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Appropriate Technology

Mental health care in the district hospital

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Psychiatric disorders are not peculiar to Western countries, and within the community served by a district general hospital in the Third World the incidence of major mental illness is about 1%; furthermore, the risk of any individual developing such a disorder is 10%.[1] Other studies in the developing world have found that 5-20% of patients have some form of psychiatric illness—commonly anxiety and depression—which may present with a variety of physical symptoms.[2] Few district hospitals have specialist psychiatric facilities or trained staff. This means that general duties doctors may have to take responsibility for providing care for patients with psychiatric illness. Help from the nursing and other health care workers is essential, although their co-operation may be difficult to obtain because of ignorance about, and prejudice towards, mental illness. My decision to initiate psychiatric visits to an upcountry hospital in Uganda was at first met with suspicion by the doctors, who thought that they would have to admit disruptive patients to their wards. Nevertheless, I received a warm welcome from medical assistants who were seeking help in the management of outpatients with somatic symptoms of anxiety and depression.

If psychiatric care is to be undertaken by general medical staff they must be familiar with modern psychiatric treatment and take the lead in preparing the other members of the hospital staff, and support them through their initial anxieties in looking after patients with psychiatric illness. It is also essential that priorities for care should be defined. Thus if Morley's guidelines are adopted those conditions that are common, disabling, disturbing, and treatable must be identified.[3] In a study in seven developing countries community representatives, health staff, and research teams selected psychiatric emergencies (acute psychosis, suicide attempts, drug and alcohol abuse), grand mal epilepsy, and chronic psychosis as their priorities.[4]

Management of psychiatric emergencies

Community leaders and village health workers have no problems in identifying patients with psychoses.[5] Many languages have their own words for the "run mad" and the "quietly mad"—for example, eddalu and l'akalogojjo in Uganda.[6,7] Probably, however, treatment will be sought only when the patient is acutely disturbed or if a hospital shows a particular interest or success in treating such patients. Acute psychoses often present with unacceptable behaviour such as abuse, going naked, overactivity, and destructiveness. The patient may arrive at the hospital tied up, handcuffed, or fastened to a large log of wood. Whatever the circumstances it is important to obtain a good history from the relatives, the local headman, or the police. In particular seek evidence of physical illness, including epilepsy, ask about alcohol and drug intake, and establish whether the patient is always fully aware of his surroundings and orientated in time, place, and person.

Patients often cooperate with the doctor given the opportunity. I once met a naked young man handcuffed to a hospital bed, which he dragged behind him through the hospital compound, waving a large stone in his free hand. The nursing staff had formed a wary circle around him. On being asked his problem the patient complained of too many injections in his buttock. After a further talk and a mug of tea he accepted a large injection of largactil into his arm. This anecdote illustrates that the staff's natural anxiety may actually encourage the patient's disturbed behaviour.

If faced with a violent patient keep calm and ensure that two or three male staff or relatives are near but not too close to be intimidating. Tell the patient that the staff are there to protect him from harm (from himself or others) and encourage him to talk. Offer food and drink but leave him plenty of "personal space." If he remains disturbed and overactive offer chlorpromazine 50-100 mg orally to help him "feel better and be in control." If he is cooperative arrange admission to a quiet room with minimal furnishings. Some hospital staff have an intuitive skill in calming the disturbed, and it is important to appreciate that time spent waiting for the patient to decide to accept treatment is more productive than a hasty attempt to overwhelm him. Physical restraint is rarely necessary and should be used only if violence persists. The aim of such restraint is to prevent the patient harming either himself or others and to administer a tranquilliser. It is best achieved by holding the patient's clothes, shoulders, mid-thighs, and calves, keeping the legs together and avoiding putting pressure on the neck, chest, or abdomen. The patient is then forced to lie face down on the mattress or floor. Remove any objects that may cause injury, such as shoes. Talk to the patient continuously, telling him when, where, and why the injection is being given. Chlorpromazine 100 mg intramuscularly (less if the patient is small or elderly) is effective and may be repeated every two hours. When oral medication is accepted the dose may be doubled, and the maintenance dose should be 200 mg (or less) four times a day. Haloperidol 5-10 mg intramuscularly half to one hourly (depending on size and age) followed by 10-20 mg given orally four times a day is an alternative regimen.[8] These drugs may cause excessive sedation and hypotension, but the commonest error is to give an inadequate dose for too short a time.

Drug treatment has largely replaced electroconvulsive therapy. Two 60 bed provincial psychiatric units in Kenya have not used electroconvulsive therapy for over 18 months (Acuda, personal communication). On rare occasions, however, patients with resistant severe psychotic depression or uncontrollable excitement may need electroconvulsive therapy, and for this they should be referred to a specialised psychiatric unit.

Making a diagnosis

ORGANIC ILLNESS

Any patient who presents in an acutely disturbed state must be examined and investigated to exclude organic disease. The history

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is also very important, and evidence of clouding of consciousness, disorientation, impaired thinking and memory, and marked anxiety with a fluctuating general state must be sought. Minor impairment of memory may be established only by questioning about recent events and asking the patient to remember a name and address after five minutes. Visual hallucinations are common in organic psychosis. Table I serves as a guide to the aetiology of acute organic reactions. The doctor should be particularly aware of the common local diseases, and in this respect it is of interest to note that the two most commonly used drugs in Butabika Mental Hospital, Uganda, were chlorpromazine and chloramphenicol. This was due to the misdiagnosis of typhoid as a functional psychosis.

TABLE I—*Causes of acute organic reactions. (Reproduced from W A Lishman's* Organic Psychiatry[35] *by kind permission)*

	Symptoms
(1) Degenerative	Presenile or senile dementias complicated by infection, anoxia, etc
(2) Space occupying lesions	Cerebral tumour, subdural haematoma, cerebral abscess
(3) Trauma	"Acute post-traumatic psychosis"
(4) Infection	Encephalitis, meningitis, subacute meningovascular syphilis. Exanthemas, streptococcal infection, septicaemia, pneumonia, influenza, typhoid, typhus, cerebral malaria, trypanosomiasis, rheumatic chorea
(5) Vascular	Acute cerebral thrombosis or embolism, episode in arteriosclerotic dementia, transient cerebral ischaemic attack, subarachnoid haemorrhage, hypertensive encephalopathy, systemic lupus erythematosus
(6) Epileptic	Psychomotor seizures, petit mal status, postictal states
(7) Metabolic	Uraemia, liver disorder, electrolyte disturbances, alkalosis, acidosis, hypercapnia, remote effects of carcinoma, porphyria
(8) Endocrine	Hyperthyroid crises, myxoedema, Addisonian crises, hypopituitarism, hypoparathyroidism and hyperparathyroidism, diabetic pre-coma, hypoglycaemia
(9) Toxic	Alcohol: Wernicke's encephalopathy, delirium tremens. Drugs: barbiturates (including withdrawal), bromides, salicylate intoxication, cannabis, LSD, prescribed medications (antiparkinsonian drugs, scopalamine, tricyclic and monoamine oxidase inhibitor antidepressants, digoxin, etc). Others: lead, arsenic, organic mercury compounds, carbon disulphide
(10) Anoxia	Bronchopneumonia, congestive cardiac failure, cardiac arrhythmias, silent coronary infarction, silent bleeding, carbon monoxide poisoning, post-anaesthetic
(11) Vitamin deficiency	Thiamine (Wernicke's encephalopathy), nicotinic acid (pellagra, acute nicotinic-acid-deficient encephalopathy, B_{12} and folic acid deficiency

FUNCTIONAL (NON-ORGANIC) PSYCHOSIS

Schizophrenia with delusions of special powers or persecution out of keeping with local beliefs, and auditory hallucinations, may present with or without excitement. The manic patient is over-active, sleepless, and disinhibited with euphoria and grandiose ideas. Such patients need to be carefully examined for evidence of physical illness once their excitement has been controlled. Chlorpromazine 50-200 mg four times a day or haloperidol 10-20 mg four times a day, reducing slowly to smaller maintenance doses depending on response, usually provides satisfactory control. Stress induced psychosis is common in developing countries. It may follow adverse life events such as bereavement or assault, but more subtle personal precipitants may be difficult to identify. Most patients with acute psychoses settle rapidly and medication may be withdrawn slowly. Those with persisting symptoms—usually chronic schizophrenia (which has a better outlook than in Western countries)—may need maintenance doses of major tranquillisers. Depot preparations such as fluphenazine decanoate 25-100 mg intramuscularly or flupenthixol 40-120 mg intramuscularly every three or four weeks may overcome problems of compliance with oral treatment. These preparations are expensive but are cheaper than repeated admissions to hospital.[9] It is advisable to keep a register of patients receiving maintenance treatment so that a failure to attend for further treatment and review may alert staff to take action to prevent a disruptive relapse.

