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PUBLIC MENTAL HEALTH ISSUES: A REVIEW

SHWETA SHARMA
College of Biotechnology, DUVASU Mathura

Abstract: A review was conducted to assess the burden of mental disorders and examine different problems and challenges at the community level. This review focused on electronic databases for studies on the prevalence and associated factors of various mental disorders at the community level. The World Health Organization estimates that mental and behavioral disorders account for approximately 12% of the global burden of disease. Various studies have shown a high prevalence of mental disorders among women, the elderly, disaster survivors, industrial workers, children, adolescents, and those with chronic illnesses. We need better living conditions, political commitment, primary health care and women's empowerment.

Index Terms- Mental health, Mental disorders, Psychiatric disorders

Introduction: Mental health is "the state of well-being in which individuals are able to fulfill their potential, cope with life's ordinary challenges, work productively and fruitfully, and contribute to their communities."

Mental health affects the whole population approaches to sustained reduction of mental disorders improving psychological well-being by providing mental health interventions to treat prevention-related psychiatric disorders influence and prevent the development of mental disorders, promotes mental health (WHO 2001). Mental health disorders refer to conditions characterized by deregulation Moods, thoughts and/or behaviors recognized by diagnostics and statistics Handbook of the American Psychiatric Association (APA), Fourth Edition (DSM-IV) (Center for Disease Control and Prevention 2013).

Mental disorders account for at least 16% of the disease burden in India and 20% globally (World Health Organization 2018). Additionally, having a mental illness may increase **your** risk of developing other illnesses: evidence shows these psychiatric disorders are associated with excessive all-cause mortality, cardiovascular disease, diabetes, and maternal and child disease. As opposed to physical Illness can increase the incidence of mental illness (Prince et al, 2007).

Impact of mental disorders

At least 18% of the global load share Illness can be due to mental disorders or self-harm. As measured by years lived with disability (Global Burden of Disease Collaborative Network 2019). Even this proportion is underestimated by over a third (Vigo et al., 2016). Major effects of mental disorders occur for four reasons: High prevalence of mental illness (Kessler et al., 2009; Polanczy et al., 2015 and Steel et al., 2014). Most lifelong mental disorders appear before adulthood with 50% of lifetime mental disorders occurring by age 14

years (Jones PB 2013) and 45% of the global human disease burden ages 10-24 due to mental disorders (Gore et al., 2011).

Effects of mental disorders may be cross-cutting different stages of the life course. Pregnant maternal psychiatric disorders, including drug use (e.g., alcohol, tobacco and cannabis) are associated with an increased risk of mental disorders in children (Campion J. 2019). Perinatal depression is associated with low birth weight (Fekadu et al., 2020) premature birth also increases the risk of childhood mental illness (Nosarti et al., 2012).

Childhood and adolescent health effects mental disorders include high health risk behaviors (e.g., self-harm, tobacco, alcohol, and drug use), mortality and suicide while embracing wider impact including poor educational outcomes, increased exclusion and school dropouts, and poor social functioning (Sellers et al., 2019).

Health effects of mental disorders in adulthood including increased health risk behaviors, including the use of tobacco, alcohol, drugs, self-harm, lack of exercise, and unbalanced diet. Other effects of mental disorders in adulthood include work-related presenteeism and absenteeism, unemployment, poverty, debt, violence (victimization and perpetration), homelessness, and reduced quality of life and well-being (Campion J. 2019).

This review article describes the most common mental disorders.

1. **Mood disorders**, especially depressive disorders: A state of sad mood and decreased interest in activities that can affect a person's thinking, behavior, emotions, and physical health (CDC 2013).

2. **Anxiety disorders**: Excessive and unrealistic worry about routine tasks or events, or about certain objects or rituals (CDC 2013).

3. **Schizophrenia:** A mental disorder characterized by a breakdown of thought processes and by poor emotional responsiveness.

Depressive Disorders

Depression is the most common mental health disorder in the community and a leading cause of disability worldwide. Worldwide, it is estimated to affect 350 million people (World Health Organization 2013). In 1990, it was the 4th leading cause of DALY (Disability-Adjusted Life Year loss) in the world (Murray and Lopez 1996), and it is estimated that in coming year it will be second leading cause (Murray and Lopez AD (1996).

Depression is a term that describes both a temporary mood state that most people experience throughout their lives and a medical disorder. It is a heterogeneous diagnosis characterized by depressed mood and/or loss of pleasure in most activities. The DSM of Psychiatric Disorders defines a depressive episode as depressed mood and loss of pleasure or interest in activities lasting at least 2 weeks.

