19. MENTAL HEALTH PROBLEMS

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19.2 Introduction

19.2.1 Depending on the way in which mental health problems are defined 10% of the population, at any one time, can be said to be affected by some kind of mental health problem. Mental distress is experienced by many people without necessarily having an exact mental health diagnosis and such people often go unrecognised and untreated.

19.2.2 Only a small minority of people with mental health problems are referred to psychiatric services, and these are typically people with severe or chronic forms of mental illness. Most people with the more severe mental health problems are rarely seen by mental health professionals until late in the episode. Indeed the majority of people with mental health problems are managed entirely by the general practitioner or may never reach a health professional. Many of these people are frequently assessed initially, and usually treated in the general (ie. non-psychiatric) setting.

19.2.3 Mental health problems may give rise to attendance needs. These are usually in the form of supervision/watching-over, but severe mental illness may also give rise to needs for attention in connection with bodily functions. Mobility needs may also occur. In people with mental distress there may be combinations of disabilities, including a mix of physical and mental disabilities. The combination of these effects needs to be taken into consideration when assessing care needs.

19.2.4 Unfortunately, an unwarranted stigma is often attached to a diagnosis of mental illness despite greater understanding in the community in recent years. Some people with mental health problems, particularly depression, therefore may tend to minimise the mental health component and maximise symptoms that relate to physical disability. Moreover, a large number of physical disorders have psychological components. Both of these components need recognition and assessment in the proper determination of care needs.

19.3 Classification

19.3.1 Various forms of mental illness have been recognised in almost every culture in the world. Mental disorders encompass a very wide range of diverse illnesses which have been given a variety of different diagnostic labels. Although the nature and severity of disability in the individual case are of paramount importance in determining the nature and level of care needs, rather than the exact diagnosis of the condition giving rise to the disability, the following broad classification of mental health disorders greatly assists in predicting the likely range and extent of care needs which may be associated with them:

The Psychoses **(19.4)**

- **Schizophrenia** **(19.5)**
- **Severe Depressive Disorder, Manic-depressive psychosis (Bipolar Depression)** **(19.6)**

The Neuroses **(19.7)**

- **Generalised Anxiety Disorder** **(19.7.3)**
- **Panic Disorder** **(19.7.4)**
- **Phobic Anxiety Disorders** **(19.7.5)**
- **Obsessive - Compulsive Disorder** **(19.7.6)**
- **Mild Depressive Disorder** **(19.7.7)**
- **The Personality Disorders** **(19.8)**
- **Dissociative (and Conversion) Disorders, Hysteria and Somatoform Disorders** **(19.9)**

The Dementias **(Chapter 21)**

Drugs and Alcohol **(Chapter 22)**
Eating Disorders **(Chapter 23)**

19.3.2 Leaving aside the dementias which are most common in the elderly, and are separately described in Chapter 21; and alcohol and drugs abuse, and eating disorders which are covered in Chapters 22 and 23 respectively, this chapter will concentrate on the mental disorders listed above [para 19.3.1].
Factitious disorders and malingering are also dealt with for convenience at the end of this chapter [Paragraphs 19.10 and 19.11]. However these disorders involve a conscious and deliberate attempt to feign illness and its symptoms and are thus not conventionally considered to be mental health disorders

19.4 The Psychoses

Psychoses are severe forms of mental illness which affect the whole personality and

are used to describe sets of symptoms which commonly go together, create a severe burden on the affected person, and frequently give rise to major disturbances of thinking and behaviour which may pose considerable attendance needs. They can affect people of any level of intelligence, most of whom will have apparently developed normally, with no intellectual problems, during childhood and adult life until the onset of the mental condition. Psychoses affect thought, mood or behaviour singly or in combination. As a result many people with a psychotic condition will have high levels of physical and intellectual abilities but have difficulties in using them because of anxiety, lack of concentration, or apathy, etc, to an extent that they have problems coping with general daily tasks. Typically a person affected by a psychotic illness loses touch with reality, has disordered thought processes, delusions (false beliefs) and/or hallucinations (eg seeing non-existent things or hearing non-existent voices). They frequently lack insight (ie. they are not aware that they are ill). Some may be on medication which leaves them forgetful or drowsy or affects their bodily functions. The two most common psychoses are schizophrenia and manic-depressive psychosis.

19.5 Schizophrenia

19.5.1 Introduction

(i) Schizophrenia is one of the most serious forms of severe mental illness. Its lifetime prevalence is nearly 1%, its annual incidence is about 10-15 cases per 100,000 people in the population and the average general practitioner probably cares for 10-20 people with schizophrenia. Around 8% of people with schizophrenia are managed entirely by their general practitioner without referral to psychiatric services.

(ii) Contrary to continuing popular belief a person affected by schizophrenia does not have a split or multiple personality but has a general disturbance of thought processes and a disruption of the personality. The condition has profound effects not just on those affected, but also on their families and friends.

(iii) Onset in men is usually before the age of 30. In women the onset is a little later, by some four years.

19.5.2 Clinical Features

(i) People with schizophrenia may demonstrate positive symptoms of psychosis such as delusions, hallucinations and thought disorder, or negative symptoms such as social withdrawal, limited and slow thought, blunted emotions, loss of initiative and the sense of enjoyment. Some people show both positive and negative features to varying extents.