Acute alcoholic psychoses (delirium tremens) may be controlled by a benzodiazepine—for example, diazepam 50-75 mg daily reducing after two or three days and stopping in a week. Haloperidol is an alternative. These patients and their families will need counselling on the hazards of excess drink and the benefits of reduced intake. Patients with epilepsy may also present with acute psychosis, which usually implies poor compliance with anti-convulsant treatment. Follow up should include supervision of medication as well as counselling of the patients and their relatives.

Management of patients with neuroses

A survey of 1624 outpatients in primary care clinics in four developing countries showed an overall frequency of psychiatric illness of 13·9%—mainly the physical symptoms of anxiety and depression.[10 11] More than 20% of outpatients who complained of weakness, dizziness, or abdominal or chest pain had a psychiatric disorder. Those with three or more symptoms were twice as likely to be mentally ill. These patients make huge demands on the hospital staff and on the hospital budget because many undergo needless investigations. In my view, the general duties doctor must be prepared to assess and when necessary treat these patients, and to do this he must be attuned to looking for depression, stress reactions, the anxiety aspects of physical illness, and the chronic symptoms of the anxiety prone individual.[12]

Patients with depressive illness may not complain of depression, but there are cross cultural core symptoms of sadness, joylessness, anxiety, tension, lack of energy, loss of interests, loss of concentration, and ideas of insufficiency, inadequacy, and worthlessness.[13] Antidepressants such as amitriptyline 25-75 mg twice daily may be very effective in these patients. In patients with anxiety, however, the doctor's first task is to help them understand that their condition has psychosocial rather than disease origins. Appropriate adjustments to their way of life may then become apparent. The doctor must promote self help and guide the patients towards tackling their own problems. Techniques of relaxation, desensitisation, implosion therapy, and brief psychotherapy with clear, feasible objectives may help the doctor to deal with patients who are often demanding and difficult to treat.[14 15] Minor tranquillisers such as diazepam and chlordiazepoxide should be used to treat only acute, severely disabling, short lived anxiety. They cannot solve psychosocial problems, and Third World health services cannot afford to follow the widespread and largely ineffective use of minor tranquillisers that has been evident in Western countries.

Patients who deliberately harm themselves or attempt suicide must be assessed carefully. Underlying psychosis or severe depression needs to be treated and all cases need close supervision while the underlying stresses on the patients and their family are assessed. It may be helpful to refer patients to community or religious leaders or, in some cases, traditional healers, who can provide further support and counselling. Nursing staff and primary health workers seldom have the time or the necessary skills to provide specialised care for such patients.

Attitudes to mental health

Mental health is now part of modern training programmes, but many hospital staff are still not yet prepared to manage patients with psychiatric disorders, especially those with neuroses, which were given a low priority in recent recommendations by the World Health Organisation.[16] I think that this is regrettable, especially with respect to depressive illness, which is common, easy to recognise, and treatable. In my view a major change in attitudes and allocation of resources to meet the needs of the mentally ill is needed. The first step could be to set up a local workshop where health staff could meet community and religious leaders, members of voluntary associations, teachers, and other interested persons to clarify priority problems and consider a community response to these. On an assignment in Swaziland, funded by the World Health Organisation, I found that the rural health motivators (mature and respected individuals with three months' general health training) grasped psychosocial concepts rapidly and were keen to help patients. Simple counselling skills could prepare them for potentially valuable work with outpatients, especially healthy young people who present with non-specific complaints such as eye strain, poor concentration, and academic failure. A manual for the

disabled has been published recently and has many other suggestions for community action.[17]

Some traditional healers specialise in mental health,[18 19] but does this mean that the doctor should cooperate with them? I believe that the wide variations in skill among such individuals must lead the doctor to be cautious, and that he should make a careful local assessment of their skills, methods of treatment, and results before committing himself to any formal liaison. It is salutary to remember, however, that patients will attend these healers anyway, both before and after they receive their Western care, regardless of the doctor's views.

Problems in childhood

Primary health care workers in the Sudan, Philippines, India, and Colombia have reported mental health problems in 12-29% of children seen.[20] Symptoms that are inconsistent, unusual, or associated with special circumstances are helpful pointers to diagnosis, as is the opinion of the attending adult.[21] Hyperkinesis may be associated with brain damage, developmental problems, or family problems.[22 23] Amphetamine up to 30 mg daily may help, though small doses of chlorpromazine, slowly increasing to 50 to 100 mg daily, may be all that is available. The attitudes of the family and school are crucial. Hysteria, manifested for example as [illegible]onia or paralysis without physical illness, usually follows stress, [illegible]gh details may need tactful exploration. Admission to hospital may allow a face saving recovery while the underlying stress factors are explored and ameliorated. Nocturnal enuresis has been managed effectively by parents in Swaziland by ignoring wetting and rewarding dry nights using star charts (Guinness, personal communication). Similar management of encopresis is possible.[24] Care of children with epilepsy must include measures to overcome negative attitudes in the community.

Mental handicap is considered to be untreatable by some doctors, but communities have placed it high on their priorities for care.[4] Parents lose heart and fail to teach domestic and self care skills, and unsatisfactory habits are established. A simple approach is to start with the control of fits or hyperkinesis and then teach that the mentally handicapped can learn but that they do so slowly. Various techniques have been devised for family use.[17] A scheme using mothers and village aides as teachers of mentally handicapped children is proving successful in Kenya (Horsfield, personal communication).

Training

The doctor in a Third World district hospital should initiate [illegible]ing schemes for health staff concentrating on a few tasks that are seen as priorities—for example, the use of drugs, restraint of the violent patient, and community care. Ask the country's psychiatrists and health teachers to visit the hospital for joint discussions with local health trainers and to take part in teaching the staff and arranging workshops. Brief psychiatric secondment for selected health staff is feasible in some countries—for example, in Bangladesh regular courses are run for district hospital doctors (Dr Hidayetal Islam, professor of psychiatry, Dacca). Zambia has a well established training scheme for medical assistants, which was started by Professor Alan Haworth. In India a similar approach has potentially wider application.[25] Further ideas may be gleaned by reviewing local pilot systems of care.[26 27] Training manuals may be most helpful, and several have been produced.[28-34] The use of flow charts is another valuable way to teach health workers.[35]

It is useful to compile a list of psychotropic drugs that are available in the hospital, together with standard dose regimens (table II). A local glossary of psychiatric terms is also helpful together with a list of local interpreters who need a brief training in how to elicit a psychiatric history. The use of non-hospital staff implies that policy decisions should be made to sanction their participation in the care of patients with psychiatric disorders. Their responsibilities and training will require the cooperation of local and probably national health trainers. Finally, the success of any training programmes should be evaluated.[36-38]

TABLE II—*Recommended psychotropic drugs for district general hospitals (second choices in parentheses)*

Chlorpromazine 25 mg, 100 mg tablet 25 mg/ml injection
Haloperidol 5 mg tablet
Fluphenazine decanoate 25 mg/ml injection
(Trifluoperazine 5 mg tablet)
(Flupenthixol decanoate 20 mg/ml injection)
Procyclidine 5 mg tablet
Diazepam 5 mg tablet
Amitriptyline 25 mg tablet
(Imipramine 25 mg tablet)
(Lithium carbonate 250 mg tablet)
(Mianserin and Nomifensine are antidepressants with fewer side effects but very expensive)
Health staff will need guidance sheets.

