# Mental Illness CPD

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# Mental illness

*noun*

## a condition which causes serious disorder in a person's behaviour or thinking.

**M**ental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest.

Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16.

One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease.

Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40 per cent provide no service at all.

Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people.

Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary

People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk. As many as nine out of ten people in prison have a mental health, drug or alcohol problem.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men.

Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013.

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in 2014-15.

Of those adults with more severe mental health problems 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions.

Unless you are in severe crisis, your family doctor or general practitioner (GP) is typically the first person to see for an assessment of your mental health. Your GP will ask you questions about how you have been feeling and what you have been experiencing. Using this information, he or she may offer guidance, medication and/or refer you for more specialist support. For example, you may be referred to a counselling service or to the community mental health team which would undertake a further assessment of your needs.

**Children and Adolescent Mental Health Services (CAMHS)**

CAMHS offer specialist mental health services to children and young people (up to age 18) and their families. CAMHS helps children and young people when they find it hard to cope with their feelings or thoughts, or find it hard to manage their behaviour.

Source: Signpost uk

PRIORITY ACTIONS FOR THE NHS BY 2020/21 1.

- A 7 day NHS – right care, right time, right quality
- People experiencing a first episode of psychosis should have access to a NICE-approved care package within 2 weeks of referral.
- The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible.
- By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.
- By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met.
- increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21.
- By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it

But 1 Billion of additional investment is needed.

Source: A report from the independent Mental Health Taskforce to the NHS in England February 2016 THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

# Types of mental illness

Anger

Anxiety & panic attacks

Depression

OCD

Phobias

Post-natal depression

PTSD

Body dysmorphic disorder

Bipolar disorder

Personality disorders

Dissociative disorder

Hearing voices

Drugs

Hypomania and mania

SAD

Stress

Sleep problems

Self esteem

Eating problems

Self harm

Suicidal feelings

Paranoia

Psychotic experiences

Schizoaffective disorder

Schizophrenia

In more detail

# Bipolar disorder

Bipolar disorder is a mental health problem that mainly affects a person's mood. If a person has bipolar disorder, they are likely to have times where they experience:

- manic or hypomanic episodes (feeling high)
- depressive episodes (feeling low)
- potentially some psychotic symptoms during manic or depressed episodes

| Diagnosis | What it means |
|---|---|
| **Bipolar I** | A person may have bipolar I if they have experienced:<br>• at least one episode of mania which has lasted longer than a week<br>They might also experience depressive episodes, although not everyone does. |
| **Bipolar II** | A person may have bipolar II if they have experienced both:<br>• at least one episode of severe depression<br>• symptoms of hypomania |
| **Cyclothymia** | A person may have cyclothymia if:<br>• They have experienced both hypomanic and depressive mood states over the course of two years or more<br>• Their symptoms aren't severe enough to meet the criteria for a diagnosis of bipolar I or bipolar II<br>This can be a difficult diagnosis to receive, because an individual may feel that they are being told their symptoms are 'not serious enough'. But in fact cyclothymia can have a serious impact on a person's life. |

What causes Bipolar disorder?

- No one knows exactly what causes bipolar disorder
- Lots of recent research has focused on looking for causes in genetics or the biology of the brain, but many researchers also believe social factors may play a part, such as difficult life events or experiencing trauma as a child.

Treatment

During depressive episode

- CBT
- Anti-depressants

During manic episode

- Medication

# Personality disorders

- The word 'personality' refers to the pattern of thoughts, feelings and behaviour that makes each of us the individuals that we are. These affect the way we think, feel and behave towards ourselves and others.
- We don't always think, feel and behave in exactly the same way – it depends on the situation we are in, the people with us and many other things. But we mostly tend to behave in fairly predictable ways.

Types of personality disorder

| **Suspicious** | **Emotional and impulsive** | **Anxious** |
|---|---|---|
| Paranoid | borderline | avoidant |
| Schizoid | histrionic | dependent |
| Schizotypal | narcissistic | obsessive compulsive |
| antisocial | | |

**Paranoid personality disorder**

An individual may:

- find it hard to confide in people, even their friends
- find it very difficult to trust other people, believing they will use you or take advantage of you
- watch others closely, looking for signs of betrayal or hostility
- read threats and danger – which others don't see – into everyday situations

**Schizoid personality disorder**

An individual may:

- be uninterested in forming close relationships with other people, including their family
- feel that relationships interfere with their freedom and tend to cause problems
- prefer to be alone with their own thoughts
- choose to live their life without interference from others
- get little pleasure from life
- have little interest in sex or intimacy
- be emotionally cold towards others

**Schizotypal personality disorder**

An individual may:

- find making close relationships extremely difficult
- think and express themselves in ways that others find 'odd', using unusual words or phrases
- behave in ways that others find eccentric
- believe that they can read minds or that they have special powers such as a 'sixth sense'
- feel anxious and tense with others who do not share these beliefs
- feel very anxious and paranoid in social situations

**Antisocial personality disorder (ASPD)**

An individual may:

- put themselves in dangerous or risky situations, often without considering the consequences for themselves or for other people
- behave dangerously and sometimes illegally
- behave in ways that are unpleasant for others
- feel very easily bored and act on impulse – they may find it difficult to hold down a job for long
- behave aggressively and get into fights easily
- do things – even though they may hurt people – to get what they want, putting their needs above others

- have a criminal record
- feel no sense of guilt if they have mistreated others
- believe that only the strongest survive and that they must do whatever it takes to lead a successful life because if they don't grab opportunities, others will
- have had a diagnosis of conduct disorder before the age of 15
- They will be at least 18 years old.

