Some Early Symptoms of Mental Disorders or What May Herald a Mental Disorder or Indicate Its Occurrence

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A careful reader is probably asking himself or herself a question whether an accurate self-diagnosis or even an initial diagnosis of a mental disorder in another person can be made by a non-professional? The author of this article maintains that SOMETIMES YES, it is possible, although it is NOT ALWAYS the case. Limitations with regard to this matter will be discussed first.

The human psyche usually functions in the way that ensures maximum stability and coherence as regards the image of oneself, also in terms of comfort, satisfaction with oneself, the feeling of being right, the belief that one has no disorder, etc. This means, among others, that our internal fundamental mechanisms (the so-called defence mechanisms and the ability to manage one's life) achieve the aforementioned aims, even at the cost of falsifying a part of reality and taking untrue convictions, feelings, memories that serve this purpose as true and fully credible. This is why, most often, we do not remember or not fully remember painful events and tend to adjust the evaluation of events and persons to the current situation and their relationship with us (for example, during an unpleasant parting or divorce it is easier to think that your ex-partner has never been trustworthy and always mean and treacherous, etc.). This is why the inability to deal with a difficult situation may be, for example, a reason for ascribing bad intentions deteriorating the situation to others. To achieve the aims described above, it is "safer and better" than to consider oneself a person with difficulties in, e.g. fulfilling social roles. Which is why thinking of oneself as an ill person with a disorder or even a problem (which is often the safest solution for one's self-esteem) and seeking help is usually one of the last reactions of the future patient.

Of course, consulting a GP or neurologist instead of a psychiatrist is, in a similar way, a "mentally" safer solution. The next line of defence is seeking help from a psychologist (commonly considered as less "embarrassing" than a psychiatrist),

coach or advisor, much less willingly from a psychotherapist or psychiatrist. Starting a drug therapy is often rejected to a greater extent than psychotherapy; a person's consent to hospitalisation is more difficult to obtain than his or her consent to the treatment in an outpatient clinic or at a day-care ward.

This is why the patient who has mental health problems often tries to ignore them by attributing them to external reasons: stress (stressful events), the weather (meteoropathy – which has nothing to do with meteors and refers to the sensitivity to certain weather conditions), other people as "toxic parents" or friends, "energy vampires" and other factors – all of them external. Meanwhile the signals about the internal source of problems are usually suppressed, ignored, associated with injustice, somatic illnesses rather than false convictions, periods of distorted emotions, disturbed family relations. Ancient philosophers had good reasons to consider self-knowledge as one of the greatest achievements and discoveries.

Not all disorders begin, emerge and develop in a similar way, especially in terms of the experience of the illness and the kinds of fundamental symptoms. Obviously, thorough exploration of the foundations of psychopathology is included in the specialist long-term training offered to psychiatrists and, to some extent, psychologists and psychotherapists.

This is why the next important issue discussed here is a simplified classification of mental disorders (a generalisation taking into account their severity) adopted for this essay:
1) neuroses, personality and other disorders, e.g. eating disorders, sleep disorders, sexual disorders,
2) affective disorders (depression and mania or depression only),
3) schizotypal disorders and
4) a separate, fourth group of mental disorders linked with other illnesses, e.g. brain damage and disease (psychoorganic disorders), the general health condition, medications taken (mood swings after steroid and other hormonal drugs, depression- or dementia-like states in hypothyroidism), disorders similar to neurosis in hyperthyroidism and many other.

The classification presented above will be helpful in describing the signals of disorders or their first symptoms. Neuroses or neurotic disorders herald their arrival in a variety of ways. In clinical practice, there are many patients who just before the onset of the disorder or its diagnosis (which is not the same) distinguished themselves from others by a high level of activity, mobilisation, resistance to stress

(apparent to some extent), started their own businesses, travelled and competed. The appearance of symptoms often thwarted these efforts and, for example, made them stay locked at home because of agoraphobia or avoid people because of a social phobia. Sometimes patients became limited by avoiding any health (and other) risk because of hypochondria and similar experiences related to fear for one's safety or the withdrawal from social and professional activity (e.g. because of the aforementioned symptoms of social phobia similar to increased insecurity, shyness, the feeling of incompetence, etc.). Others, on the other hand, in their own opinion and that of their environment, have stood out for a long time or forever because of such "weakness-related" qualities. There was yet another group who did not reveal any distinct features of the kind and seemed similar to the rest of the society.

