ADITUM Journal of Clinical Psychology and Mental Health Care

Open Access Research Article

In Shortly about Mental State

Siniša Franjić
Independent Researcher

Article Info

Received: May 29, 2021
Accepted: June 13, 2021
Published: June 16, 2021

***Corresponding author:** Siniša Franjić, Independent Researcher

Citation: Siniša Franjić. "In Shortly about Mental State.''. Clinical Psychology and Mental Health Care, 2(5); DOI: http;//doi.org/03.2021/1.10035.

Abstract

Mental health is an integral part of general health and is an important resource for the individual, family and nation. Mental health problems and disorders, due to relatively high prevalence, frequent onset in young adulthood, possible chronic course, impaired quality of life of patients and their families and a significant share in the use of health care, are one of the priority public health problems in the world. People with impaired mental health have increased morbidity and mortality from physical illness. The number of suicides, which is an indicator of mental health threats, is higher in many countries than the number of people killed in traffic accidents. Mental disorders stigmatize, cause great subjective suffering and greatly reduce the quality of life of sufferers as well as their surroundings. Their care leads to a direct economic burden on society, but also indirectly, due to reduced productivity, sick leave and disability of the sick.

Keywords: mental health; mental state examination; mental disorder

Introduction

Mental health problems are a recognizable risk factor involved in the process of becoming addicted [1]. The psychotropic effects of drugs and alcohol provide significant reinforcing effects, particularly for people troubled by anxiety, depression, fears, mania, and psychosis. Distressed individuals suffering from these conditions learn to abuse substances more quickly and have fewer protective factors and resources to support self-regulation. These emotional and psychological conditions can affect the process of change by influencing decisional considerations, interfering with cognitive/experiential and behavioral processes of change, undermining selfefficacy, and increasing temptations to engage in the addictive behavior. How this vulnerability operates to move individuals forward through the stages of addiction is the key to understanding the high comorbidity prevalence of addiction in the mentally ill.

On the other hand, addictive behaviors can trigger or contribute to the development of psychiatric disorders. Psychotropic substances create altered brain and mood states that most often are ephemeral and last only as long as the drug's biologically active life. However, at times drug effects can trigger severe reactions that last well beyond the drugtaking incident. Many initial psychotic breaks in individuals who later become diagnosed with schizophrenia or bipolar disorder co-occur with drug or alcohol use, although it is not always clear whether drug use simply provided an occasion or was a contributory cause to the psychotic symptoms and emerging mental illness. The interplay between mental illness and addiction is complicated and reciprocal. The interaction is best understood in light of the process of becoming addicted in order to tease apart effects of decision making, impaired judgment, behavioral engagement, progression to addiction, and how these interacting problems sustain each other.

Our minds and bodies consist of subjective experience, which involves sensorially or perceptually accessible 'givens' expressed in different sign systems – such as oral and written languages – and kinds of desire common to all human beings, such as the desire for safety, the desire for love, the desire for recognition [2]. The question of what is the relation between the language we use to capture the forms of experiencing and the material-object-language of the natural sciences seems to be without any clear or real answer. Even though we have better and better knowledge of regular correlations between specific patterns of neuron firing, on the one hand, and instances of conscious experience (data accessed through the senses, conscious, emotional, cognitive, or

conative states), on the other, no fully satisfactory explanation of the relations between neural processes and the subjectively experienced character of mental states is yet available. Nobody knows, at this time, just what such an explanation might look like. At the same time, we still talk of the veracity of subjective experience. Although, thoughts and attitudes for some people need correction, we cannot assume that subjectivity and consciousness are naturally misdirected, a mask for defensive selfishness, or a distorting mirror of the truth for all of us.

Older People

Particular dynamics of social position, inequalities and mental health coalesce at the individual level, as we approach retirement and become older adults [3]. Older adults who are healthy, have an adequate source of income, educated beyond a basic level, active and retain extended social networks tend to adjust well to the challenge of retirement. Compared to people who retire voluntarily, those who are forced into retirement tend to be more depressed and unhealthy. A common cultural assumption has been that early retirement is inherently beneficial because it affords opportunities for more leisure and relief from the stress of job conditions and dissatisfaction. However, recent evidence suggests instead that it is associated with cognitive decline. This may be attributed in part to the shrinking of social networks (particularly at work) that keep people mentally agile. This recognition of the importance of environmental and social networks is now translating into policies that also recognize their importance. In particular it has had an impact on new ways of thinking about primary and social care, which focus on the environmental and social settings of ageing. In relation to the increasingly recognized importance of the degree or lack of social connectivity, via social networks, two sociologically imbued terms have tended to be used interchangeably: 'loneliness' and 'social isolation'.