Conclusion

The general duties doctor can provide effective mental health care in a district hospital. Although psychoses usually take precedence over neuroses, local priorities of care must be identified. Intervention and appropriate management of these disorders may be achieved with limited facilities and scant resources.[16] The most important hurdle may well be that of overcoming local ignorance and prejudice.

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Suggestions for further reading

Tropical Doctor: Issues July 1983 to April 1985 contain a series of articles on the recognition and management of mental illness in adults and children for the general doctor working independently and far from advanced medical centres.

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Essex B, Gosling H. *Programme for identification and management of mental health problems*. (Tropical health series.) Edinburgh and London: Churchill Livingstone, 1982. (Softback £2·30.) Carefully evaluated and practical flow charts especially useful in teaching health staff who will work in isolation.
World Health Organisation. Organisation of mental health services in developing countries. *WHO Tech Rep Ser* 1975;No 564. Basic document for all health teachers and administrators.
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The following publications illustrate that mental health is a broad, positive concept and not simply the absence of mental illness. They are helpful in provoking staff to think beyond hospital walls.

World Health Organisation. *Promoting health in the human environment*. Geneva: WHO, 1975.
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mental health in india

'problems encountered . . .'

Dr. A. S. Mahal

Mental health is defined as not only freedom from illness, but as positive health in the sense that the individual is happy and satisfied, is adjusted in his social circle and has good capacity for work in order to produce enough for his maintenance and that of his dependents. The ideal state of health in a community is that in which all members of the community are having this standard of health. All those who are concerned with mental health, work towards this ideal. We in India fall much short of this. We are in the early stages of organising services for coping with serious mental health problems.

Types of illness

One has to understand the nature and magnitude of mental health problems, in order to get a fair idea of the task ahead of us. Major mental illnesses are named psychoses. There are gross disturbances of behaviour in these. One percent of our population suffer from psychosis at any time. There are at a conservative estimate more than five million psychotic patients in India. Minor mental illnesses are called psycho-neuroses and personality disorders. Examples of minor mental illnesses are patients of hysteria, anxiety neurosis, obsessive compulsive neurosis, phobias, reactive depression, psychopathic personality, drug addiction, alcoholism, sexual deviations, etc. The estimate of minor mental illnesses varies in different studies. As a conservative estimate about 10 per cent of the population suffer from minor mental illnesses.

Another major category of mental health problems is that of mental retardation. About 1 per cent of the population suffer from this disability. Still another major problem is that of epilepsy. Again, approximately, 1 per cent of the population suffer from epilepsy.

Problems encountered

Mentally disturbed persons have difficulties in their life. They fail to form mutually satisfying interpersonal relationships with other human beings. They have chronic interpersonal problems, which do not get solved without expert help. In this category may be considered cases of marital discord, some of the chronic parent-child and employee-employer problems. These cause a lot of human suffering, and are both the result and the cause of mental ill health. These exist in any community in very large numbers. Serious emotional upsets

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also result in such abnormal behaviour as is seen in cases of suicide and attempted suicide. In each large town and city in India, a number of persons are brought to hospitals every day, after having made an attempt at suicide.

Indequate facilities

For the management of major mental health problems we have in India 38 mental hospitals spread all over the country. Most of the states have one or more mental hospitals. These hospitals have in them about 20,000 beds. For catering to half a million seriously disturbed mental patients in our country this number is utterly inadequate. These facilities are being utilised by less than 1 per cent of the total number of psychotic patients that we have amongst us. Most of these beds in our mental hospitals are occupied by chronic mental patients, who are held in mental hospitals for indefinite stay without much active treatment being given to them. Very few beds are available in our mental hospitals for admission of new cases. These mental patients can be treated and restored back to their homes and jobs. Most of the first admission cases, if they are brought early for treatment, recover from their illness and are able to return to normal life, and to treatment as outpatients. More facilities, and preferably geographically more dispersed, need to be created for the treatment of these patients. With the availability of trained psychiatrists, clinical psychologists, psychiatric social workers, occupational therapists and psychiatric nurses on the staff of some of our mental hospitals, such quick turn over wards are now being organised in them. Most mental hospitals have also started outpatient departments, which give outpatient treatment to a variety of mental patients.

In the last decade psychiatry departments have been added to a number of medical colleges with facilities for outpatients departments as well as psychiatric wards in their general hospitals. These O.P.D.s and psychiatric wards are helping a large number of patients with minor mental illnesses. This is a welcome addition to existing mental health facilities.

Urban bias and rural neglect

In large towns and big cities some charitable hospitals and nursing homes have also recently started helping mental patients with the additon of O.P.D. facilities and provision for admission of less disturbed mental patients. Also these urban areas have practising psychiatrists who cater to the needs of patients who consult them on payment.

Facilities for the care of the mentally retarded are few. There are a few institutions in our cities for the care of the profoundly and severely mentally retarded. Facilities for the mildly and moderately mentally retarded are even fewer in number. Epileptics are cared for by physicians, neurologists as well as psychiatrists. Disturbed epileptics share existing facilities with other mental patients in our mental hospitals. Child Guidance Clinics have recently come up in some cities for helping emotionally disturbed children.

Almost all these facilities exist only in towns and cities. The vast rural population has no facilities for the care of mentally ill patients. When in serious need, they have to travel long distances to avail of these facilities in towns. In less serious cases and even in serious cases when they cannot afford it, they do without any psychiatric help.

Training programmes

In India we now have facilities for the training of personnel for mental health care. Mental patients are cared for by a team of professionals consisting of psychiatrists, helped by clinical psychologists, psychiatric social workers, occupational therapists and psychiatric nurses. We train in India about 100 psychiatrists a year. The major training institution is the National Institute of Mental Health and Neurosciences, Bangalore. There is another training centre at Ranchi. Both these institutions also train clinical psychologists and psychiatric social workers. Bangalore trains psychiatric nurses also. Psychiatrists are also trained in psychiatry departments of medical institutes and upgraded psychiatry departments of some medical colleges. Courses for psychologists and social workers are run in 26 universities in India.

With trained professionals coming out of our institutions we have the necessary personnel for rapid expansion of facilities for mental health care of our people. We can do it as fast as our resources permit us, and as fast as we plan to utilise these professionals. It is tragic that in the absence of rapid expansion of mental health care facilities and to get better pay, some of the trained staff is leaving India to go abroad.

The Delhi scene

Delhi being the capital city of India, has a number of institutions giving psychiatric care. Hospital for Mental Diseases, Shahdara, has 350 beds. In addition, 250 newly constructed beds are ready for occupation as soon as it is equipped and staffed. It runs an O.P.D. which caters to a large number of patients. There are O.P.D. and psychiatric wards at A.I.I.M.S., Safdarjung, Willingdon, Loknayak J.P. Narayan, and Pant Hospitals. Hindu Rao Hospital has an O.P.D. Sir Ganga Ram, Mool Chand, Kharaiti Ram, Holy Family and Saint Stephen's Hospitals have O.P.D.s as well as facilities for admission in general wards and nursing homes. A number of psychiatrists in private practice run clinics for the benefit of patients.

