Understanding Mental Illness

Key facts and information about common types of mental illness

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Mental Illness Awareness Week 2016

Understanding mental illness

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Mental health or mental illness?

Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against developing such problems. It is characterised by a person's ability to fulfil key functions and activities, including the ability to (a) learn; (b) feel, express and manage a range of positive and negative emotions; (c) form and maintain good relationships with others; (d) cope with and manage change and uncertainty.

Although the terms are often used interchangeably, **mental health and mental illness are not the same thing**; but they are not mutually exclusive. It is common for someone to experience poor mental health at some point in their lives without ever having a diagnosable mental illness. It is less known that it is also possible for someone with a mental illness to be perfectly mentally healthy. **A mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your day-to-day ability to function**.

Mental illness refers to a wide range of medically diagnosable mental health conditions — disorders that affect your mood, thinking and behaviour. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours. A mental illness can make you miserable and can cause problems in your daily life, such as at school or work or in relationships. In most cases, symptoms can be managed with a combination of medications and talking therapies (psychotherapy).

Severe mental illness is a term used for **longstanding conditions** and affects about 1% of the population.

Types of mental illness

There are many types of mental illness but the easiest way of defining them are as either **psychotic** or **neurotic**. Most conditions fit into either of these categories.

Neurotic conditions

These are the **most common** type of mental illness. Neurotic conditions **refer to a mental disorder involving distress, but not hallucinations nor delusions** - they are not outside socially acceptable norms. The individual is still in touch with reality.

Many of us can feel depressed for example, but if you have clinical depression it is a far **deeper experience** than what an average person would describe as 'feeling depressed'. Having clinical depression is an illness that has a **marked effect on your life**, preventing the patients from being able to work or look after themselves properly which in extreme cases leads to suicide.

Other examples of neurotic illnesses are **Phobias**, **Obsessive Compulsive Disorder** and **Anxiety**.

Psychotic conditions

These conditions are **unrelated to 'normal' emotions;** they cause abnormal thinking and perceptions. **Patients experience reality differently** from most people; they may experience:

- Hallucinations—hearing, smelling, feeling or seeing things which aren't actually present
- Delusions—having strange thoughts or beliefs that can make the person feel they are being persecuted, controlled or being sent secret messages. They are persistent and organised and do not go away after receiving logical or accurate information
- Thought disorders—muddled or blocked thinking
- Lack of insight or denial—not recognising that they are unwell
- Unusual excitement or avoidance of contact

Examples of psychotic illnesses are **Schizophrenia** and **some personality disorders**.

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How many people are affected?

Depending on the technical definition of mental illness used, between 10-25% of people in the UK can be considered to have had a mental illness at some point in their lives. Like many other illnesses it is **common** and can occur at **any time** and happen **to any one of us**. In the 2013 UK Wellbeing Survey, nearly 1 in 5 people in the UK aged 16 and older showed symptoms of anxiety or depression. This percentage was higher for females (21.5%) than for males (14.8%). A recent index of 301 diseases found mental health problems to be one of the **main causes of the overall disease burden worldwide** and in total causing over 40 million years of disability in 20 to 29-year-olds.

Cost of mental health problems

The costs associated with mental health problems are harder to quantify than those associated with physical problems such as cancer. The value of human health is not merely financial, *but* **calculating the costs of mental health problems for the economy can be persuasive (if not necessary) when making the case for investment in mental health prevention and mental health services.**

Mental health problems cost the UK economy an estimated £70-£100 bn each year through suffering, health and social care costs and losses in productivity. It is the leading cause of sickness absence, causing 70 million days lost from work each year.

People who experience mental health problems face more stigma and discrimination than those with physical health conditions, with the exception of those with HIV/AIDS. A UK survey of over 2,000 adults found that 56% would not hire someone with depression, *even if he/she was the best candidate for the job*.

General violence and mental illness

One of the most discriminatory stereotypes that persists is the incorrect association between mental health problems and violent behaviour. The media may play a role in exacerbating this stereotype: 14% of national newspaper articles addressing mental health issues referred to those with mental health problems as being a danger to others.