Service provision for older people is skewed towards providing for dementia. However, there has been some effort to provide for older people experiencing depression from within primary care. Treatment regimens for depression seem to mirror those being provided for other groups, which focus mainly on the use of antidepressants. More normalized activities might seem to offer better amelioration. For example, gardens have been identified as a 'therapeutic landscape': gardening activities have been found to offer comfort and the opportunity for emotional and spiritual renewal, and communal gardening activity on allotments has been found to contribute to psychological well-being, through the provision of a mutually supportive environment. This may enhance emotional well-being by combating social isolation. However, social norms about depression and its management among health professionals are likely to have an impact on access to the means of prevention and management. Therapeutic nihilism (the feeling that nothing can be done for this group of patients) is a feature of primary care professionals' views, while older patients also seem to be characterized by passivity and limited expectations of treatment.

Children

Through the lens of the care system, it is possible to look at the likely longer-term outcomes of adversity in early life [4]. Sadly, kids in care give us a clear model for tracing the results of early abandonment, abuse, or neglect. Statistics covering 13–17-year-olds placed in residential care units reveal the devastating impact of an unstable or traumatic upbringing— 96 percent of them had psychiatric disorders or problems with substances, compared with 15 percent of the general adolescent population. Other figures showed that, compared to other adolescents, young care leavers were four times more likely to have a mental health problem, five times less likely to achieve good academic grades, and three times more likely to be in trouble with the law.

The example of children in care is used as a clear case of young people who have likely been neglected or mistreated by biological parents. There are plenty of other people, who never went into care, who will also have also experienced childhood stress, trauma, or hardship. Whether or not you can track them through institutions—in care, psychiatric hospitals, custody, and prison—you can certainly find them in community mental health centers, addiction services, and rehabs.

MSE

The mental state examination (MSE) is a systematic appraisal of the appearance, behaviour, mental functioning and overall demeanour of a person [5]. In other words, it reflects a person's psychological functioning at a given point in time. The MSE is usually put into a time frame (e.g. the preceding 2 weeks). The history and mental state examination will lead to the formation of differential diagnoses. Most of us inherently perform many aspects of the MSE every time we interact with, or observe others. Observations of the mental state are important in determining a person's capacity to function, and whether psychiatric follow-up is required. Judgements about mental state should always consider the developmental level of the patient and age-appropriateness of the noted behaviour. If there is any indication of current suicidal or homicidal ideation, then the person must be urgently referred for assessment by a qualified mental health clinician. An MSE includes the following eight areas: appearance, behaviour, speech, mood, thought, perception, cognition and insight.

The doctor should consider the patient's mental functioning under the following headings when making an assessment of the mental state, indicating the relevance of any findings to the specific test of capacity [6]. It is also important to document any medical or psychometric tests or other assessment tools used in the process.

By contrast with mental illness or organic brain syndromes, personality disorders present particular problems in relation to assessment of capacity. Such patients have disorders which affect many areas of mental and social functioning, as well as behaviour. They often experience profound mood disturbances and are frequently impulsive. Their thought processes are unusual, but they are not deluded. It is the manner in which persons weigh decisions in the balance which is generally affected, not their ability to think. Assessment of capacity in such patients is extremely difficult since there are no clear-cut abnormalities in the mental state, such as hallucinations or delusions, and yet the doctor often perceives that they are not making decisions in the way that an ordinary person would. There should be no automatic assumption that this necessarily indicates impaired capacity.

Mental Disorder

Mental disorders are defined in diagnostic and statistical manuals such as The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and The International Statistical Classification of Diseases and Related Health Problems (ICD-10), and include a broad range of syndromes, which are generally characterized by some combination of abnormal thoughts, emotions, behaviour, and/or cognitive impairments that have an effect on a person's ability to function and may also affect his or her relationships with others [7]. The term 'mental disorder' is often used to refer to:

1. The major mental illnesses (e.g. schizophrenia, bipolar affective disorders, depression, generalized anxiety disorder, phobias, obsessive-compulsive disorders, eating disorders, dementias, and delirium).
2. Conditions of developmental origin (e.g. intellectual/learning disabilities, autism spectrum conditions, and personality disorders).
3. Substance dependency (e.g. alcohol or other mind-altering substances).
4. Symptoms associated with physical illnesses (e.g. affective disorders in Parkinson's and Huntington's diseases).

