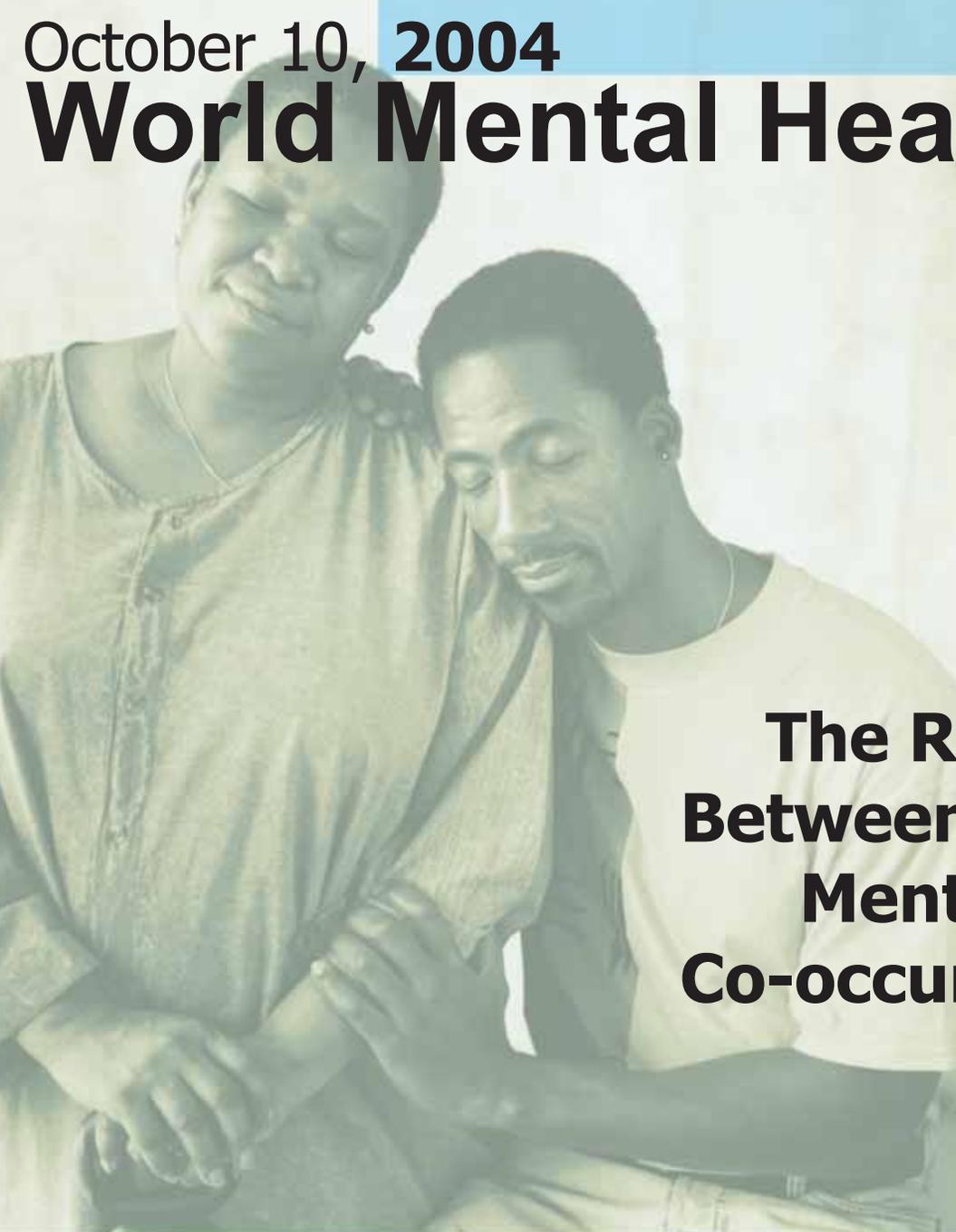


October 10, 2004

# World Mental Health Day



**The Relationship  
Between Physical and  
Mental Health:  
Co-occurring Disorders**



*World Federation for Mental Health*

# Table of Contents

Letter from the Honorary Chair of World Mental Health Day: Mrs. Rosalynn Carter

Letter from the WFMH President, L. Patt Franciosi, PhD and WMHDAY Committee Chair, Prof. John Copeland

World of Thanks

## **Section One: The Relationship Between Physical & Mental Health: Co-occurring Disorders**

- Introduction
- Diabetes and Mental Disorders
- Cancer and Mental Disorders
- Cardiovascular Disease and Mental Disorders
- HIV/AIDS and Mental Disorders
- The Mind and Body Connection
- The Impact of Physical Health Problems for Persons with Severe Mental Disorders

## **Section Two: Taking Action/What You Can Do**

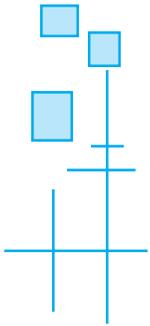
- From Concept to Program: Integrating Models, Systems and People
- Publicizing Your Event
- Sample World Mental Health Day 2004 Proclamation
- WFMH Membership Application
- World Mental Health Day 2004 Report Form

## **Section Three: Reference Information**

- The World Federation for Mental Health: A Profile
- WFMH Board of Directors
- World Mental Health Day 2004 International Advisory Committee
- World Mental Health Day 2004 Endorsers
- Resources and Websites

**2004 world mental health day**  
*The Relationship between Physical and  
Mental Health: Co-occurring Disorders*

**October 10, 2004**



Dear Friends,

The theme for the 2004 World Mental Health Day, *The Relationship of Physical and Mental Health: Co-Occurring Mental and Physical Disorders*, emphasizes a holistic approach to health and wellness. Since 1946 when the World Health Organization defined health as “the complete state of physical, mental, and social well-being...not merely the absence of disease,” we have gradually come to understand that the most effective remedies treat both body and mind.

Chronic or catastrophic illnesses like cancer, diabetes, heart disease, and HIV/AIDS take a huge toll on sufferers – and survivors - and often lead to serious psychological disorders, particularly depression. Likewise, individuals afflicted with severe and persistent mental illnesses are frequently affected with a variety of physical disorders and complications. For a number of reasons, many of which are addressed in the accompanying materials, coordinating care for co-occurring disorders remains a serious challenge. Both medical practitioners and mental health professionals can use this opportunity to devise creative strategies for bridging the mental and physical aspects of healthcare. And affected individuals and families can help increase awareness to encourage and promote more comprehensive systems of treatment.

This year’s World Mental Health Day global education packet includes information and resources about many of the most common co-occurring physical and mental disorders. I hope you will join the countless others – organizations, government officials, community leaders, and ordinary citizens - in over 150 countries that will engage in educational activities around this issue. Together we can focus worldwide attention on the importance of incorporating mental health in advancing general good health and well-being for all people.

Sincerely,

Rosalynn Carter  
Honorary Chair





# **World Federation for Mental Health**

## **Federation Mondiale pour la Sante Mentale**

2001 North Beauregard Street, Ste. 950 Alexandria, VA 22311 USA Tel: 703-838-7543 Fax: 703-519-7648 E-mail: info@wfmh.com

### **President**

L. Patt Franciosi, PhD  
932 West Shaker Circle  
Mequon, WI 53092  
USA

### **President-Elect**

Shona Sturgeon, MSW  
South Africa

### **Immediate Past President**

Pirkko Lahti  
Finland

### **Treasurer**

Edward Pennington  
Canada

### **Honorary Secretary**

Janet Meagher, AM  
Australia

### **Board Members At Large**

Paulo Alterwain, MD  
Uruguay

Maan A. Barry, PhD  
Yemen

Chueh Chang, ScD  
Taiwan

Anthony Fowke, AM  
Australia

Brian Howard  
Ireland

Beverly Long, MPH  
USA

Janet Paleo  
USA

Richard Studer  
USA

Deborah Wan  
Hong Kong

### **Regional Vice Presidents**

AFRICA  
Elizabeth Matare  
Zimbabwe

EASTERN MEDITERRANEAN  
Ahmed Abou El-Azayem, MD  
Egypt

EUROPE  
Leo de Graff  
The Netherlands

MEXICO & CENTRAL  
AMERICA  
Virginia Gonzalez Torres  
Mexico

NORTH AMERICA &  
CARIBBEAN  
Cynthia Wainscott  
USA

OCEANIA  
Peter McGeorge, MBChB  
New Zealand

SOUTH AMERICA  
Miguel R. Jorge, MD  
Brazil

SOUTHEAST ASIA  
Regina de Jesus  
Philippines

WESTERN PACIFIC  
Kazuyoshi Yamamoto, MD  
Japan

### **At The United Nations**

GENEVA  
Stanislas Flache, MD

NEW YORK  
Nancy E. Wallace, CSW

### **At The Secretariat**

Secretary General/CEO

### **Mailing Address**

PO Box 16810  
Alexandria, VA 22302-0810  
USA

Dear Friends and Supporters of World Mental Health Day:

We approach this World Mental Health Day with great enthusiasm as we bring much needed attention to the concept of optimal health. We have chosen to focus on the relationship between physical and mental health by examining the consequences of co-occurring disorders as we attempt to eliminate the gaps in treatment that have long existed.

Over the years, research conducted in the field of mental health has brought to our attention that mental health inherently affects physical health and physical health affects mental health. The two are inseparable in terms of achieving a more complete state of wellness.

Sadly, for many years the separation and differences in the treatment of physical and mental health have been widely accepted. The time has come to reinforce what we stand for – mind and body are inseparable: health is the complete state of well being – and “there is no health without mental health!” We hope you will use this material to the best of your ability and help us close the gap between physical and mental health issues and care.

Your dedication to the distribution of information, through the auspice of World Mental Health Day, is, at a minimum, courageous, powerful and inspiring. We thank you for your efforts and encourage you to continue to celebrate World Mental Health Day by educating and empowering change in your communities!

Sincerely,

*L. Patt Franciosi*  
**President**  
WFMH Board of Directors

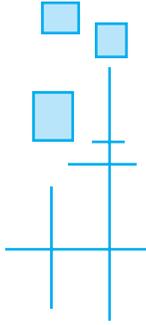
*John RM Copeland*  
**Chair**  
WMHDay Committee

Honorary President - Tsung Yi Lin, MD - Canada

An international non-governmental organization in Consultative Status to the United Nations and its specialized agencies

The Federation is a not-for-profit 501 (c) (3) organization

## **World of Thanks**



As we began this New Year, we chose a new focus for the 2004 WMHDAY campaign. Our theme for this year is intended to focus attention on an emerging recognition of the integral relationship between physical and mental health. By placing greater emphasis on the concept that “There is no health without mental health,” we can encourage the creation of a “full body approach” to health care and treatment. In the coming years, WFMH plans to highlight more closely some of the topics and issues presented in this year’s overview campaign.

The 2004 World Mental Health Day theme is *The Relationship between Physical and Mental Health: Co-occurring Disorders*. This topic has been exciting and challenging to research and write. The WFMH staff, writers, researchers and Advisory Committee have worked diligently to locate accurate and useable research and program-based information together for you. We encourage you to continue researching this subject and to build your knowledge about these important issues so that you may go out and teach others of what you have learned.

WFMH would like to thank those special people who contributed their time and knowledge to help create this planning packet. A very special thanks goes out to our principal writer, Ellen Mercer, for her positive support and writing ability throughout this project and to our additional contributors of material – Dr Robert Levin, Preston Garrison and Dr R.S. Murthy — for their important contributions.

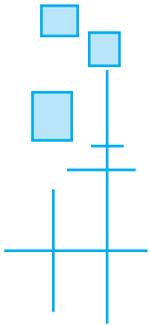
We acknowledge support for the project provided by the members of the International Advisory Committee, especially our chair, Professor John Copeland. We thank the WFMH staff, Board, our translators from Allied Languages, our printing company Smith-Litho, and our designer, Wade Jennings. We wish to express our special thanks for supporting this project and the mental health movement to those organizations that gave us permission to use and distribute their material in the packet.

As we all know, this wonderful project would not be possible without the financial support we receive from our sponsors. We would like to recognize the World Mental Health Day sponsors and contributors for this year: Bristol Myers Squibb as our main sponsor, along with contributing support from AstraZeneca, Eli Lilly and Company, Otsuka America and Organon International. This support makes it possible for the WFMH to send this packet to thousands of people in need of educational material, free of any charge. Please make sure to send your own personal “thank you” to the supporters of the 2004 WMHDAY global planning packet.

In closing, the WFMH would like to thank the thousands of individuals, organizations and government agencies for their continued involvement in this international education and awareness project. The future of this project depends on you and all the wonderful events planned around the world. We thank you for your efforts and wish you much success in your 2004 campaign events!



**October 10, 2004**

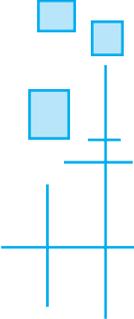


## **Section One: The Relationship Between Physical and Mental Health**

- Introduction
- Diabetes and Mental Disorders
- Cancer and Mental Disorders
- Cardiovascular Disease and Mental Disorders
- HIV/AIDS and Mental Disorders
- The Mind and Body Connection
- The Impact of Physical Health Problems for Persons with Severe Mental Disorders



## **Introduction**



A meaningful definition of health as a “healthy state of well being” should address the whole person, “the general condition of body and mind.” After all, “*health*” derives from the Greek word meaning “*whole*.”

The World Health Organization describes health as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” In order for an individual to be viewed as generally healthy, one should look at the complete person with all that involves. Mental well being cannot be separated from physical well being. To look at one aspect without the other does a disservice to the overall health of the individual. Mental and physical health and illness represent crucial parts of life that are deeply interdependent.

It has been stated that there are five areas of health or wellness to focus on when considering optimal health. Those are Physical Health, Emotional Health, Social Health, Spiritual Health and Intellectual Health. We will bring attention to the physical and emotional parts of total wellness for our 2004 campaign.

Studies have shown that each has a major impact on the other: cancer, cardiovascular disease, diabetes, HIV/AIDS, and other illnesses should not be viewed in isolation from the possible mental and psychological issues of an individual.

The World Health Organization has emphasized that the presence of major physical diseases affects the mental health of individuals as well as of entire families. And, further, that mental health is as important as physical health to the overall welfare of individuals, societies, and countries.

It is common for an individual to have two or more mental disorders at the same time; the same is true with mental and physical disorders. It has been shown that people with schizophrenia experience far more physical health problems influencing overall health and life expectancy than people in the general population. Many of these problems result from behaviour issues causing obesity, smoking, and substance abuse that lead to hypertension, heart disease, diabetes, and cancer. Others relate to medications given for one disease that create other illness. Individuals with schizophrenia tend to be either reluctant or unable to report other problems, according to Dr. Ian Banks of the United Kingdom. These patients also often delay going to the doctor for treatment.

An Australian study shows that individuals with schizophrenia were found to be 2.9 times more likely to die of natural causes, especially cardiovascular disease, than those in the general population. It appears that detection of physical illness in people living with schizophrenia is very poor. There are some apparent reasons why diagnosis and treatment of physical illness in this population is difficult:

- Some non-psychiatrists are hesitant to treat people with serious mental illness.
- There may be a lack of follow-up of patients with mental illness, due to the patient’s lack of motivation.
- There are often a number of changes of the treating doctors, thereby keeping the person’s history from being developed.
- Some psychiatrists believe that a general practitioner should handle physical health matters.
- Physical examinations are conducted far too infrequently by psychiatrists.
- There is not enough time and money for physical examinations in mental health care.

Many people with chronic physical diseases, such as diabetes and cancer, experience emotional and psychological problems that often aren’t detected or treated adequately. Also, many people with a mental illness often have an undiagnosed physical illness.

- Australian Dept. of Health and Ageing

Anxiety and depression often cause adverse changes in a person's immune system thus making way for any number of physical illnesses. A person's mental health has a profound effect on his or her behaviour as far as diet, exercise, sexual practices, smoking, etc. which may further the chances of adverse physical illnesses. Mentally ill individuals can have difficulty communicating their physical needs and problems. Many mentally ill people have a very high tolerance for pain and a reduction in pain sensitivity due to antipsychotic medications. People frequently seek help for physical ailments that may actually be symptoms of depression, such as allergic reactions, ulcers, or other disorders. It is clear that primary care physicians should look at potential mental health causes and consequences of physical illness in order to provide the best possible treatment. Too often this important link is overlooked.

The Pan American Health Organization indicates that many discoveries in behavioural health are already successfully applied to clinical medical and public health problems and that technology dealing with behavioural change must be applied to health promotion in many more nations and communities and must be taught in every school for health professionals.

A ground-breaking meeting at the U.S. National Institute for Mental Health (NIMH) entitled *The Unwanted Cotraveler: Depression's Toll on Other Illnesses* was held in March 2001 and brought together government officials, researchers, academics, mental health professionals, mental health consumers, and members of the public. The former NIMH Director, Dr. Steven Hyman, stressed the fact that depression is a brain disease profoundly affecting the physical being, including the structure of the brain. Thus, the same chemistry that affects the brain also affects major physical illnesses such as diabetes, cardiovascular disease, and others. A number of participants in this meeting discussed about the role of stigma in these equations. As long as mental illness is seen as existing apart from physical illnesses, it will not receive the attention – or the funding – that it needs. A representative of the National Depressive and Manic-Depressive Association spoke of a survey completed by her organization showing that 78 percent of Americans with depression had not experienced complete control of their illness within the previous two months. She noted that if a chronic illness, such as diabetes, wasn't completely controlled for the same percentage of diabetics, there would be a public outcry. She further stated that if people and their doctors can't recognize the symptoms of depression or if people refuse to get treatment, depression would remain highly undiagnosed and untreated.

Human behaviour plays a central role in the maintenance of health and the prevention of disease.

U.S. Institute of Medicine (2001)

The World Health Organization has been in the forefront of development of mental health services, especially in developing countries. This organization has reported that 4 of the 10 leading causes of disability in the United States and other developed countries are mental disorders, including major depression, bipolar disorder, and schizophrenia. One of the first initiatives in developing countries was a project in Brazil, Colombia, Egypt, India, Philippines, Sudan, and Senegal to examine the feasibility of integrating mental health in general health care (1975-1981). The most recent effort is the publication of the World Health Report 2001 on Mental Health. The World Health Report 2001 has supported the movement to integrate mental health care into general health services in developing countries. A number of countries have used this approach to organize essential mental health services. In developing countries with limited resources this has meant a new beginning of care for people with mental disorders. India started training primary health care workers in 1975, forming the basis of the National Mental Health Programme formulated in 1982. Currently the government supports 100 district level programmes in 30 states. In Cambodia, the ministry of health trained a core group of personnel in community mental health, who in turn trained selected general medical staff at district hospitals. In the Islamic Republic of Iran, efforts to integrate mental health care started in the late 1980s and the programme has since been extended to the whole country, with services now covering almost the whole of the rural population (about 20 million people). Countries such as Afghanistan, Malaysia, Morocco, Nepal, Pakistan, Saudi Arabia, South Africa, the United Republic of Tanzania, and Zimbabwe have adopted similar approaches. Some studies have been carried out to evaluate the impact of integration, but more are urgently needed.

We live in an exciting time for innovations in treatment of illnesses. Many of the most feared illnesses of the body, such as cancer, heart disease, diabetes and more are increasingly seen as treatable, survivable, even curable

ailments. Yet, despite unprecedented knowledge gained in recent decades about the brain and human behaviour, mental health is not given the priority that it deserves and needs. In 1999, the U.S. Surgeon-General's report on Mental Health recognized the extremely close relationship between our mental and physical health and well being. Then-Surgeon General David Satcher, M.D., Ph.D., stated that "Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between 'mental' and 'physical' health."

There have been many studies supporting the need to view physical and mental health together. A New York City Community Health Survey showed that significant emotional distress could affect physical health. A person who is very depressed or anxious may be more likely than others to engage in behaviour that may increase poor physical health and, in turn, physical illness may increase or even cause depression and anxiety. It's a vicious cycle. The good news is that appropriate treatment for emotional problems can greatly improve the functioning of someone with physical illness. This study, along with many others, demonstrates that primary care providers can learn to recognize, treat, or make referrals for people with mental health problems.

A joint position paper prepared by the Canadian Psychiatric Association and the College of Family Physicians of Canada stated, "In theory, the family physician and the psychiatrist are natural partners in the mental health care system. While neither may be able to meet every need of a client with a mental disorder, each can offer complementary services, which enables them to play a key role at different stages of an episode of illness and the subsequent period of recovery.

Collaborative care between the family physicians and psychiatrists is a critical step toward improving the overall care received by people with mental disorders." This paper highlights mental health problems in family medicine where it indicates that approximately a third of all family practice patients have identifiable mental health problems and that the statistics may be even higher for teenagers and the elderly. In addition, these organizations explored the difficult issues of access between mental health professionals and family practitioners, problems in communication, and a lack of personal contact. These researchers urge the promotion of an integrated and holistic approach to physical and mental health problems to ensure a greater continuity of care.

The World Health Organization's "Guide to Mental and Neurological Health in Primary Care" states that in a general-practice surgery, every third or fourth person seen has some form of mental disorder. This document indicates that the way in which services are provided emphasizes the importance of primary care as a setting for mental health care – showing the importance of people in primary care working more closely with those in mental health services. Good mental health care is a collaborative effort that includes primary care physicians, nurses, school counsellors, and mental health professionals.

The U.S. Institute of Medicine (2001) has reported that one of the greatest advances in determinations of disease over the past two decades has been the identification of social and psychological conditions that influence mortality.

For integration of mental health into general health care to be successful, policy-makers need to consider the following:

- General health staff must have the knowledge, skills and motivation to treat and manage people living with mental disorders.
- There needs to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary levels.
- Basic psychotropic drugs must be available at primary and secondary care levels.
- Mental health specialists are required to provide support to monitor general healthcare personnel.
- Effective referral links between primary, secondary and tertiary levels of care need to be in place.
- Funds must be redistributed from tertiary to secondary and primary levels of care or new funds must be made available.
- Recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities.

World Health Organization, 2001 World Health Report

Medical science is making huge advances on understanding chronic illnesses like dementia, diabetes, Parkinsonism, etc. But at the same time, the world is faced with dramatic increases in non-communicable diseases such as mental disorders, cardiovascular disease, cancer, etc. A full understanding of interactions between health and behaviour is important in the prevention and treatment of many diseases plaguing the world today.

Recent years have witnessed the accumulation of a great number of studies in both areas of basic and clinical sciences showing a clear relationship between biological, psychological and socio-economic aspects of human life in health and disease.

Dr. Ahmad Mohit, WHO-EMRO

Dr. Richard Nakamura of the U.S. National Institute of Mental Health urges primary care physicians to watch for individuals who experience many different illnesses because there may be signs of depression that mask or cause other illnesses. He has indicated that physical symptoms that mask depression can be allergic reactions, ulcers, or other disorders. He believes that viewing physical symptoms as unrelated to mental disorders, or vice versa, is missing the entire picture of the individual.

The American Psychiatric Association (APA) has emphasized that there is growing evidence supporting the strong link between mental disorders and physical illnesses. The more serious the medical condition, the more likely the person will experience a mental health problem. The risk of depression is generally higher for people with serious medical illnesses such as heart disease, cancer, and diabetes. In addition, people with a mental illness may have more difficulty functioning on a day-to-day basis and may be unable to adhere to treatments that have been prescribed. People who are diagnosed and treated for co-existing illnesses often experience an overall improvement in their medical condition and their quality of life. The APA further states, "the link between mental disorders and physical illnesses must be addressed if both are to be treated successfully." It is clear that mental health problems can have the same symptoms as physical problems; poor physical health can make mental health problems worse. It is extremely important, according to the Royal College of Psychiatrists, for a prompt assessment of physical health to be carried out in people being admitted to mental health units.

Antipsychotic medications are very important to the medical management of many psychotic conditions, as shown in a 2003 Consensus Development Conference of the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity and published in the *Journal of Clinical Psychiatry*. The so-called "second generation antipsychotics" (SGAs) have been improved from the first such medications available, there are also some side effects that may influence diseases such as diabetes and cardiovascular diseases. It was shown, for example, that there is considerable evidence that treatment with these medications, especially with individuals with schizophrenia, can cause a rapid increase in body weight in the first few months, increasing the risk of these other types of diseases.

Physical activity and good nutrition have been shown to be important factors in good mental health and psychological well being. Activity and nutrition helps individuals avoid mental disorders, recover from mental disorders, and improve the quality of life for everyone. These same behavioural factors influence physical health as well – in areas of prevention, diagnosis, and treatment. Thus, an interdisciplinary approach incorporating the physical and mental states of an individual has been proven to be the most effective way of addressing all health issues. Motivation towards wellness is a mental health issue and can go a long way in helping solve physical problems.

An Australian study has recommended steps that should be taken to further the diagnosis and treatment of co-existing mental and physical disorders:

- Physicians should routinely collect data on a standard checklist and core information data sheet concerning physical health.
- Psychiatric services should be adequately equipped to carry out basic medical needs.
- Refresher training should be regularly provided for psychiatrists and key members of multidisciplinary community psychiatric teams. This should include elements of detection, management and preventive counselling.
- Specific interdisciplinary teams with broad medical and psychiatric expertise and training should be created. These could serve in enhanced models of shared care.

- Formal programmes to address training and other issues should be set up at a national or regional level in each country.

While many mental disorders may present themselves in primary care settings, major depression is one of the more prevalent conditions, afflicting an estimated 5-9% of those who see a general physician. There is also evidence that shows that most people with depression receive mental health care from primary care physicians, therefore, prompting special attention to the integration of mental health services and primary health care. It has also been shown that a barrier to the integration of mental health services and primary health care is the lack of motivation on the part of consumers, providers, and payors.

