors*

People's attitudes to sex are influenced by their upbringing and attitudes within their families of origin. Relationships with parents and siblings influence later close relationships.

Young people who enter puberty earlier than their peers may feel ashamed and embarrassed. Those with late puberty may feel ashamed and inadequate. The response of the child's family is an important mediating factor.

A person's sexual knowledge, skills and ability to communicate about sex all contribute to the quality of his or her sexual relations. A belief in certain sexual myths will affect a person's sexual behaviour. A person's values and attitudes will influence his or her willingness to use sexual fantasy and erotica, and may proscribe certain activities—for example, oral sex.

Difficulties in sexual functioning are important consequences of childhood sexual abuse. The risk is increased if the abuse occurred at an older age, was frequent, and was associated with more negative experiences, such as threats, coercion or dislike of the other person. Penetrative sexual abuse is more traumatic than non-penetrative abuse.

### *Precipitating factors*

Simple tiredness may be a significant contributing factor to sexual problems. The recommendation to practice sensate focus and other exercises may only exacerbate the problem. Any general stressor, such as the loss or death of a loved one, work difficulties or financial problems can have an impact on sexual functioning. Physical illness may have a psychological impact in addition to any direct physical impact. The discomfort that follows childbirth may persist and be complicated by depression or fatigue. An episode of sexual failure may lead to persistent problems as a consequence of performance anxiety. Couples undergoing invitro fertilisation treatment may develop sexual problems in response to the diagnosis of infertility. Sexual behaviour may be affected not only by the normal physiological changes of ageing, but exacerbated by negative attitudes to ageing—for example, myths about sexuality being the exclusive domain of the young and beautiful. After sexual assault, sexual problems are among the last symptoms of the trauma to resolve. Behaviours that summon memories of the assault are especially likely to persist.

### *Perpetuating factors*

Most couples with sexual problems also report marital difficulties<sup>1</sup>. There may be difficulties communicating about sexual matters, in particular, about one's likes and dislikes. Episodes of infidelity can lead to feelings of guilt, anger, resentment and inadequacy. The response of a person's partner to an episode of sexual dysfunction will influence his or her response to it. A fear of intimacy or loss of attractiveness may play a part.

Underlying assumptions about sexuality, including beliefs in sexual myths (see following page), influence sexual functioning. Some people find themselves more focused on observing themselves and thinking about how they are performing than in enjoying the experience. A couple's sexual relationship will be affected by their access to a private, warm and comfortable place. Tiredness and overwork are common precipitating and perpetuating factors.

### *Psychiatric disorders*

Reduced sexual desire is a feature of depression. In mania, there may be disinhibition and an increase in sexual behaviour that may later lead to shame and embarrassment. Schizophrenia is generally associated with a reduced sexual desire. Anorexia nervosa is often associated with a loss of interest in sex—the avoidance of mature female sexual functioning may contribute to the genesis of the illness.

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<sup>1</sup> Zimmer D. Does marital therapy enhance the effectiveness of treatment for sexual dysfunction? *Journal of Sex and Marital Therapy* 1987; 13, 193–20.

## General approaches to treatment

The following approaches are applicable to the treatment of most sexual problems. For some patients, education and the provision of self-help texts may be the only interventions required.

### Education

The aims of education are to provide new information, to dispel myths and misunderstandings, to reduce anxiety and to increase the couple's confidence. Patients should be asked to buy one of the self-help texts mentioned on page 197. Negotiate the language you use and make sure that any technical terms are understood. It is probably best to begin by using medical terminology and then adapt your language to that used by the couple.

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### **Educational interventions include providing new information, dispelling myths and providing reference material.**

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Have some pictures demonstrating male and female anatomy. It is useful to begin by comparing the general anatomy of the two and then to move on to the sexual anatomy. Discuss the normal variation in the shape and size of secondary sexual characteristics. Explain the role of the clitoris in orgasm. Note that the vagina is most sensitive at the entrance and that the inner two thirds are sensitive mainly to pressure. Have some diagrams that illustrate internal sexual anatomy. Explain the sexual response cycle—excitement, plateau, orgasm and resolution phases.

Address any myths that the couple have about sexual functioning (see below). Reassure people about sex and ageing, in particular, that pleasurable sexual activity continues after menopause.

#### *Some common sexual myths*

- Physical contact must always lead to sex.
- Good sex must always end in orgasm.
- Good sex equals intercourse.
- The man should always take the lead.
- Sex should always be spontaneous.
- A man should not express his feelings.
- A man should be ready for sex at any time.
- An erection should be there for the duration of sexual activity.
- A woman should not initiate sex.
- A woman should not enjoy sex too much, masturbate or use a vibrator.
- Men and women today are no longer influenced by old-fashioned sex-role stereotypes.
- Couples should have sex several times a week.
- Couples should always have orgasm simultaneously.
- A person should know intuitively what his or her partner wishes without being told.
- A woman should always be prepared to have sex if her partner wants it.
- A woman should be able to have an orgasm without direct stimulation of her clitoris.
- A woman should have an orgasm every time she has sex.

References include:

*For the therapist*

- Masters WH, Johnson VE. *Human Sexual Response*. New York, Bantam Books, 1966.
- Masters WH, Johnson VE. *Human Sexual Inadequacy*. New York, Bantam Books, 1980.
- Hawton K. *Sex Therapy: a Practical Guide*. New York, Oxford University Press, 1985.
- Spence SH. *Psychosexual Therapy: a Cognitive-Behavioural Approach*. London, Chapman and Hall, 1991.

*For the patient*

- Heiman JR, LoPiccolo L, LoPiccolo J. *Becoming Orgasmic: a Sexual Growth Programme for Women*. Englewood Cliffs, Prentice-Hall, 1976.
- Delvin D. *The Book of Love*. London, New English Library, 1974.
- Williams W. *Man, Woman and Sexual Desire: Self-Help for Men and Women with Deficient or Incompatible Sexual Drives or Interests*. Sydney, Williams and Wilkins, 1986.
- Llewellyn-Jones D. *Everywoman: A Gynaecological Guide for Life*. London, Faber and Faber, 1982.
- Llewellyn-Jones D. *Everyman*. Oxford University Press, 1986.

### **Promoting a positive sexual attitude**

Making love does not necessarily involve sexual intercourse, orgasm or ejaculation. Warwick Williams formulates the 'key sexual attitude' as, 'Lovemaking means literally that—interacting physically and emotionally with someone you care about. Arousal, intercourse and orgasms are non-essential and simply possible lovemaking options'.<sup>1</sup> He recommends a number of exercises that promote this attitude—making love at times when you do not feel like it, but are also not strongly averse to it; monitoring yourself for negative thoughts about sexual performance and using cognitive restructuring to correct these thoughts; discussing with your partner what you think and how you feel when he or she wants to have sex but you do not; discussing with your partner the positive side of lovemaking that does not involve sexual intercourse (e.g. no performance anxiety, does not matter if you are tired, there are more opportunities); discussing the truth of the key sexual attitude with others; using autosuggestion (e.g. after performing a relaxation exercise, repeating to oneself a positive, affirming thought such as, 'Having sex is just one of many ways of expressing love'); and repeating such a thought six times on a given cue (e.g. every time you have a drink).

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**The key sexual attitude is that lovemaking is not just about genital sexual relations, but rather, interacting physically and emotionally with someone you love.**

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### **Structured problem solving**

This is discussed in Chapter 6. Here is an example applied to the treatment of a sexual problem.

Nigel and Polly have had difficulties in their sexual relationship since Nigel's mother, Margaret, moved in six months ago. They formulate the problem as follows: 'We need to find more private time together'.

They generate the following possible solutions:

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<sup>1</sup> Williams W. *Man, Woman and Sexual Desire*. Sydney: Williams and Wilkins, 1986, p130.



- Margaret to spend one night a week with Nigel's brother, Martin
- Margaret to live with Martin
- Nigel and Polly to go out together once a week
- Margaret to move out to a retirement village

They decide on the third option. The steps they need to take are for Nigel to check his after-hours roster to make sure he has every Thursday off; Polly to book a table at a restaurant; and Nigel to talk to Margaret about what she would like to do on Thursday nights.

A month later, Margaret is spending every Thursday night with Martin and his family. Nigel and Polly usually pick her up on their way from their night out. Last week they went to the theatre, the first time for either of them in the past five years. They report improvements in both their general relationship and their sexual relationship.

### Cognitive behaviour therapy

The topic is discussed in detail in Chapter 10. Some examples of cognitive restructuring in sexual therapy are given in Table 2.

**Table 20-2: Some examples of cognitive restructuring in sexual therapy**

Automatic thought	Rational response
<p>Jean suffers vaginismus. While performing the sensate focus exercise, she thinks:</p> <p>Wayne won't stop here.</p> <p>I will never be able to do this.</p>	<p>(mind-reading) He has agreed to the ban on sexual intercourse. I know I can trust him.</p> <p>(fortune-telling) Doctor Black says this is not such an uncommon problem and treatment is very successful.</p>
<p>Mark suffers impotence. During sensate focus exercises, he thinks:</p> <p>I'm a loser.</p> <p>Bernice only says I'm attractive because she feels sorry for me.</p>	<p>(labelling) I have a problem, but I am working at it. The doctor says there are good success rates, and Bernice is keen to help. Our marriage is strong and our children are doing well.</p> <p>(refusing to accept praise) I may not be a model, but a number of others have commented on my good looks.</p>



## **Marital therapy interventions**

Sexual problems may be one manifestation of marital difficulties. If the marriage problem is severe and there is a lack of affection between the couple, then sexual therapy is contraindicated. However, mild degrees of marital discord can be dealt with during sexual therapy. For a discussion of marital therapy techniques, see pages 47–49. An example of reciprocal negotiation is given below:

Judith and Andrew are each asked to make a list of things that they would like the other to do for them. These wishes should be relatively easy to perform and low in cost.

Judith's list includes the following:

- Go out to the movies together next week.
- Be in bed by 10.30pm.
- Give her a kiss before leaving for work and on arriving home.
- Go for a walk in the botanical gardens at the weekend.

Andrew's list includes:

- Give him a back rub.
- Prepare a meal for the visit of an old friend.
- Arrange to be home early one night a week so he can go to indoor cricket.
- Encourage him to go to indoor cricket.

## **Non-genital sensate focus**

The aims of this exercise are to improve trust between the couple, to help them feel relaxed in situations of physical intimacy, and to promote communication about how they are feeling during sexual activity. The immediate aim is not sexual intercourse, or even sexual arousal; indeed, the couple is asked to abstain from sexual intercourse during this stage of therapy. Instead, they aim to provide pleasure to each other through caressing parts of the body other than the genitals and female breasts. They take turns in providing pleasure to the other through caressing, kissing or the use of oils or lotion.

One of the most important components of this exercise is the promotion of communication between the couple. The (woman) receiving the caresses should communicate how she feels and what gives her pleasure. She may guide her partner's hand. She may state what she prefers and whether she would like it done softer, harder, faster or slower. The (man) giving the caresses should observe his partner and learn to pick up her cues.

The couple need to find around 40 minutes at least three times a week to practice this exercise. They need a quiet, warm place where they will not be interrupted. Because of their anxiety, some couples may need to begin the exercise clothed or in a darkened room. They then work step by step towards providing each other with pleasure while naked in a softly lit room.

If one or other of the individuals is overworked or tired, practising this exercise may only exacerbate the problem—deal with the tiredness and its causes first.

The initiator of the exercise might be chosen by a toss of a coin. However, if one partner is particularly anxious, feels pressured or is habitually the one who agrees to rather than initiates sex, then he or she begins as the initiator.

After around 10 minutes the roles of giver and receiver of pleasure should be reversed. Both will then have two turns in each role. Ask clients to note the feelings and thoughts they have during the exercise and use this as material for cognitive restructuring (see Chapter 10). The couple should not proceed to genital sensate focus exercises until both feel relaxed performing this exercise.

## Genital sensate focusing

The emphasis is again on giving and receiving pleasure rather than on arousal. However, in this exercise, the couple also stimulate each other's genitals. The ban on sexual intercourse remains. An essential component is the ability to communicate during sexual relations. The (man) receiving the caresses should provide feedback to his partner about how he feels and what he likes. He may guide her hand. Contact proceeds from gentle stroking of the thighs and abdomen to genital caresses. Initially, one partner alternates with the other, but later the couple may provide pleasure to each other at the same time.

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**Sensate focus exercises aim to remove anxiety about sexual performance through a focus on giving and receiving pleasure without necessarily proceeding to sexual intercourse.**

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## Diagnosis and treatment of specific conditions

For a diagnosis to be made, the symptoms must be persistent or recurrent, and cause significant distress, disability and handicap.

### Mismatched libidos

This does not appear in the DSM-IV, but may be one of the commonest presentations of sexual problems. Although each member of the couple has normal sexual desire, there is a mismatch between the two.<sup>1</sup>

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**Although each member of a couple may have a normal sexual desire, they may be mismatched.**

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#### *Treatment*

- Consider the differential diagnoses – hypoactive sexual desire disorder, sexual aversion disorder, female sexual arousal disorder and male erectile disorder (see below)
- Use exercises to promote a positive sexual attitude, as discussed above.
- Develop an understanding of three possible situations and how to deal with them<sup>2</sup>:
  - ◇ The couple both feel like having sex at the same time. Apart from the early stages of a relationship, this situation is uncommon.
  - ◇ One partner is in the mood for sex, but the other, while not being actively averse to it, is not. This is probably the commonest situation. The person is encouraged to make love, but with no promise that it will lead to sexual intercourse. For example, he or she may relieve the partner's sexual arousal through manual stimulation or the use of a vibrator.
  - ◇ One partner feels actively averse to having sex. In this situation, it is essential that (he) is able to decline lovemaking. (He) might use a passive means of providing relief to his partner—for example, by using a vibrator. Alternatively, (he) communicates, without apology, but also without anger, that (he) cannot make love now.

### Hypoactive sexual desire disorder

The essential feature is a lack of sexual fantasy and desire for sexual activity. It may be pervasive

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<sup>1</sup> Williams W. *Man, Woman and Sexual Desire*. Sydney: Williams and Wilkins, 1986.

<sup>2</sup> *ibid*.

or only occur in specific situations, or be limited to one partner or one sexual activity. It is often associated with reduced arousal and difficulties with orgasm.

#### *Treatment*

Because of the many possible causes of this problem, it is essential to make a comprehensive formulation in order to individualise treatment.

- Use the general approaches to treatment mentioned above – education, developing the ‘key sexual attitude’, marital therapy, structured problem solving, cognitive behavioural approaches and sensate focus.
- In some cases, it may be possible to increase the number of opportunities for heightened sexual desire—for example, by organising nights out together or, if acceptable to the couple, through the use of fantasy or erotica.

### **Sexual Aversion Disorder**

This involves an aversion to and active avoidance of genital contact with the person’s sexual partner. Facing a sexual situation, he or she may suffer anxiety, panic attacks or feelings of disgust.

#### *Treatment*

The principles of treatment are the same as for phobias (see pages 145–147).

- Use non-specific approaches as above – education, structured problem solving, cognitive behavioural therapy, marital therapy and sensate focus.
- The cornerstone of treatment is graduated exposure. A hierarchy of feared situations is compiled that is specific to the individual. For example, one woman may be primarily afraid of becoming pregnant, while another may have an aversion to semen. After being taught methods of relaxation (see Appendices 4, 5 and 6), the person is exposed to feared situations progressing from the least to the most feared. Therapy may also progress from exposure in imagination to exposure in vivo. It is important that anxiety is reduced on exposure to each step (desensitisation) before progression to the next stage. If the person cannot tolerate the next step and escapes from it, the reduction in anxiety negatively reinforces avoidance. The use of benzodiazepines is discouraged.

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**The principles of treatment of sexual aversion disorder are the same as for phobias.**

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### **Female sexual arousal disorder**

This is characterised by a failure of normal physiological changes in response to sexual arousal: pelvic vasocongestion, vaginal lubrication and swelling of the external genitalia. An essential text is Heiman, Lopiccolo and Lopiccolo’s book<sup>1</sup>.

#### *Treatment*

The specific techniques used in a particular case will depend on the individual formulation.

- Use non-specific approaches as above – education, promoting the ‘key sexual attitude’, structured problem solving, cognitive behavioural therapy, marital therapy and sensate focus.
- The woman is encouraged to practise masturbation exercises. When she can arouse herself by this means, her partner becomes involved, initially observing her stimulate herself and later being guided by her to provide stimulation as part of genital sensate focus exercises.

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<sup>1</sup> Heiman JR, LoPiccolo L, LoPiccolo J. *Becoming Orgasmic: a Sexual Growth Programme for Women*. Englewood Cliffs, Prentice-Hall, 1976.

If acceptable, a vibrator can be used. The couple then proceed to sexual intercourse. This should first involve only vaginal containment of the penis with the woman providing clitoral stimulation.

- For post-menopausal women, a vaginal cream may be prescribed to enhance lubrication. Oestrogen creams may be prescribed.
- Negative cognitions may include negative beliefs about a woman masturbating, especially in front of her partner; the man may feel a failure for being unable to satisfy his partner. The cognitive restructuring needs to be approached sensitively with care taken to take into account the value systems of the individuals involved.

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**Masturbation exercises are the cornerstone of the treatment of female sexual arousal disorder.**

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### **Male erectile disorder**

This involves a persistent or recurrent inability to attain or sustain an erection during sexual activity. In the DSM-IV, the condition is distinguished from sexual dysfunction due to a general medical condition. However, both physiological and psychological factors are often involved.

#### *Treatment*

- Treat any underlying physical condition.
- Use non-specific techniques – education, promotion of the ‘key sexual attitude’, structured problem solving and relationship counselling as above.
- The couple begin with sensate focus exercises, at first with the additional request that the man tries not to develop an erection, but rather focuses on the pleasure his partner provides. This reduces performance anxiety and self-observation, and encourages him to focus instead on receiving pleasure. The exercise is often best performed in the morning when the man’s erection is at its firmest. His partner may use gels or lubricants, or perform oral sex.
- The couple cease penile stimulation when the man has a firm erection, allow the erection to subside, and then repeat the process two or three times. This exercise helps reduce anxiety about losing an erection.
- In some cases, the anxiety is around maintaining an erection on vaginal penetration. The man should first practise ejaculating outside the vagina. Next, his partner progresses from rubbing his penis against her clitoris, to vaginal containment, and then to thrusting and completion of intercourse.
- Cognitive approaches may be used to address thoughts associated with performance anxiety.

#### *Physical treatments*

Sildenafil (Viagra) is an inhibitor of phosphodiesterase 5, the enzyme that breaks down cyclic guanosine monophosphate (cGMP). This in turn maintains arteriolar relaxation, mediated by nitric oxide, and so increases the duration and rigidity of erections in response to sexual stimulation. The dose is between 25mg and 100mg taken around one hour before sexual intercourse. Inhibitors of CYP3A4, including cimetidine, erythromycin and ketoconazole, slow its breakdown. It is contraindicated within 24 hours of taking nitrates (therapeutically for cardiovascular disease or recreationally as amyl nitrate). It should be used with care in men in whom sexual activity may precipitate adverse cardiovascular events, and in those with degenerative retinal disorders. Side effects include headache, flushing, dyspepsia, nasal congestion, diarrhoea and visual changes including a blue aura. Research into the use of sildenafil for women with sexual problems is under investigation.

Other physical treatments include intracavernosal injection of alprostadil (Caverject), transurethral alprostadil administered via a micro-suppository, vacuum constriction devices, vascular surgery and penile implants. Note that men with low testosterone suffer low sexual desire and rarely present complaining of erectile dysfunction.

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**Contraindications to the use of sildenafil include the use of nitrates, severe cardiovascular disease and degenerative retinal disorders.**

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### **Female orgasmic disorder**

This involves a persistent or recurrent delay in or absence of orgasm.

#### *Treatment*

- The woman is usually seen on her own at the beginning of treatment. A useful self-help guide is Heiman, LoPiccolo and LoPiccolo's book<sup>1</sup>.
- Non-specific approaches include education and a discussion of her sexual attitudes.
- She is asked to examine and to become relaxed about her own body. She is then asked to note three positive and three negative things about her body.
- The next step is genital self-examination. She begins by identifying the different parts of her genital anatomy. She records her feelings and thoughts during self-examination, which then form material for cognitive restructuring. She then begins to explore herself with a finger. She should not be trying to produce an orgasm at this stage.
- Practice Kegel exercises. These involve recognising, gaining control of, and strengthening, the pubococcygeal muscles—those that interrupt micturition.
- She is then asked to identify sensitive spots, including the clitoris, and to proceed to masturbation. She may use erotica, fantasy or a vibrator.
- Once she is able to produce an orgasm through self-stimulation, her partner can be involved. She may begin by stimulating herself to orgasm in his presence and then by showing him what gives her pleasure. During sexual intercourse, she continues to stimulate her clitoris. The couple may then cease clitoral stimulation just before orgasm. However, a percentage of women will not experience orgasm by vaginal penetration alone, continuing to require some clitoral stimulation.
- Issues that may be relevant in cognitive restructuring include the belief that self-stimulation is not acceptable, that one's genitals are ugly, that a woman should be able to orgasm through vaginal stimulation alone, and fears of loss of control. The partner's attitudes may also need to be addressed; for example the belief that he is inadequate if he cannot stimulate his partner to orgasm.

### **Male orgasmic disorder**

The disorder is sometimes referred to as inhibited or retarded ejaculation. It most commonly occurs in the context of sexual intercourse. Most men can experience orgasm from masturbation or from manual stimulation by their partners.

#### *Treatment*

- Treatment involves a graduated series of activities that move towards sexual intercourse. The man may begin with self-stimulation alone and then, in the presence of his partner. They then proceed to sensate focus exercises. Lubricants can be used as well as fantasy and erotica. The

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<sup>1</sup> Heiman JR, LoPiccolo L, LoPiccolo J. *Becoming Orgasmic: a sexual growth program for women*, new Jersey, Prentice-Hall, 1976.

couple then move to sexual intercourse with the man masturbating and then inserting his penis just before ejaculation.

- Negative cognitions that can impair orgasm include a fear of loss of control, a fear of pregnancy and negative responses to genitals.
- In cases where there are specific phobias, treatment proceeds as for sexual aversion disorder (see page 195).

### **Premature ejaculation**

The main feature is ejaculation after minimal stimulation, or before or shortly after penetration. Premature ejaculation is often experienced by young men during their first attempts at intercourse, but is only a problem if it persists.

#### *Treatment*

- The stop-start technique begins with the man attending to his level of arousal during masturbation, in particular, identifying the point of ejaculatory inevitability. He then practises ceasing self-stimulation just before this point is reached, allowing his arousal to subside before repeating the exercise. A similar progression it then practised with his partner. At first, the partner provides manual stimulation. Intercourse begins with brief containment and withdrawal. The times of penetration and the vigour of movements of penis in vagina then gradually increase.
- The squeeze technique is only indicated if the stop-start exercise is unsuccessful. The penis is grasped with the thumb on the fraenum and index and middle finger across the coronal sulcus, and squeezed for around 5–10 seconds during high arousal. It is advisable to test the pressure required on the erect penis prior to practising the exercise.

### **Dyspareunia**

This refers to pain experienced during intercourse.

#### *Treatment*

- Treat any physical cause. Common causes include vaginal infection, venereal disease and inadequate lubrication. Causes of deep dyspareunia include endometriosis, pelvic inflammatory disease and ovarian tumour.
- Use non-specific techniques including education, relationship counselling (where applicable), relaxation and structured problem solving.
- When the pain is the result of impaired arousal, use the sensate focus exercises as discussed above.
- Give advice on positions that limit penetration, such as rear-entry and side-by-side.
- Practise Kegel exercises to enhance muscle control.
- Typical cognitive distortions include fears that one's genitals are abnormal, or of falling pregnant. The partner may fear harming her.

### **Vaginismus**

The characteristic feature is the involuntary contraction of the muscles of the outer third of the vagina on vaginal penetration. It is commoner in young women and is associated with negative attitudes to sex and with past sexual abuse.

#### *Differential diagnosis*

Vaginismus may complicate any of the physical disorders that cause dyspareunia.

#### *Treatment*

- Treat the underlying medical condition
- Non-specific approaches include education, relaxation training and relationship counselling

where applicable.

- Construct a hierarchy of activities that successively approximate full penetration. Begin with self-observation and self-touching and move towards the insertion of one, two and then three fingers. The partner is then involved. Follow a similar progression during genital sensate focus.

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**The treatment of vaginismus includes progression through a hierarchy of activities that eventually lead to full penetration.**

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## Referral

Unless you have undergone some supervised training in sexual therapy it is probably best to limit yourself to the provision of information and recommendation of self-help manuals.

Indications for referral include the following:

- if you dislike or are sexually attracted to an individual
- if you are uncomfortable with the values or practices of the clients; for example, if you are uncomfortable treating a homosexual couple
- where the problems are long-standing, severe and have not responded to treatment
- where an individual has a history of serious sexual abuse
- if complications develop during treatment, such as serious marital discord
- in complex cases where multiple problems coexist
- if you do not feel confident in offering therapy.

## A note on testosterone treatment

Testosterone can only be prescribed on an authority script to males with androgen deficiency with established pituitary or testicular disorders; to males under 18 with micropenis or constitutional delay of growth or puberty; or to males 40 years and older without these disorders, with at least two morning blood samples taken on different mornings in which testosterone is less than 8 nmol per L, or 8–15 nmol per L if LH is greater than 1.5 times the normal range. It is a sought-after drug of abuse. It is advisable to check pituitary function to clarify whether any dysfunction is at the level of the pituitary or the testes. Low testosterone causes low libido; sufferers rarely present complaining of erectile problems. Men prescribed testosterone should be warned about hypogonadism, which may persist for more than 12 months after the cessation of treatment.

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**The main presenting complaint of men with hypogonadism is low sexual desire.**

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## Homosexual patients

The problems that homosexual couples most often present with are the same as for heterosexuals and the principles of treatment are the same. If you are uncomfortable with homosexuality, you should refer them elsewhere. Because of ingrained negative attitudes to homosexuality, be careful to monitor your countertransference in dealing with homosexual clients. Some specific issues with regard to the treatment of male and female homosexual couples are discussed below.

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**If you are uncomfortable with homosexuality, refer homosexual couples presenting with sexual problems to a colleague with expertise in this area.**

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### *Homosexual females*

The commonest reasons for presentation are low frequency of genital sexual activity and mismatched sexual desire. As with other couples, treatment may primarily involve education and reassurance<sup>1</sup>.

Myths that can be addressed through cognitive restructuring include:

- Because I am a woman, I must know what my partner likes without asking her.
- Other lesbian couples have sex more often than we do.
- Women should not take the initiative in sexual encounters.

The internalisation of societal homophobic attitudes may lead to low self-esteem and inhibited sexual activity and behaviour. It may be associated with the following negative beliefs:

- If I am not sexually active, I am not really homosexual.
- If I take a passive role, I am not really lesbian.

Useful references include books by Loulan<sup>2</sup> and Barbach<sup>3</sup>.

### *Homosexual males*

The commonest problem that leads homosexual men to seek help is erectile dysfunction. While most sexual problems presented by homosexual men are similar to those of heterosexual men, some specific differences are discussed below.

Gay sex includes mutual masturbation, oral and anal sex. Anal spasm is treated through the exclusion of physical causes (e.g. anal fissure), the provision of information, giving permission, and graduated insertion exercises similar to the treatment of vaginismus. Problems in sexual arousal may follow from demands for rapid response to sexual approaches in gay meeting places. On one hand, the individual may be opposed to this sort of activity in which sex is separated from intimacy or love. On the other hand, difficulties may develop in primary relationships because of fears of intimacy. A fear of contracting HIV infection may also play a part. Internalised homophobic attitudes can be addressed through cognitive restructuring. Many homosexual men continue to wrestle with their sexual identity.

There are often particular pressures on homosexual relationships. Gay male relationships are more at risk than heterosexual marriages. Moreover, gay partners are said to be more likely to have relationships outside a primary relationship<sup>4</sup>. Concerns about how gay couples will be accepted by friends, family and other members of society may lead to anxiety about being discovered and a desire to maintain secrecy. Many homosexuals remain single. Others may marry, but continue to have homosexual fantasies and involve themselves in covert sexual activities.

## **Sexual therapy in other special populations**

For a discussion of special aspects of sexual therapy in the elderly, the intellectually disabled and the physically disabled, I refer the reader to Spence's book<sup>5</sup>. Sexual therapy in a transcultural setting is discussed in D'Ardenne's paper<sup>6</sup>.

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<sup>1</sup> Falco KL. *Psychotherapy with lesbian clients: theory into practice*. New York, Brunner Mazel: 1991.

<sup>2</sup> Loulan J. *Lesbian Sex*. San Francisco, Spinsters Park: 1984.

<sup>3</sup> Barbach L. *For Yourself*. New York, Doubleday: 1975.

<sup>4</sup> Reece R. Special issues in the etiologies and treatments of sexual problems amongst gay men. *Journal of Homosexuality*. 1988,15: 43-57.

<sup>5</sup> Spence SH. *Psychosexual Therapy: a Cognitive-Behavioural Approach*. London, Chapman and Hall, 1991: pp 243-278.

<sup>6</sup> D'Ardenne P. Sexual dysfunction in a transcultural setting: assessment, treatment and research. *Sexual and Marital Therapy*. 1986, 1: 23-24.



# Chapter 21

## Trauma, memory and dissociation

The dissociative disorders are the subject of increasing attention in psychiatric research and clinical practice. Among psychiatric in-patients, their prevalence has been estimated to be around 5 per cent. A surprising finding of the National Survey of Mental Health and Wellbeing was that the commonest anxiety disorder in the adult population, with a 12-month prevalence of 3.3 per cent<sup>1</sup> was post-traumatic stress disorder. Dissociative disorders are generally regarded as being among the post-traumatic syndromes: others include post-traumatic stress disorder (Chapter 15), borderline personality disorder (Chapter 23) and some of the somatoform disorders (Chapter 19). People who repeatedly self-harm have often been the victims of abuse (Chapter 3). Pure dissociative disorders are rare; more commonly, people present with a variety of dissociative, somatoform, anxiety and depressive symptoms, sometimes associated with self-harming behaviour and, in some cases, in the context of a personality disorder.