A 2014 mental health report by the Department of Health stated "Most people with mental health problems are not violent and most people who are violent are not mentally ill." It has further been estimated that the risk of violence by people with mental health problems ranges from just 3% to 5%.

In fact, **people with mental health problems are more likely to be victims of violence compared to those without mental health problems**. In a 2013 British survey among persons with severe mental health problems, it was found that 45% had been victims of crime in the previous year.

- 20% of those with mental health problems had experienced a violent assault (3 times more likely than those without)
- women with severe mental health problems were 10 times more likely to experience assault than those without
- people with mental health problems were more likely to report that police had been unfair to them compared to the general population

Information and facts on this hand-out were gathered from a range of online sources: The Mental Health Foundation (www.mentalhealth.org.uk), Mind (www.mind.org.uk), Mayo Clinic (www.mayoclinic.org), US National Alliance on Mental Illness (NAMI) (www.nami.org), Rethink (www.rethink.org) and the NHS .

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Range of mental illnesses

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How many mental disorders are there?

There is disagreement in various fields of mental health care, including the field of psychiatry, over the definitions and criteria used to delineate various disorders. Of particular concern to some professionals is whether some of these conditions should be classified as 'mental illnesses' at all, or whether they would be better described as neurological disorders, or in other ways. This means **it is hard to count the exact number of mental disorders**.

The *International Statistical Classification of Diseases and Related Health Problems* (ICD) is published by the World Health Organization. It carefully codes and details every clinically recognised health condition/classification for international use, including a section on mental and behavioural disorders. The diagnostic criteria and information in the ICD are revised and updated with each new version. There are 100 categories in the ICD-10 chapter which deals with mental and behavioural disorders. **This partial list contains some conditions currently recognised by the ICD for educational use only.** This is in no way a complete list of mental disorders.

How many have you heard of before?

- Dementia in Alzheimer's disease
- Vascular dementia
- Dementia in other diseases
- Delirium (not induced)
- Mental and behavioural disorders due to psychoactive substance use (drugs, alcohol…)
- Substance addiction
- Dependence syndrome
- Simple schizophrenia
- Catatonic schizophrenia
- Paranoid schizophrenia
- Schizotypal disorder
- Persistent delusional disorder
- Induced delusional disorder
- Schizoaffective disorder (manic, depressive, mixed, unspecified)
- Bipolar affective disorder
- Depression (mild, severe)
- Hypomania
- Cyclothymia
- Dysthymia
- Persistent mood disorder unspecified
- Social anxiety disorder
- Phobic anxiety disorders
- Panic disorder
- Generalised anxiety disorder
- Obsessive-compulsive disorder
- Acute stress reaction
- Post-traumatic stress disorder
- Adjustment disorder
- Dissociative amnesia
- Dissociative fugue
- Dissociative motor disorder
- Trance and possession disorder
- Ganser's syndrome
- Multiple personality disorder
- Somatisation disorder
- Hypochondriacal disorder
- Neurasthenia
- Depersonalisation-derealisation syndrome
- Neurotic disorder unspecified
- Anorexia nervosa (typical, atypical)
- Bulimia nervosa (typical, atypical)
- Binge eating disorder
- Eating disorder unspecified
- Insomnia
- Hypersomnia
- Somnambulism (sleepwalking)
- Night terrors
- Paranoid personality disorder
- Schizoid personality disorder
- Dissocial personality disorder
- Anankastic personality disorder
- Histrionic personality disorder
- Borderline personality disorder
- Pathological gambling
- Pyromania
- Kleptomania
- Paedophilia
- Sadomasochism
- Multiple disorders of sexual preference
- Sexual maturation disorder
- Psychosexual development disorder unspecified
- Mental retardation (mild, moderate, severe, other)

Information and facts on this page were obtained from the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), a medical classification list by the World Health Organization (WHO) which can be accessed online.

Understanding addiction

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Addiction is a **chronic brain disease** that causes compulsive drug use, despite harmful consequences to the addicted individual and to those around them.

