

MENTAL HEALTH

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Summary

Mental disorders are defined by patterns of clinically recognizable symptoms reflecting abnormal or distressing subjective experiences (anxiety, hearing voices) and maladaptive behavior, usually accompanied by social or occupational impairment. Brain

dysfunction, often resulting from the individual's genetic endowment, is the basis of an increased vulnerability to a variety of environmental stresses (psychological or physicochemical) that may trigger clinical illness. A study by the World Health Organization and the World Bank established that 10 of the leading causes of disability in the world were mental disorders (unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia, and obsessive-compulsive disorder). Together, these are responsible for over 10% of the global burden of ill health, and this is expected to rise to 15% by the year 2020. The economic costs of mental ill health are equally high. Surveys have demonstrated that, at any time, over 15% of the adult population have sufficiently extensive psychiatric symptoms to meet diagnostic criteria for one or more mental disorders, most commonly depressive or anxiety disorders or alcohol or drug dependence, and the lifetime risk is higher still: over 20% for any mental disorder and about 1% for severe disorders such as schizophrenia and manic depressive (bipolar) disorder. Both the symptoms and the prevalence of mental disorders are surprisingly constant throughout the world, and there is no evidence that the prevalence of mental illness changed substantially during the twentieth century. However, the era of institutional care has given way to an era of community care and more effective treatment, in which community mental health teams or general practitioners treat patients, even those with acute psychotic illnesses, in their own homes or in small residential hostels without admitting them to hospital. On the basis of present understanding, the greatest scope for effective prevention of mental disorders is probably in early childhood through ensuring healthy neurodevelopment, an adequate nurturing environment, and continuity of parental (or surrogate) care.

1. Introduction

In current non-technical usage, the term "mental health" refers to a broad range of organized human activities (e.g. mental health care, services, associations, programs); to certain qualitative attributes of individuals or groups (personal mental health, community mental health); or to predicaments stemming from within the person (mental health problems, mental ill health). The term lacks precise definition but it generally conveys ideas and expectations about positive subjective experiences, attitudes, and capacities that conform to a set of social and cultural values. According to the World Health Organization (WHO), mental health is "the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice, and the attainment and preservation of conditions of fundamental equality." The roots of this all-embracing concept can be traced to Plato (mental health as wisdom and justice in the psyche); Spinoza (mental health as freedom of the mind); Heinroth (mental health as the assimilation within the ego of the principles of the conscience); Nietzsche (good mental health can coexist with disease); and Freud (mental health as insight into one's own motivational processes). These ideas have counterparts in the great religions.

While mental health can hardly be said to be a scientific concept, mental illness (synonyms: mental disorder or psychiatric disorder) is amenable to a stricter definition. Having replaced "madness," the notion of mental illness oscillated, until recently, between two extreme views: (a) mental disorders are brain disorders; and (b) mental

disorders are the manifestation of intrapsychic conflict or trauma. At present, largely as result of advances in the neurosciences, these two positions are no longer regarded as mutually exclusive. Whereas in many mental disorders overt brain disease or a more subtle alteration in brain circuitry is likely to be the primary disturbance leading to symptoms, it is also true that psychological stress and learned behavioral responses may secondarily lead to morphological or physiological changes in the brain. Generally, mental disorders are defined by patterns of clinically recognizable symptoms reflecting abnormal or distressing subjective experiences (anxiety, hearing voices) and abnormal behaviors, usually accompanied by social or occupational impairment. In principle, current thinking does not posit a fundamental difference between physical and mental disorders. However, since the specific causal pathways, including the precise nature of brain dysfunction, are not fully understood, and few biological tests (or markers) are available for their reliable identification, the diagnosis of most mental disorders remains clinical (i.e. based on careful evaluation of the history of the person and the presenting symptoms).

2. The Social and Economic Cost of Mental Illness

Until quite recently mental disorders were not regarded as a major public health problem, at least in a global context. This was partly because it was not appreciated that the prevalence of most types of disorder is just as high in developing as in industrial countries, but mainly because public health has traditionally measured the relative importance of different types of disease by comparing their mortality rates, and despite their association with suicide most mental disorders are rarely lethal. This perception was dramatically changed by a study in the 1990s, commissioned by the World Bank and WHO, that attempted to quantify the lifelong social handicaps (measured in disability adjusted life years or DALYS) imposed by diseases of different kinds. The results of this study suggested that the burden imposed by unipolar major depression alone was greater worldwide than the burden imposed by ischemic heart disease, tuberculosis, malaria, AIDS, or any form of cancer. A subsequent report estimated that 10 of the leading causes of disability were mental disorders (unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia, and obsessive-compulsive disorder), that these were corporately responsible for over 10% of the world's total burden of ill health, and that this would rise to 15% by the year 2020.

