Hughes' Outline of Modern Psychiatry

Fifth Edition

David Gill
Consultant Psychiatrist
Lister Hospital
Stevenage: Hertfordshire Partnership NHS Trust

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Dedication

I am grateful to all my teachers, especially Roger Chitty, Neil Davies and Chris Bass, and to my colleagues and patients.

For Mandy and Bertie.

Contents

Preface

I am most grateful to Dr Jennifer Barraclough for inviting me to help with the previous edition of this book. Following her retirement from clinical psychiatry, I am grateful to her and to John Wiley for the opportunity to prepare a new edition. Any good qualities it may have are hers; its many faults are mine alone.

For reasons of confidentiality, the clinical examples are made up of composite case histories and do not refer to real individual patients.

Some of the references are to internet sites; these may be open to criticism as being potentially impermanent, but they have the merit of availability and they are free at point of access.

Part I The nature and assessment of psychiatric disorder

1 Classification

Psychiatry is the branch of medicine that deals with mental, emotional, and behavioural disorders. In psychiatry, as in other branches of medicine, classification of disease is useful for the following:

- *Informing clinical practice*. By placing a given patient's disorder into a recognized diagnostic category, the clinician is able to make an appropriate choice of treatment, and judge the probable future outcome. Using a classification system in this way does not, of course, remove the need to consider and respect those features that are unique to each individual case.

- *Communication between professionals*. A universally understood classification system permits efficient communication, whether in everyday clinical practice when colleagues are discussing a case, or in the national and international literature.

- *A basis for research*. Research workers require a classification system in order to investigate the causes, clinical features, natural history, and response to treatment of the various psychiatric disorders.

- *Service planning*. The type of treatment services required in a given area will depend on the frequency of different disorders within the local population.

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However, we must not forget that the existing classifications, in our present, highly imperfect state of knowledge, may be little more than a convenient shorthand, rather than a statement of fundamental scientific truth.

For example, we may say that a patient has a diagnosis of 'F45.4 persistent somatoform pain disorder' under ICD-10 (see below). This may sound very scientific. However, fundamentally, all it means is that the patient has chronic pain, unexplained by physical pathology, with some indication of underlying psychosocial problems. Hence, use of this term should not lead us to delude ourselves that we have a clear understanding of the cause of the patient's problems, let alone a specific effective treatment deriving from it.

The basis of classification

The most rigorous type of classification is one based on cause, such as a single-gene defect (e.g. Huntington's chorea) or a chromosomal anomaly (e.g. Down's syndrome caused by trisomy 21). However, for most psychiatric disorders, this is not applicable, and so official psychiatric classification systems largely consist of descriptive accounts of clinical syndromes, each with its characteristic symptoms, signs, and natural history.

Reliability and validity

Reliability

A diagnosis may be said to be reliable if the same observer reaches the same diagnosis in a repeat of the same clinical situation (test–retest reliability), or if two observers reach the same diagnosis in the same clinical situation (interrater reliability). Studies in clinical practice have often shown low reliability for psychiatric diagnosis because psychiatrists differ in the way they interview patients and interpret the information elicited. Diagnostic practices also vary between different parts of the world. Reliability is better for individual symptoms and signs. Reliability can be improved by using standardized interviews and questionnaires (Chapter 3), and by using the diagnostic criteria laid down in ICD-10 and DSM-IV (see below). This is necessary for research purposes, but it is too time-consuming to be a usual part of daily clinical practice.

Validity

The validity of a diagnosis is more difficult to ascertain than its reliability. If a classification is to be valid ('based on truth or correct reasoning'), the categories

it contains should describe disorders, which really are separate from one another. Various types of validity have been distinguished, such as *face validity*, which is to do with whether the diagnosis 'looks right', that is, whether it appears, on inspection, to deal with the matters it says it is going to deal with.

Ways of testing the validity of diagnostic groupings include the following:

- examining the consistency of symptom patterns. Statistical techniques such as 'cluster analysis' and 'discriminant function analysis' facilitate this process
- demonstration of consistent genetic and biological correlates
- demonstration of a consistent natural history and long-term outcome
- demonstration of a consistent treatment response.

