INTRODUCTION TO MENTAL HEALTH

PH150
Fall 2013
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Topics

- **Subjective Experience:**
  - From the perspective of mentally ill persons

- **Context**
  - Public attitudes toward the mentally ill

- **Definition and Diagnosis:**
  - What are mental disorders?

- **Prevalence:**
  - How common are mental disorders?

- **Mental Health Disparities:**
  - Who is most at risk?

- **Prevention:**
  - When and how?
THE SUBJECTIVE EXPERIENCE OF MENTAL ILLNESS

In their own words.
Career
model of mental illness

Aneshensel 2013
PUBLIC PERCEPTIONS OF MENTAL ILLNESS

Stigma: Fear and Loathing
2006 Public perceptions of the causes of mental illness

<table>
<thead>
<tr>
<th>Biological</th>
<th>Social</th>
<th>Person</th>
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<tbody>
<tr>
<td>Genetics</td>
<td>Stress</td>
<td>Ubringing</td>
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<tr>
<td>Biochemical</td>
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<td>Bad Character</td>
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- Genetics
- Biochemical
- Stress
- Ubringing
- Bad Character
- God's Will

- Depression
- Schizophrenia
Stigma:
an attribute that is deeply discrediting and reduces the bearer “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3).

Social Distance: Depression
Willingness to:
• Move next door 81%
• Work closely with 54%
• Marry into family 45%
Perceived Dangerousness
Likely to hurt others:
• Depression – 33%
• Schizophrenia – 55%

Social Control:
Should be coerced by law to:
• Take RX:
  • Depression 26%
  • Schizophrenia 50%
• Admitted to hospital
  • Depression 27%
  • Schizophrenia 54%
WHAT IS MENTAL ILLNESS?

Diagnostic criteria
Mental Disorder

Clinically significant
• behavioral or psychological syndrome or pattern
• that occurs in an individual
• and is associated with
  • distress or
  • disability or
• a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Source:
Diagnostic and Statistical Manual IV-R (DSM IV)
American Psychiatric Association
Typical Criteria for diagnosis

1. Co-occurrence of multiple symptoms
2. Duration
3. Severity
4. Impairment
5. Exclusions

- Sad
- Guilty
- Sleepless
Disorder or Normal?

- Normal for the person
- Normal for the society

- Social construction of mental illness
  - Homosexuality
  - Medicalization of sadness
  - Only have psychiatric disorders in societies where there are psychiatrists
EXAMPLES

Depression and schizophrenia
Major Depressive Disorder

- 2+ weeks depressed mood
- OR loss of interest or pleasure in nearly all activities.

- At least four additional symptoms
  - Appetite +/-
  - Sleep +/-
  - Psychomotor activity +/-
  - Fatigue or decreased energy
  - Feelings of worthlessness or guilt
  - Difficulty concentrating or making decisions
  - Recurrent thoughts of death or suicidal thoughts or plans or attempts.
Major Depressive Disorder, Continued

- Symptoms most of the day, nearly every day for at least 2 weeks
- Clinically significant distress or Impairment in social roles
- Course: often protracted (untreated average 4 mos.) and recurrent (60% have second episode)

Single most common form of psychiatric disorder
Schizophrenia

- At least 2 symptoms present during a 1 month period
  - Delusions (sufficient if bizarre)
  - Hallucinations (sufficient if running commentary, or two voices conversing)
  - Disorganized speech
  - Disorganized or catatonic behavior
- Negative symptoms:
  - affective flattening
  - flattening of speech (alogia)
  - Lack of motivation [avolition]
  - inability to experience pleasure {anhedonia}
**Schizophrenia** 2006

$62.7 billion.

• Treatment (22.7 billion) plus indirect costs like lost productivity

**Depression** 2000

$83.1 billion

• $26.1 billion dollars direct medical costs
• 5.4 billion dollars suicide-related mortality costs,
• $51.5 billion dollars were workplace costs.

**Lifetime Prevalence**

• Major Depressive Disorder 16.2%
• Schizophrenia .5 – 1.5%
HOW COMMON?

Lifetime and 1-year prevalence
Community Surveys to Estimate Prevalence

• Prevalence
  • # Cases/Population, at a specific time, in a given location

• Large Community-Based Samples
  • Help-seeking makes clinical samples inappropriate
  • Rare disorders require large samples

• Fully structured lay interviews scored with computer algorithms to generate DSM “pseudo” diagnoses
Example: National Comorbidity Replication Study (NCS-R)

2001-2003

- U.S. national sample adults aged 18+
  - English speaking
  - Face-to-face interviews
  - Response rate 70.9%
- N = 9,282 (X .50% = 46 cases for psychoses)
- WHO Composite International Diagnostic Interview (CIDI) → DSM-IV Diagnoses
Prevalence of Major Depression
U.S. Adults, 18 and Older
2001-2002

- Lifetime = 32.6 = 35.1 million US adults
- 12 month = 13.1 = 14.2 million US adults
- Gender ratio female: male 2:1
12-Month Prevalence, NCS-R

12-Month Prevalence

- Any disorder
- Any substance
- Any impulse control
- Any mood
- Any anxiety

Percent
NCS-R, Lifetime Prevalence

Number Lifetime Disorders (%)

0 1 2 3+

Disorders

0 10 20 30 40 50 60

NCS-R, Lifetime Prevalence
12-month Prevalence of Mental Illness and Affected Population, NCS and Baltimore ECA
12 month, US Adults.

- Serious and persistent: 2.6% (4.8 million)
- Serious: 5.4% (10.0 million)
- Any disorder: 23.9% (44.2 million)
WHO IS MOST AT RISK?

