Prepared for integrating of Adolescent Health and Development Domains into pre-service nursing curriculum at The Hong Kong Polytechnic University, World Health Organization Collaborative Centre for Community Health Services. Supported by WHO, Western Pacific Regional Office

Module 5
Understanding of Mental Health and Illness in Adolescents

I. Introduction

The mental health of our adolescents is an issue of global concern: there is a growing incidence of adolescent mental health problems in the world, the impact of which is very high in psychological, social and economic terms. The state of mental health can be described as a continuum between mental well-being and mental illness. At one end of the spectrum is complete mental health and at the other end is mental illness, but the cut-off between the normal and the abnormal is very hard to define. According to the World Health Organization, mental health is an integral component of health through which a person realizes his or her own cognitive, affective and relational abilities; these abilities enable the person to cope effectively with the stresses of life, and to work productively and fruitfully towards making a contribution to their community (WHO, 2001).

II. Learning Objectives

Upon completion of this module, learners will be able to:

1. Describe the epidemiology of mental illnesses in adolescents.
2. Identify some mental illnesses that are common in adolescents.
3. Describe factors contributing to psychosocial and mental health, and those leading to mental health problems.
4. Recognize and provide initial management of common mental illnesses.
5. Apply appropriate interview skills to collect information on psychosocial history and to identify psychosocial problems in adolescents

Sources:

1. World Health Organization. (2009). World Health Organization: Adolescent Job Aid. World Health Organization.
2. World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Facilitator Guide - New Modules. World Health Organization.
3. World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Handout - New Modules. World Health Organization.

III. Contents

Upon completion of this module, learners will be able to:

- Describe the epidemiology of mental illnesses in adolescents.
- Identify some mental illnesses that are common in adolescents.
- Describe factors contributing to psychosocial and mental health, and those leading to mental health problems.
- Recognize and provide initial management of common mental illnesses.
- Adopt appropriate interview skills to collect information on psychosocial history and to identify psychosocial problems in adolescents.

Objective 1: Describe the epidemiology of mental illnesses in adolescents

Activities

Activity 5.1: Group discussion

List behavioural problems belonging to the normal adolescent developmental process, which are transitory in nature and which do not indicate mental illness.

Discuss the influence of culture and context in the assessment of problematic behaviour.

Adopt from World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Facilitator Guide - New Modules. World Health Organization.

Activity 2.3: Global Impact of Mental Illness during Adolescence

Now we will consider the impact of mental illness during adolescence.

Slide L2-7

Global Impact of Mental Illness during Adolescence

1. Mental disorders: four of the ten causes of disability worldwide for all people
2. Data not disaggregated into adolescent age group.
3. Mental illness: large proportion of the disease burden for young in all societies
4. Suicide: leading cause of death in young people
5. Most mental health needs in adolescents are unmet.

Reference: The World Health Report 2001 - Mental Health: new understanding, new hope

Talking Points

1. Globally and for people of all ages, mental disorders represent four of the ten leading causes of disability. Mental and behavioural disorders are estimated to account for 12% of the global burden of disease. Around 20% of all patients seen by primary health care professionals have one or more mental disorders.

2. It is difficult to accurately assess the global scope of adolescent mental illness because most data on mental health does not separate out adolescents from the data for children or adults. However, it is clear that there are adolescents in every country and every culture who suffer from mental health problems.

3. Mental illness represents a large proportion of the disease burden in young people for all societies. Around 20% of the world's children and adolescents are estimated to have mental disorders or problems, with similar types of disorders being reported across cultures. About half of all lifelong mental disorders commence before 14 years of age and 70 per cent by age 24.

   It is estimated that one in every four or five young people will suffer from at least one mental disorder each year. Mental and behavioural disorders of childhood and adolescence are very costly to society in both human and financial terms because many of these disorders can be precursors to much more disabling disorders later in life.

4. Globally, suicide is the third leading cause of death among adolescents. The most common mental disorder leading to suicide is depression. There is evidence that adequate prevention and treatment of some mental and behavioural disorders can reduce suicide rates. Interventions need to be directed at individuals, families, schools and other sectors of the general community.

5. Most mental health needs in adolescents are unmet, even in high-income countries. The budget for mental health is less than 1% of the total health expenditure in many countries. The promotion of mental health is crucial during adolescence. Early recognition and treatment of mental disorders in adolescents should be a priority to ensure successful treatment and long-lasting recovery.

Say: Meeting young people's mental health needs is essential if they are to fulfil their potential and be able to contribute fully to the support and development of their families and communities.
Mental and behavioural disorders can have a tremendous impact on individual adolescents, their families and their communities.

Indicators of mental health in adolescents

- a capacity to initiate, develop and sustain mutually satisfying personal relationships
- a capacity to maintain healthy relationships with family members
- an ability to develop psychologically, emotionally, creatively, intellectually and spiritually
- an ability to develop a sense of moral right and wrong
- a capacity for managing internal and external challenges
- being productive in learning and work
- a sense of self-identity and of self-worth

Adolescent psychopathology

Psychopathology refers to "patterns of behaviours, cognitions, and emotions that are abnormal, disruptive, or distressing either to the person or others around the person" (Phares 2003, p. 2).

There are two classification systems currently used to denote specific types of psychopathology. They are the Diagnostic and Statistical Manual of Mental Illnesses of the American Psychiatric Association, 4th edition Revision (DSM-IV-TR) and the International Classification of Diseases, 10th edition (ICD-10).

