Psychological Disorders and Therapy

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Epidemiology

According to the WHO, one half of all the suffering due to ill-health in western Europe is due to mental illness. It accounts for as much suffering as all physical illnesses put together (WHO International Consortium in Psychiatric Epidemiology, 2000)

- Depression has now superseded stroke as the number one cause of disability (WHO, 2005)

UK Mental Health

- 1 in 4 British adults experience at least one diagnosable mental health problem in any one year, and 1 in 6 experiences this at any given time.
- Mixed anxiety & depression is the most common mental disorder in Britain, with almost 9% of people meeting criteria for diagnosis.
- Between 8-12% of the population experience depression in any year.

The Office for National Statistics Psychiatric Morbidity report, 2001

Case study

- *Michelle, a working mother of two, is in a rush to pick her kids up from school. Whilst waiting in heavy traffic she starts to feel anxious and notices her heart beating rapidly, she starts sweating and her vision becomes blurry. She thinks "I'm having a heart attack!" It becomes unbearable and she leaves the road at the nearest exit. All subsequent cardiac investigations were normal. She hasn't been back in the car since.*

Panic Attack (DSM-IV)

- Four or more of the following symptoms:
  - palpitations, pounding heart, or accelerated heart rate
  - sweating
  - trembling or shaking
  - sensations of shortness of breath or smothering
  - chest pain or discomfort
  - feeling dizzy, unsteady, lightheaded, or faint
  - feelings of unreality (derealization) or being detached from oneself (depersonalization)
  - fear of losing control or going crazy
  - fear of dying
  - paresthesias (numbness or tingling sensations)
  - chills or hot flushes
-

Panic Disorder (DSM-IV)

- A. Both (1) and (2):
- 1. recurrent unexpected **panic attacks**
- 2. at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
  - persistent concern about having additional attacks
  - worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
  - significant change in behaviour related to the attacks

Panic Disorder

- B. The presence (or absence) of agoraphobia
- C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- D. The panic attacks are not better accounted for by another mental disorder

Agoraphobia

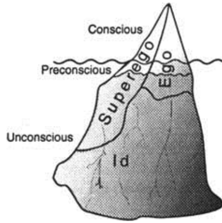
- Develops as a complication of panic attacks
- Agoraphobia may arise by the fear of having a panic attack in a setting from which there is no easy means of escape
- As a result, sufferers of agoraphobia avoid public and/or unfamiliar places, especially large, open, spaces where there are few 'places to hide' or prevent easy escape

Psychological Treatments

- Goal of all psychotherapy is to help people change maladaptive thoughts, feelings, and behavior patterns

Four major schools:
- Psychodynamic
- Behavioural
- Cognitive
- Systemic

Psychodynamic therapy



Psychodynamic Techniques

- Free Association: clients verbally report without censorship any thoughts, feelings, or images that enter their awareness
  - Provides clues about important themes and issues
- Transference: the client responds irrationally to the analyst as if she or he were an important figure from the client's life
  - Most important process in psychoanalysis?

Psychodynamic Approach to Panic

- Panic patients have particular difficulties with angry feelings and fantasies, such as wishes for revenge
- Attempt to convert an angry affect into a more affiliative one, diminishing the threat to an attachment figure
- A panic patient may feel that a therapist, unable to tolerate the patient's anger, might become judgmental or rejecting

Systemic Therapy

- Roots in postmodernism and family therapy
- Many different schools
  (e.g. Strategic, Structural, Milan, post-Milan, Social Constructionism, Solution-Focused and Narrative)
- Common idea is that symptoms are not assigned to one particular individual who is labelled 'the problem' but rather examined and understood in the context in which they have arisen
- Symptoms are seen as problems in interaction and communication between people rather than as existing within persons

'Circularity'

- The focus is not on the individual and their internal states but views distress and problems experienced as intimately bound up with relationships.

- Symptoms are seen as problems in interaction and communication between people rather than as existing within persons.

