MODULE

Common Mental Illnesses

For the Ethiopian Health Center Team

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UNIT ONE

INTRODUCTION

1.1. Purpose and use of the module

This module is intended to serve as a general learning material about Common mental illnesses for the health center team: Health officer (HO), environmental health technician (EHT), public health nurse (PHN), medical laboratory technician (MLT) and the community health worker (CHW). The basic and general concepts about the illnesses, their public health significance, the causation, epidemiology, clinical features, management, and the strategies for prevention and control are discussed in simple and quite understandable ways.

The module can also be used by other categories of health professionals. Moreover, it can also be used as a reference material for professionals working in health centers. This material may also be used as a learning material in training workshops, and seminars for members of the health center team, community health workers and caregivers. However, it should be

Part I: Contains common questions to be answered by all categories of the health center team.

Part II: The questions are prepared for the specific categories; health officer, public health nurse; select and do the portion indicated for your specific category.

- ü When you are sure that you are through with the core module, proceed to read the satellite module corresponding to your profession or interest.
- ü Evaluate yourself using the post-test after you have read the modules completely (the core and the specific satellite).
- ü Go through the task analysis for the health center team members in comparison with that of your own.

Note: You may refer to the list of abbreviations and glossary at the end of the module for terms that are not clear.

UNIT TWO

CORE MODULE

2.1.Pre - test

Answer the following questions on a separate answer sheet.

2.1.1. Part I: Pre - test for all categories of the health center team

Write “True” or “False” for questions 1-5, the letter of choice for questions 6-10 and write short answers for the questions 11-15.

1. Mental illness is not

Part II: Questions specific to a category of the health center team

A. For health officers

Answer the following questions

1. Which of the following is /are primarily generalized type(s) of seizure?
   A. Absence or petit mal seizure


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7. Which of the following is not true about the different anxiety disorders?
    A. Generalized anxiety disorder can be treated best with benzodiazepines, antidepressants

12. Laboratory investigations are not necessary in patients with seizure at all.
    A. True B. False
13. Depression has a better prognosis than mania.
    A. True B. False
14. Lithium is the first line of treatment for bipolar disorder in the Ethiopian situation.
    A. True B. False
15. Electro convulsive therapy can be used as first mode of treatment for mood disorder.
    A. True B. False
16. Psychotherapy can be useful in a patient with acute manic episode.
    A. True B. False
17. Generalized anxiety involves excessive worry about actual circumstances, events or conflicts.
    A. True B. False
18. When do you need to refer a patient with mood disorder?
19. State the signs and symptoms of patients with major depressive episode and manic episode.
20. List the physical and somatic complaints in a patient with anxiety disorder.
21. Refer to the case study on the learning activity and answer the following questions.
    A. What is the most probable diagnosis?
    B. What specific treatment would you initiate for this patient?
22. Define schizophrenia.
23. List the different sub-types of schizophrenia.
24. Write the dosage of chlorpromazine for a patient with schizophrenia.
25. When do you decide on withdrawal of maintenance treatment for a trial period in treating schizophrenia?
26. State the overall prognosis of schizophrenia.
27. What are the behavioral and physical effects of khat?

Part III. Answer the following questions on separate answer sheet

1. Identify the incorrect statement
   A. Seizure is a paroxysmal, uncontrolled, abnormal discharge of electrical activity in the brain.
   B. A brief sensory experience is termed as an aura.
   C. Epileptic cry is a cry which occurs in all cases of epilepsy.
   D. A prodromal phase is a phase which follows some seizures and may last minutes or hours.

2. Which of the following is not the drug treatment of epilepsy?
   A. Phenobarbital
   B. Phenytoin
   C. Carbamazepine
   D. Halloperidol

3. Which of the following dangerous activities should be avoided or undertaken only with special safe guards in seizure disorders?
   1. Working or sitting near fire 2.Tree climbing 3. Fluid drinking
   4. Horse back riding 5. Swimming

   Choose the best combination of the alternatives.
   A. 1, 2, 3 B. 3, 4, 5 C. 1,2,4,5 D. 1,2,3,4

4. Which of the following is not a precipitating factor for seizure disorder?
   A. Stress
   B. Lack of sleep
   C. Emotional stability
   D. Alcohol over indulgence

5. Identify the incorrect statement.
   A. Euphoria is one of the least symptoms of manic disorder.
   B. Heightened psychomotor activity is one of the main symptoms of manic disorders.
   C. Flight of ideas is a common phenomenon in manic psychoses.
   D. Mania is one of the illnesses which affect human being.

not regarded as life-threatening problems are seen to be insignificant and unworthy of attention.