Mood disorders may include only depression (also called "unipolar depression") or manic episodes (like bipolar disorder, classically called as "manic depressive illness"). People with mood disorders experience significant stress or disturbance in social, occupational, academic, or other important areas function.

Major depressive disorder is recurrent major depressive disorder, with frequent flares and flares repetition. The more severe and prolonged the symptoms in the first episode, the less likely it is to be completely cured, as it may be due to delays in receiving effective treatment (Murray and Lopez 1996).

Bipolar disorder is characterized by at least one manic or mixed episode (mania and depression) with or without a history of major depression (American Psychiatric Association 1994). People who have had one episode of bipolar disorder are more likely to experience future episodes. Recovery from disability varies from person to person. People with purely manic episodes do better than people with mania and depression and tend to take longer to recover and prolong the course of chronic illness. Patients with bipolar disorder have a mortality rate two to three times higher than that of the general population and a higher suicide rate (Fogarty et al., 1994)

Child or spousal abuse or other violent behavior may occur during severe manic episodes. Moreover, Bipolar disorder often presents with loss of insight, leading to treatment resistance, financial hardship, illegal behavior, and substance abuse. Other associated problems include occupational or educational failure, financial difficulties, substance abuse, illegal activities and divorce (American Psychiatric Association 1994).

The estimated prevalence of major depression among 16-65 year olds in the UK is 21/1000 (17 men, 25 women). Risk factors for depressive disorders include individual (such as age, gender, and migration history), familial factors, social factors (such as socioeconomic status), and life events. In addition, the current phase of the economic crisis, with rising unemployment and poverty, and cuts in social security, can affect people's mental health (World Health Organization.) People with depression lose 5.6 hours of productive work each week when they become depressed (Stewart et al., 2003), and 50% of lost work productivity is due to absenteeism and short-term disability (Kessler et al., 1999). Mood disorders are often associated with other psychiatric disorders such as anxiety disorders, personality disorders, substance abuse, and addiction. The presence of another mental illness increases its severity become ill and has a poor prognosis. People with mood disorders are at increased risk of suicide.

Dysthymic Disorder

Dysthymic Disorder (DD) is a primary axis mood disorder characterized by overtly mild depressive symptoms and symptom persistence (i.e., at least two years in duration). People with this disorder feel depressed most of the day, more than the rest of the day, for more days than not, as well as at least two of the following diagnostic symptoms: (1) poor appetite or overeating; (2) insomnia or hypersomnia; (3) low energy or fatigue; (4) low self esteem; (5) poor concentration or difficulty making decisions; and (6) feelings of hopelessness

Discriminatory Depressive Disorder: A Simple Approach

All patients with depression **should** be **evaluated** for DD. This **is** easily accomplished by presenting the patient with a **chart comparing** and **contrasting** DD and major **depression. (Fig 1)**

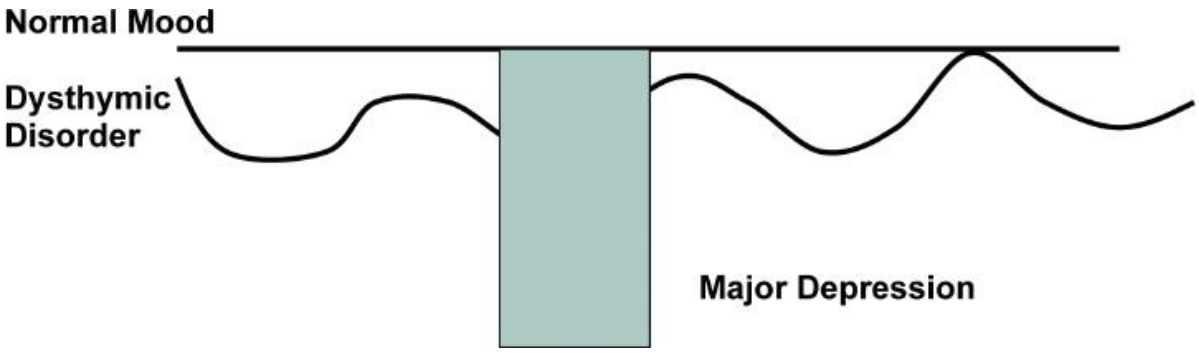

Figure that can be presented to differentiate between dysthymia disorder and major depressive disorder

In explaining the differences to patients, DD is characterized by an insidious onset, delirium symptoms lasting at least 2 years, and possibly a short period of normal mood. In contrast, major depression is characterized by a fairly well-defined onset, sustained symptoms, and discrete episodes. It has been found that simultaneously discussing these syndromes and illustrating them with patients enables rapid determination of the offending syndrome. In contrast, major depression is characterized by a fairly well-defined onset, persistent symptoms, and discrete episodes.

