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Introduction

This report critically examines and details the diagnosis, classification, treatments, and rehabilitation services of three mental disorders (General Anxiety Disorder, Schizophrenia, Autism) featured within the ICD-10 manual (WHO,2010).

1.0 General Anxiety Disorder (GAD)

The main characteristics of Generalized Anxiety Disorder (GAD) are excessive worry and anxiety (apprehensive expectation or anxious apprehension), persistent symptoms (more than half of the days for at least 6 months) and difficulty to control several events or activities such as work or school performance. Excessive worry and anxiety mean that their intensity, duration, or frequency are disproportionate to the actual probability or impact of the feared event (Bados, 2005).

1.2 Classification

General Anxiety Disorder (F41.1) is classified under “Neurotic, stress-related and somatoform disorders” (F40-F48) in the ICD-10 manual (WHO,2022) as a disorder in which symptoms such as nervousness, palpitations, dizziness, sweating, trembling, and muscular tensions are persistent and provoked by environmental circumstances.

1.3 Statistics of General Anxiety Disorder in the UK

According to a study conducted by The Priory Group (2022), the UK occupies the 62nd place worldwide in the incidence of GAD. Women are twice as likely to suffer from it; 1 in 5 women, as opposed to 1 in 8 men, to be precise. Despite being a highly treatable disorder, only 36.9% receive treatment (Anxiety UK, 2020).

1.4 Causes (Aetiology)

The most common areas of concern tend to refer to circumstances of daily life; Topics such as family, friends, interpersonal relationships in general, money, work, studies, housekeeping, and one's health and that of others are common. Worries can be about minor things such as chores, car repairs, or being late for a date or appointment (Roussos, 2016).

Social worries seem to have more weight in predicting the general tendency to worry than physical or financial worries. Worry can be defined as a chain of thoughts and images (especially the former) charged with negative affect, relatively uncontrollable, and towards a future danger that is perceived as uncontrollable; or in other words, continuous thoughts about the future danger that are experienced as aversive and relatively uncontrollable. This orientation toward the future is clear even when it seems that the concern refers to something

past, such as the implications of something that was said at a meeting, for example (Bados, 2005).

People with GAD worry about things that are unlikely to happen or if they do happen are much more manageable and less dramatic than they think. Patients with GAD have relatively constant worries and are usually only able to let go of one worrying topic when a new worrying topic emerges (Elide Alférez, 2012).

Other risks associated with developing GAD include a family history of psychiatric disorders, emotional or physical trauma, socioeconomic status, substance abuse or dependence, or chronic painful illnesses (NICE, 2022).

1.5 Signs and Symptoms

Anxiety and worry are associated with symptoms such as restlessness or impatience, getting tired easily, difficulty concentrating or going blank, irritability, muscle tension, and sleep disturbances (difficulty falling or staying asleep, or unsatisfactory sleep and not repairable). Although the symptoms mentioned seem the most important, other possible physical symptoms are tremors, jerks, muscle pain or numbness, cold and clammy hands, dry mouth, sweating, nausea or diarrhoea, urinary frequency, difficulty swallowing or lumps in the throat and exaggerated responses when startled (MIND, 2019).

1.6 Diagnosis

To be diagnosed with GAD it is required that three or more of the common six symptoms (one in children) are present and that some of them have been habitually present (more than half of the days) during the last 6 months. GAD requires that the worry, anxiety, or physical symptoms produce clinically significant distress or impairment in the person's social, occupational, or other important areas of functioning (Bados, 2005).

One of the steps of the assessment includes the General Anxiety Disorder Questionnaire (GAD-7). In this questionnaire, the patient should answer how often have they been bothered by any of the following symptoms in the last two weeks:

- Feelings of fear and dread.
- Persistent irritability.
- Restlessness.
- Inability to relax.
- Worrying excessively.
- Inability to stop worrying.
- Nervousness, anxiousness, or edginess.

It is also advisable to take a brief medical history to check if certain medical conditions, medications, or drugs may be responsible for the symptoms or contributing to the symptoms themselves. If two or more years have passed since the last medical check-up, it is advisable to ask the patient to let one be made to rule out possible biological causes such as iron deficiency (Roussos, 2016).

1.7 Current treatments

The treatment of anxiety will depend on many aspects: if we are facing a consolidated disorder, its frequency and intensity (Borges, 2018).

