AN OVERVIEW OF MENTAL HEALTH

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Abstract

Health is an essential quality in human being. It is defined as a state of complete physical, mental and social well- being and not merely the absence of disease (WHO, 2003). This definition intends to embrace the other components that contribute to positive health like spiritual, emotional, behavioral and cultural.

***Keywords**: Health, mental health*

'Health is wealth' is a very common and famous saying. "*The Sanskrit word "Swastha" expresses it more elegantly as "one who is collected in self, calm, composed, healthy, at ease etc". The Urdu word "Sehat" has a similar connotation in the Arabic- "Sehat", meaning "correct, exact, balanced etc.*" (Mishra, 2003). The World Health Organization (WHO 2001) defines health as a multidimensional concept, which includes physical, social and psychological health. There is usually a tendency to look only in terms physical health when we generally talk about health. Mental health is not considered while talking or thinking about health, even though mental health is a crucial part of our well-being. As Mishra demonstrates, "If one has lost one's mental health-the capacity to work, to enjoy, to think clearly, and to express emotion properly, all things one has acquired are worthless and will bring no happiness". (Mishra, 2003, pp 3)

WHO (2001) defined mental health as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life and is able to make a contribution to his or her community. Mental Health is not just the 'absence of disease', but includes a state of complete physical, mental and social well-being. Mental health problem includes a variety of difficulties, ranging from mild psychological distress to more severe mental health disturbances. Psychological distress is an emotional condition that not only induces negative attitude about self, others and one's environment; it is also characterized by unpleasant feelings such as tension, worry, worthlessness and irritability. An individual's psychological, social and occupational functioning is also affected apart from its effects on relationships, work and health (Doherty et al, 2009). Mental Health Act (2010) defines mental illness "as disorder of mood, thought, perception orientation or memory which causes significant distress to a person or impairs a person's behavior, judgment and ability to recognize reality or impairs the person's ability to meet the demands of normal life and includes mental conditions associated with the abuse of alcohol and drug, but excludes mental retardation". (Mental Health Act, 2010, pp 8) The above definitions of mental health include components like ability to enjoy life, cope with stresses; flexibility and productivity that are essential aspects of a healthy life.

However, mental health concerns occupy less priority in comparison to physical health in our communities, most likely owing to the stigma attached to it or because of the traditional point of view on health. Consequently, mentally ill patients are treated in an unsympathetic environment. Mentally ill patients suffer from a double burden. Apart from struggling with the symptoms and disabilities of their condition, they also have to deal with the discrimination they face from society and their families. . It is important to understand that the myths and misconceptions attached to mental

health often lead to the low priority and discrimination of mentally ill patients. (Patrick et al, 2002).

The spectrum of consequences of mental disorders and illness are quite high. Those with mental illness experience many disabilities in various aspects of their life such as limitation in physical, psychological and social functioning. Due to this, their quality of life is poor and not only is the individual, but their families and communities are also affected. Mental health has long been neglected and a higher number of patients with mental disorders have been leading a life of complete segregation. They are also seen as 'different' and incurable.

An Overview of Mental Health Problem

Most of the surveys and researches show that mental health problems are among the most important contributors to the global burden of disease and disability. Mental and neurological conditions account for 12.3% of disability adjusted life years. The latest global burden of disease study in 2008 reported neuropsychiatric conditions represent 13% of total disease burden. (WHO, 2001 and Litt et al 2012).

Many researches done in western countries and non-western countries give us a clear picture of mental illness in communities. Data of epidemiological study or other studies on the prevalence of different mental illnesses in different countries shows that prevalence of psychoses, organic brain syndrome as belonging to the category of severe mental disorders and all neuroses as belonging to the class of common mental disorders. These mental illnesses (severe mental disorders and common mental illness) contribute hugely in western countries as well as non-western countries and substance use and drug use disorders also contribute significantly to the prevalence of mental illness in western countries and non-western countries.

Many researches have shown high prevalence of mental disorder in western countries. Gouttebarge et al (2015) studied five European countries (Finland, France, Norway, Spain and Sweden). Findings of this study shows the high prevalence of distress, 18 (Sweden), 43 for anxiety/depression (Norway), 33 for sleeping disturbance (Spain), 17 for adverse alcohol behavior (Finland).

Polanczyk et al (2015) undertook meta-analysis in 27 countries on 198 studies; their study revealed the prevalence of mental disorder 13.4, 6.5 for anxiety, 2.6 for depressive, 3.4 for attention deficit hyperactivity disorder and 5.7 for disruptive disorder.

