## Mental Health Information

Please note that mental health service providers in Bolton may not be able to provide services in your language.

## Anxiety

Anxiety is a normal emotional feeling. In fact, most people would say it helps them to perform best. It is normal to feel anxious in unfamiliar or distressing situations. It, however, becomes a problem when it is out of control and gets severe enough that it starts interfering with one's functioning. Typical signs include faster heartbeat, short breaths, sweating, giddiness and/or fainting, tension and apprehensions of something unpleasant to happen

## Panic Attacks

Panic attacks are sudden feelings of intense anxiety and may include trembling, sweating, shortness of breath, thumping heartbeat, dizziness or choking. During an attack, one feels seriously ill or about to die. The attacks may last for a few minutes but can be very distressing and fearful.

Panic attacks can be effectively treated with drugs (usually anti anxiety or/and antidepressants) and counselling and some specific psychotherapy.

## Migraine

Migraine is a common type of headache that is thought to affect about 15-18 % of women and 6% of men. In migraine, headache comes in attacks with complete freedom from symptoms between attacks. The presentation is with headache that can be severe and is typically unilateral, pulsating and often accompanied by nausea, sickness, eye symptoms and severe distress. In some cases, the attack is preceded by visual disturbances or numbness.

Migraine is treatable in most cases. The first step in the management is to identify and avoid triggers. Factors reported to provoke attacks in some patients include stress, alcohol, bright light, hunger or specific foods, such as chocolate or cheese. The drug treatment includes use of painkillers, and prophylactic medicines that are worth considering for patients with two or more attacks per month. Such treatment can reduce the severity and/or frequency of attacks.

## Anorexia

This is a type of eating disorder. In this disorder, the body weight is usually maintained at least 15% below the expected or average body weight for the individual's age and sex. Weight loss is self induced and/or sustained through the avoidance of eating and through the utilisation of other weight loss tactics such as self-induced vomiting, laxative or diuretic abuse, excessive exercise, and appetite suppressants. Anorexia is a chronic relapsing type of illness. A significant number of patients do get better with appropriate interventions but about 15-20% carry a bad prognosis due to medical and psychosocial complications.

## What is depression?

Most of us feel low, sad & depressed especially after disturbing distressing events but we

find ways and means to get over it in time. But some people get so depressed that they are unable to carry on with their daily routine activities and their whole life seems bleak and hopeless. When such depressive symptoms persist and interfere with one's functioning, a diagnosis of depression is considered.

**Causes of depression:**

Depression can be caused by obvious reasons like loss, bereavement, adverse life events or a physical illness. Childbirth, migration, retirement, career change or any major threat/loss may also cause depression. Vulnerability has been cited in women after hormonal changes, during postnatal period, with a number of young children. Depression is associated with various neurological or medical illnesses and may coincide with viral infections and with treatment or withdrawal of certain drugs may precipitate depressive symptoms. And least but not the least there may be a family history suggestive of a strong genetic component

**Signs & Symptoms:**

Typical signs of depression include low mood, lack of interest, feeling tired, losing appetite or weight, poor concentration, disturbances in sleep, lack of sexual drive and pessimism about future. The depressive may have a low esteem or feel worthless, shameful or guilty. Suicidal ideas, thoughts or even attempts may also be found in some patients. Depression may also present with many physical symptoms like aches, pains, agitation, retardation, and medical complaints with no apparent cause and increasing concerns and undue worry about physical well-being

**Children, adolescents & depression:**

Major depression in children and adolescents is not uncommon. Depressed youngsters often suffer in silence. In most western societies, the rate of adolescent suicides has increased and it is suggested that there is a strong association between depressive disorders and suicide in the young. The depression in this age group usually presents as sadness of mood, poor concentration, low self -esteem, lack of confidence, low energy and social withdrawal. The doctors usually use multiple sources of information, including reports from parents, teachers, and peer groups before making a diagnosis of depression. Use of routine antidepressant drugs is not recommended in children suffering from depression and non-drug interventions are usually preferred. Most children recover in the short term, but the recurrence rate is high.

**Depression in old age:**

Depression is very common in old age. It is generally observed that about 15% of over 65's living in the community suffer from depression. Poor physical health, loneliness, lack of confiding relationship and changes in health, or social circumstances are contributing factors for depression in this age group. Depression can be effectively treated in the elderly with antidepressant drugs but older people are more vulnerable to side effects and drug interactions. Psychological therapy is also recommended in many cases.

**Risks of suicide in depression:**

Suicide is a major risk factor in depression. More than 50 % of all suicides are related to depressive illnesses and suicide accounts for about 10-15% of deaths among persons with mood disorders. Patients expressing suicidal thoughts or such feelings, therefore,

need to be taken seriously and require probing and detailed assessment of their depression.

