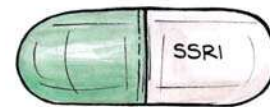


The Ultimate Alphabet GP Guide to Unusual Psychiatric Disorders continued



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26. Kuru

An epidemic started in the early 1900s in Papua New Guinea amongst the Fore people.¹ Kuru also known as 'the laughing death's' early symptoms included laughing, headaches, joint pains and progressive tremors, ataxia, depression and, ultimately, dysphagia, total paralysis and death. It was mostly women and children affected by the disease and 200 a year would die in the region. Dr Michael Alpers read about this condition and travelled to PNG to research the disease. He went on to live among the people for over 40 years and noticed children born after 1960 didn't contract the disease and that this coincided with colonies banning their cultural and ritual practices, including endocannibalism.²



Carleton Gajdusek, a virologist, found that it was a new disease of the brain but was confused because it didn't appear to be infectious or transmissible. Alpers and Carleton used the tissue of an 11-year-old girl to infect two chimpanzees. The chimpanzees contracted Kuru, proving it was transmissible. *Carleton won a Nobel prize for discovering, 'unconventional viruses', however, another scientist, Prusiner, stated it was caused by Prion proteins and he subsequently won the Nobel prize.³ Prions aren't living organisms in addition, they do not have DNA or RNA. When normal, they are thought to be involved in copper binding or signal transduction. They turn pathological through spontaneous changes in the folding of the protein which creates a cascade as the miss-folded protein makes other prions miss-fold. These miss-folded proteins build up in the brain to form fibrils and plaques and causes dementia. There is no treatment.⁴

Contributed by Laura McManus

27. Lima Syndrome

Lima syndrome is named after a mass abduction in Lima, Peru in 1996. Members of a militant movement captured around 400 people who attended a party at the residence of the Japanese ambassador to Peru and held them hostage for 128 days.¹ The terrorists developed empathy towards the hostages and consequently released most of them. This phenomenon is the opposite of Stockholm syndrome. Victims established a rapport with their kidnappers which encouraged them to sympathise with their victims and provide an opportunity for them to escape.²



On the other hand, another influential factor is the personality trait of the kidnappers. For example, there is a theory that if the kidnapper has a less marked and decisive personality, or if they are young and inexperienced, it may be more likely for their behaviour to change over the course of the kidnapping because of the influence of the victim's behaviour.¹ Similar to Stockholm Syndrome, time seems to play a vital role in behavioural change.³

The key feature of this syndrome is the process of developing empathy towards one's victims and eventually liberating them. An example of this syndrome is arguably evident in the story of Beauty and the Beast! Initially when the Belle is captured, the Beast behaves aggressively towards her. However, in response, Belle remains generous to him and converses calmly with him. Over time, this influences the Beast's behaviour that develops compassion and love towards Belle and finally releases her from captivity.

Contributed by Nikbita Pasanuru

28. Latah Syndrome

Latah syndrome is a culturally-bound syndrome in Malaysia and Indonesia, and is characterised by imitative and automatic response behaviour to stimuli. It is regarded as non-delusional due to the patterns of behaviour noticed and its association with the local culture. It involves an exaggerated response to sudden fright or trauma, causing behaviours such as involuntary echolalia, echopraxia or trance-like states.¹



Although startle phenomenon is a physiological response in every individual, it has been recognised more in the Malay community, particularly in middle aged women. Precipitating factors include recent death in the family, life crisis or even menopause.² However, Latah is not considered a mental illness among the local community, but was medicalised by Western authors in the early 20th Century. It is believed that Malay communities have a predisposition to have extreme startle response to minimal stimuli and there may be a genetic determinant.¹

Among the community, it is first recognised as an exaggerated startle response by onlookers. Later, while experiencing a state of emotional disorganisation, the individual may be intentionally provoked by observers purely for amusement, causing hyperarousal in the individual. It can be provoked by commands which the victim is likely to obey despite them being violent or embarrassing.² Ronald Simon, an ethnographer, studied this syndrome among North American women and deduced that Latah can be taught and wondered if it is a culturally bound syndrome. In DSM V, Latah syndrome was removed perhaps due to the controversy that surrounds it.²