Religion and culture have great influence on the perception of the causation and the remedies of mental illnesses in Ethiopia. The majority of Ethiopians believe that all diseases, particularly mental illnesses are afflictions caused by supernatural evil factors.

Research done by Giel and co-workers between 1966 to 1969 from 4 general outpatient clinics in Ethiopia indicate that 6.8-18.0% of the attendees had psychiatric disorders (1). After the development of new screening methods, a prevalence of 12% was found for mental disorders in a small sample in Addis Ababa. The same instrument was used and a prevalence of 12.3% was found in a sample of mothers from the town of Jimma. Tafari et al. (1991) reported a prevalence of 17.2% in a larger sample of a rural community (1).

Most people in the country use traditional methods for treating mental illness and those who look for a modern treatment method do so after trying several local means (1).

Despite the fact that epidemiological findings consistently indicate that serious mental disorders in low income countries are as common as in the developed world, the opposite belief seems to govern the attitude and decisions of many health planners in low-income countries. As a result, the mental health service is not given its due priority. The idea that mental illnesses are less common in low-income countries than in developed countries has been disputed. The results of more recent studies suggest that some mental disorders like depression and anxiety are even more prevalent in low - income countries than in the developed world**.** Although it is clearly understood that mental illness can lead to poverty, disability, malnutrition and infection, it requires far-sightedness to appreciate the link between mortality and serious mental problems (1).

members kept him at home chained and confined to a small room so that no one can see him. He was not eating well sinc


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In a community study among children, 3 - 4% of those less than nine year-olds, and 5 - 10% of 10 - 19 years suffered from psychiatric illnesses.

2.7. Etiologic factors of mental illness

There is no known single causative agent for mental illnesses. Mental illnesses are caused by one or more of the following factors.

1. Genetic factors such as abnormalities in chromosomes may cause mental illness. Children from mentally ill parents are more likely to develop mental illnesses than children of healthy parents.
2. Organic factors like cerebrovascular diseases, nervous system diseases, endocrine diseases and chronic illnesses such as epilepsy are associated with mental illnesses.
3. Social and environmental crises like poverty, tension, emotional stress, occupational and financial difficulties, unhappy marriage, broken homes, abuse and neglect, population mobility, frustration, changes in life due to environmental factors like earthquakes, flood and epidemics are associated with mental illness.

2.8. Clinical features of common mental illnesses

Mental illnesses have diverse signs and symptoms, which are grouped or clustered together to become a specific diagnosis. These groups of symptoms and signs should be persistent and intense to indicate mental illness. Examples of some clinical disorders are discussed below.

I. Disorders of perception

The most distinctive phenomena in mental illnesses are disorders of perception.

They are:

- ü Illusion: Misinterpretation of real external sensory stimuli

  E.g. A person looks at a cracked wall and sees branched tree.

- ü Hallucination: False sensory perception not associated with real external stimuli.

  E.g. A person sees spiders and snakes on the ceiling of his or her room where there are none.

II. Disorder of thinking

- ü Delusion: Patients may have fixed false beliefs that can not be corrected by reassuring and are not ordinarily accepted by other members of the particular person's culture.

  E.g. A person believes that an external force controls him or her, a spaceman sends him message by radio.

The patients may also have exaggerated self-importance.

E.g. A person believes he is the Prime Minister of Ethiopia when he or she is not.

III. Disorders of emotion

This involves a sustained abnormal feeling tone experienced by patient. Such patients may have low mood, anger, anxiety or excessive happiness without any reason.

E.g. 1. A person laughs at a sad event like death of a loved one.

2. A depressed person might feel that life isn't worth living.

IV. Disorders of motor activity

These are abnormalities of social behavior, facial expressions and posturing.

E.g. Standing on one leg for a long time.

V. Disorders of memory

This is the inability to retain and recall information (distortion of recall).

E.g.1. A person suddenly and unexpectedly leaves home and is unable to return.