The place of trauma in the aetiology of these disorders remains controversial. Indeed, there is a history of fluctuations between periods of acceptance and repudiation of the disorders themselves. Freud, in his early formulation of hysterical phenomena, attributed the symptoms to early trauma, especially childhood sexual abuse. However, he later rejected the 'seduction theory' and postulated instead that the memories of his patients were the result of fantasy rather than of actual events. In legal settings, doctors are sometimes asked to give an opinion on whether traumatic memories are the result of past abuse, of conscious or unconscious fabrication, the result of suggestion from an over-zealous therapist, or some combination of these.

The most recent demonstration of this controversy has been the debate over false memory syndrome. In a number of highly publicised cases, legal action was taken against alleged perpetrators of child sexual abuse, often family members of the complainant, on the basis of memories of abuse that were recovered during therapy. The legal process forced a polarisation of opinion on whether or not the abuse actually occurred. The devastating effects of these cases, irrespective of the legal outcome, further polarise the debate.

Most writers presently agree on the centrality of traumatic experiences in the aetiology of these disorders. However, it should be remembered that reactions to stress and trauma vary considerably from one person to another. Some individuals develop dissociative disorders or other post-traumatic syndromes after exposure to relatively minor trauma, while others cope with severe and prolonged trauma without developing a post-traumatic syndrome.

In this chapter, I first briefly review evidence of the profound effect of psychological trauma on memory. I then discuss the assessment and diagnosis of dissociative disorders and the principles of their treatment. Although general practitioners will not be expected to provide this treatment, they should nevertheless be able to make the diagnosis and to refer patients appropriately. They should be aware of the difficult transference and countertransference responses that can occur when dealing with these people, and they should consider these disorders in the differential diagnoses of other disorders, including psychotic disorders, with which they may be confused.

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**General practitioners need to be able to diagnose dissociative disorders, consider them in the differential diagnosis of psychotic disorders, and be aware of common countertransference responses to people who suffer from them.**

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<sup>1</sup> Andrews G, Hall W, Teesson M, Henderson S. *The Mental Health of Australians*. Canberra: Mental Health Branch, Commonwealth Department of Health and Aged Care, 1999.

## Effects of trauma on memory

There is ample evidence of the profound effect that severe psychological trauma has on memory. Much of this evidence comes from case reports of soldiers diagnosed with shell shock during the First World War. There are similar reports of people involved in other military conflicts, and of victims of natural disasters, torture, child sexual abuse and personal violence.

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**Trauma has profound effects on memory. An inability to voluntarily recall traumatic events is coupled to an unconscious recall of these events in dreams, re-enactments and flashbacks.**

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On one hand, there is often an inability to consciously recall events. The amnesia may be for the specific event, but can also be for longer periods. In psychogenic fugue, the sufferer is unable to recall basic facts of his or her personal history and identity. On the other hand, the events are engraved in memory and find expression in dreams, re-enactments and flashbacks. Cues to the trauma may trigger these painful memories.

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**At the time of the traumatic event, dissociation is adaptive, because it isolates the person from an otherwise intolerable experience.**

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Dissociation is a psychological process through which traumatic memories, physical sensations, affects and ideas are stored and processed separately from, and are partially or completely inaccessible to, the rest of conscious experience. At the time of a traumatic experience, this process is adaptive, because it isolates the person from an event that might otherwise overwhelm him or her. He or she may even experience the event as if it is happening to another person. However, in the long term, a failure to integrate the experience within the person's life story may lead to serious disability and handicap (see Box 21-1).

### **Box 21-1: Post-traumatic stress disorder**

An army sergeant is amnesic for a traumatic combat experience. He suffers flashbacks in which he is immobilised with fear as he re-experiences a battle scene. He sleeps poorly and is irritable and aggressive. He uses alcohol to lessen his constant anxiety. While serving in Vietnam, his platoon was ambushed and a friend lay dying just five meters from him. He was unable to give any assistance because of enemy fire that continued until relief arrived two hours later. By this time, his friend had died.

*Comment:* Central to his role as a platoon commander are his leadership skills and his ability to stay calm in a crisis. The feelings of shame, guilt and helplessness that he experienced during combat are in conflict with this part of his identity.

## Assessment

Consider the following four core dissociative symptoms:

- *amnesia* – People with dissociative disorders may have gaps in memory or a sense of having 'lost time'. They may lose track of conversations, or reach the destination of a journey and forget how they got there. As mentioned above, amnesia may be accompanied by flashbacks of traumatic events. Traumatic amnesia needs to be distinguished from simple forgetting, or failure to encode information due to impaired concentration.
- *depersonalisation* – This is an unpleasant feeling of being detached from oneself. A man may feel as if he is standing beside himself observing his own actions. The observing self may be heard commenting on the participating self (pseudohallucination). People with dissociative disorders often have difficulty describing the experience. The process may be adaptive during

exposure to a traumatic event, since it distances the person from involvement in the event and the associated pain, emotional distress and personal meaning.

- *derealisation* – The person feels detached from the outside world, which seems unreal, unfamiliar and strange. Events may appear slowed down. Sounds may be muffled. Derealisation often accompanies depersonalisation.
- *identity confusion/alteration* – The person lacks a coherent sense of who he or she is. A man may feel that he must act like someone else in social or work situations. There may be confusion over sexual identity. In cases of dissociative identity disorder, there may be separate personalities (alters) each with different names and distinctive attitudes and skills. The alters may be variably amnesic for the presence and actions of each other.

Consider the diagnosis of a dissociative disorder in people who have had a large number of diagnoses in the past. Have a high index of suspicion when assessing people with a cluster of somatoform and mood symptoms such as headaches (including migraine), recurrent pelvic and abdominal pain, chronic fatigue, mood instability, self-harming, anxiety symptoms and eating disorders.

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**Consider the diagnosis of a dissociative disorder in people presenting with a cluster of the following symptoms: headaches (including migraine), recurrent abdominal pain, chronic fatigue, mood instability, anxiety and eating disorders.**

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The victims of trauma often suffer low self-esteem with strong feelings of guilt and shame over the traumatic events. Even those who suffered abuse as a child often feel that they were somehow to blame. At the time of the event, they were powerless to influence what happened, but being entirely dependent on the abusers, they may have had no choice but to believe that they were at fault.

### Formulation

The likelihood of developing a post-traumatic syndrome increases with the intensity and duration of exposure to a trauma. Vulnerability to dissociative disorders and other posttraumatic syndromes also includes genetic and a number of other biological factors, including certain neuro-endocrine factors. Psychological factors that predispose to their development include certain personality traits (neuroticism and introversion), a history of mental illness, and past exposure to trauma. Social factors include a history of negative parenting, early separation from parents and low levels of education. A high level of social supports in the aftermath of a trauma is protective.

The social relationships of abused people may continue to be influenced by past trauma. Through repetition compulsion, the person may continue to be revictimised, or through identification with the aggressor, the person may go on to abuse others (see Box 21-2).

#### **Box 21-2: Repetition compulsion and identification with the aggressor**

- A young woman, who as a child was a victim of sexual abuse by her stepfather, works as a prostitute and lives with a man who physically abuses her.

*Comment:* The stepfather, despite being abusive, was a central nurturing figure in her upbringing and has set the model for the sort of people she will seek out in future intimate relationships (repetition compulsion).

- The father under investigation for abuse of his four-year-old son was himself the victim of physical abuse by his alcoholic father.

*Comment:* He has identified with his father (identification with the aggressor).

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**People abused as children may later be victimised by abusive partners.**

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**Diagnosis and differential diagnosis**

The DSM-IV includes several dissociative disorders. Dissociative amnesia involves an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness. Dissociative fugue is characterised by unexpected travel away from home with an inability to recall one's past. Dissociative identity disorder, DID (previously called multiple personality disorder) is characterised by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behaviour. Depersonalisation disorder involves a feeling of being detached from one's mental processes or body. However, it is rare for people to present with one of these syndromes alone. More commonly, people present with a combination of dissociative, somatoform, anxiety and depressive symptoms.

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**In general practice settings, dissociative symptoms most commonly occur in combination with somatoform, anxiety and depressive symptoms.**

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There is considerable overlap between the symptoms of dissociative disorders and other posttraumatic syndromes. Post-traumatic stress disorder often involves amnesia and re-enactment together with symptoms of increased arousal and avoidance of stimuli associated with the disorder. Borderline personality disorder may be associated with a history of child sexual abuse and is characterised by a dysregulation of emotional control. Dissociative symptoms may occur in the context of anxiety and depressive disorders or be co-morbid with these disorders. People with more complex dissociative conditions who have a history of childhood abuse also have high frequencies of non-organic pain, conversion symptoms and other physical complaints.

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**Other disorders that may arise as sequelae to traumatic experiences include post-traumatic stress disorder, borderline personality disorder, anxiety disorders, depression and the syndromes of unexplained physical symptoms.**

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Amnestic syndromes may be confused with organic mental disorders and substance abuse disorders. However, in these disorders there will be a defined physical cause and more global cognitive dysfunction. It is often more difficult to distinguish dissociation, especially in its more florid manifestations, from psychotic disorders. The full range of first rank symptoms of schizophrenia has been described in people with dissociative identity disorder. However, people with dissociative disorders rarely exhibit the negative symptoms of schizophrenia (amotivation, apathy, social withdrawal and anhedonia).

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**People with severe dissociative disorders can suffer a variety of symptoms typical of psychotic disorders.**

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**Treatment**

Therapy with people who suffer dissociative disorders is difficult and generally best left to a specialist in the area. Some will not be able to engage in any reconstructive therapy and are instead offered support, counselling and structured problem solving (see Chapters 6 and 8). It is desirable for these patients to form a therapeutic alliance with one general practitioner in order to avoid the iatrogenic complications of somatisation, including multiple investigations and procedures. Close liaison between the general practitioner and the therapist is essential.

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**The general practitioner should try to establish a therapeutic alliance with the patient with a dissociative disorder, avoid unnecessary investigations of somatic complaints, and work in close liaison with the person's therapist.**

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Psychotherapy for dissociative disorders can be divided into three stages: providing safety and stability; recovering and processing the traumatic memories; and reintegrating the person's sense of identity and enhancing his or her ability to lead a fulfilling life and make enduring friendships. Helping the person process the traumatic event is best left to a specialist therapist. A person should never be forced to relive past trauma. This can be unbearable for him or her and may even constitute re-traumatisation.

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**The therapist should never force a person to relive past traumatic experiences. This can be unbearable and constitute re-traumatisation.**

---

### **Safety and stability**

People presenting with dissociative disorders for the first time are often in crisis. The principles of crisis intervention described in Chapter 6 are applicable here. In the face of frightening nightmares and flashbacks, and the negative reactions of other people to her behaviour, a young woman with dissociative symptoms is at risk of self-harm or suicide. Try to establish a therapeutic alliance by listening to her complaints, empathising with her suffering and promoting trust and hope. Simple grounding techniques may be useful if she begins to dissociate during the interview—ask her to let her hands feel the chair on which she is sitting, feel the floor through her shoes, open her eyes, look at you, and state her name and address.

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**Grounding techniques for a (woman) in crisis include asking her to let her hands feel the chair, feel the floor through her shoes, open her eyes, look at you, and state her name and address.**

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When dealing with someone with dissociative identity disorder it is important to recognise the different alters while, at the same time, reinforcing the fact that they exist within one person. You might address yourself to 'you all', or you might ask the alter in control to communicate with the other alters. Establish an agreement with all of the alters about therapy and the person's safety. Uncovering the cues to flashbacks will give clues to the meaning of the traumatic experience and will also give the person a greater sense of control over his or her symptoms.

### **Dealing with the traumatic memories**

This part of therapy will not be dealt with by the general practitioner. The aim is not merely to re-experience the event but rather to reprocess the event and its meaning so that the person gains a sense of control over it. The event is often linked to a number of painful affects: guilt, shame, grief, rage, helplessness and fear. The person needs to address the personal meaning of the event.

### **Reintegration and resolution**

The aim is for the (woman) to be able to accept the traumatic experience and to incorporate it into her life-story. The experience may challenge her meaning structure, her perception and view of herself and the world. With the re-integration of the dissociated material into conscious memory, the aim is for her to be freed to re-enter into life with the energy to make new relationships and to return to work and other fulfilling activities.

## Medication

No drugs have been shown to be specifically effective in the treatment of dissociative disorders. However, co-morbid conditions often require the appropriate drug treatment.

## Transference and countertransference

At any time in therapy, the person who has been traumatised may experience a variety of transference phenomena associated with the original trauma. He or she may identify with the affect or behaviour of any of the participants in it. The therapist will also experience a number of characteristic countertransference responses. Gabbard has drawn attention to four of these: the victim, the abuser, the rescuer and the uninvolved mother<sup>1</sup> (see Box 21–3). You need to set limits on your availability, and the frequency and length of therapy. A failure to adhere to these limits may only lead to exhaustion, and even to boundary violations. Moreover, making oneself constantly available only reinforces the person's belief that he or she is helpless. In the worst case, it may lead to a repetition of the person's past abuse.

### Box 21–3: Transference and countertransference

- A young woman who suffered sexual abuse at the hands of her older brother discloses the abuse during therapy. Her general practitioner is both shocked by the description of events and fascinated by her presentation of different alters. He feels a strong desire to rescue her. He has an impulse to care for her as if she is his child.

*Comment:* The general practitioner should recognise the countertransference wish to rescue. The belief that she will get better simply by caring and loving her is unfounded. He should refer her to a specialist in the treatment of dissociative disorders.

- Bent on alleviating her suffering at all costs, he is unable to set limits on session times. He begins seeing her more frequently, and consultations sometimes extend for over an hour. He begins seeing her in the last appointment slot each day. The appointments run past the time that the reception staff finish work, leaving him alone in the rooms with her. She begins ringing him at home, sometimes in the middle of the night. Any evidence of fatigue or exasperation with her demands is met by accusations that he does not care for her. She requires constant help for recurrent suicidal thoughts. One day, he receives a call from a medical resident at the local hospital informing him that she has taken an overdose. She states that the precipitant was the GP's unavailability.

*Comment:* In his efforts to rescue her, the GP is inadvertently making things worse. His inability to be the perfect therapist leads to an emergence of the abuser in the transference—the general practitioner begins to feel like the victim and he experiences the patient as an abuser.

- The therapist finds himself getting bored and fighting to stay awake as she continues to describe her difficulties.

*Comment:* In the countertransference, he may be feeling like her uninvolved mother. He should reflect on this and recognise the possible repetition of an important aspect of the original trauma.

## The false memory debate

There is clear evidence that childhood sexual abuse, like other forms of abuse and trauma, can have a wide range of effects on psychological functioning, including amnesia. The memories of the event may be recalled at some later date through various forms of re-experiencing (nightmares, flashbacks and re-enactments) and begin to be accessible to consciousness. Memory is processed in a number of steps: encoding, storage, retrieval and presentation. The memory of an event can be influenced at any of these stages. Memories can be altered by suggestion at the stage of retrieval. Without collateral evidence, it is often impossible to know whether an event actually took place. It is therefore wise to adopt a neutral stance, avoiding on one hand, disbelief of what

<sup>1</sup> Gabbard GO. *Psychodynamic Psychiatry in Clinical Practice*. DSM-IV Ed. Washington. American Psychiatric Press 1994.

the person tells you and, on the other, avoiding suggestion about what might have happened. Be forthright with the person about your uncertainty and avoid being coerced into taking a stand one way or the other. Instead, focus on the person's current suffering and disability, and work towards lessening his or her distress and improving his or her level of functioning.

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**In dealing with memories uncovered in therapy, it is wise to adopt a neutral stance, avoiding on one hand, disbelief of what the person tells you, and on the other, avoiding suggestion about what might have happened.**

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# Chapter 22

## Psychotic disorders

For people suffering their first psychotic episode, there is an average delay of one year between the development of symptoms and treatment of their condition. Seventy-five per cent of these people will have contacted their general practitioner during this period, but failed to gain access to care. Unfortunately, the longer the delay in treatment, the worse the person's prognosis, a consequence not only of a deterioration in psychosocial functioning, but also of neurobiological changes. Just as prolonged coma and lengthy periods of post-traumatic amnesia are associated with poorer clinical outcomes, prolonged psychosis also appears to be 'bad' for the brain.

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**There is an average delay of one year between the development of psychotic symptoms and the commencement of treatment.**

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## Background

### Psychoses

The psychoses are conditions in which there is a loss of contact with reality. A person may develop false ideas about reality (delusions), experience false perceptions of reality (hallucinations) or suffer formal thought disorder (tangentiality, loose association, incoherence). Psychotic symptoms may occur as a consequence of a medical condition. In particular, the delirious patient may suffer any kind of psychotic symptom. Medical conditions are at the top of the diagnostic hierarchy and must be excluded before making the diagnosis of a functional psychosis. The principal functional psychoses are schizophrenia and bipolar mood disorder.

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**Medical conditions are at the top of the diagnostic hierarchy and must be excluded before diagnosing a functional psychosis.**

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The division of the functional psychoses into these two broad divisions reflects the influence of the German psychiatrist, Emil Kraepelin who, in the fifth edition of his textbook, published in 1896, made a distinction between two major syndromes, which he labelled dementia praecox (i.e. schizophrenia) and manic-depressive insanity (i.e. bipolar mood disorder). He made this distinction not only on the basis of characteristic symptoms and signs, but also on assumptions about their natural histories. Dementia praecox, as the term implies, was thought to be a chronic illness with a deteriorating course, while manic-depression was thought to be episodic with full recovery between exacerbations.

This classification has been very influential and remains the basis of the DSM-IV and ICD 10 systems. However, it has recently come under challenge. People may present with features of both conditions. Rates of misdiagnosis of around 30 per cent have been reported. The same person may present with symptoms of schizophrenia on one occasion and bipolar mood disorder on another. Between 25 and 40 per cent of people presenting with schizophrenia recover and have no further psychotic episode, while some people with bipolar mood disorder suffer a chronic illness with severe disability and handicap and, in some cases, the development of negative symptoms. As a consequence, people presenting for the first time with psychotic symptoms are often diagnosed as suffering a psychotic illness rather than schizophrenia or bipolar disorder<sup>1</sup>.

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<sup>1</sup> McGorry P. A treatment-relevant classification of psychotic disorders. *Australian and New Zealand Journal of Psychiatry* 1995; 29:555-558.

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**Functional psychotic disorders do not always fit neatly into the categories of schizophrenia and bipolar disorder.**

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**Epidemiology**

The lifetime prevalence of schizophrenia is around one per cent. The first episode usually occurs in late teens, or early to mid-twenties. On average, females develop the illness a few years later than males. Bipolar disorder affects around 1.2 per cent of the population. The commonest age of onset is in the third decade, but it can occur at any age.

**Aetiology**

Schizophrenia appears to be caused by abnormalities in the development of the brain that become manifest in late adolescence or the early twenties, a time when the differentiation and maturation of the central nervous system is at its most complex. In many, but not all cases, the neurodevelopmental abnormalities are genetically determined. However, the pattern of inheritance does not conform to classical Mendelian genetics. Instead, multiple genes, each producing only a small effect on its own, combine to increase vulnerability. The risk of a person developing schizophrenia if one parent has the disorder is around 12 per cent (i.e. about ten times the risk in the general population). If both parents suffer from schizophrenia, the risk is around 40 per cent.

Neurodevelopmental models of schizophrenia propose that genetic and non-genetic factors cause subtle alterations to the organisation of the brain in utero. Complications of pregnancy and childbirth may put the affected infant at increased risk of developing schizophrenia as an adult. Prenatal exposure to viruses has also been examined; however, the research is inconclusive.

Genetic factors are also implicated in the cause of bipolar disorder. The risk of developing an affective disorder is around 30 per cent if one parent suffers an affective disorder (bipolar disorder, major depression or schizo-affective disorder) and 50–75 per cent if both parents suffer an affective disorder. Mood disorders are associated with dysregulation in a number of biogenic amine systems, including norepinephrine, serotonin and dopamine. Abnormalities have also been observed in neuro-endocrine regulation, sleep architecture, circadian rhythms, and cerebral metabolism and blood flow.

Doctors are often asked whether drugs such as marijuana or amphetamines cause schizophrenia. There is presently no conclusive evidence to support this proposition. However, marijuana and other psychoactive substances may precipitate an acute episode in someone with a predisposition to psychosis. Continued use will hasten relapse and worsen the prognosis.

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**Although the use of psychoactive drugs such as marijuana and amphetamines may precipitate acute episodes of psychosis and worsen prognosis, there is presently no conclusive evidence that these substances cause schizophrenia.**

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**Natural history and prognosis**

There is a critical period of between two and five years after the first episode of schizophrenia when most of the impairment, disability and handicap arise. Therefore, active intervention is desirable during this stage of the illness. Recent studies suggest that the prognosis for schizophrenia is not as poor as previously thought. Between 25 per cent and 40 per cent of people who suffer a psychotic episode recover and never have another episode. Indicators of good prognosis include a rapid rate of onset, rapid recovery from the first episode, the presence of affective symptoms, stable pre-morbid personality, absence of blunted affect, presence of perplexity and confusion during the acute episode, later age of onset, early treatment, strong family support, and the absence of co-morbid problems such as substance abuse.

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**Active intervention is desirable in the first two to five years after the onset of schizophrenia, the period when most of the impairment, disability and handicap arise.**

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Prior to the onset of psychotic symptoms proper, people with schizophrenia often suffer a number of prodromal symptoms. The prodrome lasts, on average, around two years. Although these symptoms are non-specific, bear in mind the possibility that they may herald the onset of schizophrenia. Have a high index of suspicion if there is a family history of psychosis or if there has been a recent marked deterioration in the person's level of functioning. See Table 22-1 for a discussion of prodromal symptoms and their treatment. The acute phase of the illness is characterised by the appearance of positive psychotic symptoms (delusions, hallucinations and formal thought disorder), accompanied by feelings of distress. There is often an identifiable precipitant to the first acute episode. A residual phase that includes many of the features of the prodrome may follow resolution of the acute phase (see Table 22-1). Negative symptoms are often a feature, including blunted or inappropriate affect (see Table 22-2). There may be high levels of disability and handicap.

The natural history of manic episodes is typically of an abrupt onset and, if left untreated, a duration of around six months. Depressive episodes usually have a slower onset and a longer duration. For people with recurrent episodes, the periods of remission tend to get shorter, and the frequency and duration of depressive episodes tend to increase.

## Assessment and diagnosis

### Schizophrenia

The diagnosis of schizophrenia requires at least six months of symptoms, including at least a month of two or more of the following: delusions, hallucinations, passivity phenomena, formal thought disorder, catatonia or negative symptoms. Some negative symptoms of schizophrenia are listed in Table 22-2.

**Table 22-1: Prodromal symptoms of schizophrenia and their management**

*Prodromal symptoms*

- cognitive changes – poor concentration, vague or woolly thinking, suspiciousness or odd preoccupation (e.g. sudden interest in a fringe religious group)
- mood changes – an anxious feeling that something in oneself or the world has changed. This experience, sometimes referred to as delusional mood, may be relieved at the moment when the person first develops a delusional explanation for what is happening (a primary delusion).
- behavioural changes – interpersonal withdrawal, loss of old friends, loss of interest in social activities, problems at work or in a course of study, deterioration in self-care, drug taking (sometimes in an attempt to self-medicate) and estrangement from family
- premorbid personality – People with schizotypal personality traits are at higher risk of developing a psychotic illness (see Chapter 23).

*Management of the prodrome*

- Consider the possibility that the above symptoms may be a prodrome to the development of psychosis and monitor for the development of psychotic symptoms.
- Use counselling and structured problem solving to deal with problems as they arise.
- Refer to appropriate agencies, e.g. to a drug and alcohol service for the treatment of substance abuse.
- Family education and support – It will often be a family member rather than the patient who first recognises the onset of psychotic symptoms.

Positive symptoms include the following:

1. *delusions* – false beliefs, foreign to the person’s culture, which cannot be shaken by logical argument. The content may be persecutory, grandiose or pseudoscientific. The content of a paranoid delusion refers to the patient him or herself. It may be grandiose or persecutory. Delusions proper are non-understandable (e.g. the traffic light turned green and he knew that he was the Messiah), while secondary delusions are understandable (e.g. for some years he had been convinced that his wife was having an affair. His belief was again confirmed when he found cigarette butts in the garden and a footprint on the lawn).
2. *passivity phenomena* – People with schizophrenia experience thought broadcast. They believe that their thoughts are accessible to others (for example, while visiting the local supermarket, a woman is mortified when she hears rude thoughts she has about her husband being broadcast throughout the building). They may experience thought insertion, believing that thoughts are put into their heads from outside; or thought withdrawal, that their own thoughts are taken away (for example, a woman believes that Hollywood stars are using her thoughts and feelings to portray characters in movies).
3. *hallucinations* – People with schizophrenia may experience hallucinations in any of the sensory modalities (auditory, visual, kinaesthetic, olfactory, gustatory). However, auditory hallucinations are the most common. They may hear voices that repeat their thoughts or provide a running commentary on their actions. There may be two or more voices discussing the person. The presence of hallucinations in other sensory modalities raises the possibility of an organic cause.
4. *formal thought disorder* – The individual jumps from topic to topic and does not take into account the needs of the listener. It can vary in degree from woolliness to incoherence. Other terms used to describe the disorder include tangentiality, looseness of association and ‘knight’s move’ thinking.
5. *catatonia* – This is defined as an increase in muscle tone at rest, which is abolished by voluntary movement. It includes mutism, stereotypy (maintaining a bizarre posture) and mannerism (odd, stilted ways of performing voluntary acts). Associated features include anhedonia, disrupted sleep patterns (e.g. sleeping during the day and staying up through the night), poor concentration, and impaired insight and judgement. Schizophrenia presents in a number of patterns. Disorganised schizophrenia is characterised by disorganised speech and behaviour, and flat or inappropriate affect. In paranoid schizophrenia, there are paranoid delusions and/or prominent hallucinations, but an absence of formal thought disorder and affective changes. A separate category exists for catatonic schizophrenia. People with undifferentiated schizophrenia have features that fit none of the above categories.

**Table 22-2: Negative symptoms of schizophrenia**

- abnormalities of affect – Blunted affect is characterised by a decrease in the intensity of emotional expression. The affect may be inappropriate. Anhedonia may be a feature.
- poverty of speech – reduced spontaneous speech
- poverty of content of speech – speech that conveys little information
- reduced motivation – The person may be inactive for long periods of time and have no interest in work or social activities.
- social withdrawal – People may spend long periods of time in their rooms, avoiding social interaction.

## **Bipolar disorder**

The diagnosis of bipolar disorder requires the occurrence of at least one manic episode, the characteristic feature of which is an abnormally elevated or irritable mood and labile affect for at least a week. Other features include a decreased need for sleep, inflated self-esteem, increased energy, pressure of speech, flight of ideas, distractibility, poor judgment (i.e. doing things at work or at school, or involvement in pleasurable activities, without regard for possible negative consequences). Flight of ideas is characterised by an increased flow of thought with a loss of goal. In contrast to the formal thought disorder of schizophrenia, the logical connections between thoughts are maintained in flight of ideas. The manic patient may suffer delusions that reflect the mood (e.g. grandiose or persecutory) or that are incongruent with the mood (e.g. delusions of reference). People with bipolar disorder are prone to suffering major depressive as well as manic episodes. As a consequence of their impaired judgement and disinhibited behaviour during manic episodes, people with bipolar disorder are at risk of suffering damage to their reputations, financial losses and legal problems. They tend to lose insight early in the course of the illness and so usually require hospitalisation, often against their will. Manic episodes range in severity from hypomania, in which the person does not suffer any marked disruption of social or occupational functioning, to mania with or without psychotic features. During some episodes, there may be a mixture of both manic and depressive features.

## **Psychotic depression**

The features of major depression were discussed in Chapter 14. They include persistently depressed mood, anhedonia, neurovegetative function disturbance, psychomotor retardation or agitation, feelings of worthlessness and guilt, poor concentration, helplessness, hopelessness, recurrent thoughts of death and suicidality. In psychotic depression, delusions may be congruent with the mood (e.g. nihilistic, hypochondriacal, paranoid or delusions of poverty) or mood incongruent (e.g. religious delusions). Hallucinations, especially auditory, may also be a feature.

## **Delusional disorder**

Delusional disorder is characterised by non-bizarre delusions occurring in the absence of other symptoms of schizophrenia. The delusions may be jealous (e.g. a man is convinced that his wife is being unfaithful), persecutory (e.g. an elderly woman believes that her neighbours are spying on her), erotomanic (e.g. a woman believes that the bishop in her church is in love with her) or somatic (e.g. a young man is convinced that he is infested with worms and keeps taking courses of medication). Delusional disorder is distinguished from schizophrenia by an absence of the following: prominent auditory or visual hallucinations, passivity experiences, formal thought disorder, catatonia or prominent negative symptoms. There may be kinaesthetic or olfactory hallucinations that are related to the delusional theme. The onset is often later than for schizophrenia, with most beginning in middle to later life. Deafness, social dislocation (e.g. immigration) and a sensitive pre-morbid personality are thought to predispose to the development of the disorder. See case example in Box 22-1.

### **Box 22-1: A woman with delusional disorder (persecutory type)**

A 75-year-old woman is brought to see you by her daughter. Over the past year, she has become increasingly suspicious of her neighbours, whom she accuses of watching and listening to her when she is in the bathroom, and of trying to poison her. She has blockaded the windows on one side of her house. The neighbours called her daughter after she cut up their hose, accusing them of trying to poison her.

She has been living alone since her husband died four years ago. Her only daughter lives interstate. She wears a hearing aid. Her daughter describes her as always having been an orderly, rather anxious person who would avoid social engagements unless accompanied by her husband.

## Differential diagnosis

The differential diagnosis of the functional psychoses includes substance abuse and physical disorders (see Table 22-3). The delirious patient may suffer any of the psychotic symptoms mentioned above—note the presence of an altered level of consciousness, disorientation, poor concentration and attention, and memory disturbance. People with dementia may suffer delusions, often persecutory, e.g. on themes that their belongings have been stolen. Epilepsy and cerebral lesions can produce psychotic symptoms. It is particularly important to consider a medical condition as the cause of psychosis in people over the age of 40 who present for the first time with psychotic symptoms. Some useful investigations are listed in Table 22-4.