(ii) People with **thought disorder** may complain of poor concentration or of their mind being blocked or emptied (thought block). They may stop in mid speech in a perplexed fashion with continuing incoherent and disconnected speech. They may have difficulty following a train of thought

to a logical conclusion, with individual thoughts having only a very peripheral connection to each other.

(iii) **Hallucinations** are false perceptions in any of the senses. The person experiences a seemingly real voice or sound or smell, for example, although nothing has actually occurred. A common clinical feature of schizophrenia is that the affected person experiences voices talking about them or telling them to do something.

(iv) **Delusions** are false beliefs held with absolute certainty, dominating the person's mind, which have no apparent basis in reality, for example a false belief of persecution.

(v) The early stages of schizophrenia can vary considerably. A typical presentation is that a family expresses concern that a personality has changed or even makes a mistaken assumption that the causes of the observed changes are due to substance (drug) abuse. A decline in personal hygiene, depressive symptoms, loss of friends or jobs, all for no good reason, are commonly encountered. About one in ten people with severe forms of schizophrenia commit suicide, usually in the younger age groups. Although there have been some specific examples of violent attacks upon strangers, in general people with schizophrenia do not pose a danger to others..

(vi) **Medication** is generally effective in controlling hallucinations, delusions and thought disorder. Depot injections of long-acting drugs at two - to four - weekly intervals are useful to ensure that medication has been taken. These have to be given regularly and are likely to be needed as long-term treatment. Relief of symptoms is achieved in at least 70% of people with such treatments. However people who are receiving medication and regular supervision on at least a weekly basis by a community psychiatric nurse or other medical professional are likely to be among the most severely affected with a significant level of care needs.

(vii) **Side-effects** of the antipsychotic drugs used may pose particular problems, especially those adverse drug effects on movement. Parkinsonian symptoms [see Chapter 15] may occur. Sedation or depressed mood, or restlessness may also be distressing.

19.5.3 Outcome

(i) Up to 20% of people with schizophrenia will require long term, highly dependent structured care, sometimes in a hostel with day and night staff.

(ii) About half of affected individuals can live relatively independent lives with the need for varying levels of support and care, but require continuing medication.

(iii) Around 30% make a complete recovery from a single episode of illness and are independent, usually working full time, and raising families. General indications of a good outlook are a rapid onset, a short duration of illness, evidence that the person may also be depressed, onset in middle age, and a previously good social and work record.

19.5.4 Care Needs

(i) In the past, the care of people with schizophrenia was largely hospital based. The emphasis now is on integration in the community whenever possible. This may include living in group homes or attending day centres.

(ii) Hostels or group homes vary in structure and support, from the high dependence that can provide 24 hour care to semi-independence of a supported flat with someone visiting daily or less often. Attendance at a day unit can improve personal functioning (for example, hygiene, conversation and friendships) as well as providing early detection of relapse.

(iii) Whilst it may appear that people are functioning relatively well in the community, this may be only because of the level of support being provided, and is not necessarily an indication of low care needs. Without that support some people might neglect to take care of their personal needs and omit to take medication. As a consequence without such support some could return to a severely disturbed mental state.

(iv) When the person's mental state is severely disturbed there may be risks of danger arising from forgetfulness due to poor concentration. There may also be a need for supervision to avoid danger both to the person and to others. A person with a severely disturbed mental state will usually require hospitalisation, at least initially.

(v) Risk of suicide must be considered in young people with severe forms of schizophrenia [see para 19.5.2(v)]. Here again hospitalisation is likely if there is a requirement for continuing supervision because of that risk, but the mere absence of hospital admissions should not be taken to indicate that the risk does not arise

19.5.5 Mobility Considerations

(i) People with schizophrenia will be physically able to walk unless another disability or illness limits walking ability.

(ii) In the early stages of schizophrenia there may be a need for guidance or supervision when the person walks outdoors. However this need is likely to be short lived. Similarly, the adverse effects of drugs (particularly those

referred to as psychotropic drugs) which may produce muscle rigidity and symptoms of Parkinsonism [see Chapter 15] which to a certain extent can limit walking ability, are unlikely to persist for more than a few weeks. Drug treatments are available which counteract these types of side-effect. In some people long-term side effects of the psychotropic medications can persist, although not to an extent likely to affect walking ability.

19.5.6 Duration of Needs

(i) See outcome at paragraph 19.5.3 above.

(ii) A rapid onset of schizophrenia in middle age, without a previous history of psychological problems, may indicate that the person will respond well to treatment and not have any long term care needs. However, a more gradual onset in a younger person may indicate that the condition and its associated disabilities is likely to persist for very many years and, indeed, in some throughout life.

(iii) The prescription of long-term medication, including the use of depot injections, may be an indication that the condition has been difficult to control and that the level of care needs in the individual person are likely to be long-standing. Similarly, a high level of professional support in the community (see paragraph 19.5.4 (ii)) is only likely to be given to those with significant ongoing disability.

