

Mental Health

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“Without mental health there can be no true physical health.”

Dr. Brock Chisholm- (*First Director-General of WHO, 1954*)

Introduction to Mental Health

- Mental health includes our **emotional, psychological, and social well-being**. It affects how **we think, feel, and act**.
- It also helps determine **how we handle stress, relate to others, and make choices**.
- It is **more than the absence of a mental disorder**; it is the ability to think, learn, and understand one's emotions and the reactions of others.

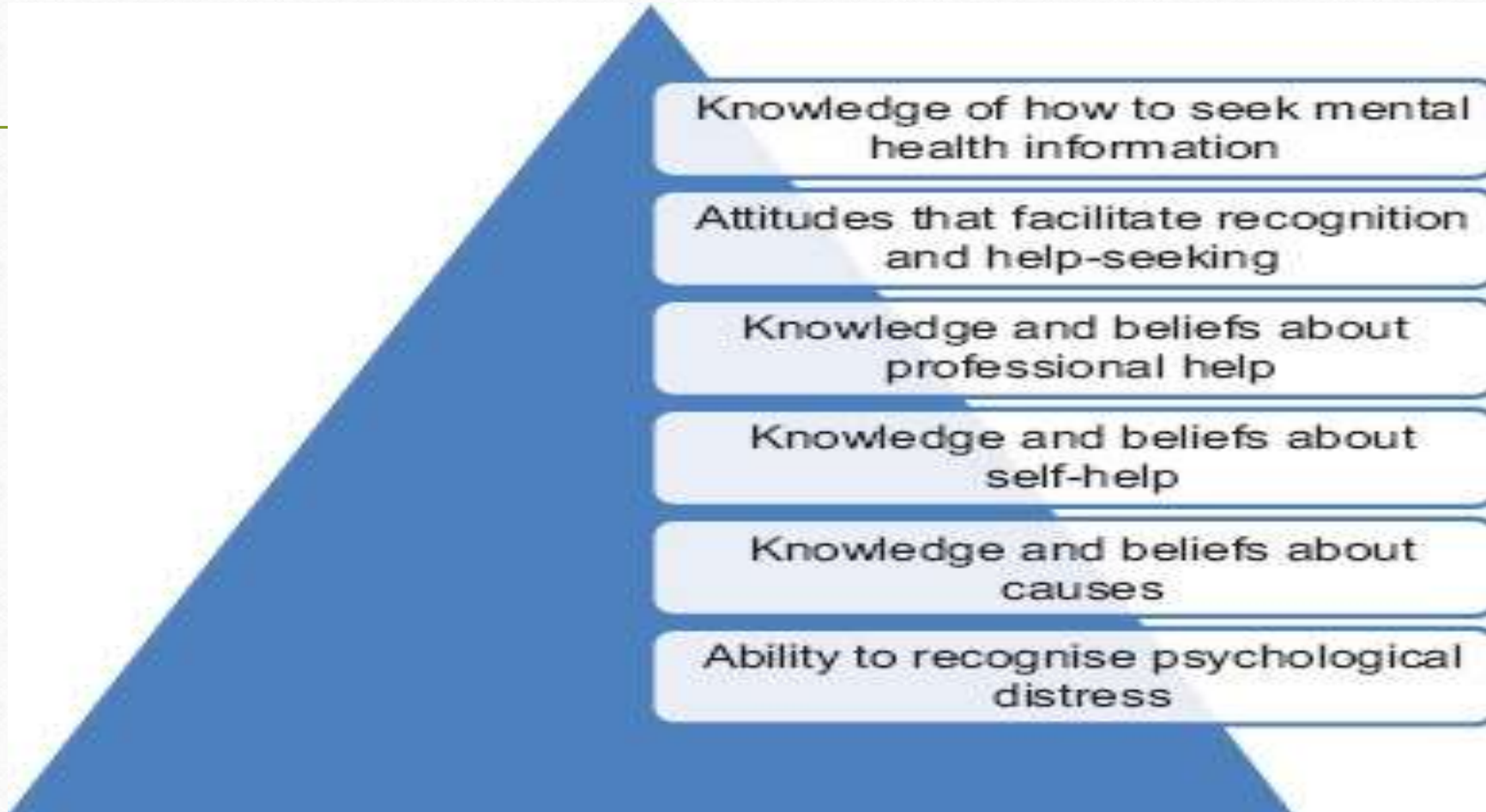
Introduction to Mental Illness and Mental Health Literacy

- A mental illness, or mental health disorder, is defined as patterns or changes in thinking, feeling or behaving that cause distress or disrupt a person's ability to function.
- Mental health literacy is a related concept which is increasingly seen as an important measure of the awareness and knowledge of mental health disorders.

Introduction to Mental Illness and Mental Health Literacy

- Health literacy has been described as **“ability to access, understand, and use the information to promote and maintain good health.”**
- Mental health literacy encompasses **recognition, causes, self-help, facilitation of professional intervention, and navigating the information highway.**

Components of mental health literacy: Jorm AF



Facts and Figures

- **792 million** people lived with a mental health disorder as per study estimates in 2017.
- This is slightly more than one in ten people globally (**10.7%**)
- **7.5 %** of the Indian population suffers from some form of mental disorder.
- Mental illnesses constitute one-sixth of all health-related disorders and India accounted for nearly 15% of the global mental, neurological and substance abuse disorder burden.