**Table 22-3: Physical disorders and substances that can cause psychotic symptoms**

*Common causes:*

- substance abuse – intoxication with alcohol, amphetamine, hallucinogens, belladonna alkaloids, cannabis, cocaine, MDTA (ecstasy) or solvents; withdrawal from alcohol and sedatives
- delirium of any cause
- dementia
- epilepsy
- neoplasm, CVA, trauma – especially involving frontal, temporal and limbic areas

*Other causes:*

- carbon monoxide poisoning
- Creutzfeld-Jacob disease
- heavy metal poisoning
- herpes encephalitis and other cerebral infections
- homocystinuria
- Huntington's disease
- hyper- or hypothyroidism
- hyper- or hypoparathyroidism
- hypoglycaemia
- neurosyphilis
- migraine
- normal pressure hydrocephalus
- pellagra
- SLE
- Wernicke's encephalopathy
- Korsakoff's psychosis
- Wilson's disease

The victims of childhood abuse may suffer a variety of psychotic symptoms in the context of a dissociative disorder (see Chapter 22). Schizoid, schizotypal and paranoid personality disorders can precede the onset of schizophrenia and share some symptoms (paranoid ideation, woolly speech, interpersonal withdrawal, odd beliefs and magical thinking).

**Table 22-4: Investigations for psychosis<sup>1</sup>**

- EEG – if temporal lobe epilepsy is suspected
- CT scan or MRI – if structural lesions are suspected (e.g. in those with atypical presentations, such as a late age of onset)
- thyroid function tests
- syphilis screen
- HIV screen
- B12 and folate
- haematological screen
- electrolyte screen
- urine/blood drug screen

## **Treatment**

### **Risk assessment**

The first step is to ensure the safety of the patient and of others. Refer to Chapter 3 for a detailed discussion of the assessment of suicidality and dangerousness. People with command hallucinations (to self-harm or to harm others) and ideas of retaliation in response to persecutory delusions are at particular risk. Individuals may be unable to care for themselves or their dependents during acute psychotic episodes.

### **The treatment setting**

People with schizophrenia usually require admission during their first psychotic episode. However, with adequate social supports, subsequent admissions are usually brief or may be avoided altogether. Community mental health teams with an extended hours capacity facilitate care in the community. If the person presents a danger to himself or herself, or others, involuntary hospitalisation may be required under the provisions of the State Mental Health Act.

Hospitalisation is usually necessary during manic episodes. People may place themselves at risk through reckless behaviour, substance abuse or unsafe sex. They may cause themselves serious financial harm through extravagant spending or poorly judged business dealings. They may cause damage to their reputations through disinhibited, sexually promiscuous, aggressive or other ill-judged behaviours. People with severe depression may require hospitalisation if they are at risk of harming themselves or others, unable to care for themselves, socially isolated, suffer psychotic symptoms or require ECT.

### **Medication**

#### *Schizophrenia*

Antipsychotic drugs are the mainstay in the treatment of acute schizophrenia and in relapse prevention. Over the past few years three new antipsychotics have become available: clozapine, risperidone and olanzapine (see Table 13-1). All have a lower propensity to cause acute extrapyramidal side effects than traditional antipsychotics and are associated with fewer negative symptoms. They may also be less likely to cause tardive dyskinesia. Clozapine is effective in cases that are resistant to treatment with traditional antipsychotics. However, it is only available through registered centres and requires close monitoring because of the risk of agranulocytosis. Parenteral preparations are useful in the treatment of people who fail to adhere to oral medication. Some practical prescribing points follow.

<sup>1</sup> McGrath J, Stedman T. How to treat schizophrenia. *Australian Doctor* 1994; October 28.



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**The newer antipsychotics have fewer extra-pyramidal side effects than traditional antipsychotics and are associated with fewer negative symptoms. Clozapine has been shown to be effective in treatment-resistant schizophrenia.**

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- When starting medications use low doses, gradually increasing to the standard prescribing range ('start low—go slow'). The very young, older and first episode patients may only require small doses to control symptoms.
- Higher doses do not produce quicker or better outcomes, only more side effects. In general, doses above 15mg equivalent of haloperidol have no greater antipsychotic effect.

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**Doses above 15mg equivalent of haloperidol have no greater antipsychotic effect, only more side effects.**

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- Agitation can settle within hours to days. However, the positive symptoms generally take between two and eight weeks to settle. Do not increase the dose every few days. Instead, be patient and wait for the drug to have its effect.

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**While agitation can settle within hours to days, the positive symptoms generally take between two and eight weeks to be alleviated.**

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- If sedation is required for agitated or aggressive patients, consider the addition of diazepam.
- Anticholinergic agents are used to prevent acute dystonic reactions when commencing or changing the dose of antipsychotics, especially the high potency traditional drugs such as haloperidol. Once a steady dose is attained, the anticholinergic can usually be withdrawn.

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**Anticholinergics can usually be withdrawn once a steady dose of the antipsychotic has been attained.**

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- In order to minimise the risk of developing tardive dyskinesia, maintenance medication needs to be continuous and at the lowest effective dose. Intermittent therapies, or 'drug holidays,' are not recommended.
- For those who have had one acute psychotic episode, and who are symptom free on medication, guidelines suggest that a medication-free trial can be considered after one or two years of treatment. For those who have had two or more acute episodes, treatment should be continued for at least five years. Some people will require indefinite treatment.
- When changing antipsychotic medications, inform patients and their carers about the risks and benefits of the new medication and the importance of monitoring for early signs of relapse. A crossover phase is usually recommended. Reduce the dose of the first medication (or cease depot preparations) and gradually increase the dose of the second medication over several weeks. When changing from a traditional antipsychotic to risperidone, a crossover phase is required to avoid a cholinergic rebound syndrome.
- People on long-term therapy with traditional antipsychotics should be assessed at least once a year for tardive dyskinesia using the AIMS of similar screening instrument (see Appendix 10). It is important to remember that traditional antipsychotics may suppress the signs of tardive dyskinesia, while at the same time causing it. The signs may first become apparent when the dose is reduced.

ECT is used in the treatment of catatonic schizophrenia, schizoaffective disorder, people with neuroleptic malignant syndrome, and in those who cannot take or are poorly responsive to antipsychotic medication.



### *Mania*

Mood stabilisers (lithium, valproate and carbamazepine) and antipsychotics are used in the treatment of acute episodes of mania. Mood stabilisers are prescribed for relapse prevention (see Chapter 13 for a discussion of the use of these drugs). Contraindications to the use of lithium include pregnancy, renal failure and recent myocardial infarction. Common reasons for non-adherence to lithium include side effects (weight gain, poor concentration, tremor, stomach upset, urinary frequency), the burden of having to take medication over the long term, a feeling that one's creativity has been lost, and a wish to maintain the elevated mood of hypomania.

The decision whether or not to embark on maintenance treatment depends on the number, severity and frequency of previous episodes; the ability of the person to recognise early signs of relapse; the presence of suicidality or dangerousness during acute episodes; and the strength of social supports. It is wise to involve the person's family and other carers in the decision. Following a first episode of mania, it is generally recommended that mood stabilisers be continued for a minimum of six months to prevent early relapse. It is essential to inform patients and their carers about the early signs of lithium toxicity and the circumstances under which it can occur (e.g. dehydration as a result of gastroenteritis or other cause). Women of childbearing age must be warned of the potential teratogenic effects of lithium.

ECT is occasionally used in the treatment of severe mania and in people with a poor response to medication.

### *Depression*

The treatment of depression is covered in detail in Chapter 14. The most effective treatment for psychotic depression is ECT, though a combination of antidepressants and antipsychotics is sometimes used. Lithium must be ceased during ECT administration.

## **Treatment adherence**

Non-adherence to prescribed antipsychotic medication is common with a reported incidence of between 11 and 80 per cent.<sup>1</sup> Some reasons for non-adherence are listed in Table 22-5.

**Table 22-5: Reasons for non-adherence to antipsychotic medication**

- unpleasant side effects or a fear of developing tardive dyskinesia
- psychotic disorganisation
- misunderstandings about the need for medication
- denial of the illness
- delusional beliefs about the treatment (e.g. the belief that he or she is being poisoned)
- an expression of autonomy
- a belief that taking medication is a sign of moral weakness and a wish to try to beat the illness on one's own
- a wish to retain ego-syntonic grandiose delusions
- an expression of difficulties with authority acted out in the transference.

The promotion of a strong therapeutic alliance will enhance adherence. Involve the patient in decision-making. Explain the reasons for your recommendations rather than trying to direct the patient to comply. Educate the patient and his or her family about the illness and the need for medication. In particular, explain possible side effects of the medication. Enlist others in helping a disorganised patient to monitor (his) medication. Dosette boxes may be useful for patients on a large number of medications. Listen to why the patient refuses to adhere and empathise with

<sup>1</sup> Corrigan PW, Liberman RP, Engel JD. From noncompliance to collaboration in the treatment of schizophrenia. *Hospital and Community Psychiatry* 1990; 41:1203–1211.

how (he) feels, but state clearly your own view and try to come to some compromise. Consider the use of depot medication.

### **Behavioural treatment of psychotic symptoms**

For many patients, medication provides only partial relief from the positive symptoms of schizophrenia, while the negative symptoms are often poorly responsive to medication. Behavioural strategies can be used to enhance symptom control.

Listening to music may help deal with auditory hallucinations. By using a Walkman, the person can move around, and also avoid disturbing others. Other techniques include distraction by watching television or playing a musical instrument; involvement in some activity (e.g. going to the gym, using exercise apparatus or going for a walk); talking to others face-to-face or over the phone; humming; or practicing relaxation exercises.

Delusions can sometimes be challenged by examining evidence for and against patients' beliefs. This is generally most effective when done in collaboration with the patient rather than by confrontation. It needs to be approached with care when patients are distressed and with those who have severe formal thought disorder.

It is also useful to identify responses that exacerbate the problems—alcohol and marijuana use, isolation and withdrawal, or shouting at voices to 'Go away'.

People with negative symptoms will be encouraged to be more active if family members or carers reward desired behaviours. Similarly, the frequency of disturbing behaviour may be reduced by rewarding the absence of these behaviours or by withdrawing reinforcement when the disturbed behaviour occurs. Patients and carers should be asked to identify precipitants to unwanted behaviours. These may then be modified to reduce the frequency of the behaviours. Daily activity schedules can be used to monitor and plan increased activity levels.

### **Relapse prevention**

Some common early signs of relapse in schizophrenia include sleep disturbance, social withdrawal, depression, anxiety, irritability, poor concentration, deterioration in work performance, worsening of positive symptoms (voices, delusions or formal thought disorder) and suspiciousness. It is important to ask the patient and his or her carers to reflect on the early symptoms of his or her last episode, and so clarify that individual's relapse signature. They need a clear plan of action should these symptoms recur. The treatment of early relapse involves increasing contact with the person and his or her carers, medication review, and dealing with the precipitants of the relapse, including substance abuse, non-adherence to medication, and life stressors.

The onset of manic episodes is often abrupt, occurring over a period of hours to days. Common early signs include a decreased need for sleep, increased activity levels, elevated or irritable mood, and grandiose or otherwise unrealistic plans. Since people commonly lose insight early in the course of the illness, it is vital to involve the family and other social supports in recognising the individual's relapse signature and seeking early treatment. Common precipitants to manic episodes include stressful life events, substance abuse, the use of antidepressant drugs, the cessation of lithium, and disruption of the sleep-wake cycle. Women with bipolar disorder are at risk of developing postnatal depression or mania. Those who recommence mood stabilisers during the postnatal period are advised not to breast-feed.

### **Rehabilitation**

Rehabilitation is the most time-consuming component of the treatment of prolonged illness. The aims of rehabilitation are to improve patients' ability to survive independently in the community, to improve their social and family functioning, to maximise their educational and vocational potential, and to optimise their involvement in leisure and recreational pursuits. In assessing a person's rehabilitation needs, it is important to consider the individual's strengths, as well as his

or her weaknesses. A rehabilitation plan will only be effective if the person is committed to its goals. Unless the goals are realistic, he or she will fail and may suffer a relapse, and you will feel frustrated. For one person a realistic goal may be a return to full-time employment; for another the appropriate goal may be maintenance of current functioning (see also goal setting in Chapter 9). It is useful to have an up-to-date list of the rehabilitation agencies in your area.

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**In assessing a person's rehabilitation needs consider both the individual's strengths and weaknesses.**

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People with psychotic illnesses may suffer deficits in social and living skills—self-care, shopping, using public transport, budgeting, cooking, housework, diet, physical health care, communication, problem solving and participation in leisure and social activities. These are addressed through skills training, the principles of which include breaking tasks down into small steps, keeping explanations clear and straightforward, repeating instructions and linking steps in a logical order. Skills training can be delivered on a one-to-one basis or in groups. Specific forms of skills training include goal setting (see Chapter 9), structured problem solving (see Chapter 6), communication and social skills training<sup>1</sup>.

Various models of occupational rehabilitation have been developed. Job support networks provide vocational assessments, social skills training and on-site assistance in the workplace. Clubhouse projects provide both in-house tasks, such as clerical duties and kitchen work, as well as supported employment opportunities negotiated by the clubhouse and shared between clients. Self-help organisations include the Schizophrenia Fellowship. The Association of Relative and Friends of the Mentally Ill (ARAFMI) is a support group for carers.

The coordination of a rehabilitation plan is time consuming for the general practitioner. However, several Medicare Schedule items introduced on the 1 November 1999 allow the general practitioner to bill for time spent in care planning and case-conferencing with other professionals involved in the person's care. Within public mental health services, case managers perform this coordinating role (see Chapter 1). A number of divisions of general practice across Australia are presently working with their local mental health services on programs of shared care. For example, the Logan Area Division of General Practice and the Logan-Beaudesert Mental Health Service have recently completed a shared care project that involved a case-manager working together with a group of six general practitioners in the care of 20 patients who suffer from schizophrenia. The project has now been extended to involve another 15 general practitioners and all of the case managers in the Service.

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**Within district mental health services, case managers coordinate patients' rehabilitation plans.**

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### **Family involvement**

As a result of the shift in the delivery of mental health services from institutions to the community, much of the burden of care now falls on families and other carers. Having a family member diagnosed with a psychotic illness is stressful. Family members often fear that others in the family, especially children, will develop a similar illness. They will mourn the loss of hopes and plans for the person. They sometimes feel ashamed because of the stigma of the illness, and guilty that they may in some way have caused it. They may have to deal with difficult and demanding behaviours and, at times, they may even be afraid for their own or the patient's safety. As a consequence, they may fear leaving the person at home alone, and be reluctant to have visitors

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<sup>1</sup> Treatment Protocol Project. *Management of Mental Disorders 2nd Ed.* World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1997.

over to stay or to take holidays. Marriages are often put under great strain.

Use counselling, structured problem solving and grief counselling to help families cope with these problems. Educate the family about the nature of the illness, the prognosis and treatment. Remind them that there is no evidence that patterns of family interaction or parental care cause schizophrenia, though family conflict, like any other stressor, can increase the likelihood of relapse. Involve the family in relapse prevention. Have a clear plan about whom they should contact in crisis, or when other problems arise. A good way of reconciling the person's right to privacy with the carers' need for information is to see the patient and the family together. Carers' groups such as the Association of Relatives and Friends of the Mentally Ill (ARAFMI) provide information and support to families of the mentally ill.

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**Use counselling and structured problem solving to help families deal with the stress of having a member with a psychotic illness.**

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### **Complications**

#### *Depression and suicidality*

Schizophrenia is frequently complicated by depression. People with schizophrenia undergo a process of mourning, which may develop into major depression as they assess the impact of the illness on their life plans. The differential diagnosis includes negative symptoms of the illness, concurrent medical problems, substance abuse and extra-pyramidal side effects of medication. Antidepressants may be prescribed, but care must be taken as they can exacerbate psychotic symptoms.

Suicide is the leading cause of premature death in people with schizophrenia with an estimated lifetime incidence of between 10 and 13 per cent. High-risk periods include the first six years after diagnosis and the period immediately following discharge from hospital. In addition to the general risk factors discussed in Chapter 3, specific risk factors in people with schizophrenia include young age, high IQ, high aspirations, high levels of pre-morbid achievement, chronic debilitating course of the illness, and an awareness of the losses sustained as a consequence of the illness. Patients may know others who have committed suicide.

Between 10 and 15 per cent of people with major depression commit suicide. People with psychomotor retardation are at risk of suicide as their condition improves and they find the energy to act. During manic episodes people may, as a consequence of their impaired judgement, place themselves at risk.

#### *Violent behaviour*

People with schizophrenia are, as a group, at higher risk of committing violent acts than others in the community. However, the assessment of risk varies widely from one individual to another and requires the consideration of a large number of factors in addition to diagnosis (see Chapter 3). During a manic episode, sufferers may be prone to threatening or assaultive behaviour. People who are psychotically depressed are generally more of a risk to themselves than to others, but they may be aggressive towards those in their delusional systems. Family members can be at risk in murder-suicide.

#### *Anxiety*

Anxiety symptoms are not uncommon in psychosis. For example, a person with persecutory delusions may develop agoraphobia out of a fear of being attacked. After a psychotic episode, people may suffer a loss of confidence and fear recurrence of the illness. Address these complications through active rehabilitation, encouraging adherence to medication, and by taking other steps to prevent relapse. The management of specific anxiety disorders is discussed in Chapter 15.

#### *Substance abuse*

The prevalence of substance abuse in people with schizophrenia has been estimated to be as high

as 40 per cent. Substance abuse worsens prognosis with longer and more frequent hospitalisations, and higher rates of homelessness, depression, suicide and violence. The management of substance abuse is described in Chapter 18. Some community mental health services offer groups for people with dual diagnosis of psychosis and substance abuse. Patients need to be educated about interactions with antipsychotic medications. People with bipolar disorder are prone to substance abuse during manic episodes, and they may self-medicate with alcohol or benzodiazepines.

#### *Physical and dental health problems*

The physical health of people with psychotic illnesses is often poor. A recent study found that ischaemic heart disease is the leading cause of excess mortality in psychiatric patients, accounting for 16 per cent of all excess deaths, compared with 8 per cent due to suicide<sup>1</sup>. There are high rates of smoking, obesity, underactivity, poor diet and poor dental health. General practitioners play an essential role in addressing these problems.

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**Complications of psychotic illnesses include depression, suicide, anxiety, substance abuse, and poor medical and dental health.**

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### **Individual therapy**

The cornerstone of the psychological treatment of people with chronic psychotic disorders is supportive psychotherapy (see Chapter 8). General practitioners are able to provide continuity of care to psychotic patients, something that is often lacking in public mental health services because of the frequent rotation of junior medical staff. Counselling and structured problem solving are used to deal with acute crises.

A strong therapeutic alliance improves compliance and is one of the most important determinants of good outcome, but is often difficult to establish with people suffering psychotic disorders. Maintain a comfortable distance—be sensitive about intruding into areas that they do not want to discuss (though this may sometimes be necessary); negotiate the frequency and length of consultations with them; and respect their personal space.

Educate patients about their illness and its treatment. Actively involve them in all aspects of their care. Clarify signs of relapse for each individual and, together with their carers, develop a clear plan of action should these appear. Be realistic about the outcome for those with chronic symptoms. Acknowledge the limits of what you can do.

Allow the person to grieve the losses associated with having the illness. People with bipolar disorder are often ashamed and embarrassed by their behaviour during manic episodes. All people who suffer a psychotic episode face the stigma of having suffered a serious mental illness. For many patients, you will be the only person with whom they can discuss their psychotic symptoms. Accepting and trying to understand these experiences will often provide relief and strengthen the therapeutic alliance.

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**Accepting and trying to understand the experiences of people with psychotic illnesses will provide relief and strengthen the therapeutic alliance.**

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General practitioners commonly see people with psychotic illnesses for routine monitoring during the stable phase. Table 22-6 summarises important aspects of care in this phase.

**Table 22-6: Routine review of people with psychotic illnesses**

#### **Goals**

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<sup>1</sup> Lawrence DM, Holman CDJ, Jablensky AV, Hobbs MST. Death rate from ischaemic heart disease in Western Australian psychiatric patients 1980–1998. *British Journal of Psychiatry* 2003; 182, 31–34.

The goals are to prevent relapse; diagnose and treat complications; improve social, occupational and leisure functioning; deal effectively with stressful events; monitor for adverse effects of medication; and optimise family functioning.

### **Length and frequency of appointments**

This depends on the person's current mental state. Patients will generally be seen around once a month for about 15 minutes, but more frequently (sometimes once a day) and for longer periods during exacerbations of the illness or in the face of stressful life events.

### **Specific interventions**

#### *Supportive psychotherapy*

The main elements are: holding and containment, genuineness, reassurance, positive reframing, explanation, suggestion and advice, encouragement, monitoring countertransference (see Chapter 8).

#### *Diagnosis and treatment of complications*

In particular, consider depression, suicidality, substance abuse and anxiety disorders.

#### *Monitor for signs of relapse*

Spend time with the patient and his or her family clarifying the relapse signature for that individual (e.g. broken sleep, withdrawal from family activities, eating alone, wearing bizarre make-up). Enlist the support of the family in spotting early signs. Treatment will depend on the assessment of the cause, but may involve an increase in medication, increased frequency of reviews, problem solving to deal with intercurrent stressors, treatment of intercurrent medical problems, counselling about adherence to medication and avoidance of substance abuse, or counselling to deal with family problems.

#### *Counselling and structured problem solving*

Use these techniques to deal with crises and other stressful life events (see Chapter 6).

#### *Education*

The family and the patient will want information about the illness, its prognosis and the treatment plan. Education is often an ongoing process, reinforcing and clarifying what has been said before, and dealing with new issues as they arise. Be sensitive to the patient's need for some denial.

#### *Treatment planning and coordination*

This will be done in collaboration with other agencies involved in the person's care. The case manager at the local mental health service is the key figure in coordinating the person's treatment and rehabilitation needs. You can use the new Medicare items for remuneration of these activities.

#### *Review of medication*

Monitor side effects and efficacy. In particular, monitor every six to twelve months for any evidence of tardive dyskinesia. For those on lithium, monitor lithium levels, renal and thyroid function. Monitor adherence. Consider the indications for the use of atypical agents.

#### *Monitoring and enhancing adherence to treatment, including medication*

Educate the patient about the side effects of the medication and collaborate with him or her in finding the best balance between side effects and therapeutic effects. Warn the patient about the dangers of ceasing medication—while there may be temporary relief of side effects, there is an increased likelihood of relapse, which may in turn mean higher doses of medication later on.

#### *Rehabilitation*

The aim is to optimise the person's social, occupational and leisure functioning. Keep in touch with the person's case manager. Always ask the person what he or she has been doing since the last appointment—has he or she been out, and how are things at home.

#### *Family involvement*

Ask to see the family regularly. Educate them about the illness and the treatment plan. Use counselling and structured problem solving to deal with acute stressors. Monitor the burden of care and the impact of the illness on individual family members and on the family system. Refer to appropriate support agencies.

#### *Monitor physical health*

Perform the same screening tests used for other patients.



# Chapter 23

## Personality disorders

Personality disorders are persistent maladaptive patterns of behaviour and of perceiving and thinking about oneself and the environment, present since adolescence, that deviate markedly from a person's cultural expectations. They cause significant distress to that person and to others with whom she or he comes in contact. The DSM-IV describes ten disorders, which fall into three groups<sup>1</sup>:

- **Cluster A** includes paranoid, schizoid and schizotypal personality disorders. People with these disorders appear odd or eccentric.
- **Cluster B** includes borderline, narcissistic, antisocial and histrionic personality disorders. People with these disorders appear dramatic, emotional and erratic.
- **Cluster C** includes obsessive–compulsive, avoidant and dependent personality disorders. Individuals with these disorders often appear anxious, constricted and fearful.

These diagnoses are purely descriptive and often an individual does not fit neatly into any one of them. Moreover, making a diagnosis does not eliminate the need to understand a person in terms of his or her history, current mental state and level of functioning. See Chapter 12 for a discussion of the psychodynamic assessment of personality.

The behaviours that constitute the personality disorders are not in themselves maladaptive. Their value can only be judged by their impact on the individual and others in the contexts in which they occur. All people have dependency needs—they underlie our social behaviour and our attachments to others. Conscientiousness and perfectionism are frequently adaptive, especially when the consequences of careless behaviour are serious. Bold ambition and dreams of ideal love and beauty can be realised in works of art and other creative productions. A vigilant and suspicious mind may be valuable in uncovering corruption. Everybody lies, and nobody is perfect. Life would be dull if everyone obeyed the rules all of the time. As health professionals, it is not our primary role to make moral judgements about the people whom we treat.

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### **The behaviours that constitute the personality disorders can only be judged as maladaptive in the contexts in which they occur.**

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These disorders are, by definition, long-standing ways of behaving and change only slowly. However, certain maladaptive traits may become attenuated over time, with or without treatment—for example, the aggressiveness of the sociopath. Unfortunately, however, some people remain difficult into old age.

General practitioners need to be aware of the common complications of the personality disorders, and to be able to diagnose and treat them. They include depression, anxiety and substance abuse. People with personality disorders are difficult to treat. Many of those whom TC O'Dowd dubbed 'heartsink patients' fall into this category<sup>2</sup>. The general practitioner needs to understand common countertransference reactions to these people. By being conscious of these, you will be less likely to act out upon them. Your communication with them will be enhanced, as will your ability to treat their intercurrent mental and physical problems. You will

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<sup>1</sup> American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.* Washington DC, American Psychiatric Association 1994.

<sup>2</sup> O'Dowd TC. Five years of heartsink patients in general practice. *British Medical Journal* 1988;297: 528–530.

avoid some of the distressing personal reactions that can complicate their treatment. Moreover, your countertransference responses will provide valuable information about the person.

The lives of people with personality disorders are often stressful and chaotic. In part, this is because rather than confront and deal with their problems, they tend to use denial, dissociation, acting out and other maladaptive defences to cope. Persuading these people to articulate and clarify their problems is often difficult. Nevertheless, the general practitioner should persist in helping the person to do so, and to use structured problem solving in dealing with them (see Chapter 6). Detailed discussion of past events, including past abuse, is generally best left to the person's therapist. Structured problem solving approaches may be supplemented by the behavioural and cognitive behavioural techniques described in Chapters 9 and 10. For people with severe personality disorders, supportive psychotherapy is used (see Chapter 8).

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**We are at greatest risk of acting out when patients arouse impulses and feelings in us that we habitually defend against.**

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In the following sections, I first describe the features of the disorders and some of their common psychiatric complications. I then describe the types of transference and countertransference reactions that commonly arise when dealing with these people, and how an understanding of these can inform treatment.

## **Cluster A**

### **Paranoid personality disorder**

Paranoid people have a pervasive suspiciousness and mistrust of others. They suspect the motives of others and are often preoccupied about whether or not friends and colleagues can be trusted. They may suspect the fidelity of their spouses. They are guarded and tend to read hidden and threatening meanings into everyday events. They bear grudges and are sensitive to anything that they perceive as a criticism.

Paranoid people may go on to develop delusional disorder or schizophrenia. Their estrangement from others places them at increased risk of depression. Their fears of others can lead to agoraphobia. They may abuse alcohol or other substances in an attempt to settle their persistent anxiety and arousal.

In the countertransference they evoke defensiveness. The interaction between you and the patient can sometimes be understood as the patient projecting their malevolent image of others onto you. First, recognise the angry feelings that you experience. Second, try to contain these feelings and not act defensively upon them. Acting out upon them may only confirm the patient's paranoid perception of you.

Be open and straightforward. If, for example, a man is suspicious about the notes you are taking, let him read them. If he criticises you for being late, apologise. Rather than dispute his perception of events, ask for more detail and empathise with how he must feel, given his paranoid beliefs. To do this, imagine how you would feel if you held similar beliefs. Do not press too hard for information from guarded patients, but rather empathise with the tension that they experience in having to be so vigilant. Do not be over-friendly, but rather maintain a professional distance. Encourage them to talk about their anger as an alternative to acting it out. Carefully monitor your countertransference. It is very easy to make a sarcastic remark or some other hurtful comment, which will only inflame the situation.

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**In dealing with a paranoid person, be open, straightforward and serious. Maintain a professional distance and do not press too hard for information.**

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In some cases, it may be possible to begin to challenge a man's misconceptions by, for example, asking him about the presence of certain crucial evidence for his beliefs. If he says that his neighbour hates him, you might ask if the neighbour has actually said so. If not, you can calmly point out the uncertainty of his judgement.

### **Schizoid/schizotypal personality disorder**

Schizoid people tend to be detached from others and display only a limited range of emotions. They have no desire for close relationships and prefer solitary activities. They are often seen as being cold and distant. Schizotypal patients are similarly detached from social relationships, but they also exhibit odd and eccentric behaviours. They may be superstitious; they may believe in telepathy or 'sixth sense'; and they are often circumstantial and vague in their speech.

Schizoid and schizotypal personality disorder may precede the development of delusional disorder or schizophrenia. People with these disorders are prone to the development of depression.

Because of their coldness and emotional distance, these people may inspire countertransference feelings of boredom, frustration or anger. The therapist may feel helpless and wish to withdraw. Schizoid people fear closeness with others and expect to drive you away. Try to stay with them, do not push and probe, be patient and respect the patient's 'silent self'. With time, they may begin to discuss previously hidden aspects of themselves and place a high value on their relationship with you.

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**With a schizoid person, tolerate the silences, do not be intrusive, and respect the person's 'silent self'.**

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## **Cluster B**

### **Borderline personality disorder**

As a group, people with borderline personality disorder are amongst the most difficult to treat. The disorder is characterised by marked instability in interpersonal relationships alternating between the extremes of idealisation and devaluation. People with borderline personality disorder cannot tolerate being alone, and make frantic efforts to avoid abandonment. They may repeatedly self-harm. Their identity is disturbed. They are impulsive in their behaviour, and they exhibit rapid and intense fluctuations in affect between boredom, dysphoria, anger and anxiety.

People with borderline personality disorder are at risk of depression, substance abuse and eating disorders. They may also be suffering the sequelae of abuse, including post-traumatic stress disorder, dissociative disorders or somatoform disorders.

A well-validated treatment for people with borderline personality disorder is dialectical behaviour therapy, developed by Marsha Linehan<sup>1</sup>. This is based largely on behavioural and cognitive behavioural techniques, but also incorporates insights from a wide range of therapies, including psychodynamic psychotherapy. The therapy is usually delivered in two concurrent parts—individual psychotherapy and skills training. The skills training component has been manualised and is usually run in group sessions of two-and-a-half hours duration, once a week over 12 months<sup>2</sup>. This approach is presently being adopted at some sites in Australia.

General practitioners should try to focus on the immediate here and now problems and stressors

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<sup>1</sup> Linehan MM. *Cognitive-Behavioural Treatment of Borderline Personality Disorder*. New York: The Guilford Press, 1993.