Therefore, it will be necessary to go to a mental health professional who will make a correct assessment of the case and propose the most appropriate treatment (Elide Alférez, 2012). Among these, they can be:

- Psychotherapeutic treatment: from the most pertinent psychological approach for the specific case, such as cognitive-behavioural therapy (CBT), systemic therapy, and mindfulness, among others.
- Pharmacological treatment: This must be assessed and prescribed by a psychiatrist. However, depending on the nature of the condition, benzodiazepines can be used (if it is a reactive condition and the treatment forecast is short-term – 2 or 3 weeks) or antidepressants if the treatment forecast is longer (usually a few months).
- Combined treatment: in some cases, it will be the most effective since it combines the two previous options, allowing it to influence from different action focuses.

1.8 Measurements of Rehabilitation

With the right medication, such as exposure therapy, concentration training, and several anxiety-coping strategies, you can recover and control your symptoms. You can learn techniques on your own (through books or classes, for example) or seek advice from a qualified professional. Anxiety disorders can be managed in several ways, including understanding anxiety. Knowing everything there is to know about anxiety is crucial to recovery. Examining the physiology of the body's "flight or fight" response, which is the body's way of coping with imminent risk, is an example of education. This reaction is inappropriately activated in people with anxiety disorders by normally harmless circumstances. Symptom control can be achieved through education and mindfulness techniques (Roussos, 2016).

1.9 Principles of care (NICE)

Practitioners should follow NICE (2022) quality standards of practice on treatment administration. These guidelines include:

- Considering patients' preferences regarding the course of their treatment.
- Monitoring progress and duration of symptoms, observing dose adjustments, switches, resistance, or adverse effects.
- Offer evidence-based psychological treatments.
- Awareness of suicide ideation.
- Data protection privacy and confidentiality.

1.10 Recommendations

According to the NCCIH (2020), several recommended complementary therapies might aid in treating and managing GAD. A meta-analysis of 14 studies involving 1.034 participants conducted by Bae et al. (2014) found that acupuncture is helpful and treating and reducing anxiety. Moreover, meditation therapy and mindfulness-based approaches produce significantly positive results in the reduction of anxiety, according to a systematic review and meta-analysis of 34 studies conducted by González-Valero et al. (2019).

2.0 Schizophrenia

The concept of schizophrenia has its origin in two Greek terms: schizo ("division", "split") and phrenos ("mind"). Whoever suffers from this disorder presents, in short, a mind split in two: a portion that is related to reality and another that interacts, to a greater or lesser degree, with an imaginary world (Lozano, 2002).

Schizophrenics are often delusional, have behavioural and emotional problems, and think illogically. Contact with people who do not suffer from this disease is very difficult since the influence of the imaginary world is very strong and impossible to ignore. Hallucinations, which involve a distortion of what is perceived, can be visual or sound, and patients usually have fluid conversations and interact with them as if they were present. The fear of potential attacks by family members and the feeling of a plot against the person are very common and it is the characters in the mind who warn them of these dangers (Castillero Mimenza, 2018).

2.2 Classification

Schizophrenia (F20-F29) is classified within the ICD-10 manual under schizotypal and delusional disorders (WHO,2022).

It is possible to distinguish various types of schizophrenia, among which are:

- Paranoid Schizophrenia: the most common, characterized by delusions and auditory hallucinations. The feeling of persecution is frequent, distorting irrelevant situations to turn them into ridicule or acts of contempt by people close or unknown.

- Disorganized Schizophrenia: people who are often unable to fend for themselves exhibit regressive behaviour and communicate inconsistently, easily losing the thread of a conversation.
- Catatonic Schizophrenia: characterized by motor dysfunctions, poor sleep patterns, and hyperactivity. Acts of violence are frequent, as well as the adoption of strange poses for long periods, in which they often skip meals and lose control of their bladder and bowels.

1.3 Statistics of Schizophrenia in the UK

According to Living with Schizophrenia UK (2017), The condition affects men and women alike, and 1 in 100 people suffer from the disease in the UK. Approximately 220.000 patients are treated yearly through the NHS.

Moreover, this illness represents 10% of the disease burden yet only receives 5.5% of research funding, less than 1% destined for cancer research.

2.4 Causes (Aetiology)

Schizophrenia is the result of a set of factors that predispose the patient to a greater or lesser extent to the development of the disease, although the causes for which the disease appears or does not manifest itself in certain patients are still a mystery (Chang Paredes, Ribot Reyes and Pérez Fernández, 2018).