19.5.7 Further Evidence

(i) In many cases, people with schizophrenia may not be able to express adequately their needs on the self-reporting claim form. A factual report from the consultant psychiatrist, the community psychiatric nurse, other mental health professional, or the general practitioner should be sought to establish the level of support and care needs required. In complex cases advice may also be sought from a Medical Services doctor to assist in posing questions which will focus on particular aspects of the person's management and care needs that require clarification.

19.6 Severe Depressive Disorder [Psychotic Depression; Manic Depressive Psychosis; Bipolar Affective Disorder]

19.6.1 Introduction:

(i) Depression is a word commonly used by people when describing feelings of unhappiness. However, depression becomes a recognisable illness when the degree of mood change is out of proportion to the circumstances and is unduly prolonged. It is also normal to feel elated at times of good fortune. Mania, however, is also a recognisable illness when the degree of elation

(ie. elevated mood) is highly abnormal and frequently accompanied by overactivity and self important ideas.

(ii) "Affect" means the same thing as mood. In those conditions where the main feature is an abnormality of mood, the term affective disorders is sometimes used.

(iii) Severe depressive disorder is sometimes called **psychotic** depression because like other psychoses it is a severe mental illness in which there can be delusions and/or hallucinations. In this type of severe depression there is most commonly no apparent cause for the profound state of misery. Because of this it is sometimes referred to as **endogenous depression**. In other words, the symptoms are caused by factors within the individual person and are unrelated to external stressors such as unsatisfactory life situations. However there are people with **endogenous depression** who, though severely depressed, do not show psychotic features like hallucinations, etc.

(iv) When psychotic depression occurs in people who also have bouts of mania with intense feelings of well being and grossly overactive behaviour, the mental illness is called **manic-depressive psychosis**. Because of these swings in mood the illness may also be called **bipolar affective disorder**.

(v) Another form of depression is usually associated with an obvious cause (eg. bereavement, redundancy, failed marriage etc) and this form is usually a much milder illness. It is referred to as mild depressive disorder or reactive **depression** or **neurotic depression** Usually this is a mild depressive disorder but in some people with reactive depression individual responses to major adverse life events can precipitate more severe forms of depressive illness. [See paragraphs 19.7.7]. Physical symptoms (eg poor appetite, weight loss, constipation, loss of sex drive) occur to a varying extent in mild depressive disorder, but are commonly much less severe than in people with severe depressive disorder, and care and mobility needs are not usually present.

(vi) **Post natal depression** is a disorder which affects women shortly after childbirth. In the great majority of cases this is a mild condition (commonly called "the baby blues") which resolves spontaneously within a few days. A few women, however, develop a severe psychotic depression which may last several weeks and require hospital treatment.

(vii) This section is not concerned with feelings of sadness or elation as normal experiences but with those mental illnesses in which the single most important feature is disturbance of mood. Sometimes, even in medical reports from general practitioners the term "depression" is used rather loosely to describe states of unhappiness rather than the recognisable mental disorder.

19.6.2 Clinical Features:

Severe Depressive Disorder:

(i) Each year around 100 per 100,000 men and at least three times as many women, develop severe depressive disorder. The mood is one of misery. It does not improve substantially in circumstances where ordinary feelings of sadness would be alleviated. However in some people with this illness the mood is usually worse in the morning and tends to improve somewhat later in the day. Pessimistic thoughts are also present. Feelings of hopelessness may occur with self-blame about minor matters. Slowness of thought may also be evident.

(ii) Lack of interest or enjoyment is common and leads to withdrawal from social activities. Reduced energy is characteristic with feelings of profound lethargy so that normal daily tasks are either not attempted or left unfinished.

(iii) Biological or physical symptoms are present. They include physical inertia, sleep disturbance, loss of appetite, loss of weight, constipation, and amenorrhoea in women of child-bearing age (absence of menstrual periods). Complaints about physical symptoms are common, sometimes with hypochondriasis (ie morbid anxiety about health). Suicidal thoughts may also occur.

(iv) In addition there may be delusions and hallucinations. These are usually centred around feelings of worthlessness

(v) Of all the severe mental illnesses, depression is the one most likely to respond to current medical treatment. The pattern of the depressive illness in the majority of cases is usually of recurrent episodes lasting several weeks or months interspersed with longer periods of normal mood. Some people experience only one episode and some are more or less continuously depressed for several years.

Mania

(vi) The central features are elation or irritability, increased activity and self-important ideas. The mood may be euphoric (intense feelings of well being) and may vary during the day. Overactivity is often persistent and can lead to physical exhaustion. The affected person is distractible starting many activities and leaving them unfinished. Sleep is often reduced; appetite is increased and in severe forms of the illness, sexual behaviour may be uninhibited. Women sometimes neglect precautions against pregnancy.

(vii) Expansive ideas of self-importance occur which at their extreme may be grandiose delusions. For example, the person may believe that he is a religious prophet or a world renowned expert on some matter. Persecution delusions may also be present. However the delusions are not long-lasting and usually disappear or change in content within days. Hallucinations also occur, usually taking the form of a voice telling the person that he has special powers, etc. Insight is impaired. The person seldom thinks he is in need of treatment.