**Is depression a treatable illness?**

Yes, depression is treatable and can be managed with great success. Depression can be treated on outpatient basis or by admitting to the hospital. This illness can be treated with medication (antidepressants) and talking treatments (psychotherapy). A number of antidepressants are available and have shown very promising results in treating and preventing depressive illnesses. As with all medications, antidepressants may have some side effects, but these may last only for a short period of time. Psychotherapies include counselling, supportive therapy, family sessions, cognitive behavioural approaches and relaxation techniques.

**Duration of treatment:**

Depression is a chronic and relapsing disorder. Over one third of patients with major depression relapse in the first year following initial remission with most relapses occurring in the first four months. It is suggested that depression needs to be treated at least for 6-9 months with antidepressant drugs after recovery and elderly patients may continue to benefit up to 12 months with continuation of drugs.

**Schizophrenia:**

Schizophrenia is one of the major mental disorders. It is characterised by disturbances of thinking and perceptions and is usually accompanied by inappropriate emotions. Patient usually presents with hearing voices when no one is around, strange and bizarre beliefs and inappropriate behaviour like irritability, hostility and suspiciousness.

Men and women from all countries are equally likely to develop this illness. Approximately one in 100 individual will develop schizophrenia and most of patients present as young adults between the ages of 15 – 25.

**Causes of schizophrenia:**

There is no single cause for schizophrenia. A combination of factors like life stress, brain dysfunction and genetic predisposition can lead to this illness. At present we still do not know what causes schizophrenia, nor do we have a total cure. We do, however, have treatments that can reduce or control many of the symptoms and help patients and live with a better quality of life.

**Schizophrenia and Family history:**

Schizophrenia does run in families and a strong genetic causative factor has been established. The risk of developing schizophrenia becomes greater, if one have a parent, sibling or close relative that has schizophrenia.

**Symptoms of schizophrenia:**

Schizophrenia can present as disturbances in thoughts, emotions, behaviour or cognition. During the early period, non-specific symptoms like general loss of interest, avoidance of social interactions, odd beliefs, odd behaviour, being short tempered or irritable and avoidance of work or dropping out of school, college or university may precede the acute

phase.

During the acute phase, psychotic symptoms like delusions, hallucinations and odd behaviour are prominent with intense mood problems. The chronic or residual phase is usually characterised by negative symptoms like apathy, inappropriate mood, social isolation and disturbances in self-care.

**Outcome / progression in schizophrenia:**

Schizophrenia is a chronic disorder. While full recovery may occur, many patients have at least some residual symptoms of varying severity. Generally 25% get complete recovery, 40% experience recurrent episodes of illness with some degree of disability, while about 35% remain chronically disabled.

**Treatment of Schizophrenia:**

The general principles to treat schizophrenia include reducing the symptoms of psychosis and disturbed behaviour, maximising the safety of the individual and others, building a trusting relationship with the patient and the carer and developing a management plan to aid recovery and prevent relapse.

Schizophrenia patients are treated with drugs (anti-psychotic or neuroleptic), psychological interventions (counselling, psychotherapy, psycho-education, behavioural management) and social interventions (support to family, identifying problems areas and needs, good planning and specific skill training).

**Schizophrenic patients & stress to the relatives:**

Schizophrenia places a lot of burden on the family. First episode and first admission of the patient may seem to be particularly stressful. Similarly chronic cases, unmanageable behaviour, aggression, hostility and deterioration in social functioning all appear to be more important. For many of the relatives, the burden is continuous and usually associated significantly with the patient's symptoms. Family treatment and involvement of careers in the management of schizophrenia is very beneficial.

**Role of education for schizophrenic patients & their families in its management:**

Education plays an important role not only understanding about the disorder but also helps in developing appropriate interventions in dealing different symptoms. This also helps the individuals and families to enable assessment of current improvement, disability and handicap and of goals to get help in these areas. It has been confirmed from a number of studies that with the use of education and relapse prevention programmes, further relapse and episodes can often be prevented.

**Dementia:**

Dementia is an illness characterised by memory impairment and disturbances in attention and concentration. Dementia occurs in 5% of people aged over 65 and in approximately 25% of those over 85. The most common cause of dementia is Alzheimer's disease. Early in the course of Alzheimer's disease, memory impairment may be indistinguishable from age related changes with complaints of memory impairment and word finding difficulties. Memory impairment gets more pronounced so that not only the detail but also the context and even important themselves may be forgotten. Poor judgement and changes in

personality commonly develop especially withdrawal, apathy and disinhibition, which may cause mood swings or personality coarsening.

**Treatment of dementia:**

The first step in the management of dementia is to establish a diagnosis. Full history, physical and mental state examination will help to exclude memory impairment that is secondary to any physical or medical disability. Once a diagnosis is made, treatment includes psychological management and use of some drugs.