Contributed by Nikbita Pasanuru

29. Morgellon's Syndrome

Morgellon's syndrome is an unusual variant of delusional parasitosis, where a person believes they have some form of fibres or material underneath their skin. In this sense it differs from Ekbom syndrome, where the infestation is with insects. Morgellon's is a relatively new condition, only being described in the 21st Century, following an American mother (Mary Leita) who noticed strands of fibres



protruding from her son's skin.¹

It is a challenging condition for GPs, as usually the sufferer totally believes that this is a dermatological condition and therefore would often be unwilling to accept a referral to psychiatric services. A 2012 study² found no conclusive evidence of clear aetiology or biopsies showing any clear dermatological cause. The study did find correlated increased rates of substance misuse and somatisation in the samples taking part.

From 2002-2010 there were several websites such as Morgellon's UK which gave information about the disorder.³ These seem to no longer be in existence, but there is a dedicated Facebook page, 'Morgellon's Disease UK: A Crime of Silence' for sufferers to share their experiences.⁴

Contributed by Anna Ressel

30. Munchausen's syndrome

The term Munchausen's syndrome was first described by Dr Richard Asher in 1951,¹ and was named after Baron Munchausen,² a fictional German aristocrat. The condition he described was one wherein patients told 'dramatic and untruthful' stories of an acute illness for any gain, be it intrinsic or extrinsic. The original definition therefore encompasses both factitious disorders and malingering, which have since been separately defined. Since Asher's first description, Munchausen's syndrome has been classified as a factitious illness, but no clear diagnostic criteria have been created.³



Munchausen's syndrome is a severe factitious disorder, wherein the patient has frequent contact with medical professionals. A factitious disorder is defined as any condition in which a patient feigns symptoms, without any obvious benefit, other than occupying the role of a sick person.³ These patients frequently have long medical histories with changing presentations and no well-defined diagnosis.

Contributed by Luke Biggs

31. Munchausen's syndrome by proxy

Originally described by Dr Roy Meadow in 1977,¹ Munchausen's syndrome by proxy is a severe form of factitious illness, wherein the patient creates illness in another individual, usually a dependent, for no extrinsic gain.² Because the patient reports symptoms in another person, Munchausen's by proxy is invariably linked to abuse, and medical professionals can be involved throughout, often as active, but unwitting, participants.³ The abuse usually takes a physical or emotional form, with neglect being more accurately described by the term 'Diogenes syndrome by proxy'.⁴



A textbook case of Munchausen syndrome by proxy was reported in 2000, and involved a mother inducing hypoglycaemic episodes in her child through covert insulin administration.⁵ It is important to note that while this is a classic presentation, the perpetrators are not necessarily

female, and the victims not necessarily children, as cases having been documented with male perpetrators and elderly victims.⁵

Contributed by Luke Biggs

32. Neuroleptic Malignant Syndrome



Neuroleptic malignant syndrome (NMS) is a life-threatening complication of antipsychotic medications.¹ The pathophysiology of NMS is not well established, but it is suspected that the dopamine blocking effects of antipsychotic medications leads to a state of hypodopaminergia.²⁻⁴ Diagnostically, patients may present with an altered mental state e.g. confusion, delirium, stupor, and also have muscle rigidity, autonomic dysfunction and hyperthermia.⁵

Neuroleptic malignant syndrome typically occurs within about two weeks of starting an antipsychotic or increasing its dose. It is characterised by:

- Raised temperature
- Muscle rigidity, which can be severe and interfere with speaking, eating and swallowing
- Altered mental status: mental status can fluctuate through the day, varying from confusion to coma
- Autonomic instability: irregular pulse rate, blood pressure fluctuation, excessive sweating, heart rhythm disturbances and urinary incontinence can be early signs
- Raised creatine kinase: excessive skeletal muscle breakdown can cause myoglobinuria and acute renal failure. The creatine kinase level in neuroleptic malignant syndrome is typically very much higher than that associated with exertion and physical contact (especially during restraint)
- Leucocytosis

Neuroleptic malignant syndrome should be differentiated from serotonin syndrome. Muscle rigidity, leucocytosis and raised creatine kinase may be absent in serotonin syndrome.

