

## Mental health – a problem of the 21st century

DAGMAR DZÚROVÁ, EVA DRAGOMIRECKÁ\*

Charles University, Department of Social Geography and Regional Development, Prague  
\*Prague Psychiatric Centre, Prague

**Abstract:** The increasing prevalence of mental health disorders is likely to be a major problem in the 21st century not only because it is one of the consequences of population ageing and improvements in overall mortality conditions, but also because it is tied to changes in life styles and tempos of living. The need to map out the actual situation appears to be a priority task in this area. Results of the CIDI questionnaire survey, based on the application of an expert-system approach to diagnosing mental diseases, confirm that neurotic anxiety disorders are the most common psychopathology in the Czech population and that their incidence is significantly higher among women. Regional differences in hidden morbidity due to mental diseases imply a similar structure of linkages as in the case of mortality, especially from the point of view of differences by sex and other determining factors.

**Key words:** mental health, psychopathology, Czech population, questionnaire survey.

This paper is based upon work done as part of the author's home institution research plan No. CEZ: J13/98:113100007.

### 1. Introduction

At the beginning of the twentieth century, the majority of people in developed countries were still dying as a result of tuberculosis, pneumonia, influenza and other infectious diseases. By the end of this century, people live and die entirely differently than their predecessors one hundred years ago. In spite of the radical changes in life styles, urbanization, information explosion and growing social tensions, even the survival chances of severely ill persons, who previously would have been destined to die, are improving thanks to the advances in medical science. However, as people live to older ages, the incidence of chronic diseases, cardiovascular problems and immunity disorders is increasing. The diseases that eventually lead to death are related, in addition to genetic dispositions, to life style and quality of mental health. At the beginning of the next century, medical science will have to face a number of new problems, such as rapidly rising prevalence and hospitalization rates for persons with chronic heart and mental diseases, increasing average ages of affected persons, and also more complicated and more serious forms of health disorders. The proportion of the elderly in population will increase and the health care expenses will grow. The increasingly costly forms of treatment and prevention are likely to result not only in further mortality decreases and improvements in survival probabilities, but also in a growing prevalence of mental disorders.



## 2. Mental health

In the absence of an unambiguous definition, mental health is understood as the absence of mental disorders, a state of well-being as well as high quality of life. Impairments of mental health lead not only to psychic disorders, behavioural problems and pathological addictions, but their consequences often create a basis for social conflicts (limited ability to communicate, unemployment, aggressiveness, criminal behaviour, family breakdown, suicide).

Mental disorders are recognized as a worldwide problem, especially since the time when mortality-based measurement of the stress due to illness was broadened to include the extent of disability. The importance of a disease is not only assessed in terms of its effect on the life expectancy but also in terms of the number of years spent with a certain disability (disability-adjusted life years, or DALYs).

The World Health Organization, in its publication *World Health Report 1999* (WHO, 1999), states that the DALYs attributable to mental disorders represent 11 per cent of the total for all diseases, a proportion equivalent, for instance, to cardiovascular diseases. The importance of mental disorders in developed countries is about twice as high than in less developed countries (23 per cent and 11 per cent, respectively). From the point of view of the total economic burden associated with morbidity, two kinds of mental disorders are found among the ten most serious diseases, especially in developed countries (Table 1).

**Table 1 Rank of selected conditions among all causes of disease burden, estimates for 1998**

Condition	Rank by burden:		
	globally	in developed countries	in developing countries
unipolar major depression	4	2	4
alcohol dependence	17	4	20
bipolar disorder	18	14	19
psychoses	22	12	24
obsessive-compulsive disorder	28	18	27
dementia	33	9	41
drug dependence	41	17	45
panic disorder	44	29	48
epilepsy	47	34	46

Source: World Health Report 1999

Use and abuse of various kinds of addictive, psychoactive substances has a substantial, although controllable, impact on mental health and well-being. Illegal use of amphetamines and psycho-stimulating drugs is increasing in all regions of the world (the use of amphetamines, especially the so-called Ecstasy, is at the moment more prevalent than the use of heroin or cocaine). According to WHO estimates, the global number of persons addicted to nicotine is about 1.15 billion (according to a World Bank Study published in 1999, more than 80 per cent of smokers live in less developed countries where the anti-smoking prevention is not adequate); the global number of persons dependent on alcohol is 120 million, and the number of those dependent on drugs is 28 million. The dependency on alcohol is generally underestimated and socially tolerated.