Many people, sometimes even sufferers themselves, do not understand why people become addicted to drugs or alcohol. It's a misconstrued perception that, once addicted, the person simply just needs to be "strong enough" or have enough willpower to stop; but the reality is that addiction is **complex**—withdrawal is uncomfortable and there could be **underlying risk factors** such as depression which can cause **relapse** if untreated.

Facts

- Although the initial decision to take *drugs* is voluntary for most people, the brain changes over time hampering an addicted person's self-control and their ability to resist impulses
- *Drugs* contain chemicals that tap into the brain's communication system and disrupt the way nerve cells normally send, receive, and process information
- A person can become addicted to a wide range of substances such as cannabis, cocaine, heroin, ecstasy, but also prescription drugs, solvents and alcohol
- Combining medications with behavioural therapy is the best way to ensure successful treatment for most patients

Myths

- Drug addiction is a voluntary behaviour and want to stop they simply need to choose to
- People don't need drug treatment—they can stop if they want to
- Drug addiction is a character flaw, and addicts are usually bad people who deserve to be punished for their mistake
- Addiction to prescription drugs is different from addiction to illegal drugs
- There is an addiction gene
- Drug and alcohol rehabilitation can cure addiction
- Treatment and rehabilitation is easy

What is 'rehab'?

'Rehab' refers to rehabilitation and in the context of addiction is an intensive structured treatment program; treatment centres may offer **inpatient** rehab (a live-in centre where you spend 24 hours a day under supervision) and/or **outpatient** rehab (where you make frequent visits to the centre, getting treatment you need while going about life 'normally').

Rehab usually involves three main steps:

1) Detox—the body rids itself of the toxic influences of the addictive substance. This is sometimes described as the hardest part of rehab as experiencing **withdrawal** is extremely common depending on the extent of addiction and substance. *Emotional* withdrawal symptoms include anxiety, restlessness, insomnia, irritability and depression. *Physical* withdrawal symptoms include sweating, palpitations, muscle tension and nausea. Withdrawal is very real, scary and uncomfortable to experience.

2) Rehab—treatment continues even after detox is complete. Individuals may engage in group and individual therapy to recognize and address the underlying causes of their addiction. They will learn how to cope with future use temptations and practice substance refusal skills in order to prevent relapse.

3) Aftercare—once an individual has successfully completed a rehab treatment program, various aftercare services may be available. These services include support groups, ongoing therapy and sober living arrangements, if needed. This depends on the specific rehab centre.

Recovery time is different for everyone, so there isn't a set amount of time that you might stay in rehab. Addiction is not easily 'cured' and true recovery may be an ongoing, life-long process. The "cure" to addiction is the ongoing decision to say "no" in the face of substance temptation – a practice that requires a lot of **hard work** and **dedication**.

Understanding anxiety disorders

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Anxiety is a word used to describe **feelings of unease, worry and fear**. It incorporates both the emotions and the physical sensations we might experience when we are worried or nervous, and is related to the **'fight or flight'** response – our normal biological reaction to feeling threatened.

Anxiety is a normal human emotion that everyone experiences at times. Anxiety disorders, however, are different, ultimately interfering with a person's ability to lead a 'normal' life. There is no single answer as to why some people experience anxiety disorders while others don't. Some reasons include genetics, childhood experiences, and diet. It is estimated that more than 1 in 10 people are likely to have a 'disabling anxiety disorder' at some stage in their life.

Five main types

Generalised Anxiety Disorder

Those with generalised anxiety disorder (GAD) feel **worried and fearful for long periods of time**, often 6 months or longer, but are **not anxious about anything specific** that is happening in their life.

Because there are lots of possible symptoms and effects of anxiety this can be quite a broad diagnosis and two people diagnosed with GAD may have very different experiences.

Social & Specific Phobias

A phobia is **an extreme fear of something**, even when that thing is very unlikely to be dangerous to you. If you have a phobia, your anxiety may be triggered by very specific situations or objects such as spiders—you may know that a spider isn't poisonous and won't bite you, but you still feel scared and stressed.

