

Overview of Mental Illness



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This booklet was produced by the **Ruah COPMI project**
(Children of Parents with Mental Illness)
as background reading for a series of cross-sectoral workshops on various
aspects of working with members of families with dependent children where
one or both parents has a mental illness.

The Overview of Mental Illness was written to assist workers whose primary
role is with the children in such families, and who feel that their lack of
experience or knowledge in relation to adults living with mental illness may
compromise any interventions they attempt.

It is hoped that this information will dispel some of the myths about mental
illness and increase workers' confidence and ability to communicate with
parents with mental illness.

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CONTENTS

| | |
|---|----|
| INTRODUCTION | 1 |
| 1. TO DEFINE MENTAL HEALTH AND MENTAL ILLNESS..... | 2 |
| 2. TO EXAMINE PREVALENCE OF MENTAL ILLNESS IN AUSTRALIA | 3 |
| 3. TO EXPLORE COMMON ASSUMPTIONS ABOUT MENTAL ILLNESS | 3 |
| Assumption: If only the referring agency would tell us the diagnosis, we would be able to manage them much better..... | 3 |
| Assumption: People with mental illness are violent or difficult to manage | 5 |
| Assumption: People with mental illness are severely and permanently incapacitated..... | 6 |
| 4. TO EXAMINE TWO EXPLANATORY MODELS OF MENTAL ILLNESS | 8 |
| Biopsychosocial model | 8 |
| The stress vulnerability model | 9 |
| 5. TO GIVE AN OVERVIEW OF MENTAL ILLNESS CLASSIFICATIONS | 12 |
| Anxiety disorders | 12 |
| Schizophrenia and other psychotic disorders..... | 12 |
| Mood disorders..... | 13 |
| Personality disorders..... | 14 |
| Substance use related disorders | 14 |
| 6. TO PROVIDE A GLOSSARY OF SYMPTOMS | 15 |

Introduction

A number of the people who will attend the session “Impact of Mental Illness on the Family” work primarily with children and may have limited knowledge about mental illness, or limited experience in interacting with adults who are exhibiting symptoms of mental illness. Often, this lack of knowledge or experience leads to practitioners being fearful, either of physical risk or of doing something that will make matters worse for the person with the mental illness or their child. Unfortunately, consumers report that practitioners’ fear or ignorance about mental illness can sometimes lead to frustrating interactions where consumers feel unheard, patronised, stigmatised, dismissed or disbelieved¹. Research into the stigma associated with mental illness has shown that mental health workers and the general public ascribe the following characteristics to people with mental illness: “unpredictable; irresponsible; socially undesirable; immature; confused; irrational; aggressive”².

The following background information is an attempt to provide some baseline mental health literacy, and to address some of the assumptions that are sometimes made by workers to the detriment of a successful worker/client interaction.

Unlike the rest of the materials in the Children of Parents with a Mental Illness workforce development series, this document refers solely to the mental illness and the person experiencing it. There is no content about children.

Aim: to increase awareness regarding the effects of mental illness on adults

Objectives:

- To define mental health and mental illness
- To examine the prevalence of mental illness in Australia
- To explore assumptions commonly made about mental illness
- To examine two explanatory models of mental illness
- To give an overview of classifications of mental illnesses
- To describe the symptoms with which people with mental illness may present

¹Consumer forums and individual consumer interviews, October 2003.

²Bakshi L, Rooney R & O’Neil K (1999) *Reducing Stigma about Mental Health in Transcultural Settings: A Guide*. Australian Transcultural Mental Health Network, Melbourne.

1. To define mental health and mental illness

Mental health: "A condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment"³.

Mental illness: "A mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities"⁴.

Mental health problems: "Mental health problems also interfere with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental illness. Mental health problems are more common mental complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into a mental disorder"⁵.

Mental health literacy: "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention, including:

- the ability to recognise specific disorders;
- knowing how to seek mental health information;
- knowledge of risk factors and causes; of self-treatments and of professional help available; and
- attitudes that promote recognition and appropriate help-seeking⁶".

