Mental Disorders: Their Typology, Characteristics and the Academic Context

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Until very recently, the subject of mental disorders, or more commonly, mental illnesses has been treated as a kind of taboo, a concept associated with “something incomprehensible”, “dangerous” or “politically incorrect”, which, at the same time, was undeniably linked with low social awareness. The development of medicine, both in the field of pharmacotherapy and psychotherapy (i.e. non-biological method of treatment) as well as public campaigns, such as “Schizophrenia – Open the Doors” (the programme implemented across the world since 1996 by the World Psychiatric Association (WPA) and coordinated in Poland by the Polish Psychological Association) or the Forum Against Depression (www.forumprzeciwdepresji.pl) have been slowly working towards the change of this approach. Undeniably, each initiative aiming to disseminate reliable and up-to-date scientific information on mental disorders and options of treatment will contribute to the recovery of the persons experiencing them as well as the members of their families and communities around them.

Before providing fundamental information on various mental health problems, let us focus on the term of a “mental illness”. It must be remembered that, because of the stigmatizing nature of this expression, the one recommended to be used in psychiatry is a “mental disorder”[1]. A “mental illness” is the term used to refer to a psychosis – a disorder in which symptoms are different from the way reality is experienced by healthy individuals in a qualitative (not just quantitative) way, one in which patients are not aware of their illness and the oddity of their way of thinking and perception, i.e. the conviction that other people control their thoughts. Various short-term disturbances of mental functioning, which may be unpleasant but do not disturb everyday life to a significant extent, may be experienced by anyone (e.g. anxiety about the future or uncertainty whether you have locked the door). For persons with mental health problems, similar symptoms persist much longer and are more severe, which has a negative effect on their everyday life and the subjective feeling of tiresomeness (e.g. the fear about the future preventing decision-making,

repeated, compulsive checking whether the door has been locked). This kind of discomfort often motivates people experiencing such problems to seek medical or psychological help, although sometimes this occurs on the initiative of third persons (e.g. concerned family members). Thus, it is important to confirm that the symptoms are clinically significant, i.e. confirm that a given psychological phenomenon is abnormal and its diagnosis is useful in the clinical procedure applied to the person experiencing it[2]. What is more, mental disorders may differ as regards their course: they may be progressive, chronic, relapsing or short-term, remitting and occur not "alone" but accompanied by other illnesses (the so-called comorbidity, e.g. neurosis and a personality disorder, a personality disorder and addiction to psychoactive substances).

The obvious question that arises here is the one about the incidence of mental disorders, i.e. how many people do they affect? Explicit determination of the prevalence of mental health problems is not possible, for one because of the complex methodology applied in epidemiology studies[3]. In 1997 the World Health Organisation (WHO) established the International Consortium in Psychiatric Epidemiology (ICPE) with an aim to coordinate epidemiological studies and analyse the data thus obtained. The Consortium coordinated, among others, the World Mental Health 2000, a study conducted in over 20 countries which confirmed that mental disorders were chronic illnesses of the biggest prevalence in the population, most commonly affecting people in early adulthood (20-25 years of age)[4].

Other data indicates that in Europe, in 2004, almost one third of adults (27%) experienced mental health difficulties. Most often, these were anxiety disorders and depression. It is also forecast that by 2020 depression will become the most common mental disorder[5]. A CBOS study from 2008 confirmed that in Poland, in 2006, there were 1.5 patients receiving treatment at psychiatric centres (about 4% of the population)[6]. It should be noted that this number is an underestimation as it does not include the patients who did not use health care services in the period included in the abovementioned study. Regardless of the absence of "explicit quantitative data", it may be stated that mental health difficulties are more prevalent than is commonly believed and just because of this reason it is good to have some fundamental knowledge about them.

Currently, there are two classifications of mental disorders applied in psychiatry: ICD-10 developed by WHO (which is used, among others, in Poland, and includes other illnesses, too) and DSM-IV-TR developed by the American Psychiatric

Association (APA). Both will soon be updated (on the basis of studies and discussions among teams of expert).

Prepared for the needs of medical statistics, the picture of mental disorders they reveal might be simplified to some extent, yet they are undeniably helpful in sorting out what we know about the fundamental characteristics of individual diagnoses (although, of course, they cannot serve as psychiatric guidebooks).

