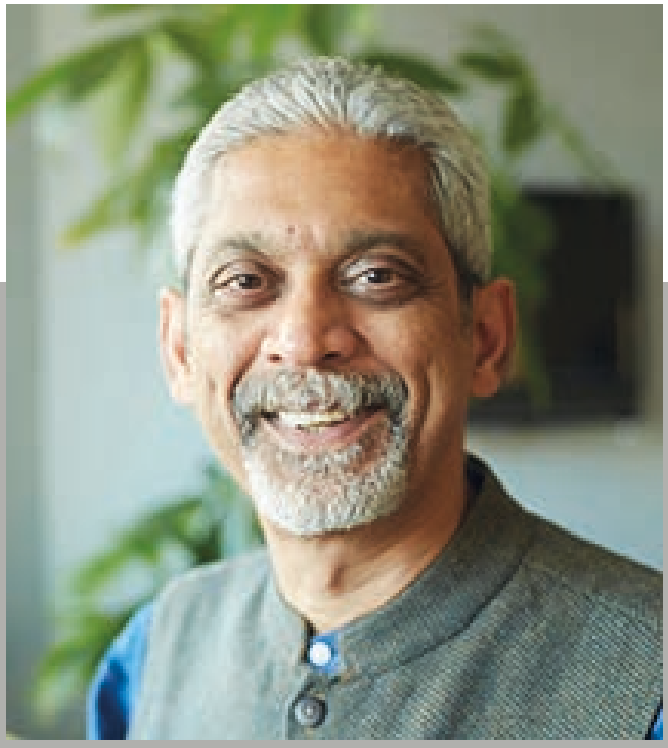
Book Author

Dr. Vikram Patel
Ph.D., M.B.,B.S.
The Pershing Square Professor of Global Health,
Harvard Medical School

WHERE THERE IS NO PSYCHIATRIST



Dr Vikram Patel, PhD is a psychiatrist and researcher best known for his work on leveraging community resources to address mental health problems. Dr Patel was educated at the University of Mumbai, (Bachelor of Medicine, Bachelor of Surgery, 1987), the University of Oxford (Master of Science, 1989) and the University of London where he was awarded a PhD in 1997 for research on mental disorders in Harare. He became a member of the Royal College of Psychiatrists in 1992.

Dr Patel's work spans a wide variety of topics and disciplines including, but not limited to epidemiology, psychiatry, clinical psychology, disability, neurological diseases, non-communicable diseases, public health, substance abuse, economic evaluation, and implementation research. His primary interest, however, is in global mental health, specifically reducing disparities in access to quality care for people with mental health problems particularly in low-resource settings. He is the Co-Founder and former Director of the Centre for Global Mental Health, London School of Hygiene and Tropical Medicine (LSHTM). He is the Co-founder and former Director of the Centre for Control of Chronic Conditions, Public Health Foundation of India and the Co-Founder and Member of the Managing Committee, Sangath, an Indian NGO which has pioneered task-sharing experiments in the areas of child development, adolescent health and mental health. Sangath won the MacArthur Foundation's International Prize for Creative and Effective Institutions in 2008 and the WHO Public Health Champion of India award in 2016. He founded and leads the Global Mental Health@Harvard intiative. He was supported by a series of Wellcome Trust Fellowships (UK) since 2000, and was awarded a Principal Research Fellowship in 2015. He is a Fellow of the UK's Academy of Medical Sciences. He has been awarded the Chalmers Medal, the Sarnat Prize, the Pardes Humanitarian Prize, an Honorary OBE and the John Dirk Canada Gairdner Award in Global Health. He has been awarded Honorary Doctorates from Georgetown University, York University and Stellenbosch University. He was listed in TIME Magazine's 100 most influential persons of the year in 2015.