Someone with a **social phobia or social anxiety disorder** has an intense fear/worry of being criticised and judged by others, or behaving in a way that might cause embarrassment or lead to ridicule. Due to this they feel very self-consciousness about everyday social situations.

Post-traumatic Stress Disorder

A person who is involved in or witnessed a **traumatic event** (eg. war or assault) normally experiences upsetting, distressing or confusing feelings afterwards. Someone whose problems are extreme such as vivid **flashbacks** of the event, lasting longer than a month, may be diagnosed with post-traumatic stress disorder (PTSD).

Some people may not develop PTSD until many years after the event, and not everyone who has experienced a traumatic event develops it.

Panic attacks

An exaggeration of your body's normal response to fear, stress or excitement. The rapid build-up of **overwhelming physical sensations** such as rapid heartbeats, sweating, nausea and chest pain.

- Feel **terrifying** and **confusing** for the sufferer to the point where they *may* believe they are having a heart attack or are going to die
- Can occur at random, or might be triggered
- Can wake you up at night
- Normally last between **5-20 minutes**
- **Frequency varies** between individuals, from only having one ever, to several times a week

Panic Disorder

This condition involves having **panic attacks** that strike **suddenly and repeatedly with no warning or trigger**.

Experiencing panic disorder can mean that you feel constantly afraid of having another panic attack, to the point that this fear itself can trigger your panic attacks.

Obsessive-Compulsive Disorder

A diagnosis might be given if your anxiety leads you to experience:

Obsessions – unwelcome thoughts, images, urges or doubts that repeatedly appear in your mind. The obsessions are often frightening or seem so horrible that you can't share them with others.

Compulsions – repetitive activities you feel compelled to do such as repeatedly checking a door to make sure it is locked. The aim of a compulsion is to try and deal with the distress caused by the obsessive thoughts and relieve the anxiety you are feeling. However, the process of repeating these compulsions is often distressing and any relief you feel is often short-lived.

Understanding eating disorders

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Eating disorders are **serious mental illnesses** that can affect anyone at any time. Girls and young women aged 12-20 are most at risk; up to 20% of cases are boys and men. The causes of eating disorders—which include a mix of genetic, biological and cultural factors—are **not yet fully understood**.

Facts

- Eating disorders are **serious mental illnesses**
- They affect **1.6 million** men and women of all ages and backgrounds in the UK
- … And have the **highest mortality rate of any mental illness** and one in five of the most seriously affected can die prematurely
- Eating disorders are **treatable** conditions and full recovery is possible

Myths

- Eating disorders are a lifestyle choice
- Eating disorders are only a modern phenomenon
- People with eating disorders are just trying to look thin like their celebrity idols
- Eating disorders are caused by bad parents
- You can tell just by looking at someone if they have an eating disorder

Four categories

Anorexia Nervosa

Although possibly the most well-known, anorexia is the **least common** eating disorder – **accounting for just 10% of cases.**

Anorexia Nervosa literally means *'loss of appetite for nervous reasons'*. However this doesn't describe how someone with the illness feels. More likely is that they just can't allow themselves to eat. They may dread that if they eat one thing, they may completely lose control and won't be able to stop.

Bulimia Nervosa

Bulimia Nervosa literally means *'hunger of an ox for nervous reasons'*, though some people affected may at times eat very little.

Bulimia is characterised by **cycles** of eating large amounts of food, called bingeing, and then experiencing guilt, or shame, which leads to purging or obsessive exercise. People with bulimia usually binge and purge in secret, and many stay the same weight or even put on weight, rather than drastically losing weight like those with anorexia.

Eating Disorder Not Otherwise Specified (EDNOS)

EDNOS is the most common type of eating disorder and **counts for ~50% of cases.**

Sometimes a person with an eating disorder will be given a diagnosis **of Eating Disorder Not Otherwise Specified {EDNOS}.** This is a medical term that is used for someone whose symptoms do not quite fit into one of the above categories, has only some symptoms of anorexia or bulimia, or has a mix of symptoms. EDNOS can be just as serious and should not be seen as a more trivial illness.

