**Mental Health**

Mental health is a level of psychological well-being, or an absence of mental illness. It is the "psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment". From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience.

**Definition:**

According to WHO, Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

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

This fact file highlights the important aspects of mental health and disorders.

According to the World Health Organization (WHO), mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others." The WHO further states that the well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community.

Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. A widely accepted definition of health by mental health specialists is psychoanalyst Sigmund Freud's definition: the capacity "to work and to love". It has been proven that Music therapy is an effective way of helping people who suffer from a mental health disorder

Most mental health professionals believe that there are a variety of contributing factors to the onset of a mental illness. Studies have found that there are physical, social, environmental and psychological causes for mental illness.

**Causes of Mental illness**

**Physical causes**

(Biological factors) Each individual’s own genetic make-up can contribute to being at risk of developing a mental illness and traumas to the brain (via a form of head-injury) can also sometimes lead to changes in personality and in some cases ‘trigger’ symptoms of an illness. Misuse of substances (such as alcohol or drugs) and deficiencies of certain vitamins and minerals in an individual’s diet can also play a part.

**Social and environmental causes**

(Factors around us) Where someone lives and their living conditions along with family and community support networks can play a part along with employment status and work stresses. Living in poverty or social isolation, being unemployed or highly stressed in your work can all put pressure on an individual’s mental health.

**Psychological factors**

(Your Psychological state) Coping with past or current traumatic experiences such as abuse, bereavement or divorce will strongly influence an individual’s mental and emotional state which can in turn have an influence on mental health.

**Family History**

There is evidence to suggest that heredity can play some part in the development of some forms of mental illness. However like with many physical health conditions (such as Heart Disease or Diabetes) that fact that a family member has experienced a mental illness does not mean that all other genetic family members will experience the same condition. As with physical health conditions, the other factors shown above will play a significant part too.

**Mental Retardation**

According to Encyclopedia of Children Health,

Mental retardation is a developmental disability that first appears in children under the age of 18. It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) that is well below average and significant limitations in daily living skills (adaptive functioning).

**Mild mental retardation**

Approximately 85 percent of the mentally retarded population is in the mildly retarded category. Their IQ score ranges from 50 to 75, and they can often acquire academic skills up to the sixth grade level. They can become fairly self-sufficient and in some cases live independently, with community and social support.

**Moderate mental retardation**

About 10 percent of the mentally retarded population is considered moderately retarded. Moderately retarded individuals have IQ scores ranging from 35 to 55. They can carry out work and self-care tasks with moderate supervision. They typically acquire communication skills in childhood and are able to live and function successfully within the community in a supervised environment such as a group home.

**Severe mental retardation**

About 3 to 4 percent of the mentally retarded population is severely retarded. Severely retarded individuals have IQ scores of 20 to 40. They may master very basic self-care skills and some communication skills. Many severely retarded individuals are able to live in a group home.

**Profound mental retardation**

Only 1 to 2 percent of the mentally retarded population is classified as profoundly retarded. Profoundly retarded individuals have IQ scores under 20 to 25. They may be able to develop basic self-care and communication skills with appropriate support and training. Their retardation is often caused by an accompanying neurological disorder. The profoundly retarded need a high level of structure and supervision.

The American Association on Mental Retardation (AAMR) has developed another widely accepted diagnostic classification system for mental retardation. The AAMR classification system focuses on the capabilities of the retarded individual rather than on the limitations. The categories describe the level of support required. They are: intermittent support, limited support, extensive support, and pervasive support. Intermittent support, for example, is support needed only occasionally, perhaps during times of stress or crisis. It is the type of support typically required for most mildly retarded individuals. At the other end of the spectrum, pervasive support, or life-long, daily support for most adaptive areas, would be required for profoundly retarded individuals.

**Causes and symptoms of Mental Retardation:**

Low IQ scores and limitations in adaptive skills are the hallmarks of mental retardation. Aggression, self-injury, and mood disorders are sometimes associated with the disability. The severity of the symptoms and the age at which they first appear depend on the cause. Children who are mentally retarded reach developmental milestones significantly later than expected, if at all. If retardation is caused by chromosomal or other genetic disorders, it is often apparent from infancy. If retardation is caused by childhood illnesses or injuries, learning and adaptive skills that were once easy may suddenly become difficult or impossible to master. In about 35 percent of cases, the cause of mental retardation cannot be found. Biological and environmental factors that can cause mental retardation include genetics, prenatal illnesses and issues, childhood illnesses and injuries, and environmental factors.

**Genetics**

About 5 percent of mental retardation is caused by hereditary factors. Mental retardation may be caused by an inherited abnormality of the genes, such as fragile X syndrome . Fragile X, a defect in the chromosome that determines sex, is the most common inherited cause of mental retardation. Single gene defects such as phenylketonuria (PKU) and other inborn errors of metabolism may also cause mental retardation if they are not found and treated early. An accident or mutation in genetic development may also cause retardation. Examples of such accidents are development of an extra chromosome 18 (trisomy 18) and Down syndrome . Down syndrome is caused by an abnormality in the development of chromosome 21. It is the most common genetic cause of mental retardation.

