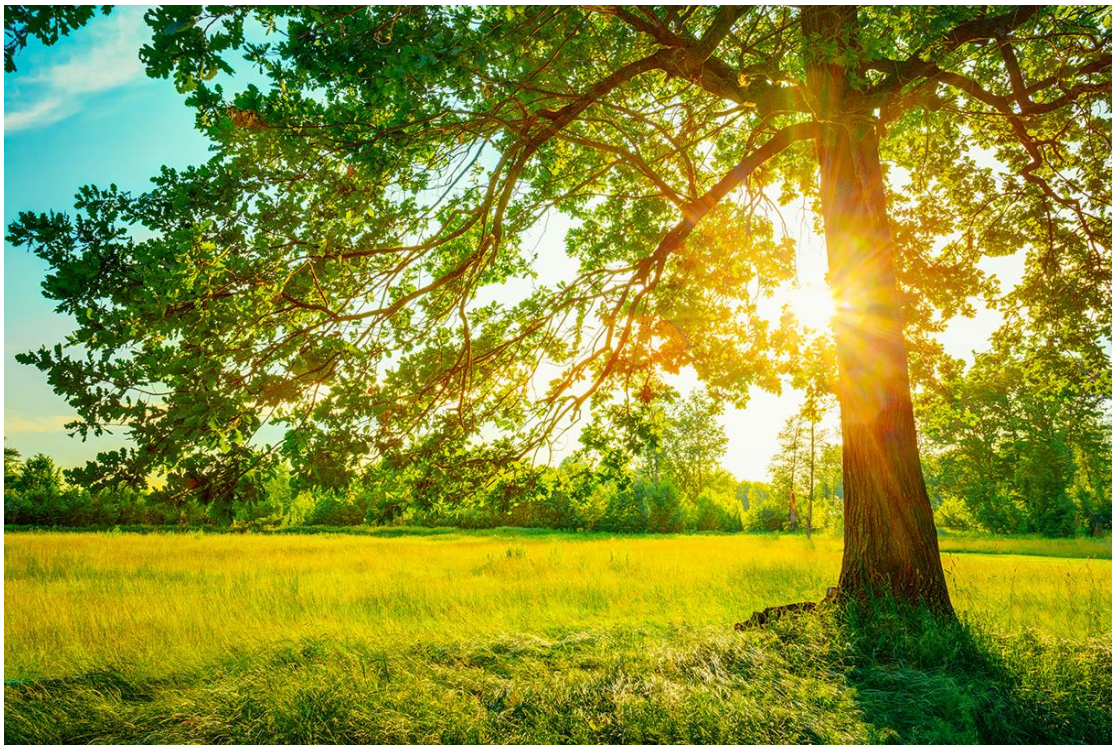
Summer 2019

Neuropsychiatry Newsletter

The voice of the Faculty of Neuropsychiatry



Featuring

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Neuropsychiatry Newsletter

Summer 2019 Edition

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Neuropsychiatry Newsletter is produced four times per year. Articles, case-reports and service descriptions should be submitted in a MS Word format by email and should not exceed 2000 words unless agreed with the Editor. Letters should not exceed 200 words. The Editor reserves the right to edit contributions as deemed necessary. Opinions expressed in the newsletter are of the authors and not of the College.

Editorial

On DoLs, Mental Health Acts and other Parliamentary work

by

Dr Kevin Foy

Editor of Neuropsychiatry Newsletter

Consultant Neuropsychiatrist,

The Walton Centre Foundation NHS Trust, Liverpool

The Neuropsychiatry Newsletter has a politically neutral editorial policy. In terms of the Brexit debate, however, the ongoing political and constitutional crises means that Parliament and the national media has been focused on Brexit and the desire to amend the Mental Capacity Act and scrap the Deprivation of Liberty Safeguards and replace it with a different scheme escaped a lot of the media attention and completed its journey through Parliament and received Royal assent in May. Liberty Protection Safeguards, the new proposed streamlined version of DoLS, is hoped to save the already stretched local authorities over £200 million per year.

The Bill has already been amended. Critics of the proposed legislation suggested that there would be a potential conflict of interest for care home managers as it was proposed they be given responsibility for the process with local authority signing off the authorization. The government back-tracked in response to this criticism and local authorities will now have the option of giving these responsibilities to the care home manager or undertaking them themselves.