He has served on four Government of India committees which include the Mental Health Policy Group (which drafted India's first national mental health policy, launched on October 10th, 2014); he also serves on several WHO Committees (Mental Health; Maternal, Child and Adolescent Health; High-Level Committee on NCDs). He was co-chair of the Scientific Advisory Board of the Grand Challenges in Global Mental Health of the National Institute for Mental Health, USA and was the Chair of the Disease Control Priorities Network group on mental, neurological and substance use disorders. His recent books include Patel, et al, Disease Control Priorities for mental, neurological and substance use disorders (World Bank, 2015); Thornicroft & Patel, Global Mental Health Trials (OUP, 2014); Patel et al, the School Counsellor Casebook (Byword, 2014); Patel et al, Global Mental Health: Principles and Practice (OUP, 2013). He is the Lead editor of the Lancet series on global mental health (2007 and 2011), the PLoS Medicine series on packages of care for mental disorders (2009) and the Lancet series on universal health care in India (2011). He is the co-editor of three Lancet Commissions (on global mental health, 2018; depression, 2022; and UHC in India, in preparation). He has 589 scientific articles published in peer reviewed journals and is ranked in the top 0.1% of scientists globally in terms of citations. He has delivered over a dozen named orations and a TED Global lecture. His book Where There Is No Psychiatrist has been translated in over 15 languages.

"This comprehensive work empowers healthcare workers in under-resourced and developing communities to build much-needed mental health care into all aspects of existing services."

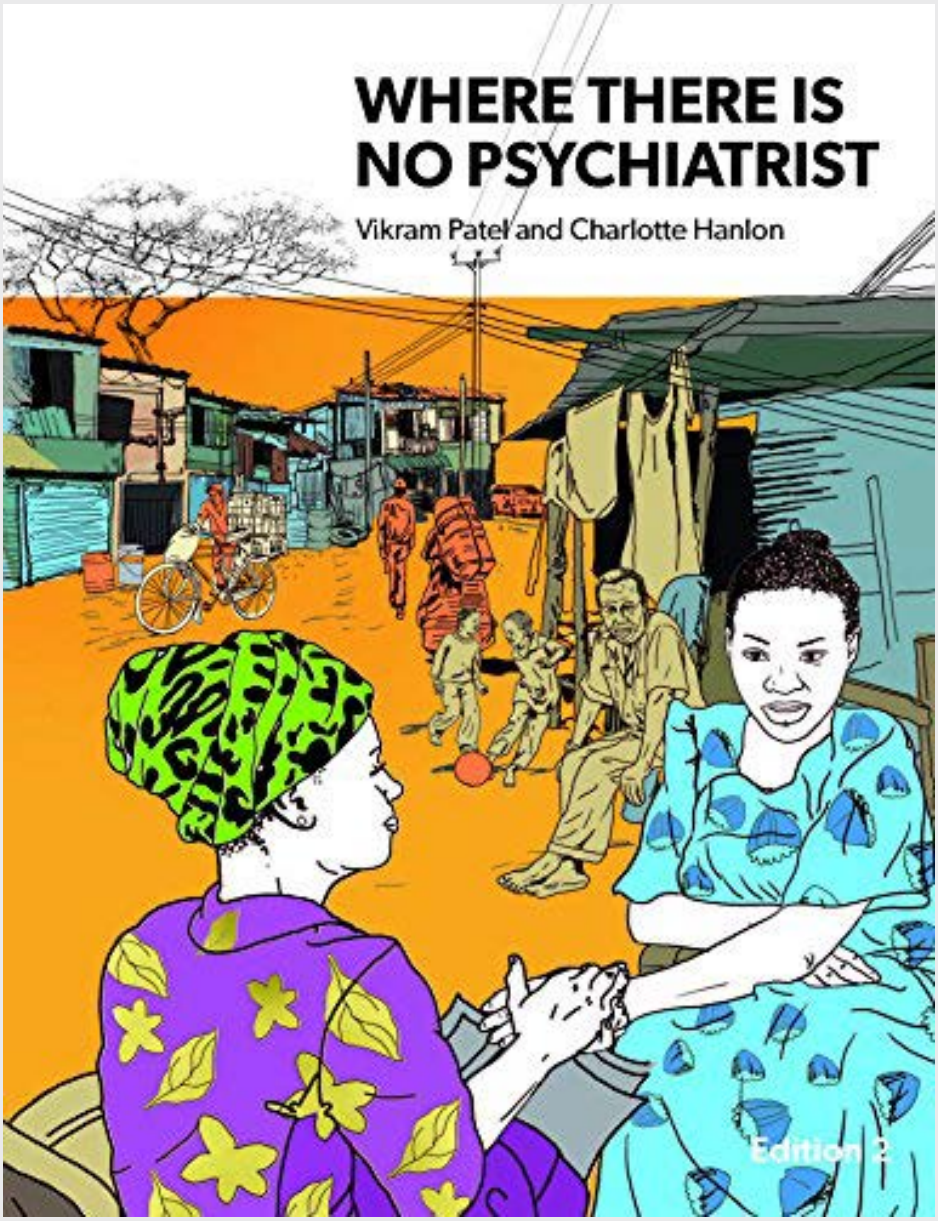
— Amazon.com review of "Where There Is No Psychiatrist"