<sup>2</sup> Linehan MM. *Skills Training Manual for Treating Borderline Personality Disorder*. New York: The Guilford Press, 1993.

confronting the individual, rather than on the person's past problems, including any past abuse. Identifying and clarifying the precipitants to self-harming behaviour is often difficult because of the person's tendency to avoid problems through the use of denial, dissociation and acting out. The precipitant to self-harming may be an unpleasant affective state, for example, a feeling of emptiness and boredom when left alone. Use counselling and structured problem solving to help these people find more effective solutions to their problems. The techniques of cognitive behavioural therapy may also be useful. The techniques of supportive psychotherapy will be used for people with severe borderline personality disorder.

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**General practitioners should focus on helping people with borderline personality disorder identify, clarify and solve their current problems, rather than dwelling at length on their past abuse.**

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People with borderline personality disorder arouse intense countertransference feelings. In response to an idealised transference, you may be tempted to act out in a variety of ways. Feeling flattered at being told that you are the only person who has ever really understood and helped a person, you may try to live up to this image of the 'perfect' therapist and have fantasies of rescuing him or her. You may regularly extend appointments beyond the agreed times. You may begin seeing a patient out of hours and in places outside your consulting rooms. You may find yourself accepting dinner engagements and even asking the person home. It is not unheard of for such patients to eventually move in with their therapists and enter into a sexual relationship with them. True to the countertransference, doctors who are drawn into these boundary violations typically act on the belief that the only way the person's problems could be alleviated was through an intimate relationship with them.

A corollary of the person's idealisation of you may be his or her devaluation of others involved in their care. Failing to acknowledge and recognise feeling so special, you may find yourself criticising your colleagues, accusing them of being unable to understand the person and of not caring enough about him or her. For devalued therapists who are struggling to cope with a hostile, self-harming patient, there is nothing harder to tolerate than the self-righteous, idealised therapist who is critical of their best attempts at treatment.

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**People with borderline personality disorder may at different times idealise or devalue their therapists.**

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This conflict can be understood through the concept of splitting, a defence mechanism that has both intrapsychic and external manifestations. The intrapsychic component involves people having polarised views of themselves and others, either all good or all bad. Instead of recognising that people are a combination of both good and bad, such people keep good and bad representations of themselves and of others separate and compartmentalised. In some cases, they have been the victims of abuse and, by keeping good and bad object representations apart, they protect the good from being destroyed by the bad. The external manifestations of splitting are seen when conflict arises between other people in their milieu—in particular, between idealised and devalued therapists. When splitting between therapists does occur, try to recognise it. Meet with your colleague and listen to his or her experience of the patient. Try to reach agreement on how the person should be treated. If possible, meet together with the patient, united in your approach. If you treat these people, you will experience what it is like to be treated as both good and bad. At one time you will be idealised, at another, devalued.

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**Idealisation and devaluation can be understood as external manifestations of splitting. Intrapsychic splitting involves keeping good and bad representations of the self and of others separate and compartmentalised.**

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It is particularly difficult to deal with the borderline patient's self-destructive behaviour, which may include cutting, over-dosing, burning with cigarettes, risk-taking and sexual promiscuity. While the intention behind these behaviours may not be to commit suicide, people with borderline personality disorder have a suicide rate of around 8 per cent. The risk of suicide in people who self-harm has been estimated to be 140 times the population average.

The self-harming behaviour may be a maladaptive way of seeking help, a behaviour learnt within past abusive relationships. It can also be understood as a type of acting out through which an unbearable affect (emptiness, boredom, anxiety, helplessness) can be neutralised.

Self-harming behaviours promote strong countertransference responses. Anger is prominent—indeed, the affect may at times be more accurately described as hate. Be careful to acknowledge such feelings to prevent acting out. You might withdraw or make a sarcastic remark. Instead of acting out the hate directly, you might, through reaction formation, do the opposite and make desperate attempts to rescue the person. Rescue fantasies may arise from anxiety and guilt about the person's behaviour, and a feeling that you are helpless to do anything about it. There is the danger that the extraordinary measures you take to stop him or her from self-harming may ultimately do more harm than good. They will reinforce the person's feelings of helplessness and could even lead to boundary violations.

Instead of embarking on desperate attempts at rescue, set clear limits about what you can and cannot realistically do. Be open and discuss these limits with the person. For example, acknowledge that ultimately the safety of a young woman is in her own hands. Seek an agreement with her to seek other more adaptive ways of dealing with her feelings by, for example, speaking to someone about how she feels. At the same time, acknowledge her need for such behaviour; recognise that it is a solution to a painful and distressing state of being. Use structured problem solving to find more adaptive ways of dealing with stressors.

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**In response to self-harming behaviour express your concern, but acknowledge the limits of what you can do. Try to reach a safety agreement with the person. Focus on the here and now issues and use structured problem solving to deal with him or her.**

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People with borderline personality disorder, unable to articulate why they have harmed themselves, may sometimes present a bland, smiling affect in response to self-harming behaviour. This response can be understood as a form of splitting in which the impulse to self-harm has become separated from the idea and the affect with which it was associated. As children, this was often the only way these people had of dealing with sexual abuse or other traumatic experiences over which they had no control. Do not join in, laughing and clowning. If you do so, you are, like the patient, probably defending against acknowledging your own fear and despair. In general, it is advisable to maintain a serious demeanour. Do not be annoyed by the bland affect—acknowledge the attempt to put a brave face on a frightening and distressing experience. Try to understand and articulate the affect that the person defends against. Ask about precipitants in order to help the person to connect the affect with the idea and the impulse. For example, it might be useful for a young man to write down what is running through his mind at times when he feels the need to harm himself.

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**In response to a bland, smiling affect, do not clown and joke or get annoyed with the person. Remain serious and concerned.**

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Do not force people to describe their experiences of abuse. This may constitute a form of abuse in itself. Instead, allow them to confront these memories when they choose. This will be difficult and unpleasant. Monitor your countertransference responses. Acknowledge to yourself any voyeuristic gratification that you experience to ensure you do not act out upon it by, for

example, probing the person for more detailed descriptions of the abuse. A paradox exhibited by people with borderline personality disorder is that while being in a state of emotional turmoil, they may nevertheless be unable to adequately grieve their losses. Assist them through the mourning process (see Chapter 7).

### **Narcissistic personality disorder**

A certain degree of narcissism (as well as dependency, suspiciousness, orderliness and denial) is normal and adaptive. Separating pathological narcissism from healthy self-regard is not always easy, but an important distinguishing feature is the inability of the narcissistic person to love others. Such people use other people and then discard them. They lack regard for the feelings of others. Their intimate relationships are impoverished. A failure of the narcissistic person to live up to his or her high expectations can predispose to depression. These people are also at risk of substance abuse.

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#### **People with narcissistic personality disorder are prone to depression and substance abuse when they fail to live up to their high expectations of themselves.**

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Grandiosity, an insatiable need for admiration and a lack of empathy with others characterise the disorder. Narcissistic people are preoccupied with fantasies of unlimited success, power, brilliance and ideal love. They are vulnerable to feeling ashamed when they fail to live up to the exacting standards that they set themselves. They have a sense of entitlement about receiving favourable treatment and expect obedience to their every wish. When not envious of others, they are convinced that others must be envious of them. Their manner is arrogant, haughty, superior and dismissive.

In the transference they may, like those with borderline personality traits, idealise the therapist. Therapists who are unaware of their own narcissistic needs may accept this projection and act out upon it, for example, by encouraging the person's devaluation of his or her previous therapists.

Boredom is a frequent countertransference response to people with narcissistic personality disorder who talk continuously about themselves while being quite oblivious of the therapist. Failure to recognise and contain these feelings may lead to withdrawal from the person, or angry retaliation at his or her selfishness.

In dealing with narcissistic people, you may feel controlled as they vigilantly observe and criticise anything that may be construed as a lack of complete attention to themselves. At such times it may be useful to interpret their response by saying, for example, 'You seemed upset when I reached for the medical record.'

You will also have to cope with the person's devaluation. If you fail to acknowledge and contain your feelings of hurt, you may be tempted to retaliate against him or her. This may be particularly difficult to avoid if you fail to acknowledge your own narcissistic needs.

### **Antisocial personality disorder**

The DSM-IV criteria for antisocial personality disorder include a history of conduct disorder in adolescence and a pervasive pattern of disregard for and violation of the rights of others. The disorder is characterised by participation in unlawful activities, lying, impulsivity, aggressiveness, a disregard for the safety of oneself and others, irresponsibility at work and at home, and a lack of remorse.

People with antisocial personality disorder are at risk of depression and substance abuse. Somatoform disorders may also be more prevalent in this group and among their relatives.

The antisocial person will try to corrupt you. For example, a patient of a psychiatrist who was having difficulty selling his house, offered to burn it down so that the psychiatrist could collect the insurance. Be careful not to laugh or otherwise show any appreciation of such a suggestion. Such people mean what they say and clear rejection and disapproval should meet such comments.

Confront the person's denial and minimisation of his antisocial behaviour. For example, if he says, 'I sorted him out,' ask exactly what he did and then clarify the action: 'You mean you hit him'.

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**With the antisocial person, confront the denial of his antisocial behaviour—do not collude with the excitement he experiences hurting others—and try to connect actions with internal affects and thoughts. Do not have high expectations of success.**

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Be careful not to empathise with the patient's sense of excitement and domination when he describes hurting someone else. Such a response is a type of pseudo-empathy and represents collusion with the person's antisocial behaviour.

Like people with borderline personality disorder, antisocial people act out strong impulses as a defence against acknowledging their affective and ideational origins—for example, their feelings of emptiness and anxiety in response to not having what they want. Try to connect actions with internal feeling states and carefully examine precipitants to impulsive behaviour.

Finally, accept the fact that these people are very difficult to change. Be resigned to the fact that they probably will succeed in deceiving you at some point. In some cases, they are probably untreatable. Do not have high expectations for success; otherwise, you are likely to be disappointed.

### **Histrionic personality disorder**

This disorder is characterised by patterns of excessive emotionality and attention seeking behaviour. Such people need to be the centre of attention. They are inappropriately seductive in their manner. Their speech is impressionistic and lacking in detail. They are suggestible and easily influenced by others, often taking on the attitudes, characteristics and even speech inflections of the people they are with. They tend to overrate the intimacy of their relationships. People with the disorder are predisposed to develop depression. They may also present with somatoform disorders.

One of the frustrations of treating histrionic people is their dramatic, yet imprecise, style of communication. Asked to describe a symptom, a histrionic man might say, 'It was like being stabbed in the back with a red-hot poker'. While superficially rather colourful, such a description provides you with little useful information. Moreover, the person with histrionic personality disorder will resist your efforts to get a clearer description of the pain. This impressionistic cognitive style is evidence of the principal defence mechanisms used by these people—denial and repression. In particular, people with histrionic personality disorder find it difficult to describe feelings. Paradoxically, their emotional and dramatic displays often defend against experiencing deeper and more disturbing feelings. Be patient and gently challenge their resistance by trying to clarify the exact nature of their symptoms. Remember, however, that by doing so you will increase their anxiety.

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**The impressionistic style of communication of people with histrionic traits is a manifestation of their primary defences—repression and denial.**

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As a further defence against threatening thoughts and feelings, histrionic people may try to switch the focus of attention onto you and begin to question you about your life. Falling into this countertransference trap, you may then find the suggestible histrionic patient taking on your own attitudes and beliefs. It is generally unwise to self-disclose to histrionic patients.

The person with histrionic personality disorder may develop an erotic transference towards you. A failure to monitor your own countertransference responses could lead to boundary violations. On the other hand, an understanding of the origins and meaning of the erotic transference can provide important insights into the patient's neurosis.

## **Cluster C**

### **Obsessive–compulsive personality disorder**

This set of personality traits is different from obsessive–compulsive disorder, which is characterised by obsessions (recurrent, unwanted thoughts) and compulsions (ritualised acts that are performed to decrease anxiety). See Chapter 15 for a discussion of obsessive–compulsive disorder.

People with obsessive–compulsive personality disorder are preoccupied with orderliness and doing things perfectly. They have a need to be in control. They tend to be rigid and lacking in spontaneity. They have difficulty seeing the wood for the trees. While some of these traits are adaptive in our society—for example, in obtaining an academic degree or in being a medical practitioner—people with this personality disorder are at risk of depression when they fail to meet their own exacting standards, and they become anxious and irritable when their sense of being in control is threatened.

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**People with obsessive–compulsive traits have a need to be in control and are prone to anxiety and irritability when this is threatened.**

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Typical countertransference reactions include boredom and irritation with the patients' circumstantial and over-inclusive speech. In response to their controlled affect, you may feel distant and cold towards them. You may overlook some of their problems because of the discomfort you have in confronting your own obsessive–compulsive traits. In response to the tendency of these people to dominate the interview, you may be drawn into a battle for control.

As with the other personality disorders, the first step in dealing with these people is to be aware of your own countertransference responses. Try to get beyond their words to uncover the feelings and impulses behind them. In particular, allow them to acknowledge their anger. In patients with obsessive–compulsive personality disorder, anger may be disguised by their use of the defence of reaction formation. For example, a man's repeated expressions of concern about another's well being may disguise his anger with that person.

### **Avoidant personality disorder**

Like schizoid people, those with avoidant personalities have difficulties in social relationships. However, unlike schizoid people who have no wish for such relationships, people with avoidant personality disorder long for intimate relationships, but avoid them, fearing rejection, humiliation and shame. They are prone to depression, anxiety disorders and substance abuse.

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**People with avoidant traits are prone to depression, anxiety and substance abuse.**

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In the countertransference, you may feel bored because of the person's silences and his or her generally inhibited behaviour. Avoidant patients expect people to be critical of them, to humiliate

them and to put them to shame. Acknowledge any such impulses so as to avoid acting out upon them. Encourage the person to confront feared social situations. Tolerate their silences.

### **Dependent personality disorder**

Dependency is a human trait that includes normal needs for approval, empathy and validation. Conflicts over dependency are features of all personality disorders—the obsessional person's fears of dependency and its attendant loss of control; the borderline person's fears of merger and rejection; the avoidant person's fear of humiliation and rejection.

People with dependent personality disorder want others to make decisions for them. They are submissive and require constant reassurance. They cannot disagree with others for fear of a loss of support or approval. They are highly vulnerable to the loss of close relationships and are preoccupied with fears of such relationships ending.

Dependent people try to persuade their therapists to tell them how they should solve their problems. Be aware of this impulse and avoid giving advice. Instead, use the techniques of counselling and structured problem solving described in Chapter 6. Dependent people may suffer a relapse following an improvement. They fear that if they get better, they will lose your support. They are at risk of becoming depressed, especially after relationships break down. Their fears of losing important relationships leave them prone to anxiety disorders.

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### **Dependent people often fear that if they get better, they will lose your support.**

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All of us have conflicts over dependency. A motivation for entering a caring profession may be to provide the care that an ideal caregiver might have given to us. Because of our own dependency issues, we may tend to deny aspects of the countertransference when dealing with dependent people. Be careful to monitor feelings of disdain or contempt for the person's clinging behaviour. On the other hand, the impulse to try to provide 'perfect care' may only lead to exhaustion and disappointment.





# Chapter 24

## Child and adolescent mental health

Child and adolescent mental health problems need to be understood in the context of:

- a) the child's stage of development
- b) the child's social context—family, school, peers and work.

### Developmental considerations

Failures to achieve normal developmental milestones (e.g. sphincter control, speech) or regression to an earlier developmental stage (e.g. enuresis, encopresis) are important diagnostic signs. The developmental stage will determine the way in which problems are expressed. The developmental stage also determines the appropriate interview and therapy techniques.

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### **Childhood mental health problems often present with signs of regression to an earlier developmental stage.**

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Adolescence is sometimes viewed as a period of 'normal crisis', but, in fact, most adolescents maintain good relationships with their parents through this phase. Adolescence involves significant maturational changes—the physiological changes of puberty; cognitive changes (in particular, the development of abstract thinking and a more sophisticated moral sense); psychological changes (in particular, the consolidation of the adolescent's identity); and increased social expectations towards increasing self-reliance and autonomy, preparation for a career, detachment from parents, and the development of intimate relationships.

### Social context

Children are dependent on adults—their parents, teachers, and others, including their general practitioner. It is often parents or teachers who first recognise that a child has a problem. A child's problems are influenced by and, in some cases, are reflections of family problems or problems at school. Treatments, especially in younger children, almost always involve the child's parents, family, and other authority figures such as teachers.

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### **The treatment of childhood mental health problems requires the involvement of parents, family members and other authority figures such as teachers.**

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The social world of adolescents includes the family, school, peers and work colleagues. The developmental changes may challenge both the family and the adolescent. For example, the parent who is dependent on a child will feel threatened when that child begins to develop more autonomy during adolescence. The adolescent's progress at school and the quality of his or her peer relationships are important measures of his or her adaptation. Problems in these areas constitute important aspects of the adolescent's disability and handicap.

## Epidemiology

### Children

Around seven per cent of children suffer moderate to severe mental health problems with a further 15 per cent having mild problems. The prevalence of conduct disorder is about four per cent, while that of emotional disorder is about 2.5 per cent. The prevalence of mental disorders overall is about twice as high among boys as it is amongst girls, though the prevalence of

emotional disorders may be slightly higher in girls.

Risk factors include low IQ, brain disorder (34 per cent prevalence of concurrent mental disorder), physical illness (10 per cent prevalence of mental disorders), discordant family relationships, mental disorder in either parent and lack of emotional warmth displayed towards the child by the parents.

## **Adolescents**

The prevalence of moderate to severe mental disorders among adolescents is between 15–20 per cent, about twice that found in childhood. The prevalence in boys peaks in early teens, while in girls it peaks in late teens. About half of the mental disorders are conduct disorders. Most of the rest are emotional/neurotic disorders. Psychotic disorders may present in this age group.

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### **The prevalence of mental disorders among adolescents is about twice that in children.**

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Mental disorders presenting in adolescence include both those typical of childhood (for example, enuresis, school refusal), as well as those typical of adult populations (major depression, panic disorder, schizophrenia and agoraphobia).

## **History and examination**

In general, children and adolescents will be seen together with one or both of their parents and often with their entire family (see also Chapter 5). The dynamics of the family interactions will be evident in the family interview. The problem may in fact be with another family member or in the family system, rather than the child who presents or is brought to see you. After the family interview, the child should be interviewed alone. This is especially important when treating adolescents.

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### **In assessing a child's mental health problems, interview the family, the child alone and the parents.**

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Although the psychiatric interview follows a similar format to that of the adult interview, there are some differences. In assessing the presenting complaint, it is important to note the context in which the problems occur. Specifically, problems may exist at home, at school or in both contexts. A specific learning difficulty, for example, may lead to problems at school but not at home. A child with disturbed parents may show no evidence of problems while at school.

In assessing the level of a child's disability and handicap, ask about relevant developmental tasks (i.e. school performance, relationships with peers, teachers and the family, evidence of any anti-social behaviour, and involvement in extra-curricular activities). Take a developmental history of the child (i.e. obstetric history, early milestones, school adjustment and social development).

Note important adverse events, for example serious medical procedures, hospital admissions, separations from parents, family bereavements, or frequent changes of address or school.

Assess the personalities of the parents—their ages, occupations, work histories, relationships with their parents, and their current marital and sexual adjustment.

The assessment of a child's mental state is best conducted in an age-appropriate setting. For young children, this is often best done by observing the child at play. The content of a child's inner world may be most eloquently expressed through his or her drawings. Useful projective tests include asking the child to draw pictures of a person and of the family, and asking what he or she would like if given three wishes. Assess the young person's developmental level and

language ability. Note his or her ability to separate from parents and his or her attitude to you. Transference and countertransference reactions may be stronger and less defended than those experienced between two adults.

## Specific conditions

The following sections deal with the diagnosis and treatment of some of the common child and youth mental disorders. I also discuss the assessment and management of child abuse, and advice to parents on managing a child's behaviour. See Chapter 18 for a discussion of alcohol and substance abuse, and Chapter 22 for the treatment of psychoses.

### Tic disorders

Tic disorders range in severity from transient tic disorder, through chronic motor or vocal tic disorder, to Tourette's disorder. Tics are rapid, repetitive, non-rhythmic movements of sudden onset. They may involve stereotyped movements or vocalisations. Although experienced as irresistible, they can be delayed. There are often premonitory sensations localised in the region of the tic. The location, duration, intensity, complexity and frequency of tics may vary over time. They tend to be exacerbated by stress, and attenuate during absorbing activities and sleep.

Simple motor tics include blinking, shrugging, grimacing and coughing. Complex motor tics include grooming, holding odd facial expressions, squinting, tapping, hopping, stomping or making rude gestures. Common simple vocal tics include throat clearing, grunting, sniffing, snorting or saying 'aaah'. Complex vocal tics include repeating words or phrases out of context such as, 'You bet'; repeating one's own words or phrases; repeating others' words, phrases or sentences; and swearing or using obscene language (coprolalia).

#### *Assessment and diagnosis*

The disorders described in DSM-IV are distinguished from one another by their duration, severity and the variety of tics present. Transient tic disorder is characterised by tics occurring on most days for at least four weeks, but for no longer than a year. Chronic motor or vocal tic disorder requires the presence of either motor or vocal tics, but not both, that occur regularly for at least a year. For a diagnosis of Tourette's disorder to be made, there must be both motor and vocal tics for at least a year. All require an onset before the age of 18 years.

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**The diagnosis of Tourette's disorder requires the presence of both motor and vocal tics for at least a year with an onset before the age of 18 years.**

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In addition to the diagnostic assessment of the tic disorder, one should also note the presence of any co-morbid conditions, in particular, obsessive-compulsive disorder, attention deficit hyperactivity disorder, depression and anxiety disorders. Assess the levels of symptoms in different settings, the levels of disability and handicap, the impact of the illness on family functioning and the presence of stressors that may be exacerbating the tics.

#### *Differential diagnosis*

Descriptions of tics and other abnormal movements are given in Table 24-1. Abnormal movements occur in a variety of physical illnesses (e.g. Huntington's disease, post-viral encephalitis, multiple sclerosis, cerebrovascular accident, and head injury) or in association with substance use (e.g. neuroleptics and stimulants). Tics must be differentiated from Parkinsonian side effects of neuroleptic medications (including tardive dyskinesia).

**Table 24-1: Abnormal involuntary movements**

tic – sudden, rapid, involuntary, purposeless, repeated movement of circumscribed groups of muscles

chorea – dancing, random, irregular, non-repetitive movements

dystonia – slow, twisting movements associated with periods of prolonged muscular tension

athetosis – slow, irregular writhing movements, usually affecting fingers, toes, face or neck muscles

myoclonus – brief, shock-like muscle contractions

hemiballismus – intermittent, large-amplitude, unilateral movements of the limbs

spasms – slow, stereotyped prolonged contractions of muscle group

#### *Epidemiology*

Transient tics occur commonly, with an estimated lifetime prevalence as high as 20 per cent. Tourette's disorder is rare, with a prevalence of around one per 2000. The disorders are more common in boys than girls<sup>1</sup>.

#### *Familial pattern*

A vulnerability to Tourette's disorder is transmitted by autosomal dominant pattern of inheritance with a higher penetrance in males (99 per cent) than in females (70 per cent)<sup>2</sup>. The vulnerability may be expressed in tic disorders of differing severity. There is an increased incidence of obsessive–compulsive disorder in people with Tourette's disorder.

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### **There is an increased incidence of obsessive–compulsive disorder in people with Tourette's disorder.**

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#### *Course and prognosis*

Tourette's disorder usually has an onset in middle childhood (average age around seven years). The illness is usually lifelong, but with periods of remission and exacerbation. The symptoms often lessen in severity in adolescence and adulthood. Around 40 per cent of people who have suffered Tourette's disorder for more than 10 years have symptoms of obsessive–compulsive disorder.

#### *Treatment*

##### *Education*

Educate the family and the child about the nature of the illness, its prognosis, treatment and rehabilitation. Doing so will reduce anxiety about the illness and strengthen the therapeutic alliance.

##### *Behavioural interventions*

The tics may be associated with behavioural disturbance, which will in turn lead to further distress, disability and handicap. Identify these problems and use the behavioural interventions described in the section on 'parenting advice' to manage them. Learning difficulties may exacerbate behaviour problems at school. These should be assessed and appropriate interventions introduced in the classroom. Teachers and sometimes the child's classmates may require education about the illness.

##### *Individual psychotherapy*

A chronic condition in which a person acts involuntarily, and often in ways that offend social mores, can lead to rejection and a lowering of self-esteem. This may in turn lead to oppositional,

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<sup>1</sup> Gabbard GO. *Treatment of Psychiatric Disorders*. Washington DC: American Psychiatric Press, 1995.

<sup>2</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition. Washington DC: American Psychiatric Association, 1994.

risk-taking, or overly dependent behaviour. Normal developmental steps may be delayed. These negative reactions can be dealt with in therapy using the counselling and structured problem solving techniques described in Chapter 6.

#### Family therapy

Issues addressed in family therapy include the stress of the illness on other family members, the exacerbation of pre-existing marital conflict, and the role of family stress and conflict in exacerbating symptoms (see Chapter 5).

#### Treat co-morbid conditions

These include obsessive-compulsive disorder, attention deficit hyperactivity disorder, depression, anxiety disorders and learning difficulties.

#### Pharmacological treatment

Clonidine, an alpha2-noradrenergic agonist, is used in doses up to 3 to 4 micrograms/kg/day orally to suppress tics. Doses begin at 50 micrograms a day, increasing by 50 micrograms a week. Doses should not exceed 300 micrograms per day<sup>1</sup>. A trial of at least three months is required to assess its full therapeutic effect. Side effects include sedation, dry mouth, headaches, postural hypotension and rebound hypertension on abrupt withdrawal.

Haloperidol, in doses up to 0.075 mg/kg/day orally has been used in the suppression of symptoms in Tourette's disorder. The dose should begin with 0.25–0.5mg orally and be gradually increased every one to two weeks<sup>1</sup>. It has a more rapid onset of action than clonidine, but also more disabling side effects, including extra-pyramidal symptoms, sedation, weight gain and endocrine abnormalities. Particular care must be taken to screen for the development of tardive dyskinesia (see Appendix 10).

Serotonin reuptake inhibitors are used to treat co-morbid obsessive-compulsive symptoms. The treatment of impulsivity, inattention and hyperactivity is more difficult as stimulants may worsen the tics. We recommend referral to a child psychiatrist if clonidine and haloperidol are ineffective or poorly tolerated.

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**The treatment of tic disorders involves education of the child and the family about the condition, advice to parents on how to deal with behaviour problems, counselling and structured problem solving to deal with stressors, treating co-morbid condition, and the use of medication to suppress the tics.**

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#### Pervasive developmental disorders

These disorders are characterised by severe impairments in social interaction and communication skills, and the presence of stereotyped behaviours, interests and activities. It is desirable for the general practitioner to be confident in both making and excluding the diagnosis. As a key person in the coordination of the different aspects of care, the general practitioner should also be familiar with the range of treatment and rehabilitation services available.

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**It is desirable for the general practitioner to be confident in both making and excluding the diagnosis of a pervasive developmental disorder.**

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In his initial description of autism in 1943, Kanner focused on how deficits in social interaction are sometimes accompanied by areas of unexpected competence such as rote memory<sup>2</sup>. Unfortunately, he also hypothesised that the condition was caused by abnormal patterns of

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<sup>1</sup> Victorian Drug Usage Advisory Committee. *Psychotropic Drug Guidelines*, 3rd Edition, North Melbourne, Victoria, Therapeutic Guidelines Ltd. 1995.

<sup>2</sup> Kanner L. Autistic disturbances of affective contact. *Nervous Child* 1943; 2:217-250.

family interaction. He later revised this theory, recognising that abnormal family interactions were usually an effect rather than a cause of the condition.

The disorder has, from the outset, been the subject of conflicting views and controversies that are a further source of distress for parents coming to terms with their child's chronic and disabling condition. Are sufferers in fact people of exceptional ability held captive by their illness? What are parents to make of the claims of the latest fad 'cure' (for example, through diet, avoidance of 'allergens', or 'hugging and holding')? Does aversive conditioning have any role in treatment?

It is important for the general practitioner to be aware of empirically tested interventions and to be sceptical of the dramatic claims of unproven and often expensive approaches to treatment. The condition has a life-long course. It can result in profound disability and handicap for the individual sufferer and considerable stress for family members. There is no cure. Instead, treatment aims to minimise individual suffering and disability, to promote development, and to support families in coping with their disabled family member.

#### *Assessment and diagnosis*

In Australia, the diagnosis of a pervasive developmental disorder is usually made by a child psychiatrist or a paediatrician. The complete assessment is multi-disciplinary. A paediatrician will perform a physical examination and arrange appropriate investigations, including a search for Fragile-X chromosome and an audiological assessment. Cognitive function will be assessed by a psychologist using an instrument such as the WAIS-R 4<sup>th</sup> edition. A speech pathologist will assess communication ability. An occupational therapist or physiotherapist will evaluate sensory and motor integration.

Using the DSM-IV criteria, the most serious disorder, autistic disorder, requires symptoms from each of the following three categories<sup>1</sup>:

1. Impairment in social interaction  
There may be limited nonverbal behaviours; a failure to make friends; no interest in sharing activities with others; and a lack of reciprocity in social interactions.
2. Impaired communication  
There may be a delay in, or a total lack of development of spoken language; an inability to initiate or sustain a conversation with others; stereotyped and repetitive use of language; or a lack of age appropriate spontaneous make-believe or social imitative play.
3. Restricted repetitive and stereotyped patterns of behaviour, interests, and activities  
These include a preoccupation with one or more restricted patterns of interest; inflexible adherence to specific, non-functional routines or rituals; motor mannerisms; and a preoccupation with parts of objects. Some examples of these impairments, and some commonly associated features, are listed in Table 24-2.

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**The diagnosis of autistic disorder requires symptoms of impaired social interaction, impaired communication, and the presence of restricted repetitive and stereotyped patterns of behaviour, interests, and activities.**

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In contrast to autistic disorder, language development is not delayed in Asperger's disorder (i.e. single words are used by the age of two years, and the child communicates in phrases by age three). Nor are there significant delays in cognitive development, or in the development of age-appropriate self-help skills, adaptive behaviour (other than in social interaction), and curiosity about the environment<sup>1</sup>. However, despite having normal language development, the higher-

<sup>1</sup>American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4<sup>th</sup> Ed. Washington DC: American Psychiatric Association, 1994.

<sup>2</sup>ibid.