The common mental illnesses affecting adolescents and described in the classification systems are depression, suicide, schizophrenia, eating disorders, learning disabilities, epilepsy, and substance abuse.

Mental health-mental illness continuum

People are judged to have a mental illness when their behaviour becomes extremely deviant, maladaptive or distressing.

Adopt from World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Facilitator Guide - New Modules. World Health Organization.

Activity 2.1: Mental Health and Mental Illness during Adolescence
Mini Lecture

Display Slide L2-1.
Say: This slide shows the spectrum of mental health.

Read the slide aloud.

Slide L2-1

Spectrum of Mental Health

The whole spectrum of mental health ranges from states of mental well-being to diagnosable mental disorders. Here is a summary of the spectrum:

1. Mental Health:

- A state of mental well-being in which the individual can realise his or her potential.
- More than just the absence of mental illness.

2. Mental Health Difficulties or Problems

- Can be part of normal adolescent development.
- Does not meet diagnostic classification of disorders: different duration, severity and impact.

3. Mental and Behavioural Disorders

- Clinically significant mental health conditions ie those that meet the diagnostic criteria.

Say: We will now look at a slide for each of these three points in detail.

Show Slide L2-2.
Read the slide and then go through the talking points.

Slide L2-2

1. Mental Health

A state of well-being in which the individual can:

- realise his or her potential,
- cope with the normal stresses of life,
- study or work productively, and
- be part of his/her community's life.

Mental health is more than an absence of mental illness.

Talking Points

1. **Mental Health**

It is important to define what we mean by mental health and to know that the majority of adolescents have good mental health. The majority of adolescents are able to realise their potential, cope with the normal stresses of adolescent life, work and study productively, and are able to be part of their communit's life and later make a contribution to their community.

The positive dimension of mental health is stressed in WHO's constitution where health is defined as: "… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Ask if there are any questions and respond.

Show Slide L2-3 and go through the talking points.

Slide L2-3

2. Mental Health Difficulties or Problems

These can be part of normal adolescent development causing:

- variations in mood (for example becoming aloof and withdrawn or antagonistic and rude, or susceptible to bursts of anger)
- temporary deviant behaviour (for example breaking rules that were previously adhered to)
- negative effect on development and quality of life

Distinguished from more serious disorders because the difficulties or problems:

- do not meet diagnostic classification
- are of different duration, severity and impact

Talking Points

2. **Mental Health Difficulties or Problems**

Mental health problems can reflect chronic difficulties but adolescents also experience a range of physical, social and psychological events that are new and unexpected. They may find some of these events distressing and they may struggle to cope with the impact.

This struggle can cause variations in their moods and periods of temporary deviant behaviour, which are part of normal adolescent development. Adolescents may experiment with "delinquent" behaviours as part of normal exploration of their own identity. It is also normal for young people to feel depressed from time to time and for this mood to last for a few days.

However, if these difficulties interfere with the adolescent's development, or if they adversely affect their quality of life emotionally, socially, or vocationally, it becomes important to seek help.

Mental health difficulties or problems can be distinguished from more serious mental health disorders because they do not meet a diagnostic classification and also because of their shorter duration, because the problem does not persist, and because the impact of the symptoms are less severe. Although it is common for young people to experience mental health difficulties or problems that require professional help, it is much less common for adolescents to be affected by a serious mental illness or disorder.

The duration and severity of these behaviours and the distress caused can affect the adolescent's mental health either mildly, moderately, significantly or acutely. This is important for determining whether the adolescent can be cared for at the primary health care level or if they need referral to psychiatric services, if these services are available.

Show Slide L2-4 and go through the talking points.

Slide L2-4

3. Mental and Behavioural Disorders

Clinically significant conditions characterized by:

- Alterations in thinking, moods (emotions), or behaviour associated with distress and/or impaired functioning that require referral to psychiatric services for management
- A range of mental and behavioural disorders that are clearly abnormal
- International Classification of Diseases (ICD10)
-

3. Mental and Behavioural Disorders

Adolescents can experience emotions, thoughts and behaviours that are distressing and disruptive. Often these represent normal phases of development, however when these signs and symptoms are frequent or severe, or last for more than 2 weeks, they may indicate a mental disorder.

Mental and behavioural disorders are defined as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behaviour that satisfy all the essential criteria established for each of the disorders. They are associated with personal distress and impaired functioning.

Mental disorders are characterized by specific signs and symptoms and usually follow a predictable natural course, unless interventions are made.

An individual can appear very distressed due to personal or social circumstances, but unless all the essential criteria for a particular disorder are satisfied, it is not classified as a mental disorder.

Mental and behavioural disorders are not just variations within the range of 'normal', but are clearly 'abnormal' or 'pathological' phenomena. One incident of abnormal behaviour or a short period of abnormal moods still does qualify as a mental disorder. Abnormalities must be sustained or recurring and they must result in personal distress and/or impaired functioning in one or more areas of life.

The International Classification of Diseases (ICD10), published by WHO, provides a complete list of mental disorders, including definitions, clinical descriptions and diagnostic guidelines. These clear definitions of mental and behavioural disorders have been classified using clinical methods similar to those used for physical disorders.