Binge Eating Disorders

Binge Eating Disorder shares some of the characteristics of bulimia; the essential difference is that the person binges *but does not purge*, or compensate in other ways. This means that these people usually become unhealthily overweight.

Some people describe their illness by saying that they use food as a comfort or to escape difficult feelings, but the effect is temporary and often followed by increased shame and disgust with themselves for their lack of control.

The Beat Helpline is open to anyone over 18 who needs support and information relating to an eating disorder including sufferers, carers and professionals (open Monday to Friday 10.30am-8.30pm, Saturday 1.00pm-4.30pm).

Telephone: **0845 634 1414** or send an e-mail to: **help@b-eat.co.uk**

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Understanding mood disorders

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Mood disorders encompass a wide array of mood issues. They are defined as psychological disorders characterised by the **elevation or lowering of a person's mood**, such as depression or bipolar disorder, could be classified as mood disorders. They can be caused by a number of environmental factors (e.g. childhood trauma or isolation) as well as an imbalance of the brain chemicals (such as serotonin and dopamine); the combination of these causes is different for everyone.

When you think of mood disorders, **depression** and **bipolar disorder** likely come to mind first. That's because these are **common, severe illnesses and leading causes of disability**. What you may not know is that two milder versions, dysthymic disorder and cyclothymic disorder, can also take a toll, and can go undiagnosed, as well as many other types of mood disorder.

Some main types

Depression (Clinical Depression)

Clinical Depression can be incredibly disorientating and debilitating. It can affect a person physically, mentally and emotionally. It can drain your energy, making it literally difficult to get out of bed. It can get in the way of your ability to work, sleep, and enjoy close relationships. It is real, and quite complex. It is not something you 'choose' to have, nor something you can simply 'snap out of'.

Common symptoms may include: feeling very low for extended periods of time, being tearful, feeling numb and hopeless, not enough or too much appetite/sleep, suicidal thoughts, etc.

Bipolar Disorders

If you have bipolar disorder, you are likely to have times where you experience:

- **manic** or **hypomanic episodes** (feeling high – having too much energy, not sleeping, racing thoughts, fast speech, etc.)
- **depressive episodes** (feeling low, tearful, lacking energy, etc.)
- **potentially some psychotic symptoms** during manic or depressed episodes (seeing, hearing or believing things that are not real)

There are 3 types of Bipolar Disorder which could be diagnosed, depending on which moods you experience and how often: Bipolar I, Bipolar II and Cyclothymia.

Treatment

Most often mood disorders are treated with a combination of medication and psychotherapy. Antidepressant are used to treat low moods, while mood stabilisers are used to treat certain

Seasonal Affective Disorder (SAD)

There is a definite link between the amount of sun a person gets, their levels of Vitamin D and mental health. Simply put, during seasons with little or no sun, some people are more likely to have to deal with depression more frequently. This is definitive of seasonal affective disorder.

Post-natal Depression

Postnatal depression can affect **women** in different ways. It can start at any point in the first year after giving birth and may develop suddenly or gradually.

Many women feel a bit down, tearful or anxious in the first week after giving birth. This is often called the "baby blues" and is so common that it's considered normal. The "baby blues" don't last for more than two weeks after giving birth.

If your symptoms last longer or start later, you could have postnatal depression.

Whether you're concerned about yourself or a loved one, these reliable helplines can offer help and advice:

Samaritans' free 24-hour distress or despair helpline (tel. 116 123)
Nightline for Uni. of York & St. Johns from 8pm-8am (tel. 01904 323735)
Refuge 24-hour helpline for advice on domestic violence (tel. 0808 2000 247)

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Understanding obsessive-compulsive disorder

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Obsessive-compulsive disorder (OCD) is described as an anxiety disorder. The condition has two main parts: obsessions and compulsions.

Obsessions – unwelcome thoughts, images, urges or doubts that repeatedly appear in your mind. The obsessions are often frightening or seem so horrible that you can't share them with others.