**Table 24-2: Signs of pervasive developmental disorders**

*Impaired social interaction*

- when spoken to, does not smile, look you in the eye, or use appropriate facial and other nonverbal gestures
- has no friends at school
- shows no interest in sharing activities or interests by, e.g. bringing, showing or pointing to objects of interest
- prefers solitary activities to social play or games
- unaware of the needs of others and does not notice another's distress

*Impaired communication*

- unable to use spoken language
- if speech is present, a marked inability to hold a conversation
- stereotyped repetitive phrases, e.g. repeating jingles
- inability to understand abstract language including jokes
- lack of imaginative play such as dressing up or playing make-believe

*Stereotyped behaviours interests and activities*

- preoccupation with one area of interest, e.g. cricket statistics or the weather
- requires that objects always be in exactly the same place in the home
- resists changes in the home environment. e.g. a new piece of furniture
- rigid adherence to routines, e.g. always taking exactly the same route to school
- stereotyped rocking or clapping
- adopting odd body postures
- fascination with spinning objects, e.g. tops, wheels of toys or fans
- attachment to an inanimate object. e.g. piece of string

*Associated features*

- mental retardation
- uneven profile of cognitive skills on neuropsychological testing
- hyperactivity, inattention, impulsivity, aggressiveness, temper tantrums
- self-harming behaviours, e.g. head banging and hand biting
- exaggerated response to sensory stimuli, e.g. sensitivity to being touched
- odd eating patterns, e.g. limited diet
- odd sleeping patterns, e.g. waking at night rocking
- abnormal affective responses e.g. laughing or crying for no apparent reason

level communication skills of these children are usually impaired, i.e. understanding metaphor and humour and the ability to modulate tone of voice appropriately.

*Differential diagnosis*

In contrast to autism, schizophrenia usually develops after a period of normal development and requires the presence of specific psychotic symptoms. In selective mutism, the communication difficulties are restricted to specific situations. Children with language disorders lack the impairments in social interaction and do not exhibit the repetitive stereotyped behaviours of pervasive developmental disorders. An additional diagnosis of autism is only made in children with mental retardation if the specific deficits in communication and social interaction and specific stereotyped behaviours are present.

*Co-morbidity*

Around 75 per cent of autistic children suffer mental retardation. By age 20, approximately one third have suffered an epileptic seizure.



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**Around 75 per cent of children with autism suffer mental retardation.**

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*Epidemiology*

The prevalence of autistic disorder is estimated to be around 2–5 per 10,000. Some Australian studies suggest that the prevalence may be as high as 10 per 10,000<sup>1</sup>. Males are affected four times as frequently as females.

*Familial pattern*

There is an increased risk among the siblings of those with autism.

*Course*

The DSM-IV criteria for autism require an onset before the age of three years. The illness follows a continuous course. Some gains in social skills may be made during school years. Higher IQ is predictive of better functioning. Few people with autism are able to live and work independently as adults, but some partial independence is achieved in about a third of cases.

*Treatment*

The aims of treatment are to minimise symptoms, to promote the development of the child, and to provide support to families and carers. While pharmacological treatments are of use in reducing unwanted behaviours, the main interventions are rehabilitative. Parents and teachers need to be involved in treatment. The general practitioner is often responsible for coordinating the care for these individuals. It is essential to educate parents and other professionals working with children with pervasive developmental disorders about the characteristics of the disorder, its diagnosis, prognosis and possible interventions.

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**General practitioners are well placed to coordinate the care of individuals with pervasive developmental disorders.**

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*Education*

The education of children with a pervasive development disorder focuses on the acquisition of daily living skills, with special emphasis on improving the primary deficits in communication and social skills. Where possible, teaching is incorporated into naturally occurring activities. Within the classroom, autistic children often respond better to visual images than to words.

*Communication therapy*

Following an assessment of how, what and with whom the child presently communicates, therapy seeks to extend the child's ability to communicate with others. Initially, nonverbal communication by use of gestures and objects may be used. Pictures and other visual representations may be used to introduce the spoken and written word. The use of facilitated communication in which a person assists the child in pointing to letters on a board is controversial. It has been repeatedly shown to reflect communication of the facilitator rather than the child. In some cases, parents have been accused, though never convicted, of child sexual abuse on the basis of facilitated communication.

*Behaviour therapy*

The behaviour therapies outlined in the section on 'parental advice' are used in managing some of the difficult behaviours exhibited by these children. Parents need to be aware of the limited capabilities of these children, especially those who also suffer mental retardation. In addition, there is also a place for the use of aversive procedures for the management of self-destructive behaviours.

*Pharmacological therapy*

A balance must be achieved between symptom reduction and the adverse side effects of medication, especially sedation. It is therefore essential, prior to commencing treatment, to

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<sup>1</sup> Tonge BJ, Brereton AV. Australia. In: Cohen DJ, Volkmar FR, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 2<sup>nd</sup> Ed. New York: John Wiley, 1997: 951–956.



carefully monitor baseline behaviours and set specific targets for symptom reduction, and to review the efficacy of treatment on this basis. Parents, teachers and other adults involved in the child's care should be consulted in setting the goals of treatment and in assessing its outcomes.

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**When prescribing medication, a balance must be sought between symptom reduction and the adverse effects of medication.**

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Until recently, the most commonly used drug was haloperidol, which is effective in reducing stereotypies, hyperactivity, distractibility and aggressive behaviour. Recommended doses begin with 0.25–0.5mg orally per day, increasing if necessary up to 0.05mg/kg/day orally<sup>1</sup>. Side effects include sedation, acute dystonia and dyskinesias. On cessation of the medication, dyskinetic symptoms have been reported to disappear in between a week and eight months. Because of its more favourable side effect profile, risperidone is now used more often.

Other agents that have been used include fenfluramine, naltrexone, tricyclic antidepressants, beta blockers, clonidine, buspirone and SSRIs. I recommend referral to a child psychiatrist for advice on prescribing these.

#### *Social skills training*

The aim of social skills training is to make children with pervasive development disorders more aware of the needs of others, to teach them to play, and to increase their interest in social interaction. Training groups often involve the participation of other children in shared, pleasurable activities that do not require complex communication. Programs also aim to improve communication skills in social situations.

#### *Individual therapy*

Because of the communication problems, it is difficult to form a therapeutic alliance with people with pervasive development disorders. However, for those with adequate language skills, attempts should be made to understand the interests and views of the child. A balance is sought between acknowledgment and validation of the child's perspective, and helping him or her to meet the demands of the environment. A goal of therapy is to help children gain an understanding of their disability, how they differ from other disabled children, and how they can gain assistance. The techniques of supportive psychotherapy are generally applicable (see Chapter 8). The principles of counselling and structured problem solving described in Chapter 6 can be used to help the sufferer deal with the stressors of everyday life. In particular, you may need to explain the consequences of intended actions that the sufferer has not anticipated.

#### *Family issues*

Having an autistic child in the family is stressful to parents and other family members. Moreover, parents are often confused by conflicting advice over diagnosis, prognosis and treatment, in particular over claims of the latest fads in treatment. They may be puzzled by the uneven development of the child across different skill areas. For example, the child may have normal visio-spatial and motor skills, but deficits in language and social interaction. They may be uncertain whether a child's behaviour problems represent oppositional behaviour or an inability to understand what should be done. Unlike children with other disabilities, the autistic child's normal appearance often belies his or her disabilities. Parents may be embarrassed by difficult behaviours in public.

The key interventions are education about the illness and about child development. Parents may benefit from learning the behavioural approaches described in the section on 'advice on parenting'. Teach structured problem solving to help parents deal with the stress of having a disabled child, and with intercurrent stressors. Refer parents to relevant community organisations that offer support, advice, assessment, treatment and respite.

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<sup>1</sup> Victorian Drug Usage Advisory Committee. *Psychotropic Drug Guidelines, 3rd Edition*, North Melbourne, Victoria, Therapeutic Guidelines Ltd. 1995.

#### *Non-government organisations*

Autistic associations in each state provide education, therapy, support and training services to people with autism, autism spectrum disorder (ASD) and Asperger's syndrome, and to their families and others involved in their care.

#### *Employment*

The majority of sufferers will not find work in open employment. Supported employment options include sheltered workshops, and situations in which a supervisor accompanies one or a small number of clients to the workplace.

#### *Residential options*

Most children with a PDD live with their parents. In Queensland, respite services are available through the Intellectual Disability Services and the Autistic Association Queensland.

### **Anorexia nervosa**

The diagnosis of anorexia nervosa is made on the basis of a refusal to maintain normal weight (more than 15 per cent below that expected); fear of gaining weight or weight phobia; disturbance of body image (i.e. perceiving one's emaciated body as fat); and amenorrhoea.

The DSM-IV recognises two types of the disorder. In the binge eating type, the sufferer regularly engages in binge-eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics or enemas). In the restricting subtype, weight loss is accomplished through dieting, fasting or excessive exercise.

#### *Differential diagnosis*

Unlike those with anorexia nervosa, people with bulimia nervosa are able to maintain their weight at or above normal levels. It is important to exclude physical conditions that can cause weight loss, including cancer and brain tumours. Depressed young people may suffer weight loss as a result of poor appetite, but they do not have the specific body image disturbance and fear of obesity characteristic of the person with anorexia. Appetite is usually only decreased in anorexia when there is severe weight loss. The agitation of the depressed person may be confused with the over-activity of the person with anorexia nervosa.

#### *Epidemiology*

The disorder predominantly affects females among whom the prevalence is around one per cent. Anorexia nervosa is rare in boys and is associated with a poor prognosis. While the prevalence among females appears to have been falling over recent years, the prevalence in young men may be rising. Although the condition of anorexia nervosa is rare, dieting among adolescent girls is very common. The peak age of onset for anorexia nervosa is between 15 and 17 years. The diagnosis is rarely made before puberty.

#### *Family pattern*

There is an increased incidence of anorexia nervosa and mood disorders among first-degree relatives.

#### *Complications*

The disorder may be complicated by depression. Cognitive changes produced by starvation include a preoccupation with food, and a concrete, black and white style of thinking. Those who have a pattern of purging and binge eating may exhibit other impulse control problems such as substance abuse. They are especially prone to suffering mood disorders.

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**Cognitive changes produced by starvation include a preoccupation with food and a concrete, black and white style of thinking.**

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Physical complications include amenorrhoea, electrolyte abnormalities, anaemia, bradycardia and other arrhythmias, cold intolerance, hypotension, hypothermia, the development of lanugo hair,

and osteoporosis. Complications of purging include loss of dental enamel, calluses on the hands and parotid enlargement. Persistent laxative abuse can lead to constipation and megacolon.

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**Physical complications of purging include electrolyte abnormalities, cardiac dysrhythmias, loss of dental enamel, calluses on the hands and parotid enlargement.**

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#### *Prognosis*

About 40 per cent of people recover fully, another 40 per cent recover to some degree, and the remaining 20 per cent follow a chronic course. The long-term mortality rate in patients admitted to university hospitals in the USA is over 10 per cent. Poor prognostic indicators include chronicity, older age at onset, very low weight, the presence of bulimia and vomiting, and poor childhood adjustment.

#### *Formulation*

A comprehensive bio-psychosocial formulation is required for each individual.

#### *Biological factors*

Evidence from family and twin studies demonstrates some genetic predisposition to the condition. The effects of starvation itself may perpetuate some of the behaviours typical of the condition.

#### *Psychological factors*

A pervasive sense of powerlessness coupled to an intense desire to exert control is an important psychological characteristic of the condition. The strict adherence to a diet can be seen as a way of maintaining control at a time when the girl is facing the many changes and demands of adolescence. The dieting itself may cause amenorrhoea and arrest physical development. Starvation tends to accentuate a rather rigid, black and white, concrete cognitive style. Paradoxically, the starvation also causes a compulsive preoccupation with food, calorie counting, and cooking.

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**The anorexic girl's strict adherence to a diet can be seen as a way of maintaining control at a time when she is facing the many changes and demands of adolescence.**

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#### *Social factors*

Social factors in the aetiology of anorexia nervosa include societal expectations that young women should be thin. The families of some young people with anorexia are characterised by patterns of over-involvement, rigidity, a diminished expression of affect, a lack of conflict resolution and a high emphasis placed on achievement. However, it is often unclear whether these are a cause or effect of the illness. Food is often an important means of communication within these families, and it becomes the vehicle for the girl's rebellion and the means through which she seeks to establish a sense of autonomy from the family. There is an increased incidence of eating disorder, affective disorder and alcoholism in the families of women with anorexia.

#### *Treatment*

In many cases, treatment can be managed on an outpatient basis. Following are some principles of treatment:

1. setting a target weight—for example, ideal body weight or BMI of 20–25 (see Table 24–3)
2. forming a therapeutic alliance and reaching an agreement with the girl to increase weight by one kg/per week until ideal body weight is reached
3. coordination with a dietician who can advise on a diet that will produce a steady weight gain
4. as weight is gained, dealing, in individual therapy with psychological and social issues that

- come to the fore, including adolescent conflicts over identity, autonomy and sexuality
5. family therapy to address issues of separation and autonomy, dealing with adverse emotional reactions (guilt, shame and anger), counselling and structured problem solving to address conflicts and other stressors within the family
  6. indications for inpatient care include:
    - rapid weight loss
    - extreme weight loss (hospital admission is advised if weight falls below a BMI of 16)
    - electrolyte disturbance, especially in the person who has concurrent bulimia and vomiting (death may result from hypokalemia)
    - severe depression with suicidal intent.

#### **Table 24-3: Calculation of Body Mass Index (BMI)**

Body Mass Index is calculated using the formula:  $\text{weight in kilograms} / [\text{height in meters}]^2$   
 For adults, a healthy BMI is between 20 and 25. For adolescents, it is a little lower, between 18.5 and 25.

A BMI less than 16 is an indication for hospitalization.

### **Bulimia nervosa**

The disorder is characterised by episodes of binge eating and compensatory behaviour to prevent weight gain. A binge is an episode in which a large amount of food is consumed in a short period of time, accompanied by a sense of loss of control. Compensatory behaviours include self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting; and excessive exercise. The person's self-esteem is strongly influenced by her evaluation of her body shape and weight.

#### *Differential diagnosis*

The disorder needs to be distinguished from neurological disorders (including epilepsy and CNS tumour) and schizophrenia. Unlike those with anorexia nervosa, people with bulimia nervosa are usually within the normal weight range or slightly overweight. Whereas those with anorexia nervosa of the restricting type tend to be excessively controlled and rigid in their behaviour, people with bulimia often have difficulty controlling their impulses. In addition to bingeing, this lack of control may be manifest in substance abuse, promiscuity and self-harming. Between 30 and 50 per cent of sufferers have features of personality dysfunction, most commonly, borderline personality disorder.

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**Whereas people with anorexia nervosa (restricting type) tend to be excessively controlled and rigid in their behaviour, those with bulimia often have difficulty controlling their impulses.**

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#### *Epidemiology*

Bulimia is a disorder of Western industrialised countries. Ninety per cent of sufferers are female. The prevalence among adolescent girls and young women is between one and three per cent.

#### *Course*

The disorder usually begins in late adolescence or early adulthood. It often persists with intermittent exacerbations and remissions occurring over a number of years.

#### *Complications*

The disorder is associated with depression, personality disorder, anxiety disorders and substance abuse.

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**Mental disorders commonly associated with bulimia include depression, personality disorder, anxiety disorder and substance abuse.**

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Medical complications include loss of dental enamel and parotid enlargement due to self-induced vomiting. Menstrual irregularities may occur. Fluid and electrolyte disturbances may be complicated by cardiac arrhythmias. Rare complications include oesophageal tears and gastric rupture.

*Family pattern*

There is an increased incidence of bulimia nervosa, mood disorders and substance abuse in the relatives of people with bulimia nervosa.

*Treatment*

- Therapeutic alliance  
Building a therapeutic alliance is often difficult. Sufferers are often secretive about their bingeing and ambivalent about abandoning their symptoms. Alternatively, they may have unrealistic expectations of rapid cure.
- Monitor for complications  
Check for the physical complications. In particular, serum electrolytes should be monitored in the young woman who is purging.

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**Serum electrolytes should be monitored in patients who purge.**

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- Education  
Explain to the young person the nature of the illness, its prevalence and theories of its cause; how starvation may in turn lead to bingeing and depressed mood; and the potential physical and psychological complications of the disorder. People also need clear nutritional advice.
- Goal setting  
The person needs advice on setting realistic goals. The aim of therapy is not to lose weight, but to stop bingeing, to understand the reasons for the behaviour, and to find more adaptive solutions to his or her problems.
- Stabilise eating  
The person should be advised not to restrict intake, but to eat three normal meals a day. Advice may be sought from a dietician.
- Individual psychotherapy  
Explain the impact of stress on symptoms. Ask her to make a diary to document the relationship between stressful events and bingeing. Use structured problem solving to deal with current stressors.

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**Use counselling and structured problem solving to identify and cope with current stressors.**

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Use cognitive behavioural techniques to correct cognitive distortions. These commonly include black and white thinking, such as 'All sweet food is bad. Therefore, I can only eat low-calorie food'; over-emphasising the negative, 'I have put on one kilogram so I might as well give up' or 'I have eaten a cake. Therefore I have no control'; magical thinking, 'Anything sweet goes straight to fat'; or mind reading, 'He doesn't speak to me. Therefore, he must think I am too fat' (see also Chapter 10).

Typical underlying assumptions include the belief that one must be approved of by others to be a good person, and more specifically, that others must approve of one's body shape and weight. In challenging these assumptions, it is important to recognise the fact that many people in our society do place a high value on people being slim. The approach should be to challenge the

validity of these attitudes and to help the individual accept that one does not have to be perfect and thin in order to be a good person.

Some patients may need to deal with issues of past sexual abuse (see also Chapter 21).

- **Family therapy**  
Educate the family about the nature of the disorder and use the principles of counselling and structured problem solving to help the family deal with precipitating stressors. However, remember that adolescents will also need individual therapy, separate from their families.
- **Behavioural approaches**  
Ask the person to identify the cues to binge eating and help them find alternative responses. These might include avoidance (e.g. planning social activities to avoid long periods alone, taking another route home to avoid passing the delicatessen) or distraction (e.g. going for a walk, listening to music, performing a relaxation exercise). The principles of exposure and response prevention are also applicable (e.g. eating sweet foods without bingeing).
- **Medication**  
Antidepressants, especially SSRIs, may be of benefit, particularly if the person suffers co-morbid depression. Do not prescribe tricyclic antidepressants to this group.

Indications for specialist referral include:

- failure of the above treatments
- severe family psychopathology
- severe co-morbid disorders such as depression, substance abuse, borderline personality disorder
- medical complications of the disorder
- a history of past sexual abuse.

Indications for hospitalisation include:

- BMI below 16
- chaotic eating and uncontrollable vomiting
- electrolyte disturbance
- hematemesis
- emaciation
- severe depression
- suicidality.

### **Attention-deficit/hyperactivity disorder (ADHD)**

The topic is controversial. Is it a medical disorder or is it merely a collection of difficult behaviours that are 'labelled' a disorder? Is there a qualitative difference between children with the disorder and those without it, or is it merely a matter of degree? If it is just a matter of degree, where do we draw the line? Should we be treating children with amphetamines? Why is the reported prevalence of the condition so varied (between 0.1 per cent and 20 per cent)? Why do most prescriptions for Ritalin originate from a small number of medical practitioners?

#### *Diagnosis*

The diagnosis is based on persistent patterns of inattention, hyperactivity and impulsivity with some symptoms presenting before the age of seven and causing significant disability and handicap in at least two settings (e.g. school and home). Symptoms of inattention include inattention to details, difficulty sustaining attention, not listening when spoken to, failing to follow through on instructions, difficulty organising tasks (especially tasks requiring sustained mental effort), losing things, being easily distracted and being forgetful. Symptoms of hyperactivity include fidgeting, inability to remain seated, running and climbing in inappropriate situations, noisiness,

being always on the go, and talking excessively. Signs of impulsivity include blurting out answers to questions, difficulty waiting turn, and constantly interrupting. For the diagnosis to be made, these symptoms need not merely to be present, but to be present often. Associated features include low self-esteem, labile mood, temper tantrums, academic underachievement, and accident proneness.

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**The diagnosis of ADHD requires persistent patterns of inattention, hyperactivity and impulsivity with some symptoms presenting before age seven.**

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There are no specific laboratory findings. The positive and negative predictive values of various complex and expensive tests are too low to be useful. There are no specific findings on physical examination.

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**There are no reliable laboratory tests for ADHD.**

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*Differential diagnosis*

It is important to distinguish the symptoms of ADHD from age appropriate behaviours in active children. Bright children placed in academically unstimulating environments may exhibit behaviours similar to those with ADHD. Similarly, children from stressful, disorganised or chaotic environments may manifest similar symptoms. It is important to make this distinction, because the treatment will be very different. Treatment of ADHD may involve the prescription of methylphenidate, which would be quite inappropriate in the case of children with what are primarily psychosocial problems. However, in some cases, both problems may coexist. The onset of depression and anxiety disorders is usually after the age of seven years. See also the diagnoses of conduct disorder and oppositional defiant disorder on the following pages.

*Epidemiology*

The disorder is more commonly diagnosed in boys. The male to female ratio is between 4:1 and 9:1. It has been estimated that between 0.1 and 5.0 per cent of school age children suffer from the disorder.

*Familial pattern*

In the families of children with ADHD there is an increased prevalence of ADHD, mood and anxiety disorders, learning disorders, substance related disorders and anti-social personality disorder.

*Prognosis*

The course of the disorder is variable. In some cases, the hyperactivity remits, while the inattention tends to persist. In most cases, the symptoms attenuate during late adolescence, but in some cases, the symptoms persist into early adulthood. The disorder is associated with learning difficulties and with the later development of anti-social personality disorder and mood disorders.

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**It is important to distinguish between the symptoms of ADHD and age appropriate behaviours in active children, or in children under stress.**

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*Treatment*

Non-pharmacological interventions include parenting advice (see pp 259–264), behavioural interventions (see Chapter 9), family assessment, support and counselling (see Chapter 5), problem solving (see Chapter 6), and the provision of practical advice such as the availability of respite. The roles of the general practitioner include making a thorough biopsychosocial assessment of the presenting problems, referring likely cases for specialist assessment, and coordinating the different professionals involved.

The assessment and treatment of ADHD is usually multi-disciplinary with a child psychiatrist or paediatrician confirming the diagnosis and advising on the use of medication. A psychologist



will often perform a neuro-psychological assessment, provide baseline measurement of target symptoms, and formulate a behaviour program. Audiometry, dietary advice and family therapy may be indicated. It is essential to liaise closely with the child's teacher and to provide clear written instructions if medication is to be dispensed at school.

Biological treatments include methylphenidate (Ritalin) at a dose of between 0.3mg and 0.8mg/kg/day, or dexamphetamine 0.15–0.4 mg/kg/day, in divided doses, in the morning and at midday. The duration of effect is around four hours, but with considerable individual variation<sup>1</sup>. Side effects include abdominal discomfort, decreased appetite, insomnia, headache, irritability, depressed mood, a delay in the height and weight spurt at puberty, and the risk of amphetamine abuse. There may be a rebound of symptoms as the medication starts to wear off in the evening. Stimulants may worsen tics. Drug holidays may be advisable over weekends or during school holidays. A trial without medication during the school term is advisable after 6–12 months of therapy.

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**Methylphenidate is prescribed in doses of 0.3–0.8 mg/kg/day, in divided doses, in the morning and at midday. Doses of dexamphetamine are between 0.15 and 0.4 mg/kg/day.**

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Tricyclics and clonidine are sometimes used in the treatment of ADHD. I recommend seeking specialist advice before prescribing these.

If medication is prescribed, it is advisable to document outcome using an instrument such as the ADHD Rating Scale administered before and after a trial of treatment<sup>2</sup>. One of the child's parents and a teacher are asked to complete the rating, indicating the frequency of each symptom on the Likert scale by selecting the single item that best describes the child.

## Conduct disorder

The diagnosis of conduct disorder is made on the basis of a pattern of behaviours that violate the norms of our society and the rights of others. Such behaviours include aggression to people and animals, destruction of property, deceitfulness and stealing, and other serious violations of the rules. These behaviours cause significant handicap at school, at work and in personal relationships.

### *Differential diagnosis*

The behaviours are more serious than in oppositional defiant disorder and include those that infringe the rights of others, aggression towards people and animals, property destruction, theft and deceit. The recent onset of antisocial behaviour in a previously well-behaved child raises the possibility of depression, mania or substance abuse.

### *Aetiology and associated conditions*

Antisocial behaviour tends to run in families. Associated conditions include criminality, alcoholism (especially in fathers) and somatisation (especially in mothers). Social factors in the aetiology of conduct disorder include parental discord and antisocial behaviour in parents. Psychological factors include deficits in the capacity to experience guilt or remorse; a failure to see rules as important; an inability to understand the consequences of one's actions, including their impact on others; and a lack of mutuality and reciprocity in relationships. Developmental problems are often evident, especially in more severe cases. Low IQ and impaired attention, concentration, memory and abstraction may be found. These may in turn be the result of an injury sustained during a violent and chaotic upbringing.

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<sup>1</sup> Victorian Drug Usage Advisory Committee. *Psychotropic Drug Guidelines*, 3rd Edition, North Melbourne, Victoria, Therapeutic Guidelines Ltd. 1995.

<sup>2</sup> See Appendix 13.



### *Epidemiology*

The disorder is present in between four and 10 per cent of children and adolescents. The rate is twice as high in boys than in girls.

### *Prognosis*

The prognosis is fair to poor. It is the most stable of childhood diagnoses over time. The disorder may progress to antisocial personality disorder in adulthood. The death rates for conduct-disordered youths are about 50 times those for normal youths. Deaths occur through accidents, suicide, homicide (especially in the US) and drug overdose.

### *Assessment*

In addition to an assessment of the child's difficult behaviours, it is important to note his or her social strengths, as these form the basis upon which progress can be made. Family issues are important. Are the problematic behaviours modelled on those of other family members? How do families respond to antisocial behaviours? What is the state of the parents' marriage? Are the parents united in their approach to dealing with the problems?

### *Treatment*

As a group, these are probably the most difficult conditions in child and adolescent psychiatry to treat. The children rarely present themselves for treatment, but rather are brought to see you at the insistence of schoolteachers, community agencies, the courts or parents. Transference issues arise quickly, particularly in those who feel most helpless. These young people may act out in the consultation by manipulation, stonewalling or even by making threats.

### *Psychosocial Treatments*

Only children with the milder forms of conduct disorder respond favourably to outpatient counselling. For the more severe cases, behavioural programs with firm limits and predictable consequences for misdeeds are required.

Caregivers must be able to cooperate with the behavioural program. Advise them to change coercive and inconsistent methods of discipline. Encourage them to set rules, negotiate compromises, and offer concrete rewards for behaviours that help others. Family sessions may be used to clarify patterns of communication, to help family members recognise certain behaviours, and to teach problem solving (see also section on 'advice on parenting', pp 259–264).

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### **Enlist the support of parents in programs that aim to improve a child's behaviour.**

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In the countertransference, it is wise to avoid over-reacting to the child's problematic behaviours. It is the child who must learn self-control. Focus on concrete issues, using counselling and structured problem solving. While psychodynamics may help you understand the problems, the interpretation of defences and other techniques of psychodynamic psychotherapy are generally not useful. Give parents clear advice and support.

### *Drug treatments*

The prescription of drugs in this group is fraught with difficulties. Drugs may be hoarded, sold or taken in overdose. It is probably best to seek specialist advice before prescribing any drugs to these young people.

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### **Drugs prescribed to adolescents with conduct disorders may be hoarded, sold, abused or taken in overdose.**

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## **Oppositional defiant disorder**

This disorder is characterised by a persistent pattern of negativistic, disobedient, hostile and defiant behaviour towards parents, teachers and other authority figures. The child often loses

his or her temper, argues with adults, defies adult's requests, deliberately annoys people, blames others for his or her mistakes, is easily annoyed by others, and is often angry, resentful, spiteful and vindictive. Associated features include irritability and mood disorder, low self-esteem, low frustration tolerance and the precocious use of substances.

#### *Differential diagnosis*

Some oppositional behaviour is a normal part of the development of a child's autonomy. It is only pathological if it is frequent, severe, and causes significant disability and handicap. The behaviours are not as severe as those found in conduct disorder. Unlike conduct disorder, the syndrome does not usually include aggression to people and animals, property destruction or a pattern of theft and deceit. The onset of oppositional behaviours in children and adolescents who have had no previous behaviour problems raises the possibility of depression, anxiety disorders, psychotic disorders or substance abuse.

#### *Epidemiology*

The prevalence has been estimated to be between 2 per cent and 16 per cent<sup>1</sup>. The disorder is more prevalent in boys before puberty, but the rates are thought to be equal in young men and women after puberty.

#### *Familial pattern*

In the families of children with the disorder, there are increased rates of depression, antisocial personality disorder and substance abuse. Parents may have a history of conduct disorder, ADHD or oppositional defiant disorder. The disorder is more common in families with marital discord.<sup>2</sup>

#### *Course and prognosis*

The symptoms usually appear before the age of eight years. The oppositional symptoms are almost always evident at home, but may also appear at school and in other situations. It may develop into conduct disorder.

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**Unlike conduct disorder, the syndrome of oppositional defiant disorder does not usually include aggression to people and animals, property destruction, stealing or other serious illegal activities.**

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#### *Treatment*

Parents are offered advice on managing the difficult behaviours (see Parenting Advice, pp 259–264). In individual therapy, children can express their autonomy in a non-controlling environment. The therapist can also diagnose and treat co-morbid depression, low self-esteem, substance abuse or psychosis.

### **Depression and suicide**

The problem of adolescent depression has been neglected in the past, in part because of an adherence to the ideological belief that children could not suffer major depression owing to the supposed immaturity of their superego development. The falsity of this belief is emphasised by the recent alarming increase in the rate of adolescent suicide.

#### *Epidemiology*

The prevalence of depression in 10-year-olds presenting to GPs is around two per cent. Among young people referred to psychiatrists, five per cent of pre-pubertal children and 15–30 per cent of adolescents suffer from depression. Suicide is the leading cause of death for people under the age of thirty. The Australian Bureau of Statistics (ABS) reports that the rate for 15 to 24 year-old males has tripled since 1960, whilst the same trend has not been observed in the equivalent

<sup>1</sup> American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition. Washington DC: American Psychiatric Association, 1994.

