To protect the rights of the author(s) and publisher we inform you that this PDF is an uncorrected proof for internal business use only by the author(s), editor(s), reviewer(s), Elsevier and typesetter Toppan Best-set. It is not allowed to publish this proof online or in print. This proof copy is the copyright property of the publisher and is confidential until formal publication.
Foreword

I am delighted to provide the foreword to the 2nd edition of Mosby's Pocketbook of Mental Health. In the day-to-day work of health, public health and other human services, mental health care is an increasingly important component of care. As identified by the World Health Organization over a decade ago, mental health is everyone's business and people with mental health problems now access and receive assistance from specialist services as well as welfare services and non-governmental organisations. Mosby's Pocketbook of Mental Health continues to be a versatile, one-stop reference text specifically targeted at Australian and New Zealand health and nursing students, paramedics, teachers and social and human services workers. This quick reference guide to clinical practice captures the core elements of mental health care including: the context of mental health care; clinical signs and interventions; medications; co-occurring disorders; and legal and ethical issues. Recovery is a foundational approach to the text, fulfilling the need to provide consumer-focused care.

The second edition has been thoroughly updated. It also features a new opening chapter, Mental health: every health professional's business, which focuses on the incidence of mental illness in the community and provides strategies for addressing what is clearly a significant societal need. Importantly, Chapter 3 includes the recently updated national practice standards for the mental health workforce and there is a new Appendix 2 covering who does what in mental health.

I had the pleasure of launching the first edition of this text at the NETNEP International Nurse Education Conference in Sydney in 2010. I can confirm that this text is what it says it is: a highly informative pocketbook written by experts in the field. As such the format of the pocketbook facilitates a wide range of health and other professionals and students to access current research evidence and best practice wherever they are working or studying.

Professor Patrick Crookes
PhD, BSc(Nurs), RN, CertEd, MACN
Contents

Foreword v
Preface ix
Authors and reviewers xi

Chapter 1 Mental health: every health professional's business 1
Chapter 2 Working in a recovery framework 9
Chapter 3 Essentials for mental health practice 21
Chapter 4 Mental health assessment 32
Chapter 5 Culture and mental health 47
Chapter 6 An overview of mental illness 59
Chapter 7 Psychiatric and associated emergencies 83
Chapter 8 Managing medications 98
Chapter 9 Contemporary talking therapies 116
Chapter 10 Co-occurring medical problems 121
Chapter 11 Loss and grief 128
Chapter 12 Law and ethics 140
Chapter 13 Settings for mental health care 148
Appendix 1 Surviving clinical placement! 158
Appendix 2 Who does what in mental health? 160
Appendix 3 Working with people with challenging behaviours 162
Appendix 4 Prescription abbreviations 164
Appendix 5 Top tips for people taking psychiatric medication 166
Appendix 6 Mental health terminology 168
Further reading and resources 190
Index 193
Preface

Approximately 450 million people worldwide have a mental health problem, with one in four people experiencing some kind of mental health issue in the course of a year. Following the reform of mental health services, including mainstreaming and the delivery of care within a recovery framework, all health workers now need a range of mental health skills and knowledge in order to practise effectively in their work with mental health consumers and their carers/families.

This handy, readable text is intended to provide easy access to immediate advice for a range of health professionals and workers, including general nurses, general practitioners, paramedics, police, mental health workers, drug and alcohol workers and allied health professionals who encounter people with mental health problems in their daily work. This text will also be useful for mental health support workers and those in consumer care roles. We have endeavoured to distil the core elements of engaging and working with people with mental health problems into practical skills and approaches that can be applied to a range of settings for care.

This second edition has been thoroughly updated to provide the latest evidence about mental health care and also includes a new chapter on the extent of mental health as a problem worldwide. At the core of mental health practice is a focus on social inclusion and recovery, culture and respect for and promotion of consumer rights in mental health care. Accordingly, we have included chapters that reflect these foci and associated ‘hands on’ strategies. We have used text boxes to provide practical tips about what to do in commonly encountered situations. Do and don’t sections give handy, practical quick guides for practice. Revised and extended appendices serve as an aide mémoire or checklist for quick reference in relation to, among other things, working with consumers with challenging behaviours, tips regarding undertaking a successful work placement and guidance about taking psychiatric medications. We have included extensive web-based resources to provide the latest bibliography of reliable electronic resources for ease of access.

In writing this book we set out to ‘cut to the core’ in terms of what practical, doable and helpful strategies would be of use to health
PREFACE

professionals who don’t have formal mental health qualifications. We think this is what we have achieved and trust readers will find this book to be a practical and useful adjunct to their professional practice.

Eimear Muir-Cochrane
Patricia Barkway
Debra Nizette
Authors and reviewers

Authors

Eimear Muir-Cochrane BSc(Hons), RN, CMHN, GradDip—Adult Ed, MNS, PhD, FACMHN, MACN
Professor and Chair of Nursing (Mental Health), School of Nursing and Midwifery, Flinders University, South Australia

Patricia Barkway RN, CMHN, FACMHN, BA (Psychology/Education), MSc(PHC)
Senior Lecturer, School of Nursing and Midwifery, Flinders University, South Australia

Debra Nizette RN, CMHN, FACN, FACMHN, DipAppSc—Nurse Ed, BAppSc—Nursing, MNS
Assistant Director of Nursing, Nursing and Midwifery Office, Queensland Health, Queensland

Reviewers

Gayelene Boardman PhD, MHSc, GDip AppSc, RN
Discipline Leader, Mental Health, Victoria University, Victoria