This broad range of mental disorders is common in primary care, with prevalence rates reported in the range of 30–50%. Many of these very varied disorders can be successfully treated or managed in a way that reduces and minimizes their impact on a person's life. Mental disorders that are serious enough potentially to complicate the management of physical health problems are also common. Accident and emergency (A&E) departments frequently see patients who have self-harmed or have suffered injuries owing to substance abuse. A person dependent on alcohol who is admitted for surgery may develop withdrawal symptoms and delirium tremens some days after admission to hospital because of forced abstinence from alcohol. Other examples are anxiety and depression, both of which may arise on a general medical ward in the context of a diagnosis of a life-limiting physical illness. People may also present with symptoms that are not readily explained in which anxiety and depression may be a significant factor.

Looking at the human mind from an interdisciplinary and multi-historical point of view, it seems like a general law that all human beings have at least some degree of fundamental capacity to think and behave like what one in the modern world would call a mentally disabled person [2]. We have an urge to imagine things that are disconnected from the objective or external world. Alienation and morbid experiences that close the world in a fixed image affect people of all ages, races, religions, and incomes. The experiences occur when you least need it, i.e., when you are very stressed, in shock, in love, in great sadness, or in great joy. As such, morbid experiences are not the result of personal weakness, lack of character, or poor upbringing. Instead, they show incredible creativity in terms of behavior and thought. They can hurt and damage our mind enormously. They can disrupt a person's thoughts, feelings, mood, and ability to relate to others, as well as the capacity to cope with the ordinary demands of life. However, the understanding of mental morbid experience and the feeling of alienation as a medical condition reduces the human mind to diagnoses, such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD), and borderline personality disorder.

Violence

Violence or aggressive behaviors are important concerns for working with forensic psychiatric patients [8]. Factors that influence an individual's proclivity for violence include the client's diagnosis, history of violent behavior, young age, neurobiology, and genetic predisposition. Previous diagnoses of psychosis, substance abuse, organic brain disorders, dementia, mental retardation, or personality disorder are highly correlated risk factors for assault. The strongest predictor of future violence is past violence. Patients with histories of violence must be monitored closely. The use of violence is often an attempt to gain control in a system where control seems lost. Patients resort to aggression when they are unable to manipulate the staff or do not get what they want. It's important for staff to remain neutral and avoid engaging in power struggles with the patient. Staff should also avoid becoming defensive when patients make disparaging remarks. Self-awareness of the nurse's past history with violence or manipulation as well as attitudes and beliefs regarding violence and victimization are important. A nurse who has been assaulted by a patient before may have difficulty caring for patients with violent pasts. It's easy to feel fear in the face of aggression. Fear can cause the nurse to avoid the patient or bend the rules. Careful and consistent team approaches to these patients helps to ensure a therapeutic approach that does not compromise safety or patient care.

When a patient enters a clinical setting and is acting out, the clinician is responsible to handle the situation in the best way possible. The first step is to recognize the problem. Violence can occur anywhere in the healthcare setting and can involve patient-patient, patient-staff, staff-staff, or any combination of these interactions, with families often also involved. Early behaviors that are indicative of aggression include pacing, restlessness, tense facial expression and body language, shouting, use of obscenities, and overreacting to stimuli. In addition, each patient has triggers to aggression and specific behaviors that are manifested in response to those triggers. Triggers can include things like hearing no to a request or loud noises on the unit. Keeping the unit safe involves a proactive approach to early identification of aggression and reduction of risk.

Criminal Law

Criminal law presupposes the "folk psychological" view of the person and behavior [9]. This psychological theory, which has many variants, causally explains behavior in part by mental states such as desires, beliefs, intentions, willings, and plans. Biological, sociological, and other psychological variables also play a role, but folk psychology considers mental states fundamental to a full explanation of human action. Lawyers, philosophers, and scientists argue about the definitions of mental states and theories of action, but that does not undermine the general claim that mental states are fundamental. The arguments and evidence disputants use to convince others itself presupposes the folk psychological view of the person. Brains don't convince each other; people do.

Folk psychology does not presuppose the truth of free will, it is consistent with the truth of determinism, it does not hold that we have minds that are independent of our bodies (although it, and ordinary speech, sound that way), and it presupposes no particular moral or political view. It does not claim that all mental states are

conscious or that people go through a conscious decision-making process each time that they act. It allows for "thoughtless," automatic, and habitual actions and for non-conscious intentions. It does presuppose that human action will at least be rationalizable by mental state explanations or that it will be responsive to reasons under the right conditions. The definition of folk psychology being used does not depend on any particular bit of folk wisdom about how people are motivated, feel, or act. Any of these bits, such as that people intend the natural and probable consequences of their actions, may be wrong. The definition insists only that human action is in part causally explained by mental states.