**Borderline personality disorder (BPD)**

An individual may:

- feel very worried about people abandoning them, and would do anything to stop that happening
- have very intense emotions that last from a few hours to a few days and can change quickly (for example, from feeling very happy and confident in the morning to feeling low and sad in the afternoon)
- not have a strong sense of who they are, and it can change depending on who they're with
- it very hard to make and keep stable relationships
- act impulsively and do things that could harm them (such as binge eating, using drugs or driving dangerously)
- have suicidal thoughts or self-harming behaviour
- feel empty and lonely a lot of the time
- get very angry, and struggle to control their anger
- When very stressed, sometimes they might:
- feel paranoid
- have psychotic experiences, such as seeing or hearing things that other people don't
- feel numb or 'checked out' and not remember things properly after they've happened

**Histrionic personality disorder**

An individual may:

- feel very uncomfortable if they are not the centre of attention
- feel much more at ease as the 'life and soul of the party'
- feel that they have to entertain people
- flirt or behave provocatively to ensure that they remain the centre of attention
- get a reputation for being dramatic and overemotional
- feel dependent on the approval of others
- be easily influenced by others

**Narcissistic personality disorder**

An individual may:

- believe that there are special reasons that make them different, better or more deserving than others
- have fragile self-esteem, so that they rely on others to recognise their worth and their needs

- feel upset if others ignore them and don't give them what you feel you deserve
- resent other people's successes
- put their own needs above other people's, and demand they do too
- be seen as selfish and 'above yourself'
- take advantage of other people

**Avoidant (or anxious) personality disorder**

An individual may:

- avoid work or social activities that mean they must be with others
- expect disapproval and criticism and be very sensitive to it
- worry constantly about being 'found out' and rejected
- worry about being ridiculed or shamed by others
- avoid relationships, friendships and intimacy because they fear rejection
- feel lonely and isolated, and inferior to others
- be reluctant to try new activities in case they embarrass themselves

**Dependent personality disorder**

An individual may:

- feel needy, weak and unable to make decisions or function properly without help or support
- allow others to assume responsibility for many areas of their life
- agree to things they feel are wrong or they dislike to avoid being alone or losing someone's support
- be afraid of being left to fend for themselves
- have low self-confidence
- see other people as being much more capable than they are
- be seen by others as much too submissive and passive

**Obsessive compulsive personality disorder (OCPD)**

An individual may:

- need to keep everything in order and under control
- set unrealistically high standards for themselves and others
- think their way is the best way of making things happen
- worry when they or others might make mistakes
- expect catastrophes if things aren't perfect
- be reluctant to spend money on themselves or others
- have a tendency to hang onto items with no obvious value

OCPD is separate from obsessive compulsive disorder (OCD), which describes a form of behaviour rather than a type of personality.

**What causes personality disorder?**

There's no clear reason why some people develop a personality disorder and others don't. Most researchers think that a complex mix of factors is involved, such as:

- the environment we grow up in (e.g. unstable or chaotic environment, little or no support from caregiver)
- early childhood and teenage experiences (e.g. neglect, loss of a parent or sudden bereavement)
- genetic factors - Some experts believe inheritance may play a part in the development of personality disorder.

**Treatment**

Research is ongoing into what treatments help people with personality disorder. More research is needed but some talking treatments have been found to help.

- Arts therapies are a way of using the arts – for example, music, art, dance or drama – in a therapeutic environment with a trained therapist.
- Cognitive Behavioural Therapy (CBT) looks at how your feelings, thoughts and behaviour influence each other and how you can change these patterns.
- Cognitive Analytic Therapy (CAT) combines CBT's practical methods with a focus on the relationship between you and your therapist. This can help you reflect on how you relate to people (including yourself) and why these patterns have developed.
- Dialectical Behaviour Therapy (DBT) – a treatment specifically developed for Borderline Personality Disorder (BPD). It uses individual and group therapy to help you learn skills to manage your emotions.
- Mentalisation Based Therapy (MBT) – a long-term talking treatment which aims to improve your ability to recognise and understand your and other people's mental states, and to help you examine your thoughts about yourself and others to see if they're valid.
- Schema therapy is usually a long-term talking treatment which aims to help you change the ways of thinking (or 'schemas') which cause you difficulty, while strengthening the ways of thinking which are helpful to you.
- Therapeutic communities (TC) – programmes where you work with a group of other people experiencing mental health problems to support each other to recover. Most therapeutic communities are residential (often in a large house) where you might stay for all or part of the week. Activities can include different types of individual or group therapy, as well as household chores and social activities. The Consortium for Therapeutic Communities provides a directory of therapeutic communities in the UK.

**Medication**

There are no drugs specifically licensed for the treatment of personality disorder. GP’s may prescribe medication to manage problems such as depression, anxiety or psychosis. These medications could include:

- antidepressants
- antipsychotics
- mood stabilisers

# Dissociative disorders

**What is dissociation?**

Dissociation is one way the mind copes with too much stress, such as during a traumatic event. The word dissociation can be used in different ways but it usually describes an experience where you feel disconnected in some way from the world around you or from yourself.

If you dissociate for a long time, especially when you are young, you may develop a dissociative disorder. Instead of dissociation being something you experience for a short time it becomes a far more common experience and often the main way you deal with stressful experiences.

| **Some dissociative experiences include:** | **A doctor or psychiatrist might call these experiences:** |
|---|---|
| • having gaps in your life where you can't remember anything that happened<br>• not being able to remember information about yourself or about things that happened in your life | dissociative amnesia |
| • travelling to a different location and taking on a new identity for a short time (without remembering your identity) | dissociative fugue |
| • feeling as though the world around you is unreal<br>• seeing objects changing in shape, size or colour<br>• seeing the world as 'lifeless' or 'foggy'<br>• feeling as if other people are robots (even though you know they are not) | derealisation |
| • feeling as though you are watching yourself in a film or looking at yourself from the outside<br>• feeling as if you are just observing your emotions<br>• feeling disconnected from parts of your body or your | depersonalisation |

| | |
|---|---|
| emotions<br>• feeling as if you are floating away<br>• feeling unsure of the boundaries between yourself and other people | |
| • your identity shifting and changing<br>• speaking in a different voice or voices<br>• using a different name or names<br>• switching between different parts of your personality<br>• feel as if you are losing control to 'someone else'<br>• experience different parts of your identity at different times<br>• acting like different people, including children | identity alteration |
| • find it very difficult to define what kind of person you are<br>• feeling as though there are different people inside you | identify confusion |

**Types of dissociative disorder**

- Dissociative identity disorder – used to be called multiple personality disorder
- Derealisation and depersonalisation disorder – experience regular depersonalisation
- Dissociative amnesia (with or without fugue) – unable to remember who you are and in the fugue travel to a new place with new identity
- Other specified dissociative disorder (OSDD)
- Unspecified dissociative disorder (UDD)

Many people with dissociative disorders have other mental health problems too. These can include:

- borderline personality disorder
- depression
- anxiety and panic attacks
- suicidal feelings
- hearing voices
- OCD

They may be associated with dissociation or they could be a separate problem.