The syndrome of alcohol addiction affects about 120 million people worldwide (World Health Report, 1998). Estimates produced by the WHO (World Health Report, 1999) indicate that alcohol consumption and smoking of cigarettes belong among the top ten risk factors contributing to the global mortality level (alcohol consumption 1.5 per cent, smoking 6 per cent). The dependency on psychoactive drugs is a significant determinant of deaths caused by self-damage or suicide.

Mental disorders are recognized as important in spite of the fact that they only rarely represent the primary cause of death. In contrast to other types of illnesses, a large proportion of mentally ill persons remains "hidden" in the population (many cases are either never diagnosed or they are diagnosed as a different disease). In addition, mental illnesses affect persons of relatively young ages, and because they are seldom properly treated they often lead to partial or complete disability. Generally, the treatment of mental health problems does not necessitate large financial inputs into technical equipment but rather a well thought-out network of services, above all at the community level, reinforced especially in the areas of prevention and counselling.

### 3. Methodological aspects

With the present state of health care in the Czech Republic which is typified by limited financial resources and a gradual transfer of responsibilities to the local and regional levels, the need to monitor the health care needs in specific regions is increasingly recognized.

In the case of mental disorders, efforts to produce qualified estimates of the numbers of persons affected are complicated by several crucial factors. The main of them is related to the difficulties of defining normality and differentiating between severe "psychiatric" cases and cases where mental problems are merely sub-clinical symptoms of an ordinary psychopathology. The lack of agreement among researchers on these issues has the effect that particular findings about mental health of the population usually differ and are incomparable. Another problem is the so-called unregistered morbidity, which is the outcome of the fact that a certain proportion of persons who are "psychiatric cases" never asks for medical assistance while others are treated for somatic health problems and are thus never declared as psychiatric patients.

The most easily accessible source of data to study factors determining the differences in mental health is statistical registration. In the area of psychiatric morbidity, one can use data about hospitalizations, visits in outpatient clinics and information on morbidity related to absences from work or disability payments.

Because it is well known that only a fractional proportion of persons experiencing mental disorders seeks psychiatric care, registration data are often supplemented by special surveys conducted through general practitioners or medical professionals in other specializations (internal medicine, gynaecology, etc.). The majority of persons with psychic disorders sees a general practitioner on a long-term basis but only about every tenth patient is referred to a psychiatrist (Škoda, 1976). Methods used in such surveys are designed to monitor also the extent of mental disorders in individual patients, not only the presence or absence of a psychiatric diagnosis. One Czech survey on psychiatric morbidity in general practice (Baudiš et al., 1986) was based on the often used Goldberg



Questionnaire of General Health (GHQ) which makes it possible to assign to each patient a number on a five-grade scale, ranging from 1 = completely healthy, to 5 = seriously ill, hospitalization for psychiatric reasons necessary. The use of questionnaires is undoubtedly useful because it also enables the collection of data on social, demographic and personal characteristics, all of which can be related to psychiatric disorders. The disadvantage is that applying different instruments and using different operationalizations of the term "psychiatric case" can render results from different surveys incomparable to each other.

Recent studies focusing on the measurement of psychopathology in a population have attempted to overcome this shortcoming by strictly relying on the international classification of diseases and defining a psychiatric case simply as a person with a psychiatric diagnosis. A population survey that measures both the unregistered and undeclared morbidity thus appears to be the best method for assessing the total number of psychic disorders.

#### 4. Mental health and geography

With some simplification, research on the geography of mental health can be classified into two categories: 1) geography of mental disorders, and 2) geography of psychiatric care (Hester, 1998). The first category comprises research which, on the basis of epidemiological data, analyses regional differences in characteristics of mental health in a certain diagnostic category in relation to environmental factors (in the so-called ecological studies, a cross-sectional approach is often applied). Research of the second kind is frequently used to plan and assess the quality of mental health care within a certain region, or to demonstrate the validity of new types of social and rehabilitation programmes for the mentally ill.

