Major advances have been made over the last twenty years with regard to the medical treatment and care of people with HIV (PHIV) but the disease remains an important global health issue. While the success of anti-retroviral medication suggests that HIV is under medical control this obscures the considerable challenges that people living with HIV continue to face.

We suggest that HIV also remains highly stigmatised and this issue is an important factor that increases poorer mental health, complicates the development of effective coping strategies and affects adherence to highly active anti-retroviral medication (HAART). For HIV+ parents, poorer coping may negatively affect their ability to effectively manage the psychosocial challenges of the complexity of issues to be addressed within their families. The interaction of personal characteristics which are already stigmatized (e.g. drug use, sexual orientation) and HIV disease provides a context in which the importance of the individual factors becomes blurred and stigma, for the people who possess these characteristics, is experienced at many levels.

However, it has been difficult to measure the direct impact of stigma on the HIV epidemic because stigma operates at multiple levels – the level of the individual as well as organisational and societal levels, which in turn is affected by different cultural or national settings. Much of the research on HIV stigma prevention has focused on changing negative attitudes towards people living with HIV, as well as HIV-positive adults’ perceptions of stigma and how this impacts on their psychological and physical wellbeing. Most interventions have sought to change stigmatizing attitudes through mass media campaigns, education about HIV transmission and of the introduction of anti-discriminatory laws. However, research suggests that HIV-related stigma is highly resistant to change. We suggest that many of the mental health difficulties associated with HIV are underpinned by the experience of HIV stigma. While poor coping with HIV (poor adherence to HAART, inadequate engagement with healthcare, non-disclosure of status to sexual partners) might not evidence of mental health difficulties per se, these issues may provide the context in which mental health difficulties are more likely to emerge. In any event, the experience of stigma is pervasive and negative and unless people with PHIV are able to identify the impact and effects on their own lives it might be difficult to disentangle the lived impact of stigma from other issues e.g. non-disclosure of status, poor adherence to HAART. Psychological interventions for mental health problems have tended to be individually focused and while this is not doubt beneficial for the particular individuals there is little evidence from the literature that these interventions have addressed the impact of stigma and experiences shape and perhaps create the emotional and psychological difficulties. It may well be that such issues emerge in the course of treatment between individual therapists and their clients but standard psychological interventions for depression, anxiety in PHIV etc. do not routinely recommend that stigma be addressed as a core feature of the therapeutic intervention. We consider that and exploration of the individual meanings and impact of stigma should be placed at the heart of any psychological intervention for PHIV.

We propose that the issue of HIV stigma should be more actively targeted in psychological interventions and its associations with disclosures difficulties, medication adherence and poor coping should be elaborated. Finally, in the fourth decade of HIV we need to place the supporting of good mental health firmly alongside effective medical interventions in order to ensure that PHIV have the best psychological, emotional and medical quality of life possible.
Are group psychotherapeutic treatments effective for patients with schizophrenia?

By Stavros Orfanos, Clara Banks & Stefan Priebe, Unit for Social and Community Psychiatry

Across both in-patient and out-patient settings, different psychological treatments for schizophrenia are delivered in groups. From an economic perspective, a group setting is seen as a useful approach, as it allows for are therapists to treat several people at the same time. From a clinical perspective, group treatments are also believed to offer social advantages related to this population, who tend to have smaller social networks and less satisfactory interpersonal relationships compared to a healthy population.

However, little empirical research has been conducted to explore whether group interventions for people with schizophrenia are effective across different treatments with varying therapeutic orientations. Whilst attempts have been made to summarise findings from controlled trials exploring the effectiveness of group psychotherapeutic treatments for schizophrenia, the conclusions from these studies are limited in scope. For example, evidence from non-evaluated group psychotherapy is included in this review was not included in these reviews, and findings are limited to a descriptive analysis of the literature.