According to MIND (2022), schizophrenia could develop from a range of causes, of which the onset is still unknown. Researchers point out a combination of personal, genetic, and environmental factors which may include:

- Trauma: stressful events may trigger the condition, such as abuse, bereavement and homelessness.
- Drug and alcohol misuse/ abuse: drugs may not directly cause the condition, but they may trigger it if dormant or worsen existing symptoms. They may also interfere with treatment efficacy.
- Genetic inheritance: having a history of schizophrenia in the family may increase the possibility by 40% if both parents have the condition as opposed to a 1% chance of developing it if both parents do not (Edwards et al., 2016).
- Brain chemistry alterations: studies carried out on the subject point out that there is a risk of developing the condition if brain development was disrupted during pregnancy or childhood (Living with Schizophrenia UK, 2017). Chemicals like dopamine also behave differently in the brain of schizophrenics. The chemical imbalances involving

neurotransmitters (serotonin and dopamine) may be one of the culprits of the development of schizophrenia (Lozano, 2002).

Schizophrenia is not related to situations of low schooling or childhood traumas, and there are no culprits for its appearance (Castillero Mimenza, 2018).

2.5 Signs/Symptoms

This disorder occurs more often in men than in women, usually beginning in adolescence or early adulthood; It should be noted that it is rare in childhood. The symptoms vary according to the stages of the disease, so at the beginning, there is irritability, tension, difficulty concentrating and sleeping (American Psychiatric Association, 2013).

Frequent signs are isolation from external reality and failure to coordinate internal impulses. There may be an abnormality in psychomotor activity (rocking when walking, peculiar motor responses or immobility). The patient often appears perplexed, eccentrically dressed, attired, and dishevelled. Scarcity of speech is common, and there is often ritualistic behaviour associated with magical thinking. The patient may be depressed and exhibit anxiety, anger, or a combination of both. Hypochondriacal ideas of reference and preoccupations may exist. Rarely during a period of arousal may a patient be confused or disoriented, but usually, there is no significant alteration in the level of consciousness (Lozano, 2002). In later stages, a person may have other signs or symptoms such as hearing or seeing things that do not exist, isolation, distraction, delusions, and expressing themselves without meaning, among others (Living With Schizophrenia UK, 2017).

2.6 Diagnosis

Psychosis, distortion of reality in the form of delusions and hallucinations are often the first manifestation of schizophrenia, but also other psychiatric illnesses. What allows an adequate diagnosis is the evolution of the patient, after the psychotic episode (Royal College of Psychiatrists, 2019)

If symptoms of schizophrenia are persistent for over a month, a GP should refer the patient to a psychiatrist for a full mental health assessment (Mental Health Foundation, 2017).

Published studies indicate that two years after the first psychotic episode, 20% of patients change the diagnosis of schizophrenia to that of another psychiatric disorder. Bipolar disorder, schizoaffective disorder, and psychoses, derived from the consumption of toxic substances, are the most frequent diagnoses once schizophrenia has been ruled out (Chang Paredes, Ribot Reyes and Pérez Fernández, 2018).

2.7 Current Treatments

While there is no known cure for schizophrenia, most people find that treatment allows them to manage the condition over time (MIND,2022). The types of treatment available are:

- Talking therapies: such as cognitive behavioural therapy (CBT) which helps identify and modify negative aspects of the condition.
- Medication: particularly antipsychotics. These drugs help to reduce and control psychotic symptoms such as hallucinations and delusions, anxiety and mania.
- Family intervention: these can be therapy sessions that help family members to deal with the condition and plan for a crisis.

It is recommended that treatment should not be interrupted even if symptoms get better, as the relapse and withdrawal might exacerbate the condition. Family members should be aware of signs that mark a relapse and should seek medical help immediately to lessen the severity of relapse and prevent rehospitalizations. It is also important to start treatment with antipsychotic medications within five years after the first episode because this is when most of the brain changes related to the illness occur (Castillero Mimenza, 2018).

2.8 Measurements of Rehabilitation

This disease is treatable with pharmacotherapy that aims to balance brain chemicals and thus help control symptoms; it is also possible to receive psychosocial support.

In most cases, symptoms improve with treatment; It is important to point out that people with this disorder have a higher risk of developing diabetes compared to the general population due to lifestyle and weight gain that can be generated by administered medications (NICE, 2022).