The study undertaken by Volkert et al (2013) present evidences for the huge burden of mental disorders in western countries. They did a meta-analysis on 25 studies in Europe and North America combined. Results of their study shows that disorders with the highest prevalence estimates were dimensional depression 19.47, 16.52 for life time major depression, 11.71 for alcohol use disorders and current disorder bipolar disorder and current agoraphobia 0.53, 4.7 for life time psychosis, 6.36 for life time generalized anxiety and 2.50 for PTSD.

McEvoy, Grove and Slade (2011) have done household survey on 8841 community residents in Australia. Their research shows the lifetime prevalence of anxiety disorder 20.0% and 12 month prevalence of anxiety disorder in 11.8%.

Another meta-analysis done by Fazel et al (2008) in Western Europe and North America over 29 studies, on 5684 respondents shows the prevalence of psychotic

illness, 12.7-11.4 for major depressive, 2.2-71 for personality disorder, 8.5-58.1 for alcohol dependence and 4.7-54.2 for drug dependence.

These researches in western countries have shown high prevalence of mental health problem in these countries. Apart from this, a lot of the research also reveals high prevalence of anxiety and depression. Anxiety and depression both are important contributors to the global burden of disease in many western and non-western countries.

Risal et al (2016) conducted study in Nepal on 2100 respondents. The result reported the prevalence of anxiety was 22.7 and 11.7 for depression. This study shows gender differences in anxiety and depression. Prevalence of anxiety shows 17.8 for female and 13.8 for male. Prevalence of depression shows 5.4 for female and 4.9 for male.

Wong et al (2016) combined 35 studies on the general population in Malaysia revealing the prevalence of generalized anxiety disorder 0.4-5.6, mixed anxiety and depression 3-5, panic without agoraphobia 0.4, phobia unspecified 0.5 and anxiety not otherwise specified 0.3-6.5.

Oneib et al (2015) has done cross- sectional study of Moroccan consultants in primary health care in two cities amongst 351 respondents. The results of this study shows the prevalence of depressive disorders as 13.7, major depressive episode at 9.1, dysthymia at 4.3, recurrent depressive episode at 38.2 and depression over a life time to17.7.

One study, done in Japan by Tsuchiya et al (2012) amongst 530 respondents' shows that twelve month prevalence of any mental disorder 9.1, any mood disorder 2.9, any substance use disorder 1.7, any anxiety disorder at 5.1 and major depressive disorder at 2.6

One South African study also shows high prevalence of anxiety disorder. This study shows that life time prevalence of anxiety disorder 15.8, mood disorder 9.8, and substance use 13.4 (Stein et al 2008)

Shen et al (2006) had done research in China, their research highlighted that twelve month prevalence of any mental disorder in China estimated 7.0. Prevalence of major depressive disorder 2.0, specific phobia 1.9, anxiety disorders 2.7, mood disorder 2.2 and substance use disorder 1.6

Researches in western and non-western countries show huge burden of mental disorders on their respective societies. Mostly researches reveal high prevalence in anxiety disorder and high prevalence of depression. Apart from anxiety and depression, drug dependence, psychotic disorders and alcohol use disorder also contribute significantly to the burden of mental disorder in western and non-western countries.

Mental health problems in India

Burden of mental illness is huge in India as in other countries. According to mental health statistics, 60-70 million people suffer from serious mental disorders across India. (http://www.acmiindia.com/ac/mental-health-statistics-in-india accessed 23 July 2014). Many researchers also found mental illness has a huge burden in India.

Rao et al (2014) conducted a survey on the population residing in a South Indian village, on a sample size of 3033. They found that 24.4% of the subjects were suffering from one or more diagnosable psychiatric disorders, 14.82 prevalence for depressive disorders, 4 for anxiety disorder, 3.95 for alcohol dependence syndrome, major depressive disorder 6.62 and generalized anxiety disorder 1.9. Their study also shows differences in psychiatric disorders according to socio-demographical profile. This research shows that depression and anxiety disorders were more prevalent

among females compared to male, substance abuse/dependence was more dominant among men. Higher prevalence of psychiatric disorders was more amongst married people. Educational qualification wise data shows that illiterate people have higher prevalence of psychiatric disorders compared to those educated (up to under graduation/ graduation). Analysis of psychiatric disorders based on occupation showed that the unemployed and daily wage workers had higher prevalence of psychiatric disorders compared to those who had a salaried occupation or did business. Family structure showed that, those living alone have a higher prevalence of psychiatric disorders. Psychiatric disorders are more prevalent amongst the upper class and lower classes compared to the middle socioeconomic class. Depression was almost equally prevalent among all socioeconomic groups.