This is why the fundamental characteristics of various mental disorders presented below are based on ICD-10. This classification distinguishes the following groups of mental health disorders[7]:

- **Organic, including symptomatic mental disorders.** These include, among others, dementia in Alzheimer's disease, vascular dementia, delirium not induced by alcohol and other psychoactive substances and an organic mood disorder. The background of these disorders is somatic and physical, they occur due to a brain disease or brain damage.

- **Mental and behavioural disorders due to psychoactive substance use**, including those due to the use of alcohol, drugs, sedatives and hypnotics.

- **Schizophrenia, schizotypal and delusional disorders**. This group of disorders is characterised by specific disturbances related to emotions, cognition and perception. The areas affected here are the feeling of one's own identity, the ability to manage oneself and relations with others. The so-called positive symptoms might also appear, which include hallucinations (delusions), i.e. perception (visual, auditory, olfactory, tactile and gustatory) of non-existent items, auditory stimuli, etc., as to which the patient is convinced they are real, or delusions, i.e. false convictions and attitudes about reality, impervious to counterarguments, e.g. the patient thinks he or she is observed or controlled by some alien forces. The course of these disorders may vary and although the typical (or stereotypical) association is that they are "incurable", chronic and destructive, a large group of patients go back to full or almost full health.

- **Mood (affective) disorders**. This group includes, among others, the following diagnoses: manic episode, bipolar affective disorder, depressive

episode, recurrent depressive disorder. What is primarily disturbed in this kind of disorders is the emotional balance of patients. Usually, it manifests itself as depression (with comorbid anxiety or without it), i.e. very severe lowering of the mood, unjustified in real terms, feeling of hopelessness about oneself, the world and the future, the loss of interests, the fall of the energy and activity level. Depression thus defined should be distinguished from the common understanding of “depression” as sadness. Mania, on the other hand, is related to an elevated mood, increase of physical and mental activity that may reveal itself as no inhibitions in contacts with others (exceeding social norms), a reduced need of sleep and conviction about one’s unlimited abilities. The absence of criticism may lead to dangerous behaviour, e.g. related to demonstrating such unlimited abilities or making risky life decisions. In bipolar affective disorder usually longer periods of depression are intertwined with shorter periods of mania of various frequency. The disorders described here may or may not be accompanied by psychotic symptoms (e.g. delusions of sinfulness or auditory hallucinations taking the form of accusing voices). In mild affective disorders, attention and ability to concentrate may be affected, but with no significant impact on the performance of everyday activities.

- **Neurotic, stress-related and somatoform disorders**. This is a large group of disorders, which includes phobic anxiety disorders (e.g. agoraphobia, social phobias), a panic disorder (with severe somatic sensations, e.g. chest pains, dyspnoea, vertigo, the secondary fear of death or the loss of control), a generalised anxiety disorder (the major characteristics here is free-floating anxiety), depressive disorder and mixed anxiety disorder (obsessive-compulsive disorder with recurrent obsessional thoughts, the so-called obsessions, and/or compulsive acts, the so-called obsessional rituals. A patient with a compulsive-obsessive disorder may, e.g. in fear of hurting someone, feel the compulsion of washing hands for many hours), reaction to severe stress, a post-traumatic syndrome disorder (PTSD), adjustment disorders (e.g. related to a serious change of living conditions or cultural context, like, for example, going abroad on a scholarship or after a divorce), dissociative disorders (e.g. memory loss without organic background, the so-called dissociative amnesia), somatoform disorders (e.g. a hypochondriac disorder – a conviction of having a “badly diagnosed” somatic disorder or a somatoform dysfunction whose fundamental characteristic includes repeated, persistent and often changing complaints about somatic

dysfunctions – of course, patients do feel, e.g., a chest pain, although its background is psychological not biological.)