As the facts are brought to our attention, we must focus our efforts on educating health systems to help change existing assumptions that split the person into unequal parts of “body” and “mind.” As Dr. Patt Franciosi, WFMH President, stated, *“Why, with all the evidence available now, do the myths and the separation of mind and body care continue? The systems of health care across the globe need a shift in policy and the delivery of health services. There would be no more excuses for marginalizing funding for the delivery of mental health services, and we would have to insure that prevention of mental illness and promotion of mental health receive their fair share of public health resources.”*

The 2004 World Mental Health Day packet will bring to light just a few of the many co-occurring disorders that are highly documented in current research and medical findings across the globe. We open this topic as our 2004 focus and we will present information on four physical illnesses – Cardiovascular Disease, Diabetes, Cancer and HIV/AIDS – and the mental disorders that tend to be most prevalent, such as anxiety, depression, schizophrenia and stress. There is much to learn and more to bring attention to as we explore the topic this year and in the future. We encourage everyone to continue to learn more about physical and mental health and empower change in our communities and in our lives.

**Health is not just the absence of disease...  
it is physical, social, emotional and spiritual  
well being.**

## References:

- American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity “Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes” in *Journal of Clinical Psychiatry* 65:2, February 2004.
- American Psychiatric Association. “Coexisting Severe Mental Disorders and Physical Illness” *Statement by the American Psychiatric Association*. July 7, 2003.
- Australian Government Department of Health and Ageing, “Forum Explores Co-Morbidity of Mental health with Other National Health Priority Issues,” BHO Summer 2002.
- Baez, Denise. *Primary Care Physicians Should Be Aware of Link Between Physical and Mental Health*. WebMD; Medscape Medical News. November 19, 2003.
- Butler, Gillian and Hope, Tony “Manage your Mind: The Mental Fitness Guide - ISBN 0192623834.
- Combs-Orme, T., Heflinger, C.A. & Simpkins, C.G. “Comorbidity of Mental Health Problems and Chronic Health Conditions in Children” in *Journal of Emotional and Behavioural Disorders*, 10, 2002. 116-125.
- Depression Alliance, 35 Westminster Bridge Road, London SE1 7JB. Tel: 020 7633 0557; Fax: 020 7633 0559; [www.depressionalliance.org](http://www.depressionalliance.org).
- Depression Alliance Cymru (Wales), 11 Plas Melin, Westbourne Road, Whitchurch, Cardiff CF4 2BT. Tel: 029 2069 2891. Information, support and understanding for people who suffer with depression and for relatives who want to help.
- DiMatteo, M. Robin, “Social Support and Patient Adherence to Medical Treatment: A Meta-Analysis” in *Health Psychology*. 2004 Mar Vol 23(2) 207-218.
- Gill D. & Hatcher S. Antidepressants for depression in medical illness (2002)

- The Cochrane, Library <http://updatesoftware.com/abstracts/ab001312.htm>
- Health and Human Behaviour: The Interplay of Biological, Behavioural, and Societal Influences. U.S. National Academy of Sciences, Institute of Medicine, 2001.
  - "Management of Serious Mental Illness" on *Medscape from WebMD* at [www.medscape.com/pages/editorial/resourcecenters/public/mentalillness/rc-mentalillness.ov](http://www.medscape.com/pages/editorial/resourcecenters/public/mentalillness/rc-mentalillness.ov).
  - *Men's Health Forum, UK*. "Ian Banks reports on Schizophrenia," May 2001.
  - "The Integration of Mental Health Services and Primary Health Care" A working meeting of the U.S. Surgeon General, November 30-December 1, 2000. [www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.html](http://www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.html).
  - "Integrating Mental Health Care into General Health Services" in *The World Health Report 2001. Mental Health: New Understanding, New Hope. Chapter 4*. The World Health Organization, 2001.
  - Jenkins, C. David, Ph.D. *Building Better Health: A Handbook of Behavioural Change*. A Pan American Health Organization Scientific and Technical Publication, No. 590, 2003.
  - Kates, Nick; Craven, Marilyn; Bishop, Joan; Clinton, Theresa; Kraftcheck, Danny; LeClair, Ken; Leverette, John; Nash, Lynn; Turner, Ty. "Shared Mental Health Care in Canada" by a joint working group of the Canadian Psychiatric Association and The College of Family Physicians of Canada, 1996. Available on line at: [www.cpa-apc.org/Publications/Position\\_Papers/Shared.asp](http://www.cpa-apc.org/Publications/Position_Papers/Shared.asp).
  - Lambert, Timothy J.R., Velakoulis, Dennis, Pantelis, Christos. "Medical Comorbidity in Schizophrenia" in *Medical Journal of Australia*, 2003; 178(9) Suppl 5 May: S67-S70.
  - MacHale, S. Managing Depression in Physical Illness (2002), *Advances in Psychiatric Treatment* 8: 297-304
  - *NYC Vital Signs, A report from the New York City Community Health Survey*. New York City Department of Health and Mental Hygiene, 2003.
  - National Institute of Mental Health – summary of proceedings of forum on *The Unwanted Cotraveler: Depression's Toll on Other Illnesses*, March 2001. Available on line at [www.nimh.nih.gov/resaerch/pittsburghhrpt.cfm](http://www.nimh.nih.gov/resaerch/pittsburghhrpt.cfm).
  - Oglesby, Carole. *Women's Mental Health and Physical Activity*. Women-Health hosted by WomenWatch, United Nations. 1999.
  - "Physical Illness Link to Suicide Risk" on BBC News, June 7, 2002.
  - *Psychiatric Patients Miss Out on Physical Health Screenings*. Royal College of Psychiatrists Press Release, June 2002.
  - Robertson M.M. & Katona C. *Depression and Physical Illness* (1997) Wiley ISBN 0471961485
  - Trickett, Shirley. *Coping with Anxiety and Depression (Overcoming Common Problems)* -ISBN 0859695921.
  - U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General – Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
  - *WHO Guide to Mental and Neurological Health in Primary Care*, World Health Organization – UK Collaborating Centre 2003-4. Available online at [www.mentalneurologicalprimarycare.org](http://www.mentalneurologicalprimarycare.org).
  - World Health Organization. *The World Health Report 2001: Mental Health: New Understanding, New Hope*. Geneva, Switzerland, 2001.

# **WORLD MENTAL HEALTH DAY**

## **The Relationship Between Physical and Mental Health**

---

### **“Physical Illness and Mental Health”**

The Royal College of Psychiatrists of the UK – [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

Many of us will, at some time, have a serious physical illness. Both the illness, and the treatment for it, can affect the way we think and feel. This leaflet is for anyone who has a serious physical illness and for their friends or relatives. It describes:

- The emotional effects of having a serious physical illness.
- What does it feel like to be anxious or depressed?
- Why are depression and anxiety more likely to happen if we have a physical illness?
- What might make you more likely to become anxious or depressed?
- When should you seek help?
- How can depression and anxiety be helped?
- How can you help yourself?
- How can family and friends help?

### **The emotional effects of having a serious physical illness**

A serious physical illness can affect every area of your life. Our relationships, our work, our spiritual beliefs and how we socialize with other people may all be affected. A serious illness can make us feel sad, frightened, worried or angry.

It may be because:

- We are uncertain about:
  - what exactly is wrong
  - how we will cope with the pain of surgery or the side-effects of medication
  - whether the treatment will help
- We feel out of control of our body and our situation generally. We may feel that there is nothing that we can do.
- We feel lonely and isolated from family and friends. Sometimes it can be difficult to talk about the illness with those close to us. We don't want to worry or upset them.

For some of us, the emotional impact of a serious physical illness can be overwhelming. Cancer or heart disease, for example, can make us very anxious and depressed. It can stop us from doing the things we need to do in our daily lives.

### **What does it feel like to be anxious or depressed?**

Anxiety and depression affect both our mind and body. Often the two happen at the same time.

Anxiety feels like:

- Constant worrying thoughts, often about the illness and its treatment.
- Fearing the worst, for example, that our illness will get worse or that we might die.

- Being very aware of our heart beating (palpitations).
- Tension and pains in our muscles.
- Being unable to relax.
- Sweating.
- Breathing too fast (hyperventilating).
- Feeling dizzy.
- Feeling faint.
- Indigestion and diarrhea.

Depression feels like:

- Feelings of unhappiness that don't go away, and are there nearly all the time.
- Being unable to enjoy anything.
- Losing interest with life.
- Finding it hard to make even simple decisions.
- Feeling utterly tired.
- Feeling restless and agitated.
- Losing appetite and weight (some people find they do the reverse and put on weight).
- Difficulty in sleeping and waking up earlier than usual.
- Losing interest in sex.
- Losing self-confidence and feeling useless, inadequate and hopeless.
- Avoiding other people.
- Feeling irritable.
- Feeling hopeless about ourselves, our situation and the world generally. We may feel as if we are never going to get better, or that we are worthless.
- Thinking of suicide - this is common in depression. It is much better to talk about it than to try to hide it.

Some of these symptoms, such as feeling tired, poor sleep and loss of appetite, may be similar to those caused by the physical illness or its treatment. If you talk through how you are feeling with a doctor or nurse, they can help to sort out whether it is your physical illness or depression that is responsible.

**Why are depression and anxiety more likely to happen if you have a serious physical illness?**

- People become depressed and anxious when they are stressed for any reason. Being ill and having treatment are stressful. This is probably the most common reason.
- Some drug treatments, such as steroids, affect the way the brain works and so cause anxiety and depression directly.
- Some physical illnesses, such as an under-active thyroid, affect the way the brain works. They cause anxiety and depression directly.

- Anxiety and depression are common. You may just happen by chance to become anxious or depressed at the same time as you become physically ill.

### **What might make you more likely to become anxious or depressed?**

You are more likely to experience severe anxiety and depression when you are physically ill if:

- You have been anxious or depressed before.
- You do not have any family or friends you can talk to about your illness.
- You are female (women report more anxiety and depression than men).
- You have other problems or stresses going on in your life at the same time. For example, redundancy, a divorce or the death of a loved one.
- You are in a lot of pain.
- Your illness is life threatening.
- Your illness stops you from looking after yourself.

The times when we are most likely to become anxious and depressed are:

- When you are first told about your illness.
- After having major surgery or if there are unpleasant side effects to your treatment.
- If the illness comes back, after you seemed to be feeling better. For example, a recurrence of cancer or a second heart attack.
- If your illness stops responding to treatment.

### **When should you seek help?**

If your feelings of anxiety and depression:

- Are worse than the fears, worries and sadness that you have had before.
- Don't seem to be getting any better with time.
- Begin to affect your feelings towards family and friends, your work and your interests.
- If you feel that life is not worth living, or that other people would be better off without you.

You may not realize you are depressed, if:

- You think all your symptoms are due to the physical illness.
- You blame yourself for being lazy or feeble.

Other people may have to reassure you about this. They may need to remind you that seeking help is not a sign of weakness. Some of us try to cope with our feelings of anxiety and depression by keeping busy. This works for some people, but can also be an excellent way of making ourselves even more stressed and exhausted. Sometimes anxiety and depression may not show themselves as feelings of unhappiness and fear, but may produce bodily pain, headaches, or sleeplessness.

It may be enough to talk things over with a relative or friend, who may be able to help you through this difficult time. But, if this doesn't seem to help, it is probably a good idea to talk to one of the doctors and nurses who are looking after you.

### **Is feeling like this a good enough reason to ask for help?**

It can be difficult asking for help with anxiety and depression when we are physically ill because:

- You may feel your distress is understandable and therefore there is nothing that can be done about it.

- You don't want to appear ungrateful, or as if you are complaining to the doctors and nurses who are providing your physical care.
- You don't want to interfere with the treatment of your physical illness, by admitting that you are having difficulty coping.
- You may feel that the doctors and nurses are too busy looking after your physical illness to be interested in your anxiety and depression.
- You feel the doctors and nurses are more interested in your physical problems than your emotional ones.

Of course we can all understand when someone with a serious physical illness becomes anxious and depressed. This does not mean that you should ignore it. Doctors and nurses are concerned about all aspects of your health, including any depression or anxiety that you are feeling. They can help by:

- Knowing about your worries and concerns about your situation.
- Making sure you know enough about your illness and its treatment.
- Helping you to talk about your feelings.
- Deciding if you need treatment for anxiety or depression.

### **How can depression and anxiety be helped?**

There are several different types of professional who may be able to help you. These include your family doctor (GP), trained counsellors, psychotherapists, clinical psychologists and psychiatrists. Any treatment suggested will depend on your symptoms, the severity of your anxiety and depression, and your circumstances. It may involve talking, antidepressant tablets or both.

### **Talking treatments**

It can be hard to express real feelings, even to close friends. It may be easier to do this with an interested professional. He or she can help you to get things in perspective and to find ways of sorting out your problems. Talking therapies are usually brief, involving up to 8 sessions. You might see somebody on your own or as part of a group. If you have a partner or carer, it could be helpful for her or him to be involved. There are many types of talking treatments but all have the following ingredients:

- A trusting relationship between the patient and the professional.
- An opportunity to talk freely and openly about your thoughts, feelings and problems.
- Help coping with worrying thoughts, bad feelings and practical problems.

### **Will it help?**

The thought of seeing someone just to talk may seem frightening or pointless, or both. However, once started, most people with a serious physical illness find it very helpful.

### **How does it work?**

Talking treatments work by helping you to be clearer about what is happening to you emotionally. They help us to find ways of coping better with feelings, thoughts and practical problems. It's also helpful to be able to talk freely with someone who you trust and who doesn't pass judgment on you.

### **How quickly does it work?**

Some people feel better straight away, simply from being able to talk about their worries. For others, it may take a few weeks.

## **Antidepressant drugs**

If your anxiety and depression is particularly bad, or goes on for a long time, a course of antidepressants may be helpful. They help people with anxiety and depression to feel better, so that they can start to enjoy life and deal with their problems effectively again. They are not tranquillizers, although they may help you feel less anxious and agitated. They can also help pain and disturbed sleep.

### **Will you feel better straight away?**

Probably not. Unlike many medicines, you won't feel the effect of antidepressants straight away. People often don't notice any improvement in their mood for two or three weeks, although some of the other problems may improve more quickly. For instance, people often notice after a few days that they are sleeping better and feeling less anxious.

### **What about the side effects?**

Like all medicines, antidepressants do have some side effects, although these are usually mild and tend to wear off as the treatment goes on. Different antidepressants have different effects. Your doctor can advise you what to expect and will want to know if anything is worrying you. If necessary, you can also take them with painkillers, antibiotics and the contraceptive pill. However, you should avoid too much alcohol - alcohol can make you very sleepy if you drink it while taking antidepressant tablets. Your doctor will advise you whether they will interfere with any treatments that you are taking for your physical illness.

### **How can you help yourself?**

As well as seeking professional help, there are a number of things you can do to help yourself.

- Share your fears and concerns with people close to you. You may be surprised - rather than finding this a burden, you may also be relieved to talk about these things.
- Ask your doctor questions about the illness. If there are aspects of the illness or its treatment that you are uncertain about - ask. If you know about your illness, you are likely to cope better with it.
- Try to eat a balanced diet. If you have lost your appetite because of worry or depression, you may lose weight. This can make your physical health worse.
- Balance the demands of your illness and the demands of your life. You will need to try and find the balance between "giving into the illness" and "pressing on regardless."
- Look after yourself. Make sure that you build relaxation, pleasurable activities and, if possible, physical exercise in your daily routine.
- Try not to drink too much alcohol to make you feel better. It can actually make anxiety and depression worse and it may interfere with your tablets.
- Try not to worry about not sleeping properly. This happens in anxiety and depression and usually gets better when your mood lifts.
- Don't change the number of tablets you are on, or stop taking them, or try other remedies, without discussing it with your doctor. If the tablets have unpleasant side effects, tell your doctor or nurse. Don't suffer in silence.

### **How can family and friends help?**

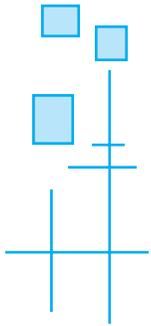
It is often a relative or friend who first notices anxiety and depression coming on in someone with a physical illness. If you have noticed someone close to you becoming depressed, gently encourage him or her to seek help. Explain that anxiety and depression are quite common and that, with help, they get

better in the great majority of cases. To see a professional, such as a psychiatrist or a psychologist, is not a slur on the patient or their family, or a sign of weakness.

- It is helpful to spend time with someone who is anxious and depressed. They don't need to be nagged, but they do need to be encouraged - perhaps to talk, but also to keep going with some of the things they normally do.
- Reassure the person who is anxious and depressed that they will get better - they may find it hard to believe that they can.
- Try to make sure they are eating a well balanced diet and help them to avoid drinking too much alcohol.
- If the anxious and depressed person is getting worse and has started to talk of not wanting to live or has hinted at harming himself (or herself), take these statements seriously and make sure that their doctor knows about this.
- Try to help the person to accept the treatment prescribed. If you have doubts about the treatment, discuss them with the doctor.

Caring for someone who is both physically ill and troubled with anxiety and depression can be exhausting. If you are getting worn out, do ask for help.

## **Diabetes and Mental Disorders**



Diabetes mellitus is a major and growing health problem in almost all countries. At least 177 million people worldwide suffer from diabetes; this figure is likely to be more than double by the year 2030, states the World Health Organization.

Diabetes can have a significant impact on the quality of life for individuals, their families, friends, carers and the wider society. The emotional and social effects are often underestimated. During the last few years, the co-morbidity of mental disorders with chronic health conditions has surfaced as a topic of considerable interest. Diabetes is considered one of the most psychologically demanding of the chronic illnesses because it requires such a strict daily routine.

Individuals with diabetes commonly must undergo extensive lifestyle changes in order to properly manage their disease, and often experience substantial stress and negative affect. Studies confirm that people with diabetes frequently experience emotional disorders: diabetics are reported to have almost three times the rate of anxiety and at least three to four times the rate of depression found in the general population. A Johns Hopkins University 13-year study of nearly 2,000 people found that those who were depressed were more than twice as likely as others to develop the disease.

Diabetes often goes undiagnosed for years, particularly among those with mental illness. In fact, according to the American Diabetes Association, approximately one-third of patients with diabetes in the U.S. population are undiagnosed. In its early stages, type 2 diabetes is often asymptomatic, and the onset, and even the existence, of symptoms frequently goes unnoticed - particularly in people with mental illness - impairing the ability to recognize or describe symptoms or changes in physical conditions. Diagnosis of diabetes may be delayed an average of 4-12 years. At the time diagnosis is made, about 50% of patients already have diabetes complications.

At least 171 million people worldwide suffer from diabetes; this figure is likely to more than double, to reach 366 million, by 2030. Most of this increase will occur as a result of a 150% rise in developing countries.

Certainly, everyone with diabetes feels sad from time to time which is only natural considering the extra responsibilities, restrictions, and worries that they face everyday. But people with diabetes may be at greater risk. Diagnosing depression in those with diabetes is challenging. Not only do many believe that depression is a normal reaction to the pain or incapacity caused by diabetes, both depression and diabetes share many of the same symptoms, namely sudden weight loss, low energy and sleep disturbances. In addition, there are studies that show that diabetes disturbs the natural balance of bodily hormones and brain chemistry. As well, depression induces hormonal changes that directly affect the body's resistance to insulin, in turn aggravating the underlying diabetes. When depression occurs in people with diabetes, it usually is associated with poor metabolic control, poor diet and adherence to treatment, and negative effects on quality of life.

Those with both conditions find it more difficult to control their diabetes. Certain symptoms associated with depression, such as loss of energy and changes in eating habits, can impede a

patient's ability to follow the recommended diabetes care regimen. This increases their risk for developing diabetic complications such as heart disease, blindness, stroke, kidney disease, birth defects, nerve damage and amputation.

A German study revealed that diabetes could also be associated with an increased likelihood of anxiety disorders. While people with diabetes were not shown to be more likely to have a mental disorder than individuals without diabetes, the relationship between diabetes and anxiety disorders remained significant after considering the age, sex, marital status, and socioeconomic status of the people being studied. However, these individuals were also shown to be controlling their diabetes adequately.

Some clinicians believe that eating disorders are more common among people with diabetes than in the general population. While diabetes does not cause eating disorders, it can set the stage for their development, making successful outcomes difficult to attain. When a diabetic has an eating disorder or an eating disturbance, he or she often falls into the dangerous behaviors of dieting, restricting and bingeing; the most dangerous practice being the misuse of their insulin. Medical complications as a result of improper use of insulin or bingeing for diabetics with eating disorders include kidney failure, heart disease, blood circulation difficulties, and eyesight damage. Diabetics with eating disorders have a threefold risk of retinopathy (permanent damage to the retina of the eye). Diagnosing an eating disorder in a diabetic can be extremely difficult, even for professionals. The dietary concerns of diabetes can easily mask the eating disordered behavior. It is often hard to tell if the behaviors are symptoms of an eating disorder or just careful dietary management of the diabetes. When confronted, eating disordered diabetics often claim that they are just practicing good dietary control. One tell-tale sign of trouble is poorly controlled blood sugars for unexplained reasons.

The best treatment is often a multidisciplinary team effort where many professionals are involved with the individual and the family: a physician to manage the diabetes and the effects of eating disorders, a mental health therapist to help define and deal with emotional issues, a family therapist to help the family, and a dietitian to provide nutritional counselling and education.

On another note, studies have shown that people with schizophrenia may be at increased risk for Type II diabetes because of the side effects of antipsychotic medication, poorer overall physical health, less healthy lifestyles, and poorer health care.

Some psychiatric medications appear to cause weight gain, thus complicating the risk and treatment for diabetes. The possibility of such an association is important to explore given that compared to the general population, those with schizophrenia appear to have an increased risk for developing serious health issues and seem to lack health care that focuses on the total wellness of the individual.

Health professionals, patients, family members and caregivers should be aware of the signs and symptoms of diabetes and especially those associated with acute diabetes conditions, such as diabetic ketoacidosis. Patients, family members, and caregivers also need to know that treatment with some atypical antipsychotics may be associated with weight gain and therefore a heightened risk of developing diabetes.

Growing concerns about the impact of antipsychotic treatment of these factors and the implications for the overall health of an already vulnerable group of people have led to the need for more awareness of the importance of careful screening and ongoing monitoring of patients to ensure their long-term health. Studies in Sweden have shown that certain newer medications, called atypical antipsychotics or SGAs, are associated with an increased risk of glucose intolerance and diabetes mellitus. In contrast, however, other older medications did not have the same association. Difficulties in glucose regulation and type-2 diabetes mellitus can, thus, occur more commonly in schizophrenia and, possibly, in family members of patients compared with healthy individuals. This concern is not only because of current medications since abnormalities in glucose regulation were first reported in schizophrenia before the introduction of antipsychotic medications. This leads to further concern that glucose regulation problems caused by antipsychotic treatment of non-diabetic patients with schizophrenia may well increase the chances of getting the disease.

Compared with the general population, people with schizophrenia appear to endure higher rates of obesity-related illnesses such as those mentioned above, even though the prevalence of obesity in people with schizophrenia appears to be the same as in the general population. There is evidence that one major side effect of antipsychotic treatment is weight gain that can lead to diabetes, as well as other diseases. This is a strong case for the need to bring both the mind and the body into an overall health care approach and reduce the chances of damaging health care issues going unnoticed.

One study of over 38,000 patients compared the association between the use of atypical antipsychotics to that of typical antipsychotic medications and diabetes. The authors report that for patients under the age of 40, all of the atypical antipsychotics were associated with an increased risk of diabetes, and for patients older than 40, all of the atypical antipsychotics except for one were associated with an increased risk of diabetes. Such conclusions recently led Japan and the European Union to require some atypical antipsychotics to include warnings about diabetes-related complications in product information sheets.

On the contrary, however, two related University of Buffalo studies examining conditions among individuals with schizophrenia or bipolar disorder indicate that it is the illness itself, not the atypical antipsychotic medications, that contributes to the increased incidence of diabetes. The authors of these studies indicate that, while the incidence of diabetes has increased in the general population since the 1940s and 1950s, it has gone down significantly in patients being treated with antipsychotic medications; thus, the medications may actually have a protective effect. They do suggest that psychiatric care be modified to include routine screening for diabetes, hypertension, and obesity. This is a strong case for the need to bring both the mind and the body into an overall health care approach and reduce the chances of damaging health care issues going unnoticed.

A recent report of the World Health Organization and International Diabetes Federation has drawn attention to the importance of encouraging psychological well being in people with diabetes. The establishment and maintenance of psychological well being is recognized as an important goal of diabetes management, which is expected to reduce the occurrence of metabolic problems and complications. Education in emotional self-regulation may have particular clinical relevance in diabetes, as emotional disturbances and ineffective coping styles have been associated with significantly poorer glycemic control, the increased report of clinical symptoms, decreased compliance and increased risk for complications. Emotional stress can contribute to the exacerbation of diabetes by direct physiological effects on glucose regulation, as well as by reducing adherence to self-care behaviours. Conversely, studies have shown that significant relationships exist between self-efficacy, self-care and measures of glycemic control. Thus, multiple lines of evidence clearly support the integration of an effective stress reduction and emotional management intervention program as a fundamental component of any diabetes management regimen.

Given the serious health risks involved with both diabetes and the above-mentioned mental disorders, it is extremely important for both patients and their doctors to understand the close connections between mental health and diabetes for the most effective treatment throughout one's life cycle. Early intervention is the key to managing all health factors and living a more productive life.

Most middle & low income countries devote less than 1% of their health budgets to mental health and an estimated 25% of the world's nations have not made any specific provision for diabetes care in national health plans.