A high index of clinical suspicion should lead clinicians to terminate antipsychotic medications and provide supportive and corrective measures. These include the administration of fluids, correcting electrolyte disturbances and utilising cooling methods to correct hyperthermia.^{2,6} There is little evidence to suggest pharmacological treatment has a role in ameliorating symptoms or improving recovery.⁷ This medical emergency presents significant challenges on both diagnostic and therapeutic levels, with mortality rates standing at 10% per episode.⁸ Combinations of antipsychotics, or concomitant use of antipsychotics and lithium or antidepressants, may increase the risk of NMS. The onset of clozapine-induced NMS does not tend to follow the classic pattern, with a reduced likelihood of tremor and rigidity.

Rarely, NMS is linked with withdrawal or reduction in dose of dopamine agonists such as levodopa, amantadine or bromocriptine. Metoclopramide and domperidone have been reported to cause NMS in some patients.

Contributed by Ciaran Grafton-Clarke

33. Nymphomania

Nymphomania is a term which refers specifically to women, who have an uncontrollable, excessive or insatiable drive to engage in coitus. There is no medical or scientific definition for a female described as a nymphomaniac, and there is a considerable debate about whether it can even be termed a disease or clinical condition.¹ The concept of nymphomania dates back to the Victorian era when it was described as 'female pathology of over-stimulated genitals'. Some of the behaviours that led to this classification include women removing their clothes in public, grabbing at the first man they see, bearing children out of wedlock or getting caught engaging in masturbation.²



In psychiatry today it is uncertain where the line is drawn between personal preferences and habits and an illness that truly affects the well-being of an individual.³ This has led to the implementation of hypersexuality disorders into the ICD and DSM classification of disease, in an attempt to distinguish between true hyper-sexuality pathologies and out-dated terms such as nymphomania.

Contributed by Ciaran Grafton-Clarke

34. Onychophagia

Onychophagia, in lay terms is known as chronic nail biting. It is a common behaviour with prevalence estimated between 20-50%.¹ It peaks in childhood/adolescence.² It is partly impulsive and partly compulsive.¹ Onychophagia's aetiology is unknown but there are genetic and environmental contributions and associations with some psychiatric disorders such as anxiety and obsessive compulsive disorder (OCD).² Onychophagia can vary in its level of severity, although there is not a clear categorisation of severity.³ Generally it is split into mild and severe:



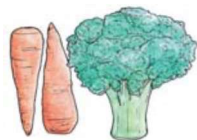
- Mild: nail biting is used to self-groom and control nail length.
- Severe: nails are bitten below the soft tissue border.³

Behaviour modification methods can be used to prevent or stop Onychophagia such as habit reversal or aversion techniques.¹ Relaxation training may also be useful in the management of Onychophagia.³

Contributed by Ellen Metcalfe

35. Orthorexia Nervosa

Orthorexia nervosa is defined as malnutrition resulting from extreme diets which are intended for health reasons¹, ritualised eating patterns and avoidance of foods believed to be unhealthy.² It most commonly occurs in adolescence.³ It was first defined in 1997 by Steven Bratman.⁴ The two main diagnostic criteria for orthorexia nervosa are:



- an obsessive focus on dietary practices believed to promote optimum health
- consequent impairment to health.⁴

Image disturbance and body weight concerns are not

required for diagnosis.⁴

There is a diagnostic overlap between orthorexia nervosa and other psychiatric conditions such as anorexia nervosa and obsessive compulsive disorder (OCD).² Current management guidance suggests cognitive-behavioural therapy and psychoeducation in addition to medical management, including selective serotonin reuptake inhibitors.²

Contributed by Ellen Metcalfe

36. Paris syndrome

Paris syndrome is a transient psychological disorder precipitated by the shock that Paris does not live up to the romanticised city that is portrayed. It usually occurs in Japanese tourists and is characterised by delusions, hallucinations, feelings of persecution, derealisation and depersonalisation.^{1,2} In severe cases, psychosomatic symptoms such as tachycardia, excessive perspiration and vomiting may be seen.³