(viii) In bipolar affective disorder or manic-depressive psychosis mania and depression may follow each other in a sequence of often rapid changes. Also included in this group are people with severe depressive disorder who may have had only one episode of mania. Moreover most people with mania eventually develop a depressive disorder. In any one year the incidence of bipolar affective disorders is 10-15 per 100,000 for men, and up to twice this rate for women.

19.6.3 Care Needs

(i) Suicide and attempted suicide are part of the pattern of some cases of severe depressive disorder. However fleeting thoughts of suicide are common in people with many mental health problems. In untreated severe depression, the only factor preventing suicide may be the associated apathy and physical inertia. The risk of suicide is therefore greatest in the early stages of treatment, when such symptoms begin to improve before there is any significant change in the overall mental state. Risk of self harm is also greater when moods swing from mania to depression or vice-versa. In these situations the person is likely to be hospitalised to guard against any risk. Only continuous supervision is likely to thwart serious suicide attempts in those at risk, and this is not practical in the home situation.

(ii) In those people with severe depressive disorder who show self-neglect there may be a need for care to maintain nutrition and cleanliness and to conduct essential business and communication. It must be remembered, however, that the majority of depressive episodes of this severity are of fairly short duration, counted in weeks rather than months. In very severe cases where the person remains motionless and mute hospitalisation is invariable.

(iii) In the great majority of people with severe depressive disorder the onset of the depressed mood is not so sudden that it demands continual supervision or watching-over at night. In people with mania who have grossly abnormal overactive and disturbed behaviour there may be a need for supervision and watching-over. Once recognised, however, treatment is instituted promptly, frequently in hospital, and in the very great majority within a few weeks there is a response to treatment.

(iv) When depression either accompanies or is a symptom of other co-existing disorders, such as alcoholism or substance abuse [See Chapter 22] or physical disability other care needs may be present.

19.6.4 Mobility Considerations

(i) Agoraphobia is a not uncommon feature of depression; it usually responds to antidepressant medication. Physical inertia and apathy may result in the carer needing to encourage the severely depressed person to get out and about. This, in itself, constitutes neither guidance nor supervision. The evidence will have to be scrutinized in the individual case to determine whether there is a need for guidance or supervision outdoors. It is unlikely however that features of this severity will last for more than a few weeks at any one time.

(ii) Apart from the rare occurrence of depressive stupor (motionless and mute) in very severely depressed people, neither the depressive disorder nor mania affects the ability to walk. Persons with depressive stupor will be hospitalised and respond to treatment within a period of weeks.

19.6.5 Duration of Needs

In the great majority of cases any evident care needs will only be for a limited period which is unlikely to exceed several months during any one episode.

19.6.6 Further Evidence

(i) In all cases of severe depressive illness or bipolar affective disorders it is highly probable that a consultant psychiatrist will have been involved in the management and treatment of the individual. Indeed the absence of any documented history of a psychiatric consultation should raise doubts about the nature and/or severity of the given diagnosis.

(ii) Hospital factual reports should be obtained. Other sources of information will be community psychiatric nurses, general practitioners and mental health social workers.

(iii) In those instances where it appears that the claim pack has been inadequately or inappropriately completed by someone described as having a mental illness of the types described here, it would be helpful if a report were obtained from an examining medical practitioner.

19.7 The Neuroses

19.7.1 Introduction

These mental illnesses are also referred to as psychoneuroses. The symptoms and disabilities associated with them are very often less severe than those encountered in the psychoses. Like the latter, however, they occur in people whose mental and intellectual development had been proceeding normally. They also differ very substantially from the psychoses in that the affected person neither loses touch with reality nor experiences disturbed thought processes. Anxiety is a symptom which they all have in common.

19.7.2 Anxiety

Anxiety is an unpleasant emotional state characterized by fearfulness and unwanted and distressing physical symptoms. It is a normal and appropriate response to stress but becomes a recognisable illness when it is disproportionate to the severity of the stress, continues after the stressor has gone, or occurs in the absence of any external stressful event. Neuroses with anxiety as the chief symptom are common: around 16% of the population are affected by some form of an anxiety illness at any one time.

19.7.3 Generalised Anxiety Disorder

(i) Anxiety disorders are not the same as the more fleeting stress reactions where anxiety occurs suddenly to stressful life events or follows some weeks later such events as loss of job, moving house, or divorce, etc. These are either acute stress reactions or adjustment reactions to stress which are generally self-limiting.

(ii) Generalised anxiety disorder affects 2-5% of the population but accounts for almost 30% of mental health problems in general practice. It is characterised by irrational worries, muscle tension, fearful feelings and physical symptoms such as rapid pulse or sweating. The disorder and its effects are mild in the very great majority of people who are prone to it. The symptoms are unpleasant but they are not likely to impair the person's ability to attend to bodily functions unaided nor are they likely to place the person or others at risk of substantial danger.

19.7.4 Panic Disorder

(i) Although panic may occur as part of different mental illnesses, panic disorder is the occurrence of unpredictable attacks of anxiety with pronounced increases in heart rate and forceful beating of the heart (ie palpitations) with sweating. Tremor may occur together with feelings of light headedness which may be due to overbreathing (hyperventilation). Common features are fears of dying and an urgent desire to flee.