Sherphard Chidarikire RN, BHlth(Nurs), MN(Nurse Pract)
Lecturer and PhD candidate; School of Health Sciences, University of Tasmania, Tasmania

Sally Drummond RN, CMHN, BN, MNP
Lecturer in Nursing/Mental Health, School of Nursing Midwifery and Indigenous Health, Charles Sturt University, New South Wales

Mental Health Lecturer, Australian Catholic University, Victoria

Kate Emond RN, BN, PGDip MentalHlth, MN
Postgraduate Mental Health Course Coordinator, Faculty of Health Sciences, La Trobe Rural Health School, Department of Rural Nursing and Midwifery, Victoria

Cindy Hoswell RN, BN, GCMH
Lecturer in Nursing, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, New South Wales; Nurse Unit Manager, Community Mental Health Drug and Alcohol, Western NSW Local Health District

K
AUTHORS AND REVIEWERS

Mairwen Jones BA(Psych), PhD
Clinic Head, The University of Sydney Anxiety Disorders Clinic, Senior Lecturer in Psychology, The University of Sydney, New South Wales

Elijah Marangu RN, MPH
Lecturer, School of Nursing and Midwifery, Deakin University, Victoria

Phil Maude RN, PhD, FACMHN
A/Professor Mental Health and Addictions Programs, RMIT University School of Health Sciences, Victoria

Anthony J O’Brien RN, BA, MPhil(Hons), FNZCMHN
Senior Lecturer School of Nursing and Centre for Mental Health Research, Faculty of Medical and Health Sciences, The University of Auckland; Nurse Specialist (Liaison Psychiatry), Auckland District Health Board

Eddie Robinson RN, MHN, MNursing, GrdCertHlth, ProfEd (GCHPE)
Mental Health Nursing Lecturer, Monash University, Victoria

Alasdair Williamson RN (RMN UK), MSc (Public Health), PGCert (HlthSci)
Senior Lecturer, Faculty of Health Science, Eastern Institute of Technology, Hawke’s Bay, New Zealand

Sue Willis RN, BN, GradDip—Adult Ed; ACMHN
Associate Lecturer, University of Western Sydney, New South Wales
CHAPTER 6

An overview of mental illness

Introduction
This chapter provides a quick reference to the common mental illnesses that health professionals may come across in their daily practice. Incidence, aetiology (causation) and description of the major mental illnesses are covered, with reference to useful websites. The major mental illnesses include disorders of anxiety, mood, thinking and perception and personality disorders. Disorders specific to particular populations—the young, the elderly, those with intellectual disabilities and substance abuse disorders—are also described here, acknowledging that intellectual disabilities, delirium and substance abuse disorders are not mental illnesses per se, but are generally discussed in association with the diagnostic groups of mental illness.

The National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics 2008) found that almost half of the 16 million Australian population aged 16–85 years (45% or 7.3 million) had a lifetime mental disorder (i.e. a mental disorder at some point in their life). One in five (20% or 3.2 million) Australians had had a mental disorder within the 12 months preceding the survey.

Primary health care
Primary health care is the first point of contact for people and health professionals in community health centres; mental health issues are the second most common presenting comorbidity. General practitioners, practice nurses and mental health nurses as well as other allied health professionals are increasingly collocated, creating opportunities to provide care and information about mental health wellbeing to the general public. Primary health care principles include a person-centred approach that is holistic and aimed at promoting mental health and preventing the development of mental health issues. Practice nurses, as well as mental health nurses in general practice settings, have a vital role in undertaking comprehensive health assessments including mental state examinations. While people with serious mental illness are treated by specialist mental health
professionals, the majority of people with mental health problems are cared for in the community.

**Diagnostic classifications**

There are two main classifications for diagnosing mental illness used around the world. The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (known as DSM-5), which is published by the American Psychiatric Association (2013), is commonly used in most states and territories in Australia. This classification system assesses the consumer across five domains, which helps with treatment planning and outcomes. The *International Statistical Classification of Diseases and Related Health Problems*, 10th revision (known as ICD-10), which is published by the World Health Organization (2010), provides a listing of clinical diagnoses that are coded and is commonly used in Europe and the northern hemisphere, as well as in some states of Australia (e.g. Queensland). The 11th edition of the ICD is due out in 2015.

While there is discussion about future classification systems referring more to the experience of mental illness and specific symptoms rather than definite categories of illness such as depression and schizophrenia, these categories remain the basis of diagnosis around the world at present. With that in mind, it is important to note that there is significant overlap between symptoms in mood disorders and other diagnoses such as personality disorders. Further, symptoms of anxiety can occur in a range of anxiety and depressive disorders. Finally, psychotic symptoms can occur in schizophrenic, depressive and bipolar conditions. In this chapter, the DSM-5 is referred to in relation to descriptions of the major mental illnesses and associated cognitive/neurological disabilities. However, this chapter is not meant to be a guide to the DSM-5 per se, but rather an overview of the common mental illnesses recognised today.

**Anxiety disorders**

**Incidence**

Approximately 10% of the population experience anxiety at a level that affects their daily life, with 2–4% having an anxiety disorder (Royal College of Psychiatrists 2013). Anxiety disorders are more common in females than males.