Book Review

Edited by
Dr. Aysha Ahmad
Resident, Department of Psychiatry Dow Medical College, Karachi

WHERE THERE IS NO PSYCHIATRIST

Where There Is No Psychiatrist is a book written by Professor Vikram Patel. It was written for general health care workers on how to deal with specific mental health problems such as violence or disruptive behavior, addiction, issues particular to adolescents, elderly, and postpartum mental illnesses etc. The second reason behind writing it was one of the perceived obstacle of increasingly complex and technical language of psychiatry. This is still one of the stumbling block in achieving community mental health or informational care for the relatives of those with mental illness. In this book, the author attempts to break down the wall that psychiatry has built around itself, with the aim of liberating mental health from its hold. Although it was written few years ago it has maintained its utility in disseminating the information relevant to mental health in clinical care and research. It is hoped that this manual will continue to empower health workers to feel confident in dealing with the identification and



management of mental illnesses. Dr. Vikram Patel in his many years of service in Zimbabwe and India saw the need for a book which would meet the needs of health workers at many levels as they encounter a variety of mental health problems in clinical practice. He brings to this book both an Asian and African understanding of mental health problem. This manual is divided into four parts. The first part deals with the overview of mental illness (introduction to mental illness, assessment of mental illness and its treatment), the second part covers the common clinical problems (behaviors that cause concern, symptoms that are medically unexplained, habits that cause problems, problems arising from loss and violence, and problems in childhood and adolescence), the third part describes the integration of mental health with other disciplines (Mental health in other contexts and mental

health promotion and advocacy) and finally the fourth part includes the localization of this manual for a specific area (medicines for mental illness and local resources). One of the most interesting and detailed section in this book is that of behaviors which cause concern. It is highly relevant as most general physicians and other health care workers often struggle with properly identifying such behaviors and managing them appropriately. The most common of these concerning behaviors is that of a person who is aggressive or violent. Initial research suggested that around 40% of those attending a health center have a mental health problem as their primary problem.

Patient who is violent:

A common belief is that people with a mental illness are dangerous because they can suddenly become aggressive. In reality, they are no more dangerous than anyone else. It is true that, in some instances, the symptoms of a mental illness can lead to aggressive behavior, but this is rare.

Pescosolido et al surveyed the American public (N=1,444) using standardized vignettes to assess their views of mental illness and treatment approaches. Respondents rated the following groups as very or somewhat likely of doing something violent to others: drug dependence (87.3%), alcohol dependence (70.9%), schizophrenia (60.9%), major depression (33.3%), and troubled (16.8%). While the probability of violence was universally overestimated, respondents correctly ranked substance abusers among the highest risk groups. Similarly, they significantly overestimated the risk of violence among patients with schizophrenia and depression, but correctly identified these among the lower ranked groups.

Some important examples of how mental illness can lead to aggression from the Book are as following:

- Hearing voices and becoming angry.
- Being stopped from carrying out your plans and dreams.
- Being unable to get a drink in time.
- Suffering from confusion.

Substance abuse appears to be a major determinant of violence and this is true whether it occurs in the context of a comorbid mental illness or not. Those with substance use disorders are main actors in community violence, perhaps accounting for as much as one third of self-reported acts of violence, and seven out of every 10 crimes of violence among offenders who are suffering from a mental disorder.