**Causes**

Trauma can cause dissociation because of the way we respond to threat. There are different theories about how exactly this leads to different dissociative disorders.

You may have heard of fight or flight. They are instinctive ways that we respond to threatening situations. But if you can't do these things (for example if you are very young) then you may respond by 'freezing' or 'flopping'.

The freeze response makes the body immobile and releases chemicals which 'numbs' your body and mind. You might feel paralysed or unable to move.

The flop response is where lots of the thinking processes in the brain are shut off. Your muscles become floppy and you act a bit like a zombie - doing what you are told without protest.

Our instinctive reactions to threat are the basis of dissociative experiences.

One theory suggests that whenever we think there is a threat, our body reduces blood flow to areas in the front of our brain (the thinking, analytical, rational part) and 'turns on' areas in our back brain (the automatic, instinctive part).

Using our back brain to freeze or flop helps protect us from trauma that we can't prevent or run away from. But reducing the blood flow to the front brain can make it more difficult to process what happens and may mean we experience dissociative symptoms.

The front brain includes areas which help us:

- understand where we are in time and space
- use language and speech
- feel connected to our body
- store memories
- make sense of information coming through our senses

A person might separate different parts of an experience so they do not have to deal with it all together. Different parts of the experience (such as actions, memories, feelings, thoughts, sensations and perceptions) may not be 'joined up'.

**Treatment**

Talking treatments are the recommended treatment for dissociative disorders - Counselling or psychotherapy will help a person explore traumatic events in their past, help them understand why they dissociate and develop alternative coping mechanisms.

Medication

There are no drugs specifically licensed for the treatment of personality disorder. GP's may prescribe medication to help manage problems such as depression, anxiety or psychosis. These medications could include:

- antidepressants
- antipsychotics
- mood stabilisers

# Psychotic episodes

Psychosis (also called a psychotic experience or psychotic episode) is when an individual perceives or interprets reality in a very different way from people around them. They might be said to 'lose touch' with reality.

The most common types of psychosis are:

- hallucinations
- delusions

An individual might also experience:

- disorganised thinking and speech

Psychosis affects people in different ways. A person might experience it once, have short episodes throughout their life, or live with it most of the time**.**

# Schizoaffective disorder

An individual may be given a diagnosis of schizoaffective disorder if they experience:

- psychotic symptoms, similar to schizophrenia, and
- mood symptoms of bipolar disorder, and
- you have both types of symptoms at the same time or within two weeks of each other

The word schizoaffective has two parts:

- 'schizo–' refers to psychotic symptoms
- '–affective' refers to mood symptoms

A person may have times when they struggle to look after themselves, and when their doctors consider that they lack insight into their behaviour or how they are feeling. They may be quite well between episodes.

The episodes vary in length. Some people have repeated episodes but this does not necessarily happen, and it may not be a lifetime diagnosis.

In general, a person may feel:

- That their thoughts are becoming very disorganised
- very confused and frightened
- angry and depressed, or excited and elated

<u>Psychotic symptoms:</u>

- Delusions
- Hallucinations

Mood symptoms

The mood symptoms are very like bipolar disorder (manic depression). They may be:

- ‘manic type’
- ‘depressive type'
- ‘mixed type'

**Causes**

The causes of schizoaffective disorder are not known.

Like other mental health problems, it may be caused by:

Stressful life events or trauma. This is more likely to be a cause if an individual has experienced stressful or traumatic events when they were too young to know how to cope with them, or had not been cared for in a way that helped them to develop coping skills. Due to this, they may be particularly vulnerable to a relapse in times of stress.

Genetic influences. The psychotic and mood symptoms tend to run in families. A person may be more likely to develop the symptoms if a close relative has a diagnosis of schizophrenia or bipolar disorder.

However, there is not much research evidence for a genetic explanation, and many people who have this diagnosis have no family history of mental health problems.

It is unknown why someone might develop schizoaffective symptoms rather than schizophrenia or bipolar disorder. It may be that all of these conditions are on a spectrum of ways that individuals may be affected by life events.

# Treatment

The National Institute for Health and Care Excellence (NICE) guidelines on the treatment of schizophrenia also cover schizoaffective disorder. They suggest that:

- A person should be offered a talking treatment
- They should be offered medication, especially for your psychotic symptoms
- The whole family should be offered family intervention
- arts therapies should be considered

Talking treatment:

- CBT
- MCBT

Medication

This the treatment a person is mostly likely to be offered first – especially if they are first diagnosed during a psychotic episode.

They may be prescribed:

- an antipsychotic, such as olanzapine or quetiapine, to treat the psychotic symptoms
- a mood stabiliser, such as lithium or valproate – especially if they have manic episodes rather than depression; or lamotrigine, which is licensed for depression in bipolar disorder
- an antidepressant, which should be used cautiously because they may cause the person to have a manic episode, or to switch between mania and depression (sometimes called 'rapid cycling')
- Some antipsychotics are licensed to treat mania as well as psychosis, so it may be that one drug might be adequate, depending on the symptoms. But it is quite likely that a person will end up taking a combination of drugs.

# Schizophrenia

Schizophrenia is a diagnosis that may be given if a person experiences some of the following symptoms:

- a lack of interest in things
- feeling disconnected from your feelings
- difficulty concentrating
- wanting to avoid people
- hallucinations
- hearing voices
- delusions
- feeling like you need to be protected.

**Causes**

It is generally agreed that schizophrenia is caused by a combination of factors rather than a single one.

**Dopamine**

Dopamine is one of the chemicals that carries messages between brain cells. There is evidence that too much dopamine may be involved in the development of schizophrenia, but it's still not clear how, or whether everyone diagnosed with schizophrenia has too much dopamine.

Neuroleptic drugs (antipsychotics), which are sometimes used to treat schizophrenia, target the dopamine system.