<sup>2</sup> *ibid.*

female cohort. Australia has the highest rate of suicide in young people in the world. For 15 to 24 year olds, the rate is 16.4 per 100,000 per year. Queensland's adolescent suicide rate is two per cent above the national average (18.4/100,000).

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**Suicide is currently the leading cause of death in males between the ages of 15 and 24 years.**

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Adolescent males living in rural areas have a higher suicide rate than do the corresponding urban cohort. Moreover, these rates are increasing. In 1986 the rate of suicide among young males from rural areas was 24/100,000. By 1992 the rate had reached 36/100,000. The corresponding urban rates in 1986 and 1992 were 21/100,000 and 26/100,000 respectively. The reverse trend applies for females, with figures for urban areas being slightly higher (5/100,000) than for rural areas (4/100,000).

*Assessment and diagnosis*

Depressed children and adolescents present with somewhat different symptoms and signs than do depressed adults. Children may have difficulty describing their mood and present instead with somatic symptoms. Their parents may bring them to see you because of behavioural problems—aggression, withdrawal, deterioration in school performance, disruption of peer relationships or school refusal. The predominant mood may be irritability rather than depression. Anger, often directed at parents, may be a feature.

Determine whether there has been any loss of interest or pleasure in their usual activities (anhedonia). Begin by asking about their hobbies and interests, and then assess whether there has been any recent change in their participation in these activities. Ask when they last did something they really enjoyed.

Poor concentration may lead to deterioration in school performance. Assess the level of hopelessness by asking about plans for the future. Listen for statements that 'no one can help' or 'nothing can help' and other evidence of helplessness. Ask about neurovegetative symptoms—insomnia, poor appetite, weight loss, diurnal mood variation and low energy levels. Observe any psychomotor retardation or agitation. Depressed young people frequently suffer co-morbid anxiety symptoms, including panic attacks, obsessions and compulsions. Rarely, there may be psychotic symptoms (e.g. hallucinations or delusions). Ask a depressed young (man) about any ideas he has of suicide or self-harm, but be prepared to follow up with a discussion of alternative ways of problem solving (see following ).

The commonest diagnosis, especially in children between 8 and 11 years old, is dysthymic disorder, rather than major depression. This syndrome is characterised by depressed or irritable mood on most days of the week over a period of at least one year. While the symptoms may not be as severe as in major depression, the level of disability and handicap, manifest by poor school performance and problems with peers and family, is often high. It is often associated with a low self-esteem and a perception of being unloved by parents, siblings, peers, teachers and others in the social environment. It may be complicated by the development of major depression in adolescence.

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**In children between the ages of 8 and 11 years, the commonest depressive syndrome is dysthymic disorder, characterised by chronic depressed or irritable mood, low self-esteem and a perception of being unloved.**

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*Differential diagnosis*

Physical disorders and substances that can cause depression are listed in Tables 17-5 and 17-7. As mentioned above, anxiety symptoms often occur in depressive disorders. It is important to distinguish the agitation of depression from the restlessness of ADHD. The first onset of symptoms in a child who previously had no behaviour problems is unlikely to be due to ADHD.

In older children and adolescents, consider the diagnosis of a psychotic disorder.

#### *Formulation*

Biological factors that should be considered in the formulation of a young person with depression include underlying physical illness or substance abuse, and a family history of affective disorder (especially bipolar disorder). Psychological factors to consider include any past history of depression, substance abuse, conduct disorder or self-harm. Social factors include family, school or relationship problems. Parental separation and divorce, mental illness in a parent (especially alcoholism, depression and suicide), and physical, emotional or sexual abuse is associated with the development of depression in young people. Children with dysthymic disorder often perceive that they are unloved.

#### *Treatment*

- This will depend on the individual formulation. The first step is to form an effective therapeutic alliance with the young person and the family.
- Educating the child and the family about depression, its symptoms, causes, prognosis and treatment will often, in itself, provide some relief. It will also improve adherence to treatment and follow-up.
- Deal with any family problems that are uncovered in the assessment. This might, for example, include the treatment of a depressed parent.
- Use the psychological therapies described in Chapters 6–12. In treating young people, you will have to see the individual alone and together with the rest of the family. Cognitive behavioural treatment is effective in the treatment of mild to moderate depression, including dysthymic disorder.
- Aim to minimise the disability and handicap associated with the depression. For example, if school refusal is a feature, insist on a return to school. It may be necessary to enlist the support of parents and teachers to ensure that this occurs.

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#### **If school refusal is a feature, insist on a return to school.**

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- I recommend the use of an SSRI in the treatment of major depression in adolescents at the usual adult doses. Tricyclics can cause sudden death and may be lethal in overdose.
- Arrange for referral to a specialist child psychiatrist or mental health service if there is poor response to treatment, if the child has serious suicidal intent, if there is serious family disturbance, or if the depression is severe—for example, with psychotic symptoms.

#### *Assessment of suicidality (see also Chapter 3)*

In assessing a young person's suicide risk, take into account the following population risk factors. Young men commit suicide at a rate around four times that of young women. Suicide rates in young people increase with age—suicide is a very rare event in pre-pubertal children. Family factors that are associated with increased risk include broken homes, early loss of a parent, mental illness in a parent (especially alcoholism, depression and suicide), and physical, emotional or sexual abuse. Associated diagnoses in the young person include depression, conduct disorder and substance abuse. Four per cent of those who deliberately self-harm go on to complete suicide within the next two years.

Ask about a young person's suicidal intent. Recent research shows that discussing the option of suicide may influence a depressed child or adolescent to act upon it. His or her problem solving capacity may be so severely impaired that any suggested solution may be adopted. Therefore, you should be prepared to follow up any inquiry about suicide with a discussion of alternative ways of coping. Reach an agreement with the young person to use the alternative plan should ideas of self-harm or suicide recur.

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**Be prepared to follow up an inquiry about suicidality with a discussion of alternative problem solving strategies.**

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Try to distinguish ideas of self-harm from ideas of suicide. Ask what the child believed was the risk of dying. Ask whether the plan included any ideas of being rescued. Assess a child's understanding of death and its permanence by asking what he or she expects to happen after death.

Suicidal and self-harming behaviour are maladaptive solutions to problems in the young person's life. Try to identify the precipitating problem. Many suicides and suicide attempts occur in the context of relationship problems. The meaning of suicide may, in some cases, be to send a message, often an angry message, to someone important in that person's life. The risk of suicide is higher if someone known to the young person has committed suicide. In some cases, problems over sexual orientation may lead an adolescent to contemplate suicide.

Determine the nature of the underlying mental disorder. The commonest diagnosis is depression. In particular, you should assess hopelessness by asking what the young person sees for the future. Other disorders associated with an increased risk of suicide include anxiety disorders, alcohol and other substance abuse, conduct disorder and psychosis.

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**Disorders commonly associated with suicidal ideation and behaviour include depression, anxiety disorders, alcohol and other substance abuse, conduct disorder and psychosis.**

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Assess the availability of means, in particular the young person's access to firearms. Ask about any previous suicide attempts, their frequency and lethality, and their motivation. Assess the level of disability and handicap by asking about functioning at home, at school and with peers.

Interview the family to obtain collateral information. Many depressed children believe that they are to blame for family problems. In some cases, parents may consciously or unconsciously promote such a belief. On the other hand, family support and cohesion, shared interests with other family members, and family support are protective.

*Treatment and prevention of suicidality*

The cornerstone of treatment is the accurate diagnosis and treatment of the underlying mental (or physical) disorder. Take steps to limit the young person's access to the means of committing suicide, in particular to lethal means such as firearms. Reach an agreement with the child and his or her family and carers to seek help before self-harming. Use counselling and structured problem solving techniques to deal with the precipitating problem. Mobilise family and social networks to provide support. Refer for specialist assessment if no safety agreement can be made, if there is severe family disruption or if the child is suffering severe depressive symptoms. See Chapter 3 for a more detailed description of these issues.

### **Anxiety disorders**

An anxiety disorder is present when the normal fight and flight response to a threatening stimulus is exaggerated, if it occurs at times when there is no realistic threat, or persists after the threat has been removed.

The diagnosis may be associated with particular patterns of disability and handicap. The physical symptoms may be taken as evidence of a medical condition and lead to extensive physical investigations. It may be associated with school refusal, which may in turn be reinforced by the secondary gains of staying at home. School refusal causes significant disability and handicap—academic problems, a loss of friends and becoming the victim of bullies. The child who reacts to minor stimuli with a fight/flight response may be seen as disobedient. Insomnia may lead to fatigue, irritability and a deterioration in school performance. The child's condition will

also have an impact on other family members. See also Chapter 15 for a detailed discussion of anxiety disorders.

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**Disability and handicap associated with anxiety disorders include school problems, school refusal, insomnia and family problems.**

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#### *Diagnosis*

The history is gained from both the child and his or her parents. Useful collateral may be obtained from schoolteachers and others with whom the child has contact. On the mental status examination, the child may be tense, shaky, vigilant and quick to startle. Observe how the child manages to separate from his or her parents.

In addition to the adult syndromes discussed in Chapter 15, the DSM IV includes Separation Anxiety Disorder as an anxiety disorder specific to childhood and young adolescents. It is characterised by excessive anxiety on separation from home or those to whom the person is attached.

The differential diagnosis includes the abuse of substances (including caffeine), thyroid and other endocrine disturbances, anaemia, and cardiac abnormalities. There may be anxiety about unwanted pregnancy, or of having contracted a sexually transmitted disease. Anxiety disorders are often co-morbid with depression. In conduct disorder, the child may stay away from home or play truant from school, but has no anxiety about the separation. The diagnosis of a particular anxiety disorder is often difficult, as a young person may present with features of several disorders. Anxiety symptoms may also complicate other Axis I disorders such as ADHD.

#### *Treatment*

The treatment of anxiety disorders in children and young people follows the same principles as the treatment of adults (see Chapter 15). Some examples are given below.

#### *Behavioural techniques*

##### 1. Relaxation

*Example:* A youth with generalised anxiety symptoms is informed about the nature of anxiety, taught controlled breathing, progressive muscular relaxation, advised how to use a relaxation tape, and taught a self-hypnosis technique (see Appendices 4–6).

##### 2. Exposure

*Example:* A nine-year-old girl who has a phobia of dogs is educated about the nature of anxiety and, in particular, about the problem of avoidance behaviours. She is taught a relaxation technique and is then progressively exposed, initially to pictures of dogs. In the final session, she is able to pat a dog in the session. At each step, she is encouraged to stay in the room with the therapist, using the relaxation technique, until her level of anxiety falls (habituation).

##### 3. Modelling

*Example:* An eight-year-old boy with needle phobia has his anxiety symptoms explained, as well as the purpose of the injection. He attends the appointment at which his older brother, who is not afraid of needles, has an injection.

##### 4. Operant conditioning

*Example:* An eight-year-old boy with behaviour problems is rewarded for good behaviour (e.g. doing the dishes, tidying his room, taking his younger sister for a walk) by being taken to the cinema with his father (positive reinforcement). When he has a temper tantrum, he has time-out in his bedroom (negative reinforcement), and when he hits his sister, he is admonished (punishment).



## 5. Cognitive-behavioural treatment

*Example:* A 13-year-old girl suffers symptoms of anxiety and depression. After assessing the problems and documenting the levels of anxiety and depression using rating scales, you explain the treatment and contract to see the girl for 12 sessions, once a week, over the following three months. The girl is asked to keep a diary of the negative thoughts that she has at times when she is feeling anxious and depressed. In the sessions, you challenge the faulty logic behind these thoughts. Later, the girl is asked to challenge the thoughts herself, both in the sessions and at times when she is suffering symptoms. She documents these in her diary and rehearses possible responses within the sessions. At the end of 12 weeks, the rating scales are again administered to assess the efficacy of treatment.

## 6. Other treatments

Although the primary treatment modality may be behavioural or cognitive-behavioural, psychodynamic principles will often inform therapy.

*Example:* A three-year-old girl continues to suffer nightmares, bed-wetting and separation anxiety nine months after her parents separated. She frequently sleeps in her mother's bed and she becomes very upset whenever her mother goes out.

The girl, who has always been pleasant, considerate, and friendly in play therapy, suddenly becomes angry while hammering pegs through a wood block. She begins swinging the mallet around her head, narrowly missing the therapist, all the time cackling with laughter. The therapist stands up and quickly regains control.

*Comment:* The child's anger with her father, previously repressed, is displaced on to the therapist and acted out.

Family interventions are often required. A parent may suffer an anxiety disorder or other Axis I condition. Parents may reinforce a child's anxiety either by failing to give adequate support, or by intervening too quickly to remove a child from situations that cause anxiety. Abused children may present with anxiety symptoms, including those of post-traumatic stress disorder. Children who are too powerful within a family may be anxious (e.g. a girl with school refusal has to stay at home to support her mother who suffers delusions that the neighbours will kidnap her if she is left alone).

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### **Check for the presence of mental health problems in the family members of children and adolescents with anxiety disorders.**

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Drug treatments may sometimes be used for specific symptoms. However, because of their uncertain efficacy, and their side effects and toxicity, I recommend referral of any young person requiring pharmacological treatment to a child psychiatrist.

## **Obsessive-compulsive disorder**

### *Assessment and diagnosis*

The diagnosis of the disorder is based on the presence of obsessions and compulsions (see Chapter 15). The Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) may assist assessment<sup>1</sup>. Between one and four per cent of children suffer obsessive-compulsive symptoms.

### *Differential diagnosis*

The differential diagnosis includes normal age-appropriate rituals of childhood. These differ from obsessions and compulsions in their transience, and the lack of disability and handicap

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<sup>1</sup> Goodman WK, Price LH. Assessment of severity and change in obsessive-compulsive disorder. *Psychiatric Clinics of North America* 1992; 15:861-869.

associated with them. Obsessions and compulsions frequently occur in the context of depression and other anxiety disorders. In a pure mood disorder, the mood symptoms will predominate. However, both disorders may coexist. Tics may be preceded by a premonitory urge, but unlike compulsions, they do not arise in response to an anxious thought or obsession. If the onset is abrupt, consider possible physical causes, including viral and bacterial infections, and substance abuse (especially amphetamine abuse).

#### *Co-morbidity*

The illness occurs most commonly together with other disorders with only around 25 per cent of symptomatic individuals suffering OCD alone. Common co-morbid diagnoses include tic disorders, depression, developmental disability, phobias and other anxiety disorders, oppositional disorder, ADHD and conduct disorder.

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### **Obsessive–compulsive disorder occurs more frequently in combination with other disorders than it does alone.**

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#### *Treatment*

Educating the family and the child about the nature of the illness will help establish a therapeutic alliance.

#### *Exposure and response prevention*

The cornerstone of treatment is exposure and response prevention (see Chapter 15).

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### **The cornerstone of the treatment of OCD is exposure and response prevention.**

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#### *Pharmacological treatment*

SSRIs are effective in the treatment of obsessions. The recommended dose of fluoxetine is 0.5 to 1mg/kg orally per day, in two divided doses (morning and noon) up to a maximum of 40mg orally per day<sup>1</sup>. Side effects include nervousness, agitation, insomnia, nausea, tremor and sexual dysfunction.

Clomipramine is also effective, but care must be taken because of potential toxic effects, including the risk of sudden death. I therefore recommend that specialist advice be sought before prescribing a tricyclic antidepressant. ECGs should be performed before commencing clomipramine and at intervals during treatment to exclude conduction abnormalities (see *Psychotropic Drug Guidelines* on pages 155–156 and 163–164<sup>2</sup>). Side effects of clomipramine include dry mouth, constipation, tiredness, sweating, abdominal pain and tremor. Doses are between 2 and 5mg/kg/day orally as a single dose or in two divided doses, and should not exceed 250mg/day. The dose should be increased gradually. Response may not occur until four to ten weeks after an effective dose is reached.

#### *Individual therapy*

In individual therapy, you should monitor for the development of co-morbid conditions and address the disability and handicap associated with the illness.

#### *Family therapy*

In family therapy, you can address the involvement of other family members in the rituals. Assess the impact of the illness on other family members. For example, siblings may resent the extra attention given to the ill child. Family members may be exasperated by the behaviours and react angrily to the child. The stress on the child may then worsen the symptoms. Parents who themselves suffer the disorder may feel guilty that they have passed it on to their child.

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<sup>1</sup> Victorian Drug Usage Advisory Committee. *Psychotropic Drug Guidelines*, 3rd Edition, North Melbourne, Victoria, Therapeutic Guidelines Ltd. 1995.

<sup>2</sup> *ibid.*



## Adjustment disorders

The reactions of young people to stress are complex. The quality of the adjustment will depend on the nature of the event itself, the context in which it occurs (e.g. how parents respond to the crisis), whether or not it precipitates chronic adversity (e.g. greater poverty), and the person's own personality and adaptation. Use counselling and structured problem solving to help the young person and his or her family deal with their problems (see Appendix 3).

### *Divorce*

Divorce is usually preceded by a period of marital conflict and family discord, and may be followed by:

- parental conflict
- parental distress or illness
- changes of house and school
- loss of family income
- compromised relationships with either parent
- new parental relationships, including parental remarriage.

Boys may exhibit more externalising behaviours, including irritability and aggression, than girls, but sex differences become fewer and perhaps more subtle as adolescence and young adulthood is reached. Some adolescents experience parental divorce as a foreshortening of the amount of time they have to grow up, and of being exposed and vulnerable. There is some evidence that as they approach young adulthood, the children of divorced parents experience more interpersonal relationship problems, including problems with intimacy. The severity of the problems may be correlated with high pre-separation parental hostility, an inability of the mother (usually the custodial parent) to form another stable relationship, and high levels of interference by one parent in the relationship of the child with the other parent after separation. In helping adolescents survive the process of divorce, use counselling and structured problem solving. Encourage agreement to sensitive arrangements concerning custody and access.

## Child abuse

It is important to intervene early in cases of child abuse in order to limit the physical and psychological sequelae. The longer the abuse continues, the more severe the psychological damage done. People who were abused as children may enter into abusive relationships in adulthood, as victim or abuser. They are themselves at risk of becoming abusing parents.

Consider the following types of abuse:

- Physical abuse usually involves excessive punishment for minor infractions, or for behaviour that is developmentally normal for the child.
- Emotional abuse may involve constant criticism, teasing and humiliation.
- Neglect is the failure to provide the child's basic needs for shelter, food, clothing and the other necessities of life.
- Emotional deprivation is the failure to provide the child with normal human contact, support and warmth.
- Sexual abuse involves the exploitation of a young person by an older person who is in a position of power over him or her. The perpetrator of the abuse may be a parent, sibling, other relative or acquaintance.

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**Abuse includes physical abuse (i.e. excessive punishment, or punishment for behaviour that is developmentally normal for the child), emotional abuse, emotional deprivation, neglect and sexual abuse.**

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Evidence of abuse comes from a variety of sources. A third party may make allegations, the child may disclose the abuse, or the general practitioner may notice signs of abuse on physical examination. Physical abuse is most often identified on examination. In cases of sexual abuse, there are often no signs on physical examination.

#### *Identifying those at risk*

A number of risk factors for child abuse have been identified in populations of people. However, child abuse can occur in families with few apparent risk factors. Conversely, most parents at risk of abusing their children never do so. The presence of risk factors should raise your concern, but the starting point must always be evidence of abuse.

The young mother who denies her pregnancy, seeks a termination of it, fails to prepare for the birth, and neglects her own health by smoking, drinking and abusing other substances, is at risk. Parents who were themselves abused as children are at higher risk, as are those who abuse drugs and alcohol and are facing multiple life stresses (e.g. financial, marital, and legal problems). Parents who abuse may take their child to see numerous different doctors, and provide vague explanations for injuries. Repeated presentations of a child with minor or vague complaints may be a call by the parent for help.

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**Parents at risk of abusing their children include young women with unwanted pregnancies, parents who were abused themselves as children, those facing severe life stressors and those who repeatedly present their children to doctors.**

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Children who suffer multiple accidents, and have a history of birth defects, failure to thrive, feeding problems and developmental delays are at higher risk. An abused child may perform poorly at school because of limited concentration. He or she may run away from home.

#### *Examination*

Observe the parents' attitude towards the child and the way the child interacts with you. Note any absence of normal fear and pain responses. The child may behave in a pseudo-mature way and display inappropriate sexual knowledge or behave in a seductive manner.

Carefully document the location, size and appearance of any injuries. The following injuries should arouse suspicion of physical abuse:

1. Fractures
  - in children under nine months of age
  - two or more fractures at different stages of recovery
  - fractures in which the injury is inconsistent with the explanation given.
2. Bruises
  - on the face or earlobes
  - on the buttocks or thighs
  - in the shape of a causative implement
  - patterned bruises (e.g. grip marks)
  - over soft areas as opposed to bony prominences.
3. Head Injury
  - subdural haematoma
  - retinal haemorrhages.
4. Burns
  - immersion burns
  - tap burns
  - in unusual sites (i.e. non-contact areas).

#### 5. Closed abdominal injuries

Abuse may be revealed in a child's drawings. The frightened child may assume an attitude of 'frozen watchfulness'. Pregnancy in a young woman under the age of 16 years, or the diagnosis of venereal disease, raises the possibility of sexual abuse.

#### *Action*

It is mandatory to report cases of suspected child abuse in all states of Australia except Western Australia. Make yourself familiar with the legal requirements in your state. Have at hand a list of specialists whom you can contact—a local paediatrician who is involved in child protection (in Queensland, this would be the person who sits on the local Suspected Child Abuse and Neglect panel, SCAN); the Department of Family Services; the police; and a crisis line (in Queensland: Crisis Care). If you are unable to contact any of the above, you can phone the major paediatric hospital in your state and speak to the paediatrician on call for suspected child abuse.

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### **It is mandatory to report cases of suspected child abuse in all states except Western Australia.**

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While the factors mentioned above might raise the possibility of abuse, it is clinical evidence that you require in your assessment. It is not your role to investigate whether or not abuse has occurred, but rather to report and document as clearly as possible any findings suggestive of abuse, and to arrange appropriate treatment and referral.

Try to be non-judgemental of the parents. In many cases, you will have to continue to support them and the child. Be open and explain that you are required under law to report any case of suspected abuse. This will deflect some of the parents' anger away from you. It is generally advisable to interview both parents together. To separate them may only make them mistrustful, angry and uncooperative. A particularly difficult situation arises when allegations are made in the context of a custody dispute. Try not to take sides. Base your conclusions on the clinical evidence. Remember that it is not your job to decide guilt or innocence, but rather to report your clinical findings.

### **Advice on parenting**

Parents often present to general practitioners for advice on managing their children's behaviour. Parenting difficulties are stressful to parents. Positive management of a child's behaviour will improve his or her self-esteem and social functioning, and prevent problems in later life.

The principles of successful parenting are based on learning theory (see Chapter 9). Under the operant conditioning paradigm, rewarding desirable behaviours increases their frequency, and escape from aversive stimuli increases the frequency of avoidance behaviour. Similarly, removing any inadvertent reinforcers reduces the frequency of undesirable behaviours. Social learning theory notes that children can learn both good and bad behaviours by observing others—parents, siblings and friends. High arousal attenuates over time (habituation) and the intensity of responses diminishes on repeated exposure (desensitisation).

Any attempt to modify a child's behaviour depends on the ability of the parent to communicate clearly with him or her. The child's attention must be gained, (e.g. by squatting down and speaking face to face with him or her). The communication must be clear, understandable and direct.

The following discussion highlights some aspects of the Triple P positive parenting program, developed by the Parenting and Family Support Centre at the University of Queensland. Contact your local community health service for information on the referral of parents with persistent difficulties in managing their children's behaviour to a Triple P group<sup>1</sup>.

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<sup>1</sup> Markie-Dadds C, Sanders MR, Turner KMT. *Every Parent's Self-help Workbook*. Milton, Queensland, Families International Publishing 1999.

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**Contact the local community health centre for information about the Triple P positive parenting program.**

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### **Causes of behavioural problems**

A child's temperament, including his or her sociability, emotional reactivity and level of activity is determined in part by genetic factors. Parents often observe a wide range of temperaments among their children. However, the behaviour of children is also influenced by a number of environmental factors over which the parents have some control. Parents should be asked to consider whether any of the following might be influencing their child's behaviour. Examples are given in Box 24-1.

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### **Parents have control over a number of factors that can influence a child's behaviour**

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1. *Accidental rewards*  
Unwanted behaviours may be inadvertently reinforced, and so increase in frequency.
2. *Escalation traps*  
A child's difficult behaviour may escalate in an attempt to get what he or she wants. If the parent gives in, the child learns that escalating bad behaviour gets the desired result (it is positively reinforced). Parents may also fall into escalation trap—the boy learns that he only really needs to do as he is told when his father gets very angry with him.
3. *Ignoring desirable behaviour*  
Unless parents are attentive to their child's activities, they may miss opportunities to reinforce desirable behaviours.
4. *Social learning*  
Children learn by observing others.
5. *Ineffective instructions*  
Instructions may be ineffective for a number of reasons. There may be too many or too few of them. The child may not be able to understand them. The instructions may be ill-timed, too vague, or contradicted by the parent's body language.
6. *Emotional messages*  
Parents may criticise the child rather than the unwanted behaviour. This may lower the child's self-esteem and make him or her feel angry, guilty and ashamed.
7. *Inconsistent rules*  
Rules will be ineffective if parents threaten certain consequences, but do not carry them out, or if the consequences are inconsistently applied.
8. *Parent's beliefs and expectations*  
Parents may fail to discipline a child because they believe the child is just going through a normal phase of development. On the other hand, they may have expectations for the child that are beyond his or her developmental capabilities. Alternatively, they may blame themselves for all of a child's difficult behaviours.
9. *Parental conflict*  
Conflict between parents is often manifest by behaviour problems among their children. Parents need to work together as a team. Disagreements should be worked out away from the children.

#### 10. Parental illness and stress

A mother's mental illness may impair her ability to discipline and care for her children. She will need extra support at this time. Parents who are under stress will have less time to attend to their children's needs. All parents need breaks from the care of their children and time to themselves.

#### 11. Factors outside the family

Children's behaviour is influenced by relationships with their peers, their ability to manage their schoolwork, and by their exposure to the media—television, movies and computer games.

### **Box 24-1: Some preventable causes of behavioural problem**

#### *Accidental rewards*

Charles is given food to stop him whining and complaining. His whining increases.

#### *Escalation traps – child*

Tom asks his mother for an ice cream. She tells him he must wait until after tea. Tom's behaviour escalates—he continues to demand the ice cream, he raises his voice and stamps his feet, and he starts crying. Finally, his mother gives him the ice cream just to silence him. The next day, Tom is again demanding a sweet before dinner.

#### *Escalation traps – parent*

James asks Lawrence to put on his shoes before they go out. When Lawrence refuses, James gets angry and begins shouting at him. A pattern becomes established that Lawrence only obeys his father's instructions when James shouts at him.

#### *Ignoring desirable behaviour*

Amanda's mother fails to notice that she has been quietly amusing herself reading.

#### *Social learning*

Andrew is in trouble at school for yelling, swearing and losing his temper. He is often witness to aggressive confrontations between his parents at home.

#### *Ineffective instructions*

Paul winks and smiles as he tells Rory not to swear.

#### *Emotional messages*

'You stupid boy!' yells Roger when Phillip trips over in the kitchen. Instead, he might have gained Phillip's attention and said, 'Don't run in the kitchen. You may trip and hurt yourself and break something. Walk in the kitchen. Run when you are outside. Now go back outside and come back in slowly'.

#### *Inconsistent rules*

Sheila asks Julia to tidy her room and put her toys back in the box. Her father, Roger, tells her not to bother as they don't have time.

#### *Parent's beliefs and expectations*

Rory's parents fail to discipline him for climbing over the furniture. Invitations to visit friends are becoming scarce.

#### *Parental illness*

Michelle is suffering from depression and has no energy to take notice of her children. She is unaware that her son, David, is playing truant from school.

## **Goals for children's behaviour**

It is often useful for parents to set goals for their children. Consider the normal developmental goals shown in Table 24-4.

**Table 24-4: Normal developmental goals**

*How to communicate and get on with others*

- expressing their views, ideas and needs appropriately
- requesting assistance or help when they need it
- cooperating with adult requests
- playing cooperatively with other children
- being aware of the feelings of others
- being aware of how their own actions affect others

*How to manage feelings*

- expressing feelings in ways that do not harm others
- controlling hurtful actions and thinking before acting
- developing positive feelings about themselves and others
- accepting rules and limits

*How to be independent*

- doing things for themselves
- keeping busy without constant adult attention
- being responsible for their own actions

*How to solve problems*

- showing an interest and curiosity in everyday things
- asking questions and developing ideas
- considering alternative solutions
- negotiating and compromising
- making decisions and solving problems for themselves

Reproduced from Markie-Dadds C, Sanders MR, Turner KMT. *Every Parent's Self-help Workbook*. Milton, Queensland: Families International Publishing, 1999, p14.

## **Promoting good behaviour and normal development**

1. *Developing positive relationships between parents and their children*

Parents need to set aside time to spend with their children. Frequent short periods of time are more effective than infrequent longer periods of time. Parents should spend time talking to their children, asking about their interests and sharing their own thoughts with them.

2. *Reinforcing desirable behaviours*

Praise, non-verbal communications (smiling, hugging), and providing safe, appropriate and interesting activities can reinforce desirable behaviours.

3. *Teaching new behaviours*

Children will imitate behaviours that their parents model. For example, if a girl sees you keeping your room tidy, she will be more likely to do the same. When a child asks a question, use the opportunity to go beyond the answer and talk about related topics.

An approach to teaching children new behaviours is to first ask them to do it. If they cannot, tell them what to do and then show them how to do it. It is often useful to break the action down into a number of steps (see Box 24-2).

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**A useful approach for teaching children new behaviours is 'ask, say, do'.**

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Praising and otherwise rewarding a child when he or she performs a new action will increase its frequency. In some cases, it may be useful for the parents to draw up a chart of desired behaviours with agreed rewards.

### **Box 24-2: Teaching new behaviours**

#### **Putting on shoes and socks**

Nigel asks Juliet to put on her shoes and socks. When she says that she doesn't know how to do it, he shows her how it is done, beginning with putting on her left sock, then left shoe, then tying a bow in the shoelaces. When she tries putting on her right sock and shoe, he praises her for each step that she gets right.

### **Managing misbehaviour**

The consequences of misbehaviour need to be clearly understood, immediate, consistent and decisive. Ask parents to consider the following suggestions. Examples are given in Box 24-3.