An interesting overview of the history of geographic approaches to mental health is provided by Holley (1998). Holley considers the interest in the geography of suicide as the first contribution to understanding of the geographic distribution of psychopathological phenomena. In most European and American countries, the statistical monitoring of suicide has a century long tradition and focuses primarily on the clarification of the relationships between the frequency of suicide and demographic, economic and other characteristics of social systems. The rationale of this approach rests, since the time of Durkheim, in the statistical stability of suicide in individual countries and the variation of suicide rates in different social systems. Opponents of this approach call attention to the possible distortions in mental health statistics (for instance, due to the tendency to avoid criminal punishment), and also criticise the premise that stability in the statistical occurrence of a phenomenon reflects its social nature. It is generally accepted that the demographic-statistical methods cannot replace psychological analysis, but they can be nevertheless helpful in describing the ecological region which can be to certain extent conducive to suicide (Dragomirecká, 1998).

Other examples of the geographic approach to mental diseases can be found in studies which, on the basis of time series of data on psychiatric hospitalizations in specific regions, have demonstrated that the probability of a person's hospitalization in a psychiatric clinic is dependent primarily on the distance between his place of residence



and the clinic. The finding that the distance from a service-providing facility predicts the intensity of its use has been repeatedly tested in both clinical and outpatient facilities and is now considered essential in the planning of psychiatric services (Holley, 1998).

The first population-wide studies on psychiatric morbidity were carried out in Great Britain following World War II, in connection with the process of building satellite cities to compensate for the destroyed parts of London (Martin, Brotherson and Chave, 1957, in Škoda, 1976). About one quarter of the 16,500 persons who participated in such a resettlement were subject to a complex medical examination, including psychiatric tests, and had been monitored over a longer period of time. Whereas the number of persons seeking psychiatric care was found to be very small (3 per 1,000 were admitted to a psychiatric clinic; less than 5 per 1,000 were referred to a psychiatric outpatient facility), nearly one third of these persons showed symptoms of a sub-clinical "neurotic syndrome". Similar results were obtained in a study conducted in 1959, which again examined the results of examinations of persons transferred to new urban settlements near London (Taylor and Chave, 1964, in Škoda, 1976). While the rate of psychiatric hospitalization was less than 2 per 1,000 persons, the incidence of the sub-clinical neurotic syndrome was 330 per 1,000 persons.

Studies focusing on the links between urbanization and psychopathology represent another area of interest in the geography of mental health. Based on data from big American cities, the so-called social-ecological studies of the 1960s articulated the hypothesis of "ecological distribution" of mental disorders. The highest prevalence rates were found in city centres, the lowest in suburban areas (Holley, 1998). However, differences in measurement methods and disparities in definitions of mental "health" and "diseases" have the effect that studies on the prevalence of psychic disorders yield widely differing results. Some sources claim that as much as 80 per cent of inhabitants of big cities experience mental disorders (Škoda, 1976).

Apart from the already mentioned approaches, qualitative methodologies have recently been increasingly applied in the geography of mental health. Studies of this kind focus primarily on individual mental health patients and treat the "hard data" (such as information on admissions to psychiatric facilities) as merely the result of mutual relationships between the patient's inner world and his/her social environment. The aim of this approach is not to obtain representative results but rather to gain an insight into the patient's world in comparison to the psychiatrist's perspective. Many studies from this field question the objectivity of traditional research methodologies, introduce into the mental health area new techniques (especially the ethnographic approach and the method of prospective monitoring including detailed descriptions of cases) and test the basic methodological and philosophical axioms of the research process.

##### **5. Retrospective survey of hidden psychopathology in the Czech Republic**

In the late 1980s the WHO initiated work on a set of instruments based on the International Classification of Diseases, with the aim to obtain mutually comparable data on the population incidence of mental disorders. The result of this effort has been the



structured questionnaire CIDI (Composite International Diagnostic Interview), a broadly applicable tool for the detection of mental disorders in a population. The CIDI questionnaire is currently used in more than 25 countries all over the world (Kessler, 1999).

The Czech Republic joined the WHO-coordinated international surveys on mental health in 1997. The survey of hidden psychopathology<sup>1</sup>, which is intended to cover the whole territory of the Czech Republic during the period from 1 July 1998 to 31 July 1999, is a sample survey organized by the Psychiatric Center Prague, in collaboration with the Institute for Health Information and Statistics (ÚZIS) and the Department for Social Geography and Regional Development at the Charles University. The survey uses a network of appropriately trained interviewers recruited mainly from university students.