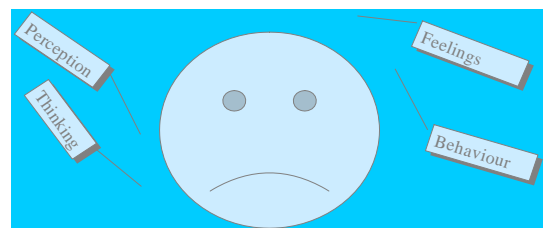
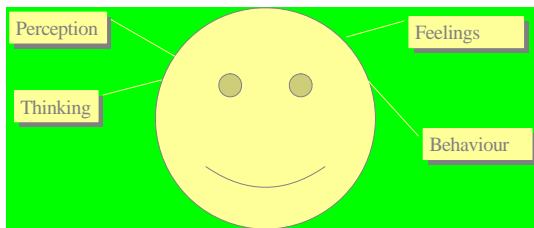
³ World Health Organisation (1975)

⁴ Australian Health Ministers. National Mental Health Plan 2003-2008. Canberra: Australian Government, 2003, p5.

⁵ Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p5.

⁶ Jorm AF, Korten AE, Jacomb PA, Christensen H, Rogers B and Pollitt P 1997 'Mental health literacy: A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment', *Medical Journal of Australia*, vol 166, p182.

Mental health and mental illness



Mental health, where harmony exists between perceptions, feelings, thinking and behaviour, enables people to:

- Distinguish fantasy from reality
- Manage their anxiety
- Match emotions to thoughts and situations
- Maintain realistic and stable sense of self
- Establish and maintain relationships
- Make sense of new experiences and learn from past experiences

Mental illness is where that harmony is disturbed, resulting in alterations in:

Thinking

- *Delusions*
- *Thought blocking*

Emotions

- *Anxiety*
- *Sadness or euphoria*
- *Ambivalence*

Perception

- *Hallucinations*

Behaviour

- *Overactivity or underactivity*
- *Risk taking*
- *Bizarre or strange behaviour*

2. To examine prevalence of mental illness in Australia⁷

- Almost 20% of adult Australians, or one in five people, will experience a mental illness at some stage in their lives.
- 3% of Australians are affected by psychotic illnesses where there is a loss of contact with reality during episodes of illness.
- Prevalence of mental illness decreases with age. Prevalence is greatest among 18-24 year olds. One third of people with a mental illness who are admitted to public hospitals are less than 30 years old. Among people 65 years and over prevalence is 6%.
- Those with a mental disorder average three days out of role (that is, not undertaking normal activity because of health problems) over a four week period (compared with one day out of role for people with no physical or mental condition).

3. To explore common assumptions about mental illness

Assumption: If only the referring agency would tell us the diagnosis, we would be able to manage them much better

⁷ Andrews, G et al (1999) The Mental Health of Australians, Mental Health Branch, Commonwealth Department of Health and Aged Care.

Clinical services working with people who are receiving treatment for a mental illness or psychiatric disability use diagnoses based on criteria outlined within the Diagnostic and Statistical Manual 4th edition, commonly known as DSM4. The criteria listed in the manual are quite detailed and comprehensive, and can often be a useful guide to appropriate treatment and likely prognosis.

Diagnosis is an essential part of the psychiatrist's task, because it assists in determining appropriate treatment, such as the correct medication to prescribe, and whether hospitalisation is indicated. Consumers may find their diagnosis either distressing or helpful in understanding what is happening for them. Other practitioners involved in the clinical management of a person with a mental illness, may find the diagnosis assists them to monitor the effectiveness and any desired or unwanted consequences of treatment.

For practitioners whose involvement with the person does not include managing the psychiatric condition, knowing the diagnosis may be of limited use, and may even be more problematic than helpful.