Solution Focused Therapy

- Steve de Shazer
- Person is not the problem
- Avoid 'problem' talk
- Look for resources not deficits
- Explore possible and preferred futures
- What is already contributing
- Client as expert

Solution Focused Approach to Panic

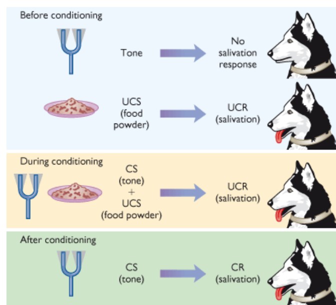
- Seek for client to generate the solution
- Use of 'miracle question':
  - *"If your panic difficulties disappeared overnight how would things be different?"*
  - *"And what would that look like?"*

Not absence of problem or vague 'happier' but concrete, observable changes

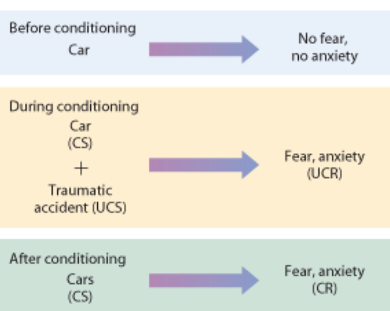
Behaviour Therapies

- Behavioural approaches believe that:
  - Maladaptive behaviours are not merely symptoms of underlying problems
    - The behaviours *are* the problem
  - Problem behaviours are learned in the same ways normal behaviours are

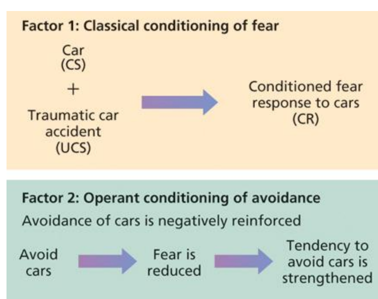
Classical Conditioning



Phobia Development



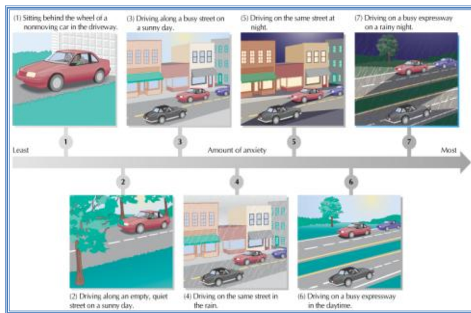
Two-factor theory of maintenance of classically conditioned associations e.g. fear



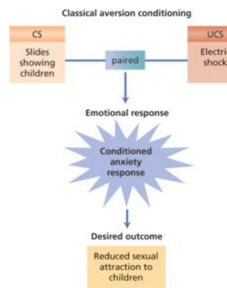
Behaviour Therapies

- Exposure Approach:
  - Treat phobias through exposure to the feared CS in the absence of the UCS
  - Response prevention is used to keep the operant avoidant response from occurring
  - Highly effective for reducing anxiety responses
  - Controversial because intense temporary anxiety is created by treatment

Systematic Desensitisation



Behaviour Therapies



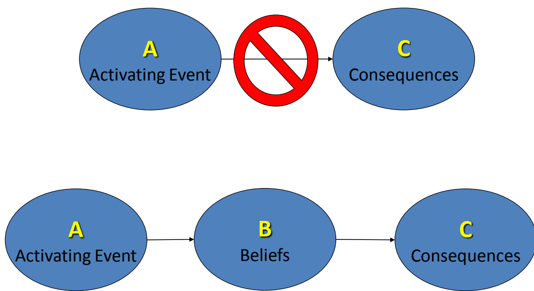
Operant Conditioning Techniques

- Therapists consistently reward desired behaviour and withhold reward for undesired behaviour.
- Commonly used by parents and teachers to change problem behaviours in children
- Often a whole environment is converted in to an operant conditioning arena, termed a **token economy**