For the mentally retarded we have institutions at Punjabi Bagh and Okhla. Schools for mentally retarded are there at Lajpat Nagar and Bhagwan Das Road. We have Child Guidance Clinics at A.I.I.M.S., the College of Nursing, and the Community Centre at Rajinder Nagar.

A unique voluntary institution functioning in Delhi is Sanjivini, at Bharatiya Vidya Bhawan, Kasturba Gandhi Marg, New Delhi, which renders help to those disturbed and desperate human beings who have made an attempt at ending their lives.

befriending

'the one discovery . . .'

Rev. Chad Varah

In the fields of suicide prevention and mental health, all new discoveries except one have been improvements in professional treatment, and particularly in psychiatry. Every development in psychological medicine and chemotherapy spreads relatively rapidly through medical journals and conferences, and each new method of psychotherapy or counselling is likely to become a craze for a while until its solid merit and appropriate application have emerged and it takes its place amongst others, both older and newer.

The one discovery which does not directly involve professionally qualified people and which makes its contribution to suicide prevention and to the mental health of the community is that which is called "Befriending". I was the one who noticed it, studied it, and gave it the opportunity to prove its effectiveness, and count myself very fortunate to have been able to make such an observation in 1953 and also to be able to put it to the test.

I had also publicised my telephone number and address so that suicidal and other lonely and despairing people might get in touch with me, day or night. This was the origin of the many types of "hot lines" which have proliferated in countries which make great use of the telephone, but of course these are not necessarily similar to The Samaritans. The response nearly overwhelmed me, but kindly disposed men and women rallied around to try to help by giving tea or coffee and a kind word and a listening ear to those who had to wait a long time for their interview with me.

These extraordinary "ordinary" people, with no qualifications but great human qualities, soon seemed to me to be more what the "clients" wanted than I was. Admittedly, some needed a professional like myself, or perhaps a psychiatrist, at a later stage, but the *first* need in the genuinely desperate cases was a listener who truly felt for the sufferer and had no advice or expertise to hide behind. It was a very vulnerable position and only the most loving souls could manage it. These "Samaritans" supported one another and of course received much appreciation and back-up from me. What they were doing was giving instant friendship to a stranger in distress, and thereby giving the person the emotional support necessary to enable him or her to see the way forward, just far enough for a suicidal act to be deferred. Their spirit was so much that of the Samaritan in the Christian parable that I felt "Samaritan" was a good name for these people, only a minority of whom were Christians.

The word "Samaritan" now has as one of its definitions in the Concise Oxford Dictionary, "member of an organisation to befriend the suicidal" and

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we hope that in the next edition "Befriending" will appear as an effective therapeutic method for depressed and lonely potential suicides.

The sense of befriending is its humility and the fellow human feeling that goes with it. The befriender has been *selected* (there is no way by which self-centred people can be turned into Samaritans) because he or she is found to be one who genuinely cares about the troubles of others, and who does not feel in any way superior to those whose lives are obviously in some disarray. Merely to be with a befriender for a while makes you feel better, even though nothing will have changed except that you have found acceptance, understanding and compassion.

What do the befrienders *do*? enquires the person who thinks of clients as collections of problems to be solved or operated upon; and the answer to such people must be "nothing mostly." That is to say, they do nothing which would make any sense to the do-gooder or impress the narrowest and most insecure type of professional. To those with open minds and hearts, the answer would be: "The befriender is not there to do for the client what he or she can possibly be expected to do for himself or herself, though some form of practical help in matters in which the client is temporarily incapacitated is not forbidden; but the befriender is not to be judged by what he or she does or even says, but by *being* the loving and attentive fellow human the client needs."

It is so simple a child can understand it. It is so profound that sages can philosophise about it indefinitely. It is so easy you could burst into joyous laughter when the miracle has happened. It is so difficult you sometimes feel you won't be able to sustain it for the necessary length of time. It is suffering and it blesses you. But words cannot make it clear: you must try to do it; or gratefully accept it when it is done to you.

adolescent suicide behaviour in india

'adolescence is a no mans land . . .'

Prof. A. Venkoba Rao

Certain general points of relevance are considered before discussing the suicide behaviour among the youth of India.

It is seen that 16.6 per cent of the population falls in the age range 15-24. This indicates that the youth forms a considerable segment of the country's population. Though the second most populous country in the world, India takes 16th place among the countries for suicide rate. The annual suicide rate varies from 6.3 - 8.8 per 100,000. Suicide is the fifth leading cause of death among adolescents in the 15-19 year group (Jacob, 1971). That adolescent suicide and attempted suicide are common in India is borne out by published data. Suicide and attempted suicide in the college campus is a familiar experience to administrators of these institutions and universities. The published records have all indicated the higher occurrence of suicide among the younger people, the greatest 'rush' group being that between 20-30 years of age.

The youth of the country has been drawing attention in recent years, as perhaps even in the times of Socrates. Student unrest and indiscipline, distractions during application to the educational curriculum, explosive outbursts for trivial authoritarian actions, strikes on a smaller or a larger scale in the schools and colleges, violence in the college campus, 'gheraoing' the so-called authoritarian figures, non-medical use of drugs in preference to attending the classes, frequenting the horror films, indulging in crime and detective literature and illicit sexual indulgence; all these and others indicate a malady of aggression among them. In a country like India with its escalating population, the youth finds itself in a state of frustration for reasons more than one. It will be worthwhile to examine them in some detail: They are of socio-pathological importance to the topic of suicide behaviour.

Unemployment: Unemployment is a daunting problem in India today, and in urban areas it is worse, especially so among the educated. This number is bound to rise in view of the expanding facilities for literacy and higher studies. Unemployment among the youthful members, even though they are supported by other members of the joint family is a cause of frustration since it carries a *stigma of social disapproval.* The unemployed youth lacks a feeling of individuality and prestige and finds himself unable to take responsibility of

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running the family in the event of the disability, or the death of the bread winner in the family. Most important, he is not preferred in marriage. His, is a lot of 'social ostracism' or 'isolation'. It is interesting to note that in India there are certain castes whose members feel it beneath their dignity to work and these are unemployed but yet are unwilling to work, even if work is offered to them. Unemployment can be a strong motivator of suicide. In a study on suicide conducted by Bagadia and colleagues in Bombay (1976), it was found that 40 per cent of the group studied had been unemployed for more than a year. Mention must be made of suicides among those who return home after higher qualification and training abroad. Unemployment among this group has resulted in suicide in several instances. In Dr. Venkoba Rao's study of 423 suicide attempts registered in the Madurai Centre, unemployment was identified as the direct precipitant of suicide attempts among 190 of the group. Unemployment due to psychiatric and physical disability can often lead to self-destructive behaviour. These are the social consequences of illness.

Job Satisfaction. Here the situation appears different from the previous group. The youth has a job on hand but finds himself unfit for it or finds it difficult to realise his desired aims and goals. This is a familiar picture among the intelligent and creative youths who find that official and administrative machinery are impediments and dampen their enthusiasm. Suicides have occurred among the personnel of research organisations in India presumably from these causes.