- A diagnosis is not always predictive of behaviour or risk – within any one diagnosis is a large range of possible presentations.
- Practitioners without clinical experience may respond to people based on an incomplete understanding of what should be expected of someone with that diagnosis, rather than appropriately to their individual needs and abilities.
- People's presentation when they are acutely unwell is often very different from when they are well.
- A non-clinical practitioner knowing the diagnosis may be seen by the person as intrusive.
- Sometimes non-clinical workers can focus on a person's diagnosis to the extent where they are busy seeking evidence to dispute it rather than working with the behaviours, needs and strengths that the person is presenting.

For this series of modules on working with families with children where a parent has a mental illness, information about working and communicating with parents with mental illness will use very broad diagnostic categories – mood disorders (depression or bipolar affective disorder), psychoses such as schizophrenia, anxiety disorders and personality disorders. The focus will be on what the parents do or say rather than on how they have been diagnosed.

Assumption: People with mental illness are violent or difficult to manage

Research indicates that people receiving treatment for a mental illness are no more dangerous than the general population. They are more likely to be the victims of violence (including self-harm or suicide) than to harm others⁸, and may themselves feel vulnerable to harm within their community.

Factors which are statistically linked with violence, some of which apply to mental health, are as follows:

- **Gender and age** – violent behaviour is highest in men, particularly those aged 15-25.
- **Social background** – people who are charged or convicted of violent crimes are drawn disproportionately from lower socioeconomic groups. Poverty is one factor affecting this, but equally important is the sense of exclusion or rejection from the benefits of society. Economically and socially deprived members of minority groups (eg Aboriginal Australians or Maori New Zealanders) are at risk of violent crime, not because of their race but because of the socioeconomic conditions in which they live. People with mental illness may also suffer exclusion and poverty, and hence for this reason their risk of offending may be increased.
- **Alcohol and drug use** – this factor is particularly relevant where a person has a concurrent psychiatric disturbance and/or social dislocation.
- **Past behaviour** – the more often the person has been violent in the past, the more likely they will be again.
- **Personality factors** – research does not show any traits that are particularly indicative of violent behaviour.
- **Threats of violence** – people who have made threats of violence, to self or to others, have a higher probability of carrying out that violence.
- **Delusions** – people who are responding fearfully or angrily to delusions or hallucinations may behave violently. Greatest risk is from people whose delusions are systematised and centred on someone with whom they are in a close relationship⁹.

⁸/www.sane.org/factsheetviolence.html

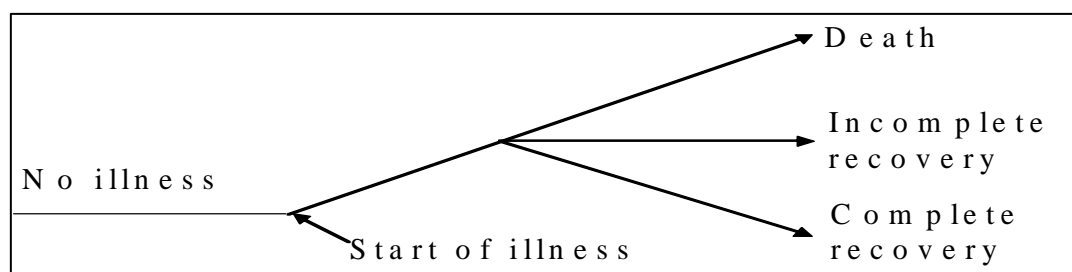
⁹ Mullen P (1994) "Forensic Psychiatry" in Bloch S and Singh BS (eds) Foundations of Clinical Psychiatry. Melbourne University Press, Melbourne, p333.

Assumption: People with mental illness are severely and permanently incapacitated

This assumption can manifest in two ways: it can be an expectation that the person with the illness has a prognosis of chronicity and deterioration with no possibility of recovery, or it can be a belief that the person's behaviour will at all times reflect the symptoms of acute illness.

