Lecture 9

Global mental health is a product of decades of interdisciplinary research in diverse transnational contexts.
Until the end of the 20th century, global mental health wasn't given much attention.
In 2015, when the SDG (sustainable development goals) were decided on by multiple nations, some goals were added that were related to global mental health.

TABLE 10-1 Mental Health in the Sustainable Development Goals

	United Nations' Sustainable Development Goals
SDG 3	Ensure healthy lives and well-being for all at all ages
SDG Target 3.4	Requests that countries: "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being"
SDG Target 3.5	Requests that countries: "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol"
SDG Target 3.8	Requests that countries: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"

The beginnings of this work is relatively new (21st century) when the lancet published the landmark series that discussed global mental health and its challenges especially in low and middle income countries. This caused work to change from reactive to proactive (proactive معناته انهم بحاولوا يحلوا المشاكل قبل ما تظهر).

Historical development is a bit important.
The earliest developments of public mental health care can be traced at least as far back as the early Islamic world of the Middle East, North Africa, and Spain.

Although accounts differ, it seems that the first hospitals that cared for persons with mental disorder were established by Islamic physicians during the ninth century CE in Baghdad and Egypt (Dols, 1987). Within a few hundred years, institutional care had spread 3,000 miles to the west in Marrakech (twelfth century) and Fez (thirteenth century), Morocco (Moussaoui & Glick, 2015).

يعني اول اشي بلشت على شكل مستشفيات خاصة للامراض النفسية خلال العهد الاموي، بعدين على شكل مراكز خاصة ضمن مستشفيات في الدولة العباسية.

They used many techniques (that are close to what we use now) to treat mental illness such as providing a relaxing environment, perfumes, and special meals.

The beginning of modern public mental health can be traced to the late eighteenth century, when there was a decided shift in beliefs about the nature of mental disorder. Before this time, "madness" was associated with a loss of rationality, which meant that persons with mental

disorders were considered as less than human and, in an effort to restore them to reason, were treated as brutes
After that public asylums were created. As soon as the public asylums opened, they were filled beyond capacity. Even though these asylums were critiqued heavily. The Lancet questioned the efficacy of asylums: “They are . . . mere houses of detention.”
But even with the bad care in these asylums the number of these asylums kept increasing especially in Europe and America.

After that, the concept of deinstitutionalization, where patients leave these asylums after a period of time and return to the community. But what happened is that the community wasn’t qualified to give the patient the proper care, so the patients ended in prisons, nursing homes, forensic institutions etc..
Deinstitutionalization is a good theoretical concept but is very hard to implement.
Some patients who were lucky to have a family after being released from the psylums recorded a positive improvement after leaving the asylums.

With the development of the WHO, a parallel interest in global mental health developed. Later on the WHO started to conduct research, create committees, and task forces for mental health.
The biggest achievement by the WHO related to mental health was that it was able to include mental disease as a part of the global burden of disease.
This is important because now research funds and grants have to consider mental health diseases now.

-Culture and mental disorders:-

First thing, you should know that there is a relation between mental disorders and culture, in fact mental disorders are embedded in its social context.
But you should keep in mind that the concept of classification for psychiatric disorders has high amounts of critics , because the classification systems worldwide don’t take care of cultural differences between patients , and this means that not all the standards are able to be applied .
So, what are these international classification systems? We have DSM-->released by APA, ICD-->released by WHO , DSM is an american system and we use it in Jordan , but most of the european countries use ICD.
U should know that psychiatric disorders are different from medical disorders, in the way of diagnoses and treatment, in medical disorders, there is a base that u can depend on , and the there is some similarities between the patients , but in psychiatric disorders this is not found, because the ability to replicate this psychophysiological pathways that distinguish the disorders from each other are not found, every patient is unique from the others.
This is the first problem, the second one is we have a lot of overlapping between different disorders(overlapping in symptoms).
Also u should know that even if you have a lot of experience, it is difficult to diagnose the mental disorders, and that leads us to 2 concepts ETIC and EMIC, in ETIC we mean universal systems that we think it can work on a every culture and patient, DSM and ICD use this method, but in EMIC we take into consideration the cultural and subcultural differences, so DSM & ICD don't take care of EMIC(يعني هم بركزوا عالامور العامة اللي بتغطي اكبر شريحة ممكنة بدون الدخول في تفاصيل المجتمعات), but

even if DSM is classified as ETIC, but it is not general enough, and that means that the classification systems are reflecting the american and european patients(EMIC).
And due to that you will find that these classification systems are not good enough in our communities because most of our psychiatric doctors are using the this classification systems exactly(حرفيا) without taking into consideration the cultural differences.
(يعني اغلب الدكاترة النفسيين بطبقوا الشروط بحذافيرها دون مراعاة الفروقات المجتمعية بين المجتمع الامريكي ومجتمعنا)

So to sum up , of course we have cultural variations in mental disorders and symptoms and these international classification systems face a lot of challenges because they don't take care of EMICs.
(remember these classification systems have versions)

حكت بعدين الدكتورة عن كيف انه في فروقات بين التصنيفات وانه عملت تجربة ولقت النتائج بين مقياسين مختلفة وحكت بعدين كيف انه العادات بتلعب دور وكيف انه بعض الصفات تعتبر اشي اعتيادي بالمجتمع مع انها ممكن تكون دليل قوي على مرض نفسي المحاضرة ممتعة وضروري تحضروها .