This international standard for diagnostic classification is applicable cross-culturally. Diverse ways of thinking and behaving across cultures may influence the way mental disorders manifest but are not, by themselves, indicative of a disorder. Culturally determined normal variations are not mental disorders, nor are social or political beliefs evidence of mental disorders.

There is more information on the ICD10 in the handout Section 2.1.4.

Review the definitions of the 3 terms on Slide L2-1. Also review slides L2-2, L2-3 and L2-4 if necessary.
Say: These definitions are important to understand. All this information is also in your handout, Section 2.1.

In this training we will also use the shorter term "mental illness" when discussing general issues that refer to both mental health difficulties or problems, and mental and behavioural disorders.

Ask: Is there anything you would like to ask or add?
Allow some discussion and then move on.

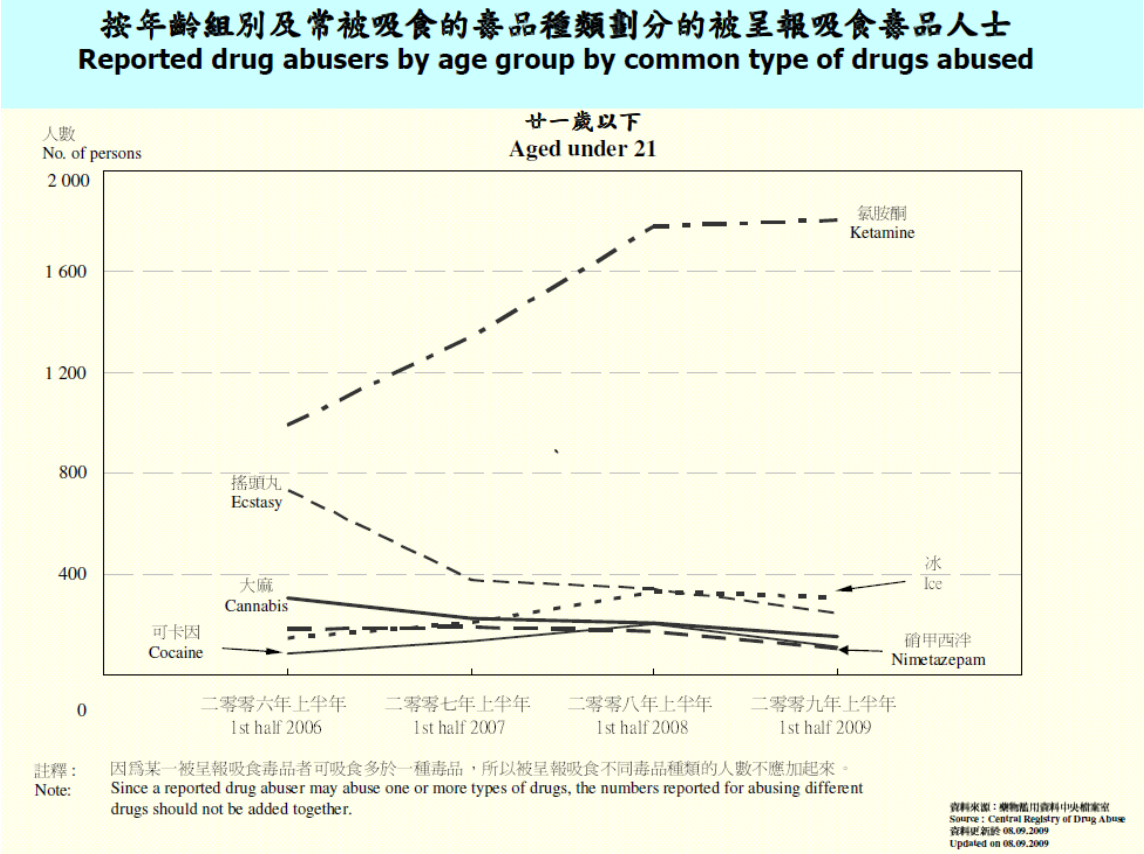
Depression

In 1988, Kashani and Sherman conducted epidemiological studies in the United States that revealed the incidence of depression in adolescents to be 4.7%. In a randomly selected sample of high school students, 22.3% of female and 11.4% of male high school students reported one current or lifetime episode of unipolar depression. The percentage of male and female students who had experienced 2 or more episodes was 4.9% and 1.6% respectively. In 1997, Garrison et al. conducted a study of adolescents aged 11-16 years in the south-eastern United States and found that the 1-year incidence of major depression was 3.3%. As these studies demonstrate, the occurrence of depression is not rare and is encountered regularly in pediatric and psychiatric practice (Benton & Lynch, 2004).

Drug abuse

Hong Kong is taken as an example for studying drug abuse. According to the findings of the Hong Kong Sheng Kung Hui Welfare Council (2002), there is a trend toward substance abuse among some adolescents in Hong Kong. Some of the Council's main findings are as follows:

1) 2% of Hong Kong adolescents are considered high risk because some of their friends are drugs users, therefore there is a higher chance that they will be forced to try drugs.
2) Most adolescents have the wrong idea about drugs; some believe they can dance better after taking drugs, or that drugs can solve their problems and depression and make them feel better.
3) The three principal drugs that drug users use are "K" (ketamine), "Fing Head" Ecstasy and "grass" (cannabis). Places where adolescents can easily take drugs are Hong Kong discos, mainland discos and friends' homes.
4) Among adolescent drugs users, 70% mix drugs with alcoholic drinks, which increases the risk of danger.
5) It was found that some adolescents, especially girls, can obtain drugs for free.