- **Behavioural syndromes associated with physiological disturbances and physical factors.** This group includes eating disorders, nonorganic sleep disorders, sexual dysfunctions not caused by an organic disorder or disease, abuse of non-dependence producing substances (e.g. antidepressants, laxatives or vitamins). Eating disorders, such as anorexia nervosa (sitophobia), bulimia nervosa (sitomania), overeating or vomiting associated with other psychological disturbances (e.g. mourning), are linked with a specific attitude to food and odd behaviour related to eating. In anorexia, drastic limitation of the amount of food consumed leads to a significant weight loss and, as a consequence, to hormonal disturbances (amenorrhea and the loss of the sexual drive in men) and extreme exhaustion leading to death when no treatment is provided (also at the somatic level, including controlled feeding). Bulimia, which includes episodes of binge eating and vomiting, is equally dangerous as it may lead to electrolyte disturbances and such complications as heart rhythm disturbances. So is the use of laxatives or diuretics and/or intense physical exercise aiming to control body mass. Patients with bulimia often experience symptoms of depression, including the feeling of shame and revulsion towards themselves. In both disorders described, the body image is disturbed as patients (usually women) see themselves as fat and unattractive.

- **Disorders of adult personality and behaviour.** This large group of disorders includes the so-called specific personality disorders (e.g. dependent personality which has an increased tendency to withdraw and transfer responsibility for his or her own decisions upon others, the fear of the inability to take care of oneself or the emotionally unstable personality with a tendency to impulsiveness regardless of the consequences and emotional instability), mixed personality disorders, habit and impulse disorders (e.g. pathological gambling, pathological stealing), gender identity disorders and disorders of sexual preference. The most common are personality disorders, which share one fundamental quality – the general way of behaviour and perception of oneself and others, usually developed during adolescence, which causes problems with functioning on a number of platforms, primarily in relationships.

- **Mental retardation**[8] – a condition related to the inhibition or incomplete development of the brain and, as a result, a lower level of cognitive ("intelligence"), social as well as mobile abilities and speech. Mental retardation may be accompanied by other mental and/or physical disorders. ICD -10 distinguishes four degrees of mental retardation: mild, moderate, severe and profound.

- **Disorders of psychological development** – in this group ICD-10 includes specific developmental disorders of speech and language, scholastic skills, motor function, pervasive developmental disorders (e.g. autism).

- **Behavioural and emotional disorders with onset usually occurring in childhood and adolescence**, including a hyperkinetic disorder, conduct disorder (e.g. oppositional defiant disorder), mixed disorders of conduct and emotions, emotional disorders with onset specific to childhood (e.g. separation anxiety disorder of childhood, sibling rivalry disorder occurring after the birth of a younger sibling, related to the struggle to get the parents'/guardian's attention), disorders of social functioning with onset specific to childhood and adolescence (e.g. elective mutism – when the child speaks only in some situations and remains silent in others), tic disorders, "other disorders", e.g. nonorganic enuresis.

- **Unspecified mental disorder** – this is an additional category applied when it is not possible to qualify the patient's conditions to any other, more precise category.

It should also be remembered that mental and behavioural disorders (e.g. irritability) may accompany other (numerous) illnesses, e.g. some infectious diseases (such as the flu or AIDS), parasite infections, tumours, hormonal disturbances (e.g. hypothyroidism), nervous system diseases (meningitis, Parkinson's disease, Alzheimer's disease, multiple sclerosis, migraine), cardiovascular system diseases (e.g. cerebrovascular diseases), gastrointestinal tract diseases (e.g. the irritable bowel syndrome) or diseases of the skin and subcutaneous tissue (e.g. atopic dermatitis) [9]. The relationship between the mental and physical condition is a separate field of study combining science and clinical practice, i.e. psychosomatic medicine, as well as clinical psychology of somatic illnesses.

In the population of university students – young adults – the most common mental disorders are, above all, neurotic disorders and stress-related disorders (primarily

adjustment disorders as, e.g., in the case of persons starting education in a new environment) and personality disorders as well as eating disorders. Less common are affective disorders and schizophrenia, schizotypal disorders and hallucinations. Each of them may have an impact on the process of studying in terms of learning as well as participation in social situations related to studying in a variety of ways.