The criminal law's criteria for responsibility, like the criteria for addiction, are acts and mental states. Thus, the criminal law is a folk-psychological institution. First, the agent must perform a prohibited intentional act (or omission) in a state of reasonably integrated consciousness (the so-called "act" requirement, sometimes misleadingly termed the "voluntary act"). Second, virtually all serious crimes require that the person had a further mental state, the mens rea, regarding the prohibited harm. Lawyers term these definitional criteria for prima facie culpability the "elements" of the crime. They are the criteria that the prosecution must prove beyond a reasonable doubt. For example, one definition of murder is the intentional killing of another human being. To be prima facie guilty of murder, the person must have intentionally performed some act that kills, such as shooting or knifing, and it must have been his intent to kill when he shot or knifed. If the agent does not act at all because his bodily movement is not intentional—for example, a reflex or spasmodic movement—then there is no violation of the prohibition. There is also no violation in cases in which the further mental state required by the definition is lacking. For example, if the defendant's intentional killing action kills only because the defendant was careless, then the defendant may be guilty of some homicide crime, but not of intentional homicide.

Hospital

Some psychiatric conditions require a long stay in hospital: usually no less than four weeks and in many cases longer [10]. This means that the nature of assessment is conditional on the needs of the client. It is becoming more recognised that if at all possible it is better to assess clients in their own homes. In the case of community teams this is possible for some types of referral, but for the most disturbed and acute illnesses, admission to hospital is another option. As part of the assessment process, a full medical and mental state examination should be followed by appropriate multidisciplinary discussion that enables the preparation of a treatment plan supported by further assessment. This assessment, usually via observation of the client, makes use of written documentation and can utilise observation checklists.

Conclusion

Mental disorders are characterized by psychological, biological, and social dysfunction of the individual, and include a range of symptoms and disorders. They are defined according to the existence of sets of symptoms, and the criteria for diagnosis are met when the sets of symptoms are relatively severe, long-lasting, and accompanied by a decrease in functional ability or disability. Symptoms may exist without meeting the criteria for clinical disorders as subclinical conditions.

References

1. DiClemente, C. C. (2018.): „Addiction and Change - How Addictions Develop and Addicted People Recover, Second Edition", The Guilford Press, New York, USA, pp. 286.
2. Joranger, L. (2019.): „An Interdisciplinary Approach to the Human Mind - Subjectivity, Science and Experiences in Change", Routledge, Taylor & Francis Group, Abingdon, UK, pp. 104.; 110.
3. Rogers, A.; Pilgrim, D. (2014.): „A Sociology of Mental Health and Illness, Fifth Edition", Open University Press, McGraw-Hill Education, Maidenhead, UK, pp. 80. – 81.
4. Burgess, B. (2017.): „How a stigmatic structure enslaves addicts" in Heather, N.; Segal, G. (eds): „Addiction and Choice - Rethinking the Relationship", Oxford University Press, Oxford, UK, pp. 412.
5. Azam, M.; Qureshi, M.; Kinnair, D. (2016.): „Psychiatry - A Clinical Handbook", Scion Publishing Ltd, Banbury, UK, pp. 17.
6. Ashton, G.; Letts, P.; Rowlands, P.; Solomons, E.; Waite, J. (2004.): „Assessment of Mental Capacity - Guidance for Doctors and Lawyers, Second Edition", British Medical Association, BMJ Publishing Group, London, UK, pp. 155. – 159.
7. Holland, A.; Fistein, E.; Walsh, C. (2019.): „Mental Health Law" in Sturgess, J.; Duane, D.; Ley, R. (eds): „A Medic's Guide to Essential Legal Matters", Oxford University Press, Oxford, UK, pp. 129. – 130.
8. Sekula, L. K.; Amar, A. F. (2016:): „Forensic Mental Health Nursing" in Amar, A. F.; Sekula, L. K. (eds): „A Practical Guide to Forensic Nursing - Incorporating Forensic Principles Into Nursing", Sigma Theta Tau International, Indianapolis, USA, pp. 232. – 233.
9. Morse, S. J. (2017.): „Addiction, choice, and criminal law" in Heather, N.; Segal, G. (eds): „Addiction and Choice - Rethinking the Relationship", Oxford University Press, Oxford, UK, pp. 429. – 430.
10. Holyoake, D. (2003.): „Reflecting on Mental Health Assessment and Advanced Nursing Practice" in McGee, P.; Castledine, G. (eds): „Advanced Nursing Practice, Second Edition", Blackwell Publishing Ltd, Oxford, UK, pp. 105.