**Stressful life events**

Highly stressful or life-changing events may trigger schizophrenia. These include:

- social isolation
- being out of work
- living in poverty
- being homeless
- losing someone close to you
- being physically or verbally abused, or harassed.

**Drug abuse**

Some people may develop symptoms of schizophrenia as a result of using cannabis or other street drugs such as cocaine and amphetamines.

If someone already have schizophrenia, using street drugs can make the symptoms worse. Drinking alcohol and smoking may also limit how effectively medicines treat the symptoms of schizophrenia.

**Inheritance**

Some families seem to be prone to schizophrenia, which suggests a genetic link. Rather than there being a specific gene for schizophrenia however, it is thought that certain genes might make some people more vulnerable to the condition.

**Other causes**

Research is happening all the time into what might cause schizophrenia. For example there is evidence that physical differences in, or injury to the brain may be linked to schizophrenia, and that some of this process might happen before someone is born. Research into other possible causes, including viruses, hormonal activity (particularly in women), diet, allergic reaction or infection is ongoing.

# Treatments in more detail

## Talking treatment

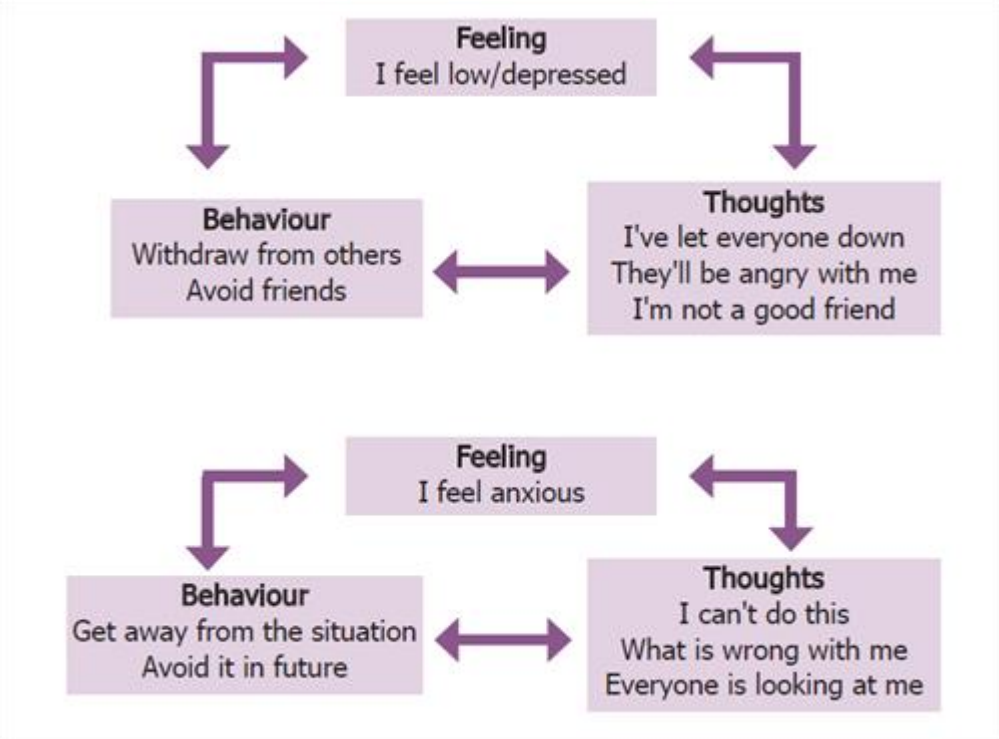
## CBT

CBT is a type of talking treatment that focuses on how your thoughts, beliefs and attitudes affect your feelings and behaviour, and teaches you coping skills for dealing with different problems.

It combines cognitive therapy (examining the things you think) and behaviour therapy (examining the things you do).

CBT is based on the idea that the way we think about situations can affect the way we feel and behave. For example, if you interpret a situation negatively then you might experience negative emotions as a result, and those bad feelings might then lead you to behave in a certain way.

If your negative interpretation of situations goes unchallenged, then these patterns in your thoughts, feelings and behaviour can become part of a continuous cycle:




CBT is a relatively flexible therapy that can be adapted to meet a person's particular needs. Evidence suggests it can be an effective treatment for a range of mental health problems, such as:

- anger problems
- anxiety and panic attacks
- borderline personality disorder
- depression
- drug or alcohol problems
- eating problems
- obsessive-compulsive disorder (OCD)
- phobias
- post-traumatic stress disorder (PTSD)
- psychosis
- schizophrenia
- sexual and relationship problems
- sleep problems

The National Institute for Health and Care Excellence (NICE) particularly recommends CBT for depression and anxiety. There are also formal adaptations of CBT to treat particular mental health problems, such as phobias, PTSD and OCD.

# CAT

Cognitive analytic therapy (CAT) combines Cognitive Behavioural Therapy's focus on current thoughts and feelings, with psychodynamic therapy's focus on past experiences. This can help you understand why you think and feel the way you do, and learn how to change the things you want to.

CAT can treat a range of mental health problems, emotional and relationship difficulties.

There is some evidence to show it is particularly helpful in treating Borderline Personality Disorder (BPD) and eating disorders.

The model emphasises collaborative work with the client, and focuses on the understanding of the patterns of maladaptive behaviours. The aim of the therapy is to enable the client to recognise these patterns, understand their origins, and subsequently to learn alternative strategies in order to cope better.

# MBCT

Mindfulness based cognitive therapy (MBCT) is a type of therapy that combines mindfulness and CBT.

This approach combines ancient wisdom and 21st century science, Mindfulness-based Cognitive Therapy (MBCT) is proving to be a powerful tool to help prevent relapse in depression and the after effects of trauma.

Designed specifically to help people who suffer repeated bouts of depression to help prevent the depression from coming back this approach can also help people who are hearing voices.

It may help a person:

- focus on what is happening around them when the voices are distracting them
- help them manage how they feel about their voices and what has happened to them in the past.

# CBTp

Cognitive behavioural therapy for psychosis (CBTp) is now recognised as an intervention for schizophrenia in clinical guidelines in the USA and in the UK. Several meta-analyses have demonstrated that CBTp is effective in diminishing psychotic symptoms as well as improving other domains such as quality of life, self-esteem, and coping strategies (Naeem et al 2016).