**Aetiology**

There are several theories, including genetic, familial history, neurochemical (imbalance of the neurotransmitter serotonin), social/cultural factors and upbringing.
Generalised anxiety disorder

Generalised anxiety disorder is characterised by persistent and troublesome worrying for a period of more than six months independent of other mental health conditions (Bermak 2008). There is controversy concerning the validity of this diagnosis and that such people are in fact ‘the worried well’. However, the prevalence rate in general practice is estimated at 8% and these people present frequently for assistance to health services (Barton et al 2012).

**Symptoms**

Symptoms are:
- a feeling of being consistently on edge
- irritability
- poor concentration
- physical tension.

**Prognosis**

Early-age onset has poorer outcomes, high relapse rates and a substantial social and economic impact on the person. It tends to have a chronic fluctuating course.

Approximately 50% of people will be free of symptoms within six months. The remainder, however, are left with a chronic and often disabling lifelong condition (Barton et al 2012).

Panic disorder

Panic disorder is different from the normal fear and anxiety reactions to stress in our lives. Symptoms of panic disorder include sudden attacks of fear and nervousness, as well as physical symptoms such as sweating and a racing heart. Symptoms need to be of more than a month’s duration, accompanied by significant behavioural changes due to the attacks and a preoccupation of concern or worry about having another attack. For a definition of panic attacks, see Chapter 7.

**Prevalence**

Approximately 1% of the population have panic disorder (Barton et al 2012), which can have a serious deleterious effect on interpersonal relationships and work life. Panic attacks are sudden and highly distressing, and can last from a few seconds to up to 20 minutes or when help arrives. People with this condition may become socially isolated as they avoid stressful situations. Comorbid conditions such as depression are common.
Phobias
A phobia is defined as a marked and persistent fear that typically lasts more than six months. Fear is cued by the presence or anticipation of a specific object or situation (e.g. flying, heights, animals, receiving an injection, seeing blood). Exposure to the phobic stimulus results in extreme anxiety. A useful mnemonic to remember the key elements necessary for a diagnosis of phobia is ‘PHOBIA’:
- **P** persistent
- **H** handicapping (restricted lifestyle)
- **O** object/situation
- **B** behaviour (avoidance)
- **I** irrational fears (recognised as such by consumer)
- **A** anxiety response.

For a diagnosis of a specific phobia, the person’s fear must result in significant interference with their functioning, not just distress.

There are five subtypes of specific phobia, depending on the type of trigger:
- **animal**: animals or insects
- **natural environment**: for example, storms, heights and water (generally childhood onset)
- **blood/injections/injury**: seeing blood or injury, or receiving an injection or other procedure (vasovagal fainting response)
- **situational**: for example, bridges, elevators and flying
- **other**: for example, choking, vomiting and contracting an illness.

Often more than one type will be present. Features associated with specific phobias include a restricted lifestyle. Comorbid conditions include other anxiety disorders, mood disorders and substance-related disorders (Evans 2012 pp 321–325).

Agoraphobia
Agoraphobia is a specific fear of being in places or situations from which escape may be difficult. The term comes from the Greek *agora*, meaning marketplace, but typical agoraphobic situations include being home alone, queuing, being in a crowd or travelling on public transport.

Obsessive-compulsive and related disorders
Obsessive-compulsive disorder (OCD) is characterised by obsessions (persistent and recurrent intrusive thoughts or feelings perceived to be
inappropriate by the person) and compulsions (thoughts, actions and behaviours that the person feels compelled to undertake in order to reduce the anxiety experienced). This disorder is no longer listed in the chapter about anxiety in the DSM-5. Any reduction in anxiety is short-lived, and the obsessive thought and associated ritual compulsive behaviours recur, causing havoc in a person’s daily life.

**How common is it?**
Between 2% and 3% of the population, with a complete remission rate of 10–15% (Albucher 2008).

**Prognosis**
Cognitive behaviour therapy (CBT) with medication (antidepressants) is the best treatment for this disabling illness. Either CBT or medication alone is less successful, with relapse in more than 50% of cases. Comorbid substance abuse—in particular, alcohol—is common.

Table 6.1 lists examples of common themes of OCD.

Newly listed disorders in the DSM-5 include hoarding disorder and excoriation (skin picking) disorder.

**TABLE 6.1**
Common themes of obsessive-compulsive behaviour

<table>
<thead>
<tr>
<th>Obsession</th>
<th>Compulsion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination</td>
<td>Excessive handwashing</td>
</tr>
<tr>
<td>Pathological doubt</td>
<td>Checking the gas is off or the door is locked</td>
</tr>
<tr>
<td>Physical illness</td>
<td>Excessive visits to a general practitioner</td>
</tr>
<tr>
<td>Need for symmetry</td>
<td>Lining things up, straightening things, counting or checking excessively</td>
</tr>
<tr>
<td>Religious</td>
<td>Excessive recitation of the rosary</td>
</tr>
</tbody>
</table>

**Post-traumatic stress disorder**
It is now acknowledged that post-traumatic stress disorder (PTSD) can follow any traumatic event, particularly if the event was life-threatening. PTSD used to be called shell shock after soldiers from World War I returned emotionally scarred from their experiences. PTSD is no longer categorised in the DSM-5 with anxiety disorders as it is described under trauma and stressor-related disorders.
Incidence
Incidence depends on the nature of the trauma. Incidence can be as high as 90% (e.g. in torture victims).

Aetiology
Aetiology is a specific traumatic event. Major traumas can include natural disasters (e.g. bushfire, flood, earthquake), robbery, accidents such as train and plane crashes, sexual and physical assault, armed combat and torture. Diagnosis is made if symptoms persist for more than one month and are associated with significant impairment or distress to the person (Posner 2008).