This review aimed to:

1. estimate the effect of different group psychotherapeutic treatments for schizophrenia, and
2. to explore whether any overall ‘group effect’ is moderated by treatment intensity, diagnosis heterogeneity and therapeutic professional.

In other words, we attempted to establish whether there is an overall ‘group effect’ across a range of group psychotherapeutic treatments as compared to treatment-as-usual (TAU). Unlike previous efforts, this review aimed to do so by statistically pooling together the existing evidence using meta-analytical techniques. If people with schizophrenia benefit from a non-specific ‘group effect’, one would expect to see clinical improvements in participants across a range of group psychotherapeutic treatments.

A systematic search of randomised controlled trials exploring the effectiveness of group psychotherapeutic treatments for people with schizophrenia was conducted and identified 5078 studies. Reviews were assessed for potential risk of bias and were explored for a range of risk. Following the exclusion of duplicates and removal of studies at the title screening phase, 1552 abstract articles were reviewed and 204 studies identified for full publication, and 34 articles were included. Seven studies used the data from three data sets, one study included data from two separate trials, and one study had two control arms. Hence in total, 32 data sets were included in the final meta-analysis.

The primary outcome was symptom scores measured after treatment had finished (including positive, negative, general, and overall symptom scores). All findings from different studies were pooled together into one analysis (meta-analysis). We compared the overall symptom scores in participants who took part in a group psychotherapeutic treatment with those who didn’t (including those who continued with treatment-as-usual and those who took part in an active sham group instead. Findings on social functioning were described narratively and meta-regression analyses on group characteristics were carried out.

Conclusion

This review found that group psychotherapeutic treatments were more effective than treatment-as-usual (TAU) in reducing negative symptoms across a diverse range of psychotherapeutic orientations. This effect was apparent only when these group psychotherapeutic treatments were compared to TAU, not active sham groups. The narrative summary of studies indicated that overall, participants in group psychotherapeutic treatments benefited more in terms of reduced social functioning deficits in the treatment condition compared to TAU. No evidence was found for an effect of therapeutic orientation or diagnostic homogeneity. However, there was a significant positive relationship between treatment intensity and reduced negative symptoms.

This study has a number of strengths. It is the first systematic review to explore the effectiveness of psychotherapeutic treatments delivered in groups using meta-analytic techniques. We used rigorous methods and a wide array of search terms encompassing a broad range of verbal and nonverbal psychotherapeutic group treatments. Stringent measures controlled for study quality.

There are also a number of potential limitations. The majority of the sample represented were outpatients (71%) and male (64%), which may limit generalisability. Furthermore, group psychotherapeutic treatments have not been assessed against individual psychotherapeutic treatments. Without controlling for the specific factors potentially relevant to the psychotherapeutic treatment itself, it is difficult to make firm conclusions about the benefits of non-specific group effects.

Overall, evidence from this review supports the view that group mechanisms underpinning different group psychotherapeutic treatments can be clinically advantageous for people with schizophrenia in the treatment of negative symptoms, and the absence of severe errors – those causing death or severe harm – are reported to occur at the administration stage; when the medication is actually being given to the patient. This means that a large percentage of the most serious harm from medication could be reduced by taking steps to combat medication errors specifically at the administration stage. However, before strategies are put in place to combat medication administration errors, it is first necessary to gain an understanding of the exact types of errors that are happening in a particular hospital. It is vital that error-reduction strategies are based upon sound information about the errors that occur most commonly in a particular setting so that the specific problem areas in that setting can be targeted for improvement.

Pharmacological therapy has become a cornerstone of treatment for a huge number of conditions and complaints; from chronic pain to high blood pressure, and from chest infections to depression. The vast majority of people admitted to hospital will now be prescribed some form of medication during their inpatient stay. The sole purpose of using medication is to try to improve the lives of those taking it, but it can often have the opposite effect – injuring or harming people instead of helping them. The National Reporting and Learning System (NRLS) is a database of all the reports of incidents involving patients to see clinical improvements in participants across a diverse range of psychotherapeutic treatments. Stringent measures controlled for study quality.