Prognosis

When psychiatry was in its infancy, the prognosis for a person experiencing mental illness was gloomy. The person may well expect to spend long periods, even the rest of their life, either confined in an asylum (with or without the use of a range of "treatments") or, if the family's resources permitted, confined in greater luxury but still under constant supervision. Now that social and legal attitudes have changed¹⁰ and effective treatments ranging from drug therapies to psychological and psychosocial interventions have been developed, this concept of mental illness being a life sentence is no longer relevant. Statistics show that the death rate for people with mental illness is 2.5 times higher than for the general population, but this increase is attributed to physical conditions such as heart disorder rather than to suicide¹¹. "Incomplete recovery" for many people experiencing mental illness might entail a number of acute episodes with long periods of wellness between, although there are still some people whose relapses are more frequent and who don't become entirely well between episodes. Many people make a complete recovery and do not become ill again.



The prognosis for a person experiencing mental illness varies not only with the type of illness, but also with the individual's resilience, supports and risk factors. Hume and Pullen comment that as a person with a spinal injury can use a wheelchair to move around and thus reduce the degree of handicap experienced, a person with mental illness may find a variety of ways to overcome or manage debilitating aspects of the illness¹². The biopsychosocial

¹⁰ The international adoption of UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991, formalised a concept of rights for people with mental illness and has led to changes in Mental Health Acts in a number of countries.

¹¹ Duty to Care: Preventable Physical Illness in People with Mental Illness, WA Centre for Health Services Research, 2001.

¹² Hume C and Pullen I (1994) Rehabilitation for Mental Health Problems Churchill Livingstone, Melbourne.

and stress vulnerability models (discussed in a later section of this paper) show that there are multiple factors which interact to affect the course of an illness. It may be that social disadvantage (for example stigma and reduced income) resulting from the illness contribute as much to a poor prognosis as the symptoms and illness process. Another important factor is the person's attitude to their illness.

Fluctuations in capacity and vulnerability

Mental illness proceeds through a number of phases, not necessarily in linear progression. The effect of the illness on the person's ability to function in their everyday life changes in the different phases, making it important for workers to assess a person's capacities and needs regularly rather than assuming that a first assessment is always going to be valid:

- Prodromal phase – this describes the period between when the person begins exhibiting symptoms and their first contact with a treatment agency. The prodromal phase is probably most noticeable in psychosis because of its duration – it can last up to 2 ½ years.¹³ It is known that intervention as early as possible in this phase can lead to better outcomes such as quicker and more complete recovery. Unfortunately, families often delay seeking treatment, for a number of reasons (lack of recognition that the signs may indicate mental illness, for example, or a family's ability to tolerate unusual behaviour, or a misinterpretation of presenting symptoms as “normal” adolescent rebellion¹⁴). Even when the family has acknowledged a problem and has sought treatment, potential treating agencies may be reluctant to become involved if symptoms are unclear, in case a “false positive” diagnosis may cause more trouble than it prevents.
- Acute illness – this describes the period when the person is showing a disturbance in thinking, emotions, perceptions or behaviour to the extent that considerably disrupts their functioning. Hospitalisation or some other form of intensive intervention may be required during this time. (Note that “acute”, meaning “immediate”, is the opposite of “chronic” meaning “long-term or ongoing” in psychiatric terms. “Chronic” may be defined as “really bad” in colloquial speech, but not in psychiatry.)
- Early recovery – during this phase, when intervention has brought the positive symptoms of illness under control, the person is able to focus on resuming everyday life. This means re-establishing relationships with friends and family, resuming (perhaps in a different way) school, work, parenting or other responsibilities, and trying to come to terms with what the illness means for their self-concept and what they had imagined for

¹³ Helgason, L. (1990) Twenty Years' Followup of First Psychiatric Presentation for Schizophrenia: What Could Have Been Prevented? Acta Scandinavica, 81:231-235.

¹⁴ Loebel, AD; Lieberman, JA; Alvir, JMJ; Mayerhoff, DI; Geisler, SH and Szymanski, SR (1992) Duration of Psychosis and Outcome in First-Episode Schizophrenia, American Journal of Psychiatry, 149(9) p1187.

their future. For some people, particularly those who are unable to accept that their symptoms were caused by mental illness, there may be one or more relapses before optimal recovery can occur.