Limitations and problems of classification

Although a great deal of work has been devoted to making the official international classification systems both reliable and valid, it must be acknowledged that they are still imperfect. The descriptive categories are continually being revised; for example, 'panic disorder' and 'post-traumatic stress disorder' were only recently listed as diagnoses, although the clinical phenomena have been recognized for many years.

The boundaries between some of the clinical syndromes are not absolute, as illustrated by the need for terms such as 'schizo-affective disorder' to describe an illness with mixed features of two supposedly discrete categories, 'schizophrenia' and 'affective disorder'. Some patients' symptoms do not fit well with any recognized category, and there is a danger that these may be forced into a residual or 'dustbin' category such as 'depression, not otherwise specified'. In insurance-based health systems, this may make the difference between receiving care or not, as insurers may restrict cover to certain 'hard' diagnostic categories.

Insensitive use of classification can lead to 'labelling' of patients. Classification systems are best used in a flexible and critical way, and clinical effort is often better directed toward relieving the patient's symptoms than excessive debate about the niceties of diagnosis.

Some mental health professionals prefer 'problem-based' to 'disease-based' care. Nurses, in particular, and also other non-medical professions such as social workers, have a tradition of a 'problem-oriented' approach. For example, if a

social worker is trying to help a mental health patient find supported accommodation, so that they can leave hospital, the details of diagnosis will be less of a priority, than the patient's coping skills, attitude to illness, lifestyle, and likely cooperation with mental health services. The same applies to cognitive behavioural psychotherapy, where the approach depends upon developing a shared understanding between patient and therapists of what the problems are and how they should be addressed; the details of the precise ICD or DSM diagnosis would be of secondary importance.

Common terms in psychiatric classification

Organic and functional

Psychiatric conditions are sometimes divided into *organic brain disorders* and *functional mental illnesses*.

Organic conditions are caused by identifiable physical pathology affecting the brain, directly or indirectly, and include, for example, *learning disabilities* (formerly known as mental handicap) and the *dementias*.

Functional conditions have usually been attributed to some kind of psychological stress, although in many cases it would be more honest to say that their cause is not known. As knowledge advances, some 'functional' conditions are likely to be reclassified as 'organic' (as currently may be happening for schizophrenia), and for this reason the term 'organic' is not used in DSM-IV.

Psychosis and neurosis

These terms have largely been removed from the international classifications but are still used in clinical practice.

Psychoses (for example, schizophrenia, bipolar affective disorder)

Psychoses are characterized by the following:

- severe illness
- symptoms outside normal experience, such as delusions and hallucinations
- loss of insight; subjective experience mistaken for external reality.

Neuroses (for example, anxiety disorders, most cases of depression)

In comparison with psychoses, neuroses may be characterized as follows:

- more common
- often less severe
- symptoms possibly understandable as an exaggeration of the normal response to stress.

Psychiatrists also deal with conditions involving abnormalities of psychological development or behaviour, such as *personality disorders*, *alcohol and drug misuse*, *sexual dysfunction*, and *eating disorders*.

The descriptive study of abnormalities of mental functions such as mood, perception, thought, volition, memory, or cognition is called *psychopathology*. Definitions of some of the terms commonly used in psychopathology are given in the Glossary at the end of this book.

Classification systems

Classification systems include *categorical*, *dimensional*, and *multiaxial* types. In the *categorical* type of classification, each case is allocated to one of several mutually exclusive groups. This simple method is the most suitable one for clinical settings. Categorical systems are usually used in a hierarchical way, so that each case receives only one main diagnosis. Organic psychoses take precedence over functional psychoses, and functional psychoses over neuroses. This can lead to oversimplification of complex cases, and does not take account of 'co-morbidity', in which two psychiatric diagnoses (for example, anxiety state and alcohol misuse) or a physical and a psychiatric diagnosis (for example, diabetes and depression) coexist.