Future research should therefore identify the underlying mechanisms for the positive effect of participating in groups and explore how they can be maximised to increase the therapeutic benefit.

Medication administration errors on mental health wards

By Alan Cottney, Clinical Pharmacist, East London NHS Foundation Trust

Pharmacological therapy has become a cornerstone of treatment for a huge number of conditions and complaints; from chronic pain to high blood pressure, and from chest infections to depression. The vast majority of people admitted to hospital will now be prescribed some form of medication during their inpatient stay. The sole purpose of using medication is to try to improve the lives of those taking it, but it can often have the opposite effect – injuring or harming people instead of helping them. The National Reporting and Learning System (NRLS) is a database of all the reports of incidents involving patients to see clinical improvements in participants across a diverse range of psychotherapeutic treatments. Stringent measures controlled for study quality.

Conclusion

The study that we conducted aimed to assess the incidence, type and clinical severity of medication administration errors. It is first necessary to gain an understanding of the exact types of errors that are happening in a particular hospital. It is vital that error-reduction strategies are based upon sound information about the errors that occur most commonly in a particular setting so that the specific problem areas in that setting can be targeted for improvement.

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Future research should therefore identify the underlying mechanisms for the positive effect of participating in groups and explore how they can be maximised to increase the therapeutic benefit.
Making decisions about whether patients and prisoners at high risk of future violence are suitable for release into the community is a difficult, and in many ways unavoidable, task. Forensic and criminal justice professionals are responsible for the detention of offenders are required to weigh many different factors relating to the individual’s history, clinical presentation, and likely environment upon release in order to reach their decisions, which will have a great impact on that individual’s freedom; and potentially also on the safety and security of society as a whole.

To make matters more complex, previous research studies have shown that ‘unstructured’ clinical decision-making is often unreliable, and can lead to incorrect evaluations of the level of risk posed by a patient. Often, therefore, professionals will make use of risk assessments and structured professional judgement (SPJ) scales such as the Clinical-Hospital-Risk-20 (CHR-20) to guide them in their decisions; yet these assessments themselves are often highly generic in their construction and do little to account for individual risk factors. Moreover, any checklist of risk-related factors truly be representative of the process of decision making in conditions of uncertainty?

These sorts of questions about risk and judgement, and how to resolve them using sophisticated modelling techniques, are what the Risk and Information Management (RIM) group in the Electronic Engineering and Computer Science department at Queen Mary University of London (QMUL) have been investigating for the last five years. In a collaboration between RIM and the Violence Prevention Research Unit (VPRU), comprising staff from the Trust and the QMUL Centre for Psychiatry lead by professor Jeremy Coid, researchers have been using a technique known as Bayesian Network. Analysis to model the factors that clinicians take into account when making decisions about offenders, and structure them in a way that provides a causal account of possible future violent offences, in the same way that a forensic professional might do.

Bayesian Network Analysis (BNAs) sounds (and looks) complicated but the technique is based on a surprisingly straightforward mathematical principle known as Bayes’ Theorem, which states that the probability of any event happening is dependent to previous events (a ‘cause’) and the likelihood of that event occurring (a ‘probability’). By using the BNAs they were able to take into account all of the factors that clinicians take into account when making decisions about offenders, and structure them in a way that provides a causal account of possible future violent offences. So far, in a previous study (Constantinou et al, 2012) researchers from RIM used BNA to examine the results of Premier League football matches during the 2011 and 2012 seasons to predict future outcomes, enabling them to ‘beat the bookies’ by offering an evidence-based decision making process for predicting the outcome of matches. You can find out more about how this system works through the project website at http://www.pi.football.com.