Suicide

In the United States it is the third leading cause of death among people aged 15 – 24 years of age. If there is no available channel of ventilation, suicide attempts may occur with the intention of seeking help. This is a particular risk to adolescents.

In China, the reported adolescent suicide rates have increased alarmingly in recent years. From 14 anonymous self-reported questionnaires studied by Gao et al. (2004), the rates of suicide ideation in adolescents were 15% to 27.1%, and the rates of actually attempted suicide were 1.9% to 9%. Depression and other psychiatric disorders, family conflicts, academic achievement, coping strategies, stressful life events, and poor quality friendships are key factors for adolescent suicidal behaviours. Intervention highlighted psycho-treatment, mental health education and consultation for adolescents

Eating disorders

- Anorexia nervosa
  This is a condition mostly seen in young women, and one which has become increasingly prevalent. Most anorexics are bright achievers in their teenage years. Males may also suffer from this disorder. The age of onset is usually in late adolescence, with occasional cases of onset at the age of eight to eleven. It occurs mainly in upper middle-class families, but sufferers may also come from any socioeconomic group.

- Bulimia nervosa
  The onset of bulimia nervosa usually occurs in adolescence or early adulthood, as many adolescents feel insecure abut their physical shape or body image with reference to perceived social values or norms. It usually affects adolescents or young adults between 17 and 25 years of age.

Learning disabilities

There are children who display superior intelligence and adequate schooling, but are diagnosed as “learning disabled” because they have great trouble acquiring a certain skill and lag significantly behind other children of their age in some areas of intellectual development. These children may have specific developmental disorders in reading, writing, spelling, speaking, calculating or other skills needed to do well in school.

It is estimated that about 10 percent of children suffer from these problems. Boys outnumber girls by around 2 to 3 among children with learning disabilities

Alcohol abuse

Younger drivers have more than their share of alcohol-related accidents. In 1994, young people aged 16-24 made up 14% of the U.S. population, yet were involved in 28% of alcohol-related traffic accidents. This is because they have comparatively little experience with alcohol (tolerance) or with driving.

Objective 2: Identify some mental illnesses that are common in adolescents

Refer to World Health Organization. Orientation Program on Adolescent Health for Health-care Providers. Facilitator Guide - New Modules. (Module L – Mental Health)

Refer to World Health Organization. Orientation Program on Adolescent for Health-care Providers. Handout - New Modules. (Module L – Mental Health)

Activities

Activity 5.2: Role play: Personal reflection

1. You suspect that one of your friends has problems with alcohol. How are you going to help him/her?

2. One of your classmates is not feeling happy recently because of poor academic results last semester. He says that he did all he could to do well in his studies, and it didn't seem to work out. He believes that only "drugs" can relieve his unhappiness. How will you help him?

Please divide yourselves into groups to perform a short role play exercise. During each interview, there is a health care worker who conducts a series of sessions (not more than 4) of counselling with a client who has had some minor personal problems recently.

After you have completed the course of counselling, please prepare a brief counselling report with the following information:
1. A summary of intake information / initial data obtained
2. A statement of the "client's" problem, with the associated factors
3. A plan of your proposed counselling strategy and schedule
4. A brief evaluation and suggestion, including possible referral to other professionals or community resources.

Commonly seen mental health conditions

In most situations, the diagnosis of mental health problems depends greatly on a client's manifested symptoms. Some common mental illnesses in adolescents are:

- Depression
- Suicide
- Schizophrenia
- Eating disorders
- Learning disabilities
- Epilepsy
- Substance abuse

1. Depression

Depression is an emotional disorder involving an overwhelming feeling of hopelessness and inadequacy; it is usually accompanied by a general retardation of psychomotor activity to the point of distress.

Signs and symptoms of depression:

– withdrawal
– quietness
– no interest in normal activities
– sudden outburst of aggressive behaviours
– loss of interest in school
– difficulty concentrating on school work
– not eating or sleeping properly
– weight loss
– somatic symptoms of headaches and/or stomachache

2. Suicide

Suicide refers to a person who intentionally kills himself / herself. From certain aspects, suicide is considered more preventable than any other cause of death. Assessment of **persons at risk** for suicide includes the application of skills in close observation and empathetic listening to detect possible **clues** and / or the specificity of any plan of deliberate self-harm.

3. Schizophrenia

Schizophrenia is a major mental illness which expresses itself in disorder of feelings, behaviour and thought, with increasing withdrawal of interest from the environment. These psychotic disturbances commonly lead to slow disintegration of the entire personality.

The actual etiology of schizophrenia is still not exactly known. However, there are several factors which have been associated with its causation. There is a complex interplay between **heredity**, **environmental**, **biochemical** and **psychosocial** factors which seems to affect the occurrence and development of the illness.

Clinical symptoms
These usually occur among people from their late teenage years to 45 years of age, with diagnosis made primarily between 17 and 27 years of age.

The symptoms fall characteristically into 2 broad categories: positive and negative.