The Czech set of survey questions – an instrument called CIDI-Core Cz. Version 2.1 – was developed from the original English CIDI document, following a permission from the WHO. The CIDI questionnaire was designed to include 15 sections, ranging from demographic data about the respondent to the respondent's assessment of the interview. The interviewers record all answers already during the interviews using the databasis of a notebook. The software equipment of CIDI was designed as an expert system capable of evaluating the answers and identifying, immediately after the end of an interview, an appropriate diagnosis of mental illness in terms of the 10<sup>th</sup> revision of the International Classification of Diseases and Causes of Death. Specifically aimed questions in the CIDI survey were designed to assess the respondent's mental health during all his/her lifetime (longitudinal, retrospective survey) and also to calculate the age interval during which the respondent experienced a given disease. The nationally representative sample of respondents, consisting of 2,500 names and addresses of permanent places of residence, was compiled using a three-stage sampling procedure based on data about all inhabitants aged 18 years and above from the Central Registry of Inhabitants of the Ministry of Interior.

### Method

Levels of morbidity due to mental diseases were assessed by means of incidence rates calculated using the "person-time incidence rate" method, or PIR (Basic Epidemiology, WHO, 1993, p. 17). The calculation of PIR was based on longitudinally arranged individual data, which permitted to evaluate events (mental diseases) experienced by respondents during their whole lifetime. Principles of the demographic (Lexis) grid and the demographic lifelines were employed. The lifelines were defined as starting in a respondent's year of birth and ending in 1999, the year of the survey. Onsets and the terminations of diseases were conceptualized as points on the lifeline, determining numbers of years lived with and without a mental disease.

Using the years of births of respondents as a criterion, six cohorts were defined (1980–89, 1970–79, 1960–69, 1950–59, 1940–49, and 1939 or earlier). Data for each birth cohort were categorized by age, using 10-year age groups ranging from 0–9 years

---

<sup>1</sup> The project No. 4978-3, entitled "Recruitment of persons and data for the survey on mental health using a probability sample of adult population of the Czech Republic" is financially supported by IGA MZ.



to 60 years or more. The "person-time incidence rate" for a given birth cohort was computed as a ratio of the sum of newly emerging diseases and the sum of disease-free years lived by members of the cohort within a given age interval. Calculations were made separately for each sex and two categories of educational attainment (with and without a school-leaving exam at the secondary level). For each of the six birth cohorts considered, two additional indicators of morbidity were calculated:

- (i) the average age at the onset of a mental disease, and
- (ii) the average length of illness.

### Results

As of 30 April 1999, only about 60 per cent of planned interviews were completed, of which 596 were with female respondents and 581 with male respondents. Initial analyses of survey results showed that 858 respondents, or 73 per cent, were never diagnosed a mental disease during their lifetime. As least one mental disorder was diagnosed in 27 per cent of respondents; only one mental disorder occurred in 19 per cent of respondents. Three groups of hidden mental disorders were most frequently experienced by our respondents:

- (i) neurotic, stress-related and somatoform disorders, dg. F40-F48 (15 per cent);
- (ii) behavioural disorders caused by the use of psychoactive substances, dg. F10-F19 (12 per cent);
- (iii) affective disorders, or mood disorders, dg. F30-F39 (9 per cent).

However, the relative importance of these three categories of disorders varied significantly in relation to the respondent's gender. Among women the most frequent mental disorders were those associated with stress and mood disorders (21 per cent and 11 per cent, respectively); among men the dominant category of mental disorders was the use of psychoactive substances, especially tobacco and alcohol (16 per cent).

The analysis of incidence rates of hidden psychopathology by age, sex, cohort membership and educational characteristics of respondents of the CIDI survey has revealed three significant findings. The basic conclusion is that the age-specific incidence rates for younger cohorts are always higher than the corresponding rates for older cohorts (taking the group 20–29 years as an example, the incidence rate for men born before 1940 is 2.7 per 1000 person-years but in the 1970–79 cohort it is almost eight times higher; Table 2). Men aged 40–49 years with a school-leaving exam exemplify the only category for which incidence rates are lower in the younger cohorts. This corresponds to results of existing analyses of behavioural change in the Czech Republic which have confirmed that following 1989, improvements in health-status characteristics have been greatest among more educated, younger persons, especially men (Blažek, J. and Džurová, D., 1998; Rychtaříková, J., 1998).