In the *dimensional* type of classification, cases are rated on a continuous scale, or several separate continuous scales, for the characteristic(s) under study, as in, for example, depressed mood.

In the *multiaxial* type of classification, each case is rated on several separate categorical systems, each measuring a different aspect (for example, psychiatric illness, personality, intelligence).

The two main classification systems in international use, ICD and DSM, will now be summarized. Both systems are due to be published in revised editions shortly.

ICD-10 (World Health Organization, 1992)

The tenth edition of the *International Classification of Disease* (ICD-10), prepared by the World Health Organization, covers the whole of medicine, and also includes a Classification of Mental and Behavioural Disorders. This is the official classification used in the UK. It is available free at http://www3.who.int/icd/currentversion/fr-icd.htm. It is a descriptive classification, with main headings as follows:

F00–F09	Organic, including symptomatic, mental disorders
F10–F19	Mental and behavioural disorders due to psychoactive substance use
F20–F29	Schizophrenia, schizotypal and delusional disorders
F30–F39	Mood (affective) disorders
F40–F48	Neurotic, stress-related, and somatoform disorders
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60–F69	Disorders of adult personality and behaviour
F70–F79	Mental retardation
F80–F89	Disorders of psychological development
F90–F98	Behavioural and emotional disorders with onset usually in childhood or adolescence
F99	Unspecified mental disorder.

Each of the main categories listed above has a number of subdivisions. Diagnostic guidelines for each condition are given in the ICD.

Some conditions relevant to psychiatry, such as suicide and self-inflicted injury or poisoning, are classified in other sections of the ICD. For example, 'factors influencing health status and contact with health services', codes Z00–Z99, is a neglected section of the ICD. Codes such as 'Z60.4 Social exclusion and rejection: Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behaviour' seem to have a common-sense basis, and offer an antidote to the potential medicalization of some life problems through over-diagnosis of mental disorder. The Z codes to some extent fill the gap in the ICD left by the absence of the axes of the DSM, which cover aspects other than the presence or absence of mental illness (see next section).

DSM-IV (American Psychiatric Association, 1994)

The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) comprises the official classification system of the American Psychiatric Association, and has been influential in the UK. DSM-IV is a multiaxial system with five axes:

Axis I: Clinical syndromes
Axis II: Developmental disorders and personality disorders
Axis III: Physical disorders and conditions
Axis IV: Severity of psychosocial stressors
Axis V: Global assessment of functioning.

The strength of this approach lies in its requiring any clinical syndrome to be considered against the background of the permanent features, such as personality characteristics and intellectual level, of the person concerned. Each syndrome is defined by a set of practical criteria.

Comparison of DSM and ICD

DSM	ICD
USA	WHO, including UK
Symptoms must be 'more than an understandable reaction' for diagnosis	No such test explicit
Mental health only	All of medicine
Subscription only	Free online
Guides only – need expert interpretation	
Consensus statements of committees – not immutable truths	

The chapter headings in this book do not follow either ICD-10 or DSM-IV exactly, because the arrangement of topics has been designed to accord with UK clinical practice rather than official classification systems.

Further reading

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Washington, DC: American Psychiatric Association.

World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: WHO. http://www3.who.int/icd/currentversion/fr-icd.htm.

2 Causes and prevention

Causation in clinical practice

It is usual in everyday psychiatry to have multiple causes acting together, involving the interplay of constitutional and environmental factors, to produce an episode of illness – so-called multifactorial causation. These factors include genetic predisposition, personality characteristics, physical disorders, social circumstances, and life experiences.

The accepted way of considering these subsidiary causes in psychiatry is in terms of various *predisposing*, *precipitating*, and *perpetuating* factors.

Case illustration

For example, a person with a depressive illness may have been predisposed to develop it through an anxious personality, the illness being precipitated by relationship breakdown and perpetuated though alcohol misuse and inactivity.