- Positive symptoms
  - Global distortion of normal functions
  - Delusion
  - Persecutory, referential, somatic, religious, or grandiose ideas
  - Conceptual disorganization
  - Hallucinations: auditory, visual, tactile, olfactory and gustatory
  - Grandiosity
  - Excitement
  - Suspiciousness or persecutory delusions?
  - Hostility

- Negative symptoms
  - Diminution or loss of normal functions
  - Emotional withdrawal
  - Blunt affect
  - Passivity or apathetic behaviour
  - Social withdrawal or lack of volition
  - Difficulty in or loss of ability in abstract thinking (loosening of associations)
  - Lack of spontaneity and conversation (logia)
  - Stereotyped thinking
  - Poor rapport with others

4 .Eating disorders

Eating illnesses are characterized by severe disturbances in eating behaviour according to DSM-IV. There are two specific illnesses: anorexia nervosa and bulimia nervosa.

Anorexia nervosa
The DSM-IV description states that there is an intense fear of becoming obese in anorexics, although weight loss occurs. It is characterized by an aversion to food, and may result in death as a result of serious malnutrition. There is intense weight loss of up to 25% of the original body weight.

- Exhibited symptoms
  - Dry, flaky or cracked skin
  - Brittle hair and nails
  - Amenorrhoea or menstrual irregularity
  - Hypothermia
  - Constipation
  - Intense fear of becoming obese
  - Loss of appetite
  - Dehydration, malnutrition with electrolyte imbalance and cardiac arrhythmias
  - Distorted body image
  - Depressed mood

Bulimia nervosa
This is considered as episodic binge eating with rapid consumption of a large amount of food in a short time. The person is aware that this behaviour is abnormal, yet afraid of his/her inability to stop eating voluntarily; the person is self-critical, and may experience depression after each episode.

- Exhibited symptoms
  - Consumes high-calorie, easily ingested food, and eats inconspicuously
  - Terminates binging or gorging by self-induced vomiting or engaging in social activities
  - May have repeated attempts to lose weight by:
    - fasting or dieting
    - abusing laxatives, enemas or diuretics
    - self-induced vomiting
    - consuming over-the-counter medications
  - weight fluctuation
  - **related complications**

5. Learning disabilities

A specific learning disability may refer to a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself as an inability to listen, speak, read, write, spell or do simple calculations.

This includes conditions like **dyslexia**, developmental **aphasia** and perceptual handicaps. However, it does not include children whose learning problems are the result of visual, hearing or motor handicaps, or mental retardation.

6. Epilepsy

Epilepsy or convulsive seizure is a manifestation of abnormal, rapid and uncontrolled neuronal electrical discharges within the brain. It is characterized by sensory, motor and autonomic disturbances. With the phenomenon of paroxysm, there are often accompanying changes in the level of consciousness.

There are several accompanying phenomena:
- Loss or derangement of consciousness or memory
- Excess or loss of muscle tone or movement
- Disturbance of the autonomic nervous system
- Alteration of sensation, including hallucination
- Other manifestations, including altered thought processes and moods

It is worth noting that a person with symptoms of epilepsy may have normal brain wave tracings on electroencephalogram (EEG) examination, and thus repeated EEG studies may be necessary.

7. Substance abuse

Abuse is described as using alcohol or drugs for the purposes of intoxication, or in the case of prescription drugs, for purposes beyond their intended use.

DSM IV Criteria for substance abuse

A maladaptive pattern of substance-use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or
- Recurrent substance use in situations in which the substance is physically hazardous
- Recurrent substance-related legal problems
- Continued substance use despite having persistent or recurrent social or interpersonal problems
- The symptoms have never met the criteria for substance dependence for the class of substance

Adolescent drug abuser

The homeostasis, or equilibrium, of the body chemistry has adapted to the drug or combination of drugs being taken. It is characterized by an outright non-acceptance of any confrontation that openly and honestly portrays the factual consequences of drug usage.

Adolescent alcohol abuser

Among college drinkers, there might be a slightly increased incidence of some alcohol-related problems, such as fighting, vandalism, poor grades, trouble with police, missing class because of hangovers, and sex. Alcohol withdrawal refers to **a group of symptoms** that may occur from suddenly stopping the use of alcohol after chronic or prolonged ingestion.

People at risk for suicide

- Elderly and adolescents
- Older divorced, separated or widowed persons
- Unemployed persons
- People with poor physical health
- Socially isolated individuals
- Members of minority groups
- Chronically or terminally ill people
- People with a previous history of suicide

It may be considered a suicidal clue when a person:

- Talks about death, suicide, and wanting to be dead
- Asks suspicious questions such as "How many of these pills would it take to kill a person?" "How long does it take to bleed to death?"
- Fears being unable to sleep or is afraid of the night
- Is overtly depressed and cries frequently
- Keeps away from others, especially in secluded areas
- Imagines that s/he has some serious physical illness like cancer
- Reveals intense feelings of guilt toward something real or imaginary, or feels worthless
- Talks or thinks about punishment, torture, or being persecuted
- Appears overtly elated or happy suddenly, with no apparent reason, after being unduly sad and depressed for a long time
- Gives away cherished personal belongings
- Appears to be greatly impulsive, and / or acting in a surprising way

Heredity factors

There is evidence from genetic studies that hereditary factors play an important role in the development of schizophrenia. Some studies have shown that it is possible, by analogy with other common familial diseases, that major genes operate in a subset of families with multiple affected members.