2. A person may find it difficult to remember what he or she had for breakfast after few hours.

VI. Disorders of consciousness

This is the impaired awareness of the self and the environment. The level of consciousness can vary between the extremes of alertness and coma.

VII. Disorders of attention and concentration

This is the inability to focus on the matter at hand and failure to maintain that focus.

VIII. Insight

This is defined as awareness of one's mental condition. Patients who do not have insight do not know that they are sick and thus fail to seek medical attention.

People who are mentally healthy may exhibit some of the traits of mental illness when they are under stress and show adaptive behavior that serves to satisfy their basic needs in a socially acceptable way. Refer to the comparative characteristics of mentally healthy and ill individuals at Section 3.3.7.1.

2.9. Diagnosis

Psychiatry deals with causes and treatment of mental illness and the care to be given to such patients, who are considered abnormal in their behavior.

In general the symptoms are too vast and complex to reach a correct diagnosis of the illness, which it needs to comprise different approaches and models.

done and most of the modalities of treatment are replaced by drug treatment.

In cases of psychiatric emergencies, the attitude the caregivers towards the patient should be calm, quiet and confident. Patient should never be lied to about what he has or where his being taken to. If patients are violent, there should be a place for physical restraint to avoid risk of injury to him/herself and others.

Misconceptions towards mental illness

1. Patients in mental hospitals are often considered as people who spend their time doing useless things and showing bizarre behavior.
2. People who have had a mental illness are viewed with suspicion and as dangerous persons.
3. Mental illness is something to be ashamed of.
4. Mental illness is caused by evil sprits (black magic).
5. Mental illness is something that cannot be cured and is contagious.

ü Prevention of nutritional deficiency

E.g.: Iodine, vitamin B deficiency.

ü Brain injuries

E.g.: Trauma as a result of road traffic accidents.

ü Control of early childhood and neonatal infections.

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UNIT THREE

SATELLITE MODULES

3.1.Satellite module for health officers

3.1.1. Purpose and use of the module

This training material is meant to introduce basic concepts of mental illnesses, which are believed to be major disorders of public health importance in Ethiopia

These are psychotic disorders, mood disorders, anxiety disorders, seizure disorder and substance related disorders, disorders related to medical conditions and somatoform disorders.

3.1.2. Directions for use

Before reading this satellite module, make sure that you have completed the pre - test and studied the core module.

Pre and post tests for the health officers are in the core module Unit 2 Section 2.1.2 (Part B).

with confidentiality, carry out the mental status examination, develop a differential diagnosis and devise a treatment plan.

A complete **psychiatric history** should include:

- Identification

  Name, age, sex, informant, relationship of informant to patient.
- Length of acquaintance
- Reasons for referral

  (E.g. severe depression, failing to respond to drug treatment)
- History of present illness including medical conditions

ü Symptoms with duration and mode of onset, course of symptoms (persistent or intermittent).

ü Time relationship between symptoms and social, psychological and physical disorders.

ü Effects on work, social functioning and relationships

ü Sleep, appetite and sexual drive disturbances

ü Any treatment given - improvement

- Family history

ü Paternal and maternal status - occupation, personality, quality of relationship with the patient and with one another,

ü Siblings - name, age, marital status, occupation, personality, mental and psychiatric illness, quality of relation with patient.

ü Social position of family - atmosphere at home, family problems - like serious illness of one parent.

ü Family history of illness - personality disorder, epilepsy, alcoholism, other neurological or medical disorder.

- Personal history

ü Abnormality during pregnancy and birth - was pregnancy wanted?

ü Difficulties in habit training and delay in achieving milestones (walking, talking, sphincter control etc...)

ü Separation from parents and reaction to it.

ü Health during childhood-serious illness especially that affecting central nervous system, febrile seizures, hospital admission

ü Nervous problems in childhood.

ü Fears, temper tantrums, shyness, stammering, blushing, sleep-walking, prolonged bed wetting, frequent night mares.

ü School - age of starting and finishing each school, types of school, academic records, relationship with teachers and pupils.

ü Occupation - chronological list of jobs, reasons for changes, present financial circumstance, satisfaction in work, any stress at work.