A few psychiatric conditions are known to result directly from specific organic pathology, such as Down's syndrome caused by trisomy 21. But, even here, the overall outcome in functional terms may be profoundly influenced by social and family factors.

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Historical background

Psychiatry goes through phases in which one or other of these various physical, social, or psychological models is regarded as most influential in psychiatric causation generally. In the early and mid-twentieth century, the psychological theories stemming from psychoanalysis (Freud) were dominant, especially in the USA. Later, 'biological' psychiatry was dominant, following the discovery – all in the 1950s – of effective mood stabilizers, antidepressants, and antipsychotic drugs.

Social factors were to the fore in the 1960s and 1970s, at the time of de-institutionalization and the 'anti-psychiatry' movement. However, ideas that psychiatric disability was mainly caused by social factors such as prejudice and 'stigma' have not been borne out.

Recently, psychological factors have staged something of a comeback, with the emergence of cognitive behavioural therapy; however, biological psychiatry, now emphasizing such factors such as 'receptors' and molecular genetics, remains influential.

The *bio-psycho-social model*, as originally derived for chronic pain patients, probably provides the most realistic overall model of causation, as we know enough to be sure that none of the above approaches is ever going to be capable alone of providing complete explanations.

This chapter outlines some general principles and research techniques. More detail regarding causation of individual disorders will be given in later chapters.

Genetics

Most psychiatric disorders show a tendency to run in families. This observation could be explained by genetic factors (nature) and/or by the influence of family and environment (nurture). Two long-established clinical research techniques have been used to distinguish these:

- *Twin studies*
  - *Comparison of monozygotic with dizygotic twins*. Any difference in the rates of illness between the types of twin can be attributed to the differences in the degree of sharing of genetic material between them.
  - *Comparison of monozygotic twins brought up together with those brought up apart.* Here the only difference is in the environment, so any differences in rates of illness between the two groups can be ascribed to the environment.
- *Adoption studies*. These examine rates of psychiatric disorder in children whose biological parents were affected but who were brought up by healthy adoptive parents, or vice versa.

Twin and adoption studies, many of which have been carried out in Scandinavia where comprehensive national records of individuals and their health are maintained, confirm a genetic predisposition for the majority of psychiatric conditions. The effect is strongest for conditions such as autism and attention deficit hyperactivity disorder (ADHD), in which there is a roughly 50-fold increase in risk in relatives; in schizophrenia, the increase is 10-fold; and in anxiety and unipolar depression, it is up to fivefold (for review, see Tandon and McGuffin, 2002).

The 'new genetics'

There have been prodigious investments of money and effort in this area. Since the last edition of this book in 1996, the human genome project has come and gone with great fanfare. However, there has as yet been little benefit to psychiatric practice. For single-gene disorders, such as Huntington's disease, research at least has a clear starting point. There is now understanding of the genetic abnormality at the chemical level; efforts at 'gene therapy', however, have yet to bear fruit.

However, long before the advent of these new techniques, studies of inheritance patterns had made it clear that the hereditary component of the major psychiatric conditions is polygenic: that is, not due to one gene, but to small contributions from a number of genes. A recent review describes some of the various techniques being used to hunt this collection of needles in a haystack: 'coordinated pathway genotype analysis, genome-wide linkage scans . . . genome-wide association studies' (Aitchison *et al*., 2005).

Use is made of quantitative trait loci (QTLs), which are genetic markers associated with the characteristics in question. The task facing researchers is huge: 'Between 100 000 and 1 000 000 markers may be required for an exhaustive sweep of the genome for all QTLs contributing to a disorder' (Aitchison *et al*., 2005).

The localization of defective genes and identification of their DNA sequences and biochemical products may have various clinical applications, including the following:

- *Diagnosis of affected or at-risk individuals*, perhaps at a presymptomatic stage: that is, screening. There are obvious implications for ethics and insurance, however.

- *Treatment possibilities*, mainly theoretical at present as regards psychiatry, including:
  - development of specific drugs

– 'gene therapy', where genes are introduced through viruses into affected individuals, as already being trialled in malignancies and in immune deficiency states.