Environmental factors

This suggests that people who develop schizophrenia have a faulty reaction to the environment and are unable to respond selectively to numerous social stimuli. People who come from poor socioeconomic areas or single-parent homes in deprived areas do not have the chance to experience achievement. In response to such a negative environment, such people tend to fantasize and create their own "play-world" in their childhood days of development.

Biochemical factors

Genetic (hereditary) predisposition
This suggests that children of schizophrenic parents are more apt to develop schizophrenia than children born to normal parents.

Biochemical predisposition
Substances similar to hallucinogens, which accumulate excessively in the body, may be a possible factor leading to the development of schizophrenia through raising dopamine levels.

Psychosocial factors

Proponents of this concept state that schizophrenia develops early in life because of various stressors. Among these are poor mother-child relationships, disturbed family interpersonal relationships, impaired sexual identity and body image, rigid concepts of reality, and repeated exposure to double-bind situations (a no-win experience in which there is no correct choice).

Possible complications

- Chronic inflammation of the oesophageal lining
- Rupture of the oesophagus
- Dilatation or rupture of the stomach
- Electrolyte imbalance with cardiac arrhythmias, or metabolic alkalosis
- Dehydration
- Dental erosion
- Irritable bowel syndrome or abnormal dilatation of the rectum

Dyslexia

- Difficulty in reading

Aphasia

- Difficulty in speaking and pronunciation

Groups of symptoms

Mild to moderate psychological symptoms
- Feelings of jumpiness or nervousness
- Feelings of shakiness
- Anxiety
- Irritability or getting easily excited
- Emotional volatility, rapid emotional changes
- Depression
- Fatigue
- Difficulty thinking clearly
- Bad dreams

Mild to moderate physical symptoms
- Headache - general, pulsating
- Sweating, especially the palms of the hands or the face
- Nausea
- Vomiting
- Loss of appetite
- Insomnia, sleeping difficulty
- Paleness
- Rapid heart rate (palpitations)
- Eyes, pupils different size (enlarged, dilated pupils)
- Skin, clammy
- Abnormal movements
- Hand tremors
- Involuntary, abnormal movements of the eyelids

Severe symptoms
- A state of confusion and (visual) hallucinations -- known as delirium tremens (“the DTs”)
- Agitation
- Fever
- Convulsions
- "Black outs" -- when the person forgets what happened during the drinking episode

Objective 3: Describe factors contributing to psychosocial and mental health, and those leading to mental health problems

Activities

Activity 5.3: Group discussions

Identify strategies to promote mental health and to prevent the occurrence of mental health problems.

Factors influencing mental health in adolescents

The causes of adolescent mental health problems are often multi-factorial in origin, with several factors interacting together to lead to a problem.

Biological factors
- genetic
- chromosomal abnormalities
- developmental (e.g. malformations of the brain)
- medical illnesses, especially neurological (affecting the brain and nervous system) or endocrine (hormonal)
- physical and chemical trauma (especially affecting the brain)
- metabolic illnesses (causing, for example, biochemical imbalance)
- toxic illnesses (substance use, heavy metals such as lead, and chemicals)
- dietary deficiencies (e.g. vitamins)

Psychological factors
- Low self-esteem
- Poorly developed coping mechanisms
- Maladaptive personality traits
- Temperament (e.g. difficult temperaments are predisposed to behavioural/ conduct problems, slow-to-warm-up temperaments are predisposed to emotional problems)

Environmental factors
- Family (e.g. poor parenting style, parental relationship difficulties, parental mental health problems, pathological communication)
- School (e.g. study stress, heavy schoolwork, school failure, negative experience)
- Peer (e.g. rejection by peers, influence of peer culture)
- Culture (e.g. influence on the expression of emotion and behaviours)
- Community (e.g. urbanisation, with increased exposure to violence, crime and stress-related illnesses, economically disadvantaged areas)
- Life events (e.g. bereavement, road accident)

Factors contributing to mental health problems

There are a multitude of etiologies that contribute to the development of mental health problems, including intrinsic and extrinsic factors. The relative importance of such factors varies according to the type of illness as well as the individual.

Genetic factors

A number of mental health problems are genetically determined, while some with a specific predisposition are determined by a single gene. Still there are some that may be determined by a large number of genes.

Genes produce their effects by controlling the enzyme systems and hence the chemical status of the body. For instance, schizophrenia and depressive illness are believed to be caused by an underlying biochemical disturbance inside the body.

Physical constitution

Various types of physique are believed to be correlated with personality.

Personality

This shows some but not complete correlation with particular illnesses. These include schizothymic and schizoid personality, cyclothymic, obsessional, hysterical, etc. The correlation is not close, as there are many people with these types of personality who never develop the type of illness to which they are allegedly predisposed.

Extrinsic causes

These may include infections, physical injury, intoxication, malnutrition and avitaminosis. Certain infections, toxic states and traumatic conditions may result in permanent damage to the brain and cause disorders such as dementia.

Psychosocial stresses

The experience of certain psychosocial stresses such as bereavement, the loss of a loved one, financial strain and loss of prestige or status may all have great impact on a person, predisposing him/her to mental illness or disorder.

It is important to assess the influence of such psychosocial stresses in relation to the appearance of a change in the psychological well-being of the person.

Various types of physique

Pyknic type

- Characterized by large body cavities in relation to short limbs and large subcostal angles with a round head and short, fat neck.
- Tends to be associated with an outgoing, frank, sociable and extraverted personality. There is a great tendency for recurrent changes in mood, varying from depression to elation.