1. *Set clear ground rules*

These should be limited to a few clearly defined and understandable rules. Rules are best stated in the positive (what the child should do), rather than the negative (what he or she should not do).

2. *Directed discussion*

After gaining the child's attention, the parent should state the problem and the reason for it. The child should be asked to state the correct way of doing the task and then to do it properly. It may be useful to ask the child to repeat the action. On successful completion of the task, the child should be praised.

3. *Ignoring minor infractions*

Minor problems such as whining, speaking in a silly voice or swearing are often best ignored. This does not apply to more serious problems, such as hitting another child. It is important that the parent continues to ignore the problem and does not respond to any escalation in the behaviour.

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### **Minor infractions are often best ignored.**

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4. *Giving clear instructions*

The parent needs to get close to the child and tell him or her clearly what to do. Children should then be praised if they do as they are told. If after about five seconds the child has not obeyed, the parent should repeat the instruction once. If the child still fails to comply, the parent should move to the next step—quiet time or time out.

5. *Back up with logical consequences*

If a child refuses to obey an instruction, it may be appropriate to withdraw an activity.

6. *Quiet time*

When a child refuses to change his or her behaviour as asked, the parent can use quiet time. The child is removed from the activity and asked to sit quietly in the same room for a set period of time. The length of time varies according to the age of the child, from one minute for a 2-year-old to five minutes for a 10-year-old. The child is ignored while in quiet time. Quiet time only begins when the child is quiet. After it is over, the incident is not mentioned again and the child is praised for good behaviour.

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### **When a child is in quiet time, he or she is asked to sit quietly in the same room for a set period or time and ignored.**

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## 7. Time out

Time out is used to deal with more serious misbehaviour—for example, hurting other children, temper tantrums or refusing to comply with quiet time. The child is removed to another room and must remain quiet for a set length of time. The room must be safe and uninteresting. The child must understand the rules of time out.

A child's behaviour may initially escalate when placed in time out. It is important that he or she is not let out while still upset, as this will only reinforce the unwanted behaviour. Time out begins from when the child becomes quiet. Time out is more effective than corporal punishment because as well as being effective, it teaches the child self-control.

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**A child in time out is removed to another room and must remain quiet for a set period of time.**

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## Forward planning

It is wise for parents to plan ahead for activities in which behaviour problems can be anticipated. This applies particularly to activities in which there is little for children to do. Parents are advised to take toys or other diversionary activities with them. They should discuss the ground rules for the child's behaviour beforehand. In some cases, there may be opportunities for incidental teaching. For example, on a long drive, parents can play 'I spy' and discuss some of the things they see out the window. Parents should plan rewards for good behaviour, for example, getting an ice cream on arrival at the destination. Consequences for misbehaviour should be discussed and understood.

### Box 24-3: Managing unwanted behaviour

#### *Set clear ground rules*

Ground rules might include: when going for a walk, stay on the footpath; keep your hands and feet to yourself; wash your hands after using the toilet; greet people when they come to the door.

#### *Directed discussion*

Rosemary fails to greet her grandparents when they arrive for lunch. Her mother, Sue, gains her attention and says, 'It is rude to ignore people when they come to visit. You should greet people when they arrive'. Later, they practice it. Sue knocks on the door and Rosemary opens it, greets her and asks her in.

#### *Backing up with logical consequences*

Alex is sitting watching television with his feet on the couch. When he refuses to move, his mother turns the television off for five minutes. After he sits quietly with his feet on the floor for five minutes she turns it back on.

#### *Quiet time*

David keeps interrupting his brother Steven who is telling the family what happened to him at school. His mother tells him, 'David, stop interrupting your brother. Listen to what he is saying'. When he fails to obey, she says, 'You have not stopped interrupting. Now go to quiet time. You can come back to the table after you have been quiet for five minutes'.

#### *Time out*

John is having a tantrum. His mother gains his attention by squatting down beside him, looking him in the face and saying, 'John, stop yelling. Speak calmly'. When the behaviour continues, she says, 'John, you are still screaming. Now go to time out'. She takes him to the bathroom, which is the agreed time-out room. The door is left open. She says, 'You must be quiet for five minutes. Then you can come out'.



# Chapter 25

## Doctors' mental health

While medical practitioners are healthier overall and have a longer life expectancy than people in the general population, they suffer higher rates of alcohol and other substance abuse, mood disorder and death by suicide. Their marriages are subject to particular stressors and, like others in the caring professions, they are at risk of suffering burnout. The causes of this excess psychiatric morbidity include certain personality traits common among doctors, the stresses of the work, and the barriers that exist to adequate prevention and treatment. A number of facilities have been set up to deal with doctors' mental health problems. General practitioners should be aware of steps that they can take to prevent developing mental health problems, and where they can get timely and effective treatment for themselves and their colleagues.

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**General practitioners need to be aware of steps that they can take to prevent developing mental illness, and where they can get timely and effective treatment for themselves and their colleagues.**

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## Epidemiology

The rate of suicide among male doctors is comparable to that of males in the general population. The rates for females are reported to be similar to their male colleagues, or about four times that for women in the general population. Rates of depression amongst doctors are thought to be higher than in the general population, though this has recently been disputed<sup>1</sup>. Around 30 per cent of medical students suffer some emotional disturbance. This percentage increases during the period of training. The prevalence among junior doctors is reported to be as high as 50 per cent. Around seven to eight per cent of doctors drink to excess. The prevalence of substance abuse is around one per cent. Some addicted doctors may have begun using drugs to self-treat anxiety and depression, or as a maladaptive way of dealing with stress. Rates of divorce amongst female doctors are higher than for male doctors, and for women in the general population. Marital difficulties may contribute to or be a consequence of mental health problems.

People working in the caring professions are at risk of developing the syndrome of burnout. Symptoms include feelings of fatigue, emotional exhaustion and apathy; a cynical attitude to work with feelings of futility and hopelessness; a loss of one's sense of humour; irritability and anger; avoidance behaviours, including a reluctance to see certain patients or difficulty going to work; clumsiness and frequent accidents; indecision and inefficiency; and persistent thoughts of resignation. The condition may be complicated by self-medication with alcohol or other drugs.

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**Compared with the general population, doctors suffer higher rates of completed suicide, substance abuse, marital problems and burnout. They may also suffer higher rates of depression.**

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<sup>1</sup> Frank E, Dingle AD. Self-reported depression and suicide attempts among US women physicians. *American Journal of Psychiatry* 1999; 156:1887-1894.

## Causes of doctors' mental health problems

Factors in the formulation of doctors' mental health problems include both predisposing personality traits and coping styles that are prevalent among members of the profession, together with stressors associated with the work.

### Personality and coping styles

Around 20 per cent of medical students exhibit obsessive–compulsive personality traits, including perfectionism, isolation of affect, conscientiousness, and a need to feel 'in control'. These traits are, in many respects, adaptive to the demands of the job. However, they also place the doctor at risk. Perfectionism may contribute to a high level of performance, but at the expense of high levels of anxiety and excessive self-criticism if something goes wrong. It is an asset to be a good organiser, but this trait can lead to personality clashes with others who also like to be in control.

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### **Obsessive–compulsive traits place the individual at risk of depression and anxiety.**

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Traits characteristic of the Type A personality are common among members of the medical profession—competitiveness, feelings of time pressure, impatience and irritability. Again, while these traits are adaptive in many situations, they are also associated with increased physical and psychological morbidity.

### Stressors

General practitioners face the everyday difficulties of running a practice together with the particular stresses associated with clinical work. Everyday problems include overwork, having to rearrange appointment schedules and coping with interruptions. In an age of consumer activism, people expect to be fully informed about the services delivered and want greater involvement in decision-making. The rising cost of medical insurance reflects increasing rates of litigation.

Doctors are envied for their high social status. They are often portrayed in the media as being greedy and overpaid. This can be particularly irritating for the general practitioner who has experienced the loss in status of the profession, and who is struggling to make a reasonable living. Unlike hospital specialists, general practitioners carry the full responsibility for their patients' care on their own. They need to keep abreast of new knowledge, not only in a specific area, but also in the field as a whole. General practitioners working in a group practice face the interpersonal demands of dealing with their colleagues and ancillary staff.

Clinical work is often very stressful. Doctors are exposed to the gamut of human suffering, including death and dying. They may hear stories of abuse and even torture. Some of their patients will be difficult and demanding. Treating colleagues and their families is often identified as being particularly stressful. Doctors often need to make difficult ethical judgements, balancing conflicting demands, for example, between the need to maintain confidentiality versus the requirement to report abuse. They are often powerless to cure and limited in their ability to minimise suffering, limitations that patients and their families are not always immediately willing to acknowledge. Doctors are constrained by standards of behaviour, especially with regard to sexual conduct, that are more exacting than those applied in most other professions. Those who are professionally isolated, especially solo practitioners working in country areas, are at high risk. Female practitioners face role strain having to strike a balance between the demands of work and family.

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**Stressors on general practitioners include the everyday difficulties of running a practice, criticism of the profession in the media, having to take responsibility for difficult clinical decisions, and living up to the high ethical standards expected of members of the profession.**

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### **Barriers to care**

People suffering drug and alcohol problems often deny their illness. The stigma attached to mental illness makes it shameful to acknowledge the problem. The man who needs to be in control will find it hard to admit that he has a problem requiring someone else's assistance. The competitive person may feel humiliated at having to acknowledge his or her own vulnerability. The man who isolates his affect and habitually uses the defence of reaction formation may be unable to recognise his emotional symptoms or to accurately describe them.

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### **Doctors may tend to deny their problems and those of their colleagues.**

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Denial of mental illness extends to our inability to recognise when colleagues are suffering. We tend to identify with them and collude with their minimisation of problems. Even when we recognise that a colleague has a problem, we may be reluctant to approach him, and feel bound not to 'dob' him in.

Doctors make difficult patients. It is easy to assume that they know everything about the problem and so neglect to educate them adequately about their illness and its treatment. They often present late. Those with drug and alcohol problems may only present to treatment when under pressure to do so from a professional body. They are frequently non-compliant and often discharge themselves from inpatient care against medical advice. Regular urine drug screens are often necessary to ensure abstinence from substance abuse.

### **Treatment and prevention**

In this section, I first discuss administrative structures that have been set up to deal with doctors' mental health problems. I then outline some preventive strategies for use by individual practitioners.

#### **Administrative structures**

A number of medical schools now provide counselling services for students and assign mentors with whom students can discuss problems in confidence. Specific training is given in dealing with death and dying, and with the difficult patient. The idea of screening for medical students at risk of developing emotional problems is fraught with difficulties. Those who are more anxious are often more empathic with patients and less likely to blame others for their mistakes. Moreover, any method of screening runs the risk of being abused as a vehicle for discrimination against minority groups.

Doctors' health advisory services have been set up in all states. These provide confidential advice, as well as assessment and referral services. Referrals may come from doctors themselves or from their colleagues. Treatment is coordinated by a senior general practitioner and delivered by senior specialists.

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### **Doctors' health advisory services provide confidential advice, as well as assessment and referral services.**

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Negative attitudes to admitting one's own vulnerability and a tendency to denigrate those who run into difficulties have been prevalent within training institutions, but may be beginning to change. Intern year was often a period of initiation in which new graduates were given considerable clinical responsibility and left to either sink or swim, often with deleterious consequences for patients. A sort of gallows humour is a feature of training hospitals and is certainly an adaptive way of coping. Unfortunately, some people fail to realise where the joke ends. One of the commonest defences against the sort of denigration that is inflicted on junior doctors is the claim that it was 'only a joke.'

## **Self-care for general practitioners**

Consider the following in managing your own stress levels and mental state:

1. Reflect on your lifestyle and make changes where necessary. Ensure that you have a balanced and regular diet. Allow time each day for breaks, lunch and physical exercise—for example, a 30-minute walk. Schedule regular holidays and other breaks away from work, such as conferences and education sessions. Rebut the voice that tells you that you cannot afford to take time off, or that your patients cannot cope without you. Avoid professional isolation by remaining in contact with peers, for example, through taking part in activities within your local division of general practice.
2. Maintain a balance between family, personal and work commitments. Setting aside time for your family and friends and for your own hobbies and interests will improve your health and leave you refreshed for work.
3. Beware of using alcohol, cigarettes and other drugs to cope with symptoms of stress.
4. Take steps to make your work environment as pleasant as possible with adequate lighting, sound insulation and ventilation. Choose comfortable furniture and select paintings and other decorations that you find relaxing.
5. Learn and use a relaxation technique, such as controlled breathing, progressive muscular relaxation, self-hypnosis, meditation or massage.
6. Use structured problem solving techniques to deal with difficulties as they arise. For emotional processing, you need to be able to discuss your problems with others whom you trust. This may occur to some extent within your own social networks, but it is also desirable to find support among peers who understand the sort of challenges that you face.

Formally or informally constituted peer review groups can serve not only educational and quality assurance functions, but also provide forums for mutual support. In particular, find a colleague or counsellor with whom you can debrief after traumatic or other difficult events.

7. Get your own general practitioner. Do not self-treat and never self-prescribe. Let your general practitioner coordinate your care. Do not fragment it by making specialist referrals yourself.

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### **Every doctor should have his or her own general practitioner.**

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8. Use the Doctors' Health Advisory Service for advice on your own problems or when a colleague needs help. In Queensland, phone (07) 3833 4352.

# Chapter 26

## Consumer and carer perspective

*Colleen Chard  
Laurel Sandilands  
Linda Urquhart*

### Living with mental illness – consumers’ and carers’ experiences

The purpose of this section is to provide an opportunity for general practitioners to gain some insight into what it is like to live with mental illness. The section was written by people within Logan City who are living with mental illness. Unfortunately, people like us are often described in ways that only reflect the nature of our illnesses, such as bipolar, schizophrenic or even obsessive–compulsive. We are also known collectively as ‘consumers’ of mental health services.

To enable the delivery of a reasonably concise message to general practitioners we address the following questions:

- What is most important to tell general practitioners?
- What is it like to have a psychotic illness?
- How did others react towards me?
- How did general practitioners react towards me?
- What helped?
- What did not help?

We have included some vignettes from our life experiences to personalise this work—however, the underlying theme of the article is that despite the illness or the labels used to describe it, we are still people. Therefore, what we ask of our general practitioner is most often the same as that asked of everyone in the community. That is, to be treated with respect and express a willingness to help whatever the presenting problem.

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### People with mental illnesses ask to be treated with respect by their general practitioners.

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### What is the most important thing to tell general practitioners?

First, I need to feel confident that I will receive continuity of care across different health care settings. While it is sometimes difficult to establish a new relationship with a health professional, this situation is exacerbated for a person with mental illness. Often there is an emotional investment in the building of such a relationship. It can be quite difficult to start over and to share quite intimate and often emotionally painful details from our life story with a relative stranger. In general, I do not wish to be perceived as different from any other person in the community; however, I accept that at times my behaviour will differ from societal norms to some degree. When establishing or continuing a health care relationship, I need my GP to ensure that appropriate records are accessed when necessary. This could help the GP to understand the signs and symptoms of my illness.

There are times when I may need a longer consultation, however, I often feel that general practitioners are reluctant to give of their time. To enable me to express my needs completely, I need to feel that my GP is willing to spend some time getting to know me as a person. There have been times when I have visited my GP and left without saying what it was I wanted to say. I like to feel that I have been listened to and not just heard.

I need to know that I can approach a GP when I am unwell and feel I can talk freely without being feared. I want to be treated with respect, not fear. When I appear to be unwell because of my presenting symptoms, I am not absent from the room. I continue to be aware of other people and their reactions to me. It can be quite hurtful to be discounted as a person because of presenting symptoms. I do not believe that I pose a physical threat to my GP or others in the community. I am a person with an illness and not the diagnosis (label). I should always be treated with respect and fairness and not with fear and uncertainty.

In the early stages of awareness of my illness, my first contact with a health professional was with my GP. When my illness first became noticeable, my GP dismissed symptoms as less serious than they were in reality. This caused a significant amount of personal stress for me, because I feared that there was something seriously wrong. The symptoms were real for me; however, I did not understand what was wrong or why it was happening. Nor could I express adequately what was happening to me. It would have been helpful for me if my GP had given me some more time to discuss my concerns.

It appears to me that good communication skills are needed to gather all information required to assess an individual's condition. I believe that I need my GP to ask a sufficient number of questions of me and to always encourage good two-way communication. I do not want to suggest that it is the sole responsibility of GPs to communicate with me. I accept my share of the responsibility for good communication; however, at times there are impediments to my ability to communicate well. It is during these times that I need others to assist me to express my need.

---

**Listen to people's complaints, empathise with how they feel, and be sensitive to verbal and non-verbal cues.**

---

### **What is it like to have a psychotic illness?**

This question appears to be best answered in adjectival terms, i.e. scary, painful, devastating, isolating, debilitating, and not to mention bloody shitty. At times, I fear the consequences of my own behaviour because I sometimes behave in ways that do not align with societal norms.

Others in the community do not understand or accept me at these times and this causes me to feel that I do not fit in to society in general. The result is that I have isolated myself from mainstream society in much the same way that an anxious person may avoid places because of fear of other people noticing that something is wrong with or different about them. Recovery from this fear and isolation is difficult and can take considerable time.

---

**Suffering a mental illness is frightening, frustrating and depressing. People with mental illnesses are often isolated.**

---

Being hospitalised in a psychiatric facility was another significant issue for me. It was scary when I was told that I had to stay in a mental hospital for a number of weeks or months and be isolated from the world outside. I was devastated and I feared my own behaviour. I became angry with people who found it hard to understand that unwell does not equal unaware. It was difficult enough to cope with the outcomes of my own behaviour without others treating me as though I had taken leave of absence from my physical self. The emotional hurt that this has caused me is immeasurable.

---

**Where possible, people generally prefer to be treated in the community rather than in a hospital.**

---

I felt a deep sadness about what was happening to me. I knew that each time I became unwell my interpersonal relationships would suffer. I would lose so much in terms of love, security and

acceptance of those I cared about. The fear of the illness that was created by these consequences caused me to feel absolute terror. Underlying the terror, I am sure there was a deep sadness, which remains with me now. It was not at all like when I suffered a serious physical illness.

Certainly, I might have been going into hospital to have my kidney removed, but my loved ones still loved me and I didn't feel as though I would quite likely lose my family life as I knew it. I sometimes do not have control over my own thoughts, or control of events that are seemingly happening around me. Although these episodes can be infrequent, the effects on me, both personally and emotionally, are no less devastating. Hospitalisation used to be the most common outcome. However, with the advent of community mental health caseworkers and better relationships with GPs, early intervention can satisfactorily stop symptoms snowballing to the point where hospitalisation becomes the outcome.

At times, I am unable to concentrate as too many thoughts are entering and rushing through my mind. Everything seems very important, I do not sleep, I do not eat, and I talk a lot. Life seems better for a while. It makes a tolerable change from being depressed. But then, so quickly, it can all escalate and it is like a roller coaster ride that I cannot get off. I do not know at what point I finally lose touch with reality, because it all happens too fast—the thoughts, the actions, the fears, the hospital, the end of life as I have grown accustomed to it yet again.

I suffered a loss of my own standard of living. After my first psychotic episode, I feared extending myself too much in case I became ill again. I was worried about returning to work in case it added stress, which caused me to become unwell again. Each time I became unwell I would suffer both financial and emotional losses. As a coping mechanism, I set up my life so that I had less to lose. This form of control enabled me to feel safer with the illness.

My husband had great difficulty coping with the nature of my mania and also its periodical reoccurrence. He always hoped that each episode was the last. Eventually it became too much for him and we separated. As my illness also affects my ability to hold down regular, fulltime employment, both of these factors have affected my standard of living. I have also lost contact with a lot of people to whom I was close. There is a tremendous amount of personal loss incurred as a result of periodic bouts of severe mental illness, which includes behaviour so extreme that people around me often never forgive or forget.

---

**People with mental illness have often suffered significant losses, including jobs, financial security and personal relationships.**

---

## **How did others react towards me?**

People close to me initially reacted with disbelief and anger. I now believe this sort of reaction is quite normal given that they were dealing with their own issues of grief and loss. However, this was not apparent to me at the time and it was not easy for me to accept their reaction to my illness. GPs could facilitate support for families of people with a diagnosed mental illness. This could assist families to reconcile themselves more quickly to possible changes in their relationship and lifestyle. Returning balance to the family would allow a more supportive environment for the person with mental illness.

---

**Involve the family and friends of people with mental illness in treatment. Educate them about the illness.**

---

Relationships with people outside of my immediate family also suffered due to my illness. Some people reacted to me by withdrawing physical and emotional contact. When my boyfriend of three years heard about my illness I found he didn't ring me as often. When he visited me in hospital he said to me, 'So what have they brainwashed you into thinking you have exactly?' When I told him of my condition an uncertain look came to his face and I realised he had



trouble accepting my illness. From that point onwards we didn't see each other as often and he didn't phone.

---

**People may react to those with mental health problems by rejection, fear, anger or criticism.**

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There were people outside my family whom I perceived reacted towards me with fear and uncertainty. When new neighbours moved in next door to me they called to ask me 'Are you really crazy?' They had apparently found out from someone that I had a mental diagnosis. They had called to ascertain whether I was someone that they should be cautious of. Most people in the community know little about mental illness. The little that is known is built on assumptions and misinformation. It is difficult to reassure people who have an uninformed opinion of people with mental illness. If there were a way to better educate the wider community about mental illness, it would no doubt benefit mental health consumers.

Due to a lack of understanding of my illness, people generally assumed that I could no longer do many things for myself.

After she found out about my illness my mother often said to me that she hoped one day I would wake up and get more involved in doing the housework. Actually, she didn't let me do any of the housework, because she seemed to think that I could no longer do things for myself. However, when she fell sick I ran the household for a week. I cooked dinner, did the dishes, vacuumed and did the laundry.

There appear to be negative attitudes in the community towards people who appear to be physically fit and yet do not hold a full-time job. People look at me as though I chose to do nothing and will not find work because for much of the time there are no external signs of my illness.

On the telephone, a friend of mine asked whether I was employed. When I replied 'no', they responded with a comment, 'It is unfortunate you haven't got a job. You could get a job if you really tried'. I explained that my illness prevented me from working, but despite my efforts, they could not understand this and went on to call me lazy.

### **How did general practitioners react towards me?**

It has sometimes been difficult to gauge GPs' reactions to me. It appears that without the necessary skill base it is difficult for them to establish a satisfactory therapeutic relationship. They therefore tend to want to treat the physiological symptoms only. In the past, I have attempted to discuss psychiatric issues only to feel as though there was no common ground on which we could meet.

Generally, I have found that some GPs related to me in much the same way as the general community. That is, I feel that I have at times perceived fear and apprehension. While this is probably to be expected, because GPs are people too, I like to think that professionalism wins through in the end and I will be responded to as an individual with a manageable illness. It certainly helped when my GP referred me to a psychiatrist and I gained some understanding of my illness.

---

**People with mental health problems want to be able to discuss their problems with their general practitioners.**

---

### **What helped?**

I value caring and consistent attitudes and behaviours towards me. I need to feel that I am important. I need to know that I will be treated the same way before, during and after onset



of my illness. I need to be treated like a person and not have my self-esteem eroded. I need to feel that I am important, but when I tell people that I have schizophrenia, they never want to talk about it. I would love somebody to say 'Oh, that's interesting, tell me about it'. I need my treating physician to be willing to address the mental level of illness, not just the physical and vice versa. That is, sometimes when I have a physical ailment it is too easy to explain this away as psychosomatic. At other times when the symptoms are psychiatric, my physician will seek a physical cause. I need this to be acknowledged so that I can work with my treating doctor to achieve early intervention for episodes of my illness.

---

**Attend to both the mental and physical health of people.**

---

I feel that I have been listened to, but when I was on the bed at my local GP's office having a skin cancer removed, he asked me what I did for a living. I mentioned that I had schizophrenia and after that he changed the subject.

It was helpful when I was given an explanation of the illness and its perceived causes. I was then able to explain to the people around me why I had been having difficulty. It was also helpful to have access to appropriate written information about my illness. I find that the majority of medical practitioners' offices or surgeries do not have enough information, especially in the form of pamphlets about mental illness.

I know of people in the community who have a mental illness and have their medication managed by their family doctor. It would be helpful to have information about where to find a GP who is willing to work with people with a mental illness (see also Box 26-1).

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**People with mental illnesses appreciate being able to discuss their illness with their general practitioners, getting information about it from them.**

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**Box 26-1: Three stages of illness**

Symptoms leave me in the same order they came. I have spent years at various stages, but now I spend a few days at most and experience only the first three stages. The first stage can appear easily, after I become overly tired or have been exposed to large groups of demanding folks with whom I feel uncomfortable. I have learnt to watch for this stage and then to examine my recent environment. Getting more sleep, in conjunction with some quiet, and a low sugar diet seem to aid in restoring the peace.

Sometimes I go into the second stage, which can easily scare me. The fear alone exacerbates my condition into the third stage. Physical illness can trigger many miserable days at this level of existence. In all stages, but especially this stage, keeping calm is important. It is very important that I talk to others. People who have helped in earlier crises can remind me of things I can do to regain control. Sometimes it really helps for people just to acknowledge that I am feeling uncomfortable, and even though they believe it will pass, they have empathy for what I am feeling. They do not try to argue me out of my feelings, but comfort and guide me<sup>1</sup>.

**What did not help?**

The primary thing, which does not help, is an unwillingness or inability to communicate with me. Included in the basket of apparent poor communication skills are mixed messages. Body language, which conflicts with verbal rapport, leaves me feeling as though a person is not really listening to me.

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<sup>1</sup>Lovejoy M. *Recovery from schizophrenia*. Hospital and Community Psychiatry 1984; 35:8.

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**People may pick up non-verbal cues that suggest that the general practitioner is not listening.**

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When I spoke to one particular doctor, his body language suggested to me that he wasn't listening. He kept fiddling with his pen in a nervous sort of way as I was speaking (see also Box 26-2).

**Box 26-2: Interventions that do not help**

It does not help when professionals pretend to know about my illness and how to treat it when they apparently do not. It is much better to admit the limits of knowledge and ability than to persist with inappropriate treatment. I know there is still much ground to cover before the scientific community fully understands the aetiology of mental illness. It is better to admit to me the limits of understanding and treatment so that I do not build up false hopes and expectations about the recovery.

One day, in deep curiosity, I quickly read my hospital chart, left in my room by a careless intern. It was then that I became aware of the words that labelled me. At first, I felt relieved. I thought, good—they know what's wrong with me. Soon they will fix it once and for all and end my torment. I was influenced by the television doctor shows in which brilliant minds quickly ended people's suffering. I patiently took my medication and waited for the magic. It never came<sup>1</sup>.

There appears to be significant social stigma associated with mental illness. Community attitudes toward people with a mental illness make it difficult for me to move freely in society. Not only do others fear my illness, but I also fear it. It creates a barrier for me. I cannot change the attitudes of everybody in the community and, as yet, the illness I have has been resistant to change. This is not to say that I am unwell all the time. In reality, I am well most of the time, and people would not know that I had a mental illness at all.

**Conclusion**

Persons diagnosed with a mental illness have the same basic needs as everyone else in the community. It is important for people with a mental illness to have good rapport with their GP. It is also important for GPs to have an understanding of mental illnesses, appropriate medications and their effects. Most importantly, we need to have a GP with a caring and approachable manner and a willingness to help at all times, especially when we are unwell.

It is also important to be aware of the power of labels in our society. It is better to relate to people with mental illness as individuals, not as schizophrenics or obsessive-compulsive, etc.

The sooner the community is more informed and educated about mental illness the better. We do not refer to people with a physical complaint by some label. It is unlikely that you will hear about a diabetic thief, but you may hear about a schizophrenic shoplifter. Labels imply that others with the same label will always behave in the same way and this is not the case. I am a person foremost, and then I am simply an individual who seeks as normal a life as possible and my deserved place in society.

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**Treat the person, not just the illness.**

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The experiences of two carers are described in Boxes 26-3 and 26-4 on the following page.

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<sup>1</sup>Lovejoy M. *Recovery from schizophrenia*. Hospital and Community Psychiatry 1984; 35:8.

### **Box 26-3: Experience of a carer (1)**

By the time my son was 17 he had become very angry and disruptive. I think the phrase we used then was, 'Here comes trouble'. That was the time he started to smoke pot. He moved to the coast at 20 years of age where he slowly deteriorated, and lost all of his possessions and job prospects.

When he came home he would be abusive and would forewarn us about people out there who were trying to kill him and would kill us also. He said these people were following him, and would shoot him if they caught him.

At this time he wore a hat and said that the fluorescent light affected his brain. As he hadn't seen a GP for some time, I went back to the doctor who treated him during his growing years. I had voiced my concerns to her and she suggested I make an appointment for him to see her. After his visit, the GP suggested that he see a local psychiatrist.

Four years ago it took three months to get an assessment by a psychiatrist and by then he was back at the coast. By this time my son was living on the streets of the Gold Coast. Again I approached the GP with the question, 'How could a person in his condition look for employment, let alone look after his well being'. She suggested I ring the police and make arrangements to get him to be taken to the hospital for an assessment. I informed my husband of my conversation with the GP and he was horrified to think of doing this. Maybe if the GP explained the Mental Health Act more clearly at this time, my son may have received his treatment earlier.

As another year passed, his behaviour got worse. He said the television sent him messages and certain songs frightened him. Finally, the GP and myself persuaded my husband to take our son to the hospital where he was given three tablets and sent home to return the next day. This was like a slap in the face, as it took me two years to get him to this point. After much persuasion, my son and I returned to the Logan Hospital where he was admitted for one month and was discharged with the diagnosis of schizophrenia.

### **Box 26-4: Experience of a carer (2)**

Our son really became withdrawn when he finished his schooling at the age of 18. Although, looking back, he had become very shy while still at school.

He spent most of the following year playing his computer or listening to music. He also played club football, although he didn't really interact with his fellow team members off the field.

Eventually, he started a TAFE course in September of the same year. He found the TAFE course very stressful, as he had to use public transport to get there and he was required to do work experience.

At the end of the sixth week, I remember he came running to the car, the happiest I'd seen him in months. He said the world was going to change and God had selected certain people to help him. These people were mainly in the music industry. I thought perhaps someone had told him this during the day, but I was concerned about the sudden changes in his mood.

The next day, which was Saturday, he woke us by running through the house screaming and telling us to look at the sky—God was coming. He told us he had seen a bright light in the sky during the night and he was sure it was a UFO. He thought his father was some kind of demon and he could smell a terrible odour. He was also experiencing strange sensations in his hands and feet as though they had suckers on them.