Deswal and Pawar (2012) conducted a study in Pune. This study reported that overall lifetime prevalence of mental disorders was found to be 5.03%. Rates among males 5.30% were higher as compared to females 4.73%. Prevalence of depression 3.14%, substance use disorder 1.39% and panic disorder 0.86% were also common. Overall, 12 month prevalence of mental disorder was found to be 3.18%, which was 3.47% among males and 2.85% among females. Prevalence of depression 1.75% was the most 12-month mental disorder, along with substance use mental disorder 0.99% and panic disorder 0.69%. Their study also shows that lifetime and twelve month prevalence of any mental disorder was the highest among employed group, depression was more among the married section.

A study conducted in Lucknow by Tiwari et al (2013) shows the overall prevalence of psychiatric disorders at 23.7, mood disorder at 7.6, neurotic, stress related disorder at 2.0 and Alzheimer disease at 2.4.

In 2010, Math and Srinivasaraju did a meta-analysis of sixteen epidemiological studies that were between 1960 and 2009. The studies selected for analysis were done on general population, either urban, rural or mixed from India. Most of the studies were community based epidemiological studies on mental and behavioral disorders reporting varying prevalence rates, ranging from 9.5 to 102 per 1000 population. Another finding for overall prevalence rates of individual mental disorders is approximately 190-200/1000 population which highlights that 20% of the population is suffering from one or other mental health problem. Another finding showed that each mentally ill patient requires 500 Rs/ per month for mental health care including medication cost, doctor fees and travelling cost to meet the doctor. Therefore, approximately, the total cost required per month will be 10,000 Rs/ crores (Math and Srinivasaraju, 2010)

The study undertaken by Mattoo and Singh (2010) in Chandigarh among 90 respondents shows the prevalence of psychosis at 34.4, bipolar disorder at 23.3, and unipolar depression at 25.6 and OCD at 7.8. Prevalence of Metabolic syndrome for severe mental illness, psychosis at 15.7, bipolar at 8.6 and unipolar depression at 17.1.

The prevalence of dementia was found to be 33.6 per 1000 by a study done in an urban population of Kerala in 2005. Alzheimer's disease was the most common cause 54% followed by vascular dementia 39% (Shaji, Bose and Verghese, 2005).

In 2001, Madhav analyzed ten Indian studies on psychiatric morbidities in the state of Uttar- Pradesh, West Bengal, Gujarat, Tamil Nadu, Kerala, Andhra Pradesh and Delhi. This study revealed that prevalence rates for all mental disorders were 65.4%

and prevalence rate for specific disorders were, 2.3% for Schizophrenia, 31.2% for affective disorders (depression-psychotic and neurotic), 18.5% for anxiety neurotic, hysteria and 4.2% for mental retardation. Data also shows that prevalence rate in urban area is marginally higher than rural (Madhav 2001)

In 2000, Ganguli conducted a meta-analysis of fifteen epidemiological studies on psychiatric morbidity in India. The study attempted to find out the followings: (1) National level prevalence rate for all mental disorders (2) National level prevalence rates for specific disorders (3) Rural- urban differences (4) Morbidity in urban industrial population as compared to rural and urban general populations and (5) Stability of Schizophrenia rate. Finding of this study were: all India prevalence rate for all mental disorder was 73% per 1000 persons with 70.5% in rural areas and 73% in urban areas. Prevalence rate for five mental disorders: 2.5% for schizophrenia, 34% for depression (psychotic and neurotic), 16.5% for anxiety disorders, 3.3% for hysteria and 5.3% for mental retardation. Schizophrenia and hysteria were more prevalent in rural areas as compared to urban areas. Mental retardations' prevalence rate was higher in urban and there was only a marginal rural-urban difference for affective and anxiety neuroses. The study also showed the urban industrial morbidity and found that factory workers have a prevalence rate of two and half times more than general city dwellers (Ganguli, 2000).