World Health Organization

## References:

- Decatur, Adam; Patil, Kashinath; Ortega, Tulio. "Anti-Psychotic Drugs May Reduce Diabetes Risk in Mentally Ill" in *What You Need to Know About Diabetes* at [www.diabetes.about.com/library/blnews/blnantipsychotics\\_503.htm](http://www.diabetes.about.com/library/blnews/blnantipsychotics_503.htm). May 3, 2003.
- "Depression" on American Diabetes Association website at [www.diabetes.org](http://www.diabetes.org)
- "Depression and Diabetes" on the National Institute of Mental Health website at [www.nimh.nih.gov](http://www.nimh.nih.gov) June 2002.
- "Diabetes Cases Could Double in Developing Countries in Next 30 Years." Press Release of the World Health Organization, November 14, 2003.
- "Diabetes and Eating Disorders," Anorexia Nervosa and Related Eating Disorders, Inc. at [www.anred.com](http://www.anred.com) September 2003.
- Hedenmalm, Karin, Hägg, Staffan, Stahl, Malin, Mortimer, Örjan, Spigset, Olav. "Glucose Intolerance with Atypical Antipsychotics" in *Drug Safety* 2002, 25(15): 1107-1116.
- Kollar, Elizabeth A.; Doraiswamy, P. Murali; Cross, James T. "Risperidone-Associated Diabetes" Presentation at The Endocrine Society's 84<sup>th</sup> Annual Meeting, June 19-22, 2002.
- Kruse, Johannes; Schmitz, Norbert; Thefeld, Wolfgang. On the Association Between Diabetes and Mental Disorders in a Community Sample in *Diabetes Care* on [www.care.diabetesjournals.org](http://www.care.diabetesjournals.org).
- Newcomer, John W.; Haupt, Dan W.; Fucetola, Robert; Melson, Angela K; Schweiger, Julia A.; Cooper, Benjamin P.; Selke, Gregg. "Abnormalities in Glucose Regulation During Antipsychotic Treatment of Schizophrenia" *Archives of General Psychiatry*/Vol 59, April 2002
- Regenold, W.T., Thapar, R.K., Marano, D., Gavirneni, S., Kondapavuluru, P.V. "Increased Prevalence of Type 2 Diabetes Mellitus Among Psychiatric Inpatients with Bipolar I Affective and Schizoaffective Disorders Independent of Psychotropic Drug Use." Erratum in: *J. Affect Disorders* 2003; 73(3):301-2, *J. Affect Disorders* 2002; 70:19-26.
- Roper, Nick A.; Bilous, Rudy W.; Kelly, William F.; Unwin, Nigel C.; Connolly, Vincent M.: "Excess Mortality in a Population with Diabetes and the Impact of Material Deprivation: Longitudinal, Population Based Study" in *British Medical Journal*, Volume 322, 9 June 2001.
- Rubin, Richard R. "Diabetes and Depression" on LifeScan One Touch website by Johnson & Johnson. Materials provided by Dr. Rubin through Johns Hopkins Health Center. October 2002. [www.lifescan.com/care/rubin/articles/depression](http://www.lifescan.com/care/rubin/articles/depression).
- Ryan, Martina C.M.; Flanagan, Susan; Kinsella, Una; Keeling, Frank; Thakore, Jogin H. "The Effects of Atypical Antipsychotics on Visceral Fat Distribution in First Episode, Drug-naïve Patients with Schizophrenia" in *Life Sciences* 74 (2004) 1999-2008.
- Watkins, Carol E. Northern County Psychiatric Associates, Psychiatric Services for Children, Adolescents, Adults, and Families. Baltimore, Maryland.
- Weiden, Peter. "Weight Gain and Diabetes Risk with Psychiatric Medications" in *New York City Voices*, Vol. VIII, No. 4, October-December 2003. Pp. 14-15.
- Woolston, Chris. "Depression and Diabetes" on BlueCross/Blue Shield's *A Healthy Me* website at [www.ahealthyme.com](http://www.ahealthyme.com). January 28, 2003.
- "Consensus Development Conference on Antipsychotic Drugs, Obesity and Diabetes" *Journal of Clinical Psychiatry* 65:2, February 2004.

# **WORLD MENTAL HEALTH DAY**

## **The Relationship Between Physical and Mental Health**

---

### **METABOLIC ISSUES IN THE TREATMENT OF SERIOUS MENTAL DISORDERS: A MATTER OF GROWING ATTENTION**

Among the many advances that have come about over the past decade in the understanding and treatment of serious mental and behavioral disorders, including schizophrenia and depression, has been the development of second-generation antipsychotic medications (SGAs). As these new medications have come available and have offered improved treatment outcomes, their use has increased rapidly. Although the SGAs have demonstrated many benefits when compared to their earlier counterparts, their use has been associated with reports of negative physical health problems, including dramatic weight gain, diabetes, and increased LDL cholesterol and triglyceride levels and decreased HDL cholesterol. (*Diabetes Care* 27:596-601, 2004).

A brief search of the World Wide Web easily demonstrates the level of media attention, public concern, and interest of governmental regulatory bodies that has been generated around reports of these negative and potentially harmful risk factors associated with SGAs in the treatment of mental disorders. Particular concern has focused on the question as to whether persons being treated with SGAs for schizophrenia are put at greater risk for diabetes as a consequence of these medications. Interest in this question is further heightened due to the high incidence of obesity and other often unrecognized and untreated physical health problems among persons with serious mental illnesses, and because of the close associations between obesity, diabetes, and dyslipidemia and cardiovascular disease.

To gain a better understanding of the relationship between the SGAs and the development of these major risk factors, the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North America Association for the Study of Obesity convened a consensus development conference in November 2003 on the subject of antipsychotic drugs and diabetes (*Diabetes Care* 27:596-601, 2004).

The consensus meeting addressed five basic questions:

- (1) What is the current use of antipsychotic drugs?
- (2) What is the prevalence of obesity, pre-diabetes, and type 2 diabetes in the populations in which the SGAs are used?
- (3) What is the relationship between the use of these drugs and the incidence of obesity or diabetes?
- (4) Given the identified risks, how should patients be monitored for the development of significant weight gain, dyslipidemia, and diabetes, and how should they be treated if diabetes develops?
- (5) What research is needed to better understand the relationship between these drugs and significant weight gain, dyslipidemia, and diabetes?

From the exploration of these questions, a number of findings and recommendations were articulated, among them:

- (1) “Overall, the limited amount of epidemiological data available suggests an increased prevalence of obesity, impaired glucose tolerance, and type 2 diabetes in people with psychiatric illness. Whether this is a function of the illness itself versus its treatment is unknown. Studies using the proper diagnoses of glucose intolerance and more complete risk factor characterization are necessary in order to resolve this issue.” (*Diabetes Care* 27:596, 2004)
- (2) “Given the serious health risks, patients taking SGAs should receive appropriate baseline screening and ongoing monitoring. The panel recommends that baseline screening measures be obtained before, or as soon as clinically feasible after, the initiation of treatment of any antipsychotic medications, including for personal and family history of

obesity, diabetes, etc., weight and height, waist circumference, blood pressure, fasting plasma glucose, and fasting lipid profile.” (*Diabetes Care* 27:596, 2004)

- (3) “The panel recommends that nutrition and physical activity counseling be provided for all patients who are overweight or obese, especially if they are starting treatment with an SGA that is associated with significant weight gain. Referral to a health care professional or programme with expertise in weight management may also be appropriate.” (*Diabetes Care* 27:596, 2004)

In summary, the panel recommended:

- Consideration of metabolic risks when starting SGAs
- Patient, family and care giver education
- Baseline screening
- Regular monitoring
- Referral to specialized services, when appropriate.

In its summary statement, the panel concluded: “SGAs are of great benefit to a wide variety of people with psychiatric disorders. As with all drugs, SGAs are associated with undesirable side effects. One constellation of adverse effects is an increased risk for obesity, diabetes and dyslipidemia. The etiology of the increased risk for metabolic abnormalities is uncertain, but their prevalence seems correlated to an increase in body weight often seen in patients taking an SGA.... These three adverse conditions are closely linked, and their prevalence appears to differ depending on the SGA used...the choice of SGA for a specific patient depends on many factors. The likelihood of developing severe metabolic disease should also be an important consideration. When prescribing a SGA, a commitment to baseline screening and follow-up monitoring is essential in order to mitigate the likelihood of developing CVD, diabetes, or other diabetes complications” (*Diabetes Care* 27:596, 2004)

#### **Reference:**

• “Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes”: *Diabetes Care* 27:596-601m 2004 © American Diabetes Association, Inc. WEB Citation: <http://care.diabetesjournals.org/cgi/content/full/27/2/596>

# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Depression and Diabetes

American Diabetes Association - [www.diabetes.org](http://www.diabetes.org)

Feeling down once in a while is normal. But some people feel a sadness that just won't go away. Life seems hopeless. Feeling this way most of the day for two weeks or more is a sign of serious depression.

At any given time, most people with diabetes do not have depression. But studies show that people with diabetes have a greater risk of depression than people without diabetes. There are no easy answers about why this is true.

The stress of daily diabetes management can build. You may feel alone or set apart from your friends and family because of all this extra work.

If you face diabetes complications such as nerve damage, or if you are having trouble keeping your blood sugar levels where you'd like, you may feel like you're losing control of your diabetes. Even tension between you and your doctor may make you feel frustrated and sad.

Just like denial, depression can get you into a vicious cycle. It can block good diabetes self-care. If you are depressed and have no energy, chances are you will find such tasks as regular blood sugar testing too much. If you feel so anxious that you can't think straight, it will be hard to keep up with a good diet. You may not feel like eating at all. Of course, this will affect your blood sugar levels.

### What to do?

Spotting depression is the first step. Getting help is the second. If you have been feeling really sad, blue, or down in the dumps, check for these symptoms:

- **Loss of pleasure** You no longer take interest in doing things you used to enjoy.
- **Change in sleep patterns** You have trouble falling asleep, you wake often during the night, or you want to sleep more than usual, including during the day.
- **Early to rise** You wake up earlier than usual and cannot get back to sleep.
- **Change in appetite** You eat more or less than you used to, resulting in a quick weight gain or weight loss.
- **Trouble concentrating** You can't watch a TV program or read an article because other thoughts or feelings get in the way.
- **Loss of energy** You feel tired all the time.
- **Nervousness** You always feel so anxious you can't sit still.
- **Guilt** You feel you "never do anything right" and worry that you are a burden to others.
- **Morning sadness** You feel worse in the morning than you do the rest of the day.
- **Suicidal thoughts** You feel you want to die or are thinking about ways to hurt yourself.

If you have three or more of these symptoms, or if you have just one or two but have been feeling bad for two weeks or more, it's time to get help.

### Getting Help

If you are feeling symptoms of depression, don't keep them to yourself. First, talk them over with your doctor. There may be a physical cause for your depression.

Diabetes that is in poor control can cause symptoms that look like depression. During the day, high or low blood sugar may make you feel tired or anxious. Low blood sugar levels can also lead to hunger and eating too much. If you have low blood sugar at night, it could disturb your sleep. If you have low blood sugar at night, you may get up often to urinate and then feel tired during the day.

Other physical causes of depression can include

- alcohol or drug abuse
- thyroid problems
- side effects from some medications

Do not stop taking a medication without telling your doctor. Your doctor will be able to help you discover if a physical problem is at the root of your sad feelings.

If you and your doctor rule out physical causes, your doctor will most likely refer you to a specialist. You might talk with a psychiatrist, psychologist, psychiatric nurse, licensed clinical social worker, or professional counsellor. In fact, your doctor may already work with mental health professionals on a diabetes treatment team.

All of these mental health professionals can guide you through the rough waters of depression. In general, there are two types of treatment. One is psychotherapy, or counselling. The other is antidepressant medication.

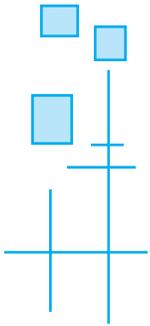
Psychotherapy with a well-trained therapist can help you look at the problems that bring on depression. It can also help you find ways to relieve the problem. Therapy can be short term or long term. You should be sure you feel at ease with the therapist you choose.

If medication is advised, you will need to consult with a psychiatrist (a medical doctor with special training in diagnosing and treating mental or emotional disorders). Psychiatrists are the only mental health professionals who can prescribe medication and treat physical causes of depression.

If you opt for trying an antidepressant drug, talk to the psychiatrist and your primary care provider about side effects, including how it might affect your blood sugar levels. Make sure that the doctors will consult about your care when needed. Many people do well with a combination of medication and psychotherapy.

If you have symptoms of depression, don't wait too long to get help. If your health care provider cannot refer you to a mental health professional, contact your local psychiatric society or psychiatry department of a medical school, or the local branch of organizations for psychiatric social workers, psychologists, or mental health counsellors.

## **Cancer and Mental Disorders**



The diagnosis of cancer can sometimes lead to depression and anxiety, which can have a profound effect on the overall health of the person dealing with the illness. Studies demonstrate that a lack of treatment in this situation can prolong the length of hospitalization, hamper effective treatment, and ultimately reduce the chances of survival. Treatment can, conversely, have a positive effect on the quality of life of the individual and decrease the number of hospital visits and increase survival rates. It is important that people diagnosed with cancer benefit from early intervention and primary care clinicians and oncologists adequately should be able to identify mental health symptoms in their clients.

Ray Berard, M.D., from South Africa has noted, however, that an oncologist rarely has the time to make a thorough mental health assessment as would be done by a mental health professional in making a diagnosis. He recommends that a more rapid method for screening needs to be developed, although it must also be deemed to accurately make any assessment. He believes that there are three main obstacles to the effective treatment of depression and anxiety in those with cancer: 1) the difficulty in diagnosing the person because of the overlap of symptoms for the person living with cancer and one suffering from depression and anxiety; 2) the clinician may not have time to spend on the assessment of psychiatric illness; and 3) there is simply not enough clinical trial data on psychiatric strategies for those dealing with depression and anxiety in oncology treatment.

The evaluation of depression in people with cancer should include:

- A careful evaluation of the person's thoughts about the diagnosis;
- Medical history;
- Personal or family history of depression or suicide;
- Current mental status;
- Physical status;
- Side effects of treatment and the disease;
- Other stresses in the person's life; and,
- Support available to the patient.

Suicide is the most serious concern in cancer patients with depression. If the individual is significantly depressed, the issue of suicide requires immediate attention to assure his or her safety. The incidence of suicide in people being treated for cancer may be as much as 10 times higher than the rate of suicide in the general population.

People who face a diagnosis of cancer experience different levels of stress and emotional upset. Fear of death, interruption of life plans, changes in body image and self-esteem, changes in the social role and lifestyle, and money and legal concerns are important issues in the life of any person with cancer. Sadness and grief are normal reactions to the crises faced with cancer, and will be experienced at times by all people. It is important, however, to distinguish between the "normal" levels of sadness and clinical depression (WHR 2001, Figure 1.3). Some people may have more trouble adjusting to the diagnosis of cancer than others and may need help in doing so.

Of course, there are those who have a diagnosis of mental disorders prior to having a diagnosis of cancer. One study has concluded that women with a recent diagnosis of depression are at a greater risk for receiving non-definitive treatment and experience worse

survival rates after a diagnosis of breast cancer. There is speculation that this may apply to other forms of cancer as well.

When people discover that they have cancer, they may have feelings of disbelief, denial, or despair. Various psychological symptoms that may emerge during that time usually lessen as a person adjusts to the diagnosis and is usually demonstrated by the person's active involvement in daily life and continuing functions as spouse, parent, employee, etc. All patients may well benefit from counselling but when symptoms are intense and long-lasting, more intensive treatment is important. One study of women with breast cancer found that those who attended weekly support groups lived an average of 18 months longer than those who didn't.

Depression affects approximately 25% of all people with cancer and can damage the person's immune system, thereby weakening the body's ability to cope with disease. People facing both depression and cancer have an array of challenges to face: they are distressed; they tend to have trouble with everyday tasks, and often find it difficult to follow medical advice. Doctors believe that depression, if left untreated, can shorten the life of a person with cancer. It is important to note that some of the symptoms of depression are similar to those in individuals undergoing cancer treatment, such as fatigue, lack of concentration, sleeplessness, and loss of appetite. Thus, a clear diagnosis is particularly important so that the depression doesn't go undetected.

People who have been chronically depressed for at least six years had an 88 percent greater risk of developing cancer within the following four years.  
– U.S. National Institute on Aging

The opportunity for mental health professionals to consult with oncologists is particularly important in making such a diagnosis. It is also important to not complicate the treatment of one illness with the treatment for another, especially when medication is involved. In some cases, however, anti-depressant medication can have some pain-relieving aspects that would help people being treated for cancer. Whatever the treatment, the clinicians needs to have a proactive approach, making sure that therapy fits the needs of each individual patient based on the clinical needs. Dr. Berard states, however, "What is common to all cancer patients, however, irrespective of the type of cancer or stage of disease, is the need for appropriate management of their psychological distress."

The question as to whether depression is a factor in causing cancer is still being studied but there is some evidence that shows that there may be some truth to the association. The National Institute of Ageing recently shook up the medical world with the results to their study tracking 4,825 people ages 71 and older. The researchers found that those who were clinically depressed for at least six years had an 88 percent greater risk of developing cancer within the next four years. The researchers speculated that depression might fuel cancer by damaging T-cells and other parts of the body that fight the disease. They have, however, indicated that more studies are needed to prove cause and effect.

The good news is that, according to researchers, a person with cancer and depression can get treatment for the mind that is a huge help for the body. A Stanford University study led by David Spiegel, M.D., showed that women with advanced breast cancer who attended a weekly support group lived approximately twice as long as another group of women who didn't have a support group. Dr. Spiegel says that treating depression in people with cancer not only eases symptoms of pain, nausea, and fatigue but it may also help these people live longer and have a better quality of life.

An equally remarkable trend was found in a later study of people with malignant melanoma in that the people who participated in group therapy were three times more likely to be alive five to six years later than those who didn't receive therapy.

Unfortunately, needed mental health treatments are not often provided for people with cancer. It is estimated that about 25% of all individuals with cancer are depressed, but only about 2% receive treatment for the depression. There are several psychiatric therapies that have been found to be beneficial for the treatment of depression related to cancer. These therapies are often used in combination and may include crisis intervention, psychotherapy, and thought/behaviour techniques. These therapies usually consist of 3 to 10 sessions and explore methods of lowering distress, improving coping and problem-solving skills; enlisting support; reshaping negative and self-defeating thoughts; and developing a close personal bond with an understanding health care provider.

A considerable amount of work has been accomplished in Asia related to the psychological aspects of cancer and its treatment. Drs. Xu Guangwei, Zhang Zongwei, and ZhuYunfeng of Beijing, China, report on the work of the Committee of Cancer Patients' Rehabilitation of the Chinese Anti-Cancer Association that is dedicated to improving the quality of life for people with cancer as well as supporting research and treatment for China's most prevalent cancers. This committee groups people according to cancer type and facilitates a support network for individuals who might not otherwise have the opportunity to interact with other people with cancer. They also offer psychological treatment, physical therapy, nutrition counselling, and medical assistance. The Taiwan Cancer Friends New Life Association reports that research shows that social and emotional support, as well as psychological assistance, can help people recover from cancer. People with cancer need emotional consultation as well as medical services. More information about their work focusing on the mind/body/spirit therapies can be found in Section VI.

In order to produce the most positive outcome, it seems clear that cancer, no matter what type, should not be treated in isolation. Mental health concerns should be reviewed carefully by the treating physician, the patient, and close family and friends who provide primary support for the individual.

## References:

- Aapro, M.; Cull, A. "Depression in Breast Cancer Patients: The Need for Treatment" in *Ann Oncol.* 1999 June; 10(6): 627-36.
- Akechi, T; Kugaya, A.; Okamura, H.; Nakano, T.; Okuyama, T.; Mikami, I.; Shima, Y.I Yamawaki, S.; Uchitomi Y. "Suicidal Thoughts in Cancer Patients: Clinical Experience in Psychooncology. *Psychiatry Clin Neurosci.* 1999 Oct; 53(5): 569-73.
- "Asian Mental and Physical Treatments" – paper of the Taiwan Cancer Friends New Life Association; [www.love-newlife.org.tw](http://www.love-newlife.org.tw).
- Baker, F.; Marcellus D.; Zabora, J.; Polland A.; Jodrey D. "Psychological Distress Among Adult Patients Being Evaluated for Bone Marrow Transplantation" *Psychosomatics.* 1997 Jan-Feb; 38(1): 10-9.
- Berard, Ray M.F. "Depression and Anxiety in Oncology: The Psychiatrist's Perspective" in the *Journal of Clinical Psychiatry* 2001; 62 (suppl 8)
- "Depression and Cancer" on the National Institute of Mental Health website: [www.nimh.nih.gov/publicat/depncancer.cfm](http://www.nimh.nih.gov/publicat/depncancer.cfm).
- Goldberg, J.A.; Scott, R.N.; Davidson P.M.; Murray G.D.; Stallard, S.; George W.D.; Maguire G.P. "Psychiatric Morbidity in the First Year after Breast Surgery. *European Journal of Surg Oncol.* 1992 Aug; 18(4): 327-31.
- Goodwin, James S.; Zhang, Dong D.; Ostir, Glenn. "Effect of Depression on Diagnosis, Treatment, and Survival of Older Women with Breast Cancer." *Journal of American Geriatrics Society* 52(1): 106-111, 2004.
- Ritterband, LM; Spielberger CD. "Depression in a Cancer Patient Population. *Journal of Clinical Psychol Med Settings.* 2001 Jun; 8(2): 85-93.
- "Supportive Care: Depression" from the National Cancer Institute on *Medem.com* at [www.medem.com](http://www.medem.com)
- "The Body Mind Connection: Cancer" in *Counseling Notes* at [www.counselingnotes.com](http://www.counselingnotes.com).
- Valentine AD, Meyers CA. "Cognitive and Mood Disturbance as Causes and Symptoms of Fatigue in Cancer Patients" in *Cancer* 2001 Sep 15; 92 (6 Suppl):1694-8.
- Woolston, Chris. "Depression and Cancer" in BlueCross/Blue Shield's *A Healthy Me* website at [www.ahealthy.com](http://www.ahealthy.com). March 25, 2003.
- Zorn, Marcia; Rowland, Julia; and Varricchio, Claudette. *Symptom Management in Cancer: Pain, Depression, and Fatigue.* National Library of Medicine Bibliography. July 2002. Available at: <http://www.nlm.nih.gov/pubs/cbm/cancersymptoms.pdf>.



# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Anxiety Disorders and Cancer

The National Cancer Institute – [www.nci.nih.gov](http://www.nci.nih.gov)

Anxiety is a normal reaction to cancer but it can interfere with a person's quality of life and the ability to follow through with cancer therapy. One may experience anxiety while undergoing a cancer screening test, waiting for test results, receiving a diagnosis, undergoing cancer treatment, or anticipating a recurrence of cancer. Anxiety associated with cancer may increase feelings of pain, interfere with one's ability to sleep, cause nausea and vomiting, and interfere with the patient's (and his/her family's) quality of life. If left untreated, severe anxiety may even shorten a patient's life. Intense anxiety associated with cancer treatment is more likely to occur in those with a history of anxiety disorders and patients who are experiencing anxiety at the time of diagnosis. Many cancer medications and treatments can aggravate feelings of anxiety.

Anxiety disorders include:

- Adjustment disorder
- Panic disorder
- Phobias
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Generalized anxiety disorder
- Anxiety disorder caused by other general medical conditions.

*Adjustment Disorder* includes behaviours or moods more extreme than expected in a reaction to a cancer diagnosis. Symptoms include severe nervousness, worry, jitteriness, and the inability to go to work, attend school or be with other people.

*Panic Disorder* causes the person to experience intense anxiety; they may suffer shortness of breath, dizziness, rapid heartbeat, trembling, profuse sweating, nausea, tingling sensations, or fears of "going crazy."

*Phobias* are ongoing fears about or avoidance of a situation or object; patients usually experience intense anxiety and avoid situations that may frighten them. Some people with cancer may fear needles, for example, or small spaces such as those they would be in for magnetic resonance imaging (MRI) scans.

*Obsessive-Compulsive Disorder* causes a person to have persistent thoughts, ideas, or images (obsessions) that are accompanied by repetitive behaviours (compulsions). These patients may be unable to follow through with cancer treatment because they are disabled by thoughts and behaviours that interfere with their ability to function normally. These disorders are rare in those who didn't have the OCD before being diagnosed with cancer.

*Generalized Anxiety Disorder* may cause some people to experience extreme and constant anxiety or unrealistic worry. They may worry that their normally very supportive family and friends won't care for them or that they can't pay for their treatment. A person with generalized anxiety may feel irritable or restless, have tense muscles, shortness of breath, heart palpitations, sweating, dizziness, and be easily fatigued.

*Treatment* depends on how the anxiety is affecting daily life for the patient. Anxiety that is caused by pain or another medical condition, a specific type of tumor, or as a side effect of medication, is usually controlled by treating the underlying cause. Treatment for anxiety begins by giving the patient adequate information and support. Developing coping strategies such as the patient viewing his or her cancer as a problem to be solved, obtaining enough information in order to fully understand his or her disease and

treatment options, and utilizing available resources and support systems, can help to relieve anxiety. Patients may also benefit from other treatment options for anxiety, such as psychotherapy, group therapy, family therapy, participating in self-help groups, hypnosis, and relaxation techniques or biofeedback. Medications may be used alone or in combination with these techniques.

*After cancer therapy* has been completed, a cancer survivor may be faced with new anxieties. They may experience anxiety when they return to work and are asked about their cancer experience, or when confronted with financial problems. A survivor may fear subsequent follow-up examinations and diagnostics tests, or they may fear a recurrence of cancer. Survivors may experience anxiety due to changes in body image, sexual dysfunction, reproductive issues, or post-traumatic stress. Survivorship programmes, support groups, counselling, and other resources are available to help people readjust to life after cancer.

# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### The Body Mind Connection – Cancer

Counseling Notes – [www.counselingnotes.com](http://www.counselingnotes.com)

Every year, people around the world are diagnosed with cancer. For example, every year about 185,000 women in the United States are surprised by a diagnosis of breast cancer, and more than 75% of them do not have a known risk factor.

The uncertainty and distress that accompanies the diagnosis continues long after that first visit to the doctor. Cancer treatment is a long process with new problems and challenges to be faced all along the way. Family, work, and social relationships are often affected. Fatigue, stress, anxiety and depression may set in. It's normal to feel overwhelmed with such devastating news. It's also important to check to make sure that you give yourself the tools and help you need to cope with this new challenge. Counseling can help you to:

- Adjust to the diagnoses
- Cope with treatment
- Come to terms with the impact cancer has on your life
- Cope with the depression that often accompanies cancer

#### *Tools for the Body:*

- Diet. This means good nutrition. Balanced meals, rich in vitamins and nutrients
- Sleep. When your body is working hard, you need sleep more than ever. Establishing good sleeping habits will help you get the rest your body needs
- Exercise. Check with your doctor for a programme that will work well for you. Exercise helps digestion, reduces stress, helps with depression and can help you sleep better
- Healthy habits. Alcohol, cigarettes, caffeine and other drugs only add problems. You have enough to cope with without adding more stress to your body.