- Long term recovery – this is the phase in which a person can use their experience of illness and recovery to build effective long-term strategies to recognise their triggers to relapse, minimise the effect of illness on their lives, and regain maximal autonomy. There may, however, be comorbid problems (substance use, personality disorder, or depression, for example) which make this autonomy difficult to achieve.

What it is important to recognise is that before there was an illness the person had strengths, interests and capacities and was able to function in the world. The illness may have interrupted some of these strengths, interests or capacities, but not all of them. It is much more useful to commence work with a person with an assumption that they DO have personal resources that they can use to maximise the support they are receiving from services, and try to elicit information about what these resources are, than to assume they do not.

Mental health consumers frequently comment that it would be nice to be treated as a person and not an illness. Recognising and working with their strengths instead of solely with their pathology is one way of acknowledging that. Another is to acknowledge the other roles they fulfil apart from "patient", such as parent or spouse.

4. To examine two explanatory models of mental illness

Biopsychosocial model

This model attempts to consider a number of factors that might contribute to or affect mental illness, in three main categories:

- **Biological factors** (physiology and biochemistry, and genetic inheritance)
- **Psychological factors** (emotional experience, interpersonal interactions and the person's upbringing)
- **Social factors** (related to cultural background and current life situation).

These factors may operate separately or in combination, at different times in a person's life. According to their timing in relation to the illness they can be said to predispose the person to the illness, precipitate it or perpetuate it:

- Predisposing factors exist long before onset of illness. A person may be vulnerable to depressive illness, for example, due to genetics or how they were brought up or the socioeconomic conditions the family lives in.
- Precipitating factors are stressors occurring just before the appearance of symptoms, either when illness is first experienced, or when it relapses. They are said to be responsible not necessarily for the illness but for its timing.
- Perpetuating factors prevent or delay resolution or improvement of symptoms.
- Protective factors reduce a person's vulnerability to the illness¹⁵

| | Biological | Psychological | Social |
|----------------------|--|---|--|
| Predisposing | Genes Maternal health in pregnancy | Upbringing Parental strife Personality traits | Cultural demands Poverty Migration |
| Precipitating | Trauma Infections Illicit drugs | Bereavement Exam failure Being jilted | Retirement Being robbed Stock-market loss |
| Perpetuating | Malnutrition Poor sanitation Dependency on drugs | Domestic violence Conflict with neighbours Worry about family members | Demands at work Refugee status Financial obligations |
| Protective | Healthy diet Taking prescribed medication | Good problem-solving skills Loving personal relationships | A rewarding career or valued role Supportive church or social community |

The stress vulnerability model

The National Practice Standards for the Mental Health Workforce require mental health professionals to “encourage and support the participation of consumers and carers in determining (or influencing) their individual treatment and care”¹⁶.

To enable a genuine collaboration between client, significant others and the worker, it is important that the person with the mental illness is made aware of ways they can affect their own progress. This means that the way the illness is conceptualised and explained to the client needs to include some variables that s/he can affect. The stress vulnerability model pulls together

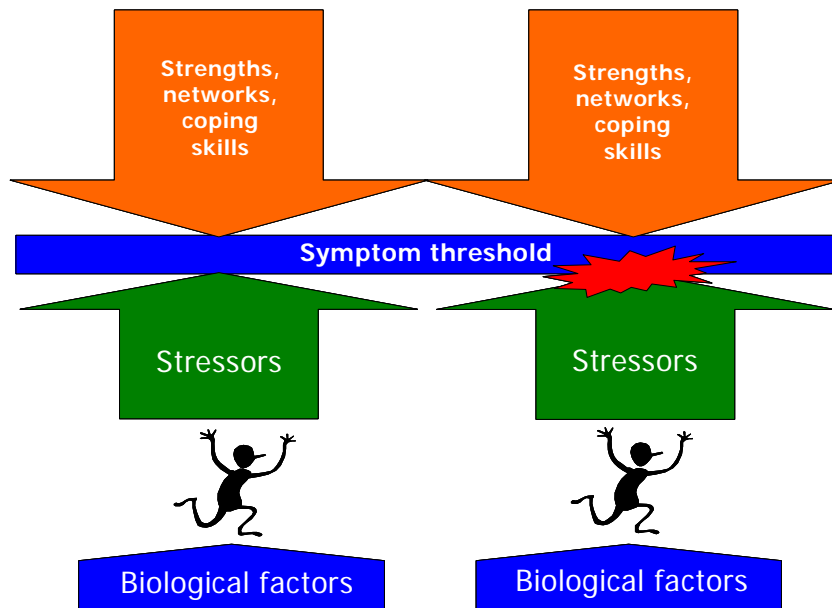
¹⁵ Adapted from Bloch S and Singh BS (1997) *Understanding Troubled Minds – A guide to mental illness and its treatment*. Melbourne, Melbourne University Press. The sections on protective factors were added by H Lette.