- Service or work experience

ü Promotion and awards

ü Disciplinary problems

ü Menstrual history, menopause

- Marital history

ü Age at marriage, how long the spouses knew each other before marriage and length of engagement

ü Previous relationships and engagements

ü Present age, occupation, health, personality of spouse.

ü Quality of marital relationship

- Sexual

ü Attitude to sex and contraception

- Children

ü Names, sex, age, date of abortions or stillbirth, emotional and physical development of children.

ü Mental and physical health of children

- Present social situation

ü Housing, composition of household, financial problems

- Previous medical history

ü Illnesses, accidents

- Previous psychiatric illness

ü Nature and duration of illness - date, duration and progress of any treatment.

ü Personality before present illness

ü Friends - few, many, superficial, close, own or opposite sex

ü Relationship with workmates and superiors

ü Use of leisure time

Hobbies and interests, memberships of societies and clubs.

ü Predominant moods.

Anxious, worrying, cheerful, optimistic, pessimistic, self-depreciating, over-confident, stable or fluctuating, controlled or demonstrative.

ü Character

Sensitive, suspicious, jealous, resentful, irritable, impulsive, selfish, timid, reserved, lack of confidence, rigid,

ü Attitudes and standards

ü Moral and religious, attitude towards health and the body

ü Habits - food, alcohol, tobacco, drug, sleep

Mental status examination

This includes evaluation of the patient at one point in time.

Behaviors to be observed are:

- Patient's general appearance: development, nourishment, grooming
- Attitude - hostile, co-operative, guarded
- Behavior - agitation, level of activity, gait
- Speech-rate, volume, tone and mode, relevance, coherence
- Mood
- Affect

- Perception
  - Hallucination
  - Illusions
- Form of thought
  - Flow of associations, loosening
  - Flight of ideas
  - Neologism, word salad, blocking
- Content of thoughts
  - Delusions
  - Obsessions
- Cognition - measures ability of the brain to function
  - Orientation
  - Concentration
  - Memory
  - Calculation
  - Reasoning
- Judgment EMC m65 -1.78dgment EMC6/-87 0Tw mi 8l0c -0.0002 gd9P

These include schiophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, psychotic disorder due to a general medical condition, and substance induced psychotic disorder, and postpartum psychosis.

Schizophrenia

Definition

Schizophrenia is a group of disorders characterized by psychotic symptoms that significantly impair functioning and that involves disturbances in feeling, thinking and behavior.

Epidemiology

1. Incidence and prevalence
   - ü The incidence of schizophrenia has been reported to range from 0.03% - 0.12%.
   - ü Life-time prevalence is approximately 1 - 1.5%.
   - ü World - wide 2 million new cases appear each year.
   - ü Prevalence, morbidity and severity of presentation are greater in urban than in rural areas and in industrialized than in the non-industrialized countries. Studies done in Addis Ababa in 1994 showed lifetime prevalence of schizophrenia to be 0.4% and one month prevalence to be 0.3%.
2. Sex ratio - the male to female ratio is 1:1.
3. Age of onset
   - ü Most common between age 15 and 35 years. Rare before the age of 10 or after the age of 40.
   - ü Earlier onset for men than for women.
4. Socio-economic status.
   - ü The highest rates of schizophrenia are found in the lower socio-economic classes. This suggests that socioeconomic factors help precipitate schizophrenia in genetically vulnerable people or that schizophrenic patients tend to drift downward in socioeconomic status.

5. Familial pattern

   ü Schizophrenia tends to run in families, (see the description below).

Prevalence of schizophrenia in specific populations

Population	Prevalence
General population	1 – 1.5 %
First – degree relative	10 – 12%
Second degree relative	5 – 6 %
Child of two schizophrenic parents	40%
Dizygotic twins	12 – 15 %
Monozygotic twins	45 – 50%

6. Religions and race

   ü Difference in epidemiology of schizophrenia among different religions and races has also been found

Etiology

Although the exact cause has not been identified, several theories have been proposed regarding the etiology of schizophrenia. A brief summary of the theories is as follows:

1. Biologic theory

This theory states that there are genetic and biochemical factors predisposing to schizophrenia.

a. Genetic theory

This theory suggests that there are genetic factors responsible in the Occurrence of schizophrenia, which can be evidenced from the high prevalence rate of schizophrenia in families than in the general population. (Refer to the description under epidemiology).

b. Biochemical theory

In this theory, increased dopamine and nor epinephrine activity and decreased GABA activity have been attributed to be causes of schizophrenia

2. Physiological theory

This theory states that schizophrenia develops early in life because of various stressors. Among these are poor mother - child relationships, deeply disturbed family interpersonal relationships, impaired sexual identity and rigid concept of reality.