In an attempt to counteract accusations that the new bill did not provide a definition of what 'deprivation of liberty' means, the government issued a statutory definition in early January 2019. However, there were concerns that the definition was not compatible with existing laws and there has been a recent decision to drop a statutory definition altogether.

Some suggested that the new legislation should have waited until the independent review of the Mental Health Act was completed. Such a pause never took place and the new LPA is anticipated to come into force in October 2020. Before that, a new code of practice will be drafted and training for professionals delivered. Similar to the Brexit debate, the end point is nearer but more unclear than ever!

News from the Executive Committee

The executive committee recently met at the College offices in Prescot Street, London. During the full agenda, a number of pertinent recent developments were discussed - the most important of which is the 30-day consultation on a draft specification for specialised neuropsychiatry and neuropsychology services. This document potentially maps out the development of neuropsychiatry within England for the future. At present access to neuropsychiatry services is patchy and can be a postcode lottery. The draft document defines our specialty and lists the reasons why specialist neuropsychiatric assessment and treatment should be a requirement in Tier 1 services i.e. regional neuroscience centres with a catchment area of more than a million. The document emphasises the need for joined up thinking and close working with our neurology, neurosurgery and neurorehabilitation colleagues with the development of multidisciplinary teams.

The Faculty Executive also discussed the recent 'Time for Change' report from the all-party parliamentary group (APPG) on acquired brain injury. The process was championed by Chris Bryant MP and pointed out the chronicity of symptoms and social consequence of acquired brain injury. The importance of neurorehabilitation, education, ABI in criminal justice system, sports concussion and welfare and benefits system was mentioned in the document. Unfortunately, despite the fact that members of the Faculty attended the APPG, there was no mention of the severe mental health consequences of brain injury or the role of psychiatry within the report. The Royal College of Psychiatrists was therefore unable to endorse the document.

The report in its entirety is available on https://www.ukabif.org.uk/wp-content/uploads/2018/10/1533_40pp_APPG-on-ABI_Report_Time-for-Change_2018_AW_SINGLES_WEB.pdf

Members of the Executive Committee recently hosted a 'Mental Health and Neurosciences Leaders Away Day' and organised by The Neurological Alliance. The day was kicked off by Professor Timothy Kendall, NHS England's National Clinical Director for Mental Health and Professor Adrian Williams, Chair of the National Neurosciences Advisory Group. The away day reflected on the problems that result the interplay between neurological and co-morbid mental health conditions and the difficulties in accessing treatment for patients with neurological symptoms. A consensus statement highlighted the need for screening of people with neurological conditions and mental health problems to be able to access tailored neuropsychiatric and neuropsychological expert assessment and treatment. The full recommendations are available at https://www.neural.org.uk/resource_library/mental-health-consensus-statement/

Post-Flight Confusion: Does flying affect the brain?

Gianetta Rands, Thomas McCabe, Chris Imrey

Introduction:

For well over a decade, clinicians working with the elderly have seen patients who developed confusion after flying on aeroplanes[1]. More recently a detailed case study has been published [2].

Our clinical information is anecdotal but through pooling our observations, the condition appears to be associated with some key clinical features- summarised below in table 1. Patients will have flown by passenger jet in the previous 2-3 days and their flights have been 1.5 – 14 hours duration. Symptoms were initially noticed by family and friends. All cases we know of are in older people.

	Observations
New symptoms noticed	Increased confusion, if diagnosed with dementia
	New confusion, if no known dementia;
	Disorientation in time and place, not recognising familiar people
	Acute change of personality
	Uncharacteristic agitation, aggression and distress
Associated with previous diagnosis	Hypertension
	Cardiovascular disease (CVD)
	Transient ischaemic attacks (TIA)
	Cerebro-vascular disease (Stroke)
	Tendency to delirium and episodic confusion
	History of sun-downing (confusion worse during early evenings)
Investigations	Usually all normal; no evidence of infections, inflammation, CVD, CVA, delirium screens negative
	One report of frontal lobe swelling on brain scan
	Cognitive testing, if done, shows deficits
Outcomes	Generally, not good. (this may not be typical; we know very few outcomes and may only get to hear about the poor ones)
	One patient needed nursing home care
	One patient died 4 weeks after repeat flight
	One patient went on to be diagnosed with dementia

Table One: Observations from cases of Post Flight Confusion:

The Physics and Physiology of Air Travel

There is a considerable amount of research data about the effects of different altitudes on human physiology- most of which has been done on fit young men. We know of no research on international air travellers and older travellers. Many aspects of the cabin environment is artificially controlled, in part due to the fact that most planes cruise at altitudes of 30,000-40,000 ft.