Anxiety Disorders

Anxiety disorders are the most common ubiquitous mental disorders experience across all ages and its output does not necessarily imply the presence of clinically significant psychiatric disorders, (Munir et al., 2019). People with Anxiety Disorders Excessive anxiety, fear, or worry they cause to avoid possible situations fear of falling out or developing Compulsive Rituals to Reduce Anxiety. Anxiety, as recently understood, refers to the brain's response to danger, a term that ranges from mild to severe. Affecting function, physical and mental health, and behavior results in maladaptation and psychiatric disorders. The difference of However, normal pathological anxiety can be difficult. Only in recent decades have scientists and clinicians been able to develop screening and diagnostic schemes to assess the prevalence of anxiety disorders (Kessler et al., 2013)

Symptoms of Anxiety

1. Physical Symptoms

A. Motoric Symptoms: Tremors; Restlessness; Muscle twitches;Fearful facial expression

B. Autonomic and Visceral Symptoms: Palpitations; Tachycardia;Sweating; Flushes; Dyspnoea; Hyperventilation; Constriction in the chest; Dry mouth; Frequency and hesitancy of micturition; Dizziness; Diarrhoea; Mydriasis

2. Psychological Symptoms A. Cognitive Symptoms: Poor concentration; Distractibility; Hyperarousal; Vigilance or scanning; Negative automatic thoughts

B. Perceptual Symptoms: Derealisation; Depersonalisation

C. Affective Symptoms: Diffuse, unpleasant, and vague sense of apprehension; Fearfulness; Inability to relax; Irritability; Feeling of impending doom (when severe)

D. Other Symptoms: Insomnia (initial); Increased sensitivity to noise; Exaggerated startle response.

According to these schemes, anxiety disorders are one of the most prevalent disorders worldwide

Types of Anxiety Disorders (according to American Psychiatric Association)

1. Generalized Anxiety Disorder (GAD)

Excessive anxiety and worry about a series of events or activities occurring for more days than not over a period of at least 6 months with associated symptoms (such as fatigue and difficulty concentrating).

2. **Specific phobia**

Marked and persistent fear of obvious objects (flying, heights, animals, etc.).

3. Post Traumatic Stress Disorder

Flashbacks, persistent frightening thoughts and memories, anger in response to a terrifying experience in which physical harm occurred or was threatened (such as rape, child abuse, war or natural disaster).

4. Social Phobia, also known as Social Anxiety Disorder

Contact with a social or performance situation almost always triggers something immediately Anxiety reactions that may be involved palpitations, trembling, sweating, gastrointestinal disorders, diarrhea, muscle tension, blush, or confusion, and which May meet criteria for panic attacks bad case.

5. Obsessive-Compulsive Disorder

Obsessions: obsessive thoughts, ideas, Intrusive impulses or images inappropriate and cause significant anxiety or pain. People with obsessions usually attempt to ignore or suppress such thoughts or to counteract them by impulse or others thoughts or actions (compulsions).

Compulsions: repetitive behaviors (e.g. hand wash, order or check) or Mental acts (praying, counting, etc.) occur in response to repetition of words) in an obsessive or ritualistic manner

6. Panic disorder

Presence of recurrent and unexpected panics seizures lasting at least 1 month persistent concern about adding Worried about the impact of attacks attack or its consequences, or serious Behavior changes related to attacks. There are three clusters of symptoms: re-experiencing, avoidance and numbing, and arousal.

Panic disorder is sometimes associated with agoraphobia - fear or avoidance of places and situations to escape to difficult, embarrassing, or where in some cases, help may not be available panic attacks or panic-like symptoms.

Anxiety disorders are described and classified in diagnostic systems such as the DSM of Mental Disorders (Cairney et al., 2008). Anxiety disorders are one of the most prevalent mental disorders in the world. The frequency varies greatly depending on the type of failure. Specific phobias are the most common anxiety disorders and panic disorders are the least common Wide. An initial literature review determined a prevalence of 3% panic, agoraphobia 6%, generalized anxiety disorder 3%, simple phobia 2.5%, 1.5% for social phobia.

Anxiety disorders begin early in life, during childhood or adolescence, often follow a chronic relapsing course (Hendriks et al., (2013) and Wardenaar et al., (2012). but may resolve spontaneously. The chronic course depends on the variable type of anxiety disorder, age of onset, periodicity of symptoms, and severity of behavior (Hendriks et al., 2013). The risk factors for anxiety disorders may vary across the lifespan and research on potential similarities and differences between age groups is needed.