#### *Tools for the Mind:*

A significant number of people with cancer experience depressive symptoms. Depression makes it more difficult to cope with illness and disease. Depression leads to missed appointments, poorer conformity with medical advice, and less ability to use social support.

Mental health care professionals can help people with cancer learn to cope with their physical, emotional and lifestyle changes. Problem solving strategies are used to help you:

- Work through fear and grief
- Decide how to explain the illness to children or other family members
- Assertively ask questions at medical visits. If you are more fully engaged in choices and treatment, you will understand the cancer and its treatment better, and will be more willing to cooperate in doing what needs to be done to get well again
- Decide on treatment options and hospital
- Stress management. Because stress suppresses the body's ability to protect itself, it makes sense to learn good stress management and coping skills
- Family and Individual Counselling provide emotional and practical support for spouses, children, parents and friends

- Relaxation and imagery exercises relieve the nausea and vomiting that may accompany chemotherapy.

Cognitive Behavioural Therapy typically emphasizes understanding and changing our patterns of thinking and behaving. A combination of individual and group treatment sometimes works best, depending on individual preference. Groups offer the chance to give and receive emotional support and to learn from the experience of others who also have cancer.

*Tools for the Soul:*

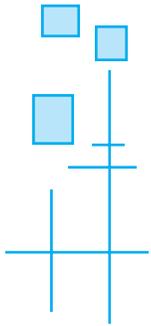
Emotional recovery often takes longer than the physical recovery and it's usually less predictable. Although our society pressures cancer survivors to quickly return to normal, cancer survivors need time to create a new self-image that incorporates both the experience and any changes in their bodies.

Because we can't change the diagnosis, our best options, then, seem to be to find a way to turn the experience into an opportunity for life-enhancing personal growth. Searching for purpose or meaning in life is a quest that provides spiritual growth and balance. Each one of us has to decide on our own path or journey and then take that first step. There are as many paths as there are people, and there are an equal number of ways to complete the journey. Practicing meditation, relaxation and imagery are all good ways to start on your path.

**2004 world mental health day**

**October 10, 2004**

## **Cardiovascular Disease and Mental Disorders**



About one in five people have an episode of major depression in their lifetimes. That number climbs to about one in two for people with heart disease. Three to five percent of the population is depressed at any given time; 18% of heart patients are depressed at any given time. The risk of heart disease is double in people with depression.

Mental stress and depression can have a profound effect on cardiovascular disease; serving as causation and implications of recovery. Studies have shown that mental stress increases oxygen demand because blood pressure and heart rates are elevated, according to David S. Sheps, M.D. from the University of Florida Health Sciences Center. An Ohio State University study of 8,000 subjects found that depressed men were 70% more likely to develop heart disease. Women had a significantly lower rate of 12% but with a dramatic increase to 78% for those cases of severe depression. A British study of 5,623 patients found that depressed men are three times more likely to develop heart damage from blockages of blood and are at higher risk for subsequent episodes than those who do not suffer from depression. The more attacks a person has, the more depressed he/she is likely to become, which may well affect the arteries and heart. It is a vicious cycle.

Approximately one-half of people with heart disease suffer an episode of major depression. The risk of heart disease is double in people with depression.

According to Rutledge and Con, there is compelling evidence that high levels of psychological distress in women are associated with an elevated risk of developing coronary artery disease as well as creating a more challenging diagnosis of the disease. While many reports place prime time for onset of coronary artery disease in women being after menopause, this study shows that it is a disease of lifetime accumulation and, thus, psychological and behavioural factors affect the potential for the disease long before menopause. Recent studies have also suggested that women with higher levels of anger and depression symptoms are more likely to smoke, abuse alcohol, be overweight, and have low levels of "good" cholesterol. Thus, this shows that psychological symptoms among women may increase their risk of cardiovascular disease directly because of biological changes or indirectly because of unhealthy lifestyle behaviours. Exclusive to women is the fact that psychological factors can have an effect in women before menopause by compromising ovarian function. Stress causes certain changes that cause a decrease in estrogen, the hormone that is believed to provide some protection to coronary artery disease.

Japanese women who report high levels of mental stress have twice the risk for stroke-related and heart-related deaths than those reporting low stress levels. Researchers, led by Hiroyasu Iso, M.D., for the Japan Collaborative Cohort Study for Evaluation of Cancer Risk, analyzed data from 30,180 men and 43,244 women between the ages of 40 and 79 and reported that 8,656 women and 6,891 men reported high mental stress. After adjusting for cardiovascular risk factors and psychological variables, women in the high-stress group had 2.24 times greater risk for stroke and 2.28 times greater risk for coronary heart disease. They also had 1.64 times the risk of any cardiovascular death. High stress women were about five years younger, more educated, more sedentary, and lower mean values of body mass index than those women reporting low mental stress. They were also more likely to have a history of diabetes and hypertension than those with less stress. These women were also more likely to be angry, feel rushed, hopeless, and unfulfilled.

There was a similar association in men, according to this Japanese study, between mental stress and heart attack. Men reporting medium or high mental stress had 1.74 times greater risk of heart attack after adjusting the physical cardiovascular risk factors.

The Center for Disease Control in the U.S. undertook a study of 3,000 men with normal blood pressure; in the 16 years of follow-up, anxiety and depression were found to double or triple the risk of developing high blood pressure. The Johns Hopkins Precursors Study of 1,190 male medical students followed for 40 years showed that those who were depressed had a substantially higher likelihood of developing coronary heart disease than did their peers and that increased risk continued up to ten years after an episode of depression. The journal *Psychosomatic Medicine* (March 2001) documented that in persons with high blood pressure, a history of depression substantially increases the risk of heart disease; in fact, those with depression had twice the risk for heart attack as those without a history of depression. Another long-term study (the National Health and Nutrition Examination Survey) found that the risk of heart disease among 5,000 women was nearly twice as high for those who had depression even though the risk of death from heart disease was unaffected by their depression. The risk of heart disease in men was found to also be nearly twice as high for those with depression while the risk of death from heart disease was much higher.

A Duke University Medical Center study has shown that mild to moderate levels of depressive symptoms combined with feelings of hostility in healthy men may raise a certain kind of protein (IL-6) that is associated with clogged arteries and a greater risk of heart attack. A test was administered to 90 healthy, non-smoking men between the ages of 18 and 45 whereby they answered two questionnaires to determine their level of depressive symptoms and hostility. Those who showed the highest levels of symptoms had IL-6 protein levels that were two to five times higher than men who scored low on each test.

Anxiety and depression double or triple the risk of developing high blood pressure, a primary reason for cardiovascular disease.

The U.S. Center for Disease Control

Other studies have shown that psychological distress and loneliness can put a serious strain on the heart and can turn a survivor of heart disease into a victim. Dean Ornish, M.D. wrote in his book [Love and Survival: The Scientific Basis for the Healing Power of Intimacy](#) "Among heart patients, depression is as good a predictor of imminent death as smoking, obesity, or a previous heart attack. Study after study shows that people who are lonely, depressed, and isolated are three to five times more likely to die prematurely than people who feel connection in their life." Researchers at the Montreal Heart Institute tracked 222 heart attack survivors and found that those with depression were approximately six times more likely than others to die within six months of their attack. These researchers later found that depression also led to a 8-fold increase in death rates 18 months after a heart attack. A Duke University study of 1,400 men and women with at least one severely blocked artery found that the unmarried patients without close friends were three times more likely than the others to die over the next five years.

A study at Johns Hopkins University showed that depression might even be implicated in the development of heart disease. This 13-year study of 1,500 subjects found that an episode of depression increased the risk of heart attack more than four-fold, even when taking smoking and other factors into account. This shows that there is very strong evidence that depression alone is very damaging to the heart. Why? Depression seems to affect the normal regulatory process of heart rate, indicating that the organ may be weaker and less flexible. Mental distress tends to encourage blood cells to clump together, which may be the beginning of blood clots.

It has been shown that postmenopausal women who experience symptoms of depression have a 50 percent greater chance of developing or dying from cardiovascular disease than women without depressive symptoms. In a study of 93,000 postmenopausal women, 15.8 percent scored positive for depressive symptoms.

A Danish study followed 730 men and women, all born in 1914 and were tested in 1964 and again in 1974 for physical and psychological symptoms of depression. Those with a high measure of depressive

symptoms had a 70% increased risk of heart attack and, in fact, those with signs of depression at the beginning of the study were 60% more likely to die early from any cause.

This leads to consideration of the effects of depression and stress on management of and recovery from cardiovascular disease. It is estimated that people with major depression are two to four times more likely to die in the months following an infarction or blockage of blood circulation to an organ, leading to tissue death. This suggests that individuals, particularly women, would benefit from depression intervention programmes at the hospital level. Women would particularly benefit because of the fact that they are much more likely to meet the depression criteria, thus, they are at a higher risk for complications and, even, death. Studies have shown that psychosocial treatment that reduces stress can reduce the rates of re-hospitalization and death rates and that both men and women respond favorably to these programmes.

It has also been shown that individuals who receive treatment for depression after a stroke have a better chance of restoring mental abilities, which are often damaged during a stroke, such as orientation, memory, language, and hand-eye coordination.

In addition, it has been determined that a stress-management programme cuts the chances that a heart patient would suffer a heart attack or need surgery by 74 percent. There is also reason to be optimistic about the theory that anti-depressants can help fight heart disease. A psychiatrist at Emory University School of Medicine has found that giving this type of medication to heart attack survivors made their platelets less “sticky” and reduced their risks of blood clots.

One study has shown that there are two main causes of mental impairment after a stroke:

- Physical damage caused by the stroke, and,
- Post-stroke depression

Depression has been shown to be common in individuals who survive heart attacks and major forms of depression are persistent in the majority of individuals. Once discharged from the hospital, people often must take new medications, give up smoking, and make changes in their lifestyles. There may be a loss of employment, concern about the effect of normal activities on the heart, and frequent visits to the doctor. These changes may cause anxiety, feelings of dependency, concern for the future, and despair. The individual's ability to make the needed changes may be even more difficult if he/she has an emotional disturbance. It is true that treating depression should enable a person to be more active in his/her health care and result in better and earlier recognition of symptoms of heart disease and adherence to recommendations for reducing the risks of further heart problems.

Prevention of chronic hostility and chronic depression may be as important to learn, as it is to quit smoking, manage cholesterol, and exercise, according to some studies. One study of individuals undergoing balloon angioplasty (a popular treatment where a thin catheter is used to open an artery so that a balloon can be inflated to allow more blood to flow to the heart) demonstrated that more than 1/3 of these patients required a repeat procedure within six months.

It was noted by Mark Goodman, a behavioural medicine specialist, that those people who were referred to him for stress reduction training because of repeat angioplasties tended to be very angry, hostile, and difficult to deal with. Other studies show that individuals with these types of personalities have higher levels of stress hormones in their blood making their arteries more likely to constrict and form blockages. On this basis, the authors of one study have developed a behaviour modification programme as part of rehabilitation for angioplasty patients in order to help them reduce their hostility and, thereby, reduce the chances that another procedure will be needed.

We have often heard the saying “think positively.” Many studies have now shown that there is hard medical evidence for the benefits of this idea in terms of heart disease. It appears, unfortunately, that the physicians who treat heart disease rarely address the possibility of depression.

While much work has been accomplished on the relationship of stress and depression on heart disease, it is important to point out other mental illnesses that may also have an impact on the person experiencing cardiac disease. Michael Davidson, M.D. of Tel Aviv University in Israel, has studied the risk of

cardiovascular disease and sudden death in schizophrenia. He has found that, in general, people with schizophrenia are at a higher risk for medical illnesses than people in the general population and are 2 to 4 times more likely to die prematurely – at least ten years earlier than their counterparts of the same age. One reason for these statistics may be the use of antipsychotic medications. These medications can cause weight gain as well as changes in the blood flow that may cause certain heart conditions.

Cardiovascular disease is the most common cause of mortality among people with schizophrenia, accounting for 34% of deaths among male patients and 31% in female patients, according to a British study. A Swedish study supports these findings in that cardiovascular disease was the largest single cause of death in both males and females with schizophrenia and mortality rates were higher than those in the general population. In addition, another study of long-term follow-up over 34-38 years of over 400 patients with affective disorders showed higher mortality compared with the general population.

Smoking is a prevalent risk factor for cardiovascular disease and it is a common habit in people living with schizophrenia. Smoking also changes the way the antipsychotic drugs manifest themselves, thereby sometimes causing the person to need higher doses to achieve the desired effect. Unfortunately, it appears that people with schizophrenia are less likely to receive adequate health care than those individuals in the general population, thereby, decreasing the opportunities for prevention of heart disease. They also seem to have a considerably higher tolerance for pain that may hinder a proper diagnosis of heart pain. It is clear that the lack of integration of the medical and mental health care systems can result in numerous additional problems for individuals with schizophrenia as well as other mental disorders.

Diagnosis and treatment of mental disorders in conjunction with treatment of cardiovascular diseases goes a long way in the successful outcomes of both categories of illnesses. These diseases should not be viewed as isolated entities if any treatment is to achieve the maximum effectiveness.

## References

- Angst F., Stassen H.H., Clayton, P.J., Angst, J. "Mortality of patients with Mood Disorders: Follow-up over 34-38 years. *J Affective Disorders* 2002; 68(2-3):167-181.
- Blumenthal, James, Newman, Mark, *et. al.* "Depression As A Risk Factor for Mortality After Coronary Artery Bypass Surgery" in the *Lancet*, August 23, 2003.
- Brown, S. "Excess Mortality of Schizophrenia: A Meta-Analysis." *British Journal Psychiatry* 1997;171:502-8.
- Cohen, Hillel W. and Alderman, Michael H. "The Association Between Depression and Cardiovascular Disease in Patients with Hypertension" in *Primary Psychiatry* 2001; 8(7): 39-54.
- Davidson, Michael. "Risk of Cardiovascular Disease and Sudden Death in Schizophrenia" in *Journal of Clinical Psychiatry*. 2002; 63, suppl. 9.
- "Depression and Heart Disease" on National Institute of Mental Health website at [www.nimh.nih.gov](http://www.nimh.nih.gov).
- "Depression and Heart Disease" on *McMan's Depression and Bipolar Webat* [www.mcmanweb.com](http://www.mcmanweb.com). July 11, 2003.
- "Depression and Heart Disease" on *LifeHeart.com* at [www.lifeheart.com](http://www.lifeheart.com). March 13, 2003.
- "High Mental Stress Linked with Increased Risk of Cardiovascular Death" in *Circulation: Journal of the American Heart Association*, August 7, 2002.
- "Hostility, Depression May Boost Heart Disease Protein Level" in Aetna IntelliHealth featuring Harvard Medical School's Consumer Health Information, July 31, 2003. [www.intelihealth.com](http://www.intelihealth.com).
- "New Study Says People Take Mental Stress to Heart" in *Circulation: Journal of the American Heart Association*, March 25, 2002.
- Ornish, Dean, *Love and Survival: The Scientific Basis for the Healing Power of Intimacy*. Harper-Collins
- Ösby U, Correia N., Brandt, L. Ekblom, A., Sparen, P., "Mortality and Causes of Death in Schizophrenia in Stockholm County, Sweden. *Schizophrenia Res* 2000;45(1-2):21-8.
- Sobel, David S. "Hostility, Depression and Heart Disease" in *Health World Online* at [www.healthy.net](http://www.healthy.net).
- "Relieving Post-Stroke Depression Also Restores Lost Mental Function in Many Patients" in *Stroke: Journal of the American Heart Association*. July 7, 2000.
- Rutledge, Thomas, Ph.D. and Con, Andrea, M.A. "Psychological Factors and Cardiovascular Disease in Women: Risk and Clinical Implications" in *Primary Psychiatry* 2001; 8(7): 55-58.
- "The Latest Research on Depression and Heart Disease" in Depression Information Center of the American Federation for Aging Research, [www.aging.org](http://www.aging.org). May 19, 2003.
- Wassertheil-Smoller, Sylvia PhD; Shumaker, Sally, PhD; Ockene, Judith, PhD; Talavera, Greg A., MD, MPH; Greenland, Philip, MD; Cochrane, Barbara, RN, PhD; Robbins, John, MD; Aragaki, Aaron, MS; Dunbar-Jacob, Jacqueline, PhD, RN; "Depressive and Cardiovascular Sequelae in Postmenopausal Women" in *Archives of Internal Medicine*, 2004 164 289.
- Woolston, Chris. "Depression and Heart Disease" on BlueCross/BlueShield's *A Healthy Me* at [www.ahealthyme.com](http://www.ahealthyme.com). March 26, 2003.
- Zeigelstein, Roy. "Heart Disease and Depression" in *Healthy Directions: Health Information from Johns Hopkins Bayview Medical Center* at [www.jhbmc.jhu.edu](http://www.jhbmc.jhu.edu). April 11, 2001.

# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Heart Disease and Depression are Common Companions

The Depression Treatment website – [www.depression-treatment.com](http://www.depression-treatment.com)

Depression is the leading cause of disability worldwide, and heart disease is by far the leading cause of death in the United States (it's currently estimated that one in three Americans will die of some form of heart disease).

Research over the past two decades has shown that depression and heart disease are common companions. Findings from recent studies indicate that depression is a significantly important risk factor for heart disease that's nearly equal to the risks presented by high blood cholesterol and high blood pressure. While it's estimated that one in six people will experience an episode of major depression at least once in their life, the number rises to one in two for people with heart disease.

Depression can appear after heart disease and/or heart disease surgery. In one investigation, nearly half of the people studied one week after cardiopulmonary bypass surgery experienced serious cognitive problems, which for some people can contribute to clinical depression.

Depression may make it harder for individuals to take the medications needed and to carry out the treatment for heart disease. Furthermore, studies have shown that most people with heart conditions aren't treated for depression, which could be the result of doctors either missing the diagnosis of the condition or attempting to treat the person's symptoms with sedatives that make depression worse.

*For Many, Heart Disease Follows Depression* - There are also multiple studies indicating that heart disease can follow depression. The kind of psychological distress experienced during depression can cause:

- Rapid heartbeat
- High blood pressure
- Faster blood clotting
- Chronically elevated levels of stress hormones, such as cortisol and adrenaline
- The activation of the sympathetic nervous system (part of the instinctive fight or flight response) can cause the heart to work harder, and
- The body's metabolism is diverted away from the type of tissue repair needed to counter heart disease.

*With Treatment, Comes Hope* - Depression is highly treatable. Knowing what the symptoms of depression are and getting therapeutic help at the very first signs of the condition can save you untold emotional pain and physical suffering. Regardless of which comes first—depression then heart disease, or heart disease then depression—effective treatment of depression is imperative.

Preventative interventions based on cognitive-behaviour therapy can promote adherence and behaviour change that can help avoid adverse outcomes associated with both depression and heart disease. With the advent of the effective medications to treat depression, more people with heart conditions can be effectively treated without risking the complicating cardiovascular side effects of many of the previously available drugs. Ongoing research is also investigating whether these treatments also reduce the associated risk of a second heart attack.

Exercise is another important measure towards reducing both depression and heart disease. Observational studies continually indicate that exercise is related to fewer depressive symptoms and adequate exercise is, of course, a major protective factor against heart disease as well. Experts recommend adopting a regimen of at least 20 minutes at a time three or more times a week, such as brisk walking.



# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Positive Mental Health and Heart Disease

The Irish Heart Foundation – [www.irishheart.ie](http://www.irishheart.ie)

The presence of social support and social networks are maybe as important as physical risk factors (not smoking, exercise and healthy cholesterol and blood pressure levels) in improving health and preventing premature deaths;

- People who do not have a warm integrated community of contacts are 2-4 times more likely dying from heart disease, stroke, cancer, respiratory disease or gastrointestinal disease.
- People who have a warm loving relationship with parents are less likely to develop heart disease, high blood pressure, ulcers, cancer or commit suicide in mid-life.
- People who feel loved are more likely to choose practices that enhance health.
- People who do not feel loved in an intimate relationship are 3 times more likely to die from heart attack, stroke, and other diseases.
- Psychological distress is a predictor of fatal ischemic stroke. (Stroke 2002 Jan; 33 (1): 7-12.)

Five key variables have been identified as possible psychological risk factors for Coronary Heart Disease:

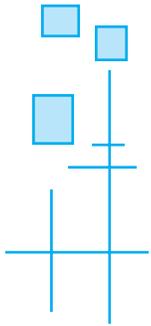
- Acute and chronic stress
- Hostility
- Depression
- Social support and
- Socio-economic status. (Annual Review of Psychology 2002;53:341-69)

Other research shows that:

- Cardiac mortality increases on psychological stressful occasions. (BMJ 2001 Dec 22;323)
- Negative emotions, familial and social support are linked with cardiovascular disease. (Herz 2001 Aug; 26(5): 316-25)
- Negative emotions can intensify a variety of health threats. Negative emotions are related to a range of diseases whose onset and course may be influenced by the immune system including cardiovascular disease, Type 2 diabetes. Resources such as a close personal relationship that diminish negative emotions enhance health in part through their positive impact on immune regulation. (Annu Rev Psychol 2002; 53:83-107)
- Deterioration in negative affect is associated with a high long-term mortality risk. Warding off deterioration in negative affect is mechanism that may explain the beneficial effect of comprehensive rehabilitation on prognosis in patients with CHD. (Circulation 2001 Oct 23;104 (17):2018-23)
- Stress is recognized as a major contributor to heart disease and researchers recognize that one of the most profound influences is of how stress affects the cardiovascular system. (RS Eliot. From Stress to Strength. New York: Bantam Books, 1994)
- Stress can be life threatening to a person who already has coronary heart disease; the result is coronary occlusion, damaged heart tissue and sometimes cardiac arrest. (Stress can make you sicker. Consumer Report on Health December: 1993, 133)
- Humans who reduce stress enjoy the benefit of lower blood pressure. (S Berwer. Anti-old-age stress. Longevity June: 1990, 82.)
- A growing body of research has shown that, among heart disease patients, mental stress is as dangerous to the heart as physical stress. (CN Bairey, et al. Mental stress as an acute trigger of left ventricular dysfunction and blood pressure elevation in coronary patients. American Journal of Cardiology 66: 1991, 28G)
- Heart disease is summarized as “some interaction of mind, body and behaviour.” Your coronary risk probably depends on how your mind interprets situations, how your body reacts, and how often your behaviour leads you into stressful situations. (Stress, Success and Samoa. Hippocrates May/June: 1987, 84)



## **HIV/AIDS and Mental Disorders**



Individuals with HIV/AIDS must pay close attention to their physical health but, in addition, there are important mental health conditions associated with the disease. Common psychological disorders associated with HIV/AIDS are depression, anxiety, and dementia. Psychiatric symptoms arise in HIV/AIDS for numerous reasons, including the direct effect of the illness on the central nervous system and the psychological reactions secondary to the stigma and fear associated with this condition. Often loved ones have died because of the disease and this adds to the fear and grief. People with HIV/AIDS have to take many medications that may have side effects and the quality of their lives may be changed forever because there is yet no cure for the disease.

Mental health care for the person with HIV infection should be a collaborative effort involving primary care practitioners, patients, mental health clinicians, case managers, and also, when appropriate, substance abuse counselors or domestic violence service providers. The stage of HIV infection and the severity of the psychiatric disorder should determine whether the medical practitioner or the psychiatrist should be the primary care practitioner. Care should be coordinated between medical and psychiatric practitioners and primary care practitioners should assist mental health clinicians in coordinating ongoing care when patients are referred to a mental health treatment program. Practitioners should develop and maintain the necessary skills to recognize and address the psychiatric disorders commonly associated with HIV and the factors that may trigger distress in persons living with HIV.

Depression is the most common psychological problem in HIV-infected individuals. While there is clearly a connection between HIV disease and depression, it is not a direct one; there is rarely a cause-and-effect relationship between the two. Many HIV-infected people with current depressive disorders have a history of depression prior to contracting HIV/AIDS. Nonetheless, depression may result in:

- low self-esteem
- anxiety
- forgetfulness
- sleep problems
- changes in appetite
- weight loss or gain
- less interest in sex
- a sense of hopelessness

Anxiety may cause a sort of numbness and emotional detachment. There is a kind of dementia called AIDS Dementia Complex (ADC) that is very common among people with advanced HIV disease. These people have problems thinking clearly and they may experience:

At the end of 2003, an estimated 40 million people worldwide were living with HIV/AIDS. An estimated 5 million new HIV infections occurred worldwide during 2003; that is 14,000 new infections each day. More than 95 percent of these new infections occurred in developing countries, and nearly 50 percent were among females.

- a lack of concentration
- loss of memory
- social withdrawal
- sluggish thinking
- a short attention span
- poor coordination
- impaired judgment
- vision problems
- altered personality

Treatment for mental disorders and dementia include medications and professional counselling; while one can be used without the other, results are best when the two methods are used together.

There is evidence that HIV positive individuals often respond differently to medications than those without the illness. They may be more sensitive and may need a “start low and go slow” approach. In addition, people living with HIV/AIDS are usually on multiple medications and there is more of a chance of drug interactions. Side effects of medications may also be quite different than in the non-HIV population; some may be helpful and some may make the current symptoms of the HIV infection worse.

Certainly, HIV/AIDS is a distressing illness and sadness is a real part of that. This sadness can relate to the illness or death of family and friends and fear related to one’s own future. The good news is that there is evidence that depression does not increase over time. It is complicated to diagnose depression because the symptoms of that disease are often very similar to that of the HIV disease itself. A loss of physical energy and a loss of interest are two different things but closely related. The fact that clients may have to push themselves to do things or they have stopped doing pleasurable activities may be due to depression, fatigue, or a lack of physical ability. To judge a lack of interest vs. a lack of capacity, a therapist might ask, “If you had the energy, are there things you’d like to do today?”

There is also evidence from studies since 1990 confirming and strengthening the impressions that people with schizophrenia have a much higher than average risk for developing HIV/AIDS and that they have special needs for protection as a public health measure. In addition, people with HIV/AIDS may be at greater risk in some countries, such as South Africa, than people in some parts of the developed world because of their additional and potentially stressful living conditions including high rates of unemployment and poverty, poor and unstable housing, inadequate social services, and high rates of crime and domestic violence.