In thinking about decision-making for high-risk offenders, our first step was to build a Bayesian Network that reflected the factors considered by forensic professionals, and model these in a way that reflected the likely causal mechanisms for an individual reoffending. We did this through a process called ‘expert knowledge elicitation’: a decision scientist from RIM would run through various ‘risk’ scenarios with a pair of forensic clinicians, who would then provide their ‘expert’ input in developing the scenarios from very basic associations between past and previous offending, to more complex networks that considered treatment and personality as risk and or mitigating factors for change. In Figure 1, we are considering how past violent convictions – a risk factor for future offending – might be moderated by treatment for violence; whereas in Figure 2 we model the additional possibility that high levels of psychopathy might interfere with successful treatment, and also provide a causal model of violence that accounts for violence risk both before and after treatment. In this way it is possible to model complex outcomes, such as someone begins treatment but fails to complete it, or does not complete it successfully (perhaps due to the presence of psychopathy). By building several sub-networks in this way, we were able to work up into a complex system of over 100 nodes that modelled the ‘expert’ decision process more accurately than any alternative SPJ or risk assessment system.

Once our model was constructed (see Figure 3), we could use existing data on violence risk factors derived from our previous study (2011: 3.96% high-risk prisoners in England and Wales – the Prisoner Cohort Study – to populate, or ‘parameterise’ the network. This means that for each node in the network, we had a set of probabilities relating it to every other node; we could then model future cases where there was only limited information about an offender, using existing information derived from our data. So, for example, if we did not know whether an offender had a previous history of substance misuse, we could use the data to infer the probability that he or she had used drugs in the past based on their offending history, social circumstances and mental illness. This is an ability unique to Bayesian Networks, known as ‘inverse inference’: inferring information from effect to cause, as well as from cause to effect. We also used the data to validate the Bayesian model by comparing it to real-life case records in the community.

Network as a risk assessment tool for future violence, and when used in this way it outperformed all the commonly used SPJ and assessment tools in successfully predicting violent recidivism among high-risk prisoners. Yet the really exciting possibility in Bayesian Networks for violence lies in the ability to use the causal structure to identify not just if an offender is likely to reoffend violently, but what specific risk factors we should target with interventions to prevent that violent offence. With adequate data, we could even extend this model to accommodate other outcomes such as recid to hospital, self-harm, suicide or relapse.

This is the usual teaching afternoon for doctors, but all staff and not only doctors will be most welcome. The presentation day will have the usual format of very brief presentations on a wide range of research projects that are being conducted in the Trust. Thus, you will get information on 14 different projects, ranging from epidemiological studies to clinical trials and qualitative work. Places are limited and will be allocated on first come first served basis. To register, please send your name and a contact email address to Research.Officers@elft.nhs.uk

Involving Children and Young People in Research

The INVOLVE website has recently been updated with information and resources on involving children and young people in research. See http://www.involving.org.uk.

Fifth Biannual Cambridge & Bedfordshire International Conference on Mental Health

Featuring high quality talks from internationally renowned experts, the conference will cover various topics, including ADHD, Bipolar Affective disorder, Schizophrenia, Neurocognition and imaging studies of Psychiatric disorders, Immunopsychiatry, Psychiatric Disorders in war regions and Transcranial Magnetic Stimulation in Psychiatry. It will also feature student (medical and PhD) and trainees presentations from UK and Europe. The last day will include talks on humanities and psychiatry. The conference will be at Clare College, Cambridge 11-14 September, 2015 registration fee for people who do not need accommodation is £75 a day. For more information and booking, see http://www.camptcrs.com

Free Research Training Courses

Noclor are running a set of Free research training workshops this autumn. These include Good Clinical Practice (GCP), Informed Consent and some new courses including “How to be a Principal Investigator” will be announced soon so keep checking back.