It was first recognized in 1986 by Professor Hiroaki Ota and since then an average of 12 people per year have been identified with this disorder and repatriated.^{3,4}

Subsequently, the Japanese embassy in Paris has established a 24-hour hotline for people suffering from the syndrome!⁴

Two subsets of the syndrome have been identified:

- Type 1 (Classic) describes an individual with a psychiatric background whose basis for visiting Paris revolves around delusional motives. The onset of symptoms occurs soon after arrival to Paris, and may even be triggered by stepping into Charles de Gaulle Airport.
- Type 2 (Delayed Expression) is usually observed in patients without a psychiatric history, whose intentions for visiting Paris were 'normal'. Symptoms occur much later (three months or more) into their stay in Paris.¹

Symptoms are provoked by certain cultural encounters such as confusion caused by language barriers, and feelings of ostracization due to contrasting manners and attitudes. These cumulative factors, combined with the anguish of combatting the mismatch between the fantasized Paris and its reality, lead to a rapid deterioration in mental state – that is Paris syndrome.^{3,4}

It is said that there is only one cure: to leave Paris and never to return.⁵

Contributed by Claire Jobanputra

37. Pica

Pica is an eating disorder characterised by an intense urge to consume non-nutritional objects, or substances which are not culturally defined as food. The term 'Pica' is derived from the Latin for magpie; a bird that collects an assortment of non-food items.¹ It was first reported by Hippocrates in 400 BC and has since been recorded world-wide.²



According to the Diagnostic and Statistical Manual

of Mental Disorders, Fifth Edition (DSM-5), for such behaviour to be considered Pica, non-food items must be eaten at least once a month at an age for which it is developmentally inappropriate, and these compulsions must be inconsistent with social or cultural norms.³ Three main subtypes of non-nutritional substances prevail in Pica:

- earth substances such as clay or dirt (geophagia)
- paper products including wallpaper or toilet paper (amylophagia)
- or ice (pagophagia)

Nevertheless, items consumed vary depending on what may be available, and chalk, soap, cloth, coal, hair and paint have also been reported as consumed items.^{4,5}

The prevalence of Pica is relatively unknown, although it is predominantly reported in people from humid countries. It is common amongst pregnant women, children, people with developmental disabilities, and may coexist with a primary eating disorder.^{3,6}

Patients with Pica can present with a varied spectrum of clinical features, sometimes manifestations of lead poisoning, and deficiencies in iron and zinc.² Thus, complications may be benign or life-threatening, highlighting the importance of identifying the ingested items.

Contributed by Claire Jobanputra

38. Porphyria

Porphyria's most famous patient is King George III, although more recent evaluation of evidence suggests that he was more likely to have suffered from manic-depressive psychosis rather than attacks of acute porphyria.¹ The porphyrias are a group of rare haematological metabolic disorders which are due to reduced activity of any of the enzymes in the heme-biosynthetic pathway.



Diagnosis is by investigation of stool or urine porphyrin levels in an attack and diagnosis may subsequently require offers of genetic family screening. Out of the various subtypes of porphyrias, four have neuropsychiatric manifestations: acute intermittent porphyria, plumboporphyria, hereditary coproporphyria and variegate porphyria.² Many are autosomal dominant but with poor penetrance so may never be clinically significant for the patient.

The porphyrias have a varied clinical course, with episodic and bizarre features. Symptoms include abdominal pain, skin lesions including photosensitivity, peripheral neuropathy, muscle weakness, vomiting and constipation. Psychiatric symptoms described in porphyrias are anxiety, hysteria, restlessness, insomnia, depression and psychosis.

Psychiatric symptoms can present in a range of ways, from aggression and impulsive behaviour, to social withdrawal and persecutory delusions.³ Electrolyte disorders may occur. The porphyrias are easy to misdiagnose or miss, due to the variety of symptoms, and attacks range from very acute to patients with chronic deficits. Porphyrias also mimic other medical and psychiatric disorders.² Described as the 'little imitator', compared with syphilis being the 'big imitator', these rare disorders should not be forgotten about.³