## PERSONALITY DISORDERS

Personality disorders are abnormal and persistent patterns of behaviour that appear to be expression of the individual's characteristic life style and mode of relating to others. Specific personality disorders are deeply ingrained and enduring behavioural patterns, which manifest inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture thinks, feels and perceives and, particularly relate to others. A few of the common points which run in major types of personality disorders are persistent and stable patterns of behaviour, inability to change, self gratification, self-centerdness and undue sensitivity.

**Treatment:**

The treatment of personality disorders is very complex and controversies still exist regarding different conceptual aspects in this area. The management, however, is multidisciplinary and success, to a great extent, depends upon the patient himself, his and the therapist's relationship to each other and patient's motivation and willingness to change. The response of treatment also remains very fluctuating and ranges from very poor to barely satisfactory. In the treatment, in addition to psychotherapy and behaviour modification techniques the role of drugs is also getting acknowledged. Drug treatment may be useful adjunct to non-drug treatment but vary according to the needs of individual patient.

## SEXUAL DISORDERS

Sexual dysfunction refers to the persistent impairment of the normal patterns of sexual interest or response. Common dysfunctions include lack or loss of sexual drive, sexual aversion, lack of sexual enjoyment, orgasmic dysfunction, premature ejaculation and gender identity disorders.

These disorders are manageable and a variety of psychological, behavioural and drug treatments are available.

**Trans-sexualism:**

Tsexualism is a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of intense discomfort with one's own sex, and wish to have surgery or hormonal replacement to make one's body as similar as possible with one's preferred sex.

Transvestism is wearing of the clothes of opposite sex principally to obtain sexual excitement and sexual arousal.

**Fetishism** is reliance on some non-living objects as a stimulus for sexual arousal and sexual gratification.

**Voyeurism** is a recurrent or persistent tendency to look at people engaging in sexual or intimate behaviour and is usually carried out without the observed people being aware.

**Paedophilia** is a sexual preference for children, boys and girls or both, usually of pre-pubertal or early pubertal age.

## ALCOHOL RELATED DISORDERS

Excessive alcohol is a major risk factor for health. 8-10% of people aged 16-74 years of age in western countries die of causes attributable to alcohol. 15-20%, of suicides in the U.K. are alcohol- related. It is estimated that 15-30% of male admissions and 8-15% of female admissions to general surgical or medical wards in Britain have alcohol-related problems and about 10-20% of all psychiatric admissions have an alcohol-related diagnosis.

### Problems related to alcohol:

Alcohol is a drug and it affects people's physical and mental health as well as behaviour. The clinical presentations of alcohol problems are heterogeneous. Gastrointestinal, cardiovascular, neurological and psychiatric problems are most frequently encountered. There is no system or organ in the body that is not affected by alcohol. Similarly, the problems associated with the inappropriate use of alcohol include difficulties in family life, employment and cost to the health care sector and the rest of the society.

### How many people have problems with alcohol?

As many people with alcohol problems remain unrecognised, there are difficulties in estimating numbers. The risk certainly increases with the amount of alcohol consumed. As per medical guidelines the risk rises significantly with weekly consumption of more than 14 units for women and 21 units for men. A unit of alcohol is defined as a standard pub measure of spirit, a glass of wine or half a pint of beer equivalent. There is no consumption limit for dependence but it is recognised that those women drinking above 36 units per week and men drinking above 51 units are likely to be experiencing severe problems with their drinking.

1. **<u>What is Mental Health?</u>**

   Many people when they hear the term mental health, think of mental illnesses. But, Mental health is for more than an absence of mental illness; mental health is something all of us want for ourselves. This is determined by:

   How we feel about ourselves.
   How we feel about others.
   How we meet the demands of everyday life.

   World Health Organization (WHO) has defined health as a state of complete physical, mental and social well-being & not merely the absence of disease or infirmity. Normal mental health, therefore, does not mean an absence of a mental illness. This is, in fact, a state of well being that keeps an individual fit emotionally, as well as, psychologically.

2. **<u>Are mental illnesses very common?</u>**

Mental illnesses are no different from physical illnesses and are very common. These can strike anyone and the chances are that in any given year, at least one in ten people will suffer from a mental illness.
Mental disorders are real, diagnosable and universal. Like physical illnesses, mental disorders cover a wide range of problems. All of us get depressed or become anxious sometimes, especially after distressing events. But with mental illnesses, these feelings carry on for a long time and make it difficult to cope with every day life.

3. **How does Mental illness affect us?**

Mental illnesses pose a major public health problem and constitute a major source of burden on health and social services. A recent report by World Health Organization (WHO) and the World Bank found that among people between the ages of 15 and 44, 33% of all Disability-Adjusted Life Years (a measure of the disease burden as reflected in the number of years lost to morbidity and mortality) were the consequences of mental health problems-about twice the burden imposed by infections and parasitic diseases, five times that of heart diseases & seven and a half times that of cancer.