Symptoms
Symptoms are in four groupings focusing on the behavioural effects of symptoms, which are: intrusion; avoidance; negative alterations in cognitions and mood; and alterations in arousal and reactivity. Two new symptoms were also added: persistent and distorted blame of self or others; and reckless or destructive behaviour (American Psychiatric Association 2013).

Prognosis
Untreated chronic PTSD may become less troublesome but not completely go away. Some people will remain severely disabled without treatment. Complete recovery occurs within six months in about half of all cases, with many others having symptoms for a year or longer after the trauma. Prognosis is worse if the person has experienced PTSD in the past (Barton et al 2012).

Assessment scales
The Impact of Events Scale (http://academic.regis.edu/clinicaleducation/pdf's/IES_scoring.pdf) is a scale of current subjective distress related to a specific event, and is based on a list of items composed of commonly reported experiences of intrusion and avoidance.

Schizophrenia
Schizophrenia is a severe mental disorder affecting approximately 1% of the population worldwide, beginning in the 16–35 age group. It occurs equally in males and females. Schizophrenia means different things for people with the condition. The diagnostic label refers only to the presence of a specific set of symptoms.
Aetiology
Aetiology is unclear, but there is some evidence of the following causes:
- **biological:** abnormalities of dopamine and serotonin (neurotransmitters)
- **genetic:** while no single genetic factor has been identified, identical and non-identical twins are more likely to develop the disease if their twin has it (i.e. more than the general population).

Prognosis
Prognosis can be improved with early intervention and shorter periods of psychosis. However, a significant percentage of people have poor quality of life due to the chronic and debilitating symptoms of this condition (Bardwell & Taylor 2012).

Diagnostic criteria
Diagnostic criteria (DSM-5) are two or more of the following for a significant proportion of time in the preceding month:
- delusions, hallucinations, disorganised speech (at least one of these symptoms)
- grossly disorganised behaviour
- negative symptoms (flat affect, lack of volition)
- social and occupational dysfunction
- evidence of dysfunction in the previous six months.

Symptoms of schizophrenia are often divided into two groups: positive and negative symptoms.

Positive symptoms
Positive symptoms involve a loss of contact with reality and include hallucinations, delusions, thought disorder and disorders of movement.

Negative symptoms
Negative symptoms refer to reductions in normal emotional and behavioural states including:
- flat affect (immobile facial expression, monotone voice)
- lack of pleasure in everyday life
- diminished ability to initiate and sustain planned activity
- speaking infrequently, even when forced to interact.

People with schizophrenia may neglect basic hygiene and need help with everyday activities when acutely unwell. People with schizophrenia
are sometimes perceived as lazy, as others do not recognise these behaviours as symptoms of schizophrenia.

**Assessment scales**
Information about the Positive and Negative Symptoms Scale (PANSS) can be found online at <www.freepdfdb.com/pdf/pans>.

**Schizoaffective disorder**
Schizoaffective disorder is characterised by the presence of symptoms of schizophrenia with an abnormal (elevated or lowered) mood.

**Schizophreniform**
Schizophreniform disorder differs only from the diagnosis of schizophrenia in that the duration of the symptoms is less than six months and functioning has not been negatively affected in the person.

**Brief psychotic disorder**
Brief psychotic disorder refers to a person experiencing a psychotic episode that endures for more than one day but less than one month.

**Drug-induced psychosis**
Drug-induced psychosis refers to a person presenting with symptoms of schizophrenia as a direct result of the ingestion of prescribed or non-prescribed medication.

**Disorders of mood**
Between 3% and 5% of the population experience depression (Sadock & Sadock 2007). Among young people aged 12–25 years depression is the most common mental health problem. Depression is a leading cause of disability in the Western world. Aetiology remains unclear, but it is thought to be a combination of biological, environmental and psychosocial factors. It is more common in women than men and has a genetic component. Around 15% of people with a major depressive disorder take their own life. It can have a chronic pathway and is often associated with other chronic physical illnesses, such as cancer, stroke and Parkinson’s disease.

**Major depressive disorder**
Criteria for diagnosis of major depressive disorder (DSM-5) are at least five of the following present in the preceding two weeks, with a significant reduction in functioning:


Chapter 6  An overview of mental illness

- depressed mood (has to be present for diagnosis)
- loss of pleasure in activities that were previously pleasurable (has to be present for diagnosis)
- significant change in weight (up or down)
- sleep disturbances
- psychomotor agitation or retardation
- loss of energy/fatigue
- feelings of worthlessness
- impaired concentration
- suicidal ideation.

Bipolar disorder
Previously known as manic depression, bipolar disorder is characterised by episodes of depression and mania. These episodes must last at least one week. Manic episodes are characterised by insomnia, boundless energy, inability to concentrate, persistently elevated mood, irritability and labile mood. Depressive episodes have the same criteria as for major depressive disorder. The incidence is between 1% and 2% (Australian Bureau of Statistics 2008).

Types of bipolar disorder
Bipolar illness is usually grouped into two types: bipolar I and bipolar II. Although bipolar I is the most studied of the two types, guidance on managing bipolar II is based on data from those studies.

People with bipolar I experience at least one lifetime episode of mania, and usually episodes of depression. People with bipolar II experience episodes of depression plus episodes of a mild form of mania called hypomania (persistent elevation of mood, energy and activity). It can take up to 10 years for a diagnosis of this disorder to be made (DSM-5).

Web resource
For a website on bipolar disorder, see <www.headspace.org.au/is-it-just-me/find-information/bipolar-disorder>.