Contributed by Elizabeth Manning

39. Q Fever



Coxiella burnetii, a Gram-negative obligate intracellular bacterium, is the aetiological agent of human Q fever. Q fever can manifest as an acute or chronic illness. Acute disease is typically a self-limiting febrile illness during which pneumonia or hepatitis can occur¹. Chronic disease, although rare, is a severe illness that usually manifests as endocarditis and occasionally as vascular infection, osteomyelitis, or chronic hepatitis.² Infections with this zoonotic pathogen occur worldwide. Q fever is considered an occupational hazard associated with domestic livestock operations.¹ People can become infected by inhaling contaminated particles of air, or through contact with the milk, urine, faeces, vaginal mucus, or semen of infected animals. People who have frequent contact with livestock face a significantly higher risk of developing Q fever. This includes farmers, veterinarians, stable hands, meat packers, and slaughterhouse workers. Living near a farm or farming facility may increase the risk. The bacteria can also be airborne.³

A number of studies have shown symptoms of mood disorders, depression, anger, and other neurocognitive problems were evident in human sufferers of Q fever.⁴

Contributed by Nick Mullin

40. Satyriasis

Satyriasis also known as hyper sexuality or nymphomania colloquially can be defined as 'exhibiting unusual or excessive concern with indulgence in sexual activity'.¹ ICD-10 classification includes 'Excessive Sexual Drive' which is subdivided into satyriasis and nymphomania for males and females respectively.² Hyper sexuality can be a primary condition itself or present as a symptom of an underlying disorder or disease. Causes of hyper sexuality are suggested to be due to hormonal imbalances or a defect in the limbic system.³ The frontal lobe is the area of the brain responsible for our personality and inhibition. If damaged this can also give rise to loss of inhibition, and sexually inappropriate behaviour, thus patients with neurodegenerative disorders such as dementia can present with it.⁴ Side effects from cognitive enhancers used in the treatment of dementia and other medication such as dopamine agonists used in Parkinson's disease have also been implicated in hyper sexuality in these groups of patients.⁵



Other disorders which may present with hyper sexuality as a symptom are bipolar disorder, schizophrenia and neurosis. Personality disorders may also give rise to symptoms. The aetiology needs to be considered as this will affect the treatment offered. If secondary to organic disease, good management of the underlying disease may improve symptoms whereas, if due to a borderline personality disorder, psychotherapy should be offered.³

Contributed by Mel Sarigul

41. Serotonin Syndrome

Serotonin Syndrome is a rare, but potentially fatal, syndrome



that occurs either when a patient is started on an SSRI antidepressant (fluoxetine, paroxetine, escitalopram, citalopram, sertraline) or the existing dose is increased. It is characterised by: agitation, tremor, shivering, diarrhoea, hyperreflexia, myoclonus, ataxia, and hyperthermia. Although, SSRIs are commonly linked to SS, many other drugs may also potentially cause hyperserotonergic symptoms.¹

The incidence of SS associated with SSRI use is ~ 1% (though many cases in which the symptoms are minor go unreported); with a mortality of < 0.1%.

Symptoms and signs of SS

- **Psychiatric / neurological** – confusion, agitation, coma
- **Neuromuscular** – myoclonus, rigidity, tremors (including shivering), hyperreflexia (usually lower rather than upper limbs), ataxia
- **Autonomic** – hyperthermia (may be secondary to prolonged seizure activity, rigidity, or muscular hyperactivity), GI upset (nausea, diarrhoea), mydriasis, tachycardia, hyper/hypotension.

Diagnosis and diagnostic criteria – Serotonin syndrome is diagnosed on the basis of clinical findings using the Hunter Toxicity Criteria Decision Rules.² To fulfil the Hunter Criteria, a patient must have taken a serotonergic agent and meet **ONE** of the following conditions:

- Spontaneous clonus
- Inducible clonus PLUS agitation or diaphoresis
- Ocular clonus PLUS agitation or diaphoresis
- Tremor PLUS hyperreflexia
- Hypertonia PLUS temperature above 38°C PLUS ocular clonus or inducible clonus.

