

# Section four

## Mental health

This section includes:

- A brief introduction to mental health problems highlighting some issues around diagnosis
- Descriptions of the main types of mental health problems giving prevalence figures and examples of symptoms

The treatments that are normally offered by mental health services are described in the '*In Practice*' section on page 39-42.

Most of us experience variations in our mental health from time to time. However for some people these variations are prolonged and can result in considerable disturbance to everyday life. This is the point at which a diagnosis of mental illness may be given.

It can be helpful to think of mental health in terms of a continuum. At one extreme would be positive wellbeing. This would include both medical and social factors and is a state of active good health rather than simply the absence of illness.

At the other end would be "serious and enduring" mental health problems. However, it is important to recognise that everyone is on this continuum and that most people fluctuate between different positions. Even people with "serious" conditions can have long periods of being well. This fluctuation is one of the reasons why many people feel uncomfortable about psychiatric labels and diagnoses. Such labels may not be a good predictor of somebody's health at a given time and may lead to stigma and preconceptions.

Where a diagnosis is given this is because a doctor or psychiatrist recognises a number of symptoms and attributes them to a particular illness. However, practitioners should be aware that diagnosis is not an exact science. In practice, some symptoms can point towards two or more illnesses and misdiagnosis can also occur. In other instances, conditions remain undiagnosed.

## Types of mental illness

### Anxiety disorders

According to the Mental Health Foundation, anxiety disorders are the most common form of psychiatric illness affecting around one in ten of the population.

Anxiety, worry and fear are feelings that everyone experiences from time to time. However, some people experience them with a severity that is out of proportion to the real threats around them. This can have a profound impact on their ability to function normally.

Diagnosis can be more complex in the event of dual diagnosis. On the one hand, anxiety disorders can be brought on by drink and drug use. On the other hand, people who have an anxiety disorder may use drink or drugs to deal with the symptoms.

## The general symptoms of anxiety disorders are:

- Feeling worried a lot of the time
- Feeling tired
- Difficulties concentrating
- Being irritable
- Problems sleeping
- Heart palpitations
- Heavy and rapid breathing
- Dizziness
- Feelings of dread or impending doom

## Anxiety disorders include:

- Generalised anxiety disorder
- Obsessive compulsive disorder
- Panic disorder
- Post traumatic stress disorder
- Social anxiety disorder
- Specific phobias
- Separation anxiety disorder

One particular form of anxiety disorder is Post Traumatic Stress Disorder (PTSD). This is a pattern of behaviour that can occur after a traumatic experience or witnessing life threatening events such as serious accidents, violent personal assaults, sexual abuse or terrorist incidents. People with PTSD often re-live the experience through nightmares and flashbacks, have problems sleeping and feel detached from reality. PTSD is complicated by the fact that it often occurs together with other mental health problems like depression, anxiety, memory problems and substance misuse.

## Depression

The severity and length of depression can vary widely from a short-term reaction to an adverse event to a prolonged episode that interferes with the ability to function, feel pleasure or maintain interest.

It is estimated that one in five people will experience depression at some point in their lives and about one in 20 people have clinical depression.

### Symptoms of depression include:

- Feelings of helplessness and hopelessness
- Feeling useless, inadequate, bad
- Self hatred, constant questioning thoughts and actions, an overwhelming need for reassurance
- Being vulnerable and over sensitive
- A loss of energy and motivation
- Agitation and restlessness
- Physical aches and pains

**In severe depression these feelings may also include:**

- Suicidal ideas
- Failure to eat or drink
- Delusions and/or hallucinations

Sometimes depression may be masked – for example, by alcohol or drugs.

## Schizophrenia

One in 100 people will experience schizophrenia during their lifetime.

Although for some people the illness may be chronic and enduring, many do recover and live ordinary lives. People are most likely to experience schizophrenia between their late teens and early twenties.

The causes of schizophrenia are still unclear though there are a number of theories. In relation to dual diagnosis, practitioners should be aware that drug use has not been conclusively shown to cause schizophrenia (or other severe and enduring mental health problems). However, long-term use of certain drugs could increase the chance of some people developing mental health problems.