The relationship between major mental illnesses such as schizophrenia and aggression, and violence, has been a topic of great debate over the last several decades. Extensive research on the stigmatization of mental illness shows that inflated public perceptions of violence in people with psychiatric illnesses make up the single most important predictor of stigmatizing attitudes about mental illness, as well as of behavioral avoidance of people with psychiatric disabilities (Angermeyer & Matschinger, 2003; Corrigan, Green, Lundin, Kubiak, & Penn, 2001b). In addition to previously stated information, the various forms of media often portray persons with psychiatric illnesses as violent, and these depictions further contribute to public perceptions of such individuals (Wahl, 1995).

Problems with aggression are not uncommon during the acute periods of a symptom exacerbation. In fact, people with psychiatric disabilities are more likely to hurt themselves than they are to hurt other people. Second, people with psychiatric disabilities, particularly schizophrenia, are more likely to engage in aggressive and violent behavior than people who do not have such disabilities are—but not nearly to the extent that many members of the general public believe. Third, the presence of substance use disorders and antisocial personality disorder in persons with psychiatric illnesses makes the scenario

more complicated, as these disorders are related to more aggression both in the general population and among persons with psychiatric disabilities. Therefore, the assessment of aggression and violence is a domain of concern in rehabilitation assessment. Few instruments have been developed for the measurement of violence or aggression in persons with psychiatric disorders. One scale is the Modified Overt Aggression Scale (Kay, Wolkenfeld, & Murrill, 1988), which provides an assessment of verbal, physical, and property aggression. This scale has support for its validity in persons with psychiatric disorders (Mueser et al., 1997b; Watts, Leese, Thomas, Atakan, & Wykes, 2003). Some instruments have shown to predict violence in persons with psychiatric disabilities (Monahan et al., 2000; Watts et al., 2004), but the role of these instruments in psychiatric rehabilitation practice is not yet established.

Current literature gives support to the early identification and treatment of substance abuse problems, and greater attention to the diagnosis and management of concurrent substance abuse disorders among seriously mentally ill as potential violence prevention strate-

gies. Rehabilitation centers should obtain a history of previous episodes of aggressive behavior and violence, based on personal report of the patient as well as collateral information from others. A positive history should be followed up with a more detailed assessment. It should focus on the understanding and delineating the circumstances in which those episodes occurred, and evaluating their level of severity. Particular attention should be given to the possible roles of medication noncompliance, antisocial personality disorder, substance abuse, and interpersonal conflict as factors contributing to aggressive behavior and violence, and rehabilitation that may reduce the likelihood of such incidents' occurring again should become a high priority.

STEPS TO IDENTIFY SIGNS OF IMPENDING VIOLENCE:

- talking louder or becoming abusive or threatening;
- fists opening and closing;
- breathing rapidly;
- fidgeting;
- tapping or punching or slapping tables, walls or the floor.

Patient who is confused:

Another important concern is that of patients who appear to be confused. Confusion is also called delirium in technical parlance.
The main features of a person who is confused are:

- She is not as aware of her surroundings as you would expect her to be
- She is not able to remember things that happened recently
- She does not know what day it is, or where she is
- She does not sleep properly at night and may be drowsy in the day
- She may be uncooperative or fearful
- She may suffer hallucinations and be suspicious
- She may be restless and aggressive.

Being confused is not the same as being muddled in thinking or talking about irrelevant matters. When people are muddled or irrelevant, they are still aware of what is going on around them.

Causes of Confusion and Agitation
Side Effects of some medicines especially in older people.
Withdrawals from Alcohol in a Dependent person.
A Brain illness: Stroke, Epilepsy, Head Injuries or Infections.
another medical illness, particularly high fevers, severe infections, dehydration, AIDS, breathing problems, kidney or liver disease;
Being drunk or high on drugs.
Severe anxiety or stress, such as after a sudden shock.