Compulsions – repetitive activities you feel compelled to do such as repeatedly checking a door to make sure it is locked. The aim of a compulsion is to try and deal with the distress caused by the obsessive thoughts and relieve the anxiety you are feeling. However, the process of repeating these compulsions is often distressing and any relief

Facts

- There is often an overinflated sense of responsibility to prevent harm and over-estimation about the perceived threat the intrusive thoughts bring
- Sufferers often go undiagnosed for many years due to a lack of understanding of the disease by both doctors and individuals—someone may suffer and not realise it as OCD
- Cognitive behavioural therapy (CBT) has been found to be the most effective treatment
- Every 12 out of every 1000 people in the UK will be suffering from OCD

Myths

- I'm a 'neat freak' so I must have OCD
- OCD is rare in children
- The main symptom of OCD is excessive hand-washing
- Individuals who suffer from the disorder don't understand how irrational their behaviour is
- People with OCD worry about things that non-sufferers don't
- It helps to just do the compulsive action and get over it so you can focus on something else
- It's easy to distract yourself from obsessions

How is OCD treated?

Treatment for obsessive-compulsive disorder depends on how much the condition is affecting your daily life—for some it can be really unmanageable and debilitating while for others it might be better.

Two main treatments are:

1) Cognitive behavioural therapy (CBT)— involving graded exposure and response prevention (ERP) (therapy that encourages you to face your fear and let the obsessive thoughts occur without "putting them right" or "neutralising" them with compulsions)

2) Medication—to control your symptoms by altering the balance of chemicals in your brain (usually elective serotonin reuptake inhibitors or SSRIs)

OCD that has a *relatively minor* impact on your daily life is usually treated with a short course of CBT involving ERP.

If you have OCD that has a more *significant* impact on your daily life, a more intensive course of CBT with ERP or SSRIs might be recommended. You may also be referred to a specialist mental health service.

If your OCD has a *severe* impact on your daily life, you will usually be referred to a specialist mental health service for a combination of intensive CBT and a course of SSRIs.

Children with OCD are usually referred to a healthcare professional with experience of treating OCD in children.

Furthermore, the level of treatment for OCD can be increased in steps until it is effective. For example, if a short course of CBT does not help, you may move on to trying SSRIs. The treatment path is normally different from person to person.

Understanding personality disorders

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The word 'personality' refers to the **pattern of thoughts, feelings and behaviour** that makes us the individuals that we are. We don't always think, feel and behave the same way – it depends on the situation we are in, the people with us, and many other things. But we do tend to behave in fairly predictable ways or patterns—and we mature and develop over time. We are usually flexible, learning from experiences to cope with life more effectively.

Those with personality disorders find this more difficult and have a more **limited range of emotions, attitudes and behaviours**. Others may find the behaviour unusual or unexpected, and may find it difficult to relate. It is easy to feel like an outcast in society.

Some main types

A wide range of people may fit the criteria for the same disorder, despite having very different personalities.

Paranoid personality disorder

Those with paranoid personality disorder find it very difficult to trust others, believing they will use you or take advantage of you. It's hard to confide in people, even friends and watch others closely, looking for signs of betrayal, unfaithfulness or hostility. It is common to read threats and danger into everyday situations.

Schizoid personality disorder

Commonly uninterested in forming close relationships with others, including family; relationships interfere with your freedom and tend to cause problems so you prefer to be alone with your own thoughts. They have chosen to live life without interference from others but in doing so get little pleasure from life, have little interest in sex or intimacy and are typically emotionally cold towards others.

Schizotypal personality disorder

Typically find making close relationships extremely difficult. Someone with schizotypal personality disorder may think and express themselves in 'odd' ways, using unusual words or phrases. They might seem eccentric, believing they can read minds or that have a 'sixth sense'. It is common to feel anxious and tense with others who do not share these beliefs and feel very anxious and paranoid in social situations.

Obsessive-compulsive personality disorder (OCPD)

Everything has to be in order and under control. Unrealistically high standards are set for yourself and others. You worry about the possibility of making mistakes (yourself or others), expecting catastrophe if things aren't perfect. Sometimes may hang on to items with no obvious value. OCPD is not obsessive compulsive disorder (OCD), which describes a behaviour rather than a type of personality.