There are two groups of symptoms. These are known as “positive” and “negative”. Positive symptoms mean that people have more experiences than normal whilst negative symptoms involve some loss of normal experience.

### Positive symptoms

#### Hallucinations and illusions

Hallucinations are perceptions that occur without connection to an appropriate source.

The most common hallucination is hearing voices. However, they can occur in any sensory form: auditory (sound), visual (sight), tactile (touch), gustatory (taste) and olfactory (smell).

Voices are usually thoughts in the mind. They can describe activities taking place, carry on a conversation, warn of dangers, or even issue orders. They can seem so loud that the person believes that they are audible to others around them.

To a person with schizophrenia, the voices appear to come from an external source. However, using modern imaging techniques, it is possible to see changes in the speech area of the brain at the time when the person says they are hearing voices. Thus, for practitioners, there is an important point: a person hearing hallucinatory voices is not simply imagining something. A measurable experience is actually happening.

#### Delusions

Delusions are false personal beliefs that are not subject to reason or evidence and are not explained by a person's usual cultural beliefs.

They make take a variety of forms. For example, about one-third of people with schizophrenia have paranoid-type symptoms. These usually involve delusions of persecution, or false and irrational beliefs

that they are being cheated, harassed, poisoned or are the subject of a conspiracy. These people often believe that a member of their family or someone close to them is making this happen.

Another form is delusions of grandeur in which the individual may believe they are a famous or important person.

Sometimes people's delusions are quite bizarre. For example, believing that a neighbour is controlling their behaviour with magnetic waves; that people on television are directing special messages to them; or that their thoughts are being broadcast aloud to others. A person experiencing delusions may try to keep them secret, knowing that others would not understand. Other people can become overwhelmed and begin to act strangely in accordance with their delusions.

## Negative symptoms

Negative symptoms are when the person experiences a degree of withdrawal from their normal life. For example, families may gradually realise that their relative's behaviour has been changing over a period of time in subtle ways. They may have become slower to think, talk and move, or indifferent to social contact. Their sleeping patterns may have changed so that they remain up all night and sleep all day. Body language may also be affected.

The overall result is a reduction of motivation, the effect of which varies from minor to severe. Negative symptoms are much less dramatic than positive, but they tend to be more persistent.

Recognising these changes can be particularly difficult if the illness develops during teenage years when it is quite acceptable for changes in behaviour to occur, particularly where the young person is experimenting with new freedoms and lifestyles.

## Bipolar disorder/manic depression

Around one in 100 people experience bipolar disorder which is also known as manic depression.

The key symptoms are unusual shifts in mood, energy and ability to function. These are severe and quite different from the normal ups and downs of everyday life.

Bipolar disorder typically develops in late adolescence or early adulthood though it is frequently not recognised until the symptoms become severe. It is often a long-term illness that must be carefully managed throughout a person's life.

Many people have long periods between episodes when they are free of symptoms. About one third have some residual symptoms and a small minority have unremitting symptoms. Symptoms of a depressive episode are described under "depression" above.

### Some of the symptoms of a manic episode include:

- Increased energy, activity, restlessness
- An overly high, euphoric mood
- Extreme irritability
- Racing thoughts and sometimes talking fast, jumping from one idea to another

- Reduction in the need for sleep
- Unrealistic beliefs in abilities and powers

People with mania are more likely to use drugs, particularly cocaine, alcohol and sleeping medications.

Sometimes severe episodes of mania or depression include psychotic symptoms. These are described in more detail under the symptoms of schizophrenia.

## Schizoaffective disorder

About one in every 200 people develops schizoaffective disorder although it is thought that this may be an underestimate.

The term is applied when symptoms of manic depression and symptoms of schizophrenia present at the same time (or within a few days of each other). Usually this diagnosis is given when the symptoms of schizophrenia are more pronounced. Schizoaffective disorder usually begins in late adolescence or early adulthood.

## Personality disorders

Approximately 10-13% of the population has a personality disorder.