Facts and Figures

- **One in seven Indians** were affected by mental disorders of varying severity in 2017. The proportional contribution of mental disorders to the total disease burden in India has almost **doubled since 1990**.
- In 2017, **197.3 million** people had mental disorders in India, including **45.7 million** (42.4–49.8) with **depressive disorders** and **44.9 million** (41.2–48.9) with **anxiety disorders**.
- The **treatment gap**, which is defined as the prevalence of mental illnesses and the proportion of patients that get treatment, is over **70 per cent**.

Facts and Figures

- As per WHO's estimates approximately 20% of youth experience mental disorders.
- The suicide rate in India in 2015 at **15.7 per** lakh, it is higher than the regional average of 12.9 and the global average of 10.6.
- Suicide is the leading cause of death among those aged 15–29 in India. There remains a massive unaddressed need within the population.

STATS ON MENTAL ILLNESS

1 in 6 people in the past week experienced a common mental health problem

Worldwide, 800,000 people die by suicide every year

Schizophrenia affects more than 21 million people worldwide

People with mental illness:
UK: 1 in 4
Australia: 1 in 5
India: 6 to 7% of population
South Africa: 16.5% of population
USA: 1 in 5

By 2020, depression is estimated to be the second biggest ailment in the world after heart disease

Half of all mental health issues begin by the age of 14; 75% by age 24

72% of male prisoners in UK suffer from two or more mental disorders

At least 16 children in the UK kill themselves each year because of bullying at school

WWW.DEFYINGMENTALILLNESS.COM

**Let's end stigma & discrimination
Let's defy mental illness**

1 in 4 patients that seek medical help in Kenya suffer from mental illness

**SOURCES INCLUDE:
WHO
MEN'S HEALTH FORUM
NIMH
ONS**

What causes mental illness?

BIOLOGICAL

- Genetic – Family History- Having a parent/twin/family member with the illness-passed on by your genes.
- Chemical imbalances in the brain (Dopamine & serotonin)
- Head injury, long term epilepsy and other such neurological conditions etc.

PSYCHOLOGICAL :

- Early adverse life experiences, such as trauma or a history of abuse (for example, child abuse, sexual assault, witnessing violence, etc.)

What causes mental illness?

- **Experiences related to other ongoing (chronic) medical conditions, such as cancer or diabetes**
- **Use of substances** such as alcohol and/or psychotropic drugs
- Having **feelings** of loneliness or isolation

SOCIAL:

- Stressful life events such as Bereavement,
- Loss of identity; property; displacement, alienation, boycott
- Experiences leading to shame and social embarrassment e.g. bullying, crimes of violence, Neglect and Maltreatment etc.

Early Warning Signs

- Experiencing one or more of the following feelings or behaviors can be an early warning sign of a problem:
- Eating or sleeping too much or too little
- Pulling away from people and usual activities
- Having low or no energy
- Feeling numb or like nothing matters
- Having unexplained aches and pains
- Feeling helpless or hopeless
- Smoking, drinking, or using drugs more than usual

Early Warning Signs

- Feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared
- Yelling or fighting with family and friends
- Experiencing severe mood swings that cause problems in relationships
- Having persistent thoughts and memories you can't get out of your head
- Hearing voices or believing things that are not true
- Thinking of harming yourself or others
- Inability to perform daily tasks like taking care of your kids or getting to work or school

BODY

Headaches
Frequent infections
Muscular tension
Fatigue
Skin irritations
Breathlessness

MIND

Worrying
Muddled thinking
Inability to concentrate
Nightmares
Indecisions
Negativity
Hasty decisions

STRESS

Loss of confidence
More fussy
Irritability
Depression
Anger
Anxiousness
Apprehension

Accident prone
Over- / under-eating
Loss of sex drive
Drinking more
Sleeplessness
Restlessness
Smoking more

EMOTIONS

BEHAVIOUR

Symptoms of Depression

Experiencing 5 or more of the following symptoms for >2 weeks may indicate a depressive disorder



Feeling sad, guilty or helpless



Reduced sense of self-worth



Loss of interest in activities



Insomnia or excessive sleeping



Digestive problems



Physical aches



Changes in weight or appetite



Trouble focusing and making decisions



Restlessness



Pessimism



Irritability



Suicidal thoughts or attempts

SIGNS AND SYMPTOMS OF ANXIETY

 @BELIEVEPHQ

WORRYING ABOUT PAST EVENTS

ALL OR NOTHING THINKING

WORRY ABOUT FUTURE EVENTS

OVERTHINKING

TIGHT CHEST

TREMBLING

MIND READING

LIGHT HEADED

EXCESSIVE WORRYING

PANIC ATTACKS

HEADACHES

STOMACH CRAMPS

"WHAT IF.."

MUSCLE TENSION

SECOND GUESSING

AVOIDANCE

"WHY CAN'T I SLEEP?"