The new techniques may bring marked clinical benefit, but they also raise ethical problems. There is a danger of patients' hopes being falsely raised, particularly by media stories about 'discovery of the gene for . . .', and doctors are already seeing possible negative effects.

Case example

A man consulted his GP in distress, having just found out that his divorced wife had Huntington's disease. He knew this disease is inherited, and that a test had recently become available to diagnose it in the presymptomatic stage. What, if anything, should he tell their 23-year-old daughter who lived with him, and who knew nothing of her mother's illness? The GP referred the man to a genetic counsellor. After prolonged discussion, in which it was explained that a test was available but preventive or symptomatic treatment was not, he decided against telling his daughter. He felt that the possibility of her finding out, through testing, that she was to develop such a disease in later life might blight her young adulthood. However, he felt that he would wish to review this decision should she later consider starting a family. He was left with the strain of carrying a secret.

Neurochemistry

Disturbance of brain biochemistry, especially involving monoamine transmitters, appears to be present in most psychiatric disorders, although it cannot be assumed that a chemical abnormality is the cause of the disorder rather than its result. Direct studies on the brains of living patients are limited for both practical and ethical reasons. Indirect techniques of investigation include the following:

- *Post-mortem brain studies*. These require brains to be harvested and frozen within a few hours of death. Findings may be influenced by recent medication,

and the condition that caused the death, as well as by the psychiatric disorder of interest.

- *Analysis of cerebrospinal fluid (CSF), blood, or urine* for precursors or metabolites of neurotransmitters. The findings are affected by many factors such as diet and exercise, and may not give an accurate reflection of concentrations in the brain itself.

- *Pharmacological studies*. Inferences about the biochemical defect present in a particular disorder may be made from studies, performed on patients or on animals, of the properties of drugs that are effective in treating that disorder.

Neuroradiology

Modern brain-imaging techniques (Chapter 3) show abnormalities of structure and function associated with major psychiatric illness, such as ventricular enlargement in chronic schizophrenia, and altered patterns of glucose uptake in the manic and depressed phases of bipolar affective disorder.

Epidemiology

Epidemiological studies investigate the frequency of psychiatric disorders, their relationship to social factors, and their natural history. They are carried out on whole populations rather than individual patients. Sources of information include the following:

- *population surveys*, in which every member of a defined population, or a random sample of it, is studied by interview or questionnaire

- *GP consultation* records

- *case registers*, which are kept in some health districts to provide information on all contacts with psychiatric services

- *hospital statistics*.

The frequency of a disorder may be expressed as *point prevalence* (the percentage of subjects with the disorder in question at one point in time) or *period prevalence* (the total percentage who receive the diagnosis during a defined period).

Incidence means the number of new cases within a defined population in a given period (rate). *Lifetime expectation* expresses the risk of an individual's developing the condition concerned sometime during their life.

The results of different surveys vary greatly. Community interview surveys find the highest rates, invariably detecting many psychiatric 'cases' that are not known to GPs, let alone to specialist services. GP and hospital statistics may be inaccurate because they reflect different definitions of a psychiatric 'case', or variations in local treatment policies. There remains a fundamental distinction between subjects who have presented themselves for medical attention, and therefore have identified themselves as patients, and those who have not so presented themselves.

Most community surveys report that 10–20 per cent of the population meet diagnostic criteria for psychiatric disorder at any one time, and that a person's lifetime risk of disorder may be as high as 50 per cent.

Several socio-demographic variables have an association with psychiatric morbidity, but the direction of cause and effect is not always clear-cut. For example, consider the following variables:

- *Sex*. Women have higher rates of most psychiatric disorders than men. This particularly applies to the common (non-psychotic) forms of anxiety and depression. Possible explanations include the following:
  - Women use health services of all kinds more frequently than men. They may be more willing to acknowledge emotional complaints and seek medical treatment, whereas men tend to express their distress through other means such as antisocial behaviour or alcohol misuse.
  - Doctors are more likely to diagnose women's symptoms as psychiatric.
  - Women suffer more psychosocial stress than men because of their role in society.
  - Biological differences, such as genetic constitution and sex hormone profile, play a role.