There is much more recognition now of the mental health aspects of HIV/AIDS than during the first couple of decades of the epidemic. Marshall Forstein, M.D., a psychiatrist who has treated many people living with HIV/AIDS and who has been very active in the AIDS programme at the American Psychiatric Association stated in 1999 that in these early years, mental health was seen as a luxury item and not an integral part of primary assessment and treatment. He believes that it is very cost effective for physicians to address the mental health needs because counselling can make a tremendous difference in whether or not a person stays on his or her medications. As well, many mental health care providers lack experience in diagnosing, assessing, and addressing the mental health needs of people affected by HIV/AIDS. Others need training to feel more comfortable with providing services to people with HIV/AIDS.

The United States Center for Mental Health Services started a program that targets prevention, education, and delivery of quality mental health treatment services to people living with HIV/AIDS. This programme is called the CMHS Mental Health Care Provider Education (MHCPE) in HIV/AIDS Program. The MHCPE II program was designed to enhance the Nation’s ability to make an impact on the HIV/AIDS epidemic. Training was provided for traditional mental health care providers (psychiatrists, psychologists, nurses, social workers, counselors, marriage and family counselors), other first line providers of mental health services (medical students, primary care physicians), and nontraditional providers (the clergy and other spiritual providers, alternative health care workers). The program studied dissemination methods in mental health and HIV/AIDS and also assessed, via Participant Feedback forms, the quality of the training and education provided. An ethics curriculum was also introduced.

To treat HIV-related depression effectively, therapists need to be flexible in terms of availability during illness episodes, willingness to make home visits, and the scope of their attention during the late stage illness when loved ones may be at the bedside. They should be prepared to talk to the individual about an increasing physical decline, approaching death, and the circumstances of death.

A positive outlook, determination and discipline are required to successfully deal with the extra stress and helping to avoid high-risk behaviours. It is very helpful for those with HIV/AIDS to keep up with the latest scientific advances, while adhering to complicated medication regimens, reshuffling schedules for doctor visits, and grieving over the death of loved ones. Depression keeps an individual from having these vital characteristics. People with HIV/AIDS can also suffer from anxiety disorders such as panic disorders.

Depression has a significant effect on quality of life, progression of disability and ability to obtain good medical care. Since the development of medications that have the potential of controlling HIV infection and increasing one's life span, treatment of major depression is even more critical. If depression is untreated, it can keep people from taking their medication and may increase the disabling effects of the illness. There is also some evidence that chronic depression may hasten the death of people living with HIV/AIDS.

Children have very special needs when they are living with HIV/AIDS and/or their parents and caregivers have the disease. UNAIDS figures in 2000 estimate that globally, 21.8 million adults have died of AIDS since the epidemic began, leaving a huge number of children as orphans. In addition, it was estimated at that time that 1.4 million children are living with HIV/AIDS around the world. Africa is home to 70% of the adults and 80% of the children living with HIV globally. There are special psychological effects of the disease that affect children, in addition to the economic, educational and social effects:

1. Children with sick parents worry about the future, where they will go and who will care for them – and they may assume that they will also have HIV/AIDS. There are times when parents don't disclose the illness to their children or explain how it is spread. This lack of information may also have a severe psychological effect on the children, as they instinctively know that the parent is not the same as before; they may internalize the situation and feel a sense of personal responsibility.
2. Loss of consistent nurture, which can lead to serious developmental problems and a loss of guidance, makes it more difficult for children to reach maturity and integrate into society.
3. Psychological damage can appear at any time after the onset of HIV/AIDS. It is often very helpful to establish a peer group where children can share similar experiences and support each other.
4. Children may not understand the situation and, thus, not be able to express their grief in a normal way. Even if they want to express their feelings, there is often no one to listen. If they have the opportunity of discussing the situation, the children's fears are alleviated and they will be able to cope better with the stress.
5. The psychological effects on children are the least visible and, often, these consequences are overlooked. Children need to be prepared, as much as possible, for the death of someone terminally ill. It can be very helpful to give the child a role in helping to care for a terminally ill parent, as it reduces the child's grief at the time of the actual death. Bereavement counselling can be very helpful prior to a death as well as after the death.
6. Emotional suffering appears in various forms, which may be different in each person. The consequences may include depression, aggression, drug abuse, inability to sleep, malnutrition, and a 'failure to thrive' where children don't grow physically or emotionally to meet their potential.

On the other hand, clinicians have, at times, reported that working with HIV-infected people can be surprisingly gratifying because the possibility of a shorter-than-average life may help individuals focus on what is really important to them, and motivate them to accomplish goals that they have aspired to in the past. Time is often quite limited but life can be more worthwhile and productive if there is a set time limit known in advance.

Some countries have become quite sensitive to the psychological and behavioural aspects of the care of persons with HIV/AIDS. One example is the programme in the Republic of Iran, where an integrated service for persons with HIV/AIDS, under the title of 'Triangular Clinics,' has been started. These user-friendly services increase the adherence to treatment as well as decrease the stigma and discrimination.

In 2001, members of Parliament from the countries of the World Health Organization's South-East Region made recommendations related to the disastrous social and economic outcomes of HIV/AIDS and mental illness. They recognized the important role played by parliamentarians in educating the public about the problems of these illnesses and in providing enough money for their prevention, management, and care. These are national epidemics and governments have an important role to play. This group emphasized the role of the family and community in the management and care of mental illness and HIV/AIDS, as well as the need for political will on the part of lawmakers around the world.

## References:

- "AIDS Education Must Consider Mental Health" in *Columbia University Record*, March 22, 1996, Vol. 21, No. 20.
- American Psychiatric Association, "Practice Guideline for the Treatment of Patients With HIV/AIDS," American Psychiatric Publishing, Inc. 2001.
- Franklin, Nora. "Mental Health Issues with HIV/AIDS," on *The Body: The Center for AIDS: HIV Treatment ALERTS* at [www.thebody.com](http://www.thebody.com).
- "Depression and HIV" from [www.athealth.com](http://www.athealth.com), June 2000.
- "Depression and HIV/AIDS" from National Institute of Mental Health. May 2002.
- Elliot, Andrew. "Depression and HIV: Assessment and Treatment" in *Perspective*, Winter/1977, Volume 9, No. 1 on *The Body: An AIDS and HIV Information Resource* at [www.thebody.com](http://www.thebody.com).
- Entwisle, Stephen. "Mental Health and HIV," AIDS Calgary (Alberta, Canada) Awareness Association
- Gottesman II, Groome CS. "HIV/AIDS Risks as a Consequences of Schizophrenia" in the *Schizophrenia Bulletin*, 1997; 23(4): 675-84.
- "Investing in Our Future, Psychological Support for Children Affected by HIV/AIDS: A Case Study in Zimbabwe and the United Republic of Tanzania." USAIDS Case Study, July 2001.
- Leiphart, Jeffrey M., Ph.D. "Mind-Body Medicine and HIV/AIDS" on *The Body: An AIDS and HIV Information Resource*. April 20, 2003.
- Levine, Jeff. "Mental Health Status of HIV Patients Often Ignored" on WebMD Medical News Archive, November 3, 1999.
- "Mental Health and HIV/AIDS," in SAMHSA's National Mental Health Information Center, Center for Mental Health Services, 1/2004.
- Murray, Christopher J.L. and Lopez, A.D. *The Global Burden of Disease*, published by The Harvard School of Public Health on behalf of The World Health Organization and The World Bank. 1996.
- Olley, B.O., Gxamza, F., Seedat, S., Reuter, H., Stein, D.J. "Psychiatric Morbidity in Recently Diagnosed HIV Patients in South Africa: A Preliminary Report" in *AIDS Bulletin of the Medical Research Council of South Africa*, April 2003, Vol. 12, No. 1.
- Rabkin, Judith. "Depressive Disorder and HIV Disease: An Uncommon Association," on *The Body: an AIDS and HIV Information Service* at [www.thebody.com](http://www.thebody.com).
- "Mental Health Services for Refugees with HIV/AIDS: A Resource Guide for Case Managers" in *Special Issues in Medical Case Management*. Immigration and Refugee Services of America, Washington, D.C., 2002.
- World Health Organization's South-East Region Press Release, 21 December 2001. SEA/PR/1332.

# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### **Depression and HIV/AIDS**

The National Institute of Health - [www.nimh.nih.gov](http://www.nimh.nih.gov)

Research has enabled many men and women, and young people living with human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), to lead fuller, more productive lives. As with other serious illnesses such as cancer, heart disease or stroke, however, HIV often can be accompanied by depression, an illness that can affect mind, mood, body and behavior. Treatments for depression helps people manage both diseases, thus enhancing survival and quality of life.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. Although as many as one in three persons with HIV may suffer from depression, the warning signs of depression are often misinterpreted. People with HIV, their families and friends, and even their physicians may assume that depressive symptoms are an inevitable reaction to being diagnosed with HIV. But depression is a separate illness that can and should be treated, even when a person is undergoing treatment for HIV or AIDS. Some of the symptoms of depression could be related to HIV, specific HIV-related disorders, or medication side effects. However, a skilled health professional will recognize the symptoms of depression and inquire about their duration and severity, diagnose the disorder, and suggest appropriate treatment.

### **Depression Facts**

Depression is a serious medical condition that affects thoughts, feelings, and the ability to function in everyday life. Depression can occur at any age. NIMH-sponsored studies estimate that 6 percent of 9 to 17-year-olds in the U.S. and almost 10 percent of American adults, or about 19 million people age 18 and older, experience some form of depression every year. Although available therapies alleviate symptoms in over 80 percent of those treated, less than half of people with depression get the help they need.

Depression results from abnormal functioning of the brain. The causes of depression are currently a matter of intense research. An interaction between genetic predisposition and life history appear to determine a person's level of risk. Episodes of depression may then be triggered by stress, difficult life events, side effects of medications, or the effects of HIV on the brain. Whatever its origins, depression can limit the energy needed to keep focused on staying healthy, and research shows that it may accelerate HIV's progression to AIDS.

### **HIV/AIDS Facts**

AIDS was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers (<http://www.nci.nih.gov/>).

HIV is spread most commonly by having sex with an infected partner. HIV also is spread through contact with infected blood, which frequently occurs among injection drug users who share needles or syringes contaminated with blood from someone infected with the virus. Women with HIV can transmit the virus to their babies during pregnancy, birth, or breast-feeding. However, if the mother takes the drug AZT during pregnancy, she can reduce significantly the chances that her baby will be infected with HIV.

Many people do not develop any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. More persistent or severe symptoms may not surface for a decade or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of "asymptomatic" (without symptoms) infection is highly individual. During the asymptomatic period, however, the virus is actively multiplying, infecting, and killing cells of the immune system, and people are highly infectious.

Many people are so debilitated by the symptoms of AIDS that they cannot hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases in which they function normally.

Over the past 10 years, researchers have developed antiretroviral drugs to fight both HIV infection and its associated infections and cancers. Currently available drugs do not cure people of HIV infection or AIDS, however, and they all have side effects that can be severe. Because no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviors that put a person at risk of infection, such as sharing needles and having unprotected sex.

### **Get Treatment for Depression**

While there are many different treatments for depression, they must be carefully chosen by a trained professional based on the circumstances of the person and family. Prescription antidepressant medications are generally well tolerated and safe for people with HIV. There are, however, possible interactions among some of the medications and side effects that require careful monitoring. Specific types of psychotherapy, or “talk” therapy, also can relieve depression.

Some individuals with HIV attempt to treat their depression with herbal remedies. However, use of herbal supplements of any kind should be discussed with a physician before they are tried. Scientists recently discovered that St. John’s wort, an herbal remedy sold over-the-counter and promoted as a treatment for mild depression, can have harmful interactions with other medications, including those prescribed for HIV. If taken together, the combination could allow the AIDS virus to rebound, perhaps in a drug-resistant form.

Treatment for depression in the context of HIV or AIDS should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the HIV/AIDS treatment. This is especially important when antidepressant medication is prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specializes in treating individuals with depression and co-occurring physical illnesses such as HIV/AIDS may be available. People with HIV/AIDS who develop depression, as well as people in treatment for depression who subsequently contract HIV, should make sure to tell any physician they visit about the full range of medications they are taking.

Recovery from depression takes time. Medications for depression can take several weeks to work and may need to be combined with ongoing psychotherapy. Not everyone responds to treatment in the same way. Prescriptions and dosing may need to be adjusted. No matter how advanced the HIV, however, the person does not have to suffer from depression. Treatment can be effective.

It takes more than access to good medical care for persons living with HIV to stay healthy. A positive outlook, determination and discipline are also required to deal with the stresses of avoiding high-risk behaviours, keeping up with the latest scientific advances, adhering to complicated medication regimens, reshuffling schedules for doctor visits, and grieving over the death of loved ones.

Other mental disorders, such as bipolar disorder (manic-depressive illness) and anxiety disorders, may occur in people with HIV or AIDS, and they too can be effectively treated.

Remember, depression is a treatable disorder of the brain. Depression can be treated in addition to whatever other illnesses a person might have, including HIV. If you think you may be depressed or know someone who is, don’t lose hope. Seek help for depression.

# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Mind/Body Medicine and HIV/AIDS

Positive Words website – [www.positivewords.com](http://www.positivewords.com)

Since the mid-1980s, researchers in mind/body medicine have studied how the mind and body connection works together in HIV/AIDS. They have looked at why some people get sick and die from HIV, while others remain free of symptoms and healthy. Some specifics follow:

1. *Beliefs*: believing that you must die from being HIV-infected can trigger fear, decreases in immunity, avoidance of health-promoting behaviour and ultimately result in a shorter life-span.
2. *Stress*: being stuck in “survival stress” for many months — where you feel somehow unsafe or threatened — can wear down immune system functioning and speed up the progression to developing AIDS.
3. *Grief*: feeling grief is normal after a significant loss of an important person, pet or cherished goal. If that grief is “held in” and not expressed for many months, it can trigger a decrease in immunity and speed up the progression of disease.
4. *Self-Disclosure to Trusted Support*: science has learned that talking about your problems honestly with someone you trust provides a boost to immune system functioning.
5. *Life Purpose and Goals*: research studies on HIV+ people who remain healthy for long periods show that these individuals typically have “reasons to live,” whether they are general purposes (“I want to enjoy my friends and family”) or specific goals (“I want to take a cooking class next month”). It appears that “reasons for living” provide a boost to the immune system and survival.
6. *Self-Assertiveness*: is defined as the ability to say “no” to something you really do not want to do, and “yes” to something that you want or like. Medical research shows that being self-assertive promotes the strength and quantity of Natural Killer (NK) cells of the immune system. This is important because NK cells can kill HIV in the body and can do so in people with very low CD4 counts.
7. *Body Care*: is defined as making sure that you are doing the right things on a regular basis to keep your body healthy. This includes being aware of your breathing patterns and correcting any problems (like shallow breathing or unconscious breath-holding). You should be drinking a minimum of eight glasses of water every day and having good nutrition and eating patterns so that all of your body, including immune cells, gets the nutrition it needs. Getting regular sleep that allows you to wake up “feeling rested” most mornings is also important.

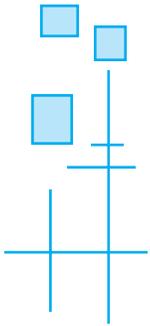
Finally, you should be getting regular (3 times per week), moderate physical exercise. An example of moderate exercise is a 20-minute brisk walk that gets you to breathe a little harder and perhaps some sweat on the forehead. Exercise also promotes the strength and quantity of these HIV-fighting NK cells.

It is important to use this new information about the mind/body connection to enhance your HIV+ health. For each of the issues mentioned above, rate yourself on how well you are doing: good, OK or poor. Then, make a list of the issues rated “poor” and pick someone to talk honestly with about each problematic issue. You may want to pick different people for different issues. After the discussion, create a plan for improvement for each “poor” issue and begin working on your plan.

For more information, visit the L.I.F.E. Programme website at [www.Shanti.org](http://www.Shanti.org). Reprinted courtesy of [www.positivewords.com](http://www.positivewords.com) by Prochilo Health, Inc.



## **The Mind and Body Connection**



Beginning in the 17<sup>th</sup> century, Western cultures separated the mind and body, giving medical science the freedom to explore the physical body while leaving the mind to the church's domain. In the last thirty years, however, scientists around the world have been studying the interconnections between the mind and body. James Gordon, M.D., of Georgetown University School of Medicine in Washington, D.C. indicates that people who are beset with poverty, job dissatisfaction, prejudice, cultural dislocation, long-term loneliness, or the sudden loss of a loved one are far more vulnerable to illness and death than those who are fulfilled in their social and interpersonal world. Mind-body medicine is considered by many to be a revolutionary 21<sup>st</sup> century approach to health care that includes a wide range of behavioural and lifestyle interventions, as important as traditional medical interventions. In the modern world of today, many illnesses are caused as much by lifestyle, dietary habits, activity level and stress as by traditional causes such as infection, virus, bacteria, and physical trauma. Mood, attitude, and belief can affect every chronic illness: fear, cynicism, hopelessness and helplessness can have a bad effect on health; whereas courage, good humour, a sense of control and helpfulness can have a beneficial effect.

Many countries benefit from the experiences of traditional healers that use herbal medicines and other natural methods of healing the sick. Often these healers work with medical and mental health professionals but, particularly in countries with very few physicians, they often work alone. Ritual and herbal medicines have been extraordinarily important to countries in Africa, for example, and traditional healers have, at times, been using cures that were not available in modern medicine. A good example is the Indian Ayurvedic medicine containing Reserpine. This medicine in the form of SARPAGANDHA (snake-root) was used for treatment of mental disorders for a few thousand years and was only discovered as a tranquilizer in the middle of the last Century. One of the important aspects of these healers is that the population trusts them and believes that they will get better if the healer helps them. Successful efforts have been made to educate healers on all aspects of serious illnesses, such as HIV/AIDS and there is increased cooperation with medical professionals, where possible. This is the case, for example, in Swaziland where the health ministry has been enlisting traditional healers in efforts to contain HIV and assist people with HIV-related illnesses. Similarly in Pakistan, mental health professionals and traditional healers have developed a cooperative approach to care for persons with neuro-psychiatric disorders. This cooperation reverses decades of separation between traditional and modern medicine.

Worrying is making up a negative thought in our mind to which our body responds - with tears, increased heart rate and blood pressure, irregular breathing, increased muscle tension, stomach tension, etc. One thought has caused millions of cellular/biochemical reactions.

The Women's Center for Mind-Body Health

In recent years, comprehensive programmes of mind/body medicine have been established at many universities and centers around the world, including Harvard University, Stanford University, the University of California, and the University of Miami in the United States. These are in addition to those in developing countries where these types of approaches have been part of society for many centuries (yoga, meditation). At these centers, patients with chronic illnesses such as cancer, AIDS, and heart disease are learning to change their habits

and attitudes as well as their diets, exercise, and thinking. Studies have shown that these individuals are functioning more effectively, feeling better and, in some cases, living longer.

To address this approach, partnerships are formed among specialists in the medical and mental specialties and mind/body specialists. The former might include physicians, nurse practitioners, and psychologists, and the latter may include biofeedback practitioners, chiropractors, nutritionists, spiritual counsellors, and yoga teachers. If this approach is used, an integrated team of caregivers addresses the mind, body, and spirit. Mind/body medicine makes use of many alternative medicine techniques and strategies including: massage, bodywork, hypnosis, exercise, meditation, biofeedback, hypnotherapy, guided imagery, yoga, herbal medicine, acupuncture, breath work, and relaxation techniques.

Individuals should remember that there are many people who are affected when one is seriously ill. Consideration needs to be given to those close to the ill person and, especially, to the needs of any primary caregivers. Mind/body connections are not meant to help people suppress their feelings about serious illness. It is perfectly normal and reasonable to be upset about being critically ill; the mind/body connection is to help the person who is ill and the significant others around the ill person to deal with the situation in the best way possible and further the possibility of their maintaining a “fighting attitude” towards the illness at hand.

The Women’s Center for Mind-Body Health has reported some remarkable studies showing the effectiveness of the mind/body approach:

- In a study of women with infertility, the pregnancy rate of a support group that met once a week for 10 weeks and included relaxation and imagery was 55%, vs. a regular support group with 52%, and a control group of only 20%.
- People, who were able to utilize self-hypnosis to imagine healing genital herpes outbreaks, decreased those outbreaks from an average of 2.5 episodes per six weeks to 0.84 episodes.
- Menopausal women with hot flashes who were taught to use the “relaxation response” had a significant decrease in hot flash intensity. This group also significantly decreased depression and anxiety symptoms.
- A group of women with premature labour treated with bed rest, who listened to a relaxation tape from 5-20 minutes per day, had significantly longer pregnancies compared to a group at bed rest alone and a non-compliant group. In addition, the relaxation group’s babies weighed significantly more than the babies of the other groups.
- Relaxation decreased by almost 2/3 the need for hospital admission due to worsening pregnancy complications of high blood pressure.

How well one thinks one is may be the best predictor of wellbeing and future health.

-Ellen Idler and Stansilav Kasi

Most physicians acknowledge the importance of life-stress, diet and exercise, but these factors are often addressed after the conventional treatments have failed. Mind/body medicine addresses behavioural and psychosocial interventions at the same time as conventional treatments. Individuals are given very active roles from the beginning in developing a treatment plan and they take responsibility for psychosocial and lifestyle parts of the plan. This approach stresses education and self-management as integral parts of clinical practice. Some people have lost sight of the extraordinary power of the mind to affect the body.

There are some challenging problems in primary care that are best treated by the mind/body approach:

- Somatization disorder: when emotional problems bring about physical symptoms when there is no physical basis for the symptoms. This may increase if doctors only look for physical reasons and prescribe tests that might make the person even more fearful of having a serious physical illness.
- Undifferentiated complaints: when the person has very vague symptoms such as chest pain, fatigue, dizziness, headache, back pain, inability to sleep, pains in the stomach, numbness,

coughing, weight loss, etc. It has been determined that a very small percentage of people who complain about these symptoms have a clear physical problem.

- Psychophysiological disorders: when people have physical complaints that are increased by stress of various kinds. Stress creates specific symptoms in different people – some may be related to the heart, some to the muscles, some to the stomach, etc. These people can benefit greatly from education in stress management.
- Post-traumatic conditions: when people have lasting effects of physical and sexual abuse, traumatic experiences and losses. Those individuals who have had such a history have more somatic symptoms than others and it is more difficult for the person in question or the physician to connect current symptoms with previous trauma.
- Chronic conditions: when people have illnesses, such as diabetes, arthritis, hypertension, and chronic heart disease, lifestyle, diet, exercise, smoking, substance abuse, and situational stress play an important role in the management of such illnesses over a lifetime. It is difficult for medication to work if these other factors are not addressed as well by the doctor and the person he/she is treating.

In mind/body medicine, one looks beyond the immediate problem to include a larger dimension of one's life. For example, a heart attack may be a signal for a person to become less defensive and hostile, to become less competitive at work, and to give more attention to relaxation, hobbies, family and the enjoyment of life.

The principles of mind/body medicine come from the view that energy is the underlying pattern of the universe. There are similarities to many Asian philosophies that view human beings as part of an interconnected, universal energy field and have believed for centuries that consciousness plays an essential role in governing physical and psychological health.

In the case of the aboriginal population of Canada, the most serious mental health problems are depression, substance abuse, family violence, high rates of suicide in certain communities, mental disorders and grief over multiple losses and disruptions of lifestyle. They believe that when we experience distress, we are “out of balance” and our minds and bodies cry out for some kind of help. If the imbalance becomes too great, good health breaks down, whether on the level of the body, the spirit, the emotions, or the mind. Neither mental illness nor physical illness can be seen as a problem separate from other aspects of the individual's life.

Mind/body medicine encompasses the following basic principles:

- Each person is unique. The reason one person becomes ill may be entirely different from another person as well as the methods of recovery may be just as individual.
- Chronic stress. Stress and a lack of balance can contribute to illness; relaxation, positive methods of coping with stress and restoration of balance can lead to health. British cardiologist Peter Nixon explains that increased stress and arousal causes many changes in the body that interferes with the immune system, use of proteins and functioning of the heart. On the positive side, stress reduction can promote healing.
- Taking self-responsibility for healing. Lawrence LeShan, Ph.D., a specialist in mind/body treatment for cancer, has shown that people being treated for cancer who took charge of their life directions were more likely to recover than those who passively accepted their diagnosis. Taking action decreases fear and depression that often comes along with serious illness.
- The body's innate healing capabilities. The body has a natural tendency to move towards health and healing and can, at times, heal itself which is clearly demonstrated in the “placebo effect” which someone in a controlled study thinks that they are taking medication when, in fact, it is a “sugar pill.” The effectiveness varies depending on how much the person expects to get better. Those who think they will get better have a greater recovery rate than those who think they will get worse.

- The importance of client-provider relationship. It has been shown that a positive attitude of the doctor can influence the outcome of a given treatment, whereas, discouraging statements can undermine the ill person's confidence and hinder the healing process. The ideal relationship has the healing process viewed as a working partnership where both parties have and show respect for the other's knowledge and intuition.
- A systems approach. Human lives are influenced by many interrelated factors, including genetics, family and socioeconomic background, diet, exercise, social support, risk-taking behaviours, attitudes, and spiritual practices. An illness may manifest itself on the physical body but it may begin in other aspects of the self, such as the mental or emotional state. Any specific disease may be present in only a small part of the body, but the interactions with all parts of the individual may be very complex.
- The energy field perspective. Each person has various fields of energy that can be measured by specific tests such as an EKG (electrocardiograph), EEG (electroencephalograph), or electroacupuncture biofeedback testing that is based on measurement of energy of acupuncture points. These energy fields are affected by changes in physical and psychological health and can be influenced by the energy fields of others. Robert Becker, M.D., found that small electric currents can stimulate cells to regenerate, fractures to heal faster, and tissue to repair itself. It is from these facts that Dolores Krieger, Ph.D., R.N., developed the technique of "Therapeutic Touch" that has been shown to be successful in decreasing anxiety, reducing pain, speeding the healing of surgical wounds and helping to correct dysfunction of the nervous system. It is the absence of touch that creates the "failure to thrive" syndrome in children when the pituitary gland does not secrete enough growth hormone.
- Illness as message, not enemy. Illness can well be a messenger to people; it can serve as a warning that other aspects in the emotional and psychosocial life need attention. Mind/body medicine encourages individuals to see the whole picture since all aspects of one's being are interrelated.