**Prenatal illnesses and issues**

Fetal alcohol syndrome affects one in 600 children in the United States. It is caused by excessive alcohol intake in the first twelve weeks (trimester) of pregnancy. Some studies have shown that even moderate alcohol use during pregnancy may cause learning disabilities in children. Drug abuse and cigarette smoking during pregnancy have also been linked to mental retardation.

Maternal infections and illnesses such as glandular disorders, rubella , toxoplasmosis , and cytomegalovirus infection may cause mental retardation. When the mother has high blood pressure ( hypertension ) or blood poisoning (toxemia), the flow of oxygen to the fetus may be reduced, causing brain damage and mental retardation.

Birth defects that cause physical deformities of the head, brain, and central nervous system frequently cause mental retardation. Neural tube defect, for example, is a birth defect in which the neural tube that forms the spinal cord does not close completely. This defect may cause children to develop an accumulation of cerebrospinal fluid on the brain ( hydrocephalus ). By putting pressure on the brain hydrocephalus can cause learning impairment.

**Childhood illnesses and injuries**

Hyperthyroidism, whooping cough, chickenpox, measles , and Hib disease (a bacterial infection) may cause mental retardation if they are not treated adequately. An infection of the membrane covering the brain (meningitis) or an inflammation of the brain itself (encephalitis) cause swelling that in turn may cause brain damage and mental retardation. Traumatic brain injury caused by a blow or a violent shake to the head may also cause brain damage and mental retardation in children.

**Environmental factors**

Ignored or neglected infants who are not provided the mental and physical stimulation required for normal development may suffer irreversible learning impairments. Children who live in poverty and suffer from malnutrition , unhealthy living conditions, and improper or inadequate medical care are at a higher risk. Exposure to lead can also cause mental retardation. Many children develop lead poisoning by eating the flaking lead-based paint often found in older buildings.

**Basic Management of Mental Retardation:**

1. Early identification of children with developmental delays is necessary to begin receiving early intervention services for children from birth to 3 years of age and early childhood education services for children aged 3-5 years, which are known to improve outcomes.

2. The mainstay of treatment of MR/ID is developing a comprehensive management plan for the condition. The complex habilitation plan for the individual requires input from care providers from multiple disciplines, including special educators, language therapists, behavioral therapists, occupational therapists, and community services that provide social support and respite care for families affected by MR/ID.

3. Preventive care: Unfortunately, routine preventive care for children and adults with MR/ID is lacking. Adaptive equipment (eg, for nonambulatory patients) and extra time (eg, double time slots) may be required to accommodate such patients. In addition, family members or other support persons may be helpful. Written plans (such as the Massachusetts Department of Developmental Services Annual Health Screening Recommendations and Health Record) are helpful for interdisciplinary team communication.

4. Physical activity and obesity are major contributors to disease in MR/ID. Very few programs exist that target healthy lifestyles (nutrition/diet, exercise, self-care, stress reduction) in those with MR/ID. Annual counseling and referral on these issues to community agencies and programs is recommended. [32] Medications (eg, antipsychotics) should be titrated to reduce the risk of obesity and metabolic issues.

5. Pain

* Manifestations of pain in people with severe to profound MR/ID include crying, screaming, grimacing, protective postures (eg, arching, fetal position), rocking, and aggression. Parent/caregiver input is key to interpretation of these behaviors, though validated tools have been used as adjuncts (such as the Pediatric Pain Profile).
* Common causes of acute pain include dental caries/abscesses, GERD, constipation, UTI, spasticity (when MR/ID is associated with cerebral palsy), pressure sores, and fractures.
* In addition, neuropathic pain due to dysautonomia or motor spasms may create chronic disturbances. Treatment should be prompt and include NSAIDs or acetaminophen for mild pain, tramadol or equivalent for moderate pain, and opioids for severe pain as indicated, and management of sources of pain. Some suggest use of gabapentin for neuropathic pain if no sources are identified and there is a history of surgery, symptoms suggesting visceral hyperalgesia (eg, associated with feedings or bowel movements), or symptoms of autonomic dysfunction and spasticity.

6. Written, verbal and pictoral forms of communication as well as gestures and demonstrations are helpful for those with MR/ID to ensure mutual understanding and improve treatment adherence.

7. Sedation/anesthesia: Patients with MR/ID requiring anesthesia may have different reactions than the general population, such as paradoxical reactions to benzodiazepines, and care should be taken to use the lowest dose and titrate slowly.

8. Sexuality/abuse: A significantly higher proportion of children and adults with MR/ID have experienced some form of abuse, with some estimates of up to 70%, which contributes to mental health issues. This should be addressed at each medical visit and especially in the setting of changes in behaviors, such as increased aggression.

9. No treatments are available specifically for cognitive deficiency. Although the pharmacologic enhancement of cognition (eg, use of donepezil in patients with Down syndrome [33] ) is an area of interest, research on such nootropic (ie, knowledge-enhancing) compounds is limited. Such drugs have not become part of the routine or even experimental clinical management of this population.