For other mental disorders, including schizophrenia, the sex ratio is equal.

- *Marital status*. For men, rates of psychiatric disorder are lower among the married than the single, divorced, or widowed. Possible explanations include the following:
  - Married life is beneficial for men's mental health.
  - Men with psychiatric disorder tend to remain single.
  - Psychiatric disorder results in marital breakdown.

  - Widowhood and divorce are stressful life events that may lead to psychiatric disorder.

For women, the pattern is different than for men. Young working-class housewives with several small children have high rates of depression and neurosis, whereas single women in paid employment have lower rates.

- *Residential area*. Urban areas, especially poor inner-city districts, have higher rates of psychiatric morbidity than rural areas. Possible explanations include the following:
  - The lack of stable social networks in inner-city areas contributes to psychiatric disorder.
  - The stresses of city life, such as overcrowding, high crime rates, and noise, contribute to psychiatric disorder.
  - Psychiatric disorder causes people to lose their jobs and social supports, and forces them to move to poorer areas.

- *Unemployment* is associated with psychiatric disorder. Possible explanations include the following:
  - The socio-economic adversity and loss of self-esteem of the unemployed contributes to psychiatric disorder.
  - Workers with psychiatric disorder are liable to lose their jobs.

- *Social class*. Manual workers show higher psychiatric morbidity than the professional/managerial classes. Possible causes include the following:
  - genetic factors
  - a stressful and unhealthy environment
  - 'drift down the social scale' caused by mental illness.

- *Nationality, and issues of 'transcultural' psychiatry*. Diagnostic statistics vary around the world. Organic brain syndromes and somatic presentations of 'functional' conditions are more common in developing societies. Suicide rates vary greatly between countries. Some of these observed differences are genuine. Others are artefactual, depending on what kinds of behaviour are considered abnormal in the culture concerned, and disappear when uniform diagnostic criteria are applied. For example, until the 1970s, the diagnosis of schizophrenia was made much more frequently in the USA than the UK. Yet, since introduction of more rigorous diagnostic criteria, it appears that schizophrenia and other major psychotic disorders occur about equally frequently in both

countries, and also in most other parts of the world. *Migrants* show high psychiatric morbidity, being especially prone to develop a range of conditions including psychotic disorders and post-traumatic stress disorder (PTSD); refugees, who have been forced to migrate rather than doing so by choice, are most at risk. Possible explanations include the following:

– Pre-existing psychiatric disorder causes people to emigrate.
– Stressful circumstances in the country of origin precipitate both emigration and psychiatric illness.
– 'Culture shock' in the new country, including a strange language and customs, and discrimination against immigrants.
– Over-diagnosis occurs as a result of mental health professionals' unfamiliarity with the culture of immigrant groups and language difficulties.

Individual life experience

Adverse experiences in childhood, such as losing one's mother or father, or being sexually abused, would be expected to increase the risk of psychiatric disorder in adult life, and most research studies tend to confirm this long-term association. There is also evidence for a short-term effect whereby psychosocial stress in adult life can precipitate psychiatric illness in predisposed people. This effect applies both for individual *life events* of a common kind, such as family bereavement or divorce, and for extraordinary disasters (see Chapter 6 on PTSD). Chronic *social stresses*, such as marital difficulties or bad housing, can also contribute. In contrast, supportive *social networks*, and close confiding relationships with others, provide some protection against psychiatric disorder following adverse life events.

Life event experience may be measured by the following:

- *official records* in the case of certain major events like widowhood or divorce
- *questionnaires*, which are relatively easy to score but involve oversimplification
- *standardized interviews*, such as the Life Events and Difficulties Schedule (LEDS) developed by Brown and Harris.

