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Read the doctor's related column, Teen troubles or drugs?

NEXT ONLINE CONSULTATION: How do you tell if your child is taking drugs? on this topic for Dr Stuttaford's answers online on Wednesday, July 25.

A reader from Sussex who has read about drug-taking among teenagers still at school asks how one can distinguish between the slightly aberrant behaviour of many adolescents and the first signs of schizophrenia or allied conditions.

This is an unusually difficult diagnosis that many parents, teachers and doctors are called on to make. Unfortunately, as is obvious to anyone who reads the newspapers carefully, in many cases either the diagnosis is missed or the severity of the disease is underrated.

The more middle-class the adolescent, the more likely it is that their friends, family and teachers will be easy-going liberals who are comparatively free of prejudice about psychiatric disease. This otherwise admirable tolerance has a downside.

Those who display a general forbearance in life are also more likely to accept unusual adolescent behaviour without seeking expert advice. Similarly doctors, who are usually egalitarian, are in my experience more loath to label someone with a tag denoting a potentially serious psychiatric disease if their father is a Cabinet minister or their mother an Oxford professor rather than, for example, a Norfolk farm-worker.

Any factor that militates against early diagnosis and treatment is denying a patient care when it may be most effective. Psychiatry is perhaps one of the few specialities in which the privileged are in danger of being less well treated. Someone with schizophrenia or an allied condition needs an early diagnosis so that effective control can be achieved before they become socially incapable and, in a small percentage of cases, dangerous.

Recreational drugs, especially cannabis, cocaine and LSD, confuse most diagnoses. These drugs have an effect on personality as well as the ability to precipitate a psychotic breakdown in people who are genetically vulnerable. When chatting to these patients it has often struck me that, had it not been for the recreational drugs, they might have gone through life with a personality that was no more bizarre often charmingly bizarre than that of their forebears.

After adolescent drug use, characteristics that would otherwise have remained covert become overt and the patient displays seriously odd, even psychotic, behaviour. If any parent or teacher has doubts, they should consult a psychiatrist who is accustomed to dealing dispassionately with adolescents from all backgrounds.

Late adolescence is a time when behaviour that heralds later schizophrenia often first becomes obvious.

It is also, as our reader suggests, an age when many adolescents show periodic evidence of apathy or depression. Most parents have at some time wondered about their sons or daughters predilection for long black coats, the bedroom walls painted black, and their refusal to meet the eye of other people. Are they suffering from some psychiatric problem or merely displaying symptoms of nothing more sinister than their age and peer group behaviour?

Junior hospital doctors were, and probably still are, taught to watch out for symptoms in adolescents that might give warning of trouble ahead. Any evidence of shallowness in an adolescents emotional reactions so that, for

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instance, they display a lack of warmth, can be important. This tendency may be betrayed by nothing more obvious than a difficulty in establishing rapport with contemporaries so that he or she becomes a loner. An inappropriate emotional response to an event that would upset most people could be significant.

Indifference, or even levity, about anothers misfortune or death is also noteworthy, and evidence of disordered or unrealistic thinking should be explored. Most peoples thoughts progress in as logical and straightforward a way as a castle moves on a chessboard. Conversely, those whose thinking is disordered have thoughts that move irregularly, like a knights move in chess, and their ideas jump from one topic to another.

Initially doctors may be baffled by a patients thought processes, but as they become familiar with the patient they learn to understand how an outlandish, even grotesque, opinion has been reached.

Potentially schizophrenic patients may also suffer from delusions and hallucinations. Their opinions are often hypercritical before they become paranoid and delusional. The paranoia is likely to be auditory hearing voices rather than visual.

One of the most common mistakes in medicine is to underrate the importance of a depressive state in adolescence. It is sometimes the first symptom of bipolar disorder or another psychosis. The family history may provide a relevant clue.

At the same time as newspapers were carrying reports on adolescent drug-taking and schizophrenic breakdown, Dr Helen Millar, a consultant psychiatrist at the Carseview Centre in Dundee, was in London talking about Invega (palliperidone), a recently licensed atypical antipsychotic. Dr Millar said that Invega was useful in treating schizophrenia as it is a once-a-day oral treatment with a smooth 24-hour action. She has found that it is effective and usually well tolerated.

Invega is said to be less likely than other medications to upset cholesterol levels and blood sugar. Early indications are that patients dont put on weight, and it is safer for patients who drink too much or take recreational drugs, as to a large extent it is not metabolised in the liver (there is a high incidence of alcohol and drug abuse among patients with a schizophreniform personality).

Parents are also recommended to telephone SANE (020-7422 5544) or visit www.sane.org.uk

What insect repellents can you recommend for a holiday in the tropics?

Many inscriptions on gravestones and memorials on the walls of British churches in the tropics serve as reminders of the deadly diseases spread by insect bites and faced by early travellers. They faced the risk of malaria wherever Anopheles mosquitoes could find so much as a dank puddle in which to breed.

Culex mosquitoes have a tropical distribution as wide as Anopheles. They dont spread malaria but can transmit encephalitis in parts of the western Pacific, Asia and the Americas. Dengue fever, also known as break-back fever, is carried from person to person by theAedesmosquito, which also spreads yellow fever. Tsetse flies are responsible for sleeping sickness, and sandflies for leish-maniasis which is even found on some Mediterranean beaches.

We are lucky in Britain. Wasps, hornets and bees may sting us to protect their nests but it is female midges, gnats, mosquitoes and horseflies that use our blood as a source of protein and are a far greater nuisance. They

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can blight many country activities, from fishing to picnicking.

Antimalarials are essential in malarial zones, but it is equally important to avoid being bitten. Wise travellers wear long sleeves and trousers, use mosquito nets and dont sit around at dawn or dusk, or in the shade of a banyan tree.

Insect repellents are as useful in Scotland as in Kenya, for insects are attracted by smell. It wont help to wear light, dark or camouflage clothing insects home in from a distance because of the carbon dioxide that we exhale, and the smell of sweat. Once within range, their sensors detect body heat so that they can settle and feed. DEET is the insect-repellent brand leader, but it may cause severe irritation in higher strengths. Sprayed on to skin, DEET is effective only for a few hours. It lasts longer if sprayed liberally on armlets and anklets, or used to impregnate clothing or mosquito nets.

Fortunately there is an alternative to DEET in areas not rife with malaria. Arnywear is an insect-repellent fabric made from an extract of lemon eucalyptus blended with lavender and wild orchid oil. As yet, there are no reports of any skin reactions. Arnywear is made into clothes and the material can be washed ten times before it loses effectiveness. 01707 228688; www.arnywear.co.uk

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