1. Air pressure. This is measured in PSI = pounds per square inch. At 40,000 feet, air pressure is 2.7psi which is incompatible with life. Currently, controlled cabin pressures are about 10.8-12.2psi, corresponding to 6-8,000 feet altitude. Sea level is 14psi.
Planes ascend to cruising heights in 20-30 minutes, and descend at similar speed. Low air pressure is associated with expansion of air spaces which are present in bowels, sinuses, and recent surgery sites. Low air pressure is associated with peripheral oedema.

2. Oxygen. At 6 – 8,000 feet altitude there is 20-26% reduction in available oxygen. Research has found this to result in haemoxyhaemoglobin saturations (PO_2) of 83-85%. At ground level, PO_2 is normally 97-99%.

Using a small pulse oximeter, one of the authors found their oxygen saturation was 98-99% at the beginning and end of the flight when the plane was on the ground. At cruising altitude the oxygen saturation dropped to 83-89%. This drop in saturation appears to be associated with a compensatory increase in heart rate in some individuals. Careful data collection using this simple methodology and samples of older and younger men and women would be an interesting study.

3. Humidity. The humidity within an air cabin at cruising altitude can be as low as 1-20%. Our 'comfort zone' is 50-65%. Low humidity can result in dehydration and reduced peripheral perfusion.

4. Cabin air quality. There are no internationally agreed standards for cabin air quality. Cabin air may contain levels of carbon dioxide (CO_2), ozone and microbes that are illegal in office spaces.

5. Legal Standards: The Warsaw Convention, 1929, appears to be the most recent legislation about airlines responsibility for their customers' health. It says that passengers are responsible for their own health. Of note, in 1929 planes were propeller planes and did not have pressurised cabins as they flew much lower than modern day jets (they usually fly lower that modern day controlled cabin environment equivalent altitudes).

6. Propeller planes: The authors are aware of a patient with mild dementia who regularly travels from the Channel Islands to London. His wife noticed that after travelling by jet plane he is more confused for several days. They now use a propeller plane service and since switching to that service, he no longer experiences post-flight confusion. Propeller planes usually fly below 5,000 feet and do not have artificially controlled cabins. Their in-flight altitudes are less than the artificially controlled altitudes of high flying jets.

Basic Physiology and Brain Responses to Hypoxia and other aspects of in-flight environments.

At normal blood oxygen saturations, cerebral perfusion pressure is auto-regulated as the difference between blood pressure and intracranial pressure. Arterial carbon dioxide levels and local metabolic activity affect cerebral perfusion. When arterial oxygen is low, the physiological responses include increases in respiratory and heart rates, and over time, increased haematocrit.

Due to the fact that air cabins are only partially pressurised, air travel is associated with a low level of hypoxia. In addition, mild cereberal oedema

may also be observed. These changes may be even more significant in individuals with chronic respiratory problems or anaemia.

At relatively low levels of anoxia, a mismatch between cellular ATP supply and demand can occur leading to hypometabolism. Depending on how long this lasts, and how good physiological adaptations are, this could result in cerebral hypoxia and cell damage. Evidence indicates that physiological auto-regulation is impaired by increasing age, sleep, alcohol, and hypnotics and maybe other factors such as various medications.

The solution may not just be to provide additional oxygen in the cabin- although this would improve blood oxygen saturation. Changed carbon dioxide concentration and other factors may have adverse effects on cerebral perfusion and unwanted side effects such as haemorrhage. Clearly, there is a limit to how much the controlled cabin air pressure can be increased without compromising the integrity of the fuselage.

Cognitive Effects of High Altitudes

Interest in the cognitive effects of high altitude started with research of James Glaisher and Henry Coxwell in the 1860s. In 1932, these effects were demonstrated with hand writing samples that became more jumbled with increasing altitude. A number of research studies have demonstrated specific cognitive difficulties at altitudes. For instance, Griva et al [3] assessed a range of cognitive functions after ascent to Everest base camp and found attention, learning, verbal abilities, and executive function declined to variable degrees with ascent to altitude. Mountain trekkers were the subjects of these studies- and ascent to altitude was substantially slower than jet planes and subjects were fitter than most air passengers. There was a wide inter-individual variability and the impairments were greater in older trekkers.