Another important conclusion stems from the observed differences in incidence rates by sex. In nearly all age groups, the incidence rates of hidden psychopathology are higher for women than for men, especially in younger and older age categories (for example, in the age groups 0–9 years and 40 years or more, rates for women are nearly twice as high as those for men; Table 2). A higher demand for psychiatric care and a poorer subjective



Table 2 Person-time incidence rates of life time psychopathology, CIDI Survey

Age groups		0-9	10-19	20-29	30-39	40-49	50-59	60+	Onset	Duration of diseases
Birth cohorts										
<b>SEX</b>										
<b>Females</b>	1980-89	0,0	53,8						16,1	2,7
	1970-79	4,7	15,3	19,4					15,7	7,9
	1960-69	2,0	6,1	9,5	18,2				24,1	7,8
	1950-59	4,1	11,2	6,3	9,3	12,3			24,6	17,1
	1940-49	2,6	7,3	2,8	7,9	9,1	13,6		31,0	18,4
	-1939	4,2	5,4	3,4	7,1	6,1	5,0	10,8	33,8	23,1
	Average	3,4	10,3	6,6	9,3	8,7	7,7	10,8	25,8	15,1
<b>Males</b>	1980-89	0,0	16,9						17,3	1,5
	1970-79	1,8	16,2	27,8					17,9	4,9
	1960-69	4,3	5,4	15,7	17,3				22,4	9,9
	1950-59	0,0	6,9	5,6	9,8	2,2			26,2	16,7
	1940-49	1,8	3,6	7,6	0,0	5,8	8,8		30,7	18,0
	-1939	0,0	3,5	3,7	10,5	5,3	3,9	2,7	34,9	18,8
	Average	1,6	7,6	10,1	7,9	4,9	5,7	2,7	25,3	12,6
<b>EDUCATION LEVEL</b>										
<b>0</b>	1980-89	0,0	31,3						16,3	2,3
	1970-79	2,1	17,9	22,8					17,2	5,5
	1960-69	0,0	5,5	15,2	26,0				24,6	8,2
	1950-59	1,9	6,0	6,4	10,8	8,9			27,3	16,0
	1940-49	0,7	4,8	4,3	4,5	7,6	12,8		34,3	15,5
	-1939	3,4	4,4	2,7	8,6	8,0	4,1	7,9	34,3	23,2
	Average	1,6	8,0	7,3	9,1	8,0	7,2	7,9	28,1	14,4
<b>1</b>	1980-89	0,0	28,6						16,8	2,2
	1970-79	4,1	14,1	24,8					16,5	7,0
	1960-69	4,9	5,9	11,5	13,8				22,3	9,5
	1950-59	2,7	14,0	5,4	7,7	5,2			22,2	18,2
	1940-49	5,0	6,6	6,9	2,9	7,2	7,2		25,4	22,7
	-1939	0,0	4,7	5,0	8,8	1,7	5,1	4,2	34,2	16,9
	Average	3,5	10,1	9,6	8,0	4,8	5,8	4,2	22,7	13,5
<b>TOTAL</b>										
<b>Total</b>	1980-89	0,0	30,0						16,5	2,3
	1970-79	3,2	15,7	23,8					16,9	6,3
	1960-69	3,2	5,7	12,7	17,7				23,1	9,0
	1950-59	2,3	9,2	6,0	9,5	7,4			25,1	16,9
	1940-49	2,2	5,4	5,2	3,9	7,5	10,9		30,9	18,3
	-1939	2,2	4,5	3,5	8,7	5,7	4,4	6,7	34,3	21,3
	Average	2,5	8,9	8,3	8,6	6,8	6,7	6,7	25,6	14,0

Notices:

\* Person-time incidence rate = (Number of people with new disease / Sum of the years at risk) \* 1000

(the sum of the free diseases years in a specific age group)

\* Education level 0 without and 1 with leaving examination

\* Average duration of diseases between respondents from the same generation

\* Onset - average years when the diseases started



health status among women aged over 65 years were documented already in a questionnaire survey undertaken in the 1980s by the Prague Psychiatric Centre (then the Research Institute for Psychiatry) among older persons living in Prague and the district of Opava (Dragomirecká, E. et al, 1992). A possible explanation of these differences could be that mental morbidity in women is more significantly than in men influenced by negative effects of school and family environments. On the contrary, in four out of the five birth cohorts considered, men aged 20–29 years display lower incidence rates than women of the same age. One of the reasons of this disparity could be excessive consumption of psychoactive drugs, alcohol and tobacco by young men.