(ii) Whilst subjectively most distressing for the person affected by the panic disorder its occurrence is unlikely to put the person or others at risk of substantial danger. The brevity and nature of the mental and physical disturbances it causes should not prevent a person attending to their bodily functions.

19.7.5 Phobic Anxiety Disorders

(i) Persons affected by these disorders recognise that their fears of particular situations or objects are excessive but are most difficult to control. Acute anxiety attacks, with or without panic disorder, occur on being confronted with the particular situation or object at the centre of their fears.

Agoraphobia

(ii) Agoraphobia tends to start between the ages of 15 and 35 and is twice as common in women as in men. Affected persons experience acute anxiety and, sometimes, panic when they are in, or anticipate being in, open spaces or in places where escape might be difficult or help might not be available. They have an intense desire to be somewhere else. Anxiety producing situations are avoided and just thinking about going into such situations may produce anxiety.

(iii) Although people affected in this way may well be distressed by being out alone, or at the thought of going out alone, this does not necessarily mean that they need supervision in order to take advantage of the faculty of walking out of doors. In each case it will be necessary to determine what function the other person provides and what would happen should that person not be there. It will be important to distinguish between whether the disabled person could not, or would prefer not to walk out of doors without the presence of another person".

(iv) Some people with agoraphobia feel better when accompanied by someone out of doors, and indeed may often be unable to face going out unless accompanied by another person. However, rarely would they be in danger should an attack occur when unaccompanied. There would be no need for guidance; though reassurance and support may be provided to some people to prevent panic attacks or to provide comfort and reassurance should they occur.

Social Phobia

(v) Social phobia is a persistent fear of performing in social situations, especially where strangers are present or where the person fears embarrassment. Their avoidance of these situations may interfere with their daily routine, work, or social life. These situations are predictable and the anxiety experienced is not likely to pose a risk of danger. Personal attention to bodily functions is unaffected.

Specific (Isolated) Phobias

(vi) This is an irrational fear of specific objects (ie spiders) or situations (ie enclosed spaces - claustrophobia). Some surveys suggest that up to 9% of the population will have a specific phobia of some kind.

(vii) The fear of being left alone in the house may bind a person to another, usually the spouse, by day and by night. If left alone they become anxious, distressed or may panic. They may not, however, be in substantial danger. A persistent agitated state may be a presenting symptom of an underlying depressive illness (agitated depression).

Post Traumatic Stress Disorder (PTSD)

(viii) Anxiety and other symptoms may briefly follow any traumatic event. Post traumatic stress disorder (PTSD) is a specific condition which may arise as a result of direct exposure to an extremely severe, life-threatening traumatic

event such as a major disaster or similar catastrophe. Severe physical assault may also result in PTSD.

(ix) PTSD needs to be distinguished from milder forms of stress reaction. Characteristic symptoms are vivid "flashbacks" in which the person relives the traumatic event; avoidance of situations which remind the person of the event; and personality changes such as irritability or blunting of the emotions. These, and symptoms of anxiety and/or depression, are particularly intense and prolonged. Symptoms must have been present for at least one month for a diagnosis of PTSD to be made, and they may last for up to two years; in some cases they will be lifelong. Confirmation of the diagnosis, and an opinion on prognosis, should be sought from the hospital or other specialist providing treatment.

(x) The effects of PTSD will depend on the features of anxiety and/or depression which are found in the individual person. Reference should thus be made to the relevant sections of this chapter.

19.7.6 Obsessive - Compulsive Disorder

(i) People with this disorder have obsessional thinking, compulsive behaviour and varying degrees of anxiety or depression.

(ii) Obsessional thoughts are words, ideas, and beliefs, recognised by the person as his own, which intrude in a compelling way into the person's mind and which he tries to exclude.

(iii) Obsessional rituals can include senseless behaviour such as washing the hands 20 or more times a day or having to check repeatedly that the gas has been turned off or a door has been locked, etc. The people are aware that these rituals are illogical but unless they perform them their feelings of anxiety can become unbearable.

(iv) Depending upon the type of obsessive thought or compulsive behaviour the life style of the person may be restructured to a varying extent. It is, however, unlikely that the manifestations of the disorder would place the person or others at risk of danger. The need for care from another in connection with bodily functions is most unlikely.

19.7.7 Mild Depressive Disorder [neurotic depression, reactive depression]

(i) The reader is advised to refer to the "Introduction" to the section on Severe Depressive Disorder [paragraph 19.6.1] for a description of depression. That section also distinguishes mild depressive disorder from severe [psychotic] depression.

(ii) In mild depressive disorder there are symptoms which can be broadly categorized as "neurotic" (ie: as a result of a neurosis rather than a psychosis) These include anxiety, phobias, obsessional symptoms. In addition to these symptoms, people with mild depressive disorders will also have a degree of low mood, lack of energy, and irritability. Biological

(physical) symptoms such as poor appetite and weight loss etc, may be found, but are usually much less severe than those which occur in people with major depressive disorder. Delusions and hallucinations do not occur.

(iii) These forms of mild depression are often brief, starting at a time of personal misfortune and subsiding when fortunes have changed or new adjustment has been made to the prevailing situation. Sometimes, however, the symptoms may persist for months or years.