SWEATING

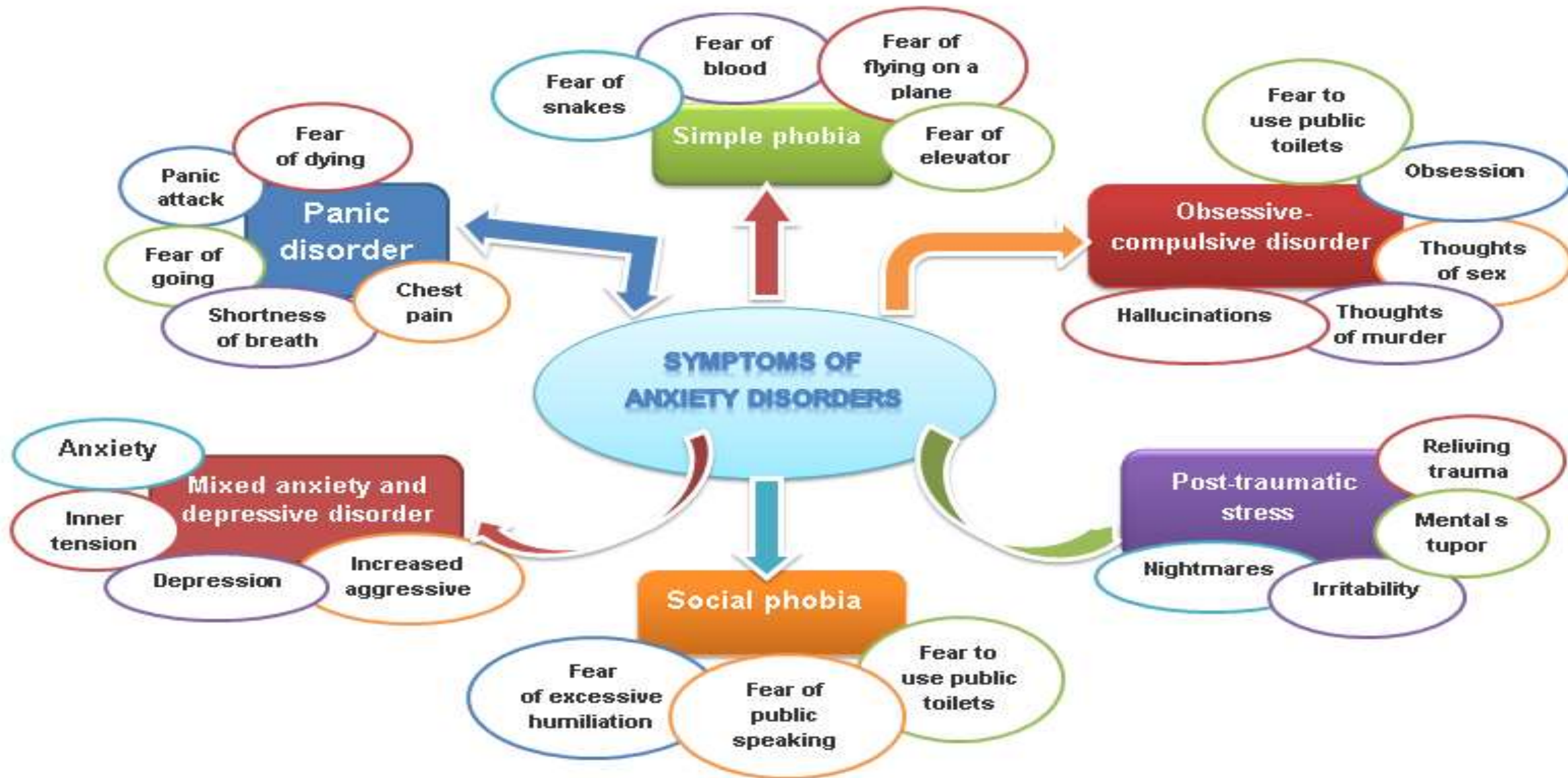
TENSENESS

LOSS OF APPETITE

"I CAN'T STOP MY WORRIES"

FEELING IRRITABLE





Symptoms of schizophrenia



Post-Traumatic Stress Disorder (PTSD)



Avoid Thinking of the Trauma



Avoid Talking of the Trauma



Easily Frightened



Negative Mood



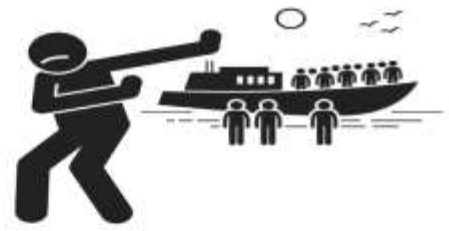
Negative Thinking



Always on Guard



Avoiding Places



Avoiding Activities



Flashbacks



Cannot Concentrate



Aggressive Behavior



Loss of Interest



Feeling Guilt or Shame



Substance Abuse



Sleeping Difficulty



Bad Dreams



**Common mental disorders among children
that hamper growth and brain development**

CHILDREN AND MENTAL ILLNESSES

Attention Deficit
Hyperactivity
Disorder (ADHD)

Anxiety
Disorders

Mood
Disorders



Autism
Spectrum
Disorder
(ASD)

Eating
Disorders

DID YOU KNOW?

1 IN 5 CHILDREN FROM THE AGES 13-18 WILL LIVE WITH A MENTAL ILLNESS



ONLY 30% OF DEPRESSED TEENS ARE BEING TREATED



MENTAL ILLNESSES CAN AFFECT



DEPRESSION AND ANXIETY ARE THE MOST COMMON MENTAL ILLNESSES



90% OF THOSE WHO COMMITTED SUICIDE HAD AN UNDERLYING MENTAL ILLNESS

{ What are the most common psychiatric disorders in childhood? }

ADHD AND BEHAVIOR DISORDERS

Children with ADHD and/or behavioral disorders may have difficulty focusing and controlling impulsive behaviors. Median age of onset is age 11.