One might also want to examine alternative approaches to mental health care, including self-help, diet and nutrition, pastoral counselling, animal assisted therapies, expressive therapies, culturally based healing arts, yoga/meditation, massage therapy, etc. The better one's mental health, the better equipped an individual is to tackle physical ailments. Janet Meagher of Australia, reports on an October 2003 meeting in Taiwan on "Body, Mind and Soul Workshop – How to Fight Cancer and Depression" where she met people living with cancer and others with mental illness who reported many of the same feelings. Each person was overcome by the impact of their diagnosis, each suffered from the loss of a defined future, loss of useful contribution to their society and loss of self image, accompanied by overwhelming grief and depression. Each participant gained a great deal from contact with the other and there was genuine empathy in the group. She also reported on a special back massage developed there because they had had a lack of human touch and they had missed it a great deal. In the group, the individuals mutually massaged each other's back for 10 to 15 minutes. This left them feeling more accepted and cared about, as human beings. After these sessions, tea or a meal was shared before leaving. The result of all of this is that a supportive and caring community developed within this small group.

Studies have brought forward the importance of "remembered wellness" which means that each ill person has stored the memory of being well. This is an important factor in the healing process when both the person undergoing treatment and the health professional believe in the benefits of treatment. Belief can well become reality. There are predictions that in the future there will be an integrated system of behavioural and medical care, involving a partnership of behavioural practitioners, physicians and nurses working together to solve the problems of a person who is ill. Dr. Gordon, mentioned earlier, believes that there is a shift in opinions of many mainstream doctors about the mind/body link to serious physical illnesses and alternative therapies to those illnesses. He has given the example of a distinguished oncologist in Washington, D.C. who, five years ago, would not have sent patients to Dr. Gordon's Mind-Body Medicine's Comprehensive Cancer Center. Currently, this same oncologist sends many patients to Dr. Gordon and appreciates the outcomes of his regimens.

## References:

- “Alternative Approaches to Mental Health Care,” U.S. Substance Abuse and Mental Health Services Administration’s National Mental Health Information Center.
- “Asian Mental and Physical Treatments” – paper of the Taiwan Cancer Friends New Life Association; [www.love-newlife.org.tw](http://www.love-newlife.org.tw).
- Carlin, Peter. “Heal the Body, Heal the Mind,” *A Healthy Me* at [www.ahealthyme.com](http://www.ahealthyme.com). Blue Cross/Blue Shield. 2003.
- Haber, Sandra. “Coping with Serious Illness: Sandra Haber, Ph.D., Answers Your Questions.” The American Psychological Association Help Center at [www.helping.apa.org/mind\\_body/haber.html](http://www.helping.apa.org/mind_body/haber.html).
- Idler, E.L.; Kasi, S.V.; and Lemke, J.H. “Self-Evaluated Health and Mortality Among the Elderly in New Haven, Connecticut, and Iowa and Washington Counties, Iowa, 1982-1986.” *American Journal of Epidemiology* 131 No. 1 (January 1990)
- Meagher, Janet. Honorary Secretary, WFMH. Personal communication, Australia, 2003.
- “Mental Health” on Gandeepam.org in India.
- “Mind/Body Basics,” The Mind/Body Medical Institute at [www.mbmi.org](http://www.mbmi.org).
- “Mind/Body Connection,” The American Psychological Association Help Center at [www.helping.apa.org/mind\\_body/](http://www.helping.apa.org/mind_body/)
- “Mind-Body Connection” The Women’s Center for Mind-Body Health, at [www.womensmindbodyhealth.info/conn31.htm](http://www.womensmindbodyhealth.info/conn31.htm).
- “Mind/Body Medicine,” *Alternative-Medicine-And-Health.Com* at [www.alternative-medicine-and-health.com/therapy/mind-body.htm](http://www.alternative-medicine-and-health.com/therapy/mind-body.htm).
- “Mind/Body Medicine,” in *Alternative Medicine*, at [www.alternativemedicine.com](http://www.alternativemedicine.com).
- “Mind/Body Medicine: An Alternative and Complementary Medicine Resource Guide” of the Alternative Medicine Foundation at [www.amfoundation.org/mindbodymed.htm](http://www.amfoundation.org/mindbodymed.htm).
- Moss, Donald. “Mind Body Medicine, Evidence-Based Medicine, Clinical Psychophysiology, and Integrative Medicine” in *Handbook of Mind-Body Medicine for Primary Care*. Sage Publications. In publication and on [www.aapb.org/public/articles/details.cfm?id=150](http://www.aapb.org/public/articles/details.cfm?id=150).
- National Indian and Inuit Community Health Representatives Organization (Canada) website at [www.niichro.com](http://www.niichro.com).
- National Center for Complementary and Alternative Medicine (one of the institutes under the U.S. National Institutes of Health) website at [www.nccam.nih.gov](http://www.nccam.nih.gov).
- “Principles of Mind/Body Medicine,” in *Alternative Medicine*, at [www.alternativemedicine.com](http://www.alternativemedicine.com).
- “Swaziland: Traditional Healers, New Partners against HIV/AIDS.” IRIN News of the United Nations Office for the Coordination of Humanitarian Affairs. February, 2003.
- Woolston, Chris. “Illness: The Mind/Body Connection,” *A Healthy Me* at [www.ahealthyme.com](http://www.ahealthyme.com). Blue Cross/Blue Shield. 2003.



# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Lifestyle Factors Impacting on Medical Conditions

The Australian Psychological Society, Ltd.

Medical conditions, illnesses and injuries can place added strain on our already at times stressful and busy lives. When we have a medical condition it usually places limitations on our capabilities and causes disruptions to our lifestyle. These limitations and disruptions can range from simple restrictions and changes to our normal routine through to major changes to our basic living pattern and lifestyle, including areas of diet, work, family, recreation and leisure.

In managing medical conditions there are several factors related to our lifestyle that can impede our recovery or cause an increase in symptoms. These factors include worry and anxiety, stress and tension, diet and exercise, sleep, and lack of social support.

### Negative thinking - worrying

*The problem of worrying*

Worrying or negative, repetitive thinking about possible adverse situations is one of the most destructive and harmful ways of thinking. People who worry a lot tend to experience high levels of anxiety and tension that adversely affect their physical health. This can add further complications when combined with a medical condition.

*Reducing worry*

Trying to stop worrying about things can be a seemingly impossible task. Psychologists are highly skilled and can assist in this area, having been trained extensively in the management of anxiety and worry. Some initial strategies to get you started are outlined below:

- If you are lacking in any information about issues (i.e. prognosis or likely outcomes and timeframes of medical conditions), pursue further information and education through appropriate sources (i.e. medical or clinical specialists).
- Try to realistically assess your worries and develop other areas to think about. Find a good friend to talk to about your concerns and get their perspective on the problem.
- Increase the amount of activity and variety in each day so that you have other things to focus on, such as reading, walking, watching a movie or any other activity that does not adversely impact upon your medical condition.
- Limit your worry to a 'worry period'. Select a specific period each day in which the worrying takes place. When you become aware of your worrying through the day, make a conscious effort to postpone it until your 'worry period'. Postponing your worry to the 'worry period' can help to reduce the frequency and duration of your worrying.
- During your 'worry period' you can begin to problem-solve your worries in order to resolve them. Do this by systematically writing down your concerns on a piece of paper. Think about the possible outcomes of your concerns, identifying both positive and negative effects. Select your preferred outcome. Make this a goal that you can work on achieving. In doing this you begin to diminish the strength of your worry.
- Develop a list of ways that you can reach this goal. Begin by developing as long a list as possible, focusing on a range of different ways that you can reach your goal, even ones that may seem unrealistic. From this list you can select one or two strategies that you can adopt to help resolve the problem that is causing you to worry. Try these strategies for a while to see how well they work. If they are not resolving the problem and reducing your worry, go back to your list and try a different strategy.

You can also use the 'worry period' to analyse your thoughts in order to reduce negative thinking which leads to worry. Ask yourself the following questions:

- How likely is it that what you are worrying about will happen?
- If it does happen, can you manage it? Has it happened before? If so, how did you manage it then? How can you better manage it?
- Is there anything positive that can come out of this situation? If so, what is it? How can you make sure it happens?

As you work through these questions identify answers that suggest that things can turn out all right. Create statements from these answers that you can repeat to yourself when you are worrying. For example, statements such as "If it happens I'll just deal with it" and "I've spent months worrying about this and it hasn't happened yet so it is unlikely to happen" can help to reduce your worry and allow you to focus on better outcomes.

## **Stress and tension**

### *Negative effects of stress and tension*

Stress and tension refer to physical arousal in the form of muscle tension and contraction. Stressful muscle tension can be experienced in a variety of areas including the eyes, jaw, neck, shoulders, lower back and abdominal area. Prolonged muscle tension can lead to aches and pains ranging from mild headaches or a stiff back to chronic migraines and muscular spasms and injury.

### *Reduction of physical tension and stress*

Reducing the physical sign of stress through recognising and relaxing muscles in the body is not as easy as it sounds. First, you have to learn to recognise when you are stressed and which muscle groups are the most tense. Then you need to develop skills in systematically relaxing all your muscles – particularly those that are most tense. This takes a lot of practice and skill to master. A psychologist can provide expert training in relaxation and stress reduction.

The following information provides some starting points to assist you in reducing stress and physical tension:

- Learn to recognise the signs of physical tension in your body. This is done by stopping and carefully thinking about how all the different muscles in your body are feeling at regular intervals every day. By doing this you will identify the muscle groups that hold the most tension when you are feeling stressed.
- Practice slow and deep breathing. Do this at regular intervals throughout the day, particularly when you begin to feel tense and stressed. As you exhale, say the word 'calm' to yourself in a soothing manner.
- Begin learning to relax. Develop pleasant imagery (i.e., scenery or pleasant memories) and imagine music you find soothing and calming and invoke these images and sounds when stressed.
- Learn a form of progressive muscle relaxation. This involves systematically contracting and relaxing all the muscles in your body to induce a strong feeling of physical relaxation. It is generally best to see your psychologist for initial training and instruction in this area.

## **Diet, exercise and sleep**

### *The three big problem areas*

Diet, exercise and sleep are three big areas that often cause further problems when people have medical conditions. Sometimes medications, treatments and symptoms such as pain can adversely impact upon appetite, energy levels and sleeping patterns.

### *Improving diet, exercise and sleep*

When coping with medical conditions it is essential that we do everything we can to maintain a healthy diet, get regular exercise, and regular and satisfactory sleep. Some basic strategies and points to remember are outlined below:

- Make sure you eat regularly throughout the day. Choose foods that are nutritious and preferably enjoyable to eat. If you don't feel like eating, continue to nibble at foods you can tolerate. If you are restricted in food choices, make sure that no inappropriate foods are accessible (i.e., throw them away so you can't be tempted). Also, if possible advise family members or friends of what your diet should be and get them to prompt you regularly.
- Keeping your body active is essential for both injury prevention and health promotion through the release of body chemicals, which assist in making you feel good. Maintaining activity is vital to promote well being. In many cases, your medical condition may restrict your ability to engage in previously enjoyed exercises. In this case it is vital to learn other alternate exercises and engage in them regularly. See your medical or clinical specialist for advice on what exercises you can do and develop a regular schedule of activity.
- Ensuring you get enough sleep is critical when you have a medical condition. Make sure you maximise your potential for good sleep by minimising naps during the day, not consuming stimulants such as tea and coffee in the evenings and exercising during the day, so your body is physically tired and ready for sleep at night.

## **Social Support**

### *Loss of Social Support*

When you have a medical condition it can often be a stressful, frustrating, isolating and lonely experience. Often when you're not feeling well your opportunities for social contact are reduced through both your own limitations and restrictions (i.e., being unable to work with colleagues or engage in social recreational activities) and lack of motivation.

### *Getting the Social Support You Need*

When you are coping with a medical condition, social support has been proven to be an effective form of assistance in maintaining your quality of life. Previously available forms of support, such as work colleagues and recreational friendships, may not necessarily be available, however other sources of social support may still be accessible.

The following points provide some suggestions for cultivating quality sources of social support and ensuring these needs are met:

- Take the time to think about all the people you still have possible contact with and develop plans to contact some and catch up.
- When you do have contact with friends advise them of where you're at and provide them with some hints on how they can best support you. Remember; if you don't tell them how to support you appropriately, then they'll never know!
- Keep regular schedules of contact throughout the week. Book regular lunches, coffees and catch-ups with people. Plan ahead to avoid unpleasant isolating gaps through the week.
- If your available social support is inadequate, think about new sources of support such as support groups, hobby and interest groups and volunteer opportunities.

A psychologist can assist in developing and implementing a plan to explore and develop more social support opportunities for you.

## **Summary**

A person's emotional health is crucial to his or her recovery from physical illness or injury. When people are ill they are more prone to anxiety and depression. Addressing worries, physical tension and stress by promoting positive thinking, good lifestyle habits around diet, exercise, relaxation, and sleep, and positive experiences through social support can improve quality of life and speed recovery.

*The Australian Psychological Society Ltd*  
*contactus@psychsociety.com.au*  
*www.psychology.org.au*

*ABN 23 000 543 788*



# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Complementary and Alternative Medicine

Taiwan Cancer Friends New Life Association – [www.love-newlife.org.tw](http://www.love-newlife.org.tw)

Many people with serious physical illnesses are exploring complementary therapies that focus on the mind, body, and spirit and add to the medical therapies. These therapies can reduce stress, lessen side effects of treatment, and enhance well being. In addition, the patient may feel more in control of his/her treatment and outcomes. Some of the therapies used in Taiwan, in addition to art therapy, humor, journaling, reiki, music therapy, pet therapy, and others are:

*Biofeedback:* a method of learning to control relaxation responses by obtaining feedback from a machine that senses when the body shows signs of tension and when the body relaxes.

*Distraction:* the use of an activity which takes the mind off of worries or discomfort, such as reading, going to movies, working with one's hands in doing needlework, painting, puzzles, etc. watching television, listening to radio, talking with friends, etc.

*Hypnosis:* puts the person into a deeply relaxed state that can help reduce discomfort and anxiety.

*Imagery:* a way of daydreaming that uses all of one's senses; such as imagining when one is moving a ball back and forth by one's own breath. The ball may appear to get bigger and bigger as it takes away more and more tension and discomfort.

*Massage Therapy:* involves touch and different methods of stroking and kneading the muscles of the body with a healing touch. A trained and licensed massage therapist should do this therapy.

*Meditation and Prayer:* a relaxation technique that allows one to focus energy and thoughts on something very specific. Another form is allowing thoughts, feelings, and images to flow through the mind. For those who believe in a higher spiritual power, prayer can provide strength, comfort and inspiration throughout the time of illness.

*Muscle Tension and Release:* when one breathes in and out deeply while tensing, and then relaxing, a particular muscle or group of muscles. This relates to "progressive relaxation" where one starts with the toes and works upward, progressively tensing and relaxing all muscles in sequence until one reaches the scalp.

*Physical Exercise:* can help lessen pain, strengthen weak muscles, restore balance, and decrease depression and fatigue.

*Rhythmic Breathing:* breathing in and out slowing and comfortably through the nose while focusing on a peaceful scene or with a clear mind. One might choose to keep the rhythm by counting along the way.

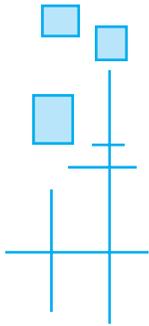
*Visualization:* similar to imagery but where one creates an inner picture that represents the fight against the illness, such as a person getting chemotherapy using images of rockets blasting away their cancer cells.

*Yoga:* a method whereby one has a quiet, comfortable place and some time each day to practice breathing, stretching, and meditation. One might want to take a yoga class, review books, audiotapes, or videotapes on yoga.

Herbal medicine, acupuncture, and related treatments are widely practiced in Taiwan and are covered by the National Health Insurance programme. These ancient healing arts have gone through considerable development, becoming scientifically -based branches of modern medicine as research gradually proves their value and effectiveness. Chinese medicine today combines age-old practices with advanced technology.



### The Impact of Physical Health Problems for Persons with Severe Mental Disorders October 10, 2004



Individuals who have a severe and persistent mental disorder, including schizophrenia or manic depression, very often present a variety of physical health problems, among them obesity, high blood pressure, and diabetes. For many of these individuals, quality medical care for their physical health needs is simply unavailable or inaccessible due to the lack of health insurance coverage or personal financial resources. In many instances, medical problems may result from negative side effects of medication being taken to manage the mental disorder; in turn, physical health problems may serve to encourage non-compliance with prescribed psychiatric medications. This section will explore these and other issues relating to physical health problems for persons with severe and persistent mental disorders.

*“People with mental illnesses are among the most marginalized people in our community. The consequences of mental illness often extend beyond the direct symptoms of the illness to affect people’s social and economic well being and all aspects of their lives.”*

*“People with mental illnesses are often isolated from family and friends. Mental illness can also affect people’s job prospects and make it difficult to secure and retain full-time employment. They face a continual discrimination based on fear of mental illness. The separation of health care for physical illnesses from [mental health] care often fragments the total care offered to this group. These factors often result in people with a mental illness not receiving adequate health care in relation to their overall health needs.”*

These introductory paragraphs are from the Consumer Summary of the Duty to Care: Physical Illness in People with Mental Illness study conducted by the Department of Public Health and Department of Psychiatry and Behavioural Science at the University of Western Australia from 1980 through 1998. It represents a major effort to determine the extent to which users of mental health services have different rates of physical illness compared with the general population. The study compared deaths, the total number of cancers that were diagnosed and hospital admission rates in people with mental illness with the general population.

The following excerpts from the Consumer Summary of the study’s findings provide an overview of the major impact that unmet physical health problems have on people with severe and persistent mental illnesses. The findings also serve as a call to action to mental health professionals, advocates and patients/consumers throughout the world, as they demonstrate the magnitude of global neglect in developing an integrated approach to health care for those who experience major mental health problems.

The nature and delivery of psychiatric services changed dramatically in the 20<sup>th</sup> century. This has resulted in a large reduction in the number of people with mental illnesses in hospitals and other mental health care facilities. More effective treatment for mental disorders, particularly the introduction of newer and more effective medicines has been the main reason for this trend. It has allowed many people with mental illnesses to be treated outside of institutions and helped them on the path to more normal lives.

*“After heart disease, mental illness is the most common cause of premature death. Also, about 30% of the non-fatal disease burden on the community is due to mental illness. Depression is the most common cause on non-fatal disease burden. A range of effective treatments exists for most mental disorders. However, a powerful stigma, based on fear of mental illness, remains a significant barrier to effective treatment and rehabilitation. Premature death is more*

*common among people with mental illness. Higher rates of physical illness among people with mental illness add to the difficulties of living with a mental illness.”*

*“Physical illness may also be the result of treatment received for a mental disorder (e. g., side effects of some medications). Physical illness may not be diagnosed or properly treated and people with mental illnesses may have their physical health problems diagnosed at a later stage.”*

*“Mental illnesses are often associated with behaviours that carry high health risks, such as smoking, alcohol and other substance abuse, obesity, poor diet and lack of exercise. Mental illnesses can create difficulty in communicating symptoms of physical illness that can further complicate diagnosis. People with mental illness are also less likely to be in contact with general health services and more likely to not have their illnesses identified and treated.”*

*“Cigarette smoking is a major risk factor for many commonly occurring physical illnesses. Smoking is common among people with mental illness. The highest rates and heaviest consumption are among those with the most serious disorders. In Western Australia, 43% of people with diagnosable mental illness smoke compared with 24% of the overall population. Despite the adverse effects smoking can have on people with mental illness, they are rarely encouraged to quit.”*

*“Alcohol abuse and use of illicit drugs are also common problems among people with mental illness. Around half of people with psychotic disorders report illicit drug use. People with mental illness also have high rates of obesity and poor nutrition.”*

*“If a mentally ill person has a physical illness when being treated for a mental illness, there is a strong possibility that the physical illness will not be diagnosed. This can occur even when the physical illness is either causing or exacerbating the mental disorder. Proper treatment of physical and mental conditions at the same time improves the overall well being of the consumer. Barriers to effectively treating people with mental illness in general practice setting have been identified. Also, some psychiatrists tend to regard themselves as specialists who shouldn't be called on to diagnose physical illnesses. The separation of mental health services has led to fragmented care for people with mental illnesses.”*

In the conclusions and recommendations drawn from their research and findings, the study's authors suggest some ways in which the negative impact of unrecognized and untreated physical health problems among people with mental illnesses can be reduced. These recommendations can also provide specific programme, service and policy advocacy opportunities and directions for organizations such as mental health associations and other advocacy groups in their own communities and countries. For example, the authors suggest that:

- *“ More integrated and cooperative approaches to health care are required to effectively meet all of the health needs of people with mental illness. Currently the fragmented approach to health care for the mentally ill sees too many people falling through the cracks, too often resulting in illness not being diagnosed or treated;*
- *Substance abuse and addiction are major problems for the mentally ill. Services to deal with addiction need to be incorporated into every day care of people with mental illness. Programmes to reduce smoking and other substance abuse among people with mental illness could lead to significant reduction in physical illness in this group;*
- *People with mental illness have not benefited from public health campaigns aimed at reducing major health risk factors. Specially targeted programmes would be welcome. More outreach services and more proactive health care is needed for people with mental illness; otherwise, they risk missing out on vital health care;*
- *Health care services must adapt to the needs of people with mental illness; otherwise this vulnerable group will continue to have an unacceptably high death rate and reduced life expectancy. There are several steps that could be taken to address these issues, including programmes to reduce smoking and other substance abuse, promote healthier lifestyles, and developing integrated health services that make diagnosing, treating and managing physical health problems a priority in the overall health care of people with mental illness.”*

Concerns about the untreated physical health problems of women diagnosed with a serious mental illness are growing, especially among consumers and advocates. The major reasons for this increasing level of concern are the fact that women who experience a serious mental health problem are much more likely than others to have their physical health complaints ignored and to have their requests for services denied; secondly, the failure to address physical health problems in a timely fashion is likely to lead to more costly interventions at a later time, resulting in negative outcomes for both the women who are affected and for the overall health care system.

One of the most extensive investigations of extent and consequences of untreated physical health problems among women diagnosed with serious mental illness was completed in June 1997 by Dr. Vivian Brown and a group of colleagues comprising the Technical Expert Group on Women, Violence and Mental Illness of the National Resource Center for the Prevention and Treatment of Alcohol, Tobacco, and Other Drugs and Mental Illness, supported by the Substance and Mental Health Services Administration of the United States Department of Health and Human Services.

As described in the Executive Summary of the report, *“The population of women diagnosed with serious mental illness includes women who have a variety of diagnoses, different treatment histories, functional levels, prognoses, race, and ethnicity. What is common to most of these women is that they are often victims of insensitive planning and inadequate physical and mental health services. Research suggests that women diagnosed with serious mental illness suffer physical illness, and even die, at rates higher than the general population.”*

The report identifies a number of key barriers that preclude women diagnosed with a serious mental illness from obtaining sensitive and coordinated health care. Among the barriers included are:

- Failure to diagnose and misdiagnosis: *Both primary care physicians and mental health professionals fail to diagnose illnesses in women with serious mental illness. In addition, practitioners often fail to uncover trauma history in psychiatric settings, substance abuse contributes to the failure to make accurate diagnosis, and there is a lack of routine gynecological screening and care.*
- Lack of gender-based studies of psychoactive medications, medication interactions, and ECT: *The result is that women are prescribed medications that have not been tested for dose-ranging and side effect profiles on women. There is also a lack of long-term research on the effects of ECT and psychotropic medications on women and fetuses.*
- Stigma: *For women diagnosed with serious mental illness, community response can be insensitive, isolating and stigmatizing.*
- Language and culture: *Systemic factors, such as lack of bilingual, bicultural staff, untrained or inadequately trained interpreters, and failure to reach out into the communities of color to create an awareness of services, can all contribute to underservice and disservice.*

Beyond systemic barriers to access and utilization of adequate and appropriate health care services, women diagnosed with serious mental illness often have co-occurring and safety-related issues that further complicate their access to care. Among these additional barriers are lack of regular and timely prenatal care during pregnancy, substance abuse that serves to exacerbate physical morbidity associated with mental disorders, homelessness, HIV/AIDS, and physical and sexual abuse.

As Dr. Brown points out, physical and sexual abuse can have particularly devastating effects on both a woman's mental and physical health and well being: *“For many women, physical and sexual abuse is the norm rather than the exception. A woman who has experienced abuse often neglects her own health, because of fear of the disclosure of the abuse and/or fear of the medical system. However, even if the woman enters the health system, she is rarely asked about physical or sexual abuse, even though such abuse, whether experienced in childhood or as an adult, leaves a legacy of physical and mental health damage.”*

Writing in a *Commentary* on the study's findings and recommendations in the Summer 1998 *Journal of the American Medical Women's Association*, Dr. Brown called on the separate care systems for physical and mental health to create linkages to promote integrated care and reduce the difficulty that women with both a serious mental illness and major physical health problems have in locating and accessing the services they need. The recommendations contained in Dr. Brown's commentary also can provide an guideline from which advocates for improved services for persons with co-existing serious mental and physical health problems can work. These recommendations include:

- *“Comprehensive assessment of physical health, mental health, trauma history, and substance abuse at all entry points into the system. No matter where she enters, a woman's needs must be met.*
- *Training for service providers. Clinicians should be trained to follow practice guidelines that focus on best practices for women diagnosed with serious mental illness and particularly on ways to avoid re-traumatizing them. Primary care providers must learn to detect physical and sexual abuse histories and to understand how these histories and possible concurrent substance abuse may interfere with the woman's ability to reveal specific health problems. Mental health professionals must recognize and take responsibility for patients' physical health problems. Both primary and mental health care professionals must be aware of the potential interactions between psychotropic medications and those prescribed for medical conditions.*
- *Reorientation from a focus on acute care to preventive health care.*
- *Access to dental care, as many women with serious mental illness and women with substance abuse problems often have serious undiagnosed oral health problems.*
- *Promoting continuity of primary and mental health care and coordination among practitioners. The high level of morbidity among women diagnosed with serious mental illness argues for aggressive coordination among providers.”*

The association between mental illness and poor physical health care has been long recognized. The *British Medical Journal* first reported on this relationship in an article appearing over 60 years ago. According to the authors of an editorial in *BMJ* in February 2001, subsequent research, in many countries, has consistently confirmed that psychiatric patients have high rates of physical illness, much of which goes undetected. Such investigations have led to calls for health professionals to be more aware of these findings and for better medical screening and treatment of psychiatric patients. So far, according to the authors, there is no evidence that this is happening, and the excess illness and mortality continue unabated, with people being managed as psychiatric outpatients being nearly twice as likely to die as the general population.

