Clinical and Forensic Psychology

Assignment: Case study

**Bertie**

**Background**

Bertie (aged nineteen) has a dual heritage, his birth mother is White British and his birth father is believed to be Black African.

1. Ethnicity violent offending, and vulnerability to **schizophrenia** (handout)
2. Most common age of onset for **schizophrenia** are young adults (find)

 Bertie’s birth mother had a diagnosis of **Bipolar Affective Disorder**.

 She was known to have abused alcohol

1. Risk factors in developing early drug or **alcohol misuse**:

Parents who abuse drugs or alcohol

Genetic vulnerability(Hasin &Katz, 2010)

Children who have negative role models

Parents who are preoccupied and less aware of what their children are doing

Families under stress

Stressful early childhood experiences/trauma histories

Children of alcoholics move from initial use to onset of alcoholic disorder (Hussong et al, 2008)

1. Being on the Scale of **FASD** can increase the risk of developing **psychotic disorders (3)**
2. **Reactive Attachment Disorder can be misdiagnosed as ADHD; also it can cause developmental problems**
3. Alcohol is depressant

and to have partners who were violent towards her.

mother has violent background

When Bertie’s mother was unwell he stayed with various family friends and relatives.

1. **Reactive Attachment Disorder**

When Bertie was two and a half he was accommodated with foster carers. His records state that on entry to care he was developmentally delayed in some areas.

1. **Could be due to above highlighted issues**

However he made significant progress and is described as “bright”. Bertie had two different foster families before being placed for adoption with Mr and Mrs Smith. During his childhood Bertie’s behaviour caused concern. Bertie was described as “always on the go” and prone to aggressive outbursts and temper tantrums.

1. **ADHD, bipolar/unipolar disorder?, personality disorder**

He was diagnosed with **Attention Deficit Hyperactivity Disorder** when he was eight. Bertie was excluded from school aged fourteen.

His relationship with his adoptive parents became increasingly fraught and after an incident where Bertie hit his adoptive mother he went to live in a young people’s hostel aged seventeen.

Bertie engaged well with mental health services and he attended an ‘emotional regulation’ group. Over the years Bertie has tried various medications for ADHD but they have had limited impact on his behaviour.

**Might not have ADHD as medication had a limited impact**

**ADHD can be misdiagnosed as Foetal Alcohol Spectrum Disorder (FASD) or autism**

Since he turned eighteen Bertie has been living alone in a bed-sit. He does not have a job. Bertie already has a criminal record for common assault and theft of a vehicle and driving without a licence.

**Presenting difficulties**

Last week Bertie was arrested after he seriously **assaulted** a stranger in a pub. Bertie’s account is that he has been **feeling very low in mood** and he had gone out for a **drink** to cheer himself up.

**Aggression due to alcohol misuse >comorbidity with psychological disorders**

**Self medicating (alcohol)**

**Low mood: Unipolar or Bipolar disorder, major depressive disorder**

He said the stranger had been “looking at me funny” and as he walked past Bertie he had “got too close”.

Fear of proximity: **ADHD affects relationships**, phobia, depression, relationship problems and/or **Reactive Attachment Disorder** + his mother has relationship problems as well

Bertie had felt a strong urge to punch the man. Once he started to Bertie had found himself unable to stop. He said “something in my head told me to do it”.

**Hearing voices: bipolar disorder, schizophrenia**

He has been clear in saying that he thinks the incident was not his fault.

**Externalising his behaviour: result of hyperactive behavior (ADHD) or conduct problems Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD) >genetic link with the father**

**Some common genetic factors have been identified as putting children at higher risk for all three disorders**

**Black youth have higher rates of conduct disorder diagnoses**

**Also as a child might be abused PTSD**

At his initial mental health assessment Bertie disclosed that he has been having great difficulty sleeping.

**Depression, Bipolar disorder, Anxiety disorders, ADHD**

He is prone to nightmares

**Nightmares: anxiety, depression, PTSD, some medications cause nightmares**

and to recurring, negative thoughts. He denies any current suicidal ideation but his records indicate that he has previously taken an overdose. Bertie describes his adoptive parents as “stupid” and says he does not want to see them.

**Negative thought can contribute to low (negative) mood, which in turn cause negative thinking**

**Negative thinking increase suicidal thinking**

**Negatively about yourself and your surroundings: anxiety, depression, personality disorder, schizophrenia, uni/bipolar disorder (contribute to depression/mania)**

**Denies suicidal ideation > he is refusing to be ill**

**NHS: suicide: most commonly depression or an alcohol problem + could be schizophrenia**

 When asked about his early history Bertie says he cannot remember any details.

**Suppression of memories could be due to PTSD**

 Bertie’s account of his previous criminal records is that he has been blamed for things he had not done.

**Again he is externalising his behaviour**

Bertie presents as a charming young man and willing to engage.

**See my dissertation material about client> open to treatment, alliance etc... it contributes to the effectiveness of the therapy**

First lower level disorders need to be checked

Vulnerability to suicide

Many experts believe a number of things determine how vulnerable a person is to suicidal thinking and behaviour. These include:

* life history – for example, having a **traumatic experience during childhood**, a history of sexual or physical abuse, or **a history of parental neglect**
* **mental health** – for example, developing a serious mental health condition, such as schizophrenia
* **lifestyle** – for example, if you misuse drugs or **misuse alcohol**
* employment – such as poor job security, low levels of job satisfaction or being **unemployed**
* **relationships – being socially isolated**, being a victim of bullying or having few close relationships
* **genetics and family history**

[**http://www.nhs.uk/Conditions/Suicide/Pages/Causes.aspx**](http://www.nhs.uk/Conditions/Suicide/Pages/Causes.aspx)

+impulsivity is associated with ADHD, Bipolar Disorder..

The estimated average age for the onset of bipolar disorder is during the early 20s

**Fact:** Some people alternate between extreme episodes of mania and depression, but most are depressed more often than they are manic. Mania may also be so mild that it goes unrecognized. People with bipolar disorder can also go for long stretches without symptoms.

People experiencing a manic episode often talk a mile a minute, sleep very little, and are hyperactive. They may also feel like they’re all-powerful, invincible, or destined for greatness.

They may also become angry, irritable, and aggressive—picking fights, lashing out when others don’t go along with their plans, and blaming anyone who criticizes their behavior. Some people even become delusional or start hearing voices.

<http://www.nhs.uk/Livewell/Blackhealth/Pages/Mentalhealth.aspx>

But people from African and African Caribbean communities, including those of white and black mixed ethnicity, can face additional problems that may affect their mental health.

Everyday life has a big impact on mental health, and black communities in the UK are still more likely than others to experience problems such as bad housing, unemployment, stress and racism, all of which can make people ill.