MOOD DISORDERS

Children with mood disorders may have persistent feelings of sadness and/or rapidly changing moods. Median age of onset is age 13.

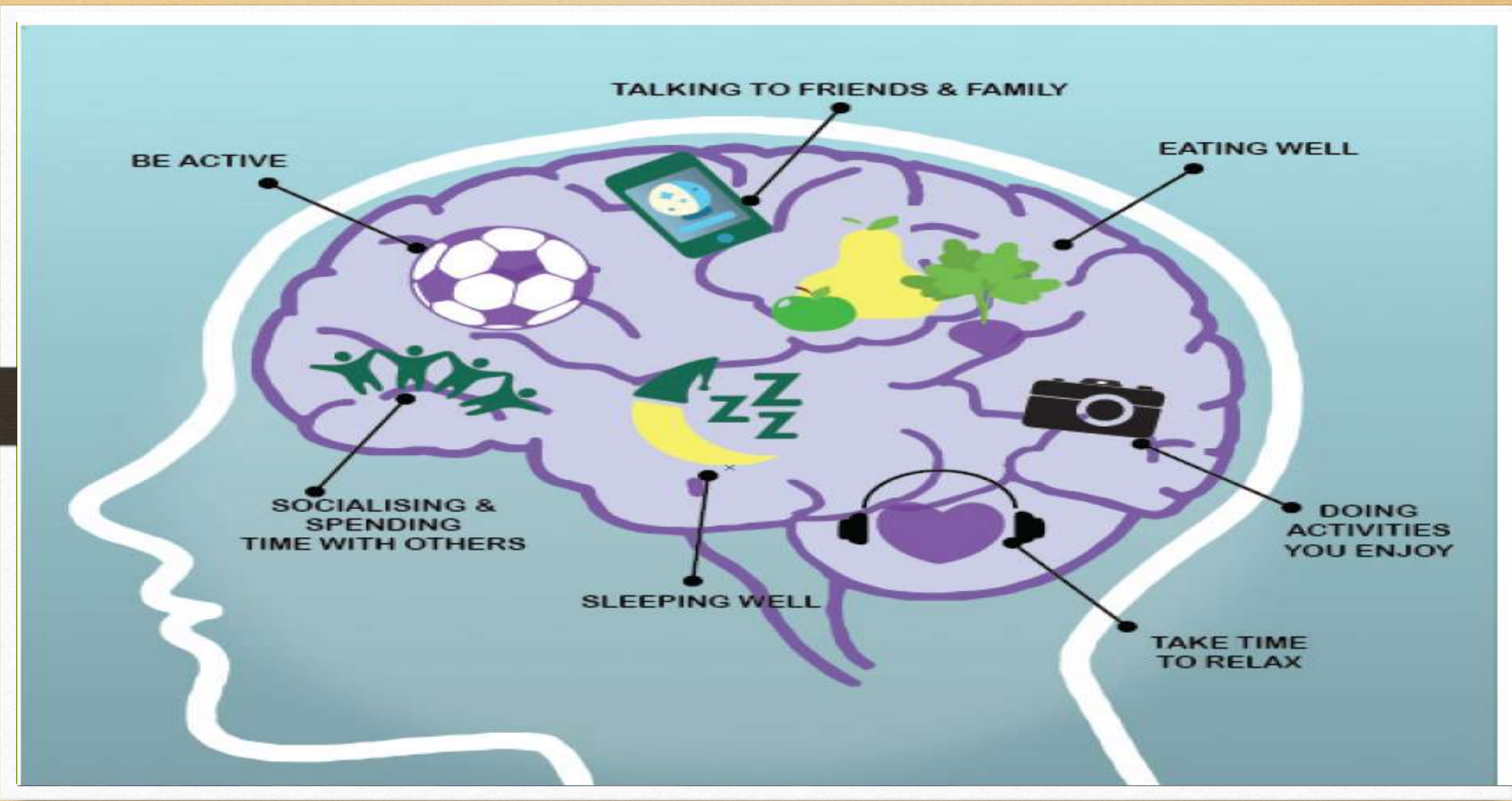
ANXIETY DISORDERS

Children with anxiety disorders respond to certain things or situations with fear and dread, as well as with physical signs of anxiety, such as a rapid heartbeat and sweating. Median age of onset is age 6.



This is how **common** mental disorders are in children and adolescents (9-17)

Mental Disorder	Six Month Prevalence (%) Age = 9-17
Anxiety Disorder	13.0
Mood Disorder	6.2
Disruptive Behavioral Disorders	10.3
Substance Use Disorders	2.0
Any Disorder	20.9



Severe Mental Disorders (SMD)

Facts and Figures

- ▶ **One in seven Indians** were affected by mental disorders of varying severity in 2017.
- ▶ Estimates suggest that **nearly 15%** of the Indian population grapples with some form of mental health issue.
- ▶ In India, the prevalence of schizophrenia is estimated to be 0.3% as per the Global Burden of Diseases (GBD) study of 1990–2017.
- ▶ The crude prevalence for **both depressive disorders and anxiety disorders was 3.3%** (3.1–3.6 for depressive disorders and 3.0–3.5 for anxiety disorders), whereas **bipolar disorders** had prevalence of **0.6%** (0.5–0.7) and **schizophrenia 0.3%** (0.2–0.3)