Childbirth and mood disorders
Although childbirth is usually seen as a happy event, some women (up to 50%) and a few men experience postpartum (after birth) blues. Symptoms include anxiety and tearfulness and may be episodic, with the person feeling happy one minute and very upset the next. The cause is unclear,
but exhaustion, hormonal changes and stress appear to play a part. If symptoms persist beyond two weeks, medical assessment for postnatal depression is required.

**Pre- and postnatal depression**

About 13% of women may develop depression during their pregnancy and it can be life-threatening (Sadock & Sadock 2007). The signs of pre- and postnatal depression are similar to general depression. Postnatal depression can develop several months after giving birth. The main symptoms that are common to postnatal depression are low mood, poor appetite, altered sleep pattern and low self-esteem. Treatment may involve medications that are not thought to cause damage to the baby.

Postpartum psychosis is rare, affecting one in 1000 mothers. This condition is characterised by depressed mood and delusions, often with thoughts of self-harm and/or harming the baby.

In Australia the National Perinatal Depression Initiative (Department of Health and Ageing 2013) aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression. This initiative benefits women who are at risk of or experiencing depression during pregnancy or in the first year following childbirth. The National Perinatal Depression Initiative involves routine and universal screening for depression for women during the perinatal period (once during pregnancy and again about four to six weeks after the birth) by a range of health professionals including midwives, child and maternal health nurses, general practitioners and Aboriginal health workers using the Edinburgh Postnatal Depression Scale. Follow-up treatment and care is also provided (Department of Health and Ageing 2013).

**Web resource**


**Disorders in young people**

**Attention deficit with hyperactivity disorder**

Attention deficit with hyperactivity disorder (ADHD) is a controversial disorder that is thought to be a syndrome of behaviours where children have more difficulty with concentrating on what they are doing (problems with attention) than other children of their age. These difficulties occur due to the way that the child’s brain works. They are not caused by brain damage, but specialised brain imaging tests can show differences in brain
function compared with children without ADHD. There is uncertainty about the incidence (perhaps 5–10%) and prevalence of this disease, and as to whether this disorder exists in adults also. Boys are more likely to be diagnosed with this disorder than girls.

Criteria for diagnosis (adapted from DSM-5) includes several of the behaviours listed below (always including both hyperactivity/impulsivity and inattention behaviours) developing before the age of 12, with a duration of longer than six months. The behaviours must not be associated with other developmental or medical conditions, must occur at home and school and must be negatively disrupting the child’s life. The behaviours are:

- lack of attention to detail with schoolwork or other activities
- has trouble organising tasks and activities
- loses things needed for tasks or activities (e.g. toys, school assignments, pencils, books)
- has trouble sticking to tasks or play activities
- does not seem to listen when spoken to directly
- does not follow through on instructions (that they are able to understand) and does not finish tasks (e.g. at school or chores at home)
- tries to get out of doing things that require a lot of thinking and concentrating (because the activities are considered hard work and tiring)
- is easily distracted and forgetful generally
- hyperactivity/impulsivity, which includes
  - fidgeting of the hands or feet, or squirming in their seat
  - being unable to remain seated in the classroom when asked to
  - running about or climbing excessively (more than most other children)
  - trouble playing quietly
  - talking ‘all the time’
  - difficulty waiting their turn
  - interrupting conversations.

Aetiology
There is no clear explanation for why ADHD happens in some children. The slight differences in the way that a child’s brain works (shown by specialised brain imaging) cause the child’s brain to deal with some activities, information and feelings in a different way from other children. There may be a familial component. Sleep apnoea (blocking of the airway during
sleep) is linked to problem behaviours in many children. Some research has shown that about 30% of children who have ADHD have some sleep apnoea. Signs of sleep apnoea include snoring (often loud snoring) and stopping breathing for a brief time during sleep. Not all children who snore have sleep apnoea, but if a child with ADHD also snores, this might be part of the problem.

**Web resource**
For more information on ADHD, see <www.cyh.com>.

**Eating disorders**

**Anorexia nervosa**
Anorexia nervosa is an eating disorder that affects 0.3–0.5% of the population. It affects more females than males (ratio 10:1). There are two main types:

- the *restricting type*, where the person inhibits food overall, is less impulsive and there are fewer self-harming behaviours and suicide attempts
- the *bingeing/purging type*, which is characterised by family history of obesity or being overweight prior to the condition developing, use of vomiting and medications to decrease weight, self-harm and suicidal behaviours (Makhdoom 2008).

**Criteria**
Diagnostic criteria for anorexia nervosa are:

- persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory and physical health)
- either an intense fear of gaining weight or of becoming fat or persistent behaviour that interferes with weight gain (even though significantly low weight)
- disturbance in the way one’s body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight (Eating Disorders Victoria 2013).

**Prognosis**
If untreated, there is a high mortality rate due to starvation or suicide. With treatment, approximately a third will fully recover, a third will have a partial recovery and a third will have chronic ongoing problems (Makhdoom 2008).
Aetiology
Aetiology includes:

- **Familial factors.** This includes a family history of depressive disorders, eating disorders and obesity and alcoholism.

- **Sociocultural factors.** This is more common in Western countries, and there is some association to professions (e.g. fashion, ballet, gymnastics) where thinness is highly desirable.

- **Individual factors.** Problems in family relationships, low self-worth, a feeling of loss of personal control and physical and sexual abuse are all risk factors.