The last but equally significant finding is related to the differences in incidence rates by educational attainment. Among respondents aged below 30 years, incidence rates for more educated persons are higher than those for persons with lower education. This seems to indicate that younger persons with completed secondary education are exposed to higher levels of stress than their less educated counterparts. In contrast, among persons aged above 30 years, i.e. those who are typically out of school and economically active, the less educated have higher incidence rates. As far as mental diseases are concerned, persons with lower education are apparently more likely to be negatively affected by factors of their work place than persons with higher education.

### Discussion

Calculations of the average age at the onset of a mental disease show that the timing of the onset is different in different birth cohorts. The older the birth cohort, the higher the average age at which mental health problems first emerge (for example, for less educated respondents born in 1980–89 the average is 16 years but for those born before 1939 it is 34 years, i.e. nearly twice as high; Table 2). Similar declines in the average age at the onset of a mental disease have been observed in a number of countries (Garrison et al., 1992; Wittchen, Knauper and Kessler, 1994). These shifts could be related to:

- (i) radical changes in the life-style of populations (changes in family structures, urbanization, feminization, etc.)
- (ii) declining validity of responses with increasing age of respondents (the more time has elapsed from the illness, the more likely it is that respondents will give incomplete or inaccurate information).

### 6. Conclusions

Similarly as in other developed countries, survey results for the Czech Republic show that the importance of mental health disorders is growing. Especially alarming is the increase in mental diseases caused by consumption of psychoactive substances. At one hand, the rising seriousness of mental health problems in the Czech Republic is a logical outcome of population ageing and improvements in overall mortality conditions; on the other hand, it is also the product of the post-1989 changes in life styles and tempos of living. Given these facts, mental disorders can be seen as an epidemic of the 21<sup>st</sup> century, and the need to map out the actual situation appears to be a priority task in this area. The



currently conducted CIDI survey of mental health, which is based on an innovative expert-system approach, is a promising instrument for obtaining a new perspective on the regional differentiation of health status characteristics of the Czech population.

## References

- BAUDIŠ, P., MUDRA, M., SMUTNÁ, R., ŠKODA, C. et al. (1986): Psychiatrická nemocnost v práci obvodního lékaře. Edice "Zprávy", sv. č. 76, 99 p.
- BEAGLEHOLE, R., BONITA, R., KJELLSTROM, T. (1993): Basic Epidemiology, WHO, Geneva, p. 175.
- BLAŽEK, J., DZÚROVÁ, D. (2000): The Decline of Mortality in the Czech Republic during the Transformation: A Counterfactual Case Study. In: Cornia, G. (eds): Economic Shocks, Social Stress and the Demographic Impact on Mortality (in press).
- DORN, M., LAWS, G. (1994): Social theory, body politics and medical geography. *The Professional Geographer* 46, 106–110.
- DRAGOMIRECKÁ, E., ŠKODA, C., OTRUBOVÁ, V., JELÍNKOVÁ, R. et al. (1992): Charakteristika příznivého a nepříznivého vývoje zdravotní a sociální situace ve stáří. *Čs. Psychiatrie*, 88, č. 1, 2–10.
- DRAGOMIRECKÁ, E. (1998): Sebevražda jako jev sociální patologie – hledisko filozofické, sociologické a psychologické. *Amireport*, 6, 28, p. 27–28.
- DZÚROVÁ, D., DRAGOMIRECKÁ, E. (1997): Social Transformation and Mental Health: The Czech Republic after 1989. *Acta Universitatis Carolinae, Suppl.* p. 179–187.
- GARRISON, C. Z., ADDY, C. L., JACKSON, K. L., et al (1992): Major depressive disorder and dysthymia in young adolescents, *American Journal of Epidemiology*, 135, p. 792–802.
- HESTER, P. (1998): The politics of methodology in "postmedical geography": mental health research and the interview. *Health & Place*, 4, p. 341–353.
- HOLLEY, H. L. (1998): Geography and mental health: a review. *Soc. Psychiatry Psychiatr. Epidemiol.* 33: 535–542.
- KEARN, R. A. (1993): Place and Health: toward a reformed medical geography. *The Professional Geographer* 45, p. 139–147.
- KESSLER, R. C. (1999): The World Health Organization International Consortium in Psychiatric Epidemiology (ICPE): initial work and future directions – the NAPE Lecture 1998. *Acta Psychiatr Scand*: 99:2–9.
- RYCHTAŘÍKOVÁ, J. (1998): Úmrtnost v České republice podle rodinného stavu (Mortality in the Czech republic by Family Status). *Demografie* 2, p. 93–102.
- ŠKODA, C. (1976): Psychiatrická nemocnost v praxi obvodního lékaře. In *Novinky v medicíně*, p. 1–58. Avicenum, Praha.
- THE WORLD BANK (1999): Curbing the epidemic: Governments and the economics of tobacco control.
- VINAŘ, O. (1997): Stres, svoboda a smrt, *Remedia populi*, 4, p. 13–17.
- WITTCHEN, H. U., KNAUPER, B., KESSLER, R. C. (1994): Lifetime Risk of Depression, *British Journal of Psychiatry*, 165, suppl. 26, p. 16–22.
- WORLD HEALTH REPORT 1998 AND 1999, Geneva.