Conclusions:

Although anecdotal, post flight confusion is recognised by many professionals who work with confused patients. The cause may be due to prolonged mild cerebral hypoxia. Research is needed to validate post flight confusion as a syndrome, to identify people at risk, and assess how those risks can be minimised. Post flight confusion could shed light on some mechanisms of delirium and contribute to our knowledge about the aetiologies and prevention of dementias.

We are collecting details of people who have presented with symptoms of Post Flight Confusion. If you see possible cases please let us know.
E: grands@re-cognitionhealth.com

In the meantime, do acquire a pulse oximeter and let us know your in-flight PO_2s!

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1. G.Rands (2002) Fear of Flying reviewed. An example of evidence based Old Age Psychiatry, Psych. Bulletin, 26. 188 – 190
2. Thomas McCabe (2017) 'Doc, can I fly to Australia?' A case report and review of delirium following long-haul flight' Psych Bulletin 41 30-32
3. Griva et al (2017) – http://openaccess.sgul.ac.uk/108848/1/journal.pone.0174277.pdf
Other references of interest:
4. The Impact of Flying on Passenger Health; a guide for healthcare professionals BMA Board of Science and Education, BMA (2004). www.bma.org.uk
5. Gianetta Rands (2011) Have we gone too far in translating ideas from aviation to patient safety? letter *BMJ 2011 342:c7309; doi:10.1136/bmj.c7309*

Gianetta Rands is a retired old age psychiatrist who now has a small private practice in London. She has previously raised concerns about post-flight confusion and published a systematic review about this in the Psych Bulletin in 2002. Her book "Women's Voices in Psychiatry" was published in 2018 by Oxford University Press.

Professor Chris Imray is a Consultant vascular and renal transplant Surgeon at University Hospitals Coventry and Warwickshire NHS Trust, Coventry.

Dr Thomas McCabe is a Psychiatry trainee who specialises in altitude medicine and research and has himself climbed 6 or the 7 highest mountains in the world. He has a webpage and a just giving page.

Audit/review of practice

What is the gold standard for assessing classification of severity of brain injury?

Janet Grace

Classification of brain injury is contentious and there are multiple non-compatible systems in use. There is an additional aspect to this problem – assessment of brain injury is carried out by medical specialists in neurosurgery, neurology, emergency medicine, neurorehabilitation and neuropsychiatry as well as by clinicians in related fields such as emergency medicine nurses, paramedics and psychologists. We approach the problem of classification from different areas of expertise. Furthermore the demands a medicolegal report will be very different from the requirements of a clinical assessment.

Clinical experience has suggested that there is no consensus as to which classification systems are most commonly used by neuropsychiatrists and other clinicians. The purpose of this survey is quantify the use of different classification systems across a sample of neuropsychiatrists to allow benchmarking of clinical practice and start a debate about practice.

Brain injury; a brief history of classifications

Russell and Smith (1961) introduced a classification system based on PTA alone. The most commonly referred to PTA scales are shown below.

PTA duration	Severity
<5 minutes	Very mild
5 – 60 minutes	Mild
1 – 24 hours	Moderate
1 – 7 days	Severe
1 – 4 weeks	Very severe
> 4 weeks	extremely severe

Jennett and Teasdale (1981) adapted from Russell and Smith (1961)

Teasdale and Jennett devised the GCS in 1974 and revised it in 1976. Below are the generally accepted cut offs for GCS

Lowest recorded GCS	Severity
13 – 15	Mild
9 - 12	Moderate
3 – 8	Severe

Duration of loss of consciousness is often combined with the PTA and GCS. For example

	GCS	PTA	LOC
Mild	13-15	< 1 day	0- 30 minutes
Moderate	9-12	>1 to < 7 days	> 30 minutes to < 24 hours
Severe	3-8	>7 days	> 24 hours

Department of Defense and Department of Veterans Affairs (2008). "Traumatic Brain Injury Task Force". *www.cdc.gov/nchs/data/icd9/Sep08TBI.pdf*.

The Mayo scale

> The criteria for a moderate to severe ABI are 1. Loss of consciousness of more than 30 minutes, 2. PTA of more than 24 hours, 3. A lowest recorded GCS of less than 13 and 4 Haematoma, contusion or haemorrhage on neuroimaging.
>
> A TBI would be classified as probable mild if there is loss of consciousness below 30 minutes, PTA is less than 24 hours, and there is a depressed, basilar, or linear skull fracture (dura intact).
>
> A possible TBI is diagnosed if there are one or more of the following symptoms: blurred vision, confusion, feeling dazed, dizziness, headache, or nausea.