Several sets of diagnostic criteria have been developed to define serotonin syndrome, of which the Hunter Criteria are most accurate (84 percent sensitive and 97 percent specific when compared with the gold standard of diagnosis by a medical toxicologist). In a comparison with the original Sternbach Criteria, the Hunter Criteria performed with greater accuracy and is less likely to miss early, mild, or subacute forms of serotonin syndrome.³

Contributed by Nick Mullin

42. Sleeping Beauty Syndrome

This uncommon sleeping disorder is also known as Kleine-Levin syndrome and can affect both males and females, but more commonly boys (4:1) and onset is usually in the teenage years.¹ It has an unknown cause, with possible onset due to an infection or neurological event. Due to its periodic nature of presentation, prevalence of the disorder is unknown.² It is a little-known disease and so diagnosis is often delayed after ruling out other possible disorders. Kleine-Levin syndrome can cause periodic behavioural and cognitive changes including hypersomnia, hyperphagia and hyper sexuality. Irritability, confusion and a feeling that one's surroundings are unreal are associated with the disorder. Episodes can last from days to weeks but most commonly around 10 days.³



Patients can recover spontaneously, rapidly and be lucid for several months, which is typical of Kleine-Levin syndrome. Diagnosis is mainly clinical as MRI and CT imaging is normally used. However, functional imaging during an episode can show reduced perfusion of the thalamic region and hypothalamus. An EEG will often be abnormal showing a slow wave delta, theta, or slowdown in basic alpha rhythm. Stimulants such as modafinil have been shown to help, as well as other antipsychotics such as risperidone and benzodiazepines to help with anxiety Kleine-Levin.³

Contributed by Jess Lewis

43. Stendhal Syndrome

Stendhal syndrome is also known as Florence Syndrome and describes the phenomenon of being psychologically overwhelmed with the artistic greatness of Florence, Italy. First described by Stendhal in the early 19th Century, an Italian psychiatrist coined the title 'Stendhal Syndrome' in 1992, after writing a report of over 100 patients who experienced acute transient psychiatric symptoms after being exposed to some of the artwork Florence has to offer.¹

This psychosomatic disorder causes rapid heartbeat, fainting, confusion and hallucinations in people who have viewed astonishing artwork.² The condition is not limited to the cultural offerings of Florence so other places of artistic beauty are likely to cause such symptoms. There is dispute amongst psychiatrists whether this is an actual psychiatric condition, but whether or not it is included in official diagnostic criteria, staff in Florence hospitals have become familiar with dealing with distressed and confused tourists who have revered the artwork of their city.¹⁻²

Contributed by Alison Thornton



44. Stockholm Syndrome

Psychological explanation for the development of a bond created between the captor and the hostage. It is thought to be a form of adaptation, which provides hope for the victim.¹ This conscious coping strategy has been seen many times and described as 'an intense bond with the captor'. It was first labelled in 1973, as 'Capture bonding', after four hostages were taken during a bank robbery. The victims defended the captors and refused to testify. The strong emotions usually develop amongst the abuse and beatings experienced by the victim,² the bond the hostage feels with the captor, thought to be created by the extreme fear, which develops into love and attachment to cope in the hostage situation. The hostage may often feel sympathy for the captors' cause and begin to believe what they say. This strategy helps to aid survival, and commonly these feelings continue after being released from the hostage situation.³



Contributed by Elizabeth Manning

45. Synaesthesia

Synaesthesia is a neuropsychological phenomenon in which sensory perceptions become mixed up, such as words being visualised as colour internally. This can be commonly manifested by the conversion of learned semantic memory into a sensory stimulus¹ so certain words (e.g. Wednesday) can be visualised as a colour (e.g. dark red with a scaly blue tinge on the outside). The synaesthetic perceptions are always internalised; synaesthetes understand that they are not hallucinating but instead perceiving stimulus in a multimodal manner.

Studies carried out in Cambridge found a 6:1 ratio of females to males, a prevalence of 1 in 2000, and a familial link.²

Historically, synaesthetes that were open about their experiences were shunned and given a diagnosis of a mental health disorder (some demographic and socio-cultural aspects of synaesthesia).

Neurological imaging has been done to see whether there is a biological basis for this unusual sensory information mix up. Studies found that when subjects with synaesthesia were given an auditory stimulus, imaging showed activation of the visual cortex.^{3,4} This supports the theory that there are abnormal connections in the brain between cortical regions.