For more information please follow the link: http://elft.intranet/events/royal_college_of_nursing_research_conference.asp

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Figure 1: A simple moderation model for predicting future violence

![Figure 1: A simple moderation model for predicting future violence](image)

![Figure 2: A simple moderation model for predicting future violence](image)

Figure 3: Completed network

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Cognitive therapy for Paranoid, Schizotypal and Schizoid Personality Disorders

By Dr Julia Renton, Consultant Clinical Psychologist, Head of Inpatient/EDAT Psychology (Bedfordshire and Luton)

Relatively few recognized cases of individuals with paranoid, schizotypal and schizoid personalities are seen within clinical services. The reason for this appears to be twofold. Firstly, these are not clients for whom seeking psychological therapy would be concordant with their belief systems and secondly, when they do present to mental health services, these clients may be allocated to inappropriate clinical pathways. Such individuals may be referred to psychiatry services and may be either incorrectly diagnosed or discharged with no further treatment once perceived as not meeting diagnostic criteria for schizophrenia. Although these disorders have historically been regarded as ‘unintelligible’, evidence has shown growing interest in their recognition. Several personality disorders (PD) are treatable, particularly with cognitive therapy for the emotional distress and unhelpful beliefs associated with these PDs. Clients with these diagnoses often present considerable difficulties in developing engagement within psychological therapy. They generally do not take on the conventional ‘sick role’ in which they are compliant, obedient and grateful as patients or therapy clients. As a result, conventional and collaborative therapeutic relationships are less likely to develop. Therefore, the development of cognitive therapy with such personalities must be the formation of a therapeutic alliance with the client. This process needs to continue at all the very beginning of the therapy through a development of mutual understanding of the individual’s difficulties (formulation), which should lead to establishing an initial sense of trust and collaboration.

Basic treatment goals for any of these three diagnoses are as follows:

1) Engage trust within therapy by exploring ambivalence, respecting the patient’s autonomy and emotional limits, and remaining non-defensive
2) Explore the impact and accuracy of unhelpful beliefs about others and to work collaboratively to develop more adaptive social behaviors
3) Experiment with more adaptive social behaviors and skills to support more functional beliefs and to reduce predominance of suspicion and mistrust.

Paranoid Personality Disorder

The essential diagnostic feature of Paranoid Personality Disorder (PPD) is a pervasive distrust and suspiciousness of others, often called mistrust, which is viewed by the individual as primarily influencing their behavior. This mistrust is not developed in response to a specific experience or set of circumstances but is more generalized.

Schizotypal Personality Disorder

This main feature seen in individuals with Schizotypal Personality Disorder (SPD) is a lack of, or indifference to, interpersonal relationships. Such individuals are often perceived as lacking empathy or feeling little or no concern from any contact they do have, irrespective of its type. The DSM-5 diagnostic criteria specify a longitudinal pattern of detachment from others and indifference to interpersonal relationships accompanied by considerably limited range of expected emotions, for example a lack of any real emotional or affective bonds.

Schizoid Personality Disorder

The main feature seen in individuals with Schizoid Personality Disorder (SPD) is a lack of an emotional or social bond with others. These individuals can often appear as aloof, detached, and unemotional. They may have difficulty forming close relationships and may avoid sharing personal thoughts or feelings with others.

The trustworthiness of friends (if they have any) or colleagues without justification, and scrutinize the actions of others for evidence of malice or ulterior motives, often reading hidden meanings. The World Health Organization’s ICD-10 Classification of Mental and Behavioral Disorders diagnostic guidelines for PPD are largely similar to those of DSM-5. Distinct and suspiciousness constitute the main diagnostic themes, although these characteristics are not as explicitly central to the diagnosis of PPD as in the DSM-5. Additionally, ICD-10 does consider the preoccupation with unsubstantiated ‘conspiratorial’ explanations to events, a combative and tunnel vision sense of personal rights and a tendency to experience excessive self-importance, which manifests in a persistent self-referential attitude.

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Recent Publications

Notification of the following publications has been received since circulation of the last newsletter. Don’t be shy!! Please send copies of papers or reference details to the Research Office (ResearchOffice@eastlondon.nhs.uk) so they can be included in this list and made available to interested staff.