As pointed out in the editorial, *“Several factors prevent people with mental illness from receiving good physical health care. People with schizophrenia are less likely than healthy [individuals] to report physical symptoms spontaneously. Some symptoms of the consequences of schizophrenia—cognitive impairment, social isolation, and suspicion—may contribute to patients not seeking care, or adhering to treatment. When they do present themselves their lack of social skills and the stigma of mental illness may also make it less likely that they receive good care.”*

*“In most industrialised countries, reform in mental health care has led to the closure of long stay mental hospitals and the development of community mental health teams. Such teams are expected to meet the whole range of health and social needs. Hospital admissions are often short and infrequent, and physical health care is not necessarily given priority. In Britain, the national service framework for mental health states that people with a severe mental illness should have their physical needs assessed. However, many mental health practitioners have little training in physical care. Physical assessments of psychiatric inpatients by junior psychiatrists are poor, and the monitoring of physical health and health education by community mental health staff is generally unsatisfactory.”*

*“Most patients with severe mental illness are in frequent contact with primary care services, and for many this is their only contact with health services. However, such contact does not necessarily ensure that they receive good physical health care. The orientation of primary care is reactive, and this does not fit well with patients who may be reluctant, or unable, to seek help. Short consultation times make it difficult for doctors to assess mental state and conduct a physical assessment, especially in vague or suspicious patients. When mental health staff accompanies patients, more emphasis may be given to psychological*

*and social issues. Doctors who are inexperienced in, or uncomfortable with, mental health work may resist intensifying their engagement with a patient by actively asking about symptoms and performing a physical examination.”*

*“The lifestyle of patients with severe mental illness suggests a need for health promotion—which can be effective. For instance, group therapy is effective in helping patients with schizophrenia stop smoking. But progress in this is hampered by negative staff attitudes. Initiatives in this area should be accompanied by research, so that the most effective approaches can be identified and widely adopted.”*

*“The evidence suggests that it is possible to improve the physical health of this vulnerable section of the population. Progress will, however, depend on both mental health and primary care staff being aware of the problem and being willing to find imaginative solutions which are acceptable and useful to patients.”*

Two meetings held recently in the United States addressed similar issues of the importance of primary care and mental health professionals working collaboratively to better understand and meet the needs of persons with severe and persistent mental illnesses who also have physical health problems. In November 2003, the Mental Health Association in New York City convened a symposium at which the connection between mental and physical health were discussed by practitioners and researchers. As reported on Medscape Medical News, Dr. Richard K. Nakamura, PhD, told the audience that *“Depression is a systemic disease that is a risk factor for the development of other diseases and illnesses. Depression is a risk factor for the development of cardiovascular disease and stroke, and it can affect treatment of diabetes mellitus and increase the risk of many other infections. Primary care physicians need to be on the lookout for patients who present regularly with lots of different illnesses or ailments.”*

A recent webcast organized by the Eli Lilly Company addressed the need for greater attention to the physical needs of mental health patients at risk for weight gain and obesity-related complications. The web cast brought together a panel of mental health experts to highlight the importance of closer monitoring of the physical needs of patients with severe and persistent mental illnesses (SPMI) to help them reduce the risk of weight-related health problems. The panel endorsed Complete Wellness: The Whole Person Treatment Approach, which provides resources to help those living with SPMI to learn about diet, exercise and healthy lifestyle modifications.

William M. Glazer, M.D., a panelist and associate clinical professor of psychiatry at Harvard Medical School, Massachusetts General Hospital and president of Glazer Medical Solutions, explained the timeliness of the webcast. *“This event is of particular importance lately, given the recent requested label change from the U.S. Food and Drug Administration for all atypical antipsychotics to include a warning about additional information on hyperglycemia and diabetes,”* Glazer said. *“The label change is a positive step for patient care because it reminds health care professionals about the need to pay attention to the physical health - in addition to the mental health - of their patients.”*

Panelists agreed that addressing the physical well being of patients with SPMI is as important as treating their mental health. However, often too little attention is paid to the physical needs of this patient population. To help address this unmet need, a new treatment approach was developed that combines education and lifestyle intervention in order to advance patient care and outcomes. The Complete Wellness approach helps patients combat primary mental illness symptoms and provides resources to mental health professionals to help those living with SPMI learn about diet, exercise and healthy lifestyle modifications.

## References:

- Baez, M. "Primary Care Physicians Should be Aware of Links Between Physical and Mental Health." *MedScape Medical News*, November 19, 2003. <http://www.medscape.com/viewarticle/464742>
- Baez, M. *Medscape Medical News*, November 19, 2003
- Brown, PhD V: "Untreated Physical Health Problems Among Women Diagnosed With Serious Mental Illness." *Journal of the American Medical Women's Association*, (Vol. 53, Number 4), Summer 1998, pages 159-160.
- Brown, PhD, Vivian: "Untreated Physical Health Problems Among Women Diagnosed with Serious Mental Illness." ©June 1997 PROTOTYPES System Change Center, Culver City CA USA [www.prototypes.org](http://www.prototypes.org)
- Coghlan, Rebecca; Lawrence, David; Holman, D'Arcy; Jablensky, Assen: "DUTY TO CARE: Physical illness in people with mental illness." *Consumer Summary*, 2001, Department of Public Health & Department of Psychiatry, University of Western Australia. [www.dph.uwa.edu.au](http://www.dph.uwa.edu.au) , page 2.
- Lilly Newsroom: "Greater Attention Needed to the Physical Needs of Mental Health Patients at Risk for Weight Gain and Obesity-related Complications," October 15, 2003. [http://newsroom.lilly.com/news/corporate/2003-10-15\\_completewellness\\_webcast?pfv/html](http://newsroom.lilly.com/news/corporate/2003-10-15_completewellness_webcast?pfv/html)
- Phelan, M.; Stradins, L.; Morrison, S. "Physical health of People with Severe Mental Illness: Can Be Improved if Primary Care and Mental Health Professionals Pay Attention To It" (Editorial) *British Medical*

# WORLD MENTAL HEALTH DAY

## The Relationship Between Physical and Mental Health

---

### Physical Health Care Needs of People with a Severe Mental Illness

RETHINK, the National Schizophrenia Fellowship (UK) – [www.rethink.org](http://www.rethink.org)

#### Rethink Policy

Rethink believes in a holistic approach to the assessment of a person's needs. It is crucial that people with a severe mental illness have routine checks, at least annually, of their physical health and receive the physical health care that they need.

#### Policy development

- 1 By *physical health care* we mean:
  - medical care for physical health problems
  - monitoring the physical side effects of anti-psychotic medication
  - promoting a healthy life-style, including exercise and nourishing diet
  - dental and optical care and attention to hearing problems.
- 2 Routine physical checks should include:
  - measurement of blood pressure and weight
  - regular dental and optical appointments
  - detection of diabetes and cancer, eg cervical smears for women
  - monitoring chest and heart, which may be adversely affected by tobacco smoking
  - detecting and monitoring the side-effects of medication.
- 3 Decisions on medication should be based on individual personal need, taking account of side-effects in the short and long term, *not* on cost. Atypical anti-psychotic drugs should be considered for all people who would benefit from them.
- 4 Doctors should:
  - recognise any possible signs of harmful side-effects of medication as early as possible
  - monitor other side-effects of medication, record service reports about side-effects and adjust prescribing, where possible
  - listen carefully when physical health problems are reported and investigate them.
- 5 In hospital, patients should have opportunities for exercise, good quality, nourishing meals and ready access to drinks (and snacks) at all times, recognising that some medication causes dryness of the mouth.
- 6 In the community, mental health services should check that patients are getting adequate meals, and arrange help with this, where necessary, including recommending a suitable diet.
- 7 Women of child-bearing age should be told whether the anti-psychotic medication they take would be safe should they become pregnant. Particular care should be taken by mental health services throughout a pregnancy to ensure that women get the help they need.
- 8 People with a severe mental illness who smoke tobacco should be offered free help and support to give up smoking.

#### Action

Rethink is campaigning for people to be assessed and have their needs met holistically. This includes consideration of their physical health care needs with an annual physical check-up.

## Questions and Answers

**Q** Are people with a severe mental illness more likely to have physical problems?

**A** Yes. This can be because of:

- the physical side-effects of medication
- being socially isolated
- poor motivation and tiredness, which are long-term effects of chronic illness
- a poor life-style, which can include homelessness, a poor diet, lack of exercise, smoking and poor personal hygiene.

**Q** Do people with a severe mental illness get the medical care they need?

**A** Often they do not because they may:

- not register with a doctor or dentist
- neglect themselves and lack self-esteem
- not readily volunteer information about their physical health
- deal with services that tend to concentrate on their own particular specialism
- not always be listened to by doctors when they report physical problems, eg some may be seen as hypochondriacs.

## Background

- 1 People with a severe mental illness have the same range of physical health problems as anyone else but, in addition, they may suffer further physical problems through:
  - side-effects of medication
  - tobacco-related problems
  - substance abuse
  - an unhealthy diet
  - lack of exercise
  - the effects of living on the streets.
- 2 In 1997, a working party led by Professor Malcolm Lader said that professionals should bear in mind the following factors which may affect the physical health of people with a severe mental illness:
  - a chaotic lifestyle
  - social circumstances, eg a downward social drift
  - any tendency to self-harm
  - social isolation
  - self-neglect
  - living in inappropriate accommodation
  - delusional conduct, eg refusing food because they believe it has been poisoned
  - accidents.
- 3 According to an international study, *Excess Mortality of Schizophrenia*, published in *the British Journal of Psychiatry* in December 1997, 80% of people with schizophrenia die from natural causes compared with 97% of the general population. The most prevalent causes of mortality of people with schizophrenia in the study (compared with 100% as the rate for the general population) were:
  - suicide 896%
  - respiratory disease 226%
  - accidents 205%
  - digestive diseases 185%
  - genito-urinary disease 161%.
- 4 It may be difficult for people with a severe mental illness to obtain medical care because:
  - they may not be registered with a GP (e.g. they may be new to an area, or have been excluded from a GP's list)
  - they cannot give a coherent account of their symptoms
  - the side-effects of their anti-psychotic medication may confuse the clinical picture.

- 5 Newer (atypical) anti-psychotic drugs are more effective in treating schizophrenia and generally have side-effects that can be better tolerated than the older medication. As a result, people may feel more motivated to take them. However, the effectiveness of any particular medication varies between individuals, as do the side-effects.
- 6 All medication has physical side-effects, which, for anti-psychotic drugs, can include:
- tardive dyskinesia, a disorder of the central nervous system linked to the use of old-style medication; it involves uncontrollable muscular movements
  - dystonia, a condition dominated by involuntary sustained muscle spasms, which can be extremely painful seizures
  - neuroleptic malignant syndrome, which involves changes in breathing and heart rate and can be fatal
  - restlessness, drowsiness, dryness of the throat and weight gain
  - reduced sexual desire and sexual dysfunction; for women, changes in their menstrual cycle and lactation
  - feeling cold or being oblivious to cold or other discomfort
  - disturbed heart rhythm and a fall in blood pressure.
- 7 Some anti-psychotic drugs are not safe to take during pregnancy.
- 8 The survey, *A Question of Choice*, (2000) undertaken jointly by, MIND and the Manic Depression Fellowship, found that the most prevalent physical side-effects of anti-psychotic medication were weight gain (62%) and effects on eyes (38%).
- 9 According to research identified in *Tobacco control policies within psychiatric and long-stay units* (2000), between 62% and 81% of people with a diagnosis of schizophrenia smoke tobacco compared with 25% of the general population. According to the Department of Health, more than 120 thousand deaths each year in the UK result from illnesses caused either entirely or partly by smoking. Smoking can also result in a high incidence of tooth decay.
- 10 A study by Menezes et al., *Drug and alcohol problems among people with a severe mental illness in South London* (1996) found prevalence rates of nearly 32% for alcohol abuse and 16% for the use of street drugs.
- 11 People with a severe mental illness may have a poor diet through:
- an inadequate income or an inability to budget efficiently
  - an inability to purchase or prepare food
  - a liking for fatty, processed foods, which can also result in tooth decay.
- 12 According to the Social Exclusion Unit, in 1998 there were still 2000 roofless people in England each night; 10,000 over a year. Of these, between 30% and 50% suffered from mental health problems.
- 13 A study, 'The health of Single Homeless People' by the University of York (1991) found that roofless people had three times the incidence of multiple physical problems (e.g. chest problems and arthritis, as the general population).
- 14 The report, *Pressure Points* (1999), by the national homelessness charity, 'Crisis,' estimated that:
- a third of people who are evicted from accommodation suffer from mental illness
  - 60% of homeless people suffer from some form of mental distress
  - 20% of roofless people have a severe mental illness
  - people who sleep rough are 35 times more likely to kill themselves than the general population.

**Author** Mike Took

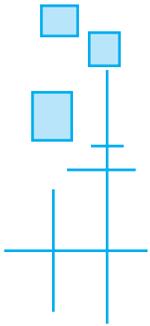
May 2001

**Rethink** is the operating name of the National Schizophrenia Fellowship, UK.



**October 10, 2004**

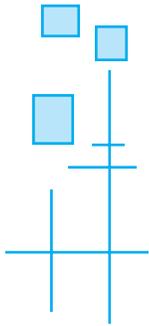
**2004 world mental health day**  
*The Relationship between Physical and  
Mental Health: Co-occurring Disorders*



## **Section Two: Taking Action/What You Can Do**

- From Concept to Program: Integrating Models, Systems, and People
- Publicizing Your Event
- Sample World Mental Health Day 2004 Proclamation
- WFMH Membership Application
- World Mental Health Day 2004 Report Form



**From Concept to Program:  
Integrating Models, Systems and People**

Recent advances in biological sciences and clinical research are uncovering how the body and mind interact directly in health and disease. It's clear that there isn't only a co-existence or co-morbidity of medical and physical conditions; there is also a primary inter-connectedness of the body and mind in the development of disease states. But for clinicians, health care systems, and patients, this new knowledge and understanding also brings new challenges. We need to implement this knowledge into the daily lives of patients and the clinical care they receive. As we know more, there is more to do. The task at hand is to inform caregivers, patients, and the public of the crucial, far reaching interrelationships between physical and mental illness.

One direct approach is to offer World Mental Health Day programs addressing this year's theme. Educational and informational programmes are an opportunity to reach out to those affected by mental illness and those providing clinical and supportive care. Just as we need to integrate conceptual views of illness and impairment, these programmes will, in like fashion, help to bring together concerned individuals, disciplines, and systems of care.

**People, Settings and Systems**

The World Mental Health Day theme of the co-occurrence of physical and mental health has meaning for a wide variety of concerned parties, settings of care, and organizational systems. However, those directly affected – patients and clinicians, both psychiatric and medical – often do not function in well defined or even overlapping groups with the advantage of direct, formal communication. Hence, one main challenge in conveying our message is to bring together the numerous groups and foster communication and collaboration around our theme.

Irrespective of one's country, community, or local culture, there seems to be a common first task: to identify the appropriate people, settings and systems for which this co-occurrence of mental and physical illness is so crucial. More specifically, there's a need to identify the relevant stakeholder groups or involved parties, such as the following: mental health clinicians, medical clinicians and other professionals, patients, local system administrators and officials, and the public at large.

**1. People with Mental Disorders:**

Numerous factors increase the risk of physical illness to the person with mental illness. Some reasons, such as vulnerability to alcohol, smoking and drug use, lifestyle factors like sedentary behavior, and poor diet secondary to illness or poverty, are often tangible and easier to identify. This also applies to the increased risk of developing serious infectious diseases, such as TB and HIV/AIDS. For example, the Zimbabwe National Association for Mental Health estimates that more than half of that country's 300,000 people with psychiatric disorders also have HIV/AIDS, which is frequently secondary to sexual abuse of vulnerable individuals.

We can also easily identify the factors that come directly from treatment itself. For example, the vast improvements in pharmacological interventions are not without a downside. Our current medications have reduced psychiatric morbidity and mortality, but they also cause discrete and serious problems of their own, with documented side effects on hematological integrity, metabolic and endocrine function, and the nervous system.

Hence, a major goal of education programmes for those with mental disorders is to increase their awareness of how associated or independent medical conditions affect their psychiatric

conditions and general well being. And, we need to convey the new and important information about how the often serious and far-reaching side effects of psychiatric medications.

## **2. People with Physical Disorders:**

We now know more about the opposite side of the medical-psychiatric coin, as clinical research tells us how medical illness creates its own burden of mental illness. It is estimated that 40 to 60 percent of heart attack patients, 18 to 20 percent of patients with coronary artery disease, and 25 percent of cancer patients develop depression. For cancer patients, the rate is approximately 25 percent, while the prevalence in neurologic disorders like Multiple Sclerosis, Parkinson's, and organic dementias such as Alzheimer's is even higher. And, from a larger perspective, it's estimated that 5 to 10 percent of medical outpatients and 10 to 14 percent of hospitalized patients have depression.

For those with medical illness, we can offer helpful, practical information about the psychiatric symptoms and conditions that commonly accompany physical disorders. People are understandably hesitant to acknowledge psychological symptoms when medically ill, but are often very relieved by open discussions of these common concerns. It can help minimize any shame, stigma, and 'self-blame' for what we know are unavoidable and everyday reactions to medical illness.

## **3. Systems of Care:**

The systems of health care - where and how people receive medical and psychiatric care and support - also play a significant role in the health and welfare of those with mental disorders. However, these factors are often more difficult to identify per se. Health care systems are often fragmented and uncoordinated, with both patients and clinicians unaware of available and appropriate resources. And, in all too many countries and locales, the systems of care are woefully incomplete or absent.

One significant factor is that those with mental illness commonly have decreased access to general medical care, even in industrialized nations where the shift from large in-patient hospitals to community care can leave people with inadequate or distressingly fragmented medical care. When medical care is available, both the stigma and prejudice of mental illness often undermines effective care and follow-up. Added to this is how mental illness often reduces the patient's ability to identify and understand the meaning of bodily feelings of physical symptoms.

In under-developed nations, where systematic care is even less available, care taking for the psychiatric patient often falls more on the extended family rather than a formal medical system of hospitals and community clinics. Here, insufficient resources of time, money, and personnel often mean medical care for the person's physical illness is just not available.

## **4. Medical Clinicians:**

Unfortunately, medical clinicians are often untrained or unequipped to recognize and treat the psychiatric and psychological symptoms of their patients. Or, they are too overwhelmed with their patients' severe medical conditions to attend to the often "more silent" and unreported psychological symptoms of their patients. It's estimated that between 30 to 50 percent of psychiatric illness goes undetected by medical clinicians. This is especially so for mental disorders such as clinical depression, anxiety, and PTSD that often go undetected in a large proportion of medical patients. In terms of depression, medical clinicians are often unaware of the need for adequate and long-term treatment with antidepressant medication and therapy. This is especially important given the troubling issue of suicide in medical patients and the elderly. It is estimated that two-thirds of those who committed suicide in the U.S. have seen their medical physician within a month of their death.

Mental health clinicians and advocates can help medical professionals care for the psychological needs of their patients via our expertise in recognizing and treating psychiatric illness. This can take the form of educational programmes for primary care clinicians focused in one's community. Such "bridge-building" programs also have a secondary benefit of creating direct and on-going liaison connections between mental health and medical professionals.

## **5. The Public:**

The issue of the relationship between medical and psychiatric disorders should also reach the general public. It is important to raise awareness for the public about, for example, how depression and anxiety influence general quality of life parameters, and more “silent” risk factors, including the relationship between anxiety disorders and hypertension. Even for “healthy” people without acute or chronic medical illnesses, there are preventive measures of screening and education for the subtle but significant effects of common psychiatric disorders on their physical well being and longevity.

### **Ideas for Programs and Interventions**

In considering specific programmes for World Mental Health Day, there are numerous options for raising the awareness of the relationship between mental and physical illness and bringing together concerned individuals. Given the far-reaching breadth of the issue, choices for a specific focus and audience would depend on the relevance to one’s locale and community.

#### **1. For Patients, Families, the Public:**

- One opportunity given our Mental Health Day theme is educating those with mental illness and their families, and the public in general, about the increased risk of medical illness. This could include a programme addressing lifestyle issues, how to use the local medical system and clinicians, and, the medical side effects of psychiatric medications.
- A programme for patients, family members, and mental health advocacy associations could include talks and discussions by both mental health and medical clinicians, including nurses and nutritionists. Relevant topics include the following: proper diet and nutrition; the medical effects of lithium, anti-depressants, anti-psychotics, and mood stabilizers; medical risks of alcohol, tobacco, and sexually-transmitted diseases; the importance of regular medical check-ups; how to obtain medical care within the respective communities and systems; and, basic discussions of medical illnesses common in psychiatric patients, such as diabetes, hypertension, and pulmonary disease, and how to recognize them.
- The Internet is another rich venue for disseminating information. Where available, the Internet and web-based programs offer access to those lacking access to information in their communities or concerned about the stigma of attending programs on mental disorders.
- Specifically, the elderly in many countries are growing more comfortable with the Internet for information and support, including the psychological and medical aspects of growing older. For example, web sites for the elderly in China have become popular and useful. Given the growth in the elderly in many countries, many of whom are homebound or with limited community resources, the Internet can be an effective way of reaching large groups of people.

#### **2. For Mental Health Clinicians and Providers:**

- Providers of mental health services could organize a programme for their clinical staff about the significance of medical conditions in their patients. Programmes for clinicians without a medical background, such as social workers and case managers, would be especially helpful, as they are often the patient’s sole contact with clinical services and are crucial for coordinating non-psychiatric care for their patients.
- These talks could be given by medical clinicians, including physicians, nurses, nutritionists, and pharmacists, with emphasis on relevant medical conditions, what to look for in their patients, and when and how to refer within the local medical community.
- Relevant topics would be as follows: common medical illnesses associated with psychiatric disorders; physical and neurologic symptoms secondary to psychiatric medications such as sweating, dry mouth, akathisia, tremor, etc; issues about diet, substance abuse, unprotected sex; and, risks of medications with pregnancy and breastfeeding.

#### **3. For Medical and Ancillary Clinicians and Caregivers:**

- Analogously, mental health staff could offer programmes for medical colleagues in their communities, especially with whom they share patients. These programmes would serve two important purposes: a forum for education, and, an opportunity to build cross-discipline working relationships bridging the gap between the medical and mental health care systems.
- Programmes could include an “open house” with invitations to other medical professionals such as dentists, midwives, nursing home staff, chiropractors, medical social workers, alternative medicine providers, etc., all of whom are confronted with the psychological burden of illness in their patients.
- Clinicians from social work, psychology, and psychiatry could offer educational seminars on the diagnosis and treatment of common psychiatric conditions. The first step would be to contact the relevant primary providers of medical care such as the family doctor or primary care clinic, or the appropriate professional organization for medical clinicians such as medical societies or government agencies.
- Educational programmes for primary care physicians and nurses can offer useful updates on current psychiatric knowledge and practice. For example, the Massachusetts Psychiatric Society initiated a continuing medical education evening seminar on psychiatry in primary care for the Massachusetts Medical Society that has grown into a popular annual program. Talks by well-known psychiatrists within the community are focused on practical psychiatric topics and delivering care within the local managed care systems.
- Topics could include how to screen for depression, anxiety, psychotic disorders, and suicidality. There could also be a focus on the psychology of aging and psychiatric symptoms common to the elderly.
- Another relevant topic is the prevalence and presentation of psychiatric conditions in women, including post-partum depression, the risks of psychiatric medication, tobacco, alcohol and drugs during pregnancy and nursing, and, the effects of hormonal changes on mood before, during, and after menopause.
- In locales where the paradigm of indigenous knowledge plays a vital role, mental health staff should consider working with alternative and spiritual healers. We need to involve all-important members of a community, especially when the culture of an American or European “psychological approach” is less relevant to underlying belief systems and values.

#### **4. For Health System Administrators and Officials:**

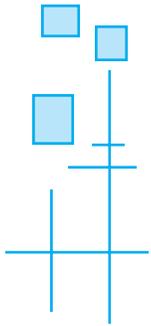
- The theme of the interrelationship of mental and physical disorders could be an opportunity to reach out to and work with medical system administrators and local government officials to help coordinate the care of patients in their community. Beyond direct clinical issues, recognizing the interplay of psychiatric and medical illness would also serve to maximize efficient and economic use of resources.
- Programmes could include an “open house” that introduces the resources of a mental health clinic or agency to interested parties in the community. Administrators could invite a wide variety of professionals aside from doctors and nurses, such as dentists, midwives, nursing home staff, chiropractors, medical social workers, alternative medicine providers, etc., all of whom are confronted with the psychological burden of illness in their patients. This could also include representatives from religious institutions or indigenous healers in one’s local community.

#### **Conclusion:**

Optimal care of patients requires integration of divergent concepts about health and disease, as well as people and providers across numerous disciplines. For both the treatment and prevention of illness, we need to overcome the understandable tendency to see medical and psychiatric conditions as separate and unrelated. World Mental Health Day gives us an opportunity to reach out to and bring together patients, medical clinicians, health care systems, and the general public. We can help by providing concrete information to individuals and clinicians about the interplay of mental illness and physical illness, and attempting to coordinate and integrate the existing systems that provide this care.