Severe Mental Disorders (SMDs)

- ▶ Is a **smaller** and more **severe subset** of mental illnesses;
- ▶ *Defined as one or more mental, behavioral, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities(NIMH).*
- ▶ Lifetime prevalence of mental disorders in India is 12.3% for common mental disorders and **1.95% for severe mental disorders.**
- ▶ The repercussions of these conditions encompass personal suffering, impaired daily functioning, and extensive societal costs
- ▶ *SMD's include: 1. Schizophrenia. 2. Bipolar disorder. 3. Depression with Psychotic Symptoms. 4. Treatment resistant Depression*

Schizophrenia

Major mental disorder characterized by the **changes in thinking, emotions**, in the **presence of conscious state**, which usually leads to **social isolation** (*Prev. rate- 1-2%, 0.5% in India*)

Alters/Impacts

- ❖ **a person's perception of reality-** hallucinations (perceiving things that are not there), delusions (false beliefs), disorganized speech and behavior
- ❖ **thinking processes-** difficulties in cognitive functioning, such as problems with memory, attention, and executive functioning.
- ❖ **emotions-** reduced emotional range, reactivity and expression,
- ❖ **and behavior-** disorganized behaviour, social withdrawal

Etiology of Schizophrenia

- ▶ **Genetic:** A family relative with schizophrenia increases the chance of developing the illness (risk increases to 10 times that of general pop.; higher in 1st degree relatives and monozygotic twins)
- ▶ **Biological :** Exposure to infection during prenatal period.
- ▶ **Biochemical:** Most prominent found to be an imbalance of dopamine (brain chemical or neurotransmitter) in the brain
- ▶ **Psychological-** Mal-adaptive **coping skills** to life events; **Poor** and Ineffective **Social Skills-** impacts formation of rewarding relationships and lead to **difficulties in resolving conflict.**
- ▶ **Social:** Experience of Stress from significant **stressful** life events such as the **loss** of someone close, business loss or **change in place of living**, can be stressful and lead to higher risk as well as relapse.

Signs and Symptoms:

The symptoms of schizophrenia mainly fall into three categories: positive, negative, and cognitive

(A) Positive Symptoms:

- 1: Talking to self
- 2: Hearing voices that are not really there
- 3: Seeing things that not really there
- 4(a): Believing Others May Harm them; 4 (b): Unreasonable Fear

Delusions: Delusions are **Firm, False, and Fixed Unshakable Beliefs that are Not Based on Reality-
e.g.- *persecution*; reference; grandeur; and control, **

Signs and Symptoms

(B) Negative Symptoms: Negative symptoms are associated with disturbances to normal emotions and behaviours:

- ▶ 1: Decreased Talking
- 2: Feeling Sad
- 3: Socially Withdrawn
- 4: Reduced Energy
- 5: Sleep Disturbance.

(C). Cognitive Symptoms: Disturbances in memory or thinking. E.g., poor concentration, poor judgement, poor problem solving skills (executive functioning),

****LACK OF INSIGHT****



Management of Schizophrenia at SHC-HWC

A comprehensive treatment plan should include:

- ▶ *Medical management*
- ▶ *Family psycho education*
- ▶ *Rehabilitation*

PSYCHOEDUCATION

Info on illness, treatment, rehabilitation

PSYCHOTHERAPY

Individual Therapy
Cognitive Behaviour Therapy



PSYCHOSOCIAL THERAPY

Life Skills, Social Skills, Vocational Skills

FAMILY Interventions

Medication Adherence,
Reduce Expressed Emotions
,Home care

BIPOLAR DISORDER

Characterized by:

- ❖ **Alternating periods of elevated mood** (mania or hypomania) **and** episodes of **depression**.
- ❖ During manic episodes- individuals may experience **heightened energy levels, decreased sleep, racing thoughts, inflated self-esteem, impulsive behavior, and an exaggerated sense of self-importance**.
- ❖ Depressive episodes are marked by **sadness, loss of interest, fatigue, and changes in appetite and sleep patterns**.
- ❖ Bipolar disorder can profoundly **impact an individual's emotions, behavior, relationships, and overall functioning**

MANIC EPISODE

Manic Episode- It is characterized by the following clinical picture which should be present for at least 1 week and cause disruption in daily living.

- ❖ a. **Elevated, Expansive Mood:** It can range from euphoria to irritability
- ❖ b. **Psychomotor Activity:** Characterized by over activity, restlessness, & excitement
- ❖ c. **Speech and Thought:** Person is more talkative, increased pressure of speech (fast and incoherent speech), use of playful language such as rhyming, joking, teasing
- ❖ d. **Goal Directed Activity:** There is marked increase in daily activity with more planning and at times execution of many activities..

DEPRESSIVE EPISODE

Depressive Episode- mainly characterized by the following clinical features, which should be present

for at least 2 weeks for the diagnosis.

