

Lecture Notes

The following notes were taken by Rena Harford at a recent Aware lecture delivered by Consultant Psychiatrist Dr. Michael Bourke.

“It’s difficult to know what patients are feeling, doctors try.”

Dr. Bourke referred to an experience of one his peers, Kay Redfield Jamison, a Professor of Child Psychiatry at John Hopkin’s Hospital, Maryland. When training residents, she found that they knew the theory well, but not what it is like to *feel* ill. She tried to explain to them (being a sufferer of manic-depression herself), and wrote in the students’ newsletter. Ms. Redfield Jamison has also written books on the subject and explained what it is like to be “high as a kite”, though it can be difficult to understand without actually experiencing it. Dr. Bourke explained that with depression, there is an intractable sense of not getting better, quite unlike feeling down or upset.

Anorexia Nervosa

The main focus of Dr Bourke’s lecture was Anorexia Nervosa. He encouraged a discussion and invited the audience to ask questions during his talk. Anorexia Nervosa, he said, is “as old as the hills”, having first been described in the 16th century.

Causes

Anorexia is fear or anxiety brought about at some stage in life when things are getting too much for the individual e.g. leaving school, moving house or getting married. From the 1980s onwards, doctors started talking about how young people affected, (10% of them males) solved problems. Two French doctors cited a concrete operational disorder and it was estimated that 60% of people in a gastroenterology clinic had a psychological component to their illness. A Canadian doctor talked about cognitive deficits. When considering body image, one wonders why patients have a different measure of their body size? It is neither an eyesight problem nor a problem with upbringing. It may lie in measuring personal ineffectiveness and being unable to work out how others are relative to you. We all have our ways of getting feedback.

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Hilda Brook, the “grandmother” of eating disorders, finds it unhelpful to return to childhood reasons while treating Anorexia Nervosa. She emphasizes working on how they think, how the brain works.

Research:

Dr. Bourke is happy to be involved in current research. He explains that some patients have had trouble making up a story to solve problems. They are not good at duck and dive and like straight questions and straight answers. This group is overrepresented in Anorexia Nervosa patients. They have difficulty

- Measuring body size
- Problem solving
- Seeing how they are relative to others

Transition:

E.g. Puberty/Marriage/Living Alone

The problem is one you cannot solve, so you retreat into a safety zone. You stop eating. It's an anxiety disorder-it's a fear, it's a panic in relation to what is happening in your life at that time. With bulimia, "When I'm upset I eat", and with Anorexia Nervosa "When I'm upset I don't eat".

In 1979, Professor Gerard Russell of Maudsley Hospital, London said that there are a group of patients that do not have the same feelings as those with Anorexia Nervosa. This group has a fear of being overweight which results in binge eating. There are many ways of bingeing;

- Skip a meal
- Exercise
- Empty the gastric contents

The last becomes a habit, hence binge vomiting, which nobody likes. As it interferes with the biology of the body, the intellect says one thing, the body says the opposite. This war takes place between biological controls and intellectual controls. It's a wrong way to try and counter a fear that you are going to lose control. When treating patients, you have to teach them a new way of dealing with that anxiety.

Obesity:

Obesity often gets left out. It is poorly understood and the origins of it are not recognised. Patients go to physicians or surgeons and psychiatrists do not get a look in. Obesity is about a short reward and not taking a longer view. The treatment involves taking short steps to goals.

Co-Morbidity:

In the late 1980s, there was a lot of discussion in relation to co-morbidity and the correlation between depression and eating disorders. Purists used to say that the eating disorder was the problem. Is it not possible to get depression and have an eating disorder at the same time?

Prozac is used in high doses to treat Bulimia. After a week, many patients are feeling great. Could bulimia be a variant of depression? (High doses of anti-depressants are also used in the treatment of OCD). Cooper of Cambridge Apostat Centre contests that depression is being treated when using anti-depressants but are used to give the patient a break, leaving time to treat them in that year.

How Depression Works:

Psychiatry has only come into its own in the last 20 years. It is so difficult to research the brain . It is very easy to research the heart. It is becoming easier to research the brain with PET scans (Position Electron Tomography).

Answering a question in relation to Omega 3 tablets, Dr. Bourke explained, "We doctors are all doubting Thomas's"-if we can't prove it, we don't prescribe it.

Nerves are like railway tracks, they have functions. Nerves don't touch or jump. What happens is that neurotransmitters affect the sodium pump and cause changes in membrane permeability.

Other causes of Depression:

- Head Injuries
- Strokes
- Virus Infections, especially Glandular Fever
- Lorian for Malaria
- Blood Pressure Tablets
- Street Drugs
- Alcohol

Persistent overuse of alcohol exhausts the brain. An amazing emotional experience, such as that of life events such as the death of a relative or getting bad news, can result in a physical disorder. These are especially important in the two years preceding the onset of depression.

Returning to Anorexia Nervosa, eating disorders can present as depression. Anorexia is not part of Depressive Disorder. Anorexia doesn't need medicine. In Bulimia however, it is different. Medicines do help with symptom control, along with psychotherapy. It is important not to over emphasize medicines. Psychotherapy is very important. Omega 3 fish oils are controversial.

Sleep is very important. Anything that interferes with it should be avoided, such as caffeine and other stimulants.

OCD (Obsessive Compulsive Disorder) can result in Major Depressive Illness. Panic attacks can lead to a brief recurrent depression.

Public Education:

Professor Bourke spoke of the difficulties encountered when trying to educate the public on mental illness. He believes there is fear of psychiatric patients, among the press and the public. He gave the example of a 3rd brother of Royal Edward VII and how, because of his epilepsy, he was hidden away from the public for his entire life. He believes there is an attempt to medicalise everything and that Bipolar Disorder may be labeled too easily. However, When Dr. Bourke qualified the only medication available for the illness was Lithium and now there are several, including Lamictal, which is very good.

Professor Bourke has a friend who has Bipolar Disorder and is a doctor. He would not take his medicines and always had a theory that "beans" would cure him. A typical medic, no respect for their own profession! "Doctors and nurses are hopeless at taking medicines!"

Food:

If kept away from junk foods, children calm down. It is nature's secret...food as a tranquilizer. When a lion feels satiated, it snoozes. If you exercise after a meal you'll get a cramp. Blood is needed for the digestion. Therefore, you don't feel like exercising after food so don't swim until one hour after it.

Professor Bourke does not agree that SSRIs (Selective Serotonin Reuptake Inhibitors) increase appetite, though the older anti-depressants did. Depression causes comfort eating.