The economic costs of mental ill health are equally high. In addition to the social and health care costs of treating episodes of illness that often persist or recur throughout adult life, there are very high costs from loss of productive capacity. Many people with chronic or recurrent illnesses remain unemployed for most of their adult lives, either because they are genuinely incapable of coping with the legitimate requirements of potential employers or simply because they are rejected on the grounds that they are known to be or have been mentally ill. Others have frequent and sometimes prolonged periods of sick leave. In addition, the patient's illness often imposes significant burdens on other members of their family who may, for example, stay at home to care for them rather than obtaining paid employment. The financial consequences of all this are very high, particularly in countries with well developed health and social care systems and few employment opportunities for people who lack marketable skills. For example, in

England, a country with a population of 50 million, it was estimated that in the late 1990s mental illness cost the country £32 billion (US\$46 billion) a year.

3. Classification and Diagnosis of Mental Disorders

Subsumed under the rubric of mental illness are a wide and heterogeneous range of conditions that have different causes (etiologies), different clinical manifestations and prognosis, and different treatment needs. There are six broad groups of mental disorder:

“Organic” mental disorders: This group includes mental and behavioral disorders due to an independently diagnosable brain degeneration (such as Alzheimer’s disease), acute brain insult (such as encephalitis or intoxication), or systemic physical disease affecting brain function (e.g. myocardial infarction, emphysema, and many infections). These disorders are traditionally referred to as “organic” or “symptomatic” but this does not imply that other mental disorders have no cerebral basis. Their hallmark manifestations involve cognitive dysfunction: memory loss (as in dementia), or clouding of consciousness (as in delirium).

Disorders due to psychoactive substance use (drugs and alcohol): These range from “harmful use” and dependence to acute and chronic psychotic illnesses with symptoms that may be difficult to distinguish from the psychotic disorders.

Psychotic disorders: These include schizophrenia, bipolar affective disorder, depression with psychotic features, delusional disorder (paranoia), and other less well-defined transient psychotic illnesses. The common denominator is the profound alteration of the way surrounding reality is perceived (delusions, hallucinations, and other “positive” symptoms), and the gradual change in personality (“negative” symptoms) that result in a loss of motivation, goal-directed behavior, and social skills.

Non-psychotic (“neurotic”) disorders: These are a motley group comprising common disorders such as anxiety, mild to moderate depression, obsessive-compulsive disorder, somatization and dissociative disorders as well as conditions in which psychological trauma or stress can be causally implicated (such as the post-traumatic stress disorder, PTSD).

Disorders of adult personality: This group includes lasting, maladaptive traits and behavior affecting interpersonal relationships, respect for social norms, or the attainment of self-esteem and personal autonomy.

Developmental disorders: These conditions are usually manifest from early childhood and range from generalized learning disability (mental retardation) and pervasive deficits of language and social skills acquisition (autism) to relatively specific disorders of sustained attention and impulse control (attention deficit and hyperactivity disorder, ADHD).

The two most influential current classifications of mental disorders, the WHO’s International Classification of Diseases (ICD-10) Chapter V and the American Psychiatric Association’s *Diagnostic and Statistical Manual* Fourth Edition (DSM-IV), are similar in many respects. Both contain explicit definitions of disorders and highly

precise (“operational”) diagnostic criteria designed to improve diagnostic agreement and the reliability of psychiatric diagnoses.

4. The Symptoms and Sequelae of Mental Illness

4.1. Symptoms

Psychiatric symptoms such as anxiety, tension, despondency, irrational fear and foreboding, difficulty concentrating, insomnia, and loss of energy and appetite are so common as to be part of most people’s personal experience. Usually they are, and are accepted as, an understandable reaction to the individual’s current difficulties. However, if they are troublesome enough to interfere for more than a few days with the activities of daily life they may lead to a medical consultation, or a request for help of some other kind, and may then justify a formal diagnosis such as generalized anxiety disorder, depressive disorder, or phobic disorder. Other psychiatric symptoms like hallucinations, delusions, and gross impairment of memory, and the serious disturbances of mentation (thought processes) and behavior that often accompany them, are much less common. They are characteristic of psychotic disorders like schizophrenia and mania, and what are called organic disorders, such as delirium and dementia, and are severely disabling. They often also interfere with the individual’s capacity to communicate with and be understood by other people, and easily lead to the alienation that is often so conspicuous and damaging a consequence of severe mental illness.

4.2. Impairment, Disability, and Handicap Associated with Mental Illness

In everyday usage, the terms impairment, disability, and handicap are often used interchangeably. However, their technical meanings are subtly different. According to the International Classification of Impairments, Disabilities and Handicaps developed by WHO, impairment is defined as “any loss or abnormality of psychological, physiological, or anatomical structure or function”; disability as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being”; and handicap as “a disadvantage for a given individual, resulting from an impairment or a disability, that prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.” The cognitive, emotional, and behavioral impairments resulting from mental disorders are often associated with high levels of disability and disproportionately severe handicap, due to still prevailing stigmatizing societal attitudes.

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Biographical Sketches

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