**ROBERT M LEVIN, MD, MPH  
DEPARTMENT OF PSYCHIATRY  
HARVARD MEDICAL SCHOOL**

## **Publicizing Your Event**



The following material will help you prepare information for the media on World Mental Health Day 2004. We are providing you with sample letters and tips on how to understand and work with the mass media. By establishing and maintaining good working relationships with your local media, you will ensure that mental health issues are covered with accuracy and sensitivity.

### **I. Understanding the News Media**

The three most important elements in a good story are action, people and substance. Match the media's needs with your message and ensure that the information is provided to them in a timely manner. In order to develop appropriate media activities and messages, ask yourself:

- What goal(s) do you want to accomplish in your WMHDAY event?
- Who is your target population?
- What messages must be developed and conveyed to influence your target audience to make the desired changes?
- What role do you want the community at large to have?
- What types of media outreach would be efficient and cost effective for accomplishing the above?

### **II. Tips for Success**

- Look for ways to tie your local event in with a national observance or campaign.
- Remember to provide information in a way that the general public will understand. Avoid using professional terms that may be confusing to your audience.
- Know facts about WMHDAY and the year's theme and have them readily available to discuss and FAX to the reporter or other interested parties.
- Consider having a radio or TV station co-sponsor your event, which would highlight the station's commitment to the community and generate free publicity for your event.
- Use the WMHDAY Theme to attract both media and public attention. Use it on all publicity related material, from invitations to fax sheets, letterhead, media kits and banners.

Keep in touch with your media contacts even after the event is over. Thank them for covering your story. Keep them informed of new issues and new information. Remember, you are trying to build long-term relationships with the media, making their job easier by keeping them up-to-date.

# SAMPLE NEWS RELEASE

FOR IMMEDIATE RELEASE

For Information Contact:

Contact Person:

Phone:

Email:

## WORLD MENTAL HEALTH DAY 2004 FOCUSES ON THE RELATIONSHIP BETWEEN MENTAL AND PHYSICAL HEALTH

\_\_\_\_\_ announces plans to commemorate World Mental Health Day 2004 by (describe your planned event here)

The theme for World Mental Health Day 2004, *The Relationship between Physical and Mental Health: Co-occurring Disorders*, focuses worldwide attention and concern on the identification, understanding and treatment of co-occurring disorders. World Mental Health Day is a global mental health education project of the World Federation for Mental Health and is distributed in over 180 countries and territories.

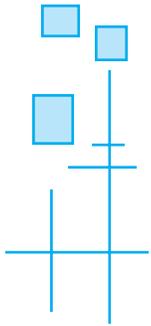
The selection of this theme reflects the need to increase the awareness of viewing health as a whole body concern. The prior US Surgeon General, David Satcher, in the 1999 Report on Mental Health states that even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable, he says. The World Health Organization also states, that mental health is as important as physical health to the overall well-being of individuals, societies and countries.

The programs and activities planned by the \_\_\_\_\_ to commemorate World Mental Health Day in \_\_\_\_\_ will help bring attention to the general public and medical communities for the need to address all aspects of health and the complete treatment of co-occurring disorders.

According to \_\_\_\_\_ of the \_\_\_\_\_ organization, World Mental Health Day is an important event in our community because it helps all of our fellow citizens learn more about mental health issues and encourages them to support improved services regarding full body health and co-occurring disorders. We urge everyone to participate in this year's World Mental Health Day events.

More information about the origins of World Mental Health Day and to receive a copy of the global campaign materials can be obtained by contacting the World Federation for Mental Health at [www.wfmh.org](http://www.wfmh.org) and [wmhday@wfmh.com](mailto:wmhday@wfmh.com). For local information please contact \_\_\_\_\_.

# Proclamation



Whereas the World Federation for Mental Health has designated “The Relationship between Physical and Mental Disorders” as the primary focus of World Mental Health Day 2004.

Now, therefore, in support of World Mental Health Day 2004, I urge all citizens of \_\_\_\_\_ to

- Participate in efforts to increase public awareness and understanding of the correlation between mental and physical health issues,
- Support advocacy efforts to encourage medical and psychiatric clinicians to work together for better health care,
- Reinforce the need for more equal treatment and funding for mental health services in public health resources.

In recognition of the pressing needs to increase public awareness of the importance of total body health, treat co-occurring disorders for complete health and well being, and the need to improve the availability and quality of mental and physical health services,

I, \_\_\_\_\_, \_\_\_\_\_  
(name) (title)

Hereby proclaim October 10, 2004

WORLD MENTAL HEALTH DAY

In \_\_\_\_\_  
(country)

And urge all my fellow citizens to take part in the activities designed for the observances of this day.

\_\_\_\_\_  
*signature*

\_\_\_\_\_  
*date*

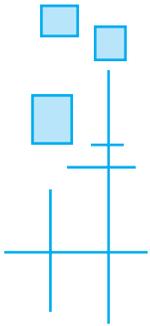
(seal)



## 2004 world mental health day

October 10, 2004

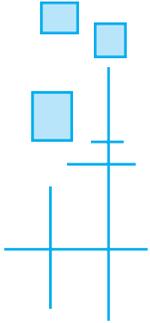
### Some Tips for celebrating World Mental Health Day



- Assemble your planning group immediately to allow maximum time for planning an event.
- Review the contents of this global education packet; begin outlining your World Mental Health Day program.
- The proclamation page provides suggested wording for your community's commitment to mental health advocacy. Before it is given to your president, prime minister, governor or mayor for signing, it should be carefully reviewed by local administrators to determine how appropriately it reflects the needs of your citizens. You are free to modify the words to suit your situation.
- You may wish to have your proclamation printed on fine quality paper for the official signature. A local attorney can help you produce an attractive formal document.
- Companies that have provided funding for World Mental Health Day are listed in the packet. Identify and communicate with your local representatives of these companies. Let them know that event planning is in progress. Ask if there are ways in which they would like to participate, such as hosting a reception, paying for the printing of your material, or sponsoring workshops, or an exhibit, or whatever your ideas are.
- Carefully consider any time-sensitive activities involving data gathering and/or compiling material for reports. Coordinate your deadlines so that publicity announcements can be released and published in time for your event.
- Begin organizing public events early enough to secure the location and the people you want for your program.
- Consider putting together printed material to hand out - such as brochures or flyers or combine the fact sheets into a small document with your organizations information included.
- To help publicize WMHD, put a link on your Website to [www.wfmh.org](http://www.wfmh.org) so others may find out about WMHD and the activities of the World Federation for Mental Health. Find other ways to 'spread the word'.
- After your event, please complete and return the Report Form along with newspaper clippings, photos and other materials produced in connection with your World Mental Health Day activity.
- After your event, call your planning group together to review what was successful, what could have been improved, and what will be beneficial to do next year.

***Ideas, Plans, Notes***

## **Membership Application**



If you are not yet a member of the World Federation for Mental Health, why not join NOW and take advantage of our *special membership enlistment rate* with this form only! Join and become a part of the worldwide mental health movement to help improve the mental and emotional well-being of people around the world! The rates below are acceptable with this form only and expire on October 10, 2004! Send back your membership form, save on your first year of benefits and be a part of the only international, multidisciplinary, grassroots advocacy and education organization concerned with all aspects of mental health!

### ***TYPES OF MEMBERSHIP***

- Individual membership, for any individual who would like to join WFMH
- Affiliate membership, for organizations that would like to be affiliated with WFMH
- Voting membership, for national or international organizations that would like to help with the matters related to WFMH, both internally and externally. Applications are available upon request.

### ***MEMBERSHIP BENEFITS***

- Opportunities for networking and collaboration with colleagues in other parts of the world with common interests and concerns
- Quarterly newsletters – bringing you timely information on global mental health issues
- Annual reports of WFMH's activities
- Reduced rates at some WFMH events including regional seminars and conferences as well as the Biennial World Congresses.

### ***MEMBERSHIP FEES***

<u>Individual membership</u>		<u>Special Rate</u>
Regular member (developed countries)	\$35	<b>\$25</b>
Developing country member (designated by OECD)	\$15	<b>\$10</b>
<u>Affiliate membership</u>		
Libraries	\$40	<b>\$30</b>
Annual budget below \$100,000	\$50	<b>\$40</b>
Annual budget of \$100,000-\$999,999	\$150	<b>\$125</b>
Annual budget of over \$1 million	\$300	<b>\$250</b>

Application on other side

**Please circle the type of membership you are applying for:**

Individual membership

Regular \$25  
Developing country \$10

Affiliate membership

Library \$30  
Budget below \$100,000 \$40  
Budget of \$100,000-\$999,999 \$125  
Budget over \$1 million \$250

**Please provide the following information:**

Organization name (only if applying as an affiliate member) \_\_\_\_\_

Main contact person \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

**Payment:**

Please charge my Visa or MasterCard (*circle one*)

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_

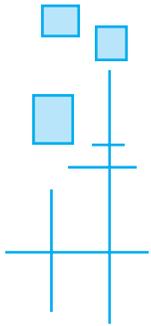
Signature \_\_\_\_\_

Check, bank draft or money order enclosed (payable to WFMH)

*Please return this form along with your payment in US Dollars to:*

**World Federation for Mental Health  
P.O. Box 16810  
Alexandria, VA 22302-0810  
USA**

# Report Form



## How Did You Celebrate The Day?

Here is your chance to let us know about your World Mental Health Day events and help us improve future education packets. The strength of this project lies in the effect it has in the field - therefore we urge you to send in a report of your 2004 activities. We hope everyone will join in, not only doing something to 'spread the word' but by letting the rest of the world know what you are doing by writing back to us! Every event - no matter how large or small - is important to us. And all pictures, news articles, and promotional materials are welcome. Most of the prominent activities, if received by January 27, 2005, will be in the World Mental Health Day Summary Report, which is compiled, published and distributed each year to friends of WFMH around the world. We look forward to hearing from all of you!

(PLEASE PRINT ALL INFORMATION)

Name \_\_\_\_\_

Organization \_\_\_\_\_

Address  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

1. Overall, how satisfied were you with the World Mental Health Day Educational Material? (circle one)

Very Satisfied   Satisfied   Neutral   Dissatisfied   Very Dissatisfied

2. Do you have any helpful suggestions on information that could be useful for future planning material?

3. Please circle the materials within the planning kit that you feel are useful for World Mental Health Day.

Introduction

Fact Sheets

Mental & Physical Disorders

Mind & Body Connection

Impact of Physical Health for Persons  
with Severe Mental Disorders

From Concept to Program

Publicizing your Event

Resources

4. What Special Events did you hold to observe World Mental Health Day?

5. If you were to choose the one outcome that you are most proud of accomplishing through your World Mental Health Day Event, this year, what would it be? (Use additional pages, if needed)

Do you know of anyone who would be interested in obtaining a copy of future World Mental Health Day Educational Material? Please **PRINT** their name and address below:

Name \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

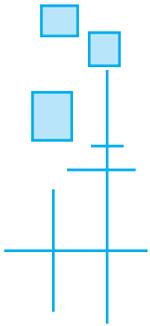
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Please return this form by mail to:  
World Federation for Mental Health  
P.O. Box 16810  
Alexandria, VA 22302-0810  
Fax: 703.519.7648

**October 10, 2004**

**2004 world mental health day**  
*The Relationship between Physical and  
Mental Health: Co-occurring Disorders*



### **Section Three: Reference Information**

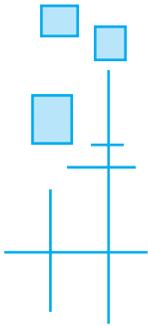
- The World Federation for Mental Health: A Profile
- WFMH Board of Directors
- World Mental Health Day 2004 International Advisory Committee
- World Mental Health Day 2004 Endorsers
- Resources and Web sites



**2004 world mental health day**

**October 10, 2004**

## **World Federation for Mental Health**



The WFMH was founded in 1948 to advance, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health.

The Federation, with members and contacts in 112 countries on six continents, has responded to the international mental health crisis through its role as the only worldwide grassroots advocacy and public education organization in the mental health field. The Federation's organizational and individual membership includes mental health workers of all disciplines, consumers/users of mental health services, family members and concerned citizens. The organization's broad and diverse membership makes possible collaboration among governments and non-governmental organizations.

Throughout its history, the Federation has been active in advancing the concerns of the mentally ill before international forums, both private and governmental, and in supporting the efforts of its member organizations at the national and regional level.

The Federation is accredited as a consultant to the United Nations and its specialized agencies, working closely with the World Health Organization, UNESCO, the UN High Commissioner for Refugees, the UN Commission on Human Rights, the International Labour Organization and others.

### **MISSION**

The mission of the World Federation for Mental Health is to promote, among all people and nations, the highest possible level of mental health in its broadest biological, medical, educational, and social aspects.

### **VISION**

The World Federation envisions a world in which mental health is a priority for all people. Public policies and programs reflect the crucial importance of mental health in the lives of individuals, families and communities, and in the political and economic stability of the world. The interdependence of mental and physical health within the social environment is fully recognized. Serious and effective programs are focused on research, training and services for promotion of mental health and optimal functioning, prevention of disorders, and care and treatment of those with mental health problems throughout the life cycle. Those who experience mental, neurological and psychological disorders are understood and accepted, and treated equitably in all aspects of community life.

### **GOALS**

- To heighten public awareness about the importance of mental health, and to gain understanding and improve attitudes about mental disorders.
- To promote mental health and optimal functioning.
- To prevent mental, neurological, and psychosocial disorders.
- To improve the care and treatment of those with mental, neurological and psychosocial disorders.

# WFMH Board of Directors

## PRESIDENT

L. Patt Franciosi, PhD - USA

## PRESIDENT-ELECT

Shona Sturgeon - SOUTH AFRICA

## IMMEDIATE PAST PRESIDENT

Pirkko Lahti - FINLAND

## BOARD MEMBERS AT LARGE

Paulo Alterwain, MD - URUGUAY

Dr. Maan A. Barry - YEMEN

Chueh Chang - TAIWAN

Tony Fowke, AM - AUSTRALIA

Brian Howard - IRELAND

Beverly Long - USA

Janet Paleo - USA

Richard Studer - USA

Deborah Wan - HONG KONG

## TREASURER

Edward Pennington - CANADA

## HONORARY SECRETARY

Janet Meagher, AM - AUSTRALIA

## REGIONAL VICE PRESIDENTS

### **Africa**

Elizabeth Matare - ZIMBABWE

### **Eastern Mediterranean**

Ahmed Abou El Azayem, MD - EGYPT

### **Europe**

Leo de Graaf - THE NETHERLANDS

### **Mexico & Central America**

Virginia Gonzalez Torres - MEXICO

### **North America & Caribbean**

Cynthia Wainscott - USA

### **Oceania**

Peter McGeorge, MBChB - NEW ZEALAND

### **South America**

Miguel R. Jorge, MD - BRAZIL

### **Southeast Asia**

Regina de Jesus - PHILIPPINES

### **Western Pacific**

Kazuyoshi Yamamoto, MD - JAPAN

## WFMH REGIONAL OFFICES

### **African Regional Council**

Isaac Mwendapole - ZAMBIA

### **Eastern Mediterranean Regional Council**

Ahmed El-Azayem, MD - EGYPT

### **European Regional Council/MHE**

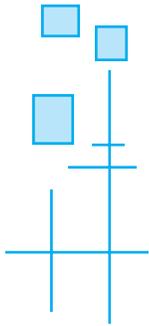
Pascale Van den Heede - BELGIUM

### **Mexico/Central America Regional Council**

Federico Puente, MD - MEXICO

**2004 world mental health day**  
**October 10, 2004**

# **International Advisory Committee**



**John Copeland, MD**  
Chair, World Mental Health Day Committee  
6 Stanley Road, Hoylake, Wirral  
Merseyside, CH47 1HW UNITED KINGDOM  
Email: jrmcop@btinternet.com

Efrain Bleiberg, MD  
Professor and Vice Chair  
Menninger Department of Psychiatry  
Director, Division of Child & Adolescent  
Psychiatry  
Baylor College of Medicine  
Texas, USA  
Email: ebleiberg@menninger.edu

Thomas Bornemann, EdD  
Director, Mental Health Program  
The Carter Center  
One Copenhill  
Atlanta, GA 30307 USA  
Email: ccmhp@emory.edu

Robert Levin, MD, MPH  
Harvard Medical School  
Boston, MA USA  
Email: rlevin@post.harvard.edu

Janet Meagher, AM  
WFMH Honorary Secretary  
27 Bullecourt Avenue  
Engadine, NSW 2233  
AUSTRALIA  
Email: janet.m@pra.org.au

Ellen Mercer, MA  
Immigration and Refugee Services of America  
1827 1/2 16th Street, N.W.  
Washington, D.C. 20009 USA  
Email: ermercerc@aol.com

Kenneth P. Moritsugu, M.D., M.P.H.  
The Deputy Surgeon General  
United States Public Health Service  
5600 Fishers Lane, Suite 18-67  
Rockville, Maryland 20857 USA  
Email: kmoritsugu@osophs.dhhs.gov

R. Srinivasa Murthy, MD  
WHO Regional Office, Eastern  
Mediterranean  
WHO Post Box 7608  
Abdul Razak Al-Sanhouri Street,  
Naser City, Cairo-11371 EGYPT  
Email: murthys@emro.who.int

Robert Pearce  
Taiwan Cancer Friends New Life Association  
2F, #163 Kang-ning Street, His-Zu City  
Taipei, TAIWAN ROC  
Email: r\_pearce@hotmail.com

Ming Fa Lin  
Taiwan Cancer Friends New Life Association  
2F, #163 Kang-ning Street, His-Zu City  
Taipei, TAIWAN ROC  
Email: love.newlife@msa.hinet.net

Emeritus Professor Beverley Raphael  
MD, FRANZCP, FRCPsych,  
Centre for Mental Health  
Locked Mail Bag 961  
North Sydney, NSW 2059  
AUSTRALIA  
Email: braph@doh.health.nsw.gov.au

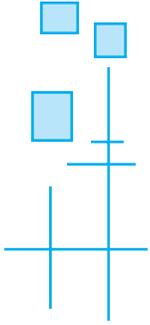
# World Mental Health Day 2004 Endorsers

*To obtain contact information on an individual endorser in your country or geographic region, contact the WFMH Secretariat by email [info@wfmh.com](mailto:info@wfmh.com)*

ALBANIA  
ANTIGUA & BARBUDA  
ARGENTINA  
AUSTRALIA  
BANGLADESH  
BELGIUM  
BELIZE  
BRAZIL  
BULGARIA  
CANADA  
COLOMBIA  
CZECH REPUBLIC  
COMMONWEALTH OF DOMINICA  
EGYPT  
FINLAND  
GEORGIA  
GERMANY  
GHANA  
GIBRALTAR  
HONG KONG  
INDIA  
INDONESIA  
IRELAND  
JAPAN  
KENYA  
KUWAIT  
LATVIA  
MALAWI  
MALAYSIA

MAURITIUS  
MEXICO  
NETHERLANDS  
NEW ZEALAND  
NIGERIA  
PHILIPPINES  
POLAND  
PORTUGAL  
PUERTO RICO  
ROMANIA  
SAUDI ARABIA  
SERBIA & MONTENEGRO  
SEYCHELLES  
SINGAPORE  
SLOVENIA  
SOUTH AFRICA  
SPAIN  
SWITZERLAND  
TAIWAN  
TANZANIA  
TURKEY  
UNITED KINGDOM  
UNITED STATES  
URUGUAY  
YEMEN  
ZAMBIA  
ZIMBABWE

## **Resources and Websites**



Additional resources and websites have been listed for further information on the topics raised in this document. Please note that there is an abundance of information available and not all resources are listed here.

### **AmfAR**

AIDS Research  
120 Wall Street, 13th Floor  
New York, NY 10005-3908  
USA  
[www.amfar.org](http://www.amfar.org)

### **American Diabetes Association**

National Center  
1701 North Beauregard Street  
Alexandria, VA 22311  
USA  
[www.diabetes.org](http://www.diabetes.org)

### **American Heart Association**

National Center  
7272 Greenville Avenue  
Dallas, TX 75231  
USA  
[www.americanheart.org](http://www.americanheart.org)

### **American Psychiatric Association**

1000 Wilson Boulevard, Suite 1825  
Arlington VA 22209-3901  
USA  
[www.psych.org](http://www.psych.org)

### **At health.com**

14241 NE Woodinville-Duvall Road, #104  
Woodinville, WA 98072-8564 USA  
[www.athealth.com](http://www.athealth.com)

### **Australian Government Department of Health & Ageing**

GPO Box 9848  
Canberra ACT 2601  
AUSTRALIA  
[www.health.gov.au](http://www.health.gov.au)

### **The Australian Psychological Society**

PO Box 38  
Flinders Lane Post Office  
MELBOURNE VIC 8009  
AUSTRALIA  
[www.psychsociety.com.au](http://www.psychsociety.com.au)

### **The Body**

Body Health Resources Corporation  
[www.thebody.com](http://www.thebody.com)

### **The Carter Center**

Mental Health Program  
One Copenhill  
Atlanta GA 30307 USA  
404-420-5165  
[www.cartercenter.org](http://www.cartercenter.org)

### **Center for Mental Health Services**

Substance Abuse & Mental Health Services  
Administration  
USDHHS  
5600 Fishers Lane  
Rockville MD 20857 USA  
[www.samhsa.gov/cmhs](http://www.samhsa.gov/cmhs)

### **Center for Mind-Body Medicine**

5225 Connecticut Avenue, NW  
Suite 414  
Washington, DC 20015 USA  
[www.cmbm.org](http://www.cmbm.org)

### **The Depression Treatment website**

[www.depression-treatment.com](http://www.depression-treatment.com)

**Immigration & Refugee Services of America**

National Alliance for Multicultural M.H.  
1717 Massachusetts Avenue, NW, Suite 200  
Washington DC 20036  
[www.refugeeusa.org](http://www.refugeeusa.org)

**International Union for Health Promotion and Education**

2 rue Auguste Comte  
92170 Canves FRANCE  
+330 1 46 45 00 59  
[www.iuhpe.org](http://www.iuhpe.org)

**International Union against Cancer**

[www.uicc.org](http://www.uicc.org)

**The Irish Heart Foundation**

4 Clyde Road, Ballsbridge, D4  
IRELAND  
[www.irishheart.ie](http://www.irishheart.ie)

**The Mental Health Foundation**

UK Office  
7th Floor, 83 Victoria Street,  
London SW1H 0HW  
UNITED KINGDOM  
[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

**Mentality**

134-138 Borough High Street  
London SE1 1LB  
UNITED KINGDOM  
[www.mentality.org.uk](http://www.mentality.org.uk)

**National Center for Complimentary and Alternative Medicine**

P.O. Box 7923  
Gaithersburg, MD 20898 USA  
[www.nccam.nih.gov](http://www.nccam.nih.gov)

**National Institute of Mental Health**

6001 Executive Boulevard  
Bethesda MD 20892 USA  
[www.nimh.nih.gov](http://www.nimh.nih.gov)

**National Mental Health Association**

2001 North Boulevard Street, 12th Floor  
Alexandria VA 22311 USA  
[www.nmha.org](http://www.nmha.org)

**Pan American Health Organization**

525 23rd St., N.W.  
Washington, D.C. 20037 USA  
[www.paho.org](http://www.paho.org)

**Rethink, National Schizophrenia Fellowship**

30 Tabernacle Street  
London EC2A 4DD  
UNITED KINGDOM  
[www.rethink.org](http://www.rethink.org)

**Royal College of Psychiatrists**

National Headquarters  
17 Belgrave Square  
London SW1X 8PG  
United Kingdom  
[www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

**Taiwan Cancer Friends New Life Association**

2F, #163 Kang-ning Street, Hsi-Zu City,  
Taipei County, TAIWAN R.O.C.  
[www.love-newlife.org.tw](http://www.love-newlife.org.tw)

**UNAIDS**

20, avenue Appia  
CH-1211 Geneva 27  
SWITZERLAND  
[www.unaids.org](http://www.unaids.org)

**UN High Commissioner for Human Rights**

Committee on the Rights of the Child  
D 214, Palais des Nations  
1211 Geneve 10 SWITZERLAND  
[www.unchr.ch](http://www.unchr.ch)

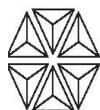
**World Health Organization**

Division of Mental Health and Substance  
Dependence  
Geneva CH-1211 SWITZERLAND  
[www.who.int](http://www.who.int)

**World Psychiatric Association**

Secretariat  
Dept. of Psychiatry & Behavioral Sciences  
Metropolitan Hospital Center  
New York Medical College  
1901 First Avenue, Suite 4M-3  
New York, NY 10029 USA  
[www.wpanet.org](http://www.wpanet.org)

These materials were supported by a charitable contribution  
from the following companies:



**Bristol-Myers Squibb Company**



**Otsuka Pharmaceutical Co., Ltd.**



*The World Federation for Mental Health would like to thank the following Sponsors of this year's World Mental Health Day project. Their assistance has been instrumental in the production and distribution of this publication. If you found this document helpful, we encourage you to send a brief thank you note to the Sponsors through the following contacts:*

**BRISTOL MYERS SQUIBB COMPANY**

Sam Sukoneck  
PO BOX 4000  
Princeton, NJ 08543-4000 USA

**ASTRAZENECA**

Nancy Olson  
1800 Concord Pike  
PO BOX 15437-OW3  
Wilmington, DE 19850 USA

**ELI LILLY AND COMPANY**

Valerie Erb Tully  
Lilly Corporate Center  
Indianapolis, IN 46285 USA

**OTSUKA AMERICA PHARMACUETICAL, INC**

Debra Kaufmann  
2440 Research Boulevard  
Rockville, MD 20850 USA

**ORGANON INTERNATIONAL**

Thomas Schrooyen  
56 Livingston Avenue  
Roseland NJ 07068 USA



For more information on World Mental Health Day or to obtain further information about the World Federation for Mental Health, contact:

World Federation for Mental Health  
PO BOX 16810

Alexandria, VA 22302-0810 USA

Phone: + 703.838.7543

Fax: +703.519.7648

Email: [wmhday@wfmh.com](mailto:wmhday@wfmh.com)

Web sites: [www.wmhday.net](http://www.wmhday.net) or [www.wfmh.org](http://www.wfmh.org)