Cognitive Therapy

- Emphasises role of attributions in understanding emotional disorders
- Originally devised for depression

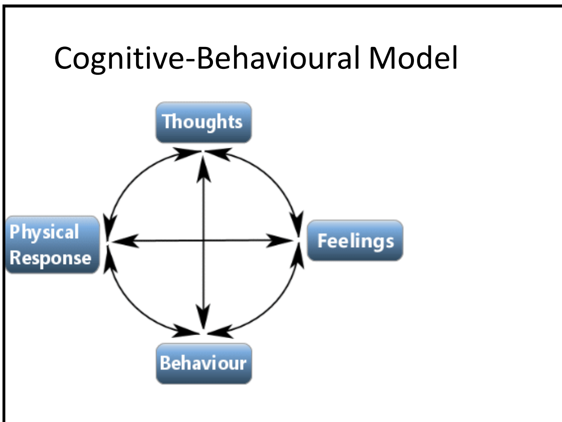
ABC MODEL



You're walking down the High Street, and someone you know walks by without acknowledging you…

THOUGHT	EMOTION
Nobody wants to talk to me, no-one likes me	Sad
Who does she think she is, ignoring me?!	Angry
Ha, she's probably hungover!	Amused
I don't want her to see me, I won't know what to say	Anxious
She obviously didn't see me	Unconcerned

Cognitive-Behavioural Model



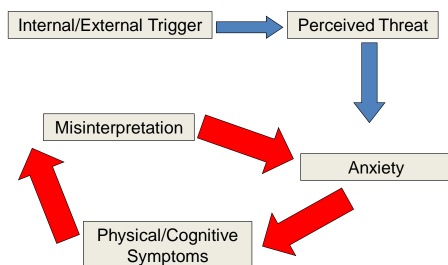
Cognitive Therapy and Panic

- Panic may only occur if bodily sensations are interpreted in a particular way
- This is the central notion behind **cognitive** models of panic

Clarke's (1986) theory of catastrophic interpretation

- Individuals with PD interpret certain bodily sensations in a catastrophic fashion
- Sensations (esp. those involved in normal anxiety responses e.g., palpitations, breathlessness, dizziness, paresthesias) are considered to be a sign of impending physical or psychological disaster
- e.g. palpitations → having heart attack

Clarke (1986)



Clarke's (1986) theory of catastrophic interpretation

- 7–28% of population will experience an occasional unexpected panic attack
- Only go on to develop PD if they develop a tendency to interpret in a catastrophic fashion
- Studies demonstrate that PD can be alleviated with cognitive techniques e.g. cognitive restructuring

Negative Thinking Traps

LABELLING: Place a fixed, global label on oneself without considering evidence that leads to a less disastrous conclusion
"I'm a loser" ; "I'm no good."

OVERGENERALIZATION: Drawing general conclusion based on single incident
"I felt nervous with others at the party; I don't think I have what it takes to make friends."

PERSONALIZATION: Inappropriately relating external events to oneself without an obvious basis for making such connections
"She didn't say hello to me because I must have done something wrong."

DICHOTOMOUS THINKING: View a situation in only two categories instead of on a continuum
"If I'm not a total success, I'm a failure"

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General Principles of Cognitive Therapy

- Emphasis on 'here-and-now'
- Goal oriented i.e. Specific and measurable
- Problem solving
- Collaborative relationship e.g. Explicit formulation
- Time-limited
- 'Scientific' approach e.g. Collecting data, testing hypotheses

Mindfulness-Based Cognitive Therapy

- Paying attention in a particular way: on purpose, in the present moment and non-judgementally.
- Fostering a 'decentred' relationship to mental contents by training clients to take a wider perspective.
- Recognising thoughts as thoughts – not 'you' and not 'reality'.