We are used to thinking of “personality” as the characteristics that make us unique. However, the term “personality disorder” is used when those personal characteristics cause someone to have regular and long term problems in the way they cope with life and interact with other people. There are different types of personality disorders. ‘*The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*’, identifies ten:

- Paranoid
- Schizoid
- Schizotypal
- Antisocial
- Borderline
- Histrionic
- Narcissistic
- Dependent
- Avoidant
- Obsessive-compulsive

An individual may have more than one. However, it is likely that some people experiencing these problems will never come into contact with mental health services. Others may easily be misdiagnosed – particularly because the symptoms may be more general than those of other mental disorders. In addition, some people may have other mental health conditions co-existing with personality disorders, but these are not always diagnosed. ‘*Co-existing problems of Mental Disorder and Substance Misuse (dual diagnosis) - an Information Manual*’ suggests that some personality disorders are more relevant to dual diagnosis than others. These include paranoid, schizoid, anti-social and borderline.

The issue of diagnosis may become more complex where substance misuse is also involved. On the one hand, to achieve a diagnosis of personality disorder the person's symptoms must not be as a result of drug or alcohol use. However, drug and alcohol dependence is often seen as a symptom of personality disorders.

When making a diagnosis, the criteria that a psychiatrist will look for may include the following:

- Symptoms have been present for an extended period of time. They are inflexible and pervasive, and are not a result of alcohol or drugs or another psychiatric disorder. The history of symptoms can usually be traced back to adolescence or at least early adulthood
- The symptoms have caused and continue to cause significant distress or negative consequences
- Problems are seen in at least two of the following areas:
  - Thoughts (ways of looking at the world thinking about self or others, and interacting)
  - Emotions (appropriateness, intensity, and range of emotional functioning)
  - Interpersonal Functioning (relationships and interpersonal skills)
  - Impulse Control

## Further discussion around personality disorders

In the past, some professionals thought that personality disorders were untreatable. Hence, commissioning of services has generally been poor or patchy. This has led to significant confusion and misunderstanding about the disorder as well as to poor or patchy commissioning of services. In order to clarify understanding, we have provided greater detail on the diagnosis and treatment of personality disorders. This information is intended to challenge myths about treatability and to alert practitioners to new guidance. It does not therefore, imply that personality disorder is a special case in terms of treatment.

### Treatment and services

A problem with services is that they have traditionally been focused on providing crisis and acute care. However, many people with personality disorders do not reach the threshold of crisis and may consequently not receive support. They may be living in an isolated way in the community without receiving care and this can become a trigger for drug or alcohol use. However more recently, there have been advances in treatment and the Government has recently published guidelines: '*Personality Disorder, no longer a diagnosis of exclusion*' (see page 69 for further details). Treatment may include medication which is mainly used to calm anxiety and stabilise mood.

In addition, psychological approaches have been shown to be effective. These include cognitive behavioural therapy (CBT) and also longer term psychotherapy. Another more specific form of therapy is Dialectical Behaviour Therapy (DBT) which is a longer-term form of CBT that has proved effective for some people with certain types of personality disorder.

Research<sup>1</sup> has looked at the effectiveness of different approaches in different settings. This includes psychological treatments, drug treatments, service models and approaches, (including therapeutic communities) and features of good management.

Whilst there is increasing data on treatment, practitioners should be aware that there may be a shortage of services in their locality. Each area should now have a strategy for the treatment of people with personality disorders and it may be helpful to identify and work with relevant people.

## Engagement

It is particularly important to establish a good working relationship from the start. Many people with personality disorders may have had bad experiences of engaging with services and of not receiving appropriate support. This can lead to a vicious circle whereby they express their frustration and are then regarded as “difficult” by services.

## Working with symptoms

Personality disorders have traditionally been viewed in medical terms, and this presents challenges to services which provide treatment based on medication. It is important to develop a better understanding from a psychological point of view, with an emphasis on changing behaviour. Try to look at the various symptoms and review whether they can be treated.

## Making assumptions

Personality disorder remains a controversial diagnosis and an area where there is still much confusion. In particular, there is debate about the label “dangerous and severe personality disorder”. In practice, workers are unlikely to encounter clients with this label. It is a term used by the Home Office rather than a diagnosis given by psychiatrists. A tiny minority of people will receive this label, many of whom are already in a special hospital or criminal justice system. It is important to avoid making assumptions.