¹⁶ National Mental Health Strategy (2002) National Practice Standards for the Mental Health Workforce. Canberra, Commonwealth Dept of Health and Ageing, p11.

three factors that have been seen to affect the course of recovery from mental illness, and presents three different approaches to affect the illness. These are:

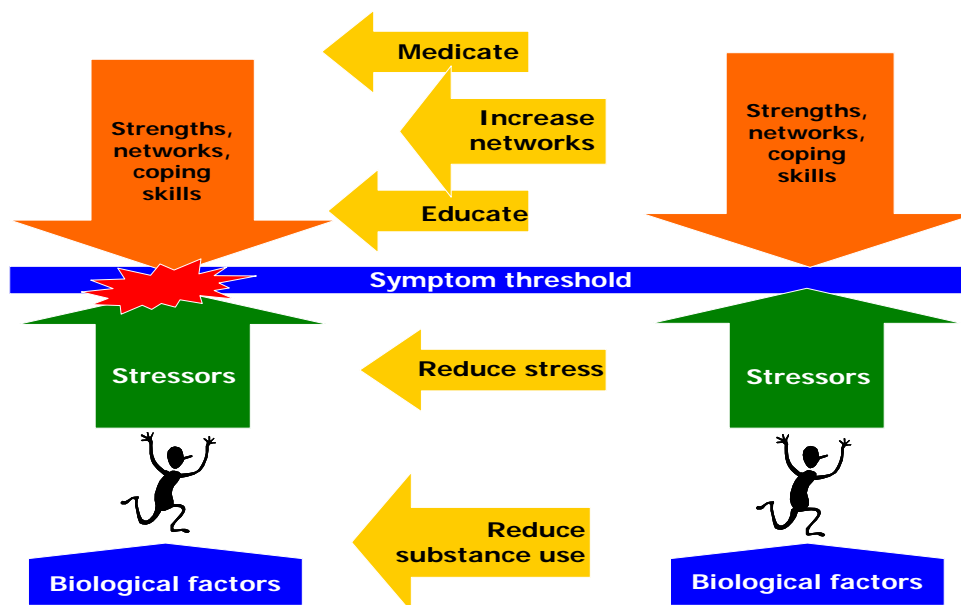
1. **Biological vulnerability** – the biological predisposition to experience mental illness. This may reflect an imbalance in brain chemistry caused by genetic factors, exposure to early biological risks, or both. Unfortunately the level of vulnerability cannot be directly measured, but what is assumed is that a person who does not have the predisposition will be less likely to develop mental illness. Someone who does have the predisposition may develop the illness if the other factors contribute to that vulnerability. *While there is no cure for biological vulnerability, some of the imbalance in brain chemistry can be treated with medication, which can reduce symptoms and the risk of relapse. Substance use can increase the biological vulnerability and work against the medication.*
2. **Stress** – refers to negative aspects within the client's environment. These may be events such as the death of a family member, loss of job, change in housing, or ongoing situations such as a home environment full of conflict. *Reducing environmental stress is a way that client, family and worker can collaborate to reduce the client's vulnerability to relapse. This may involve work on reducing the tension in the family such as new conflict resolution skills or limit-setting strategies or ways of communicating. It may also mean looking for a balance between over-stimulation (which can be too demanding and stressful) and a lack of structure or meaningful activity (which creates its own stress).*
3. **Coping skills or strengths** – refers to the client's ability to handle stress effectively and thus reduce the negative effects of stress. This might include relaxation skills, social skills, or connection with good support networks. *Work on a person's coping skills, networks or strengths enables them to deal with more stressful situations, or to no longer perceive them as stressful. This kind of work can involve relaxation techniques or ways of dealing with persistent symptoms. It may also include broadening social support networks or encouraging the development of meaningful vocational or leisure roles, where the person's vulnerability can be reduced by an increase in self-esteem¹⁷.*

