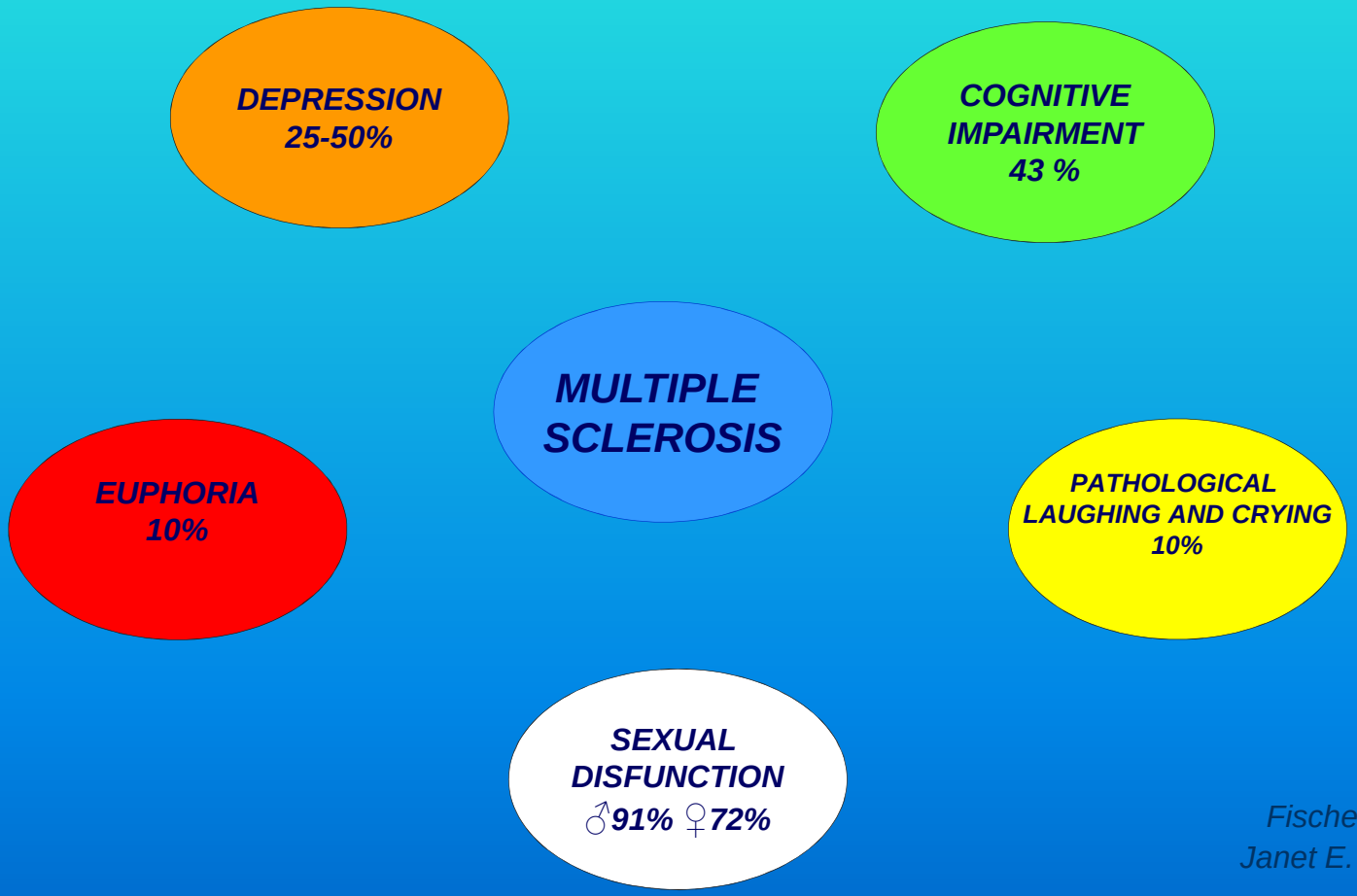
Psychiatrist in Community Based Neurological Rehabilitation