Psychoses (schizophrenia and similar disorders), unlike neuroses, are sometimes heralded by very surprising behaviour of the patient, odd and inadequate, singled out of fairly good everyday functioning (this phenomenon was described as paragnomen by a psychiatry professor from Krakow, Eugeniusz Brzezicki, and popularised by Antoni Kępiński, Polish luminary of psychiatry, also from Krakow, in his excellent books). This might include giving a bath to the TV set or painting the flat in odd patterns. A mental illness might also creep in slowly. Unfortunately, most symptoms are not considered by patients as the symptoms of a disorder, something wrong or bad but as right, accurate convictions, sometimes commendable or coming from divine creatures. False perception (hallucinations) is considered correct perception of reality and information from the outside that undermines it is seen as deliberate misinformation (e.g. part of collusion), mistakes, etc. Oddity (weirdness) of the patient's behaviour is not noticed by the patient himself or herself, disturbances of reality on many levels may not be examined (tested) by the patient because of the very nature of the condition.

Depression is an illness whose first symptoms may be withdrawing from everyday life, neglecting oneself and one's own matters, indifference, discontinuation of efforts, professional work, personal hygiene or even a suicide attempt, successful suicide or suicide preceded with the murder of one's family members (the so-called extended suicide). Fortunately, the most severe symptoms do not appear in onset as the first signals. The surroundings of the future patient more often than the patient himself or herself is able to notice great and unjustified sadness (low mood), pessimism, the feeling of hopelessness, apathy, slow down, the loss of hope for better future, etc. But it is not easy (the patient may hide it or hide himself or herself at home avoiding even the family members) and it is especially difficult for the patient

as, in his or her opinion, a bad mood, the feeling of guilt, conviction of his or her own sinfulness are justified and adequate instead of being related to an illness and inadequate. In this respect, depression (affective disorders in general including mania) is equally difficult to self-diagnose as schizophrenia.

The feeling of being ill, abnormal, ill-fitted as a person, alien and wrong is one of the most important determinants of milder disorders, primarily neuroses. In the most serious mood swings and schizotypal disorders patients do not consider themselves ill, which is why they are reluctant to start treatment. This is why one of the most important symptoms of a severe disorder is, paradoxically, the absence of the feeling of being ill and an irrefutable conviction of being healthy and right in one's all beliefs (also those entirely false and unfeasible called delusions) or the convictions that the voices, images or other sensations (non-existent, called visual or auditory delusions) are true. The feeling of a patient that "he has gone mad", "he may go mad", or "he may hurt someone" proves little mental health problems, if any, or robust health. The willingness to be examined and discuss one's mental condition, reasons for concern and accept or take into account the interlocutor's opinion is yet another solid proof of mental health (partially, at least).

What can we see in friends before they fall ill? Generally speaking, it is more than we can see in ourselves (provided that we are interested in others and have motivation to find out more about them). Our observation of others is not disturbed by the aforementioned defence mechanisms (except for, maybe, the perception of children by parents and the perception of persons similar to us); their biblical "motes in the eye" are more prominent than our own "beams". Of course, because of our hurt interests, feelings, anger and the feeling of injustice (or, which is harder to believe, guilt) we find it easier to ascribe stupidity, bad will, negligence or absent-mindedness rather than mental disorders to others while forgetfulness or absent-mindedness may, in fact, be a symptom of dementia, depression (drowning into overwhelming, all-encompassing sadness), schizophrenia (e.g. some kind of "being lost" in the "voices", i.e. auditory delusions), neurosis in the form of dissociative memory and an attention disorder, personality disorder, etc. Persons who fall ill should not be blamed for the illness but who remembers about it when they feel hurt, deceived, injured and used?