3. Organic theory

This states that schizophrenia arises from functional deficit occurring in the brain caused by stressors such as infection, poison and trauma.

Precipitating events

1. Psychosocial stressors

   Social and economic stresses are associated with high rate of schizophrenia.
2. Traumatic events like death of a loved one and past sexual, physical and emotional abuse can be associated with schizophrenia.
3. Drug and alcohol abuse

   Certain drugs (e.g. amphetamine, cocaine, hallucinogens, phencyclidine) and alcohol may precipitate schizophrenia.

Clinical features

Patients with schizophrenia present with the following manifestations.

- ü Abnormal content and form of thought

  For example, delusions of persecution, of reference, of grandiosity, of being controlled and of mind reading. There are also delusions of thought broadcasting, insertion and withdrawal.

- ü Distorted perception

  This could be an illusion or hallucination. The hallucination could be auditory, visual, olfactory, gustatory, tactile or somatic.

  An illusion is a misperception or misinterpretation of real external sensory stimuli: e.g. piece of rope being perceived as snake

- ü Illogical form of thought

  For example, circumstantiality, tangentiality, incoherence, flight of ideas, loosening of associations, thought blocking, clang association and neologism.

- ü Changed affect

  For example, blunted affect, flat affect, inappropriate affect, poor eye contact, unchanged facial expression and decreased spontaneous movements.

- ü Altered volition

  For example, inadequate drive or motivation and marked ambivalence.

- ü Change in psychomotor behavior

  Such as agitation, abnormal posturing as in catatonia.

- ü Impaired overall functioning

  The patient's level of functioning declines or the patient fails to achieve the expected level and hence can't lead a productive life.

- ü Impaired interpersonal functioning

  For example, social withdrawal, emotional detachment and aggressiveness.

- ü Impaired sense of self.

  For example, gender confusion, inability to distinguish internal from external reality.

Diagnosis

For the diagnosis of schizophrenia different varieties of diagnostic systems have been used. DSM - IV and ICD-10 diagnostic criteria are used currently. DSM - IV diagnostic criteria is described below.

DSM – IV Diagnostic criteria for schizophrenia

A. Two or more of the following symptoms present for most of 1 month.
    1. Delusions
    2. Hallucinations
    3. Disorganized speech
    4. Grossly disorganized or catatonic behavior.
    5. Negative symptoms

    Note: Only one of those is required if delusions are bizarre or if hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or if there are two or more voices conversing with each other.

B. Marked social or occupational impairment

C. Duration: Continuous signs of disturbance persist for at least 6 months. This 6 month period must include at least 1 month of symptoms that meet criterion A.

D. Symptoms of schizoaffective and mood disorder are ruled out.

E. Substance abuse and medical conditions are ruled out as etiologies.

Schizophrenia subtypes

In all of the following subtypes of schizophrenia, the diagnostic criteria for schizophrenia must be met first, particularly criterion A symptoms:

1. Paranoid type

A. Preoccupation with one or more delusions or frequent auditory hallucinations
B. Does not have prominent disorganized speech, disorganized behavior, flat or inappropriate affect, or catatonic behavior

2. Disorganized type

A. All of the following are prominent:
    1. Disorganized speech
    2. Disorganized behavior

3. Flat or inappropriate affect

B. Does not meet criteria for catatonic type

3. Catatonic type

Clinical picture is dominated by at least two of the following:

a. Motor immobility as evidenced by catalepsy or stupor

b. Excessive motor activity (apparently purposeless and not influenced by external stimuli)

c. Extreme negativism or mutism

d. Peculiarities of voluntary movement, such as posturing, stereotyped movements, prominent mannerisms, or prominent grimacing.

e. Echolalia or echopraxia

4. Undifferentiated type:

Symptoms of schizophrenia criterion A are present, but the criteria are not met for paranoid, catatonic or disorganized types.