What to do immediately when dealing with a confused patient:

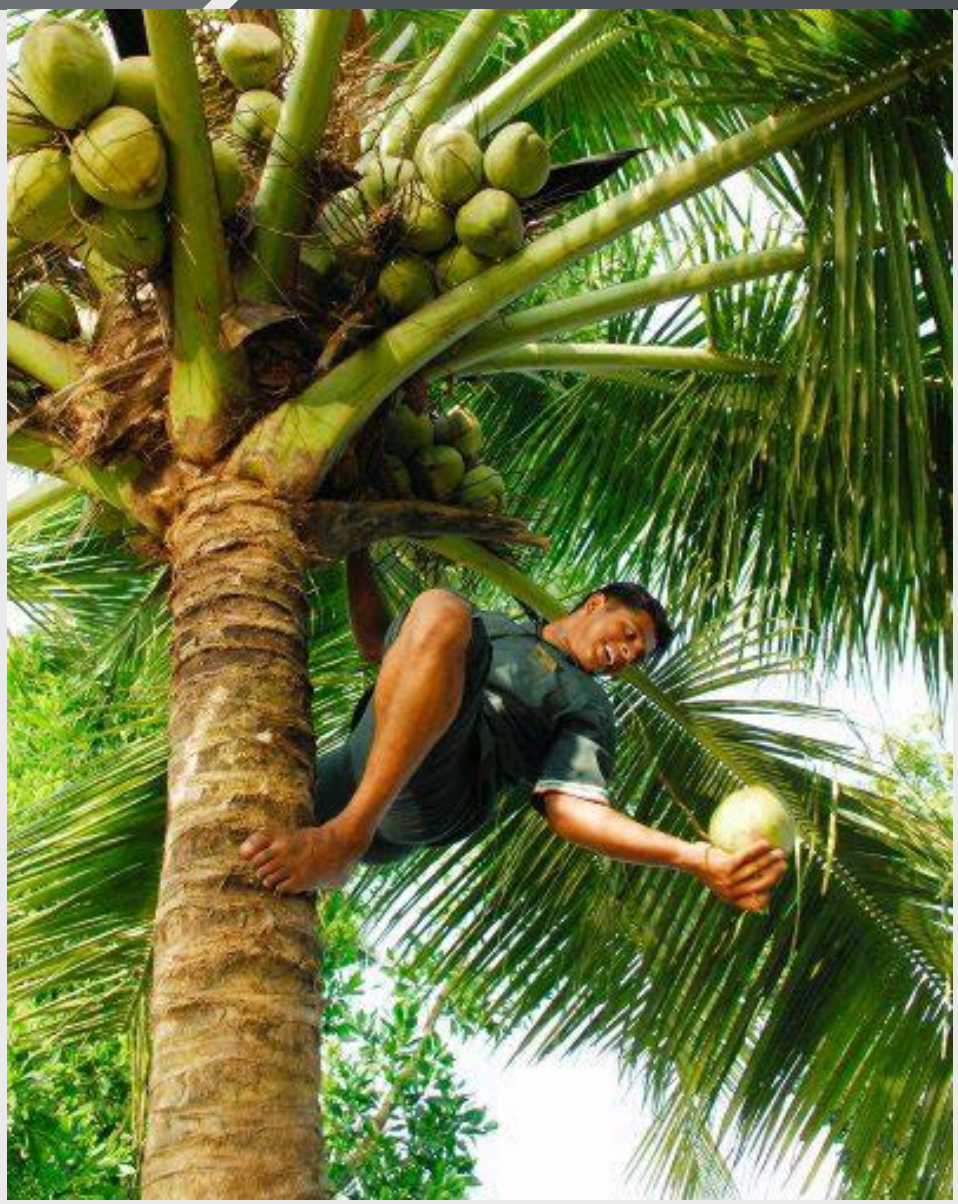
- Rule out an emergency that needs immediate medical attention. This would include serious infections, strokes or head injuries or alcohol withdrawal syndrome with complications such as fits. These conditions may need urgent transfer to a hospital.
- Place the person in a private room, if possible, with a health worker or relative to monitor him. The room should not be too dark or too brightly lit.