Physical symptoms
Physical symptoms include:

- loss of muscle mass
- fine downy body hair
- hypotension (low blood pressure)
- bradycardia (low pulse rate)
- anaemia (low iron blood count)
- eroded teeth enamel.

Mental health symptoms
Mental health symptoms include:

- low self-esteem
- poor concentration
- depression
- insomnia
- loss of appetite
- poor memory
- lack of energy
- social withdrawal
- obsessive behaviour around food.

Bulimia nervosa
Bulimia nervosa is an eating disorder where the person has patterns of bingeing and purging, causing emotional distress, preoccupation with body shape and weight, and often normal body weight. It affects 1–3% of young adult females, and is less common in males. Onset usually occurs in late adolescence, and it is more common in Westernised countries.
Criteria
Diagnostic criteria for bulimia nervosa (DSM-5) are:
- craving for food
- preoccupation with eating
- a pattern of overeating followed by compensatory behaviour to reverse food intake (exercise or purging or self-induced vomiting).

Physical and psychological symptoms
Symptoms are similar to that for anorexia nervosa, but body weight may be within the normal range. Purging-related symptoms include:
- stomach ulcers
- tooth decay
- irregular heart beat
- oesophageal/gastric perforation
- constipation
- electrolyte (salt) imbalance.

Intellectual disability
About 1% of the population have an intellectual disability. Intellectual disability is not a mental illness per se; rather it is a neurodevelopment disorder, and is listed in the DSM-5.

Aetiology
Aetiology may be various, including infections, trauma, toxins, problems during childbirth and genetic problems (e.g. Down syndrome, Angelman’s syndrome).

Criteria for diagnosis
In the new DSM-5 less emphasis is placed on an IQ (measure of intelligence) of less than 70 for diagnosis. Instead, it focuses on problems with functioning in the following areas: communication with others; activities of daily living; and lack of independence are key.

Treatment
Recovery-based models of care focus on personal strengths and maximum level of functioning in the community.

Assessment tools
Assessment tools include the Mini Psychiatric Assessment Schedule for Adults with Developmental Disabilities (Mini PAS-ADD) (www.pasadd
.co.uk). It is an accessible assessment tool based on a life-events checklist and the person’s symptoms.

**Web resources**

See <www.intellectualdisability.info> for more information on intellectual disabilities. This is a UK-based information website about the nature of intellectual disability and resources. See also <www.disability.vic.gov.au>, which is a website for people with a disability, their family and carers.

**Autism spectrum disorder**

In the DSM-5, autism spectrum disorder in a new name that conflates four previously separate disorders into one condition. Asperger’s disorder is not included in the 2013 manual and neither is autism disorder. Autism spectrum disorder is characterised by deficits in social communication and social interaction, as well as restricted repetitive behaviours, interests and activities.

**Personality disorders**

Personality can be defined as a person’s lifelong, persistent and enduring characteristics and attitudes, including their ways of thinking, feeling and behaving. These characteristics affect all aspects of a person’s life, including their work, social and personal relationships. Personality disorder can be defined as abnormal, extreme, inflexible and pervasive variations from the normal range of one or more personality attributes, causing suffering to the person as well as those around them. Personality has generally formed by about 16 years of age, and so after this age a disorder can be diagnosed. Personality traits are continuous and need to be distinguished from episodic symptoms and behaviours that occur with mental illness.

Diagnosing and treating personality disorders remains controversial and problematic, as critics of these diagnoses believe that personality, by definition, cannot be changed and therefore is untreatable by the mental health system. What we do know is that people with serious mental illnesses also often have personality problems and that health professionals have a legitimate role in reducing the distress and suffering they endure on a daily basis (MacLean 2008). Appendix 3 provides guidance on working with people with challenging behaviours.

In the DSM-5, personality disorders are classified based on the principal personality features. In clinical practice, there is often overlap between diagnostic categories.
Aetiology
There are a number of theories of personality disorder, which can be summarised as being based on:

- **Genetic factors.** There appears to be some evidence that affective disorders and personality disorders (borderline personality disorder) are linked.
- **Sociocultural factors.** Poor family relationships with physical and/or sexual abuse in childhood, and behavioural difficulties in childhood, may increase the risk of developing a personality disorder in adulthood.

Incidence
It is thought that about 3% of the general population has a borderline personality disorder, the most common disorder of personality. Rates for other personality disorders are much smaller and hard to establish. Within inpatient mental health settings, as many as 30% of patients may have a diagnosis of a personality disorder, many of which have another mental illness (Sadock & Sadock 2007).

Prognosis
Prognosis is variable, and it can be poor. In borderline personality disorder, risk of suicide is high.

Personality disorder groups
There are three groups of personality disorders (see Table 6.2):