It is important to note that although schizophrenia is a chronic condition, it is possible to improve the patient's quality of life. Psychotherapy and the provision of certain drugs are part of the medical recommendations to treat schizophrenic symptoms and achieve the highest possible degree of social integration. It is essential to keep these people connected to reality through constant stimuli, which is very difficult, given the absorbing nature of their imaginary world and its manipulative characters (Lozano, 2002).

2.9 Guidance and principles of care (NICE)

According to NICE (2020) standards, adults diagnose are to start treatment within the first 2 weeks of referral. Early intervention is paramount for reducing the risk and duration of

untreated psychosis. Treatment offered should be evidence-based, including psychological, pharmacological, social, occupational, and educational interventions.

According to the Human Rights Act 1998, inhuman and degrading treatment of patients is prohibited. Patients have the right to liberty and security, and they shall not be deprived of these unless they pose a threat to themselves or others. Moreover, the persistence of the disorder must justify continuous detention (Leung, 2002).

2.10 Recommendations

Schizophrenics are 6 to 7 times more likely to be unemployed due to the social stigmatization of the disease, and this hurts their mental and physical health. Supported employment schemes should be offered to patients that wish to work and service providers (GP, Health and Social Care practitioners) must ensure that they are aware of local referral pathways to said schemes (NICE, 2022).

People with mental disorders represent a group to which a certain social rejection is directed, so they have been linked to a process of stigmatization, as well as to negative behaviours and prejudices. The most common stereotypes regarding mental illness are dangerousness, violence, unpredictability and character weakness, responsibility for the illness and incompetence in self-care. This stigmatization of people with a mental disorder has a negative influence on finding a job, housing, or maintaining social relationships with friends or a partner. On the other hand, these consequences lead to a worsening of their situation and lead to social maladjustment, low self-esteem, depression, and an increased family burden. This situation makes it difficult and sometimes prevents real reintegration into the community, which does not facilitate the main objective of psychosocial rehabilitation. The social stigma that persists in our environment together with the misconceptions about schizophrenia is a reality that prevents adequate social reintegration in this type of patient. Strategies that modify the false concepts that persist about this mental condition are needed in our society (Chang Paredes, Ribot Reyes and Pérez Fernández, 2018).

3.0 Autism

Autism Spectrum Disorder (ASD) is considered a condition that persists throughout life and can range from mild personality changes to serious disability. It is characterized by social behaviour changes, verbal and non-verbal deficits and activity limitations. It affects cognitive, emotional, and social abilities (Vázquez-Villagrán et al., 2017).

Asperger's syndrome is often thought of as a kind of "high-functioning" autism. High-functioning autism generally means that a person's language skills and development are considered "normal" according to neurotypical standards. (Psicología Ya, 2021).

3.2 Classification

Autism is classified under Disorders of psychological development (F80-F89) within the ICD-10 manual (2010).

There are 5 main types of autism; people who suffer from it can be located at any point on the spectrum:

- Autism.
- Rett syndrome.
- Asperger syndrome.
- Disintegrated childhood disorder or Heller syndrome.
- Pervasive developmental disorder not otherwise specified.

3.3 Statistics of Autism in the UK

According to the National Autistic Society (2022), 1 in 100 people are on the autistic spectrum and approximately 700.000 autistic children and adults in the UK. There are 15 times more men and boys than women and girls. Women are more likely to get late diagnoses or be misdiagnosed with anxiety since there are gender stereotypes that prevent taking into account that women and girls are socialised differently and are often better at mirroring or masking emotions than their male counterparts.

3.4 Causes (Aetiology)

Autism has a genetic cause, although these factors are not enough to explain the problem by themselves, at the same time, hereditary transmission involves a cognitive abnormality that can induce autism but cannot be limited exclusively to this condition (Lozano, 2002).

The origin of autism is unknown and the heterogeneous presentation of the difficulties that it entails makes it difficult to define whether it is a disorder, a disease, or a condition. Some medical illnesses are associated, in addition to organic problems of various kinds, with autism on occasions and certain neurological syndromes that also present autism among their symptoms (National Autistic Society, 2018).

3.5 Signs/Symptoms

People with autistic disorder have a wide range of symptoms in their behaviour, which includes hyperactivity, very short attention spans, impulsiveness, aggressiveness, self-injurious behaviours, and tantrums. There may be strange responses to sensory stimuli. For example, high pain thresholds, hypersensitivity to sounds or being touched, overreactions to lights and smells, and fascination with certain stimuli (Montagud Rubio, 2020).