Studies indicate that there is a strong correlation between measures of PTA and GCS, confounding any assessment of an individual measure to predict outcome.

There is a significant question as to whether any assessment of peri-traumatic markers predicts outcome with a degree of accuracy that is clinically useful. The evidence for superiority of one scale over another is contradictory and even the most robust studies show that PTA accounts for only one third of the variance in outcome raising the question of whether there is any point in classifying severity. The MRC CRASH trials rely on GCS, CT findings and pupil reactivity with no assessment of PTA (http://www.crash.lshtm.ac.uk/Risk%20calculator/).

In view of the contradictory research regarding utility of classification systems, a survey of current practice was undertaken.

Method

Twenty-three consultant neuropsychiatrists were contacted to comment on how they classified brain injury, which classification system they used and why.

Results

	Areas of work	Preferred classification system
1	NHS and private	Narrative description
2	Private only	Vets
3	NHS only	Vets
4	NHS and private	DSM V
5	NHS	Mayo
6	Private	Mayo
7	Private	Mayo
8	NHS	Narrative
9	NHS and private	Narrative
10	NHS and private	Mayo
11	NHS and private	Mayo/narrative/Russell and Smith
12	NHS and private	Mayo
13	NHS and private	WHO
14		Does not see TBI patients
15	NHS and private	Mayo
16	private	Mayo or narrative
17	NHS and private	Narrative
18	NHS	Mayo or narrative
19	Private	Mayo
20	NHS and private	Mayo or narrative
21	NHS	Narrative

21/23 people responded. 1/21 did not see brain injury patients so were excluded from the analysis.

There is no consistency either between practitioners or, at times, within an individual's practice as to classification system used. 4/20 used different criteria depending on the circumstances. Only 1/20 used a single dimensional measure (PTA per the Russell criteria) and that was not consistent. The most commonly used criteria were the Mayo (11/20). 8/20 used a narrative description for some or all assessments rather than an externally validated system. 1/20 relied on DSM V.

Some respondents expressed dissatisfaction with all systems. One respondent wrote

> *"As a neuropsychiatrist, all systems fail to cater for our area of expertise and I often fall back on narrative accounts"*

As a group we seem to have become quite keen on radiology findings

> "*I have switched to using Mayo because it is the newest and the only one that takes radiology into consideration and it also does not differentiate between moderate and severe because it recognises that outcome is variable regardless"*

Another expressed concern at the uncertainty

> "*There is a lot of confusion re severity in Brain Injury among Medicolegal experts so your question is very relevant"*

Conclusions

There is no consistency in assessing the severity of brain injury based on peri-traumatic markers. There is a near consensus that more than one peri-traumatic criteria should be relied on and the comments expressed concern that no system was particularly useful.

In terms of accepted practice, it would be difficult to identify a "*reasonable body of opinion*" as we are so diverse in what we do.

Outcome

Is it worthwhile doing a further survey, maybe through the Faculty, regarding current practice? There is a big sample group (about 3000 members, but not all are consultant neuropsychiatrists). We could extend the scope and ask about preferred use of classification systems and relationship to outcome? This may be useful for both medicolegal work, but also establishing a benchmark for criticism of clinical work and possibly getting our (neuropsychiatrists') voices heard in development of future systems.

Dr Janet Grace is a consultant neuropsychiatrist with special interest in the interaction between acquired brain injury and mental capacity. Until recently she was clinical lead at the Regional Neurobehavioural Unit at Walkergate Park Hospital where she managed the psychiatric sequalae and severe behavioural problems associated with acquired brain injury.

Conference Report

Neuropsychiatry – 2018 A Global Approach

11th International Congress of the International Neuropsychiatric Association: 15-17th of February 2018, Bangalore, India; Conference Report

Vijay Harbishettar, Rahul Rao and Anitha Siddappa

The 11th International Congress of the International Neuropsychiatric Association (INA) jointly organised by the INA and National Institute of Mental Health and Neurosciences (NIMHANS) at the NIMHANS Convention Centre, Bangalore was attended by over 450 delegates and 35 Speakers from 14 different countries. A total of 120 posters were presented that included 24 posters from outside India.