- **Cluster A—the odd or eccentric.** As a group, these people tend to be perceived as odd, eccentric and withdrawn. This group of personality disorders includes paranoid personality disorder, schizoid personality disorder and schizotypical personality disorder.
- **Cluster B—the dramatic and emotional.** People with these disorders appear dramatic, emotional and erratic. This group of personality disorders includes histrionic personality disorder, antisocial personality disorder, narcissistic personality disorder and borderline personality disorder.
- **Cluster C—the anxious or fearful.** People with these disorders appear highly anxious and fearful of events and people. This group of personality disorders includes avoidant personality disorder, obsessive-compulsive personality disorder and dependent personality disorder.
<table>
<thead>
<tr>
<th>Personality disorders by type</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster A</strong></td>
<td></td>
</tr>
<tr>
<td>Paranoid</td>
<td>Distrusting and suspicious</td>
</tr>
<tr>
<td></td>
<td>Highly sensitive</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Cold and unemotional</td>
</tr>
<tr>
<td></td>
<td>Lack of interest in other people</td>
</tr>
<tr>
<td></td>
<td>Very introspective</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Socially isolative</td>
</tr>
<tr>
<td></td>
<td>Has unusual ideas</td>
</tr>
<tr>
<td></td>
<td>Often has odd behaviours and appearance</td>
</tr>
<tr>
<td><strong>Cluster B</strong></td>
<td></td>
</tr>
<tr>
<td>Borderline</td>
<td>Unstable relationships with other people</td>
</tr>
<tr>
<td></td>
<td>Poor self-image</td>
</tr>
<tr>
<td></td>
<td>Unpredictable and erratic moods</td>
</tr>
<tr>
<td></td>
<td>Impulsive substance use and abuse</td>
</tr>
<tr>
<td></td>
<td>Impulsive self-harming behaviours</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Strong sense of entitlement</td>
</tr>
<tr>
<td></td>
<td>Grandiose</td>
</tr>
<tr>
<td></td>
<td>Seeks admiration</td>
</tr>
<tr>
<td></td>
<td>Lack of empathy for others</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Tendency to violate the boundaries of others</td>
</tr>
<tr>
<td></td>
<td>Superficial charm</td>
</tr>
<tr>
<td></td>
<td>Poor behaviour control: expressions of irritability, threats, aggression and verbal abuse</td>
</tr>
<tr>
<td>Histrionic</td>
<td>Excessive attention-seeking behaviours</td>
</tr>
<tr>
<td></td>
<td>Egocentric</td>
</tr>
<tr>
<td></td>
<td>Highly emotional</td>
</tr>
<tr>
<td><strong>Cluster C</strong></td>
<td></td>
</tr>
<tr>
<td>Avoidant</td>
<td>Insecure</td>
</tr>
<tr>
<td></td>
<td>Social isolation due to fears of rejection or humiliation by others</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>Preoccupation with orderliness and control over situations</td>
</tr>
<tr>
<td></td>
<td>Rigid behaviour</td>
</tr>
<tr>
<td></td>
<td>Perfectionism</td>
</tr>
<tr>
<td>Dependent</td>
<td>Excessive need to be taken care of</td>
</tr>
<tr>
<td></td>
<td>Clinging, submissive</td>
</tr>
<tr>
<td></td>
<td>Feels helpless when not in a relationship</td>
</tr>
</tbody>
</table>

Assessment tools
The Minnesota Multiphasic Personality Inventory is a commonly used personality test in mental health and copies can be found online at <http://psychcentral.com/lib/minnesota-multiphasic-personality-inventory-mmpi/0005959>. It is used by professionals to examine personality structure and psychopathology.

Web resource
For more information on personality disorders, see the Australian Government Department of Health and Ageing website, which outlines the main types, possible causes, treatment options and where to go for help at <www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-w-whatper>.

Disorders in older people
Delirium
Delirium is not a mental illness or disorder. Rather, it is a reversible clinical syndrome, which is often commonly confused with other disorders such as depression. It is a relatively common health problem in old age, particularly with those in residential care or in hospital. It is marked by an acute disturbance in attention and thinking. Any changes in old age associated with a decline in function and/or thinking are not normal, and need to be investigated and treated. It is very easily confused with dementia or depression. Delirium is an acute medical condition, which can lead to death. It should be treated as a medical emergency. Delirium can be precipitated by:
- pain
- drug or alcohol withdrawal
- infections
- dehydration and/or constipation
- other disorders (e.g. cancer, neurological disorders)
- immobility
- kidney or liver problems
- lack of sleep.

Diagnostic criteria
The three main criteria for a diagnosis of delirium are:
- rapid onset of symptoms (hours) and/or fluctuating mental state
- attention span impairment
- change in cognitive function / altered perception (e.g. hallucinations, thought disorder).
Chapter 6  An overview of mental illness

It is extremely important to differentiate between delirium and other disorders, such as dementia and depression, in order to provide the most appropriate care. Essential differences are listed in Table 6.3.

Aide mémoire: Depression develops over days and weeks, dementia develops over months and delirium develops over hours.

Dementia
Dementia affects about 10% of people aged older than 60 and about 40% of people aged older than 85. There are two main types: Alzheimer’s dementia (more common) and vascular dementia (Australian Institute of Health and Welfare (AIHW) 2007).

Dementia is characterised by one or more of the following cognitive disturbances:
- difficulties with speech
- disturbance of memory
- loss of motor control

<table>
<thead>
<tr>
<th>Mental state assessment</th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Hours to days</td>
<td>Over months</td>
<td>One or more weeks</td>
</tr>
<tr>
<td>Behaviour</td>
<td>Restless and uneasy</td>
<td>Wandering and searching</td>
<td>Slowed, changes to activities of daily living, eating and sleeping</td>
</tr>
<tr>
<td>Cognition</td>
<td>Impaired</td>
<td>Impaired</td>
<td>Slowed, may seem impaired</td>
</tr>
<tr>
<td>Attention</td>
<td>Poor/ fluctuates</td>
<td>Impaired</td>
<td>May appear impaired</td>
</tr>
<tr>
<td>Affect</td>
<td>Changeable; may be irritable or flat, withdrawn</td>
<td>Normal/ flat/ confused</td>
<td>Sad/ irritable/ worried/ depressed/ guilty</td>
</tr>
<tr>
<td>Thought</td>
<td>May be incoherent</td>
<td>Shallow; content may be paranoid due to memory problems</td>
<td>Slowed up, guilty thoughts, hypochondria</td>
</tr>
<tr>
<td>Judgment</td>
<td>Often impaired</td>
<td>Declining</td>
<td>May seem impaired</td>
</tr>
<tr>
<td>Insight</td>
<td>Poor</td>
<td>Reduced</td>
<td>Changeable</td>
</tr>
</tbody>
</table>
decline from previous level of functioning
impaired social or occupational abilities and performance.