Depression (DSM-IV)

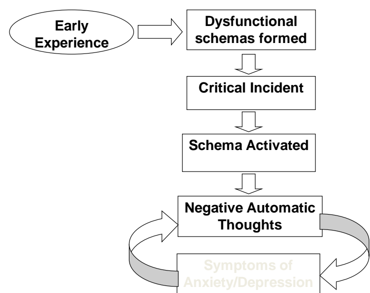
- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either
  (1) depressed mood or
  (2) loss of interest or pleasure.

- (3) Loss of appetite
- (4) Insomnia or Hypersomnia nearly every day
- (5) psychomotor agitation or retardation nearly every day
- (6) fatigue or loss of energy nearly every day
- (7) feelings of worthlessness or excessive or inappropriate guilt
- (8) diminished ability to think or concentrate
- (9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

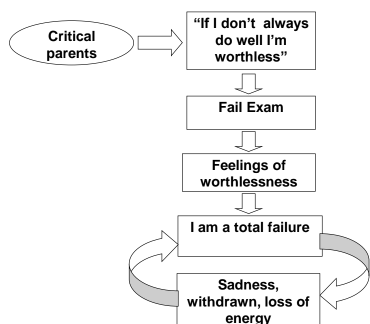
Depression (DSM-IV)

- B. The symptoms do not meet criteria for a Mixed Episode
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement,

Beck's schema theory



Beck's schema theory



Evaluating Psychotherapies

- The Specificity Question: which types of therapy administered by which kinds of therapists to which kinds of clients having which kinds of problems produce which kinds of effects?
  - Ongoing question for psychotherapy research
  - Attempts to establish an evidence base

Evaluating Psychotherapies

- Eysenck (1952):
  - Found that the rate of **spontaneous recovery** in the absence of any treatment was just as high as the success rates reported by psychotherapists
  - Called for more objective measures of clients' improvement
  - Sparked intense controversy and stimulated a great deal of research

Psychotherapy Research Methods

- Research Techniques:
  - Present multiple case studies of people who have received similar treatment
  - Survey large numbers of clients and measure their reactions to their experience
  - Randomised Controlled Trial: clients are randomly assigned to treatment or control conditions; groups are then compared on outcome measures
  - Meta-analyses

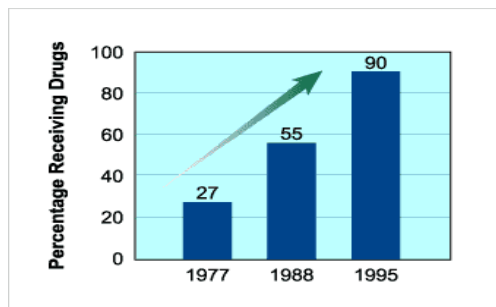
Evidence Base for CBT

	Recovery Rate
• All Anxiety Disorders	71%
• Panic disorder	75%
• Posttraumatic stress disorder	75%
• Social Phobia	76%
• Generalised anxiety disorder	69%
• Obsessive compulsive disorder	49%
• Specific Phobias	81%
• Major depressive disorder	60%

CBT vs Medication

- CBT has been shown to have significantly lower relapse rates than anti-depressant medications.
- Panic disorder: 5% vs 40%
- Social Phobia: 0% vs 33%
- OCD: 12% vs 45%
- Depression 45% vs 86%

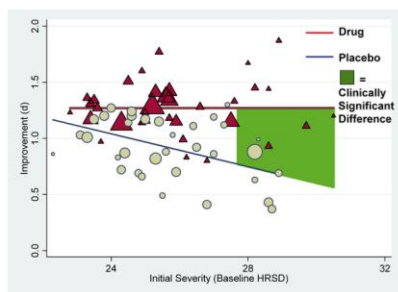
Use of Drugs in Treating Psychological Disorders



Antidepressants: Placebo?