Things to remember when dealing with a person who has attempted suicide

1. Suicide is often due to mental illnesses such as depression or alcohol misuse.
2. Many people who attempt suicide have a severe life problem such as marital or financial difficulties.
3. Suicide is also associated with long-standing or serious physical illnesses.
4. Never take a suicide threat lightly.
5. Asking someone about suicidal thoughts does not make it more likely that they will end their life. On the contrary, most will feel relieved.
6. Emergency treatment of the suicide attempt is a priority. Once the person is medically stable, treat any mental illness and identify relatives or friends who can provide support.

- Keep the family well informed about what is happening.
- Make sure the person is taking enough fluids; if there is any concern about dehydration, insert an intravenous line for fluids. This line can also be used for medication.
- Remind the person where he is, and what day and time it is. Reassure him that he is safe with you in the clinic.
- Some confused people can become aggressive or hurt themselves, for example, by pulling out their intravenous tubes. You may need to restrain them on a clinic bed. Drugs can also be used to calm them – diazepam, 5–10 mg, by intramuscular injection three or four times a day, and then orally once the person improves, or haloperidol, 2.5–5 mg, by intramuscular injection three or four times a day, and then orally once the person improves.

Similarly there are many situations where proper identification and management is needed. Quite a few have been described by the author as follows:



Person who attempts self-harm or suicide:

In simple words the term "Suicide" means to end your own life. For most people who experience protracted distress, thoughts of suicide are fleeting and pass quickly; they are often a reaction to a recent unhappy event. Most individuals will talk it over with friends or relatives, or work out solutions to their problems and the thoughts will go away. For some, however, suicidal thoughts or plans become more persistent and are associated with mental illnesses and severe life difficulties. The following mental illnesses are associated with suicide:

- Depression. This is the most important cause of suicide.
- Alcohol and drug misuse.
- Long-term health problems.
- Severe mental disorders. People with a psychosis are also at a risk of ending their life through suicide.

Social and personal factors play an important role in the cause of the mental illness. Important social factors that can make a person unhappy and suicidal include:

- Unhappy relationships, particularly an unhappy marriage
- Poverty and economic difficulties, particularly when these happen suddenly, such as when a person loses a job
- losing a loved one, for example through bereavement
- Not having friends with whom to share problems and feelings. Teenagers may become suicidal when they fail in school or have fights at home with their parents.

According to the WHO, in 2015, about 800,000 suicides were documented worldwide, and globally 78% of all completed suicides occur in low- and middle-income countries. Overall, suicides account for 1.4% of premature deaths worldwide. During the second and third decades of life, suicide is the second leading cause of death. Completed suicides are 3 times more common in males than females; for suicide attempts, an inverse ratio can be found. Suicide attempts are up to thirty times more common compared to suicides; they're an important predictor of repeated attempts as well as completed suicides. On the whole, suicide rates vary among the genders and through different age groups, and the methods differ according to countries/regions.

The methods that are commonly used for self-harm are hanging, self-poisoning with pesticides, and use of firearms. Most of the suicides across the world are related to psychiatric illnesses. The most common associated disorders are, depression, substance use, and psychosis, however anxiety, personality-, eating- and trauma-related disorders as well as organic brain disorders significantly add to unnatural causes of death compared to the general population. Taken as a whole the matter is quite complex and underreporting is likely to be present. Keeping all this at the forefront, suicides can, at least partially, be prevented by restricting access to the means of suicide, by providing primary care physicians and general healthcare workers means and the proper training to identify at risk people, to assess and manage respective crises, provide adequate follow-up instructions and care as well as address the way this is

reported by the media. Suicidality represents a major societal and health care problem; therefore it should be given a high priority.

Person who has fits:

Seizures, convulsions or fits are when a person suddenly shows a change in behavior or consciousness lasting for a few minutes. In some seizures, there are shaking movements of the body (called convulsions), with loss of consciousness. There are also seizures in which the person may be fully or partly awake. The only changes may be short periods of losing touch with reality or repeated movements, such as smacking the lips. Epilepsy is an illness where seizures occur repeatedly. If a person has at least two seizures in a month, one can diagnose epilepsy. In adults, three types of seizures are recognized:

- **Generalized seizures.** These are seizures (also called grand mal or major epilepsy) in which the person loses consciousness for a few minutes. His body becomes stiff and shakes in jerky manner. This seizure may be associated with biting of the tongue, passing urine and injury because of the sudden fall or the movements.