Before CBTp was introduced in the early 1990s there was much concern that targeting delusions directly was likely to make matters worse. At the root of this concern was the assumption that psychotic symptoms such as delusion are different from normal experiences and therefore not amenable to reason or normal mechanisms of learning. However, the research indicates that CBTp can be successful as there is some evidence to suggest that normal reasoning could be involved in the formation and maintenance of delusional beliefs.

# MBT

Mentalisationn based therapy (MBT) is a form of psychodynamic psychotherapy, developed and manualised by Peter Fonagy and Anthony Bateman. MBT was designed for individuals with borderline personality disorder (BPD), who suffer from disorganised attachment and allegedly failed to develop a mentalisation capacity within the context of an attachment relationship

MBT is a long-term talking treatment which aims to improve your ability to recognise and understand your and other people's mental states, and help you examine your thoughts about yourself and others to see if they're valid.

MBT is based on the concept that people with BPD have a poor capacity to mentalise.

Mentalisation is the ability to think about thinking. This means examining your own thoughts and beliefs, and assessing whether they're useful, realistic and based on reality.

For example, many people with BPD will have a sudden urge to self-harm and then fulfil that urge without questioning it. They lack the ability to "step back" from that urge and say to themselves: "That's not a healthy way of thinking and I'm only thinking this way because I'm upset."

# DBT

Dialectical behaviour therapy (DBT) is a type of talking therapy which was originally developed by an American psychologist named Marsha Linehan. It is based on cognitive behavioural therapy (CBT), but has been adapted to meet the particular needs of people who experience emotions very intensely.

It is mainly used to treat problems associated with borderline personality disorder (BPD), such as:

- repeated self-harming
- attempting suicide
- using alcohol or drugs to control emotions
- eating problems, such as binge eating and purging
- unstable relationships.

DBT is based on CBT but also includes mindfulness types forms of acceptance coupled with a strong emphasis on the therapist as an ally.

There are typically four skills modules:

1. Distress tolerance – teaching you how you can deal with crises in a more effective way, without having to resort to self-harming or other problematic behaviours.
2. Interpersonal effectiveness – teaching you how to ask for things and say no to other people, while maintaining your self-respect and important relationships.
3. Emotion regulation – a set of skills you can use to understand, be more aware and have more control over your emotions.

4. Mindfulness – a set of skills that help you focus your attention and live your life in the present, rather than being distracted by worries about the past or the future.

This is a very broad and diverse area of inquiry so I have chosen to focus on x number of particular domains of research.

Early responses to stress

Biological mechanisms all involved in detecting and responding to stress: – HPA axis, areas of pfc involved in executive functioning and the amygdala.

# TC

Therapeutic communities (TCs)

Therapeutic communities (TCs) are structured environments where people with a range of complex psychological conditions and needs come together to interact and take part in therapy.

TCs are designed to help people with long-standing emotional problems and a history of self-harming by teaching them skills needed to interact socially with others.

Most TCs are residential, such as in large houses, where you stay for around one to four days a week.

As well as taking part in individual and group therapy, you would be expected to do other activities designed to improve your social skills and self-confidence, such as:

household chores

meal preparation

games, sports and other recreational activities

regular community meetings – where people discuss any issues that have arisen in the community

TCs are run on a democratic basis. This means that each resident and staff member has a vote on how the TC should be run, including whether a person is suitable for admission to that community.

Even if your care team thinks you may benefit from spending time in a TC, it doesn't automatically mean the TC will allow you to join.

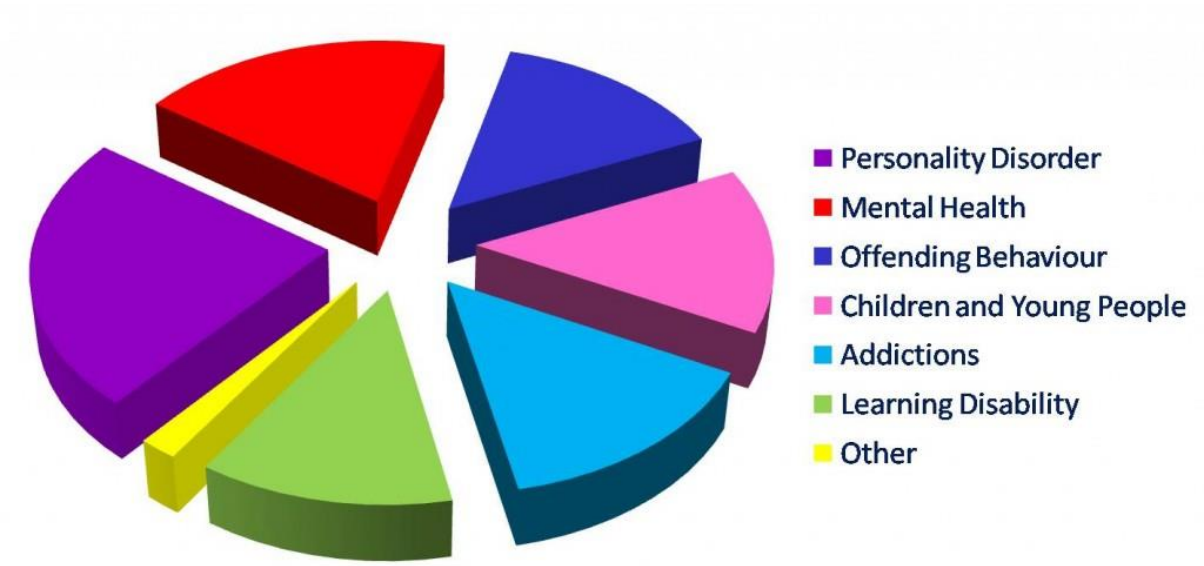
Many TCs set guidelines on what is considered acceptable behaviour within the community, such as not drinking alcohol, no violence to other residents or staff, and no attempts at self-harming. Those who break these guidelines are usually told to leave the TC.

Different forms of therapeutic community have evolved from various origins. One clear strand is for specific treatment of those with personality disorders.