- ▶ a. **Depressed Mood:** Sadness, no interest in daily activities
- ▶ b. **Depressed Cognition:** Hopelessness, Helplessness & Worthlessness can lead to difficulty in thinking & concentration
- ▶ c. **Psychomotor Activity:** Slowed thinking & activity, decreased energy
- ▶ d. **Physical Symptoms:** Heaviness of head, body aches, easy fatiguability

DEPRESSIVE EPISODE

- e. **Biological symptoms:** Insomnia, loss of appetite and weight, loss of sexual drive, Risk of suicide and death wishes
- f. **Psychotic Symptoms:** Delusion & hallucinations, and inappropriate behaviour

COGNITIVE THERAPY
To correct depressive cog, nition

BEHAVIOUR THERAPY
Assertiveness, Problem Solving and Decision
Makiing Skills

SUPPORTIVE THERAPY
Ventilation; Reassurance

FAMILY THERAPY
Reduce intrafamilial conflicts
Reduce Expressed Emotions

GROUP THERAPY
Reduce Negative Emotions anger, guilt, anxiety

RED FLAGS IN SMDS

- ▶ When there is risk of suicide or harm to others
- ▶ Catatonic behaviour symptoms (abnormal movements – no movement/speech/response to stimuli or excessive movements)
- ▶ Poor general health condition.
- ▶ Refusal to take orally (meals & medications).

INTRODUCTION

According to National Mental Health Survey, around 10% of people in the general population have CMDs.

Around 2.68% of people have depressive disorders
3.53% of people have neurotic and stress related disorders (including anxiety disorders) in the community.

Depressive and anxiety disorders are the commonest CMDs at primary health care setting.

INTRODUCTION

Co-occurrence of more than one psychiatric illness is common

Mixed depression-anxiety disorder is the commonest co-occurrence in primary care.

CMDs are more prevalent amongst women than men.

A significant part of the general population also suffer from psychosomatic disorders.

ETIOLOG Y OF CMDs



multi-factorial in origin.



The risk for developing these disorders is inherited genetically.



At the molecular level there is derangement in serotonin and norepinephrine levels in the brain.

COMMON
MENTAL
DISORDE
RS

Depressive Disorders

Anxiety Disorders

Somatization Disorder/
Psychosomatic Disorders

DEPRESSIVE DISORDER



Presence of pervasive and persistent low mood,



Loss of interest and enjoyment in ordinary/routine thing and experiences,



Increased fatiguability



For at least 2 weeks.

Risk Factors for Depressive Disorder

Depressive disorder in first degree relatives

Stressful life events

Chronic or disabling medical illness
(Diabetes, obesity, cardiovascular diseases)

Depressive disorders may appear even without any risk factors similar to idiopathic (primary) hypertension.

CLINICAL FEATURES

Core Symptoms

Pervasive Low Mood/Sadness:

Sadness is present on almost all days, present during all situations (even joyous moments).

Loss of Interest and Enjoyment:

There is loss of interest in daily activities, work, loss of enjoyment of previously pleasurable activities.

Reduced Energy:

There is feeling of decreased bodily energy, easy fatiguability (disproportionate to work done). All of which lead to reduced activity.

CLINICAL FEATURES

Additional Symptoms

Reduced Concentration and Attention:

During daily activities and work, reduced self-esteem and self-confidence.

Hopelessness: Bleak and pessimistic view of future.

Ideas of Guilt and Unworthiness: The patient is self-reproachful and self-critical. He/she also feels less worthy.

Death wishes, ideas or acts of self-harm or suicide.

Diminished appetite, disturbed sleep, reduced weight, marked loss of libido.

DIAGNOSIS

Presence of at least **TWO core symptoms** and at least **THREE**

additional symptoms for **more than TWO weeks** is required to

confirm the diagnosis of Depressive Disorder.

ANXIETY DISORDERS



1. GENERALIZED
ANXIETY
DISORDER



2. PANIC
DISORDER

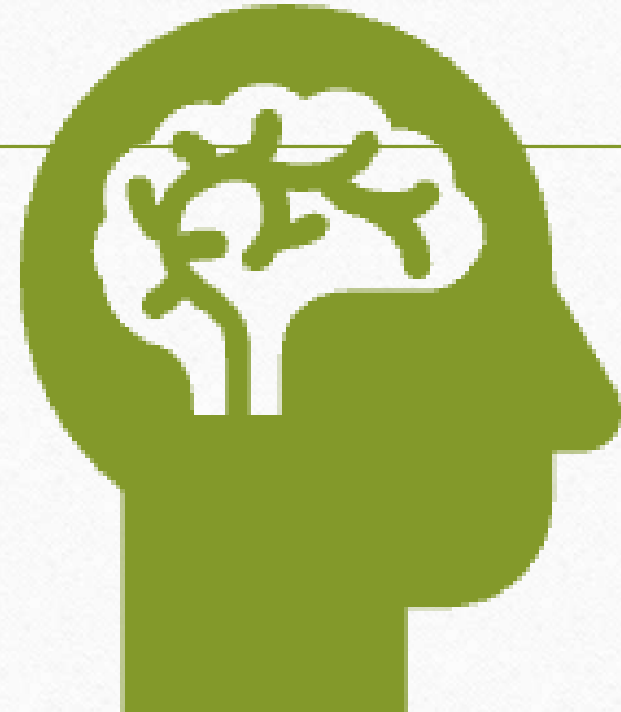


3. SOCIAL
ANXIETY
DISORDER

GENERALIZED ANXIETY DISORDERS

GAD is characterized by :

- Excessive fear,
- Tension,
- Stress,
- Anxiety and worry about a number of events or activities,
- Occurring on more days than not for a period of at least 6 months.