The impact of this experience is entirely individual – for most people the association with words and colours can provide a different way of working memory and be used in a positive, if not pleasant style. However, there are examples of synaesthetes who not only visualise sounds but can interpret visual stimulus audibly, and find it distressing to be in a ‘loud’ colour environment.

Contributed by Nirmol Meah



46. Trichotillomania

This chronic hair pulling condition is illustrated by repeated pulling of hair from one's body, either with hands or tweezers, leading to substantial hair loss. This condition is more prevalent in women than men, and studies suggest that 0.6-3.6% of adults are affected by it.¹

Trichotillomania is described as an impulse control disorder and studies have investigated links between this condition and anxiety and obsessive-compulsive disorders.²

It is included in DSM-5 under Obsessive-Compulsive and Related Disorders, where five criteria are required:

- the person purposefully removes hair from any region of the body
- the person has tried to decrease or stop the pulling
- the person suffers distress and impairment in functioning
- the hair pulling cannot be accredited to another medical condition e.g. skin disorders
- the hair pulling cannot be better explained by the symptoms of a different mental disorder (for example, in body dysmorphic disorder).³



Shame and low self-esteem are commonly suffered by those with trichotillomania. Medical professionals tend to have insufficient knowledge on this condition, leading to poor care and confusion over treatment.¹

Contributed by Elizabeth Manning

47. Wendigo Syndrome

Wendigo Syndrome, or Wendigo Psychosis, is the culture-bound psychotic syndrome of having an intense hunger for human flesh, despite other food being available and is commonly associated with cannibalism.



The term ‘Wendigo’ comes from a North American (Algonquian) folk tale about an evil spirit which possessed people and caused them to become cannibals. The spirit was believed to possess an individual if they became too greedy or selfish and forced them to become ‘wild’ and ‘savage’ and eventually attack their family and loved ones. This tale was thought to promote a behaviour of selflessness amongst their people but was often taken very literally as well.¹

Despite this being only a folk tale, the North American Indians were also the first to report a true psychological phenomenon where members of their tribes would suddenly become violent and aggressive, threatening others and claiming they craved human flesh. The similarity to their tale of the Wendigo led to sufferers being executed if their native healers could not cure the illness, believing the cause to be an evil spirit.²

The first written descriptions of this phenomenon appeared during the colonisation of North America in the 17th and 18th Century. French travellers would often describe, in detail, accounts of men becoming ‘rabid’ and attacking their loved ones with the aim to consume their flesh. The most well-known case, ‘Swift Runner’, in 1878, describes a man who murdered and consumed his wife and five children during an intense storm, despite an emergency food supply only being a few miles away. This was the first written account to specifically describe the cause being ‘Wendigo Psychosis’.³

Wendigo Psychosis has only ever been reported in North America, leading it to be known as a ‘culture-bound’ syndrome. This also led to its actual existence being called into question and heavily disputed in the 1960s after reports of this syndrome became incredibly infrequent. However, due to the number of cases and eye-witness accounts, some form of psychotic origin to these reports cannot be ignored.

Having delusions of craving human flesh and dreaming of cannibalism is frequently reported across the world as a symptom in cases of paranoid schizophrenia and psychotic depression. As Wendigo Syndrome is, by definition, only the ‘intense hunger’ for human flesh and not the cannibalistic act itself, these cases could therefore be described as Wendigo Syndrome.⁴

However, due to the dispute and lack of knowledge surrounding the syndrome, these delusions are only seen as a symptom of the psychotic illness and not described or reported as Wendigo Syndrome itself.

In conclusion, Wendigo Syndrome, the delusion of craving human flesh, is most likely a true symptom still

seen today. However, due to lack of knowledge, it is not described as the syndrome itself and only as a symptom of the overlying psychotic disorder.