While some people with BPD have reported that the time spent in a TC helped their symptoms, there's not yet enough evidence to tell whether TCs would help everyone with BPD.

Also, because of the often strict rules on behaviour, a TC would probably not be suitable if a person were having significant difficulties controlling their behaviour.

Types of TC




# Schema therapy

Schema therapy was developed by Jeffrey E. Young for use in treatment of personality disorders and chronic disorders, or as when patients fail to respond or relapse after having been through other therapies (for example, traditional cognitive behavioural therapy). Schema therapy is an integrative psychotherapy combining theory and techniques from previously existing therapies, including cognitive behavioural therapy, psychoanalytic object relations theory, attachment theory, and Gestalt therapy.

The schemas that are targeted in treatment are enduring and self-defeating patterns that typically begin early in life. These patterns consist of negative/dysfunctional thoughts and feelings, have been repeated and elaborated upon, and pose obstacles for accomplishing one's goals and getting one's needs met. Some examples of schema beliefs are: "I'm unlovable," "I'm a failure," "People don't care about me," "I'm not important," "Something bad is going to happen," "People will leave me," "I will never get my needs met," "I will never be good enough," and so on.

Schema-Focused Therapy consists of three stages. First is the assessment phase, in which schemas are identified during the initial sessions. Questionnaires may be used as well to get a clear picture of the various patterns involved. Next comes the emotional awareness and experiential phase, wherein patients get in touch with these schemas and learn how to spot them when they are operating in their day-to-day life. Thirdly, the behavioural change stage becomes the focus, during which the client is actively involved in replacing negative, habitual thoughts and behaviours with new, healthy cognitive and behavioural options.

# Family based intervention

Family therapy or systemic therapy as it's sometimes known can use techniques from various therapeutic styles, with the aim of helping a family understand any difficulties they're going through, particularly in their relationships to each other. The therapist can then help them reflect and identify how they can change any problems they might want to.

Family therapy can help with any issues that someone wants to address as part of a whole family. This might include:

- mental health problems as they impact family relationships
- physical health problems as they impact family relationships
- other family issues like bereavement, adoption, divorce, abuse and other conflict.

# Medication

Psychiatric medication includes all drugs which can be prescribed to treat different types of mental health problems, or to reduce the symptoms.

There are four main types of psychiatric medication:

| Type of psychiatric medication | What it's prescribed for |
|---|---|
| **Antidepressants** | • depression<br>• some forms of anxiety<br>• some eating disorders |
| **Antipsychotics** | • psychosis<br>• schizophrenia |

| | |
|---|---|
| | • schizoaffective disorder<br>• hypomania and mania<br>• bipolar disorder<br>• sometimes severe anxiety |
| **Mood stabilisers** | • bipolar disorder<br>• hypomania and mania<br>• sometimes recurrent severe depression |
| **Sleeping pills and minor tranquillisers** | • severe insomnia (inability to sleep)<br>• severe anxiety |

## Anti-depressants

There are several different types of antidepressants, which were developed at different times. They all tend to act on the same brain chemicals and cause similar effects, but the different types have different chemical structures, and may have different side effects.

The different types are:

- selective serotonin reuptake inhibitors (SSRIs)
- serotonin and noradrenaline reuptake inhibitors (SNRIs)
- tricyclics and tricyclic-related drugs
- monoamine oxidase inhibitors (MAOIs)
- other antidepressants

SSRIs - They work by blocking the reuptake of serotonin into the nerve cell that released it, which prolongs its action in the brain. The side effects that SSRIs can cause are generally easier to cope with than those of other types of antidepressants.
They're the most commonly prescribed type of antidepressant in the UK.

SNRIs - The first of these was developed in the early 1990s, so they're one of the newer types of antidepressant.
They're very similar in action to SSRIs, but they act on noradrenaline as well as serotonin.
They have a more selective action than tricyclics, which means they're better at targeting the brain chemicals which affect your mood, without causing unwanted side effects.
They're sometimes preferred for treating more severe depression and anxiety.

Tricyclics - They're the oldest type of antidepressant, first developed in the 1950s.
They work by prolonging the action of noradrenaline and serotonin in the brain.
They're called ‘tricyclic’ because of their chemical structure, which has three rings.
They tend to cause more unpleasant side effects compared with other types of antidepressants.

Monoamine oxidase inhibitors (MAOIs) - They work by making it harder for an enzyme (monoamine oxidase) that breaks down noradrenaline and serotonin to do its job, causing these chemicals to stay active in the body for longer.
They can have dangerous interactions with some kinds of food, so when taking MAOIs, an individual needs to follow a careful diet.
Because of these interactions, a person is not likely to be prescribed an MAOI unless they've tried all other types of antidepressant and none of them have worked.
They should only be prescribed by specialists.

## Anti-psychotics

Antipsychotics (sometimes called neuroleptics or in the past major tranquillisers) are psychiatric drugs which are available on prescription, and are licensed to treat types of mental health problems whose symptoms include psychotic experiences. These include:

- schizophrenia
- schizoaffective disorder
- some forms of bipolar disorder
- severe depression

Some antipsychotics may also be used to treat:

- severe anxiety (but only in very low doses)
- physical problems, such as persistent hiccups, problems with balance and nausea (feeling sick)
- agitation and psychotic experiences in dementia (although they're not usually recommended in this case)

Antipsychotics can be prescribed to be taken in various different ways. Most commonly this will be orally in tablet or liquid form, but some of them can also be prescribed as depot injections.

<u>Informed consent</u>
The law says that an individual has the right to make an informed decision about which treatment(s) they have. To consent properly, a person needs to have enough information to understand what the treatment is, what its benefits should be, possible harms it might cause, its chance of success, and available alternative treatments.

Even after they have given their consent they can change their mind at any time. Consent is fundamental to treatment, and treatment given without consent can amount to assault and negligence.

However, if a person is in hospital as an involuntary patient under the Mental Health Act (sectioned), they can be treated without their consent.