Reddy & Chandrasekhar (1998) did a meta-analysis of thirteen psychiatric epidemiological studies which covered the period from 1967 to 1995. Seven of the studies were conducted in the state of West Bengal. Two studies were conducted in Uttar Pradesh and one each in Tamil Nadu, Punjab, Kerala and Union territory of Pondicherry. It was conducted both in rural and urban areas in all these states, covering a total of 6550 families with 33,572 persons. Total estimated prevalence rate of mental disorders was 58.2% per thousand populations. Different categories of disorder covered were- Organic psychosis 0.4%, schizophrenia 2.7%, affective disorders 12.3%, mental retardation 6.9%, epilepsy 4.4%, neurotic disorder 20.7 %, alcohol drug addiction6.9% and miscellaneous group 3.9% were estimated. Based on the findings, this study indicated that there are 1.5 crore people suffering from severe mental disorder in India. Prevalence rates of urban and rural was 80.8% and 48.9% respectively. Only epilepsy and hysteria were high in rural communities whereas depression, mental retardation, all neurotic disorders (except hysteria), behavioral and emotional disorders were significantly high in urban communities. Women have higher prevalence rate of 64.8% than men i.e. 51.9%. Manic affective psychosis was higher in men and organic psychosis, manic depression, endogenous depression and all neurotic disorders were significantly higher among females (Reddy & Chandrasekhar, 1998).

In 1972, Sethi, Gupta and Kumar conducted a study on 500 rural families from four villages (Gauri, Amausi, Gehru and Natkur) situated at a distance of 12 to 20 miles from Lucknow. This study covered a total of 2691 population sample. This study reported that 17% of the families were found to by psychiatrically disturbed. Out of the 2691 population, 106 were psychiatric patients. Thus, the psychiatric morbidity rate was 3.9% or 39 per one thousand. According to diagnostic breakup, findings showed that mental retardation was 64.2%, psycho- neurosis-17.0%, schizophrenia-2.8%, epilepsy-5.7%, personality disorders-3.8% and miscellaneous group-6.5%. This

study also found psycho-neurosis and psychosis to be much less common in rural population compared to an earlier urban survey (Sethi, Gupta and kumar, 1972)

In 1974, Sethi et al conducted another study that covered 850 families with 4,481 populations from Lucknow city (urban). This study reported the prevalence rate for all mental illness to be 67 per 1000. According to diagnostic breakup, the result showed that neuroses was 41%, affective disorders- 12%, schizophrenia- 4%, mental retardation- 16 %, Organic brain syndrome (non-psychotic)-7% and miscellaneous group-21%. Prevalence rates were higher for psychiatric disorders in the age group of 30 years and above. Result also showed that prevalence rates were higher for housewives, separated, and widowed and the unemployed (Sethi et al, 1974)

Thacore, Gupta and Suraiya conducted a study in 1975 for psychiatric morbidity in a north Indian community over a period of one year, reported and covering 2,696 individuals. Out of these, 220 individuals were found to be suffering from psychiatric illness. This study reported the prevalence rates for all mental disorder as 82 per 1000 population with significantly higher rate in the age group 26-65 years and married population compared to unmarried. The prevalence rates for mental retardation and alcoholism was higher in slum areas (Thacore, Gupta &Suraiya, 1975)

First major survey of psychiatric problems was conducted in Agra (rural and urban), Uttar Pradesh. Dube (1970) conducted a study with 29,468 samples in Agra to estimate prevalence rates of all mental disorders. The study reported prevalence of mental health disorders as per the following break up- rural 18 per 1000 population, semi-rural 25 per 1000 population, urban 25 per 1000 population and total 23.8 per 1000 population (Dube, 1970).

In 1998, Tiwari and Srivastava conducted a study on neuropsychiatric morbidity ("the study and treatment of psychiatric aspects of aging and mental disorders of elderly people or the functional/mental disorders of people") in rural Uttar Pradesh which was field based. It reported that prevalence rates for psychiatric illness in geriatric group was 42.2% and neurotic depression, manic depressive psychosis- depressed and anxiety state were more prevalent. The study reported that psychiatric morbidity was much higher in geriatric population 42.2% compared to the non-geriatric population 3.97% (Tiwari & Srivastava, 1998).

Another study done among the elderly in south India in 2009 found the prevalence of depression to be 12.7 percent. On the contrary, the prevalence of mental disorders was reported to be as high as 26.7 percent by a study in elderly with predominant depressive disorders, dementia, generalized anxiety disorder, alcohol dependence and bipolar disorder (Seby, Chaudhury and Chakarborty, 2011).

Conclusion: Above mentioned researches shows that India also has high prevalence of mental disorders like other countries. If we look at state wise data, then we see that most of the researches were conducted in Uttar-Pradesh and these researches show high prevalence of mental disorders. Apart from this, these researches also show high prevalence of mental disorders in married, illiterate, unemployed and living alone group and also show gender differences in mental disorders.

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