Inauguration of Conference by customary lighting the lamp, saying goes "From Darkness to Light"

The conference began with a talk by Semir Zeki (UK) entitled 'The Objectivity of Subjective Truths' which examined the ability of the brain to accept different interpretations of scenarios but only one interpretation consciously at any one time. The neuropsychologist, Narinder Kapur (UK), then spoke on unconscious cognitive, emotional and social bias. Michael Trimble (UK) brought the first plenary session to a close by discussing, with illustrations, that prediction as a fundamental property of brain and so musicians tend to bring in ambiguity.

The second Plenary Session began with a presentation by Eileen Joyce (UK) linking the pathological changes in Parkinson's disease with the behavioural and psychiatric symptoms seen in the condition. David Arciniegas (USA) subsequently, via tele-link, discussed psychiatric symptoms in various neurological illnesses and dementia. This session concluded with Florence Thibaut (France) presenting a talk entitled 'Biomarkers in Schizophrenia'.

The next session began with the formal inauguration of the conference. Michael Trimble (UK) discussed brain and mind interface in epilepsy and took us back into history with his evolutionary approach. BN Gangadhar (India) brought and Indian perspective on mind and body and the importance of wellness from 5000 BC. Parminder Sachdev (Australia) discussed the visual pathways describing how a visualised object is converted into a sensory signal and perceived by central processing.

The third plenary session was opened by Ingmar Skoog (Sweden) who discussed findings from his 50 years Gothenberg cohort study. The importance of the use of PET scans to assist early detection of Alzheimer's disease (AD) and its validation parameters was then discussed by Chris Rowe (Australia). The session concluded with Parminder Sachdev's talk on neuroimaging in neuropsychiatry.

Day two commenced with Dale Hesdorffer (USA) who discussed comorbidities in epilepsy. Valsamma Eapen (Australia) discussed various pathways in brain was discussed that correlates with the behavioural problems in childhood. Then Ralph Martins (Australia) University discussed biomarkers for early diagnosis of AD based on his experience with large cohort study of 1200 People over twelve years.

The fifth plenary session began with Ennapadam Krishnamoorthy (India) discussing how managing mental and social well-being are key components in treating individual patients and shared his experiences of using all round holistic assessment and offering treatment including complementary therapies. Then came the Haim Belmaker (Israel) who discussed the neuropsychiatric effects of lithium and its mechanism of action. Ehud Klein (Israel) critically evaluated evidence of transcranial magnetic stimulation (TMS).

The action in Hall A began by critically evaluating the evidence base for ECT in psychosis by Jagdisha Thirthahalli (India). This was followed by a talk on TMS by Ganesan Venkatasubramanian (India). He gave hope regarding TMS with data on its benefits in depression, OCD and negative symptoms of schizophrenia. After that Urvaksh Mehta (India) gave talk on the how TMS can used to understand psychopathology in various conditions. The next speaker was Ipsit Vahia (USA) who briefed on the utility of technology to diagnose and monitor various conditions. Continuing on the discussion of technology, Prabhat Chand (India) gave a talk on how technology

has helped reach out to very rural parts of India. Then Mathew Varghese (India) spoke on his online Caregiver Program for Dementia. Then K Muralidharan (India) spoke about neuropsychological deficits in early bipolar 1 disorder. The next talk was about Cellular Models in Psychiatry by Biju Vishwanath (India). John P John (India) spoke on historical reference to how Alzheimer's disease and schizophrenia might have common roots as highlighted by Kraeplin.

In Hall B, the session began with Gilberto Brofman (Brazil) speaking about clozapine. Riaz Baber (USA) discussed mindfulness. The inflammatory hypothesis of depression was discussed by Raz Yirmiya (Israel). Then Nurit Yormiya (Israel), from experience of her own longitudinal follow up study of preterm births for period of 5 years, discussed early social communication behaviour and risk factors. The next two talks began with Kenichi Meguro (Japan) discussing how language as a cognitive function can lead to different phenomenonology and Nakatsuka (Japan) discussed the secondary behavioural symptoms include delusions in 40-70% of Alzehimers Disease. Vorapan Sananaroong (Thailand) discussed language phonology, morphology, syntax, semantics and pragmatics.