¹⁷ Mueser KT and Gingerich S (1994) Coping with Schizophrenia: A Guide for Families. Oakland, CA: New Harbinger Publications: pp21-23.



This diagrammatic representation shows how there is initially a balance where the person's strengths, networks and coping skills are able to deal with the stressors and biological factors (vulnerabilities) to an extent where there are no symptoms. However, if the vulnerabilities increase before the person acquires new strengths, coping skills or networks to deal with them, then the stressors can push them over the symptom threshold and signs of illness will appear.

The diagram below shows that once the symptom threshold has been reached, there are some obvious points at which the vulnerabilities can be reduced or the strengths enhanced. This offers a range of options for ways the person can work or be assisted to work towards recovery.



5. To give an overview of mental illness classifications

Anxiety disorders

Anxiety is a normal reaction to danger, threat or stress, which in most cases is a functional response that helps people keep themselves safe and alert. One in ten people, however, experience anxiety that is severe or prolonged enough to disrupt their everyday lives. Anxiety disorders can affect a person:

- Emotionally (worry, uneasiness, irritability, fear of impending doom)
- Physically (heart palpitations, muscle tension, headaches, nausea, sweating)
- Behaviourally (avoidance of certain situations, performance of rituals).

The person is usually aware that the symptoms are abnormal, but has difficulty in controlling them. Some examples of anxiety disorders are panic disorder, generalised anxiety disorder, obsessive compulsive disorder, post traumatic stress disorder, social phobia, and a range of specific phobias.

Common interventions

Anxiety disorders are often treated with psychological approaches such as cognitive behavioural therapy. Among medications prescribed for anxiety disorders are the **benzodiazepines** (the family of anti-anxiety drugs which includes Valium, Serepax and Rohypnol) which have a high potential for dependency, and **beta blockers**, drugs which reduce physical symptoms of anxiety and can thus prevent the emotional experience of anxiety from escalating.

Schizophrenia and other psychotic disorders

These disorders are characterised by disturbances of thought and perception. That is, people experiencing a psychosis may hear, see, smell, feel or taste things that other people do not (**hallucinations**) or may interpret or explain what they experience in ways that other members of their culture do not (**delusions, thought disorder**). Because people suffering from acute psychosis are often unaware that their experiences are part of an illness (**lack of insight**) they can be difficult to engage in treatment. Examples of psychotic disorders are schizophrenia, schizophreniform psychosis, schizoaffective psychosis, and brief psychotic episode.

Common interventions

Early intervention with **antipsychotic medication** (also known as **neuroleptics**) can often quickly resolve the so-called **positive symptoms**. Negative **symptoms** such as lack of motivation, flattened affect, and lack of ability to experience pleasure are more resistant to treatment, although such **atypical antipsychotics** as **clozapine** can sometimes affect negative as

Common interventions

- Antidepressant medications of various kinds
- Mood stabilisers, such as Lithium or Carbamazepine
- Antipsychotic medication
- Electroconvulsive therapy for severe depression that is not responding to medication.

Personality disorders

These are psychiatric disorders in the sense that they occupy an entire axis under DSMIV, but are considered to be a persistent pattern since adulthood rather than episodic or treatable illnesses. In effect, this means that it is extremely difficult for a person with personality disorder to obtain treatment unless there is some other disorder present which is considered to be treatable. Unfortunately, due to the types of behaviour that are sometimes seen in people with personality disorder, they tend to be excluded from services and to experience quite judgmental responses from professionals.