(iv) The magnitude of change in mood, its duration, and the effects of associated neurotic symptoms rarely result in significant or prolonged care needs. People with mild depressive disorder should not require guidance or supervision when walking out of doors. If anxiety is evident as the principal feature of an individual person's mild depression then reference should be made to the section of this chapter on Anxiety [paragraph 19.7.3].

19.7.8 Care Needs and Mobility Considerations- The Neuroses

(i) As with physical illnesses the care and mobility needs can vary considerably between people who have the different types of neurosis, and can vary just as much between people who have the same type of neurosis (ie. anxiety, panic disorder, mild depressive disorder, etc). Each case must be considered on the basis of the manifestation of the mental health problem and the needs that may bring in each individual.

(ii) Anxiety (with or without panic episodes) is likely to be the principal feature among people who are affected by the different neuroses. Even in mild depressive disorder anxiety is a prominent symptom. The mental symptoms, and sometimes physical accompaniments, of anxiety can be highly distressing but they are unlikely to require attention from another in connection with bodily functions. Moreover the effects of anxiety or panic episodes are unlikely to place the person or others at risk of danger.

(iii) Even in those people with agoraphobia or social phobias who demand to be accompanied, these events will be predictable and intermittent and not amount to a need for supervision. Although reassurance and comfort may be welcomed by the affected person when walking outdoors, there would be no need for guidance by virtue of the heightened anxiety state or panic episode should these occur. Furthermore, the affected person's mental and behavioural responses to the onset of acute anxiety and/or panic when outdoors, whether or not accompanied, are not likely to lead to danger to the person or others. Claims that the panic episodes could result in the person becoming disorientated and not knowing how to get to a particular destination, or that there is a risk of an impulsive action (eg: running out under a bus) are most unlikely consequences of even severe panic episodes.

(iv) In people with mild depressive disorder the degree of mood change, its variability and duration, and the effects of accompanying anxiety, rarely result in significant care needs.

19.7.9 Further Evidence

(i) Information obtained from someone who is caring for, and familiar with the disabled person is likely to provide a fuller picture of the needs which may arise in those people with mental health problems falling into the group of neurotic illnesses.

(ii) Few of those people affected by one of the anxiety illnesses or mild depressive disorder will have been under the care of a consultant psychiatrist. The majority of these people with the milder forms of mental health problems are managed by the general practitioner. A factual report from the general practitioner supplemented, if necessary, by a report from the community psychiatric nurse will be helpful.

(iii) With regard to the risk of danger a relative's fears may not always provide the necessary evidence of a need for supervision - whether this be when the person is walking outdoors or in the home environment. Assumptions about care needs cannot be based solely on the common manifestations of a particular diagnosis.

(iv) In those cases where it appears that the claim pack has been inadequately or inappropriately completed by or on behalf of someone described as having a mental illness or mental health problems, it would be helpful if a report were obtained from an examining medical practitioner.

19.8 Personality Disorders

19.8.1 Introduction

(i) Personality refers to those persisting characteristics of a person that are demonstrated by the ways in which the person behaves or reacts in a wide variety of circumstances. These characteristics or traits can be used to describe, in broad terms, the type of personality. For example, a person who is basically friendly, outgoing and likes mixing with other people is said to have a "social trait" to the personality. Some persons are by nature very cautious and careful ("obsessional trait") or very easily provoked to aggression ("aggressive trait"), or falling in very easily with the wishes of others ("dependent trait"). People's personalities are a mix of these various traits but one is usually more evident than the others.

(ii) In a few people the main (dominant) personality trait is so overbearing and predominant that it causes major difficulties to the person and for other people. Such a person is then said to have a **personality disorder.**

19.8.2 General Features

(i) Personality disorders can cause considerable problems to the persons who have them, to the persons' families and to people with whom they come in contact.

(ii) The behaviour of people with personality disorders will depend on the particular type of dominant personality trait, and can vary from being unable to take any responsibility for themselves to being thoroughly impulsive and irresponsible in their actions. Very rarely there are severe personality disorders which are difficult to differentiate from psychiatric illness.

(iii) People with a predominantly **dependent personality disorder** are weak-willed, passive and readily compliant with the wishes of others. They may avoid responsibilities and lack self reliance, drive and enthusiasm. Some react by persuading other people continually to help and assist them because of what they describe as their own helplessness. If married or in long-term relationships, such people may have the support of more self-reliant spouses or partners who may care for their every need. Sometimes this support is provided by several members of the family or by a son or daughter who may have committed their life to supporting and caring for the perceived helplessness and demands of the highly dependent and demanding parent.

(iv) Another type of personality disorder which may make demands on other people for support and care is the **antisocial (dissocial) personality disorder**. This type of personality disorder is sometimes referred to as **psychopathic**. However this term is no longer in routine use because it has certain connotations which are pejorative, deprecatory or are coloured by the loose use of the term in the media and drama to describe criminal or murderous individuals. At one extreme the person with an antisocial personality disorder can show lack of guilt, highly impulsive behaviour and failure to learn from life experiences. When these are accompanied by low tolerance of other people's needs and violence or aggression they may, indeed, lead to repeated offences against the law.