Histrionic personality disorders, hypochondriac neurotic disorders, episodes of severe anxiety (panic attacks) may involve the patients and their surroundings to a great extent from the very start, which especially applies to people who are obliged

to provide assistance or feel they have such responsibility. This kind of patients sometimes repeatedly ask for help approaching family physicians, school psychologists, friends, relatives who do “all they can” but often may not be able to successfully diagnose the patient or inform him or her effectively about it (because of the aforementioned defence mechanisms).

Personality disorders, in particular emotionally unstable personality (and its borderline sub-type), impulsive personality, personality-related addictions, passive-dependent personality and others may signal their existence throughout the patient’s entire life, but in most cases they are usually the most burdensome for the individual’s close environment, especially his or her family members or persons dependent on him or her, e.g. employees who report to him or her. They are the ones who sign up for treatment themselves or seek advice, possibly try to organise therapy for the individual with a personality disorder. The initial symptoms of various personality disorders may serve as repeated patterns of dissatisfaction of family members with the patient, leaving him or her, his/her dismissal, people moving away from him or her, as well as similar models of parting and divorce that occur repeatedly, inability to maintain permanent employment, making the same choice consistently, etc.

This is why one of the most important signals of a personality disorder in a young adult is difficulty with university study:

1) failing exams because of symptoms (or rather “incomprehensible” reasons beyond the patient’s control),
2) inability to adjust to students’ groups and students’ life in any of its variants (or the variant desired by the patient),
3) procrastinating the period of study and especially its final components such as BA or MA papers,
4) regular conflicts (“inability to get along with”) with university teachers or tutors (many, all or a specific personality type such as older men from another generation or young teachers who have just been promoted) as those who have power or control, etc.

5) getting enrolled in too many subjects, courses, programmes, scientific clubs,

6) becoming too close or too departed from one’s friends, inability to separate oneself from one’s parents, etc.

Organic mental disorders may start in yet another way, for example by the general deterioration of neuropsychological functions such as memory, attention, concentration, or may be related to cause-effect factors, e.g. a series of head injuries (car accidents, boxing), severe meningitis or carbon monoxide poisoning.

A question might be asked about the usefulness of various psychological texts and personality assessment scales available, e.g., in the Internet or in professional publications. It is limited; usually in clinical practice they are interpreted by a specialist in combination with the clinical picture of the patient examined (in fact this picture is the most important factor in the diagnosis), so the importance of the direct examination by a psychiatrist or psychologist needs to be emphasised again (only a psychologist may interpret psychological tests).

When in doubt whose opinion is more important or more urgent, that of a psychologist or psychiatrist, it should be remembered that in urgent cases related to the illness diagnosis, especially the differentiation between various types of illnesses mentioned here, and non-psychiatric health conditions of the patient in the context of, e.g., a pharmacological intervention at night, referral to the hospital, calling an ambulance, the most important is to contact the psychiatrist. A psychologist (preferably specializing in clinical psychology, not in advertising or labour) or psychotherapist (preferably certified or recommended by the Polish Psychiatric or Psychological Association – providing the definition of the scope of competencies and education of a psychotherapist in our country is still an on-going legislative process and a part of it is the preparation of the Healthcare Professions Act, which focuses on psychotherapy) may play an equivalent role when there are later visits necessary or the situation is less urgent.

And now, a handful of reassuring, hopefully, information: many problems, sad situations, disturbances of one's well-being, sexual life, response to stress, even those very painful, DO NOT herald a disorder and belong to the category of emotions experienced by healthy individuals who will remain healthy. The human psyche is quite resistant and signals about discomfort or overload such as anxiety before an exam, persistent checking of its date, suspicion towards the examination commission or examined friends do not herald a disorder. First of all, when they appear in the moments of great stress and cease easily, they may be understood by the person who experiences them and is willing to conduct a critical analysis of them applying the sense of reality (the kind of reasoning like: the commission is made of regular teachers, even if I think that they are not friendly, maybe it is because I am

concerned about the fact that I did not prepare myself well and am afraid of a punishment such as an exam).

Concluding, when in doubt about the mental health of yourself or your family members, friends or people you know, seek professional help. It will definitely not hurt. Remember that a referral is not necessary if you want to visit a psychiatrist and that there is no obligation to go to your local doctor. The information exchanged during the visit is confidential. The only requirement is to have valid health insurance, but in severe mental disorders it is not required, either.