Marriage and Sex. In India, marriages are usually arranged and are determined by factors like status, economic parity and caste. Adherence to this may result often in unwilling and forced marriages. These may result in suicide attempts or completed suicide. The boy or the girl may be forced into marriage against his or her wish by the authoritative parents. In some instances they submit in obedience to the wishes of the elders although that means the sacrifice of their personal choice. Where the traditional way is disregarded, marriage takes place on the basis of personal choice, but they do not meet with parental approval. Or else such a marriage is not allowed and the lovers, not uncommonly, commit suicide together, or in some cases the disappointed one alone succumbs and the other gets on with a happy marital life elsewhere. Among the Indians, as in other cultures, a high value is placed on semen as the fountain of robust health. Its loss through masturbation or nocturnal emission may result in under-valuation or devaluation of the youth's sexual power and lead to a fear of impotence and failure in marital life, or depression and psychogenic impotence and suicide behaviour. Impotence, either from physical or psychological causes, is not an infrequent cause of self-destructive behaviour.

Failure in Examination. It is not an unusual experience in India to read in the newspapers about a minor epidemic of suicide following the announcement of the results of university or school examinations. Invariably, these are acts of 'impulsiveness'. More important are those instances that are tied up with the family's economic status and its prestige. Indian society attaches a label of superiority to the educated, especially in the rural areas. There are students from poverty-stricken homes where parents stake their all for the youngster's education. Failure under these circumstances

naturally means loss of everything monetary, and the disappointment of cherished ambitions. The result is suicide by the student and occasionally by the disappointed person. Failure symbolises a loss of prestige and a dashing-down of the expectations of the family and a bleak future.

Impact of Industrialisation. The general trend in suicide in Afro-Asian countries is one of a higher rate for younger age groups and a relatively low rate for the elder group. This is generally attributed to the cultural values like respect and reverence for the aged, and the important role that is played by elders in the familial and social situations. Those societies in Asia where the impact of industrialisation has been intense, this trend has been found to be gradually reversed. In India such a reversal has not yet taken place and the pattern of suicide is typically that of the reported Asiatic pattern. The few studies done on suicide in rural areas confirm that the pattern is similar to that in the urban settings—youth outnumber the elderly.

In a recent study from the suicide centre, at Erskine Hospital, the causes of suicide were listed as: Misunderstanding with family members like parents, spouses and in-laws (28), failure in love affairs (3), proverty (4) and unemployment (25) and other miscellaneous causes like dysmenorrhoea (12), etc. Six were psychiatrically ill, three had defects such as stammering, epilepsy, etc., three had personality disorders, one was psychogenically impotent. Our earlier studies (Venkoba Rao, 1965) indicated a ratio of 1:8 to 1:12 for completed to attempted suicide. In the present series of 432 cases collected early this year, there have been only five completed suicides. This puts the ratio of completed to attempted suicide at nearly 1:86. This phenomenal improvement of the situation is to be attributed to the setting-up of a separate resuscitation and detoxication unit in the hospital during the last five years. The new set-up has all the facilities available for the dangerously poisoned or accident-involved patient in a single place. This type of secondary prevention must answer some of the criticism against the suicide prevention programme. True this type of saving is not likely to lower the rate of suicide in a given area. However, as Farberow (1976) has rightly remarked the aim of the movement is not as much to bring down the suicide rate as the saving of the life of an individual.

Adolescence is a no man's land. The problems of adolescents need identification and understanding. Unless tangible solutions are offered by the conjoint action of families, educational and social organisations and governmental machinery, frustration—the final common pathway and the prime motivation for self-destruction—is likely to continue unmitigated. Studies in India have revealed that adolescent suicides and attempted suicides are common and social, educational, family, marital and sexual factors play an important part. If adolescence has been called a period of freedom, resorting to suicide behaviour is a form of escape from it.

from one who was helped . . .

मुझे संजीवनी में आकर . . .

कई बार व्यक्ति के जीवन में ऐसा हो जाता है कि कई तरह की दिमागी परेशानियाँ आ जाती हैं और व्यक्ति उनमें उलझ जाता है। ये उलझनें कई बार तो वास्तविक होती हैं पर कई अवसरों पर सिर्फ कुछेक परेशानियों का सामना करने में असमर्थ होने पर व्यक्ति हीन भावना से ग्रस्त हो जाता है। उसमें हीनता का इतना प्रभाव पड़ जाता है कि किसी और से विचार-विमर्श करने तक की हिम्मत खो बैठता है जिसका परिणाम यह होता है कि व्यक्ति अपने आप में ही परेशानियों में उलझा रहता है जो आगे जाकर एक बड़ी परेशानी का रूप ले लेती है। कुछ मास पहले मैं भी ऐसे ही एक जाल में उलझा हुआ था।

बचपन से ही मैं एकांतप्रिय रहा। मेरी सभी रूचियाँ एकांतप्रियता से मेल खाती रहीं। इससे मैं लोगों से अलग-थलग रहा। न किसी से मन की कोई बात कहनी और न ही पूछनी। कोई भी परेशानी आती तो उसको अकेले में बैठा सोचता रहता और अधिक सोचने के कारण परेशानी के असली रूप से हट जाता। ऐसी आदत के समय में कुछ ऐसी असफलताएं सामने आयीं जो कि किसी भी व्यक्ति के जीवन में स्वाभाविक हो सकती हैं। पर मैं इन असफलताओं के कारण अपने में कई कमियाँ महसूस करता। हर कदम उलटा लगता, दूसरे की हर बात का मतलब उलटा लेता, अपने हरेक काम में दोष निकालता, अपने गुणों की तरफ कभी गर्दन उठा कर न देखता जबकि अपराधी भावना के कारण गर्दन झुकती जाती। ऐसा लगता हीनता का कुँज हूं व इसलिए सारी सृष्टि मेरे विरुद्ध है। ऐसे समय में अगर किसी से व्यापक सलाह ले लेता तो इसका इतना बड़ा रूप बनता ही नहीं पर मन में यह बात घर कर गई थी कि किसी को बताऊंगा तो सुनने वाला व्यक्ति मुझे तुच्छ समझेगा। भाग्य था मेरा कि परेशानी के भयानक रूप बनने से पहले ही एक अंग्रेजी समाचार-पत्र में 'संजीवनी' पर सम्पादकीय पढ़ा। कुछ दिन तो सोचता रहा कि वहाँ जाऊं और अपनी उलझन बताऊं। सोचता था कि मेरी परेशानी, जिसको मैं उस समय एक मनोरोग समझता था, में भला ये लोग, 'संजीवनी' क्या कर सकती है। मेरा रोग जो है सो है मैं खुद ही इससे निपटूंगा। पर फिर सोचा कि जाने में क्या हर्ज है। मेरी तुच्छता तो सिर्फ इन लोगों तक ही रहेगी।

जब मैं 'संजीवनी' में आकर मिला तो मैंने अपनी उलझन को एक मनोरोग का ही रूप देकर बताया। आरम्भ में तो ये लोग, 'संजीवनी', भी मेरी परेशानी को न समझ सके क्योंकि उनका रुख भी मैंने मनोरोग की ओर मोड़ दिया था। पर ज्यों-ज्यों मैं इनके सामने अपने मन को खोलता गया त्यों-त्यों ये लोग तथा मैं खुद भी समझता गया कि किसी तरह का कोई रोग मुझ में नहीं। मनोरोग का वहम तो सिर्फ बड़े-बड़े हास्पिटल में