There are several possible explanations why antipsychotic drugs can be effective in controlling and reducing psychotic symptoms:

- Blocking the action of dopamine. Researchers believe that some psychotic experiences are caused by the brain producing too much of a chemical called dopamine (dopamine is a

neurotransmitter, which means that it passes messages around the brain). Most antipsychotic drugs are known to block some of the dopamine receptors in the brain – this reduces the flow of messages, which may be too frequent in psychotic states.
- Affecting other brain chemicals. Most antipsychotics are known to affect other brain chemicals too, such as the neurotransmitters serotonin and noradrenaline, which are both thought to be involved in regulating mood.
- Parkinsonism. Some academics have suggested that antipsychotics may actually work by causing Parkinsonism (a movement disorder) – not just the physical symptoms, which are well known neuromuscular side effects of these drugs, but also the psychological symptoms, such as not feeling emotions and losing interest in activities.

Types of Anti-Psychotic drug

First generation (older) antipsychotics (Haloperidol, Chlorpromazine)

Key facts:

- mostly developed and first licensed in the 1950s
- sometimes referred to as 'typicals'
- these divide into various chemical groups which all act in a very similar way and can cause very similar side effects, including severe neuromuscular side effects
- however, they're not all the same – for example, some may cause more severe movement disorders than others, or be more likely to make the person more drowsy

Second generation (newer) antipsychotics (Olanzipine, Clozapine, Rispirisdone, Quetiapine)

Key facts:

- mostly developed and first licensed in the 1990s
- sometimes referred to as 'atypicals'
- in general these cause less severe neuromuscular side effects than first generation antipsychotics
- some also cause fewer sexual side effects compared to first generation antipsychotics
- however, second generation antipsychotics are more likely to cause serious metabolic side effects, including rapid weight gain

# Mood stabilisers

Mood stabilisers are psychiatric drugs that are licensed as part of the long-term treatment for:

- bipolar disorder
- mania and hypomania
- sometimes recurrent severe depression

Some of the individual drugs we call mood stabilisers are actually very different chemical substances from each other. But health care professionals often group them together, because they can all help to stabilise your mood if you experience problems with extreme highs, extreme lows, or mood swings between extreme highs and lows.

Which drugs are mood stabilisers?

The 5 individual drugs that can be used as mood stabilisers are:

- lithium (Camcolit, Liskonum, Priadel, Lithonate, Litarex, Li-liquid)
- carbamazepine (Tegretol)
- lamotrigine (Lamictal)
- valproate (Depakote, Epilim)
- asenapine (Sycrest)

**lithium** - Natural mineral – lithium is actually an element that occurs naturally in the environment, not a manufactured drug.

**carbamazapine, lamotrigine and valproate** - Anticonvulsants – these 3 drugs are actually anticonvulsant medication (also known as antiepileptic medication), which were all originally made for treating epilepsy. Epilepsy is a neurological disorder that can cause seizures.

**Asenapine** - Antipsychotic – asenepine is actually an antipsychotic drug, but it is usually only used as a mood stabiliser.

# Sleeping pills & minor tranquilisers

Sleeping pills and minor tranquillisers are prescribed for severe anxiety and sleeping problems. They include:

- benzodiazepines for both anxiety and sleeping problems
- drugs for anxiety only
- drugs for sleeping problems only

Sleeping pills and minor tranquillisers are sedatives. This means they slow down your body and brain's functions, such as your breathing, heartbeat and thought processes.

These drugs are sometimes called sleeping pills, minor tranquillisers or sedatives. Doctors may also call them hypnotics and anxiolytics.

Benzodiazepines act as a sedative – slowing down the body's functions – and are used for both sleeping problems and anxiety.

They work by increasing the effect of a brain chemical called GABA (gamma amino butyric acid). GABA reduces brain activity in the areas of the brain responsible for:

- rational thought
- memory
- emotions
- essential functions, such as breathing

The main effects of benzodiazepines are:

- sedation

- reduced anxiety
- muscle relaxation

Benzodiazepines (eg Diazepam – Valium) are very effective in the short term but they may stop working if you take them continuously for more than a few months. This is because your brain adjusts to their effect, and may be hypersensitive to natural brain chemicals when they are stopped.

Benzodiazepines are generally viewed as safe and effective for short-term use. Long-term use is controversial because of concerns about adverse psychological and physical effects, decreasing effectiveness, and physical dependence and withdrawal.

Sleeping pills

# Other treatments

## Art therapy

Arts (or creative) therapies involve using the arts in a therapeutic environment with a trained therapist.

The different types of regulated of arts therapies include:

- dance movement therapy
- dramatherapy
- music therapy
- visual art therapy

In arts therapy, your therapist helps you to create something — such as a piece of music, a drawing, a play or a dance routine — as a way of expressing your feelings, often without using words.

## ECT

ECT (Electroconvulsive Therapy) is a treatment that involves sending an electric current through the brain to trigger an epileptic seizure to relieve the symptoms of some mental health problem.

The treatment is given under a general anaesthetic and using muscle relaxants, so that your muscles only twitch slightly, and your body does not convulse during the seizure.

What problems can ECT treat?

ECT is mainly used if you:

- have severe, life-threatening depression
- have not responded to medication or talking treatments

- have found it helpful in the past and have asked to receive it again
- have severe postnatal depression

It may sometime be used if you:

- are experiencing a manic or psychotic episode which is severe or is lasting a long time
- are catatonic (staying frozen in one position for a long time; or repeating the same movement for no obvious reason; or being extremely restless, unrelated to medication)
- It may also be used when it is important to have an immediate effect; for example, because you are so depressed that you are unable to eat or drink, and are in danger of kidney failure.

No-one is sure how ECT works, but it is known to change patterns of blood flow in the brain, and also change the way energy is used in parts of the brain that are thought to be involved in depression. It may cause changes in brain chemistry, although how these are related to symptoms is not understood.