First of all, each disorder, mental or physical, is related to a certain level of concentration on oneself and one's symptoms, either by getting involved in the drug spiral related to the symptoms of neurotic disorders, concentration on how you are assessed by others in personality disorders, striving for perfection in anorexia, concealing the "off-putting" symptoms in bulimia, the inability to find yourself in adjustment disorders, misery in mood disorders or a conviction about being a victim of a plot in delusional disorders. The abovementioned disorders may have a negative impact on the ability to concentrate and remember information as well as the readiness to participate in university classes or take exams (e.g. because of fear related to a grade, embarrassment, possible appearance of burdensome symptoms, a conviction about the hostility of others, the feeling that "it makes no sense anyway"). The fear of failure or making excessive demands on oneself (as in, e.g., a narcissistic personality disorder) or the fear of taking responsibility for oneself (as in a dependent personality disorder) may be related to the inability to meet the deadline for a semester paper or MA thesis.

Of course, it is not possible to establish unambiguously the cause and effect relationship that would provide an adequate, "universal" picture and the background of each disorder – it is only possible as part of a personalised diagnosis, updated on a daily basis, offered as part of psychotherapy of one specific person by a therapist in psychopathology and psychotherapy.

Nevertheless, the impact of the environment (e.g. family, friends or work) and support provided by it to the patient is commonly considered as one of the key factors in the development and treatment of mental disorders. It seems that the academic world fits into this pattern and the awareness of mental disorders among academic teachers may be helpful, both in the didactic process (e.g. adjusting the exam form) and in optimising the process of recovery for patients. It may even help to discover the problem, which is budding or concealed from the work environment, and encourage the person to consult a specialist in mental health.

Endnotes:

[1] See J. Rybakowski, S. Pużyński, J. Wciórka (eds), *Psychiatria. Podstawy psychiatrii*., t. 1. [*An Introduction to Psychiatry. Vol.1*.] Elsevier Urban & Partner, Wrocław 2010.

[2] Ibid.

[3] See M. Kantorska-Janiec, A. Kiejna, G. Świątkiewicz, M. Zagnańska, *Epidemiologia zaburzeń psychicznych – dotychczasowe doświadczenia.* [*The Epidemiology of Mental Disorders - Experiences until Today*] "Psychiatria Polska", 2009, 43 (4): pp. 375–385.

[4] See J. Rybakowski, S. Pużyński, J. Wciórka (edit.), *Psychiatria. Podstawy psychiatrii.*, t. 1., [*An Introduction to Psychiatry. Vol.1*.] op. cit.

[5] Załącznik do Uchwały Nr 90/2007 Rady Ministrów z dnia 15 maja 2007 r. Narodowy Program Zdrowia na lata 2007-2015, [*The National Health Plan 2007-2015. An Annex to Resolution 90/2007 of the Council of Ministers of 15 May 2007*] www.mz.gov.pl/wwwfiles/ma_struktura/docs/zal_urm_npz_90_15052007p.pdf

[6] CBOS. *Osoby chore psychicznie w społeczeństwie, komunikat z badań*, [*CBOS*. *People with Mental Health Difficulties. Conclusions from the Study*] Warsaw, August 2008, www.cbos.pl.

[7] See S. Pużyński, J. Wciórka, *Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10. Opisy kliniczne i wskazówki diagnostyczne* [*The Classification of Mental Disorders and Behavioural Disorders According to ICD-10. Clinical Descriptions and Diagnostic Guidelines] Vesalius*, second edition, Krakow 2000.

[8] Because of the pejorative tinge of this term, efforts are being made to replace it with "intellectual disability", the term used interchangeably in written works.

[9] See S. Pużyński, J. Wciórka, op.cit.

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3. Pużyński S., Wiórka J., *Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10. Opisy kliniczne i wskazówki diagnostyczne Vesalius*, second edition, Krakow 2000.

4. Rybakowski J., Pużyński S., Wciórka J. (eds), *Psychiatria. Podstawy psychiatrii*., t.1. [*An Introduction to Psychiatry. Vol.1.*] Elsevier Urban & Partner, Wrocław 2010.
5. Załącznik do Uchwały Nr 90/2007 Rady Ministrów z dnia 15 maja 2007 r. Narodowy Program Zdrowia na lata 2007-2015 [*The National Health Plan 2007-2015. An Annex to Resolution 90/2007 of the Council of Ministers of 15 May 2007*], www.mz.gov.pl/wwwfiles/ma_struktura/docs/zal_urm_npz_90_15052007p.pdf.