ANNA BOGUCKA-BONIKOWSKA

NEUROPSYCHIATRIC SYNDROMES

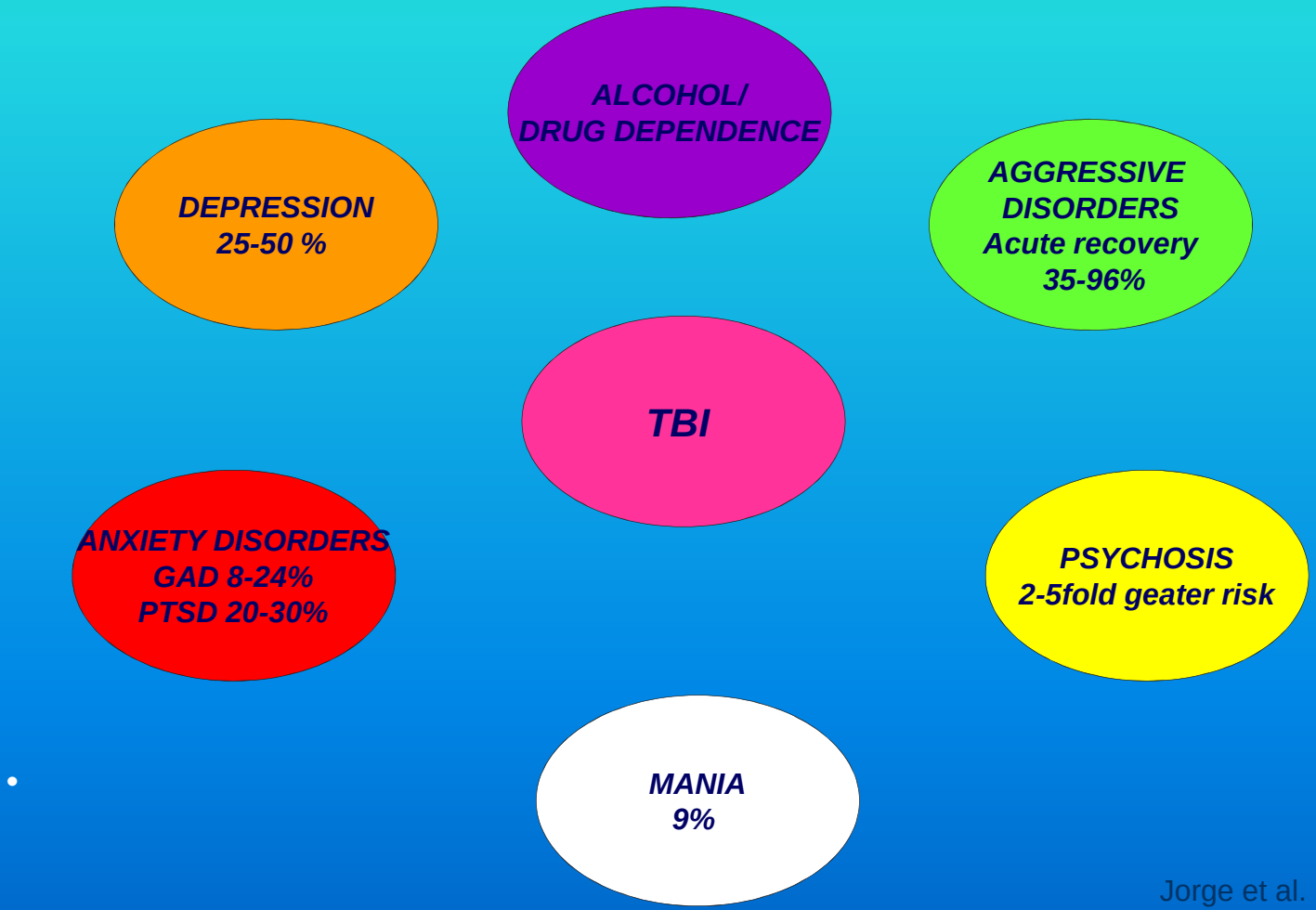
- Depression
- Mania
- Anxiety (PTSD, GAD, OCD)
- Personality Alterations
- Psychosis
- Agression

MULTIPLE SCLEROSIS



Fischer JS. 1999
Janet E. et al 2003

TRAUMATIC BRAIN INJURY



Jorge et al. 1993
Gualtieri and Cox 1991

NEUROPSYCHIATRIC SYNDROMES

- The psychiatric symptoms impair quality of life
- Psychiatric morbidity associated with physical illness is also a risk factor for deliberate self-harm and for completed suicide.
- Psychiatric disorders are also likely to have an effect on the outcomes of treatment for neurological disease.
- Health service costs are greater for patients with physical illness and psychiatric comorbidity; lengths of stay are longer for hospital inpatients; the functional outcomes of rehabilitation may be poorer
- There is some evidence that there may also be an increased mortality.

Identifying cases

The two main diagnostic questions:

- Does the patient have a diagnosable mental disorder?
- Is any change in mental state part of a normal response to illness?

  (grief for lost function, altered role and status, increased dependence)

NEUROPSYCHIATRIC SYNDROMES - DEPRESSION

very often overlooked

many neurological diseases without mood changes produce symptoms that are characteristic of depressive episodes

Symptoms:

- diminished pleasure and interest, weight loss, insomnia, agitation, retardation, impaired concentration, psychomotor slowing, fatigue,
- feelings of sadness, worthlessness, hopelessness, and recurrent thoughts of death or suicide - most dependable indicators of a depressive syndrome

INCREASED RISK OF SUICIDE

NEUROPSYCHIATRIC SYNDROMES - PSYCHOSIS

PSYCHOSIS (delusions, halucination)

Delusions - false beliefs held despite evidence to the contrary,

- most common in diseases affecting the temporal lobe cortex or the basal ganglia
- delusions are not reactions to declining intellectual function; the more intact the delusional patient's cognition, the more complex the delusions tend to be
- there is no delusional content that distinguishes neurological illnesses from idiopathic psychotic processes such as schizophrenia (persecutory beliefs)

NEUROPSYCHIATRIC SYNDROMES - PSYCHOSIS

Hallucinations are sensory perceptions occurring without the appropriate stimulation of the corresponding sensory organ.