- Kirsch et al (1998) analyzed 38 published clinical trials involving more than 3,000 depressed patients.
- Conclusion: At least 75 percent of the antidepressant effect was also produced by placebos
- Moncrieff, Wessely & Hardy (2004) Conducted systematic Cochrane review of Active placebos versus antidepressants for depression.
- They found, once blinded, efficacy of antidepressants was even smaller

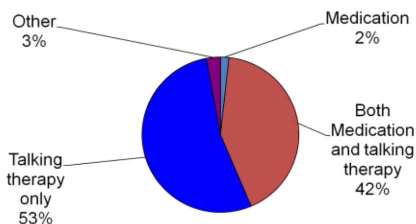
Kirsch, 2008 – FDA Unpublished data



NICE guidelines

- CBT recommended as first line treatment for:
  Depression,
  Social anxiety,
  PTSD,
  Generalised anxiety disorder,
  OCD,
  Bulimia,
  Panic disorder and specific phobia
  (see NICE at www.nice.org.uk)

"Which treatment do you prefer for your stress, anxiety or depression?"



Improving Access to Psychological Therapies (IAPT)

- NICE guidelines recommend CBT for number of disorders
- 2¾ million people will go to the GP with a mental problem in a year although only 4% of these have received therapy in the last year (Office of National Statistics)
- The resulting loss of output can be calculated as £17 billion, which includes roughly £9 billion in benefit payments (Layard, 2006)
- Estimated need for "10,000 more therapists" by 2013

iapt

Improving Access to Psychological Therapies

NHS

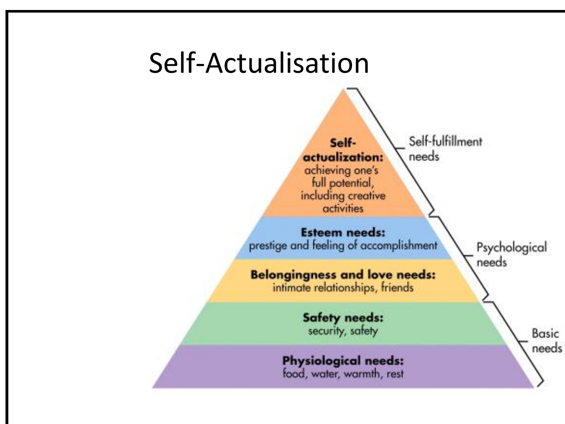
- The programme began in 2006 with demonstration sites in Doncaster and Newham focusing on improving access to psychological therapies services for adults of working age.
- By 31 March 2011:
- 142 of the 151 Primary Care Trusts in England have a service from this programme in at least part of their area and just over 50 per cent of the adult population has access
- **3,660** new cognitive behavioural therapy workers have been trained
- Over **600,000** people started treatment, over **350,000** completed it, over 120,000 moved to recovery and over 23,000 came off sick pay or benefits between October 2008 and 31 March 2011

Happiness & Positive Psychology

- “We believe that a psychology of positive human functioning will arise that achieves a scientific understanding and effective interventions to build thriving in individuals, families, and communities.”

(Seligman & Csikszentmihalyi)

Self-Actualisation



National Wellbeing Project

- David Cameron argues that gross domestic product (GDP) - the standard measure of economic activity used around the world - is no longer up to the job.
- The Office for National Statistics will lead a debate called the National Wellbeing Project which will seek to establish the key areas that matter most to people's wellbeing.

National Well Being Project

Measure Your Happiness

How happy are you? Sure, you may think you know, but this little test will help you keep score. The Satisfaction with Life Scale was devised in 1980 by University of Illinois psychologist Edward Diener, a founding father of happiness research. Since then the scale has been used by researchers around the world.

Read the following five statements. Then use a 1-to-7 scale to rate your level of agreement.

1	2	3	4	5	6	7
Not at all true			Moderately true			Absolutely true

1. In most ways my life is close to my ideal.
2. The conditions of my life are excellent.
3. I am satisfied with my life.
4. So far I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

Total score __________

Scoring: • 31 to 35: you are extremely satisfied with your life • 26 to 30: very satisfied • 21 to 25: slightly satisfied • 20 is the neutral point • 15 to 19: slightly dissatisfied • 10 to 14: dissatisfied • 5 to 9: extremely dissatisfied