Diagnosis

The diagnosis applies if you have personality difficulties which affect **all aspects** of your life, **all the time**, and make life difficult for you and for those around you. The diagnosis *does not include* personality changes caused by a life event such as a sudden traumatic incident, or physical injury.

Disorders show themselves in different ways. Psychiatrists in the UK tend to use a system which identifies **10 different types of personality disorder**. These **types** can be grouped into **three categories**:

Suspicious	Emotional and impulsive	Anxious
paranoid	borderline	avoidant
schizoid	histrionic	dependent
schizotypal	narcissistic	obsessive compulsive
antisocial		

This method is **controversial**—*some* psychiatrists disagree with its use, and many people who are given the diagnosis find it stigmatising and unhelpful.

Borderline personality disorder

There is a strong sense of not knowing who you really are. Others may describe you as 'changeable' with mood swings. It is common to have brief psychotic episodes, hearing voices or seeing things that others don't. It is easy to do things on impulse, which you later regret, have episodes of harming yourself, and think about taking your own life. Typically there is a history of stormy or broken relationships and so there is a tendency to cling on to damaging ones, because you are terrified of being alone.

Histrionic personality disorder

Comfortable when the 'centre of attention' or the 'life and soul of the party' as it feels like you have to entertain people. It is easy to get a reputation for being dramatic and overemotional when the reality is you are dependent on the approval of others

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Understanding psychotic disorders

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Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations (seeing or hearing things that are not real) or delusions (unusual believes that are irrational, e.g. thinking that your neighbour is plotting to kill you). **Psychosis isn't a condition in itself— it's triggered by other conditions** which indicate that the person has in some way lost touch with reality.

Psychotic disorders are severe mental disorders that display symptoms of psychosis.

Causes of psychosis

Each case is different and the exact cause is not always clear. Sometimes a sufferer may be undiagnosed for so long that it is not possible to find out. Nonetheless, causes of psychosis have three main classifications: psychosis caused by (a) psychological or mental conditions; (b) general medical conditions; (c) substance use (drugs or alcohol).

Psychological conditions:

- schizophrenia
- bipolar disorder
- severe stress or anxiety
- severe depression
- lack of sleep or insomnia

The underlying psychological cause will often influence the type of psychotic episode someone experiences.

For example, a person with bipolar disorder is more likely to have delusions of grandeur, whereas someone with schizophrenia is more likely to develop paranoid delusions.

General medical conditions:

- brain diseases such as Parkinson's disease, Huntington's disease
- brain tumours or cysts
- dementia (including Alzheimer's disease)
- HIV and AIDs, syphilis, and other infections that attack the brain
- some types of epilepsy
- stroke

Treatment

Treatment for psychosis usually involves using a combination of:

- **antipsychotic medication** – which can help relieve the symptoms of psychosis
- **psychological therapies** – the one-to-one talking therapy cognitive behavioural therapy (CBT) has proved successful in helping people with schizophrenia and, in appropriate cases, family therapy has been shown to reduce the need for hospital treatment in people with psychosis
- **social support** – support with social needs, such as education, employment or accommodation

Facts

- Schizophrenia can affect anyone, regardless of culture, race, economic status, sex or ethnicity.
- Both genetics and environment can play roles in the development of schizophrenia.
- Psychosis affects three out of every 100 people. It is most likely to be diagnosed in young adults, but symptoms can be present in anyone. Three out of every 100 people will experience a psychotic episode at some time in their lives.
- The average age of onset for men is late teens to early 20's and for women the mid-20's to early 30's.
- People experiencing psychosis are not more violent or dangerous!

Medication: facts & mental health

Medication is a very individual matter. Some take medication for their mental health while some prefer other methods of help, such as talking therapy. Those diagnosed with a mental illness often find that a *combination* of medication and talking therapy works best.

This page aims to provide an informative introduction to medication for mental health: why and when should people take it, how does it work, and what is it like?