जाकर हो गया था जहां मैं एक छोटी-सी बीमारी के लिए जाया करता था, वहां आये अन्य रोगियों से सुन-सुन कर अपने को भी एक बड़ी बीमारी का शिकार समझ बैठा था। डाक्टर्स भी अन्य मरीजों की तरह मेरा भी इलाज करते रहे और जब इलाज न हुआ तो मेरे में एक काल्पनिक मनोरोग का रूप बढ़ता गया जिससे मेरे में एक हीन भावना की भ्रांति बन गई। फिर इन लोगों ने मेरी परेशानी का वास्तविक रूप बताया कि मैं सिर्फ अपने दु:ख को अपने में दबाए रखने के कारण उलझ गया हूं। इनके सहयोग से मैंने अपनी उलझनों का सिरा ढूंढ़ा जिसके मिल जाने पर अपनी एक-एक उलझन की गाँठ को सुलझाते हुए पूरी परेशानी को दूर करता गया। यहां आकर मुझे आश्चर्य हुआ कि कई मुझ जैसे व्यक्ति बे-वजह अपने को हीन समझ बैठते हैं। व्यक्ति चाहे किसी भी स्तर का हो उसमें अवगुण व कमी तो होगी ही। किसी में किसी तरह की, किसी में किस तरह की। अगर कमियां, अवगुण न हो तो व्यक्ति देवता हो जाय और अगर हम अपनी कोई कमी किसी दूसरे के सहयोग से दूर करते हैं तो इसमें हीनता किस बात की। कल तो हम भी किसी को किसी कार्य में मदद कर सकते हैं।

मुझे 'संजीवनी' में आकर जीवन के वास्तविक रूप को पहचान कर यह अनुभूति हुई कि आगे बढ़ने का, जीवन की मुसीबतों से लड़ने का एक दीपक जलता रहना चाहिए। जलते हुए दीपक को, चाहे उसकी लौ कितनी भी मंद क्यों न हो, सहयोग देकर उज्जवल किया जा सकता है पर बुझे हुए दीपक को सहयोग से नहीं जलाया जा सकता। उसके लिए तो एक ज्योति लानी पड़ेगी। तो आशा का दीपक सदा जलता रहना चाहिए।

अब जब बिना 'संजीवनी' के सहयोग से चल रहा हूं तो किसी बात की परेशानी नहीं, अफसोस नहीं, दु:ख नहीं, दर्द नहीं। यह जान चुका हूं कि जीवन में दु:ख-सुख आते ही रहते हैं। जब सुख का आनंद लिया है तो दु:ख को भी झेलना होगा। जैसे सुख गया दु:ख भी चला जायेगा। सच कह रहा हूं दु:ख को झेलने में भी अब मजा आता है। एक सुख मिलता है कि देखो कैसे-कैसे मेरे जीवन में दु:ख आए, रुकावटें आईं, परेशानियां आईं पर मैं झेल गया, पार कर गया। व्यक्ति सफल भी वो ही है जो दु:खों को झेल गया और असफल वो जो न झेल सका। दु:ख तो, जब तक जीवन है, रहेंगे ही, तो क्यों न एक दूसरे को सहायता ले देकर इन दु:खों को, परेशानियों को कम किया जाए, झेला जाए।

"संजीवनी" से नया जीवन लेकर दिलेरी से जीता हुआ एक व्यक्तित्व।

the techniques of counselling

'when stresses mount...'

Dr. Mrs. V. Veeraraghavan

Counselling is perhaps the oldest of human relationships. From time immemorial individuals with problems have "talked over" their personal difficulties with friends, relatives, priests and other close acquaintances. Counselling has come to be viewed as a professional or semi-professional service only during the first decade of the 20th century.

Counselling is carried on in different settings with different people with different kind of problems. Thus, there are many types of counselling techniques, each one of which is applied to a specific type of problem. For instance, counselling in a crisis-intervention type situation is totally different from counselling aimed at personality growth and development. Similarly, counselling in colleges and universities is very different from counselling in a school setting or in an industrial setting. Each of the different types of counselling connotes a variety of activities, including friendly listening, giving of information, psychotherapy to the maladjusted, referral services and many more.

Whether it is a problem involving only the individual, or his entire family, or a problem of a student or employee or an individual with a psychological breakdown, counselling has as its main aim of helping individuals cope with their problems; it aims to relieve tension, reduce self-depreciatory feelings, and reinforce ego strength.

The need for counselling services has increased in the modern world partly due to the increasing instability arising out of various changes in the world, in the family, in the occupational fields, etc. and partly due to the inability to make use of the available psychiatric services because of the stigma attached to such settings.

To be more specific, the changes in the family structure, the changes in the school, work situations, etc. have created more stress for individuals to make an adequate adjustment and lead a mentally healthy life. Nevertheless, individuals somehow move forward overcoming obstacles and attempt to keep up this mental equilibrium. However, when stresses mount and go beyond the individual's coping mechanism a breakdown results. This need not necessarily be a neurotic or psychotic breakdown but it may merely be a state of imbalance or

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Kuchipudi

1. MANDODARI SABDAM :

A popular and traditional mimetic and dramatic dance, wherein the love and marriage of Ravana and Mandodari is described. In this, (a) The dancer seeks the permission of King Krishna Deva Rayalu of Vijanagaram Empire to be allowed to perform the dance. (b) She describes the movements of a frog which lives in a lake surrounded by bees and flowers in the water. (c) She shows King Ravana on his magnificent chariot, fully clad in his glittering jewellery and silken robes, wielding a sword and shield.

As his gaze falls upon the frog, it is transformed into a beautiful princess who is Mandodari.

(d) The climax of the dance is reached when the dancer alternately portrays the loving glances of Ravana and Mandodari, culminating in their marriage.

2. SWARA-JATHI :

The typical footwork, hand-movements, postures and gestures of the Kuchipudi style are brought out admirably in this technical dance piece, where there is no "Abhinaya" or expression. Set in Raga Athana and Adi Tala.

3. BHAMA-KALAPAM :

This is the 'piece de resistance' of Kuchipudi dance, wherein the pride and vanity of the beautiful and haughty queen, Satyabhama are first described. She calls herself the most desired consort of Sri Krishna and struts vainly boasting of her parentage, her wealth and so on.

She asks her friend to go and seek out the Lord Krishna and bring him to her chamber, and shyly dances, refusing to divulge the name of her Lord, but only indicating his features.

On hearing Sri Krishna's flute, she pines for him and wallows in 'Viraha' or separation.

4. THARANGAM :

The concluding item is a brisk and rhythmic devotional piece, where the mood projected is one of pure ecstasy, as the dancer executes complex rhythmic patterns.

Dedicated to Lord Krishna, this is a composition of Saint Narayana Teertha of the 17th century.

The dance ends with the dancer performing on the edges of a brass plate.

confusion, wherein a little psychological support, understanding and insight would put the individual back on the road to recovery. Some, of course, may need more than mere support and require help in handling their personal relationships more satisfactorily. Still others may need help in ridding themselves of their crippling complexes and in development of a more adequate personality.

Thus, counselling may be carried on at an individual level on a one-to-one relationship or at a group level, with one or more members of the individual's family or with significant 'others' in the individual's environment. Whether at one-to-one or group level, the overall aim of counselling is to help the individual enhance his capacity for social functioning. This goal is achieved primarily through bringing about changes in the individual's feeling and through increasing his self-awareness.

Changes in feeling take place largely through the medium of relationship which is deliberately created by the counsellor so that the individual with the problem could discuss, frankly and without any inhibition, all his problems and concerns. This is achieved by the counsellor by maintaining an attitude of acceptance of the individual. and encouraging him to verbalise his anxiety, fear, hostility and self-doubts. This very process of verbalisation contributes to the relieving of tension in the individual and also creates in him a hope that a solution can be found for his problems. The atmosphere created by the counsellor also helps the individual to absorb some of the objectivity, calmness and confidence of the counsellor and this in turn contributes to gaining emotional support.

There are many techniques of establishing rapport with individuals and each individual needs a different approach and understanding in order for the counsellor to establish an adequate working relationship. The person with the problem should be encouraged to narrate his story in his own way and the counsellor should be alert and observant to all the changes that may occur in the individual during the interview. The areas of tension should be recognised and appropriately responded to. While every effort should be made to secure all the relevant information, the counsellor should be careful not to push his inquiries too far or else the troubled person becomes more anxious than before.