Social distribution of disorder
Multi-Group Comparison
National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) N = 43,093

12-month Prevalence of Any Mood Disorder by Race/Ethnicity

Huang et al. 2006

MDD, dysthymia, bipolar I and bipolar II.
Explaining the Low Rates of Disorder among Racial/Ethnic Minority Groups

- **ARTIFACT** (i.e., survey under-estimates)
  - Design features of the studies that *differentially* affect members of minority groups
    - e.g., Mental illness among non-respondents greater among members of minority groups
  - Subcultural factors that influence responses to survey questions
    - e.g., Naysaying (to not loose face, violate cultural norms) greater among minorities
  - Not capturing cultural idioms or forms of distress that are more common among minorities
• REAL DIFFERENCES
  • Protective sociodemographic characteristics
    • e.g., intact family structure
  • Protective cultural practices
    • e.g., emphasis on collectivism, extended family
  • Effective coping practices
    • e.g. religiosity
### Lifetime Prevalence (%) by Gender
#### NIMH Collaborative Psychiatric Epidemiology Surveys

<table>
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<tr>
<th>Disorders</th>
<th>Males</th>
<th>Females</th>
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<tbody>
<tr>
<td>Any Mood Disorder</td>
<td>14.4</td>
<td>22.31</td>
</tr>
<tr>
<td>Any Anxiety Disorder</td>
<td>17.1</td>
<td>25.46</td>
</tr>
<tr>
<td>Any Substance Disorder</td>
<td>17.6</td>
<td>7.86</td>
</tr>
<tr>
<td><em>Any Mood, Anxiety Substance Disorder</em></td>
<td>33.9</td>
<td>38.25</td>
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• **Gender differences**
  - Men and women experience depression similarly, and men are less depressed than women.

• **Masked depression**
  - Restrictive norms about how men should think, feel and behave lead to unexpressed depression

• **Masculine depression**
  - Traditional masculine gender norms (e.g., emotional stoicism, competitiveness) lead to more externalizing symptoms

• **Gendered responding**
  - Social learning of gender norms lead men to respond to negative affect differently than women, e.g., rumination
Socioeconomic status

• **Social Causation**
  Adverse circumstances of life coupled with lack of resources lead to mental disorder

• **Social Selection**
  People with mental disorders are selected into lower educational and occupational positions (and hence income levels) because of their conditions (also known as “downward social drift”)

• Both of these processes contribute to the association between SES and some mental disorders to some degree.
  • For most disorders, SES-> more pronounced,
  • Schizophrenia an exception
Policy Implications

• To the extent that it’s **social causation**, then policy and intervention should target:
  • Socially based adversities and restricted resources
    • Neighborhood revitalization programs
    • Creation of safe communal areas for social exchange

• To the extent that it’s **social selection**, then policy and intervention should:
  • Protect people with mental illness from the downward mobility that flows from the disabilities of their conditions or the stigma that accompanies it.
    • Enforcement of laws against terminating people on the basis of illness
    • Employment workshops
PREVENTION

When and who?
## Median Age of Onset

<table>
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<tr>
<th>Age Range</th>
<th>Disorders</th>
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| Under age 10 | - Specific Phobia  
             | - Separation Anxiety  
             | - Attention Deficit-Hyperactivity |
| 11-19     | - Social Phobia  
             | - Obsessive Compulsive  
             | - Oppositional Defiant  
             | - Conduct Disorder  
             | - Intermittent Explosive  
             | - Drug Abuse |
| 20-30     | - Panic  
             | - Agoraphobia  
             | - Post-traumatic Stress  
             | - Bipolar  
             | - Alcohol Abuse/Dependence  
             | - Drug Dependence |
| 30-39     | - Generalized Anxiety  
             | - Depression  
             | - Dysthymia |

- Any Disorder: Median = 14!
Intervention Targets

- **Primary Prevention: Prevent onset**
  - Universal – the population as a whole regardless of risk
  - Selective – Individuals at high risk of developing disorder
  - Indicated – Individuals who are symptomatic

- **Secondary Prevention/Treatment: Early detection and treatment**
  - Prevent condition from getting worse
  - Reduce duration

- **Tertiary Prevention/Treatment: Established cases**
  - reduce disability
  - enhance recovery
  - maintenance
    - Prevent relapses (reoccurrence during recovery)
    - Prevent recurrence (reoccurrence after remission)
Cognitive Behavioral Therapy

- **Time-limited, goal-oriented therapy**
  - using specific technique
  - to change dysfunctional emotions, behaviors and cognitions.

- **Uses cognitive restructuring:**
  - learning to refute cognitive distortions, such as irrational thinking,
  - with more accurate and beneficial ones.
• People with mental illnesses can and do recover.
• They manage their conditions and go on to lead happy, healthy, productive lives.
• They contribute to society and make the world a better place.
• People with mental illness can often benefit from medication, rehabilitation, talk therapy, self help or a combination of these.
• One of the most important factors in recovery is the understanding and acceptance of family and friends.
Empowerment Model of Recovery from Mental Illness

by Daniel B. Fisher, M.D., Ph.D. and Laurie Ahern

©1998 National Empowerment Center, Inc.
MENTAL HEALTH

The goal
Mental Health: Not just the Absence of Mental Illness

• “a state of successful performance of mental function,
• resulting in productive activities,
• fulfilling relationships with people, and
• the ability to adapt to change and
• to cope with adversity”

• Surgeon General David Satcher, 1999.
Getting help

- The counseling center
  - Counseling and Psychological Services
    - [http://www.caps.ucla.edu/](http://www.caps.ucla.edu/)
    - 310-825-0768