Why medication?

There are many different reasons for taking medication.

Your GP and/or psychiatrist will help you decide whether taking medication is necessary.

Here are some of the reasons behind decisions:

1. Symptoms of mental illness often indicate that some chemicals in your brain are no longer working properly and you need medication to restore the balance.

2. If you have been unwell for some time and you don't seem to be getting better, medication might be more effective if not necessary. For example, if you have been continuously depressed, have trouble sleeping, are very low on energy and/or find it impossible to do your daily tasks.

3. In some occasions medication may be necessary to stabilise you in order to enable you to participate in talking therapy. For example, if you are unable to get out of bed or if severe depression is easily triggered when a difficult topic is brought up, it may be difficult for you to make progress in talking therapy.

Stigma

Stigma surrounding taking medication for mental illnesses is largely unaddressed. This has several main consequences: (1) sufferers are less likely to *seek* effective medical treatment which may lead to a worsening of the health condition; (2) patients are much less likely to *adhere to* prescribed regimens; (3) *self-stigmatisation* is reinforced, deepening the effects of (1) and (2).

Prescriptions

You should only take medicine prescribed to you.

Your GP can prescribe antidepressants without consulting a psychiatrist.

Medication such as mood stabilisers or antipsychotics require a **psychiatrist** to assess you, who will then let your GP know which medication, if any, to prescribe.

Each individual drug can have two kinds of names:

A generic name – this is the drug's medical name.

A trade name – this is a name that may be given by the company that makes the drug.

A drug only has one generic name – but it might also have several different trade names if more than one company makes it. For example, the antidepressant *fluoxetine* (generic name) can also be referred to as trade names *Prozac, Prozep* and *Oxactin*. If your prescription has suddenly changed or if you are concerned about your prescription, consult your doctor.

Side effects

Most medication, regardless of what it's for, has side effects. Everybody is different; each person can react differently to the same medication. Talk about your concerns regarding side effects with your doctor.

Most side effects wear off after 2-4 few weeks; it is important that you don't quit the medication suddenly as this is likely to make you feel worse.

Remember it can take time to find a medicine that's right for you.

Medication: advice

Ask/tell your GP

You always have the right to **voice your concerns** and ask your GP any questions that you might have. **Some useful questions to ask if you are thinking about taking medication might be:**

1. Why you are being prescribed the medication, directions of use, length of use, and importantly: how it is supposed to help you.

2. About the possible side effects you may have when starting your medication.

3. How long the medication will take to work. Most medication takes at least 2 weeks or longer to *begin* working.

4. Any other questions you have no matter how "silly" about the medication.

It will be useful to tell your doctor about all medications and supplements you're already taking. Remind them about any allergies or problems you have had with medicines in the past.

Get answers online

It is always a good idea to do your own research alongside your doctor's advice, especially if you are thinking about seeking medical treatment. For more information about making choices and managing problems related to medication, visit **Rethink's help page**:
https://www.rethink.org/diagnosis-treatment/medications

Or visit the **official NHS page** on antidepressant drugs here:
http://www.nhs.uk/conditions/antidepressant-drugs

The charity **Mind** also has great help pages:

http://www.mind.org.uk/

Your choice

In most cases it is your choice whether or not you want to accept the clinical recommendation. If you're offered medication, you usually have the right to refuse it and to ask for an alternative treatment.

Exceptions

There are some **special circumstances** where you *might* be required by law to take medication:

1. If you have been admitted to hospital under the Mental Health Act (sometimes called being sectioned).
2. If you have been discharged from hospital under certain sections of the Mental Health Act, and are being treated on a community treatment order (CTO).

If you are in a situation like this, search for information on consent to treatment for guidance on what steps you can take to challenge the decision.

Preparing for a crisis

If you are worried that you might be forced to take medication if you become very unwell in the future, while you're feeling well enough you could write a **crisis plan** or advance statement.

In a crisis plan you can explain:

- Which drugs have and haven't helped you in the past.
- What you would like to happen, or not to happen, if you become very unwell.