- **Partial seizures.** These may occur in an awake person or in a person who is confused or has lost touch with her surroundings. The seizures are very varied in their nature. Some can be entirely localized to one area of the body, for example jerky movements of the arm. Other seizures may involve complex behaviors such as smacking the lips and buttoning and unbuttoning a shirt. Many people experience a warning or 'aura' that the seizure is about to start.

- **'Hysterical' or 'conversion' seizures.** These are more common in young women and are associated with psychological stress. Their characteristic is that they do not follow any typical pattern described above.

Epilepsy is not a mental illness. It is caused by electrical changes in the brain. However, epilepsy is often considered a mental health problem for many reasons. Many cultures consider epilepsy as being caused by supernatural forces, such as witchcraft, similar to some types of mental illness. In partial seizures, odd behaviors may be observed. Epilepsy can cause great stress on a person. Many people with epilepsy develop emotional problems. Psychoses, depression and suicidal behavior are all commoner in people with epilepsy. Finally, one type of seizure in adults (the conversion seizure) is entirely psychological in origin. Thus, it is important not to ignore the mental health needs of people with epilepsy.

Telling An Epileptic Seizure From A Hysterical Seizure

1. The epileptic seizure follows one of the patterns described earlier; the hysterical seizure is usually bizarre or variable in its pattern.
2. Cyanosis, tongue bite, frothing, self-injury and passing urine are typical features of epileptic seizures, but not of hysterical seizures.
3. People with hysterical seizures never lose consciousness. Even when they may appear to be unconscious, they resist attempts to comfort them, showing that they are still awake.
4. Sometimes, the same person may have both types of seizure; in such situations, extra care is needed before determining which type of seizure the person has had.

Telling A Seizure From A Faint

1. A seizure starts suddenly whereas a faint is gradual.
2. The duration of unconsciousness is usually only seconds in a faint, but at least a few minutes in a seizure.
3. Convulsions (i.e. jerky movements) are very rare in a faint but common in seizures.
4. Biting one's tongue, frothing at the mouth, passing urine and cyanosis (going blue) are seen only in seizures.
5. People recover quickly after a faint, whereas they may be drowsy or complain of a headache and confusion after a seizure.

Mental health concerns after delivery:

Pregnancy and the first year after childbirth (which collectively can be referred to as the perinatal period) is the most transformative period in a woman's life. This timeframe is a vulnerable period that presents a number of challenges for women. Specifically, an increased risk for onset or worsening of psychiatric illness including mood disorders, anxiety disorders and psychosis exists during the first three months postpartum. All types of psychiatric disorders can occur during the postpartum period, with many chronic disorders starting before pregnancy and persisting throughout pregnancy into the postpartum period. In pregnancy, depressive and anxiety disorders are common with recent population estimates of 11% for depressive disorders and 15% for anxiety disorders. Further, antenatal anxiety and depression are one of the greatest risk factors for postpartum psychiatric disorders (PPD). Inadequate social support and a history of adverse life events increases the risk for PPDs in all