On the last day of the Conference, in Hall A, speaker Dr Ravi Yadav (Israel) covered a broad range of neuropsychiatric aspects of movement disorders. The genetics of neurodegenerative disorders was discussed by Sanjeev Jain (India). After this epilepsy and its neuropsychiatric aspects was discussed by Sanjib Sinha and Senthil Reddi (India) respectively. In an interesting presentation, neurosurgeon Dwarakanath (India) discussed deep brain stimulation and gamma knife surgery.

The Australian Symposium began with a discussion of preventative aspects of Alzheimer’s disease by Rebecca Koncz and Parminder Sachdev.

During a session exclusively dedicated to ‘Women in Neuropsychiatry’, Florence Thibaut discussed substance misuse issues with comorbidity in women followed Prabha Chandra’s (India) talk on postpartum psychosis.

The other session was on functional neurological disorders supported by the British Neuropsychiatric Association and RCPsych Faculty of Neuropsychiatry. Tim Nicholson (UK) explained how the

various terminologies could be confusing and stigmatising. Niruj Agrawal (UK) gave insights into the management and emphasised the need of early diagnosis, effective triaging, collaborative MDT approach and individualised case management.

A session marked as European Symposium presented by Mr Peter Maeck, an author, photographer and a carer for dementia titled "Rememberance of things Present: Making peace with dementia". David Neary's (UK) presentation on clinical approaches to confusional states was a crisp account of subacute confusional states which are difficult to assess and diagnose. There is dysfunction in cortico- thalamo-cortico neuronal network which affects memory consolidation, explained Greek clinician Dmitri Dekeios speaking on sleep biomarkers. Vascular dementia in the Indian scenario by Suvarna Alladi followed was by a discussion of the Gothenburg cohort study highlighting the silent vascular burden of stroke risk factors in vascular dementia by once again Ingmar Skoog.

The INA Raymond Cajal Lecture was delivered on macro and micro perception in the visual world by Semir Zeki followed by the INA Alwyn Lishman Lecture on 'Neurodegeneration, a Natural Model of Understanding Cognition and Behaviour' by Julie Snowden (UK). In conclusion, the International Conference successfully gave a platform for exchange of wealth of knowledge on contemporary global neuropsychiatry. The weather in Bangalore was consistently pleasant throughout.

Acknowledgements: Thanks to the Hosting team lead by INA President Krishnamoorthy, Chennai, and Professor Mathew Varghese, NIMHANS, Bangalore.

Dr Vijaykumar Harbishettar is a Consultant Psychiatrist and Ad-hoc Faculty in Geriatric Psychiatry, NIMHANS, Bangalore

Dr Rahul Rao is the Post-Graduate Resident in Psychiatry at M S Ramaiah Medical College, Bangalore

Dr Anitha Siddappa, Consultant Geriatric Psychiatrist working in Nightingale Medical Trust, Bangalore