During the process of counselling, because of verbalising the most disturbing thoughts and feelings, the troubled person feels less tense and anxious and thus is able to develop the capacity to look at his problems more objectively than before. The counsellor endeavours to assist the individual to gain proper understanding of his situation, his own attitudes and behaviour that contribute to his problems. The degree to which the person would gain an understanding depends a great deal on the nature and extent of the problem; for instance, the counsellor should be able to assess whether in dealing with the problem only the patient is involved or one or more of his family members are also involved. Should it be necessary, the counsellor should bring into the therapeutic process the significant 'others' in the patient's life and if deemed necessary, may have to help correct their behaviour also, so that the patient could lead a more adequately adjusted life. Thus the social strains and stresses, physical and mental health as well as the capacity of the individual to enable use of 'counselling' should be

assessed in order to restore the individual back to a normal level of functioning.

Counselling thus involves much more than 'advice rendering'. While an individual coming for help may 'ask' for 'advice' he may not really need advice, but only an opportunity to discuss his doubts and problems which are crippling his capacity to deal effectively with the environment. Through discussions, the individual is able not only to gain an understanding of his problem, the etiology of the same, but also to arrive at a self-determined course of action. It is well for the counsellor to remember that a solution arrived at on one's own is always more acceptable to the individual than the one given by the counsellor or 'others'.

Thus, the techniques of counselling involve more than rendering advice; it requires the skill to understand a problem, its psychodynamics. To a psychologically troubled individual, in addition to helping him assess his practical difficulties, it also helps him analyse his own contradictory feelings and attitudes. In short, the process of counselling is geared to helping the troubled person to engage in a process of self-examination.

Thus counselling is a psychological service rendered to strengthen the capacity of the individual to handle and cope with his life problems. In the process, it not only deals with the individual on a one-to-one relationship but also endeavours to mobilize the available resources in the community towards helping the person with his problems. While involved in these processes, the counsellor avoids the temptation to "solve" the problems for the individual or make the latter dependent on him.

In conclusion it may be stated that counselling is a developing field and its role is well recognised as a helping service. There are many voluntary and government agencies which employ trained persons as counsellors and thus meet part of the demand for counselling services. People facing a crisis in their personal life, people with family and marital problems and people with problems in their occupation and other areas of life turn to the counsellor for help in finding a solution to their problems. Not only adults need counselling services but also children.

Even though in great demand, such services cannot possibly be initiated and maintained by the government in a poor country like India. The voluntary organisations should take up the responsibility and offer such ameliorative and preventive services to those who need it, and who cannot and do not make use of such services offered as part of a psychiatric setting. Kudos to Sanjivini which has come forward to offer services with a band of young and enthusiastic workers.

World Health Forum

Leon Eisenberg

Preventing mental, neurological and psychosocial disorders

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Leon Eisenberg

Preventing mental, neurological and psychosocial disorders

Mental, neurological and psychosocial disorders constitute an enormous public health burden. A comprehensive programme directed against their biological and social causes could substantially reduce suffering, the destruction of human potential, and economic loss. It would require the commitment of governments and coordinated action by many social sectors.

In the early decades of the twentieth century, claims that the mental hygiene movement would prevent adult psychiatric disorders proved to be unfounded. Even today we know so little about such disorders as schizophrenia, parkinsonism and senile dementia that we cannot design programmes for their prevention. Nevertheless, prevention is important in some areas. At the turn of the century, mental hospitals were full of patients with general paresis and pellagra; today, both diseases are rare in the developed world, the first because of effective treatment for syphilis and the second because of improved diet. Many other neuropsychiatric disorders can be tackled effectively. In the schizophrenias and affective disorders, the frequency with which there is troublesome behaviour or a chronic inability of patients to look after themselves can be reduced if the health team, community and family respond promptly and constructively. The public should be educated about the nature and extent of mental health problems and, where possible, about their treatment and prevention. Without an informed public there is little hope of persuading governments to make the necessary policy decisions.

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An underestimated problem

The magnitude of the mental, neurological and psychosocial disorders is usually underestimated because:

— vital statistics measure mortality rather than morbidity;

— even where morbidity is recorded, the extent of neuropsychiatric morbidity is not properly monitored;

— the tabulation of causes of death according to disease entities does not indicate the underlying behavioural

causes, e.g., alcohol abuse as the cause of cirrhosis or motor vehicle accidents.

Mental and neurological disorders

Mental retardation. The prevalence of severe mental retardation below the age of 18 is 3–4 per 1000; that of mild mental retardation is 20–30 per 1000. In the developing world in particular, faulty delivery methods can lead to birth traumas and the central nervous system can be damaged by bacterial and parasitic infections. Of particular importance is the mild mental retardation and maladaptation associated with severe social disadvantage.

Acquired lesions of the central nervous system. Damage to brain tissue resulting from trauma, infection, malnutrition, hypertensive encephalopathy, pollutants, nutritional deficiency and other factors is a major source of impairment. It has been estimated that 400 million persons suffer from iodine deficiency; their offspring are at risk of brain damage *in utero (1).* Particular attention must be paid to the debilitating effects of cerebrovascular accidents secondary to uncontrolled hypertension, a rapidly increasing problem in developing countries. Cerebrospinal meningitis, trypanosomiasis and cysticercosis are major causes of brain damage. Persistent infections, even when the brain is not directly invaded, impair cognitive efficiency.

It is wrong to use potentially toxic drugs when what is needed is social support, or to rely on institutional care for patients who can be restored to function while in the community.

Peripheral nervous system damage. Inadequate or unbalanced diet, metabolic diseases, infections, traumas and toxins can cause incapacitating peripheral neuropathies with numerous social and psychiatric consequences.

Psychoses. The prevalence of severe mental disorders such as schizophrenia, affective disorders and chronic brain syndromes is estimated to be not less than 1%; somewhat more than 45 million mentally ill persons suffer compromised social and occupational function because of these conditions. The annual incidence of schizophrenia is approximately 0.1 per 1000 in the population aged 15–54 years. The rate for depressive disorders is several times higher.

Dementia. Dementia can be caused by metabolic, toxic, infectious and circulatory diseases. The burden on health services rises as an increasing proportion of the population survives to older ages and becomes vulnerable to senile dementia of the Alzheimer type.

Epilepsy. The prevalence of epilepsy in the population is 3–5 per 1000 in the industrialized world and 15–20 or even 50 per 1000 in some areas of the developing world. This tenfold difference in prevalence provides a measure of what could be accomplished by a comprehensive programme of prevention in the developing countries. The extent of social handicap resulting from epilepsy varies with its type, the adequacy of medical management, and community acceptance of or support for patients.

Emotional and conduct disorders. Such disorders are estimated to affect 5–15% of the general population. Not all cases require treatment but some can lead to major impairment. Disorders of conduct, which are frequent

among schoolchildren and interfere with learning in the classroom and with social adjustment, often respond well to simple treatments (e.g., behaviour therapy and the counselling of parents), although recurrence is common. Learning disorders, whether or not they are associated with other psychiatric symptoms, require special help in the classroom in order to avoid secondary emotional problems and occupational handicaps.

Behaviour injurious to health

Alcohol-related problems. Recent decades have witnessed considerable increases in alcohol consumption and a parallel increase in alcohol-related problems, including cirrhosis of the liver, difficulties at work and home, and alcohol-related traffic accidents. Alcohol abuse by the individual has devastating effects on the family. A particularly tragic consequence of drinking during pregnancy is the fetal alcohol syndrome.