countries and levels of society. However, this risk is increased in poorer socioeconomic populations and lower income countries, due to poverty and limited access to health care. In recent years, awareness of the potentially serious adverse consequences in both the mother and the baby associated with untreated perinatal psychiatric illness has increased. Maternal suicide due to postpartum mood disorders (including unipolar and bipolar depressive disorders) is a leading cause of maternal mortality. In addition, perinatal mood disorders are associated with an increased risk for low birth weight and premature birth, impaired mother-infant attachment, and infant malnutrition during the first year of life. Postpartum depression, comprising major depressive disorder and subthreshold depression, has an estimated point prevalence of 13% in high-income countries, and 20% in low-income and middle-income countries, 3 months postpartum. In women with a history of any eating disorder, the prevalence of postpartum depression has been estimated at 35%. Studies of postpartum depression often rely on self-reported questionnaires, including the commonly used Edinburgh Postnatal Depression Scale (EPDS). There is consensus that childbirth is a strong and potent risk factor for bipolar disorder. Indeed, the risk of underlying bipolarity in first-onset depression that occurs in the postpartum period is higher than in first-onset depression that occurs outside the perinatal period. In addition, women with bipolar disorder have a high risk of postpartum episodes, including depression, anxiety, mania and psychosis. The onset of a severe mental disorder requiring acute inpatient psychiatric treatment in the first postpartum months is ~1 per 1,000 births. In women with severe postpartum psychiatric illness, maternal suicide is often a predominate concern. Although maternal suicide is a leading cause of maternal mortality, the rates of completed suicide in postpartum women are lower than those in age-matched women without children. Nonetheless, the prevention of maternal suicide is paramount and requires careful monitoring during the postpartum period and possibly extending beyond the first year. For example, one study demonstrated that most postpartum suicides occurred between 9 and 12 months postpartum and that the perinatal suicides were by highly lethal means (such as via firearm), suggesting that limiting follow-up to 1, 3 or 6 months postpartum might be insufficient. Keeping in mind, the morbidity and mortality of postpartum psychosis, episodes of psychosis might be best considered to represent women having a bipolar disorder with a puerperal trigger. Understanding this trigger will be of key note and should allow the development of new treatments and, eventually, enable the prevention of psychosis or prevent unfavorable outcomes in women at high risk. Effective evidence based treatment approaches are available for psychosis and depression, including psychopharmacology, psychotherapy and ECT and circadian manipulation. However, postpartum depression and postpartum psychosis require different and targeted treatment approaches and therefore, bipolarity must be considered in the evaluation and management of all women with postpartum mood and anxiety disorders. In addition, primary treatment goals should include the limitation of the current episode and the prevention of future episodes (including unipolar or bipolar disease with multiple episodes, and chronic anxiety). Whether there a continuum of severity between postpartum depression and postpartum psychosis, or whether these disorders represent different conditions with different etiological factors requires further study. A potential barrier to the engagement and retention of women in the treatment of postpartum mood disorders is stigma. Understand this stigma and the fear that women have regarding postpartum mood disorders is essential. The voices of women with postpartum mood disorders must be incorporated into the development of services to ensure the needs of women, their infants and families are met In each of the scenarios described above as well as shown in tabular form, this book aims to educate the general medical practitioner and other health care workers about what exactly is the behavior that they are dealing with, its root causes, the special interview techniques as well as investigations, the immediate management, possible complications and when to refer the patient to a specialized unit. This book was written after the author's experiences working in Middle and Lower Income Countries where the impact of culture and societal factors on mental health and its various disorders was observed. It was to integrate common mental health phenomena into primary care and to remove unnecessary jargon to make it easier for the general practitioners and health care workers to be able to help the patients in need. Dr. Vikram has worked extensively on transcultural psychiatry, child and adolescent psychiatry, and global mental health. Global mental health is defined as a discipline of global health and, as with the mission of global health, its primary goal is to improve the health of people worldwide, with a strong focus on equity and access. There is no health without mental health and that mental health and physical health interact with each other in very diverse and intimate ways. Therefore, any attempt to improve the mental health of individuals and populations will inevitably have a positive impact on the physical health of those individuals and populations.

"There is no health without mental health. I think we know, through a large body of evidence that mental health and physical health interact with each other in very diverse and intimate ways. Therefore, any attempt that we make to improve the mental health of individuals and populations will inevitably have a positive impact on the physical health of those individuals and populations. Therefore, investing in global mental health is, ultimately, an investment in global health."
-Dr. Vikram Patel

REFERENCES:

1) Where There is No Psychiatrist by Dr. Vikram Patel
2) Stuart H. Violence and mental illness: an overview. World Psychiatry. 2003 Jun;2(2):121.
3) Principles and Practice of Psychiatric Rehabilitation: An Empirical Approach by Patrick W. Corrigan 2nd Edition.
4) Bachmann S. Epidemiology of suicide and the psychiatric perspective. International journal of environmental research and public health. 2018 Jul;15(7):1425.
5) Meltzer-Brody S, Howard LM, Bergink V, Vigod S, Jones I, Munk-Olsen T et al. Postpartum psychiatric disorders. Nature Review Disease Primers. 2018 Apr 26.