We managed to calm him down, but by midday he still couldn't relax. Our first thought was that someone might have slipped some kind of drug into his drink at college the day before. He had always been strongly against drugs, so we knew it wasn't something he would have taken deliberately.

At this time, I decided to ring our local medical centre to get some advice. The GP on duty said to bring him straight down, which we did. She took us in and had a quiet talk with our son asking him his name, if he knew what day it was etc. She then asked him what he had been experiencing. When he had finished, she asked him where he would probably feel most safe. He thought he would feel safer in hospital. She then wrote out a referral for Princess Alexandra Hospital and he was admitted that evening.

Although it was a horrendous experience at the time, I think the whole situation was made so much easier by the sympathetic and caring attitude of our GP.



## Further information

### Training course

#### SPHERE program

The SPHERE program comprises four components: a case-identification system designed specifically for use in primary care; an initial four-seminar training program for managing anxiety and depression; a 12-month disease management program for depressive disorders; and the provision of ongoing educational and practice support. For general practitioners who have completed the initial training program, a further series of seminars is offered on cognitive behavioural treatments, chronic fatigue and chronic pain, geriatric depression and adolescent mental health problems. The program has been developed within the Academic Department of Psychiatry, St George Hospital and Community Health Service, Kogarah, NSW<sup>1</sup>.

#### Essential texts

1. Writing group. *Therapeutic Guidelines: Psychotropic Version 4, 2000*. North Melbourne, Therapeutic Guidelines Ltd, 2001.

Since drug treatments change so rapidly, you need to get each new edition as it becomes available.

2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington, DC, American Psychiatric Association, 1994.

This is the definitive guide to diagnosis.

#### Reference texts

1. Treatment Protocol Project. *Management of Mental Disorders*. 2nd ed. Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1997.

This comprehensive reference in two volumes covers the recognition and treatment of mental disorders. It contains resource materials, including interview schedules and assessment instruments to aid management decisions and to monitor progress, plus educational handouts and homework exercises for patients.

2. Bloch S, Singh BS. *Foundations of Clinical Psychiatry*. Second Edition. Carlton South, Melbourne University Press, 2001.

This is a succinct and well-written textbook of psychiatry.

3. Keks N, Burrows GD eds. *MJA Practice Essentials – Mental Health*. North Sydney, NSW: Australasian Medical Publishing Company Limited, 1998.

This is a succinct but comprehensive guide to assist general practitioners to deliver psychiatric care in the community.

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<sup>1</sup>Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. *Treating Depression and Anxiety in General Practice: Training Manual*. Kogarah, NSW: Educational Health Solutions, 1998.

## Appendix 1 – Example of a SPHERE Questionnaire

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Region	Practice number	GP surname	GP initial	Postcode	Patient number

### SPHERE - GP

Female ☐ Male ☐ Date of Birth    Postcode

Day Month Year

We would like to know about your general health.  
For **ALL** questions, please fill in the appropriate  
response circle. Please fill in the circles like this: ●

*For example:*

*Are you troubled by nightmares?*

some of  
the time  
or never ☐ a good  
part of  
the time ☒ most  
of the  
time ☐

Over the **past few weeks** have you been troubled by:

	never or some of the time	a good part of the time	most of the time		never or some of the time	a good part of the time	most of the time
1. Headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Sore throats?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling irritable or cranky?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Numb or tingling sensations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Poor memory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Feeling constantly under strain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Pains in your arms or legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Joint pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Feeling nervous or tense?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Weak muscles?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Muscle pain after activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23. Feeling frustrated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Waking up tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Diarrhoea or constipation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Rapidly changing moods?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25. Poor sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Fainting spells?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26. Getting annoyed easily?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Nausea?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27. Everything getting on top of you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Arms or legs feeling heavy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28. Dizziness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Feeling unhappy and depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29. Feeling tired after rest or relaxation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Gas or bloating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30. Poor concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Fevers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	31. Tired muscles after activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Back Pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	32. Feeling lost for words?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Needing to sleep longer?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	33. Losing confidence?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Prolonged tiredness after activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	34. Being unable to overcome difficulties?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you recently:

35. thought that you should cut down on alcohol or addictive drugs?

No Yes

☐ ☐

36. had a friend, relative or doctor suggest that you should cut down on alcohol or addictive drugs?

☐ ☐

Reason for seeing your doctor today: \_\_\_\_\_

Today's date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day	Month	Year			

Adapted from: Hickie I, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. Treating depression and anxiety in general practice: training manual. Kogarah, NSW: Educational Health solutions, 1998. Note: This example is provided for your information only. Original copies of this form can be obtained from Educational Health Solutions, Suite 13, 3<sup>rd</sup> Floor, St George private Hospital and Medical Complex, 1 South Street, Kogarah, NSW 2217. These forms can then be sent to the above address to be analysed. Alternatively, a CD-ROM is available for their analysis.

## Appendix 2 – Mini-Mental State Examination<sup>1</sup>

This instrument can be used to give a quantitative estimate of the severity of a person's cognitive impairment, or to serially document cognitive change. A score of less than 20 suggests a diagnosis of dementia, delirium, schizophrenia or affective disorder. Such a score is not found in normal elderly people or in those with a primary diagnosis of neurosis or personality disorder. The test is not expected to replace a complete clinical appraisal in reaching a final diagnosis.

### Instructions for administration of mini-mental state examination

#### *Orientation*

1. Ask for the date. Then ask specifically for any parts omitted, e.g. 'Can you also tell me what season it is?' Give one point for each correct answer.
2. Ask in turn 'Can you tell me the name of this hospital?', (and city or suburb, etc). Give one point for each correct answer. Note that this instrument was standardised for use in hospital populations. In general practice, you might ask the street and the practice name instead of the hospital and ward.

#### *Registration*

Ask the person if you may test his or her memory. Then state the names of three unrelated objects (e.g. ball, pen, key) slowly and clearly, about one second each. After you have said all three, ask the person to repeat them. This first repetition determines the score (0–3), but keep saying them until he or she can repeat all three, up to six trials. If the person does not eventually learn all three, recall (see below) cannot be meaningfully tested.

#### *Attention and calculation*

Ask the person to begin with 100 and count backwards by seven. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of correct answers. If the person cannot or will not perform this task, ask him or her to spell the word 'world' backwards. The score is the number of letters in correct order, e.g. dlrow = 5, dlrow = 3.

#### *Recall*

Ask the person if he or she can recall the three words you previously asked him or her to remember. Score 0–3.

#### *Language*

Naming – Show the person a watch and ask him or her what it is. Repeat with a pencil. Score 0–2.

Repetition – Ask the person to repeat the sentence after you. Allow only one trial. Score 0 or 1.

Three-stage command – Give the person a plain blank piece of paper and repeat the command. Score 1 point for each part correctly executed.

Reading – On a blank piece of paper print the sentence 'CLOSE YOUR EYES' in letters large enough for the person to see clearly. Ask him or her to read it and do what it says. Score 1 point only if the person actually closes his or her eyes.

Writing – Give the person a blank piece of paper and ask him or her to write a sentence for you. Do not dictate a sentence—it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.

Copying – On a clean piece of paper, draw intersecting pentagons, each side about one inch, and ask him or her to copy it exactly as it is. All 10 angles must be present and two must intersect to score 1 point. Tremor and rotation are ignored.

Estimate the person's level of sensorium along a continuum, from alert on the left to coma on the right.

<sup>1</sup>Folstein MF, Folstein SE, McHugh PR. 'Mini-Mental State': a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 1975 12: 189–198.

## MINI-MENTAL STATE

Patient: ..... Examiner: .....

Date: .....

Max.

Score SCORE

### Orientation

5 ( ) What is the (year) (season) (date) (day) (month)?

5 ( ) Where are we: (state) (city) (suburb) (hospital) (floor/ward)?

### Registration

3 ( ) Name three objects: one second to say each.  
Then ask the person all three after you have said them.  
Give 1 point for each correct answer. Then repeat them until  
he learns all three.  
Count trials and record.  
Trials =

### Attention and Calculation

5 ( ) Serial 7s. 1 point for each correct. Stop after five answers.  
Alternatively, spell 'world' backwards.

### Recall

3 ( ) Ask for the three objects repeated above. Give 1 point for each correct.

### Language

9 ( ) Name a pencil and watch (2 points)  
Repeat the following: 'No ifs, and or buts'. (1 Point)  
Follow a three-stage command:  
    'Take a paper in your right hand, fold it in half, and put it  
    on the floor'.  
    (3 points)  
Read and obey the following:  
    CLOSE YOUR EYES (1 point)  
    Write a sentence (1 point)  
    Copy design (1 point)

Total score: ..... (Maximum score = 30)

ASSESS level of consciousness along a continuum:

30                      Alert                      Drowsy                      Stupor                      Coma



## Appendix 3 – Structured problem solving

Use this chart to help solve problems that are causing you stress. If problems are not dealt with, they often worsen and cause more stress.

1. Make a list of the things that are worrying you.
2. Choose the problem that you want to deal with first and write it down as a need or a goal (e.g. 'I need to find a job', rather than 'I don't know what to do with myself'. Or, 'I need to have more money in the bank', rather than 'I haven't got enough money').
3. Write down all the possible solutions you can think of. List all solutions, including bad or silly ones—the aim, at this stage, is not to decide if a solution is good or bad. You might want to ask other people whom you trust to suggest some other possible solutions.
4. Beside a list of the possible solutions, draw two columns and write in them the advantages and disadvantages of each. Your GP or another person you trust may be able to help you with this.
5. Choose the best solution. It does not have to be the perfect solution—there rarely is such a thing. But it is better to try some solution than to do nothing at all.
6. Write down the steps needed to carry it out. Include the things you need to do, the resources that you require (e.g. a car or a day off work), the hurdles you need to overcome, and the time you anticipate that it will take. You may need to rehearse some of the steps (e.g. a difficult interview or phone call). Decide on your goals so that after you have put the plan into action, you can assess how well it worked (for example, the goal might be having more money in the bank, going out with friends once a week, or having fewer arguments with your spouse).
7. Put the plan into action.
8. Review how effective the solution was. First of all, congratulate yourself on trying to solve the problem rather than doing nothing. What have you achieved? What problems remain? Should you continue with the current solution, modify it or try a different approach?
9. Repeat the process for the remaining problems.

Note: When you are under severe stress, your ability to solve problems is often impaired. Avoid making major life decisions in the midst of a crisis.

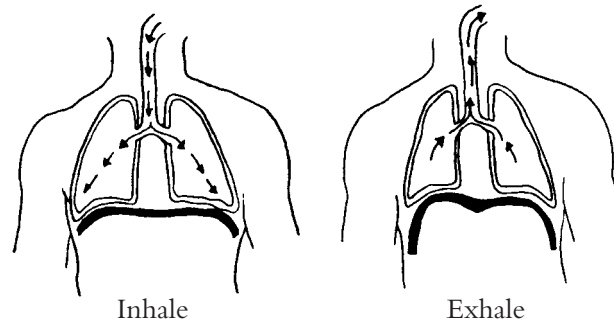
## Appendix 4 – Controlled breathing exercises

### 1. *Monitor your breathing rate*

Use your watch to monitor the number of breaths you take per minute at rest. The normal rate is between 10 and 14.

### 2. *Diaphragmatic breathing*

When people are anxious they tend to use muscles that lift the rib cage to breathe. When they are relaxed, they breathe using the diaphragm, a large muscle that stretches across the bottom of the rib cage and works like a large piston (see diagram below).



- Sit upright or lie flat.
- Place both hands across the upper abdomen, just below the rib cage, with the fingers of one hand just touching the fingers of the other hand.
- Breathe in through your nose.
- As you breathe in, the fingers will move apart.

### 3. *Slow breathing exercise*

When people are anxious they tend to over breathe. This then worsens the anxiety and can cause a number of physical symptoms: dizziness, chest pain, tingling in the fingers, a choking feeling, rapid heart rate, cold sweats, nausea, muscle tension and fatigue. This exercise helps you to slow your breathing down to a normal rate.

- Take a normal diaphragmatic breath.
- Hold your breath for 10 seconds.
- Breathe out. As you do so, say the word 'relax'.
- Then breathe in and out in six-second cycles, three seconds in and three seconds out. Say 'In, two, three' as you breathe in, and 'Relax, two, three' as you breathe out.
- After a minute (10 breaths), hold your breath for 10 seconds and repeat the cycle.
- Do the exercise for around five minutes.

### 4. *Check your rate of breathing*

On completion of the exercise, record your breathing rate again.

## Appendix 5 – Progressive muscular relaxation

This method of relaxation involves tensing muscle groups in sequence.

- Find a quiet place where you will not be interrupted for at least 20 minutes.
- Sit in a comfortable chair with your feet flat on the floor.
- Close your eyes.
- Perform the controlled breathing exercise for five minutes.
- Tense each of the following muscle groups for five seconds as you breathe in. Then relax for five seconds as you breathe out and say 'relax'.

Hands – clench fists

Forearms – bend hands up at the wrist

Forearms and upper arms – bend your elbows and tense your upper arm and forearm

Shoulders – lift your shoulders

Neck – move your neck forward, then back, then to the left, then to the right

Neck – turn your head to the right, then to the left

Neck – tense the muscles at the front of your neck

Forehead and scalp – raise your eyebrows

Face – screw up your eyes

Jaw – clench your teeth

Jaw – open your mouth wide

Chest – breathe in deeply

Abdomen – pull in your abdomen

Back – tense your back muscles as if lifting a heavy weight

Buttocks – tighten your buttocks

Calves and hamstrings – pull your heels against the floor

Thighs – push your toes into the floor

Calves – bend back your feet

Feet – curl your toes down

- Continue the controlled breathing for five minutes.

*Note:*

- You will need around 20 minutes to complete this exercise.
- You can use the same principles to relax specific muscle groups when you notice they are becoming tense.
- You can perform similar exercises while standing, e.g. standing on tiptoe, clasping your hands behind your back, pressing the palms of your hands together in front of you etc.
- Audiotapes are available from Queensland Health that take you through the exercise.

## Appendix 6 – Self-hypnosis

Self-hypnosis can help you take your mind off your things you are worrying about and make you aware of things in your environment that can help your body to relax and make you feel safe. The more you practice it, the better you will get.

Say 5 things you can SEE around you.

Say 5 things you can HEAR around you.

Say 5 things you can FEEL in your body.

Say 4 things you can SEE around you.

Say 4 things you can HEAR around you.

Say 4 things you can FEEL in your body.

Say 3 things you can SEE around you.

Say 3 things you can HEAR around you.

Say 3 things you can FEEL in your body.

Say 2 things you can SEE around you.

Say 2 things you can HEAR around you.

Say 2 things you can FEEL in your body.

Say 1 thing you can SEE around you.

Say 1 thing you can HEAR around you.

Say 1 thing you can FEEL in your body.

It does not matter if you use the same things to see, feel or hear when repeating the exercise. At the end of the exercise, take a deep breath in and slowly out again, saying the word 'calm'.

## Appendix 7 – Daily activity schedule

	Sunday	R	Monday	R	Tuesday	R	Wednesday	R	Thursday	R	Friday	R	Saturday	R
Morning 0600–0900 0900–1200														
Afternoon 1200–1500 1500–1800														
Evening 1800–2100 2100–2400														

R = rating of pleasure or satisfaction. Rate your level of pleasure in doing things that you enjoy. Rate your satisfaction in fulfilling obligations and duties that you need to perform. Use a scale of 0 (= no pleasure or satisfaction) to 10 (= high level of pleasure or satisfaction).

## Appendix 8 – Treatment of agoraphobia by exposure to the feared situation

After people have suffered a panic attack, they often avoid the place where it occurred for fear they will have another panic attack. Later, they may fear going to other places. Their lives become increasingly dominated by their fears, and they may finally be unable to leave the house unless accompanied by their spouse or a close friend.

The aim of this treatment is to break this cycle, overcome your fears, and once again feel comfortable going out.

1. Use the slow breathing technique and the progressive muscle relaxation before each step. You can also use these exercises to control your anxiety in the feared situation.
2. Make a list of the situations that make you feel panicky or fearful.
3. Arrange them in order from least fearful to most fearful.
4. Choose one that you feel can cope with.
5. Write down the specific fears you have about that situation (e.g. at the cinema, that you won't be able to get out).
6. Make a list of the steps that you will need to take.  
For example: going to the cinema:
  - go with friend and sit outside
  - go alone and sit outside
  - go with friend and sit in the foyer
  - go alone and sit in the foyer
  - go with friend to a weekday matinee and sit near the door
  - go alone to a weekday matinee and sit near the door
  - go with friend on a Saturday night and sit near the door
  - go alone on a Saturday night and sit near the door
  - go with friend on a Saturday night and sit in the middle of the theatre
  - go on a Saturday night alone and sit in the middle of the theatre.
7. Put the first step into action.
8. It is important that you stay in the situation until your anxiety has lessened.
9. Monitor your level of anxiety and notice how it starts to decrease the longer you stay in the situation.
10. Wait until you no longer feel anxious before moving to the next step.

Note: Aim to do without any 'safety aids'. These might include having other people with you (as in the example), or using devices such as mobile phones. The treatment requires you to confront your anxiety at each step.

## Appendix 9 – Recording feelings, automatic thoughts and the situations in which they arise

People often talk to themselves mentally. However, they are not always aware of this self-talk. It is useful to identify your self-talk at times when you are experiencing unpleasant feelings. You can then examine and, when appropriate, challenge these thoughts.

The best approach is to record your feelings and thoughts near to the time that you experience them. Draw three columns on a piece of paper. In the first column record the situation you are in. In the second describe the feeling. In the third, write down your automatic thoughts.

Some words used to describe feelings include: angry, annoyed, anxious, ashamed, blue, depressed, devastated, disappointed, disgusted, down, elated, embarrassed, frustrated, guilty, happy, humiliated, insecure, irritable, looked down on, miserable, nervous, sad, scared, terrified, unhappy, unloved.

The thoughts that you particularly want to identify are those that give a negative personal meaning to the situation in which they arise. For example, a man feels miserable when he fails to get the job that he applied for. The voice in his head is saying, 'I'm a failure'. Some thoughts are predictions about what the event means for the future. For example, the man mentioned above may think, 'Now I will never get a job'. Others reflect on how we think others will react to us, for example, 'Everybody will think I am a fool'.

For the purposes of this exercise, some thoughts do not need to be recorded. Thoughts that are descriptions of how you feel should be recorded as feelings (for example, 'I feel embarrassed'). Descriptions of your thinking or experience should not be recorded either (for example, 'I could barely think straight, it was so stressful'). Instead, try to recall the thought itself and record that (for example, 'I will never be able to get this right').

Situation	Feeling	Thought
I did not get the job.	miserable	I'm a failure. Everybody will think I'm a fool. I will never get a job.
He ignored me when I entered the room.	disappointed and unhappy	I'm a bore. He dislikes me and thinks I'm unattractive. I will never be popular.

## Appendix 10 – Abnormal Involuntary Movement Scale (AIMS)

Name \_\_\_\_\_ Examiner \_\_\_\_\_

Date \_\_\_\_\_

### Examination procedure

Either before or after completing the examination procedure observe the person unobtrusively, at rest (e.g. in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

Ask the person whether there is anything in his or her mouth (e.g. chewing gum) and if there is, to remove it.

Ask the person about the current condition of his or her teeth. Ask the person if she or he wears dentures. Do teeth or dentures bother the person now?

Ask the person whether she or he notices any movements in mouth, face, hands or feet. If yes, ask to describe and to what extent they currently bother the person or interfere with his or her activities.

- 1 Have the person sit on chair with hands on knees, legs slightly apart and feet flat on the floor. (Look at entire body for movements while in this position.)
- 2 Ask the person to sit with hands hanging unsupported—if male, between legs, if female and wearing a dress, hanging over knees. (Observe hands and other body areas.)
- 3 Ask the person to open mouth. (Observe tongue at rest.) Do this twice.
- 4 Ask the person to protrude tongue. (Observe abnormalities of tongue movement.) Do this twice.
- 5 \*Ask the person to tap thumb, with each finger, as rapidly as possible for 10–15 seconds; separately with right hand, then with left hand. (Observe facial and leg movements.)
- 6 Flex and extend the person's left and right arms (one at a time), noting any rigidity.
- 7 Ask the person to stand up. (Observe in profile. Observe all body areas again, hips included.)
- 8 \*Ask the person to extend both arms outstretched in front with palms down. (Observe trunk, legs and mouth.)
- 9 \*Have the person walk a few paces, turn, and walk back to chair. (Observe hands and gait.) Do this twice.

\* *Activated movements*

Note: A detailed scoring chart for the AIMS can be found in Guy W. ECDEU Assessment Manual for Psychopharmacology. Washington DC: US Department of Health, Education and Welfare, 1976: 534–537.



## Appendix 11 – Treatment of sleep disturbance

### History

In taking the history, note the following:

1. The presenting complaint

- the pattern of the sleep problem – difficulty falling asleep, early morning wakening, broken sleep or unrefreshing sleep
- the duration of the problem, and any precipitants
- daytime drowsiness – in particular, ask about the ability to stay awake during passive or dull activities
- the daily routine – getting up, going to work, taking naps, going to bed
- associated symptoms – for example, in sleep apnoea, there may be morning headache and confusion

2. Drug and alcohol history

The following prescription drugs may interfere with sleep:

- steroids
- theophylline
- decongestants
- benzodiazepines, especially during withdrawal (Short-acting benzodiazepines such as alprazolam can cause early morning wakening due to withdrawal.)
- anti-depressants, including MAOIs, SSRIs and moclobemide, especially early in treatment or following a dose increase
- chemotherapeutic agents
- thyroid replacement hormones
- oral contraceptives
- anti-hypertensives, including beta blockers and alpha methyl dopa.

Non-prescription substances that can cause insomnia include:

- alcohol
- nicotine
- caffeine
- amphetamine
- cocaine

3. Relevant medical history

In particular, the following interfere with sleep:

- congestive cardiac failure
- chronic airway disease
- any condition that causes pain, for example arthritis and peptic ulcer
- diabetes may cause sleep problems through painful neuropathies or hypoglycaemic episodes
- Parkinson's disease

4. Past psychiatric history

The following are commonly associated with sleep disturbance:

- depression
- panic disorder
- mania
- generalised anxiety disorder
- post-traumatic stress disorder
- anorexia nervosa
- schizophrenia

5. Collateral history from spouse or partner

People with sleep apnoea will typically have episodes of snoring that grow in volume until interrupted by a period of apnoea (see below). The partner may provide the history, clarify any stressors or other precipitants, and confirm the person's alcohol and drug history.

6. Sleep diary

The commonest cause of daytime sleepiness is not getting enough sleep, something that the person may not be aware of until asked to document it. The diary may also uncover other problems in sleep hygiene (see below).

## Diagnosis and treatment

1. No diagnosis

People are sometimes unaware that sleep requirements vary from one person to another. They may present complaining that they do not get as much sleep as other family members, or that they do not sleep a particular number of hours. If there has been no recent change in the pattern of sleep, and if the person is fully refreshed by his or her sleep and experiences no daytime sleepiness, then the pattern is probably normal for that individual.

Treatment:

Education and reassurance

2. Disrupted sleeping habit

Making a sleep diary will often indicate that the person, because of work, domestic and social commitments, simply does not allow enough time for sleep. Sleeping-in over the weekend may further exacerbate the problem. Similarly, many people develop disrupted sleep in the face of stress. The pattern may then continue even after the stress has been resolved.

Treatment:

Improve sleep habit (see guidelines for improving the sleep habit, Table 14-3)

3. Disorders of the sleep/wake cycle

People at risk of these disorders include those travelling frequently across different time zones, for example, airline staff, shift workers, and people with chaotic sleep patterns. There is considerable variation in the ability of individuals to adapt to these changes.

Treatment:

Education (see Table 14-3)

4. Insomnia due to a physical condition

Treat the underlying condition There may be a coexistent mental disorder (e.g. depression or anxiety).

5. Insomnia due to a mental disorder

Treat the primary disorder.

- a) Adjustment disorder – This is probably the commonest cause of sleep difficulties among people presenting to general practitioners. The disrupted sleep patterns may persist after the stress has been resolved.

Major depression is often accompanied by early morning wakening, but may present with any of the patterns of insomnia. Sometimes depression is associated with an increase in sleep time.

- b) Anxiety disorders (panic disorder, generalised anxiety disorder, post-traumatic stress disorder) – The most typical pattern is difficulty getting to sleep. People suffering post-traumatic stress disorder may suffer nightmares of the traumatic event.
- c) Mania – There is, typically, a decreased need for sleep
- d) Schizophrenia – The sleep pattern is often disrupted in acute psychosis. People with chronic schizophrenia may have a reversed sleep cycle, sleeping through the day and staying awake through the night.

6. Specific sleep disorders

- a) *Sleep apnoea* – An apnoeic episode occurs when there is a cessation of airflow for greater than 10 seconds. The diagnosis of sleep apnoea requires at least five episodes per hour or 30 overnight. In central sleep apnoea, respiratory effort stops; in obstructive sleep apnoea, airflow ceases despite an increase in respiratory effort. The apnoeic episodes end when the person is aroused from sleep. The person may be unaware of this disrupted sleep pattern. Complications include cardiac arrhythmias, hypertension, pulmonary hypertension and sudden death.

It has been estimated that up to 40 per cent of people presenting with excessive daytime sleepiness may suffer from sleep apnoea. The condition most commonly affects middle-aged or older men. Obese men are at higher risk (Pickwickian syndrome). Sufferers may complain of tiredness and an inability to stay awake during the day, but may not report problems with sleep. The spouse may describe loud snoring, gasping, and apnoeic episodes. There may be morning headaches and depression.

You may need to refer the person for sleep studies. These include measurements of airflow, ECG, EEG and electromyogram recordings. Some centres require referral from a respiratory physician.

Treatment includes the avoidance of medications or substances that depress respiration, including alcohol and sedative anti-depressants. Various mechanical devices and surgical procedures have been developed to alleviate obstruction.

- b) *Narcolepsy* – This is a rare condition affecting around four in 10,000 people that is caused by the frequent intrusion of periods of REM sleep during normal waking hours. Symptoms include daytime sleepiness, sleep attacks, cataplexy (a sudden loss of muscle tone), hypnagogic hallucinations, sleep paralysis (being unable to move on waking) and, rarely, blackouts that are sometimes associated with automatic behaviours similar to dissociative episodes (e.g. travelling somewhere and then forgetting how one got there). Onset is usually before the age of 30. It is potentially dangerous because of the risk of accidents.

Investigations include sleep studies, which reveal the rapid appearance of REM periods after the onset of sleep (within 10 seconds). Treatment involves taking forced naps regularly during the day, the use of stimulants (amphetamine or methylphenidate) and tricyclic antidepressants for cataplexy.

## Appendix 12 – Edinburgh Postnatal Depression Scale (EPDS)<sup>1</sup>

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist primary care health professionals to detect mothers suffering from postnatal depression, which is a distressing disorder more prolonged than the ‘blues’ (which occur in the first week after delivery), but less severe than puerperal psychosis.

Previous studies have shown that postnatal depression affects at least ten per cent of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term effects on the family.

The EPDS was developed at health centres in Livingstone and Edinburgh. It consists of 10 short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than five minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases, it may be usefully repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

### Instructions for users

1. The mother is asked to underline the response that comes closest to how she has been feeling in the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty reading.
5. The EPDS may be used at six to eight weeks to screen postnatal women. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.
6. Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1 and 0). The total score is calculated by adding together the score for each of the 10 items.

---

<sup>1</sup> Cox JL, Holden JM, and Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 1987; 150:782-786.

## The Edinburgh Postnatal Depression Scale

J. L. Cox, J. M. Holden, R. Sagovsky

Department of Psychiatry, University of Edinburgh

---

Name:

Address:

Baby's age:

As you have recently had a baby, we would like to know how you are feeling. Please underline the answer which comes closest to how you have felt in the past seven days, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all of the time

Yes, most of the time

No, not very often

No, not at all

This would mean: 'I have felt happy most of the time' during the past seven days. Please complete the other questions in the same way.

---

### In the past seven days:

1. I have been able to see the funny side of things

As much as I always could

Not quite so much now

Definitely not so much now

Not at all

2. I have looked forward with enjoyment to things

As much as I ever did

Rather less than I used to

Definitely less than I used to

Hardly at all

\*3. I have blamed myself unnecessarily when things went wrong

Yes, most of the time

Yes, some of the time

No, not very often

No, never

4. I have been anxious or worried for no good reason

No, not at all

Hardly ever

Yes, sometimes

Yes, very often

**In the past seven days:**

\*5. I have felt scared or panicky for no very good reason

Yes, quite a lot

Yes, sometimes

No, not much

No, not at all

\*6. Things have been getting on top of me

Yes, most of the time I haven't been able to cope at all

Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

\*7. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

\*8. I have felt sad or miserable

Yes, most of the time

Yes, quite often

No, not very often

No, not at all

\*9. I have been so unhappy that I have been crying

Yes, most of the time

Yes, quite often

Only occasionally

No, never

\*10. The thought of harming myself has occurred to me

Yes, quite often

Sometimes

Hardly ever

Never

## Appendix 13 – The ADHD rating scale<sup>1</sup>

**Child's Name** ..... **Age**..... **Grade**.....

**Completed by** .....

Circle the number in the ONE column that best describes the child.

	Not at all	Just a little	Pretty much	Very much
Often fidgets or squirms in seat	0	1	2	3
Has difficulty remaining seated	0	1	2	3
Is easily distracted	0	1	2	3
Has difficulty awaiting turn in groups	0	1	2	3
Often blurts out answers to questions	0	1	2	3
Has difficulty following instructions	0	1	2	3
Has difficulty sustaining attention to tasks	0	1	2	3
Often shifts from one uncompleted activity to another	0	1	2	3
Has difficulty playing quietly	0	1	2	3
Often talks excessively	0	1	2	3
Often interrupts or intrudes on others	0	1	2	3
Often does not seem to listen	0	1	2	3
Often loses things necessary for tasks	0	1	2	3
Often engaged in physically dangerous activities without considering consequences	0	1	2	3

<sup>1</sup>Reproduced with permission of the author, GJ DuPaul, Program Coordinator, School of Psychology, Lehigh University, 111 Research Drive, Bethlehem PA 18015. From DuPaul GJ, Power TJ, Anastopoulos AD, Reid R. *ADHD Rating Scale-IV: Checklists, Norms and Interpretation*. New York: Guilford, 1998.





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