## DUŠEVNÍ ZDRAVÍ – PROBLÉM 21. STOLETÍ

### Résumé

Závažnost problematiky duševního zdraví se stává problémem pro 21. století nejen v důsledku demografického stárnutí a prodloužení naděje dožití na jedné straně, ale také změnou životního stylu, tempa, způsobu



života na straně druhé, v České republice pak také „porevolučními“ celospolečenskými změnami. S cílem získat vzájemně porovnatelné údaje o výskytu duševních poruch v populaci iniciovala koncem 80. let Světová zdravotnická organizace vytvoření souboru instrumentů založených na Mezinárodní klasifikaci nemocí. K vyhledávání duševních poruch v běžné populaci je určen strukturovaný dotazník CIDI, založený na výpočtu diagnóz duševních onemocnění metodou expertního systému, který se v současné době používá ve více než 25 zemích světa. V r. 1997 se stala účastníkem tohoto mezinárodního šetření duševního zdraví, koordinovaného Světovou zdravotnickou organizací, také Česká republika.

Výsledky CIDI šetření české populace v období let 1998/99, založené na kohortních analýzách úrovně míry incidence skryté psychopatologie, odhalily z hlediska věku, pohlaví a vzdělání tři významná zjištění. Základním zjištěním byla skutečnost, že téměř ve všech věkových skupinách došlo v rámci kohort k nárůstu úrovně incidence skryté psychopatologie. Další závěr vyplynul z porovnání hodnot úrovně míry incidence v rámci pohlaví. Téměř ve všech věkových skupinách byla zjištěna u žen vyšší míra incidence skryté psychopatologie než u mužů, zejména v nejnižších a nejvyšších věkových kategoriích. Posledním neméně významným zjištěním bylo potvrzení diferenciací míry incidence skryté psychopatologie z hlediska vzdělání respondentů. Osoby s nižším vzděláním jsou zřejmě z hlediska nemocnosti duševními chorobami více zasaženy negativními faktory pracovního prostředí než osoby se vzděláním vyšším.

Duševním poruchám se dostává jejich důležitosti navzdory tomu, že jsou málokdy prvotní příčinou smrti. Na rozdíl od ostatních případů onemocnění, velký podíl duševně nemocných zůstává v populaci „skryt“. Postihují však člověka v relativně nízkém věku a vyšší mírou neléčeného průběhu často ústí do částečné nebo úplné invalidity. Léčení duševních potíží většinou nevyžaduje velké finanční náklady na technická zařízení, ale „promyšlenou“ síť služeb, zejména na komunitní úrovni, posílenou zejména v oblasti prevence a poradenství. Zmapování aktuální situace se v této oblasti jeví jako prvořadý úkol.