Athletic type

- Wide shoulders and narrow hips, with well developed bones and muscles.
- Tends to be associated with shyness.

Objective 4: Recognize and provide initial management of common mental illnesses

Depression

1. Biological intervention
   - Use of medication, e.g. antidepressants (with severe symptoms)
   - Monitor nutrition / hydration status
   - Assist with energy conservation measures
   - Institute safety measures
   - Assist with establishing regular sleep patterns
   - Encourage self-care management

2. Psychological intervention
   - Cognitive therapy: dispel client's irrational beliefs and distorted attitudes in reducing depressive symptoms
   - Behavioural therapy: techniques include activity scheduling, self-control therapy, social skills training and problem solving
   - Individual psychotherapy: provide support and reassurance during crisis; explore and resolve interpersonal losses, role disputes and transitions, social isolation, or deficits in social skills that may precipitate depressive states.

3. Social intervention
   - Provide guidance about interactions with others, including in the work environment
   - Enlist aid of family for support
   - Assist with group/ family/ marriage therapy
   - Refer to community agencies
   - Institute protective environmental precautions

Suicide

There are three levels of nursing intervention focuses on prevention of self-destruction:

1. Primary prevention
   - Focuses on elimination of factors causing or contributing to the development of the illness or disorder

2. Secondary prevention
   - To identify and treat physical or emotional illnesses in the early stages before they what? develop? becoming a disturbance to the person

3. Tertiary prevention
   - This aims at reducing any residual disability after an illness

Schizophrenia

1. Immediate Management of schizophrenia
   - Hospitalization
   - Pharmacotherapy (antipsychotic, antidepressants & anxiolytic)
   - Monitoring of symptoms & medication side effects

2. Longer-term management of schizophrenia and the maintenance of medication
   - Use of diversionary tactics, relaxation techniques and recreational activities in reducing distress associated with hallucinations

3. Family education
   - Educate family about the disorder, possible relapses and the need for early intervention
   - Enable family to express their feelings (anger, guilt, shame, sadness, a sense of loss, isolation and ambivalence) and their stress, and to offer support

4. Individual cognitive behavioural therapy
   - Help to develop skills and appropriate coping strategies

5. Social skills and vocational training

6. Assist with social problem e.g. finances, housing, employment and family conflict

7. Social support and rehabilitation

Eating disorder

1. Symptom stabilization
2. Nutritional rehabilitation (encourage regular, balanced meals in consultation with a dietician)
3. Achieving a balanced exercise regime and ensuring sufficient sleep and rest
4. Psychotherapy (develop a realistic perception of self-image, enhance self-esteem and help to develop adaptive coping mechanisms)
5. Cognitive behavioural treatment
6. Biochemical intervention e.g. antidepressant
7. Family interventions (resolve disturbed patterns of interactions)
8. Non-traditional Treatment e.g. support group

Learning disability

There are varieties of approaches to treatment of learning disabilities of children. Some learning disabled children who are also hyperactive can be treated with drugs or special diets.

There are special classroom activities using various instructional techniques tailor made to the specific needs of children. Such programmes should be carried out in special environment which helps to facilitate children's learning.

It is anticipated that learning disabled and hyperactive children may be more concentrate to learn under certain environment which provides them with appropriate stimuli.

Epilepsy

- Move the person away from any potential dangers
- Turn patient into semi-prone or recovery position, and ensure clear airway
- Try to prevent biting of tongue with a padded gag
- Summon medical help if seizure lasts more than 3 minutes
- Give oxygen if needed

Substance abuse

1. Harm reduction
   - prevent harm resulting from substance abuse e.g. educate the public and drug users the dangers of using illicit drugs, drinking and driving, and what action to take in

2. Medical management
   - medical management will be required in overdose, acute intoxication and withdrawal
   - involve detoxification, close monitoring of vital signs and metabolic status, gastric lavage, and resuscitator measures

3. Motivational enhancement
   - employ motivational interviewing techniques to help the adolescents consider the pros and cons of continuing substance use and giving up

4. Family therapy
   - family therapy has shown to be effective in improving parent-adolescent relationships and reducing substance use
   - parent training and family problem solving training will be involved

5. Relapse prevention
   - examine factors implicated in previous relapses, anticipating “high risk” situations, developing strategies to deal with these situation and putting them into practice

Objective 5: Adopt appropriate interview skills to collect information on psychosocial history and to identify psychosocial problems in adolescents

Activities

Activity 5.4: Interactive Role Play

Please divide yourselves into groups to perform a short role play exercise. During each interview, there is a health care worker who conducts a brief interview with a client. Another person will be a reviewer who closely watches the interview process.

- Client

The group member who performs the client's role will think of a problem (can be a real-life problem or an imaginary one) to describe to the member playing the counsellor's role.

- Counsellor

The member who performs the counsellor's role should try to identify one issue concerned with the "client", preferably with a brief account of the associated factors.

- Observer

The member who performs the observer's role will observe the whole interview process and jot down the main points, issues or themes from the dialogue.

The interview

In a psychiatric setting, a client interview is not just an act of history-taking, but also a way of eliciting clinical signs.

The initial interview is of particular importance as it is the first step with which a health care worker builds up a good working relationship with a client. The maintenance of the therapeutic working relationship should be upheld through the continuous use of good communication skills.