Common interventions

- Medication may be prescribed for coexisting conditions such as Post-traumatic Stress Disorder or Depression, but very rarely is medication considered useful to treat the personality disorder itself.
- Psychological interventions such as Rational Emotive Therapy have shown some success in long-term management of people with Borderline Personality Disorder.

Substance use related disorders

There are a number of classifications in DSMIV which relate to substance use. They are divided into:

- Substance use disorders (dependence and abuse)
- Substance-induced disorders (intoxication, withdrawal, psychosis).

It is sometimes quite difficult to differentiate between symptoms of intoxication or withdrawal and symptoms of mental illness. This can be further exacerbated by the fact that many people whose substance use is problematic have a coexisting mental illness, and many people with a mental illness also have problematic substance use. This comorbidity (also known as “dual diagnosis” or “coexisting disorders”) can often lead to difficulties for the person in seeking treatment, when drug and alcohol treatment agencies may consider the mental illness to be the primary condition, and mental health services consider the problem to be primarily substance-related.

Sometimes the substance use is an attempt by the person to manage unpleasant symptoms caused either by the mental illness or by the medication prescribed to control the mental illness.

Common interventions

- Detoxification (removing access to the substance and managing any withdrawal symptoms)
- Psychological interventions (eg motivational counselling)
- Medication to manage withdrawal (Methadone for opiate withdrawals; Hemicneurin for alcohol withdrawals) or to block the effects of a drug (eg Naltrexone) or to reverse overdose (eg Narcan).

6. To provide a glossary of symptoms

Delusion: a belief which is not shared by the person's society or culture and which is maintained despite all evidence to the contrary. It is a preoccupation which seriously interferes with the workings of the person's life. The content may be spoken about openly or inferred. Common types are delusions of grandeur, persecution, jealousy or guilt.

Often present in: psychotic disorders such as schizophrenia, acute mania, major depression. Also may be seen in organic conditions such as dementia or acute intoxication/withdrawal.

Hallucination: a sensory perception that seems real to the person experiencing it, but is not perceived by others. It can affect any of the senses.

Often present in: psychotic disorders such as schizophrenia, acute mania, major depression. Also may be seen in organic conditions such as epilepsy, acute intoxication/withdrawal.

Formal thought disorder: disturbances in the logical connections between ideas rather than in the content of speech (or writing). There are a number of types of thought disorder. Thought disorder makes it extremely difficult for a listener (or reader) to follow what the person is attempting to communicate, as the links between words or ideas are not evident.

Often present in: psychotic disorders.

Positive symptoms: This term is used to differentiate some of the symptoms of psychosis from others because they require different management. Positive symptoms of psychosis are those that ***are present but shouldn't be***. That is, delusions, hallucinations and thought disorder are present in people with psychosis but not in people who are mentally well.

Negative symptoms: This is the other group of symptoms often present in psychosis, those that ***should be present but are not***. That is, certain behaviours that can be seen in healthy individuals are notably absent in people experiencing psychosis. Unfortunately negative symptoms can be quite resistant to treatment, and can persist even after the positive symptoms have

disappeared to the extent the person is considered to have “recovered” from an acute episode of illness. Some negative symptoms of psychosis are:

- Avolition: very difficult to motivate, lacking energy and showing no interest in activities or in everyday routine
- Ahedonia: loss of enjoyment in usually pleasurable activities such as eating, socialising or sex
- Alogia: absence or reduction in amount or content of speech, including very slow or brief responses in conversation
- Flat affect: the person does not show emotions, and appears unresponsive to what is happening around him/her.

Note that it is often difficult to differentiate some of these negative symptoms from other conditions such as depression or medication side effects¹⁸.

¹⁸ Schizophrenia Fellowship of NSW (2001) The Schizophrenias: Guidelines for a holistic approach to clinical practice. NSW Health Department.

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