-Cross-Cultural Methods and Approaches for Mental Health Research and Services:-

Here we should take care of cultural equivalence, so we need to understand some concepts :-
1- content equivalence: here the phenomenon we are studying is considered a mental disorder in this culture and the other culture.
2- semantic equivalence : meaning, the doctor didn't anything except this word
(Does the meaning of each item remain the same after translation? من الكتاب)
3- technical equivalence: using the same techniques to study the phenomenon, so u can't use different techniques because the results will be unreliable.
4- criterion(standard) equivalence : comparing the results I've got with international criterias, if the results after comparing are all the same then this is criteria equivalence .
Also we have transcultural translation

(المقصود هنا انه الترجمة ما تكون حرفي بل لازم تكون نابعة عن فهم للغة ولثقافة المجتمع)
الدكتورة بعدين ذكرت خطوات عشان تتأكد انه الترجمة صحيحة وتراعي الفروقات بين اللغات والمجتمعات الخ.....

And remember, we are here talking about the variation between cultures and how to solve the problem of differences between culture.
In the field of clinical services, the DSM in its last version has added tool which is called "Cultural Formulation Interview"

An example:-

EXHIBIT 10-1 Cultural Formulation Interview in DSM-5

This CFI is a tool for clinicians and treatment teams to improve mental health services by assuring that cultural factors are integrated into diagnoses, treatment planning, and delivery of care. The CFI includes four components:

- Cultural definition of the problem: Explanatory models including prominent idioms of distress, reasons for treatment seeking, and impact on functioning.
- Cultural perceptions of the cause, context, and support: Cultural models of causation, impact on and influence of one's social network, culturally relevant interpretations of social stressors, and cultural identity of the individual.
- Cultural factors affecting self-coping and past help-seeking: Self-coping, past help seeking, and prior barriers to care and recovery.
- Cultural factors affecting current help seeking: Patient preferences related to social networks and religion, and clinician–patient relationship factors. The provider must identify differences and similarities in cultural and social status that might influence diagnosis and treatment.

Modified from American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, DC: American Psychiatric Publishers, Incorporated.

So what is the idea behind this tool?
For each psychological problem this tool will help us highlighting the cultural definition, perception, factors that have been used by the patient in the past and and factors that are affecting him now, so this tool helps the practitioner to take into consideration the EMICs of that particular patient

-The Determinants of Mental Disorders:-

There is an agreement between researchers that most psychiatric disorders are considered biologically based, and that means there is biological predisposition(genetic, chemical imbalances…)
So the psychosocial, cultural, and emotional factors play a role in the onset, severity , prognosis , and treatment.

(العوامل الاجتماعية لا تسبب المرض النفسي وانما تظهره)

TABLE 10-3 Selected Risk and Protective Factors for Mental Health

Domain	Risk Factors	Protective Factors
Biological	■ Exposure to toxins (e.g., tobacco and alcohol) during pregnancy ■ Genetic tendency to psychiatric disorder ■ Head trauma ■ HIV/AIDS and other physical illnesses	■ Age-appropriate physical development ■ Good physical health ■ Services provided at mother–baby clinics
Psychological	■ Maladaptive personality traits ■ Effects of emotional, physical and sexual abuse, and neglect	■ Ability to learn from experiences ■ Good self-esteem ■ High level of problem-solving ability ■ Social skills
Social		
Family	■ Divorce ■ Family conflict ■ Poor family discipline ■ Poor family management ■ No family	■ Family attachment ■ Opportunities for positive involvement in family ■ Rewards for involvement in family
School or workplace	■ Failure to perform at the expected level ■ Low degree of commitment to school or workplace ■ Inadequate/inappropriate educational provision or training opportunities ■ Experiences of bullying and victimization	■ Opportunities for involvement in school or occupational activities ■ Supportive, stimulating school environment that is tailored to children's developmental needs
Community	■ Community disorganization ■ Effects of discrimination ■ Exposure to violence ■ Social conflict and migration ■ Poverty ■ Transitions (e.g., urbanization)	■ Connectedness to community ■ Opportunities for constructive use of leisure ■ Positive cultural experiences ■ Positive role models ■ Rewards for community involvement

Some numbers…
1-Schizophrenia: 23 m cases in 2015
2-Bipolar Disorder: 44 m cases in 2015
3-Substance Use Disorders: 63 m cases in 2015

▸ Interventions:-

Now regarding interventions, we need policies and plans and without them the work will be random and (reactive not proactive).
Also it is very important to support human resources(the workers in the field of mental health).
Also we need interventions on the level of primary, secondary and tertiary levels and that means we don't only intervent when the disease occurs (prevention….)
We have hidden patients who are the families
(الاب او الام مريض باحد الامراض النفسية ومطلوب منه الاهتمام بنفسه وبابنائه)

The intervention might be on the level of population, and here it means strategies, policies ,regulatory interventions, intervention in taxations, laws , working on stigma and public discrimination.
And the intervention might be on the level of community, here we are talking mainly on life skills training in schools (school based programs) and they are extremely effective.
And the intervention might be on the level of healthcare providers, and this intervention is focusing mainly on the health care providers and the workers in mental field.

Humanitarian Emergencies:-
There is a concept known as PFA (Psychological First Aid) which is very important for people who were in wars or disasters (this intervention is extremely important)

حكت عن توصيات منظمة الصحة العالمية صفحة 457 بس كانهم مش مطلوبين

Where to go in this field? And what researches say?
The positive thing that mental health have become priorities in researches and global agenda .
The global mental health agenda by WHO most of the nations have signed for it including Jordan, this agenda is seeking to have cultural competency in the field of mental health so every person can get the mental care that suits him/her regarding all the aspects in the next decades.