5. Residual type

A. Criterion A for schizophrenia is no longer met, and criteria for other subtypes of schizophrenia are not met.

B. Evidence of the disturbance (evidenced by negative symptoms or two or more criterion A symptoms) is present in an attenuated form.

Course and prognosis

Course

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as bizarre delusions and hallucination tend to diminish, while the more residual negative symptoms such as poor hygiene, flattened emotional response and various abnormal behaviors increase.

Relapse rates are approximately 40% in 2 years on medication and 80% in 2 years off medication.

Suicide is attempted in 50 % of patients; 10% are successful.

Prognosis

Approximately one third of patients lead somewhat normal lives, one third continue to experience significant symptoms but can function within the society, and the remaining one third are markedly impaired and require frequent hospitalizations.

Differential Diagnosis

Schizophrenia should be differentiated from the following disorders.

1. Medical and neurological disorders.
2. Schizophreniform disorder symptoms are identical to schizophrenia but duration is less than 6 months.
3. Brief psychotic disorders symptoms lasting less than 1 month.
4. Mood disorder
5. Schizoaffective disorder in which mood symptoms develop concurrently with symptoms of schizophrenia.
6. Delusional disorder
7. Personality disorder
8. Factitious disorder

Management

Clinical management of schizophrenic patient may include hospitalization and antipsychotic medication as well as psychosocial treatments.

A. Pharmacological

1. The antipsychotic drugs used include

- Phenothiazines
  - Chlorpromazine
  - Thioridazine
  - Fluphenazine
  - Trifluperazine, etc
- Butyrophenones
  - Haloperidol
  - Droperidol
- Atypical antipsychotics
  - Clozapine
  - Risperidone
  - Olanzepine
  - Ometiopine

2. Available drugs in Ethiopia

- Chlorpromazine
- Thioridazine
- Haloperidol and
- Fluphenazine
- Trifluphenazine are the commonly used drugs.

3. Dosages

Chlorpromazine

The response to chlorpromazine is variable among different patients. Therefore, dosage should be individualized. Dosages of 150mg to 1200mg daily in 3 - 6 divided doses may be required to control the symptoms. Many cases are brought under control on a dosage of 200 - 400 mg daily. When improvement is established, the dosage may be reduced to a maintenance level which usually

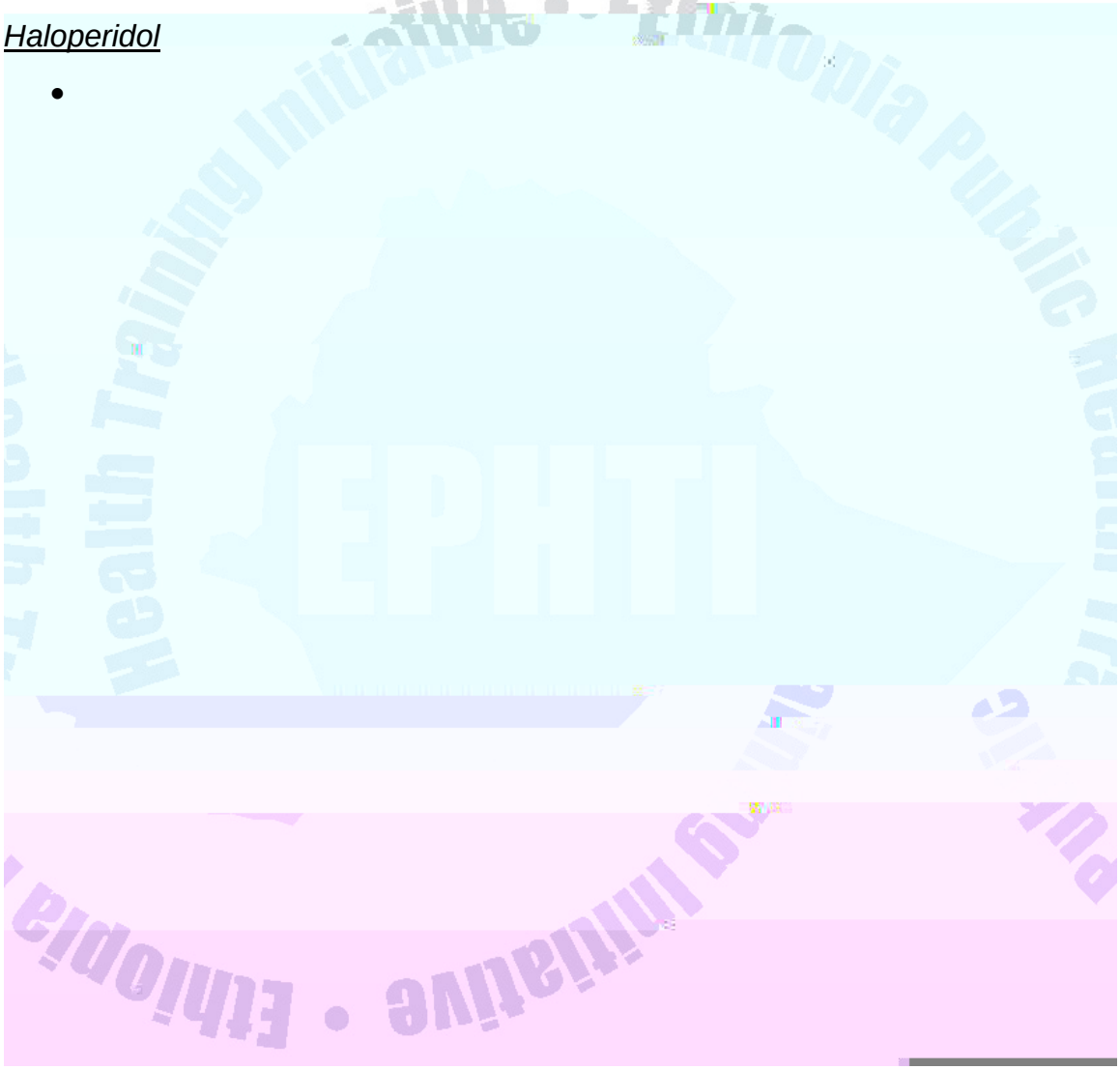
ranges between 100 and 300 mg daily. But much higher doses may be required in some instances.