The effects of life experiences can be satisfactorily investigated only by prospective follow-up of people subjected to adversity, but such studies take many years to complete and are expensive. Many published studies have therefore

used retrospective methods, and their interpretation is subject to error for the following reasons:

- *Mistaking the direction of causality*. An event apparently precipitating an illness (such as losing a job) may really be the result of changes in the patient's behaviour during the prodromal phase of that illness.

- *Effort after meaning*. Some patients unwittingly exaggerate their experience of life event stress in order to explain the illness. For example, a woman who has given birth to a baby with a congenital abnormality will be more likely than a control to report adverse events during pregnancy.

- *Inaccurate recollection of timing of life events in relation to illness onset*.

- *Recall bias*. For example, depressed persons naturally tend to recall negative memories in preference to positive ones; this means they are intrinsically more likely to recall adverse life events than control subjects.

Kindling refers to a presumed process whereby repeated applications of a stimulus produce an escalating response. This theory has been used to try to understand the course, for example, of recurrent unipolar depression, in which the time between episodes tends to decrease, and the role of life events in provoking an episode becomes less prominent (see Chapter 5).

Prevention of psychiatric disorder

A cynic might say that a work called *Prevention of Psychiatric Disorder* would be in danger of winning a prize for the world's shortest book. But this would be too negative a view. In fact, most mental health professionals spend most of their time on prevention in the sense of *secondary* prevention.

Secondary prevention is reduction of severity of existing disease and prevention of relapse by means of early detection and treatment. Prevention of relapse may be achieved by drug therapy, psychotherapy, and/or social support for patients who have recovered from an episode of mental illness. This most important work is done by trying to optimize the care of existing psychiatric patients.

Tertiary prevention, so called, means reduction of the handicaps that may result from established disease, as in rehabilitation programmes to prevent patients from becoming needlessly disabled for employment and community services to reduce the burden on families. It really merges with secondary

prevention in the community mental health team environment; for example, if the patient's family are involved in the care of the patient, they will be entitled to a 'carer's assessment' under the terms of the Care Programme Approach. And links can be forged with local schemes for returning people to work, such as Employment Direct, Job Centre Plus, etc.

The value of early detection of relapse in existing patients is not in dispute. Education of patients and carers is vital. When education extends to organized campaigns directed at other health professionals and the general public, however (as in the Royal College of Psychiatrists' recent 'Defeat Depression' campaign), it becomes more controversial. It is clearly in the interests of the drug companies who tend to pay for such campaigns that diagnosis of depression should be increased. Increased prescription of antidepressant medication will then follow. However, there is a danger of medicalizing normal states of distress.

Use of screening questionnaires (Chapter 3) in medical settings, has been advocated. However, screening has not so far, at least in the case of depression, met standard UK criteria for introduction on a routine basis (Gilbody *et al.*, 2006).

Primary prevention is prevention of disease from developing in the first place. The following list of measures might be important for psychiatry, although hard evidence of effectiveness is not available for all of them:

- *medical and public health measures* to avert damage to the brain:
  - genetic counselling and prenatal diagnosis (Chapter 19)
  - improved care during pregnancy and childbirth
  - improved infant welfare services including immunization
  - control of infections, such as meningitis and HIV disease
  - avoidance of nutritional deficiencies
  - reduction of alcohol and drug misuse
  - reduction of pollution such as atmospheric lead
  - prevention of accidents, and hence of head injury, as, for example by using seat belts and crash helmets
  - provision of adequate housing.

- *psychological approaches*:
  - counselling for the bereaved, divorced, and other groups known to have a high risk of illness
  - crisis intervention for victims of major trauma has been advocated in the form of debriefing; however, contrary to expectations, this has been found to be harmful in some cases. It appears that most people cope better from

their own resources; perhaps being forced to talk about the experience again serves to retraumatize (Rose *et al.*, 2002).
– social work with disturbed families with particular emphasis on counterbalancing adverse effects on children.

Many of the measures noted above under primary prevention are outside the sphere of influence of psychiatrists. Concentrating on secondary and tertiary prevention is more practical and has the additional benefit of focusing services on those most in need.

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