4. **Are mental illnesses treatable?**

Yes, mental illnesses are treatable and preventable. There are different treatments available like drugs, talking treatments or psychological therapies, counselling and specific family and group therapies. Mental illnesses can be treated while staying at home or depending on one's condition, admission to the hospital may be needed. Most people who need care in hospital because of mental ill-health are admitted "informally" and are free to leave when they want to. But sometimes people become seriously ill and do not recognise this. In the interest of their health or safety or to protect other people, they then, need to be taken to the hospital or special units under Mental Health Act. Compulsory admission to hospital is referred to as "sectioning". The 1983 Mental Health Act is the main document that lays down when and how this can happen and sets out the safe guards to ensure that the power isn't abused.

5. **Do children suffer from mental illness?**

There has been a considerable increase in the incidence of mental health problems in children and young people. It is suggested that between 10% and 20% of this population at any one time have mental disorders that are severe enough to cause significant impairment in functioning and warrant treatment. Emotional and behavioural disorders are usually the common presentation. The emotional problems may present as anxiety, phobia, fear and depression. The behavioural problems may take the form of hyperactivity, attention deficit and conduct disorders.
The treatment of these disorders generally includes child guidance, supportive psychotherapy, family therapy and behaviour modification techniques. Drug treatment is limited but does have an important place in the management of some disorders.

6. **How can we get help for mental health problems?**

People with mental health problems should not suffer in silence. If you are feeling down, out of control, or start to have suicidal thoughts, try to talk things over with someone. If your problems carry on or get worse, then you should go to your doctor. Your GP is not just there to treat physical illnesses, but is equally skilled at helping with emotional ones. One should not feel guilty or embarrassed about getting help. And, just like a physical illness, the earlier you seek help, the quicker you will recover.

7. **What is the difference between a psychiatrist and a psychologist?**

Psychiatrists are primarily medical doctors who are specialised in treating mental and nerve disorders. They are trained as doctors first and then skilled in treating psychiatric disorders. Psychologists are professionals with expertise in offering non-drug treatments like counselling, psychotherapy and individual work. They have a basic degree in psychology and have attained experience in clinical work.

8. **Do hormonal changes affect mental health in women?**

Hormones have an important effect on mental and physical well being of an individual. Women are more vulnerable to the hormonal changes and may present with specific mental health problems like Pre-menstrual symptoms (PMS), post-natal blues, depression following childbirth and mood and other symptoms related to menopause.

9. **Are mental illnesses related to suicide?**

Suicide accounts for about 10% of deaths among psychiatric patients and life-threatening attempts are much more common than fatalities. The findings of National Confidential Inquiry into Suicide and Homicide by people with mental illness (1999) estimated that 24% of general population suicides have been in contact with mental health services in the year before death. Forty per cent of suicides in the inquiry sample were in patients who were in the hospital at the time of death or had left hospital in the previous three months.

10. **Effects of culture on mental health?**

Culture plays an important role in the formation of personality. In terms of mental illnesses, it is generally accepted that cultural norms do influence the presentation and management of many mental health problems. Some culture-bound syndromes have been described in some settings that require specialised treatment. Similarly ethnic minorities may have different presentations of their mental health problems as compared to the native population. For example, in African communities, possession states, hysteria and spiritual influences are very common. Similarly in Asian communities, mental illnesses may present as physical and medical problems that may mask underlying psychological and emotional distresses.

11. **Influence of religion on on mental health?**

Mental illness may present with some links to religion in some cases. Religious contents may be mistaken as abnormal beliefs as well as religious rituals may be considered as eccentric behaviour, especially, in secular societies. In western cultures, where religious practices may not be common, such experiences may be labelled as mental illnesses. It is, therefore, very important to give due consideration to religion with reference to mental well-being. The role of religion in the treatment of many mental health problems is well acknowledged. Sharing religion with others of the same ideology secures a supportive culture and religious communities may have their own coping strategies.

12. **Have there been any standards of fitness to drive for patients with mental illnesses?**

Very careful consideration is required regarding the fitness to drive by patients suffering from mental illnesses. Patients suffering from major illnesses like psychosis,

schizophrenia, depression or dependency on alcohol or drugs, or with such a history, or requiring psychiatric drugs with tranquillizers, are not recommended for driving until declared fit by the doctors. Patients have to inform DVLA about any change in their medical or psychiatric condition and about any treatment in this regard. Medical practitioners may, in accordance with guidelines of General Medical Council and other professional bodies, inform DVLA where the public is at risk , a patient has failed to fulfill the Road Traffic Act, the patient is not complying with the treatment or their mental state has deteriorated to the point that they are likely to be a source of danger to the public.