(v) Alcohol abuse or drug dependency may be a feature of some people with serious personality disorders. In such cases reference should be made to Chapter 22.

19.8.3 Care Needs

(i) People with a personality disorder (or a member of their family) may claim that there are care needs because of the effects of the personality disorder. In those with a dependent personality disorder attention to bodily functions may be claimed. However the person with such a

personality disorder will usually be capable of attending to their bodily functions in the absence of any other co-existing disabilities. However, people with dependent personality disorder may experience greater difficulties in coping with the needs which may arise from co-existing disabilities.

(ii) Impulsive or irresponsible behaviour by some people with antisocial personality disorders may be advanced as a reason for supervision or watching-over. It would be rare for someone with such an antisocial personality disorder which produces behaviour that poses danger to the person or others to be permitted to remain in the community.

(iii) **Therapeutic community methods** are sometimes used, in which people with the more severe forms of personality disorder reside in, or attend, a therapeutic community for several months where they can talk about their problems in relationships and try to help other members of the group to identify and resolve their own problems. This form of therapy as well as group or individual counselling may be of benefit. However, treatment in such a therapeutic community does not imply the presence of any significant care needs.

19.8.4 Mobility Considerations

(i) Supervision when walking out of doors is most unlikely to be required by someone living in the community who has a personality disorder. [See also paragraph 19.7.8 above].

19.8.5 Further Evidence

(i) The borderline between the limits of a normal personality and personality disorder is hard to define. Moreover, the effects of personality disorders themselves are highly variable. It is very likely that someone with a personality disorder whose effects are so disruptive or disordered that they are claimed to give rise to care needs, will have been assessed by a consultant psychiatrist and will be known to the local psychiatric and social community services.

(ii) Confirmation of the diagnosis and an assessment of its principal features is essential. Information should thus be sought from a hospital doctor (usually, consultant psychiatrist) who has been involved in the case. It may also be helpful to seek information from the general practitioner or mental health care worker.

19.9 Dissociative (and Conversion) Disorders; Hysteria, and Somatoform Disorders)

19.9.1 Introduction

(i) **In dissociative and conversion disorders** the predominant symptoms are physical . The term conversion disorder implies that in the affected person anxiety has been replaced by (or "converted into") physical symptoms. It

is assumed that the physical symptoms serve a function in that they enable the affected individual to avoid situations with which they cannot cope. These disorders are also forms of neurosis; but in view of their importance and the critically important need to differentiate them from malingering where an apparent disability is out of proportion to the physical condition, this separate section is devoted to them and related disorders.

(ii) An alternative name for these disorders is **hysteria**. Although this term is still in use, many psychiatrists avoid it because colloquially it is used to describe exaggerated and extravagant displays of emotion. This is not the meaning of hysteria when used in the clinical context.

(iii) **Somatoform** or **Somatization disorder** is a type of conversion disorder. It is used to denote a chronic condition characterised by a history of numerous, variable and recurrent physical complaints that may begin in early life and persist for many years. These physical symptoms are not accounted for by physical disease. In one form of the disorder there are complaints of chronic pain which cannot be explained by any primary physical or mental disorder.

(iv) A dissociative (or conversion) symptom suggests physical illness but occurs in the absence of relevant physical findings and any evidence of physical disease. The symptom arises from unconscious psychological mechanisms.

(v) A definite diagnosis of a dissociative (or conversion) disorder made by a consultant psychiatrist implies that attempts have already been made to ensure that as far as possible underlying relevant physical disease has been excluded.

(vi) In reaching that diagnosis the psychiatrist also has to be satisfied that the symptoms arise unconsciously rather than consciously and deliberately. The deliberate feigning of symptoms is known as **malingering** and this is dealt with separately at paragraph 19.11.

19.9.2 Clinical Features

(i) Although dissociative and conversion symptoms are produced unconsciously they are shaped, in the individual person, by that person's knowledge and understanding of illness. Usually there are **discrepancies between the signs (clinical findings) and symptoms (what the person complains of)** and those of an identifiable specific disease. For example, a report of a medical examination may reveal a pattern of loss of sensation in a part of the body that does not correspond to the way in which that part of the body is supplied by nerves which carry the feeling of sensation to touch, etc.

(ii) **Secondary gain** is a term which is sometimes used in medical reports on people with dissociative disorders. This means that the symptom confers some immediate advantage on the affected individual. An example of secondary gain is the advantage that conversion disorder which manifests as, say, paralysis of the legs, might bring by relieving the person from the stressful care of a relative with severe disabilities.

(iii) The manifestations of these dissociative disorders are many, ranging from muscle paralysis and unusual patterns of walking (disorders of gait) through convulsions to apparent blindness or deafness and the complaint of chronic pain

(iv) **Psychogenic** is another word which may be used to describe a symptom of a dissociative or conversion disorder.

(v) People with **somatization disorder** have multiple complaints over long periods. They may consult many doctors throughout life. Associated depressive and anxiety symptoms are common.

(vi) **Hypochondriacal disorder i**s a persistent preoccupation with the possibility of having a serious illness. Frequently, people with this disorder attach major significance to even minor symptoms

(vii) Adopting the "**sick role**" or the "**patient role**" also appears sometimes in medical reports. They are not very helpful because they may indicate that the person has a dissociative (conversion) disorder or that the role has been adopted as a matter of choice. "Illness behaviour" is a common response to a situation which is perceived as an intolerable predicament. The advice of a Medical Services doctor should help to clarify the situation.