‘Dis-sociated’ - a documentary about dissociative seizures

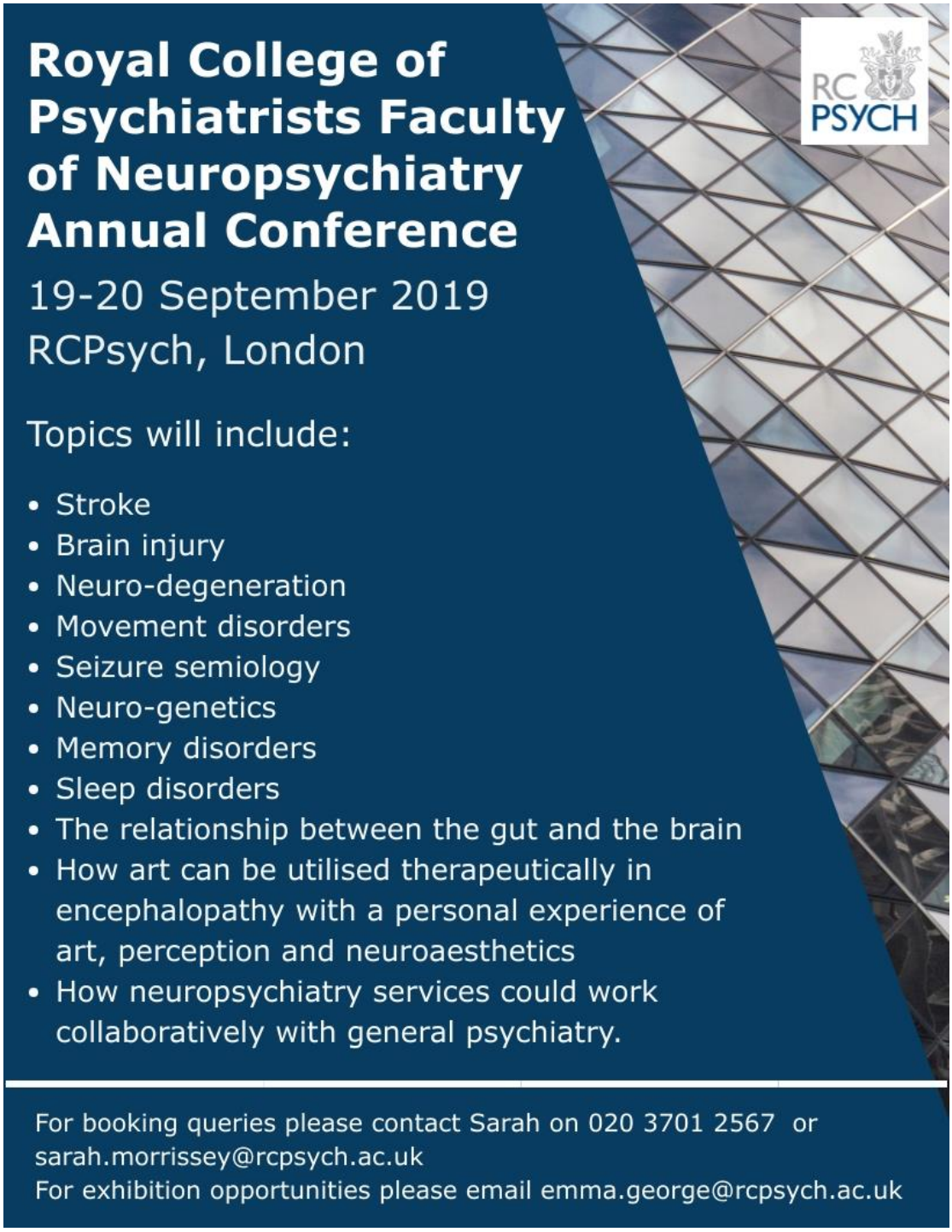
Over the last two decades there has been an impressive rise in research interest in dissociative seizures, and our understanding of this common condition has increased considerably. Nevertheless, patients often end up in limbo. Neurologists tell them that their problem is not “neurological”, but psychiatrists may feel uncertain how to help them - and patients may not want to see them anyway, because they cannot believe their problem could be “psychological”.

“Dis-sociated” is the first full-length (51 minute) documentary about dissociative seizures and is now available - free to view or show - on YouTube:

https://www.youtube.com/channel/UC0h5tSMk6wq2ZiEi8FM-7xg

The film was produced as a declaration of friendship. Clea Martin Vargas, who made this film, was inspired to dedicate herself to this project when her friend developed dissociative seizures and struggled to find any useful information about her condition for several years. The film follows Clea’s friend on a journey of self-discovery which ultimately leads to the resolution of the seizures. It also captures the stories of four other individuals with dissociative seizures who share their experiences and insights. Although not everyone portrayed in the film achieves control or understanding of their seizures, they all come across as individuals doing their best to get better and make the most of their lives. While up-to-date expert explanations of dissociative seizures are provided by internationally recognised experts such as Lorna Myers from the US or Markus Reuber from the UK, the most striking aspect of the film are the contributions made by the five individuals with dissociative seizures.

This film was intended to raise awareness and understanding of dissociative seizures among the general public, but it is an excellent therapeutic tool to show people affected by dissociative seizures how life can go on and how they can get better. Patients may find it easier to learn lessons about living with d~~D~~issociative s~~S~~eiziures from other individuals with the condition than from their doctors.


Royal College of Psychiatrists Faculty of Neuropsychiatry Annual Conference
19-20 September 2019
RCPsych, London
Topics will include:
• Stroke
• Brain injury
• Neuro-degeneration
• Movement disorders
• Seizure semiology
• Neuro-genetics
• Memory disorders
• Sleep disorders
• The relationship between the gut and the brain
• How art can be utilised therapeutically in encephalopathy with a personal experience of art, perception and neuroaesthetics
• How neuropsychiatry services could work collaboratively with general psychiatry.
RC PSYCH
For booking queries please contact Sarah on 020 3701 2567 or sarah.morrissey@rcpsych.ac.uk
For exhibition opportunities please email emma.george@rcpsych.ac.uk