Aetiology
Aetiologies include:
- Alzheimer’s disease
- stroke
- Parkinson’s disease
- vascular diseases
- Huntington’s disease
- infections, trauma, tumours and vitamin deficiencies (Moyle 2012).

Prognosis
Dementia is gradual, leading to a decline in previous functioning. Treatment is symptomatic. There is a large human cost to the family and carers, with most people with dementia being cared for in supported residential care towards the end of their lives. Recent developments in medications have seen the use of memory-enhancing drugs that can support better thinking and memory but do not reduce the progression of the disease.

Assessment scales
The Mini-Mental State Examination (MMSE), an abbreviated form of the mental state examination (MSE), is based on observable behaviour in a consumer assessment interview (www.minimental.com). The Rowland Universal Dementia Assessment Scale (RUDAS) is a multicultural cognitive assessment scale (www.alzheimers.org.au).

Other mental disorders in older people
Older people are particularly prone to depression because of a range of life events, including physical illness, isolation, chronic pain and bereavement. The presence of depression is not a sign that the person will necessarily develop dementia or Alzheimer’s disease. Schizophrenia and bipolar disorder are less likely to occur in the older population, but given the chronic nature of these illnesses, older adults may be living with this condition.

Web resource
Alzheimer’s Australia is the peak body providing support and advocacy for the 500,000 Australians living with dementia: see <www.alzheimers.org.au>.
Substance abuse disorders

Substance abuse disorders are the second most prevalent of the mental health disorders and affect approximately 5% of Australian adults (Australian Bureau of Statistics 2008). Substance abuse can involve alcohol, cannabis, stimulants (amphetamines, cocaine), sedatives (temazepam, oxazepam, diazepam) and opioids (morphine and codeine). It is considered that 25% of men and 50% of women with substance abuse disorders have an underlying anxiety disorder or depression (Rothbard et al 2009). This disorder commonly occurs with people with a mental illness.

Diagnostic criteria

The DSM-5 defines substance abuse in the following way:

- A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
  1. recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
  2. recurrent substance use in situations in which it is physically hazardous (e.g. driving a car or operating a machine when impaired by substance use)
  3. recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)
  4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights).

- The symptoms have never met the criteria for substance dependence. Substance dependence refers to the following symptoms and behaviours. There is a maladaptive pattern of use leading to clinically significant impairment involving three or more of the following occurring in a 12-month period:
  1. tolerance
  2. withdrawal
  3. desire to reduce and unsuccessful attempts to reduce use
  4. increase in amounts taken over time
  5. increasing time spent on activities associated with gaining substances
6. reduction of activities because of use
7. use continues despite knowledge of having a physical or psychological problem caused or exacerbated by the substance (Curtis 2009).

**Assessment scales**
Assessment scales include:
- the AUDIT alcohol assessment scale at <www.therightmix.gov.au>
- the CAGE alcohol screening test, which is one of the oldest and most popular screening tools for alcohol abuse. It is a short, four-question test that diagnoses alcohol problems over a lifetime. See <www.healthyplace.com>.

**Web resource**
See the AIHW website at <www.aihw.gov.au>. The impact of the use of drugs and alcohol within the Australian population has become increasingly evident. The AIHW has estimated that in 2003 around 16,700 deaths were drug or alcohol related. The AIHW collects data and reports on two broad categories of drug-related and alcohol-related information. These categories are general population information, which includes the prevalence and impact of drug and alcohol use within Australia, and service-related information, which details the characteristics of alcohol and other drug treatment services and their clients.

**Conclusion**
The most common mental illnesses have been included in this chapter as an introduction to the types of symptoms, thoughts, feelings, behaviours and beliefs that people with a mental illness may have and suffer from. Diagnostic groups are helpful only in as much as they group symptoms together to gain a clear understanding of what is happening for the person. Some symptoms, such as altered mood, altered perceptions and suicidal feelings, can occur across a range of mental illnesses. Finally, each person with a mental illness has a unique experience and, for that reason, carefully designed individualised care is required by trained health professionals.

**REFERENCES**
Chapter 6  An overview of mental illness


WEB RESOURCES

Beyond Blue. <http://www.beyondblue.org.au>. Beyond Blue is an Australian organisation provides information about depression to consumers, carers and health professionals.
National Drug Strategy. <www.nationaldrugstrategy.gov.au>. This website provides information about the National Drug Strategy and the advisory structures that support the strategy, links to the current drug campaign sites, key research and data components and links to relevant governments, professional organisations and drug-related portal sites.


Royal College of Psychiatrists UK. <http://www.rcpsych.ac.uk/publications.aspx>. This website provides information about major mental illnesses for health professionals and the general public.

World Health Organization (WHO). <www.who.int/topics/mental_disorders/en>. WHO is the health arm of the United Nations and provides up-to-date information on a wide range of health-related data. WHO’s classification of diseases (ICD-10) is available at <www.who.int/classifications/icd/en>. 