Many anxiety disorders develop between childhood and adulthood (Beesdo-Baum and Knappe (2012). As a matter of fact, 90% of people who develop primary anxiety disorder did so before the age of 41 and 75 % before the age of 21. As people get older, symptoms of anxiety disorders may differ, and older groups may be more difficult to assess than younger ones. Because anxiety disorders are highly comorbid with depression in older adults, there are some differences and limitations in assessing symptoms in older adults. It might be necessary to investigate further anxiety and depression among older individuals because of the observed association between cognitive decline and anxiety (Beesdo-Baum and Knappe (2012).

Studies show that anxiety disorders are common. More research is needed to properly understand anxiety disorders and their impact on health and quality of life. Cross-sectional and longitudinal studies suggest that anxiety is associated with cognitive decline and dementia. These studies include additional research into anxiety dimensional measures to better elucidate the underlying structure and interrelationships between anxiety disorders and anxiety disorders and other psychiatric disorders, and a better understanding of the validity of concepts and measures.

Schizophrenia

Schizophrenia is a devastating mental disorder that impairs mental and social functioning, often leading to the development of comorbidities (Schultz et al., 2007). The term "schizophrenia" is felt by many to be inadequate - it does not describe a single disorder, but a "heterogeneous syndrome" - patients who share some symptoms. It is characterized by disruption of thought processes and lack of typical emotional responses. Positive symptoms include confused thinking, delusions (false or irrational beliefs), hallucinations (seeing or hearing things that don't exist), and strange behavior. People who suffer from schizophrenia have difficulties performing tasks that require abstract memory and sustained attention. Negative symptoms – i.e. Superficiality or dullness of feelings and emotions, lack of language (Alogia), lack of pleasure (Anhedonia), lack of desire to form relationships (Antisociality), and lack of motivation. (Apathy) - restricts the patient's ability to work, attend school, care for children, or make friends (Mandal and Nizamie 2004).

The prevalence of schizophrenia in the general population is estimated to be between 0.2% and 2%, depending on the scale used. However, the prevalence 1% is generally accepted as a best estimate (Hafner

and an der Heiden1997). About 1% of the population can have an episode of schizophrenia lasting at least 6 months. Two-thirds of these have an additional impact (Mandal and Nizamie 2004). The most common risk factors for schizophrenia include individual factors (age, risk decreases with age; sex, males develop the disease earlier and have more severe symptoms), familial factors, social factors (schizophrenia is twice as common in unmarried and divorced people). as in the case of married or widowed eight times more common in the lowest socioeconomic groups), life events (discrimination), famine, malnutrition (e.g. folic acid deficiency). Schizophrenia is one of the top ten causes of disability in developed countries around the world. The majority of people with schizophrenia do not reach 'normal' milestones related to social functioning, productivity, housing and self-care. In addition, people with schizophrenia typically underperform compared to expectations based on the achievements of family members and their own functioning prior to diagnosis (Wilk et al., 2005) These disorders appear early in the disease (Reichenberg et al. 2009) and are clearly detectable by the time the diagnosis of schizophrenia is established (Caspi et al., 2003). These disorders are also stable and, in most cases, are not caused by psychosis itself, as the disorder may be present during periods when psychotic symptoms are under control (Keefe et al., 2006).

Historically, many psychological hypotheses have been proposed to explain schizophrenia. Today, medicine recognizes schizophrenia as a disease of the brain. The exact cause is unknown, but Dysfunction of neurotransmitters can lead to disease symptoms. This anomaly can be either a structural consequence or cause brain abnormalities (Cornblatt et al., 1999). A combination of genetic and environmental factors is believed to be involved in the development of this dysfunction. These factors seem to influence brain development at critical stages during pregnancy and after birth.

Genetic Influence

Relatives of people with schizophrenia are 10 times more likely to develop schizophrenia than the general population or children of two parents' 40% chance of developing schizophrenia (Keks et al., 2000)

Environmental Factors

Although the evidence to date is inconclusive, potential environmental factors for the development of schizophrenia include prenatal or perinatal trauma, time and place of birth, and viral infection. While studies have established a link between severe social disadvantage and schizophrenia, the results suggest that social factors do not cause schizophrenia, but rather the reverse may be true: poor social circumstances are likely a result of the disorder (Hafner and an der Heiden 1997)

Although currently diagnosed schizophrenia does not necessarily lead to severe exacerbations, it is usually chronic and has significant psychological consequences. The better the premorbid social adjustment, the better the prognosis. Individuals with good interpersonal skills and good psychosocial adjustment perform better premorbidly than premorbid withdrawals. Outcomes in schizophrenia tend to be worse than those in mood disorders at the level of functioning. Like mood disorders, it is associated with an increased risk of suicide, but has a much shorter life expectancy because suicide tends to occur in young adulthood. Symptoms tend to plateau after years, but symptoms do not resolve until after age 50.

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