Autism signs are predominantly behavioural and cognitive with different degrees of severity. Characteristics include impairment in communication abilities, breakdown in social interactions, behaving repetitively, restrictively, stereotypically, and disinterest in varied activities, further signs can be impaired adaptive abilities, sensory disorders, aggressive behaviour and self-harm (Vázquez-Villagrán et al., 2017).

At about 12 months after birth, signs that relate to this condition become visible. The child may also avoid eye contact, not respond when called and be generally more focused on objects than people (Crowe and Salt, 2014).

3.6 Diagnosis

To get diagnosed, the first step is to talk to either a GP, health professional or approach a special educational needs coordinator (SENCO) within the child's school (NHS, 2019).

The diagnostic process must be carried out based on the collection of information on the child's developmental history. Teachers, parents, and important people in the child's life are interviewed. Information will be collected on neurobiological development, evolutionary milestones, communicative behaviour, social, and motor skills, and the primary signs of the first autistic symptoms. Data will be collected on the child's environment, their relationship manner, patterns of behaviour and interaction with children of the same age and adults, degree of participation in structured group activities, day-care adaptation, and early childhood education (Vázquez-Villagrán et al., 2017).

3.7 Current Treatments

To carry out management treatment, the participation of a multidisciplinary team that includes specialists with knowledge about the diagnosis and treatment of autism spectrum disorders, family members, teachers and people who maintain direct contact with the child and who generate some influence through their interactions (Vázquez-Villagrán et al., 2017).

Drugs are not to be prescribed to treat the core symptoms of autism, as they have been proven to be ineffective and potentially harmful (Montagud Rubio, 2020).

3.8 Measurements of Rehabilitation

There is no "cure" for Autistic Spectrum Disorders; it requires understanding and support. Many people will benefit from the support that helps them live in a world designed for people without autism (National Autistic Society, 2018).

In general, the prognosis of patients is variable and will depend on the early care that is offered to them and the seriousness of the underlying aetiologies. The best prognosis belongs to those

patients who have access to different treatments, and with environmental conditions and family members that favour their development (Vázquez-Villagrán et al., 2017).

There are a wide variety of therapies and interventions available that are proven to be helpful and improve the quality of life and well being of autistic people (National Autistic Society, 2018). Programmes such as Applied Behaviour Analysis (ABA), that is aimed at improving speech, communication, and problematic behaviours; or Sensory and Motor/Physical Interventions, that help with motor coordination and improve sensory balance and functioning.

3.9 Guidance and principles of care (NICE)

According to NICE (2021) guidelines, practitioners working with autistic patients should work in close contact with the patients, their families, or carers, while taking time to build a supportive, trusting, non-judgemental and empathic relationship.

Safeguarding vulnerable patients is paramount to adhere to quality standards while observing the Human Rights Act 1998 parameters (Leung, 2002).

3.10 Recommendations

The factors that are associated with a better prognosis are the development of communicative language prior to the age of six, the presence of mild mental retardation or none in non-verbal intelligence tests, and the earliest and most intensive psychotherapeutic intervention possible. Cooperation between specialists such as psychiatrists, neurologists, neuroscientists, speech therapists, psychologists, occupational therapists, and educators is paramount for the promotion and understanding of the condition and allowing a more appropriate approach to patients (Vázquez-Villagrán et al., 2017).

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Appendix A:

Generalised Anxiety Disorder Questionnaire GAD –7.

generalised anxiety disorder (GAD).^[1,2]

Generalised Anxiety Disorder Questionnaire (GAD-7)	
Over the last 2 weeks, how often have you been bothered by any of the following problems?	
Feeling nervous, anxious or on edge?	Not at all Several days More than half the days Nearly every day
Not being able to stop or control worrying?	Not at all Several days More than half the days Nearly every day
Worrying too much about different things?	Not at all Several days More than half the days Nearly every day
Trouble relaxing?	Not at all Several days More than half the days Nearly every day
Being so restless that it is hard to sit still?	Not at all Several days More than half the days Nearly every day
Becoming easily annoyed or irritable?	Not at all Several days More than half the days Nearly every day
Feeling afraid as if something awful might happen?	Not at all Several days More than half the days Nearly every day
Total= /21	