Thioridazine

- 50 - 500 mg daily. The upper limit of Thioridazine can go upto 800 mg/day in divided doses.
- Monitor with EKG as it causes ventricular arrhythemia.

Haloperidol

-



3.1.5.2. Mood disorders

Introduction

Mood disorder is characterized by feeling of depression or euphoria sometimes with psychotic features.

Specific ‘mood episodes’ should be identified which help as building blocks for diagnosing ‘mood disorders’.

Four types of mood episodes are identified.

- Major depressive episodes
- Mixed episode
- Manic episode
- Hypo manic episode

A. Major depressive episode (MDE)

This is characterized by a feeling of anhedonia, withdrawal from family and friends, loss of libido, weight loss, anorexia, disturbed sleep (like insomnia or hypersomnia) of at least fifteen days duration.

On examination - such patients may have psychomotor retardation, agitation, sad mood, soft, low monotonous speech, suicidal ideas, feeling of hopelessness, worthlessness, guilt, delusions, hallucination, poverty of thought, poor concentration and memory.

B. Manic episode

This is a distinct period of elevated or irritable mood that lasts at least 1 week.

Such patients have disinhibited behavior, hyper sexuality, and excessive energy.

C. Mixed episodes

Such patients meet the criteria for two at the above disorders, which last over a week. They have pressured speech, irritability and the need for little sle-8je5ech, i

Lifetime prevalence of mood disorders is found to be 1.6% in Addis Ababa and 6.2 % in Butajira (1).

Age is not associated with risk but depressive disorders are believed to begin during adolescence.

Female sex is found to be significantly associated with mood disorders in a local study in Butajira (1).

The risk decreases with increasing educational attainment.

There is lower risk in the employed than the unemployed.

Ethiology

ü Biological

- Neuro chemical
  - Increased level of norepinephrine, serotonin, dopamine in mania.
  - Decreased level in depression.
- Hormonal
  - Hypothalamus-pituitary-adrenal axis involved

    E.g. Increased cortisol level in depression

    Decreased immune functions in mania and depression
- Genetic

  Both disorders tend to run in families

ü Psychosocial

- Stress
- Psychoanalytic
  - Loss of a loved one
- Cognitive
  - Negative self view
  - Negative interpretation of experience
  - Negative view of future