Communication skills

The important elements of communication skills in psychiatric assessment:

- Give explanations
  - The purpose of the interview, and how the interview will proceed
- The environment
  - Make the client feel comfortable without feeling inferior
- Building rapport
  - Interviewer should appear to be friendly, showing willingness to help client
  - Approach or receive client in a friendly manner, with a warm smiling face

- Ensure privacy
  - Preferably conducted in a sound-proof room, free from interruption

- Make client relax
  - Sit squarely - interviewer should not be seated directly opposite the client

- Listening attitude
  - Interviewer should adopt a "listening" attitude, allowing client adequate time to talk
  - Avoid running the interview in a hurried manner
  - Be aware of the client's verbal and non-verbal communications

- Verbal
  - Tone and clarity of voice
  - Vocabulary used
  - Word speed

- Non-verbal
  - Gestures and positioning
  - Facial expressions
  - Eye contact and gazing

- Handle complaints
  - Listen to the client's complaints first, then reinforce the reasons why an interview might be needed.

- Manage the interview
  - Keep the client to the relevant topics by bringing him back to the point if he strays
  - Use direct questions about specific items of information
  - Provide opportunities for the client to talk spontaneously

- Show acceptance
  - There may always be information disclosed by the client that is seemingly bizarre, but the interviewer should not have/ show any bias toward or against the client.

Non-verbal

- General appearance
- Posture
- Body or physical contact
- Movements
- Use of touch
- Observations of client: ways of sitting, dressing, smelling, looking, physical gestures or positioning

IV. Case Studies

Case study 1

SARS Phobia Syndrome

During the recent outbreak of SARS, Patrick was admitted to hospital for 2 weeks because of fever, diarrhoea and muscle ache. He is aged fifteen. His parents were infected with SARS for unknown reasons. They were hospitalized and their condition is improving with treatment. A few days ago, Patrick was confirmed as not infected with SARS and was discharged home. His hospital experience, however, produced a traumatic impact on him. He is excessively worried about his health and gets anxious easily. He wears a mask even when he is at home. He washes his hands many times a day. He is afraid of going to public places for fear of contracting SARS. His SARS phobia makes him stay at home most of the time and he is experiencing increasing difficulty going to school.

Role play / Discussion:

You are asked to perform a mental health examination including the use of semi-structured interview tools and checklists. Discuss the main considerations and communication skills required during your interview with Patrick.

Case study 2

Conduct disorder

Jonathan is a 15-year-old boy who is referred to a clinical psychologist for behavioural problems. In the past 6 months he has been absent from school and run away from home a number of times. He has repeatedly attempted to destroy public property and caused cruelty to animals. His parents have long-standing marital problems. They often quarrel over financial matters. They do not provide much supervision over Jonathan. They are invited to an interview with Jonathan.

Role play / Discussion:

You are asked to perform a mental health examination including the use of semi-structured interview tools and checklists. Discuss the main considerations and communication skills required during the interview with Jonathan and his parents.

Case study 3

Eating disorder

Jessica is 17 years old. She is of average weight and apparently healthy. Recently she has become anxious about eating too much or feeling badly about herself. She also does not go out with friends at times because she does not wish to be faced with the pressure to eat. She reports that she has a good relationship with her friends and family. She has been engaging in daily purging for a few weeks. She says she needs to lose weight. She does not appear to have suffered long-term effects, such as an oesophageal tear or significant tooth enamel erosion.

Role play / Discussion:

You are asked to perform a mental health examination including the use of semi-structured interview tools and checklists. Discuss the main considerations and communication skills required during your interview with Jessica.

Case study 4

Psychosis

Johnson, a 15-year-old boy, is currently an F.1 student in a secondary school. He came to Hong Kong from the Chinese mainland six years ago. He appeared restless and scared one month ago. Gradually he has become dull and slowed down. He has not been eating well for over a month. He had two brief episodes of depressed mood three years and one year ago, with social withdrawal, sleep and appetite disturbance and refusal of school, which were resolved spontaneously. He has no family history of mental health problems.

A mental status examination was performed on him. He had very slow responses. He talked very little and he felt as though someone was persecuting him. He had auditory hallucinations.

Role play / Discussion:

You are asked to perform a mental health examination including the use of semi-structured interview tools and checklists. Discuss the main considerations and communication skills required during your interview with Johnson.

Case study 5

Psychosis

A 15-year-old girl presents with sleep problems of three months' duration: how do you organise your history taking?

Role play / Discussion:

You are asked to perform a mental health examination including the use of semi-structured interview tools and checklists. Discuss the main considerations and communication skills required in interviewing this girl and your assessment of the girl's suicidal risk during the interview.

V. Summary

Adolescence is a time of major cognitive development and mastery of cognitive and physical skills, and it is also an important time for the continuing development of self-esteem. Self-esteem is a key feature of a fulfilling life and has an enormous influence on mental health. A mental disorder can devastate an adolescent's self-esteem, emotional, social and cognitive development. Primary care health professionals are increasingly the primary source of care for adolescents with mild to moderate depressive symptoms. Even after referring an adolescent with mood symptoms for mental health assessment and treatment, primary care health professionals need to collaborate with mental health professionals in supporting the adolescent and his/her family. Interventions should be focused in the key areas of self, family, school and friends.

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