CLINICAL FEATURES

- An experience of excessive and uncontrollable anxiety/tension/worry with no obvious reason or trivial reason, for many months (>6 months).

The characteristics are:

- **Apprehension**- patient has worries about misfortunes (about family, health, finances, work etc), feeling 'on the edge', difficulty in concentration.
- **Motor tension**- being restless, fidgety, trembling, inability to relax, tension headaches.
- **Autonomic overactivity**- light-headedness, sweating, tachycardia or tachypnoea, epigastric discomfort, dizziness, dry mouth etc.

The above symptoms must be present for at least 6 months to diagnose GAD.

DIFFERENTIAL DIAGNOSIS

Hyperthyroidism

Pheochromocytoma

Alcohol, benzodiazepine, opioid withdrawal

Social anxiety disorder

Obsessive compulsive disorder

Adjustment disorder

Post-Traumatic Stress Disorder

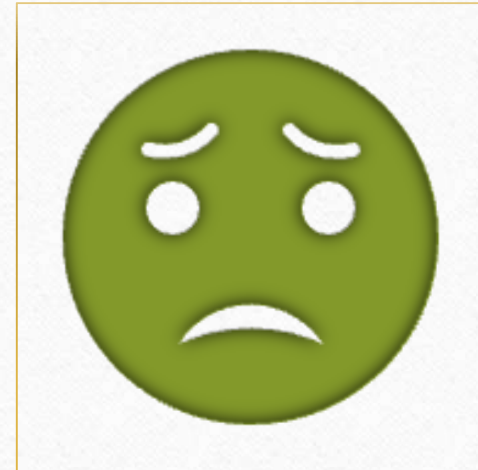
PANIC DISORDER

Characterized by recurrent, unexpected attacks of extreme anxiety (panic), accompanied by worry about having another attack for at least one month.

Risk Factors :

Panic disorder in first degree relative.

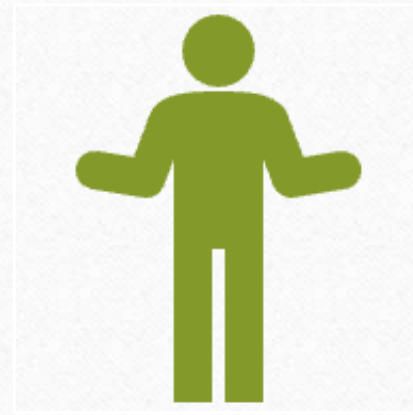
Stressful life events.



CLINICAL FEATURES



Recurrent attacks of intense anxiety (panic), which are not restricted to any particular situation and are therefore unpredictable.



Anticipatory anxiety- persistent fear of having another attack.

It is an abrupt surge of intense fear or discomfort that reaches a peak within minutes and during which time, any of the following symptoms occur: (1m)

- Palpitations,
- sweating,
- tremors,
- sensation of shortness of breath,
- feeling of choking,
- chest discomfort,
- nausea,
- feeling dizzy,
- tingling or numbness,
- fear of losing control or going crazy,
- fear of dying.

DIFFERENTIAL DIAGNOSIS

Anemia	Heart failure	Paradoxical atrial tachycardia	Mitral valve prolapse	Asthma	Pulmonary embolus
Epilepsy	Transient Ischemic Attack	Cerebrovascular accident	Alcohol, benzodiazepine, opioid withdrawal	Hypoglycemia Hyperthyroidism	Pheochromocytoma
	Hypoparathyroidism	Premenstrual syndrome	Specific phobias	Social anxiety disorder Agoraphobia	

SOCIAL ANXIETY DISORDER

Characterized by irrational, excessive and disproportionate fear of humiliation or embarrassment in social settings.

Risk Factors : Social anxiety disorder in first degree relative.

CLINICAL FEATURES

- Fear of scrutiny by other people- others are observing my clothes, my hair style, my walking style, my way of speech, my eating style etc.
- Avoidance of social situations (fear of embarrassing oneself)—avoiding eating in public, speaking in public, conversing with people of opposite sex.
- Associated with low self-esteem and fear of criticism.

CLINICAL FEATURES

Associated Symptoms

- Blushing,
- hand tremors,
- nausea,
- urgency for micturition,
- panic attacks.

The above symptoms usually begin in the adolescence and take many years before patients seek help.

DIFFERENTIAL DIAGNOSIS

Normal shyness

Agoraphobia

Panic disorder

Generalized anxiety disorder

SOMATISATION DISORDER



characterized by repeated presentation of physical symptoms without a physical cause.



Patients request repeatedly for investigations in spite of negative findings and reassurances by doctors.



Risk factor : Stressful life events

CLINICAL FEATURE SIGN

Presents with multiple, recurrent physical symptoms for many months.

Doctor Shopping with repeated negative investigations

persistent refusal to accept advice or reassurance that there is no physical explanation for the symptoms.

COMMON SYMPTOMS

Gastrointestinal sensations- pain, belching, regurgitation, nausea etc.

Abnormal skin sensations- itching, burning, tingling, numbness etc.

Pains- limb pain, back ache, head ache etc.

Sexual and menstrual complaints.

Minor anxiety and depressive symptoms may also be present.