Visual hallucinations are common in neurological illness.

Gustatory and *olfactory hallucinations*

Auditory hallucinations

NEUROPSYCHIATRIC SYNDROMES - MANIA

Mania abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week.

Symptoms :

- inflated self-esteem or grandiosity
- decreased need for sleep
- more talkative than usual
- flight of ideas or subjective experience that thoughts are racing
- increase in goal-directed activity or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., sexual indiscretions, or foolish business investments)

a single episode, recurrent mania, or alternating periods of depression and mania

NEUROPSYCHIATRIC SYNDROMES

Personality Alterations

- apathy and impairment of motivation and ambition
- „childish”: impulsivity, poor tolerance of frustration, being demanding and self-centred, and generally lacking the ability to take on the adult role in terms of independent decision-making.
- antisocial behaviours and disinhibition
- sexual disinhibition

The most significant problems at 1, 5 , 15 years postinjury (Livingston et al. 1985)

NEUROPSYCHIATRIC SYNDROMES

- **Anxiety**

a state of apprehension, tension, or uneasiness that occurs in anticipation of internal or external danger. The anxiety syndrome includes motor tension, autonomic hyperactivity, apprehensive expectation, and heightened vigilance.

- **Post Traumatic Stress Disorders (PTSD)**

painful reexperiencing of the event, a pattern of avoidance and emotional numbing, and fairly constant hyperarousal, feelings of guilt, rejection, and humiliation, dissociative states, panic attacks, illusions and hallucinations

The disorder may not develop until months or even years after the event.

Identifying cases

Common reasons for failing to recognize psychiatric disorders:

1. the questions simply are not asked,

2. the questions may be asked, but in circumstances where it is difficult for the patient to answer honestly (no privacy, the person asking is obviously too busy to listen to any but a conventional answer)

3. the expressions of distress may be dismissed:
   ‘Of course it's natural you will feel like that' means to the patient ‘So please don't mention it again'

The clinical interview is the mainstay of diagnosis and identifying those who need referral to specialist services

Identifying cases

- several questionnaires, which may be used to screen for patients with psychiatric problems - useful for alerting staff to the presence of symptoms

- consider the possibility of psychiatric problems when:

the patient is doing worse in rehabilitation than the severity of the disease would suggest they should be,

when there are multiple complaints that are difficult to explain,

when multiple drug treatments are being administered without conspicuous benefit.

Identifying cases

Hamilton Rating Scale for Depression (HAM-D)	17 items, total scores 0 to 50: scores of 7 or less may be considered normal; 8 to 13, mild; 14 to 18, moderate; 19 to 22, severe; and 23 and above very severe, clinician raters, trained lay administrators as well. Time 15 - 20 minutes.
Beck Depression Inventory (BDI)	21 self-report items, the total score ranges from 0 to 84. Scores of 0 to 9 are considered minimal; 10 to 16, mild; 17 to 29, moderate; and 30 to 63, severe. Time : 5 - 10 minutes.
Hamilton Rating Scale for Anxiety	14 items, total score ranging from 0 to 56. A score of **14** has been suggested as the threshold for clinically significant anxiety. The scale is designed to be administered by a clinician
Overt Agression Scale (OAS)	The scale includes items that assess verbal aggression, physical aggression against objects, physical aggression against self and others
Overt Agitation Severity Scale (OASS)	Rates 14 problematic behaviors, can be used in acute and leng-term rehabilitation settings

Identifying cases

Alcohol Use Disorders Identification Test (AUDIT)	a brief screening instrument designed for the early detection of hazardous and harmful alcohol use. Total score of 0 to 40. Time: 5 minutes. Does not require professional training. Threshold score: **8**
General Health Questionnaire	
Symptom Checklist	
Young Mania Rating Scale (YMRS)	a checklist of 11 items rated either 0 to 4 (seven items) or 0 to 8 (four items). The total score ranges from 0 to 60. Ratings include clinical observation

Drug treatment – general principles

1. Start low, go slow

2. Therapeutic trial of all medication (adequate dosage and duration)

3. Continous reassessment of clinical condition

4. Monitor drug-drug interaction

Psychological treatments

Group and individual psychotherapy

Special therapeutic problems:

- Denial, guilt, shame, anger
- Stigmatization and marginality
- Loneliness
- Therapy may need to be modified to allow for fatigue or concentration problems, and sessions need to be arranged flexibly

Family members should be involved in the patient’s treatment