The ECT Accreditation Service (run by the Royal College of Psychiatrists) reported on a survey of 78 ECT clinics in England and Wales in 2012-2013. This reported the results of 1895 courses of treatment in 1789 people:

- improved ('minimally', 'much' or 'very much'): 1712
- no change: 113
- worse: 28

# Early Intervention

In 2011, No Health Without Mental Health highlighted the effectiveness of early intervention in psychosis (EIP) services for people experiencing first episode psychosis. There is good evidence that these services help people to recover and to gain a good quality of life. EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes

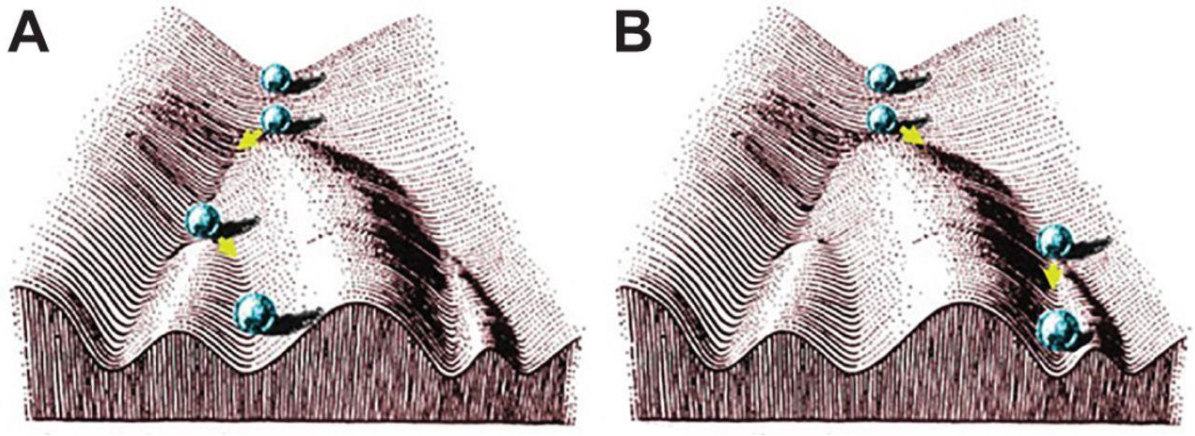
The access and waiting time standard for early intervention in psychosis (EIP) services requires that, from 1 April 2016 more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65. In response to the recommendation of the Mental Health Taskforce, NHS England has committed to ensuring that, by 2020/21, the standard will be extended to reach at least 60% of people experiencing first episode psychosis.

(National collaborating centre for mental health 2016)

Earlier intervention

Much of the research into mental illness cites negative experiences in childhood (ie neglect, abuse, bereavement etc) that could act as a contributing factor in the onset of a mental disorder.

As is usually the case there are many other variables that can impact an individual.




Conrad Waddington, a British developmental biologist formulated the theory in 1940 of the epigenetic landscape as a metaphor for how gene regulation modulates development. Among other metaphors, Waddington asks us to imagine a number of marbles rolling down a hill. The marbles will compete for the grooves on the slope, and come to rest at the lowest points. These points represent the eventual cell fates, that is, tissue types.

Thus in terms of how we develop in life, although some elements are predetermined, it is also our environment and experience that shapes our lives.

**Stress**

'Stress that occurs in early life, including the prenatal period, has been shown to be particularly consequential, most likely because many biological systems are undergoing rapid development and maturation during this time, and their development is shaped, for better or worse, by the environment'. Fisher et al 2016

Parental care (in many animal species maternal care) is an important mediator of the effects of early adversity on development. Care that is sensitive and responsive, as well as predictably delivered, appears to have the potential to buffer the developing organism from the effects of stress. In contrast, the absence of developmentally supportive care not only fail to protect the organism from stress, but may also represent a source of adversity and thereby amplify the effects of early stress. (Fisher et al 2016)

In recent years, policy makers and the general public have become increasingly aware of the effects of early stress on development. The Adverse Childhood Experiences (ACE; Anda et al 2006) study, which showed a consistent gradient between the number of adverse experiences and the risk of psychiatric disorders, addictions, heart disease, diabetes and any other problematic health and mental health outcomes, has stimulate public awareness. (Fisher et al 2016)

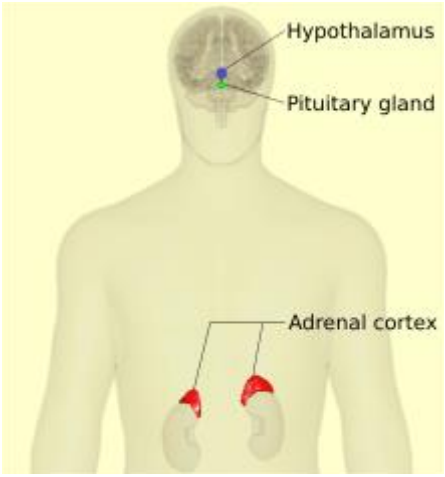
If a child's experience in early life includes persistent stress then they can experience 'toxic stress'. "Toxic stress" (Shonkoff et al 2012) refers to the chronic activation of the body's stress response system in the absence of a supporting caregiver.

"trauma-informed care" (Bremness & Polzin 2013) refers to services that recognise and respond to the pervasive and lasting impact of experiences of extreme adversity.

Notably in clinical psychology and mental health care communities, the understanding that negative early experiences can exert a lasting impact on the individual dates back to the origins of these fields in psychoanalytic theory. Consequently, many psychotherapeutic approaches focus either explicitly or implicitly on addressing and resolving the effects of negative early-life experiences, especially those that occur within one's family of origin. However only very recently have scientists interested in psychotherapeutic interventions begun to incorporate neurobiology into their work. This work could be pivotal. In the context of randomised clinical trials to assess the efficacy of these interventions, it incorporates an understanding of the plasticity of key brain systems that have been affected by early stress; and finally, it has the potential to provide information about therapeutic moderators (ie whether differences in the responsiveness to therapeutic approaches are the result of alterations in specific brain systems). Fisher et al 2016

**HPA Axis**

The hypothalamic pituitary axis (HPA) is a complex set of direct influences and feedback interactions among three endocrine glands: the hypothalamus, and the adrenal glands.




The HPA axis controls reactions to stress and regulates many body processes, including digestion, the immune system, mood and emotions, sexuality, and energy storage and expenditure.

The HPA axis also interacts with many other physiological systems as but one component of a broader "neuro-symphony" of stress (Joels & Baram 2009).

The developmental plasticity of the HPA axis makes this system susceptible to insult early in life yet also responsive to properly timed psychotherapeutic interventions.

(Fisher et al 2016).