(viii) **Functional Overlay** is another term which may be found in medical reports. This is usually interpreted as unconscious exaggeration or elaboration of symptoms for which there is an organic basis. However it may be used by some doctors to indicate an element of conscious exaggeration too. When it appears in reports Adjudication Officers are advised to seek advice from a Medical Services doctor for interpretation of its meaning in the particular context.

19.9.3 Care Needs and Mobility Considerations

(i) Most people with dissociative and conversion disorders of recent onset recover quickly (ie within a matter of several months). Those cases that persist for longer than a year are likely to continue for many more years.

(ii) People with dissociative (or conversion) disorders including those with somatization are neither consciously nor deliberately feigning their symptoms. Thus care needs and mobility requirements must be assessed on the same basis as if the manifest disabilities were due to a recognised specific physical disease

19.9.4 Further Evidence

(i) It is absolutely essential that a reported diagnosis of dissociative or conversion disorder, hysteria or somatization is confirmed by obtaining a factual report from a hospital attended by the person or from a doctor or community psychiatric nurse in the psychiatric services involved with the person.

(ii) Sometimes a report from an examining medical practitioner or a factual report from the GP will mention a diagnosis of somatization, hysteria or dissociative/conversion disorder, or use the term psychogenic. In these circumstances, and in the absence of any documented confirmation of the diagnosis by a consultant psychiatrist, advice should be sought from a Medical Services doctor on the most appropriate source of further evidence to confirm or refute the diagnosis and to establish the nature and extent of the resultant disabilities.

19.10 Factitious Disorder

19.10.1 Factitious disorder refers to the intentional physical self injury or the production of physical signs of disease or the feigning of physical or psychological symptoms, with the apparent aim of being diagnosed as ill.

19.10.2 This disorder is <u>not</u> the same as malingering [see paragraph 19.11] in that its primary aim is not to bring external rewards such as avoidance of duties or fraudulent financial gain, but to obtain medical attention. People with factitious disorder often have very disturbed personalities.

19.10.3 Some common features seen in people with factitious disorder are skin lesions which are produced by self-injury **(this is sometimes called dermatitis artefacta)** or their presenting with an apparent high body temperature (pyrexia) produced by various means, such as rubbing the bulb of a clinical thermometer to produce frictional heat or dipping the thermometer in a hot drink when unobserved. Some people with this disorder may deliberately aggravate an existing physical disorder, for example by preventing the healing of the ulcers which sometimes occur due to varicose veins in the legs.

19.10.4 **Munchausen syndrome** is a rare but extreme form of the disorder in which the affected individual will give a plausible account of an illness with feigned symptoms and signs. These may include psychiatric symptoms. These people often present themselves at a series of different hospitals using different names.

19.10.5 **Munchausen syndrome by proxy** is used to describe a condition in which an adult with a personality disorder, in charge of a child, gives a false account of symptoms in the child and may fake physical signs of illness in the child.

19.10.6 Care Needs and Mobility Considerations

Although there is no evidence that financial gain is involved in people with factitious disorder, and though some affected people may also have abnormal personalities [see paragraph 19.8], there is nevertheless a conscious and deliberate intention to simulate illness. There is no specific treatment and though supportive counselling may be offered, many people affected by this disorder refuse treatment. Counselling cannot be considered as attention to bodily functions since it focuses on ways in which the affected person may come to terms with and cope with their own difficulties. Care needs and mobility requirements should not arise in people with factitious disorders in the absence of co-existing illnesses and disabilities which are not the product of conscious intentions to deceive.

19.10.7 Further Evidence

By its very nature and the conclusions which necessarily follow it, a diagnosis of factitious disorder must be confirmed by seeking a comprehensive report from a consultant psychiatrist. In all cases where this disorder is mentioned advice should be sought from a Medical Services doctor for assistance in framing questions to put to the psychiatrist and in interpreting the subsequent report.

19.11 Malingering

19.11.1 Malingering is the **fraudulent** imitation or exaggeration of symptoms with the intention of gaining financial or other rewards or material benefits. It is this obvious external gain that distinguishes malingering from factitious disorder [see paragraph 19.10]. Malingering is not common.

19.11.2 **Overstatement of degree of disability and needs** should not be classed as malingering without there first having been established that apparent exaggeration of care needs and mobility requirements is not due to a misunderstanding of the questions listed in the claim packs or, indeed, the eligibility requirements for an award of DLA or AA. [See also Chapter 2.3 and 2.4]

19.11.3 Care Needs and Mobility Considerations

Obviously, any portrayal of care/mobility needs by someone who is malingering is justifiably dismissed.

19.11.4 Further Evidence

The seriousness of an allegation of malingering is such that it must <u>not</u> be accepted without documented authoritative confirmation. Since the procedures which may be followed upon the confirmation of malingering

may well have grave consequences for the malingerer, it is essential that advice is sought from a Medical Services doctor and senior BA management for the subsequent handling of the matter.