Contributed by Steven Hallett

48. Wilson's Disease

Wilson's Disease is a rare inherited disorder of copper metabolism, first described by British neurologist Samuel Alexander Kinnier Wilson in 1912.¹ Also known as hepatolenticular degeneration, Wilson's causes hepatic copper accumulation and subsequent deposition in tissues and organs throughout the body; most notably the brain and liver. Inherited as an autosomal recessive trait, Wilson's disease is caused by mutations in the ATP7B gene on chromosome 13 – a gene that would usually code for the binding of copper to caeruloplasmin and its excretion into bile.^{1,2} The typical onset is during the second or third decade of life, typically presenting as liver disease in children and adolescents, and as neuropsychiatric illness in young adults.¹

The psychiatric features are present in approximately one-third of people with the disease, and can be the main presenting complaint – including abrupt behavioural changes, such as aggression, depression with suicidal ideation or psychosis.¹ Neurological features involve tremor, ataxia or altered gait, dysphagia, dysarthria, dystonias and dyskinesias. Hepatic features of the disease vary in severity from raised serum aminotransferases or hepatomegaly, to acute liver failure or even chronic hepatitis and cirrhosis. Other signs include Kayser-Fleischer rings (present in 95% of those with symptomatic disease), sunflower cataracts, haemolysis, blue lunulae (lunulae are the white part of the nail bed) and early-onset arthritis.¹ Wilson's Disease should be considered as a differential diagnosis in any patient with unusual liver or neurological abnormalities. Diagnosis can be established via liver biopsy, or less invasively via clinical signs along with low serum caeruloplasmin or elevated 24-hour urinary copper excretion.¹

Conservative management involves a copper-restricted diet. Lifelong oral chelating agents are the treatment for Wilson's, penicillamine requires careful monitoring due to side effects (rash, nausea, fever pancytopenia) which are deemed intolerable for about one third of patients. Such patients commence zinc acetate or trientine therapy instead. Complications include liver failure; an indication for liver transplantation. Genetic screening in siblings is advisable as asymptomatic homozygotes also need treating.

Contributed by Sarah Lawrence

49. Yellow fever and psychiatric sequelae

Yellow fever is a tropical virus (flavivirus) spread by mosquitos (mainly the Aedes and Haemogogus species). It occurs most in tropical and subtropical parts of South America, parts of the Caribbean, and Africa (most common).¹ Initial symptoms are non-specific and so can be difficult to diagnose: fever, chills, loss of appetite, nausea, muscle pains, particularly in the back,



and headaches. This is until the disease progresses, when the features include: liver and kidney damage, jaundice and bleeding from orifices.² Although little research has been done on yellow fever alone and psychiatric sequelae, there is strong evidence from those suffering other types of flavavirus infection, go on to suffer from mental health problems in later years. Examples of this include Dengue fever (causing higher incidence of mania, anxiety and depression)^{3,4} and Japanese encephalitis (30–50% of people develop neurological or psychiatric sequelae).⁵ It may be possible that Yellow fever is linked with psychiatry in a similar way, but it is difficult to study these possible long-term links because the death rate from yellow fever has been estimated at over 50%⁶ and many people die within 10 days. Interestingly, Dr Benjamin Rush, who is named the 'Father of American Psychiatry', was one of three physicians who stayed in Philadelphia during the Yellow fever outbreak of 1793 and was the first to conclude that mental illness was a disease of the mind. Perhaps Dr Rush had determined this from experience of treating the probable psychiatric aspects of Yellow fever at the time?

Contributed by Megan Buoey

50. Zoophilia

Zoophilia is classed as an 'other disorder of sexual preference' by ICD-10,³ so technically doesn't have a specific diagnostic classification code. It is classified as a disorder of sexual preference involving sexual activity with animals. Sexual activity involving animals has existed since primitive times.³ There is some blurring between the terms 'zoophilia' and 'bestiality', with the clearest distinction being that Zoophilia is a sexual desire towards animals (which may involve lust/fantasies and masturbation) whereas bestiality is the physical act of engaging in sexual activity with an animal.

Bestiality remains a criminal offence under the 1956 Sexual Offences Act.³ Several studies^{4,5} have shown a correlation between forensic offences, psychiatric inpatients and Zoophilia, but the exact prevalence amongst the general population is unknown. In some of the studies there doesn't seem to be any association between Zoophilia and animal cruelty and dissocial personality disorder, suggesting the motives behind the behaviour may be sexually driven, rather than cruelty or a desire to inflict pain.

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