The above symptoms should be present for at least six months for diagnosing Somatisation Disorder.

DIFFERENTIAL DIAGNOSIS

- General medical conditions Eg- gastritis, arthritis, anemia, chronic infections (HIV, TB), peripheral neuropathies, endocrinopathies, connective tissue disorders.
- Chronic fatigue syndrome
- Fibromyalgia
- Depressive disorder
- Anxiety disorders

INVESTIGATION GUIDELINES FOR CMDs

- No laboratory investigation is required for making a psychiatric diagnosis.
- Investigations are used to:
 - a. Rule out any other medical etiology leading to symptoms mimicking psychiatric illness.
 - b. Help in ruling out co-morbid medical illnesses, so that the medications can be selected appropriately.
- Complete Hemogram, liver functions test, renal function test, serum electrolytes, thyroid function tests and ECG are NOT advised to make diagnosis.

TREATMENT FOR CMDs



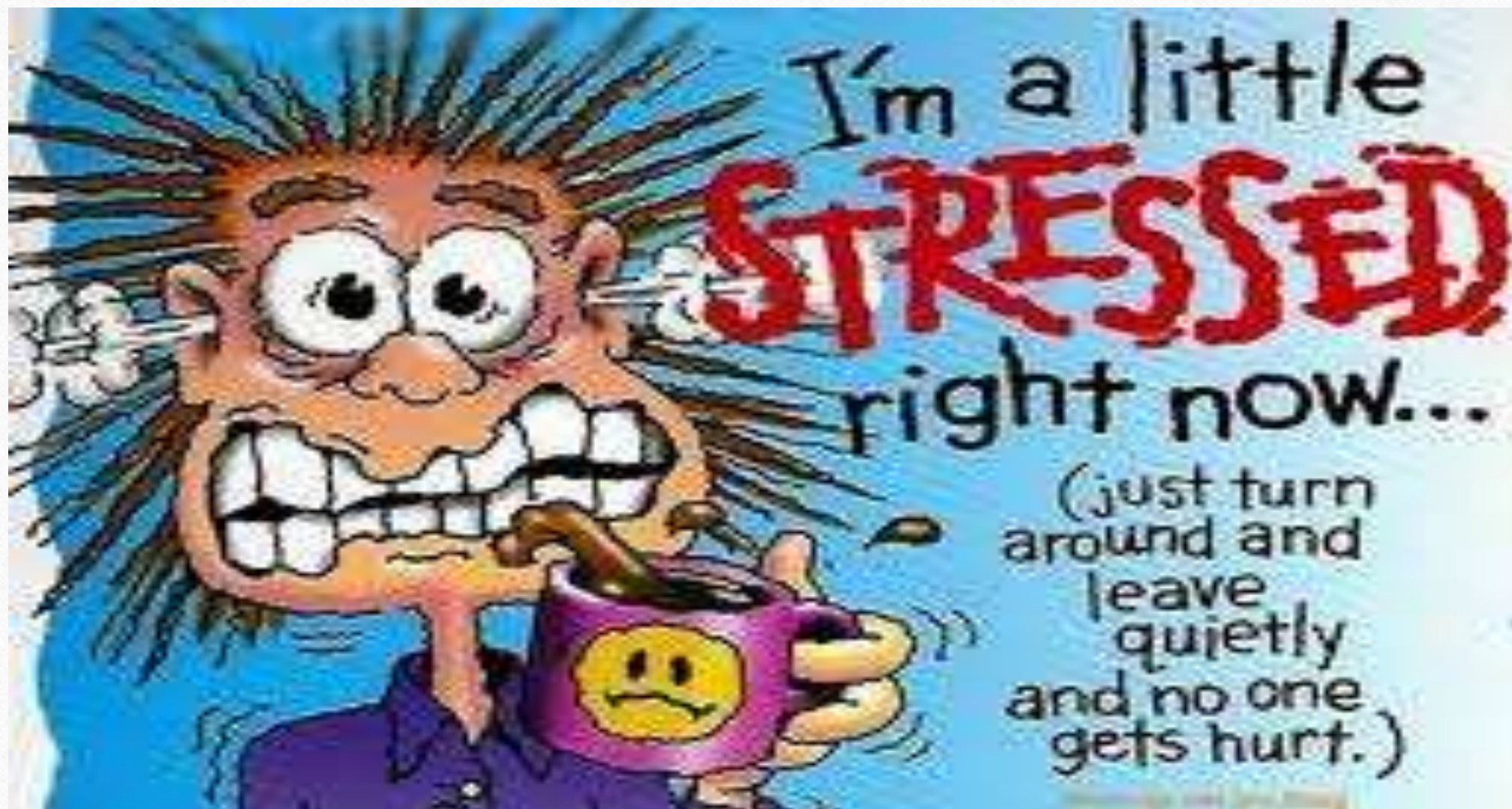
A. Pharmacological Interventions



B. Non-pharmacological Interventions
(Psychosocial Interventions)

Conclusion

- Mental and physical health are equally important components of overall health.
- For example, depression increases the risk for many types of physical health problems, particularly long-lasting conditions like diabetes, heart disease, and stroke. Similarly, the presence of chronic conditions can increase the risk for mental illness.
- Mental health literacy leads to easy identification and detection of symptoms of illnesses leading to early treatment thereby improving recovery and better quality of life.



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