In the WHO European Region, the number of countries with an annual per capita intake of more than 10 litres of pure alcohol increased from three in 1950 to 18 in 1979. Countries in the WHO Western Pacific Region have reported that there were sharp increases in alcohol-related health damage, crime and accidents during the 1970s. Although some countries in Europe and North America are now reporting a levelling off or even a modest decline in alcohol consumption, the global trend is still upwards, with particularly sharp increases in commercially produced alcoholic beverages in some developing countries in Africa, Latin America and the Western Pacific. However, it is notable that in Australia between 1978 and 1984 a 10% reduction in per capita consumption of alcohol was accompanied by a 30% reduction in deaths caused by alcohol.

Drug abuse. Drug abuse and dependence have increased in most countries *(2)*. There are some 48 million drug abusers in the world, including 30 million cannabis users, 1.6 million coca leaf chewers, and 1.7 and 0.7 million people dependent on opium and heroin respectively. Cocaine abuse is widespread and increasing. Amphetamines, barbiturates, sedatives and tranquillizers are consumed in most countries and their abuse, as well as multiple drug abuse, is increasing throughout the world in parallel with their increasing availability. Large regions have become dependent on the income derived from growing cannabis, the opium poppy and the coca shrub, and this adds to the difficulty of implementing control measures.

Mental deterioration in the elderly can also be prevented by avoiding unnecessary hospitalization.

Psychotropic drug abuse. The ready availability of psychotropic substances, insufficient and often misleading information and unjustifiable prescribing practices have led to the overuse and abuse of psychotropic drugs.

Tobacco dependence. Smoking is a socially induced form of behaviour maintained by dependence on nicotine. It causes a high proportion of cases of cancer, chronic bronchitis and myocardial infarction. Between 1976 and 1980 tobacco consumption decreased annually by 1.1% in the industrialized countries but increased by 2.1% annually in the developing countries. Besides premature deaths, which have been estimated at over 1 million per annum, innumerable cases of debilitating diseases, such as chronic obstructive lung disease, are

caused by smoking. The proportion of women of reproductive age who smoke regularly, already high in most industrialized countries, has been increasing rapidly in the developing world.

Conditions of life that lead to disease

Many health-damaging circumstances are beyond the control of the individual: homelessness, unemployment, lack of access to health and social services, the loss of social cohesion in slum areas, forced migration, racial and other discrimination, forced idleness in refugee settlements, war, and the threat of nuclear war.

In addition to these factors, individual life-styles can influence the risk of disease. Although the significance of excess animal fat in the diet, insufficient physical exercise and psychosocial stress in the epidemic of cardiovascular disease affecting the industrialized world cannot be precisely quantified, most authorities agree that these are important risk factors. Behavioural patterns certainly influence disease pathogenesis and it is important to make full use of our knowledge of mental health and our psychosocial skills to design interventions aimed at preventing disease that is secondary to unfavourable behaviour.

Disorders of conduct are frequent among schoolchildren and often respond well to simple treatments.

In this connection, methods of dealing with excessive stress merit further study; stress becomes a pathological agent when it is intense, persistent, and beyond the coping capacity of the individual.

Violence. Violence, including accidents, homicide and suicide, is one of the main causes of death in most countries. Psychosocial factors and mental disturbance play an important role in its occurrence. Child abuse and wife battering are among the particularly dramatic indicators of violence in the family.

Excessive risk-taking by young people. Experimenting with drugs and alcohol, sexual activity without precautions against sexually transmitted diseases, adolescent pregnancy, driving at excessive speed, and challenging established guidelines for health and safety result in serious morbidity and mortality. Pregnancy in girls aged 15 or less leads to a cycle of disadvantage. The immature mother is unable to care properly for her child, while her maternal responsibility is a barrier to the education and employment essential for her own development.

Family breakdown. Family breakdown interferes with the upbringing of children. A household headed by a woman is more likely to be below the poverty threshold than one headed by a man, adding to the mother's difficulty in raising a family. Weakened family units also contribute to community disorganization and a variety of psychosocial and other health problems.

Somatic symptoms resulting from psychosocial distress Many patients who consult primary health care workers either have no ascertainable biological abnormality or, if they have one, complain disproportionately about their discomfort and dysfunction. Unless the psychosocial source of physical symptoms is recognized, the people affected are likely to be inappropriately investigated and treated, cause excessive cost to the health system or themselves, and become chronic

patients vainly seeking relief. The inclusion of basic mental health care as part of primary care reduces the cost of treatment and improves its outcome.

Proposals for action

It should be noted that intersectoral coordination is essential for the success of the measures outlined below.

Measures to be undertaken by the health sector

Success in carrying out preventive and therapeutic measures depends greatly on the psychosocial skills of primary health care workers, i.e., on their sensitivity, empathy and ability to communicate, as well as on a thorough knowledge of the community, its culture and its resources. Training in these skills is therefore no less essential than is the customary technical training. In their absence, diagnostic errors multiply, adherence to treatment recommendations declines, health workers exhibit "burn-out", and the health facility fails to achieve its goals.

Prenatal and perinatal care. In view of the need to protect the fetus and the newborn child and to provide optimum conditions for development, and given the high mortality and morbidity associated with prematurity and low birth weight:

- high priority should be given to the provision of adequate food and to education about nutrition to all pregnant women;
- direct counselling of pregnant women should be practised to reduce the prevalence of developmental anomalies and low birth weight caused by cigarette smoking and the consumption of alcohol during pregnancy;
- in areas where neonatal tetanus is prevalent, pregnant women should receive tetanus toxoid after the first trimester and birth attendants should be trained in sterile techniques for cutting the umbilical cord;
- in iodine-deficient areas, women of child-bearing age should be given iodized oil injections or iodized salt in order to prevent the congenital iodine deficiency syndrome;
- birth attendants should be trained to recognize high-risk pregnancies and to refer deliveries that are expected to be complicated to specialist facilities, since the prevention of obstetrical complications can reduce the number of children with central nervous system damage;
- the promotion of breast-feeding should be an integral component of primary health care.

Programmes for child nutrition. These should be a major component of prevention because malnutrition can impair cognitive and social development.

Immunization. The immunization of children against measles, rubella, mumps, poliomyelitis, tetanus, whooping-cough, and diphtheria could make an important contribution to the prevention of brain damage.

Family planning. Child development is adversely affected when mothers have too many children at unduly short intervals or when they are too young or too old. Education on family planning and access to effective means of contraception are therefore essential elements in maternal and child care.

Measures against abuse of and dependence on psychoactive substances

Primary health care workers should routinely counsel patients against smoking. Although only 3–5% will respond by stopping smoking, there is a large gain from the public health standpoint because of the high prevalence of the habit. Repeated efforts to quit have cumulatively higher rates of success and a low initial response should not discourage subsequent efforts.

Health workers can be trained to recognize the early stages of alcohol and drug abuse, using WHO manuals and guidelines. Brief counselling can help a significant number of patients to alter their behaviour before dependence and irreversible damage occur.

Crisis intervention in primary health care

In the event of acute loss (e.g., the death of a spouse, which increases morbidity and mortality among survivors), there is some evidence that group and individual counselling of the bereaved can diminish risk. Self-help and mutual aid groups can improve health at minimum cost to the health services. Well-trained crisis intervention units can handle a variety of acute mental health problems and thus prevent chronic difficulties.

Prevention of iatrogenic damage

Failure to diagnose and correctly treat psychosocial disorders results in iatrogenic damage. Thus it is wrong to use potentially toxic drugs when what is needed is social support, or to rely on institutional care for patients who can be restored to function while in the community.

Health workers can be trained to inquire routinely about psychosocial problems in the course of evaluating new patients. This enables them to recognize symptoms that indicate psychological distress and to avoid the overuse of psychotropic and other drugs and the iatrogeny that results from such practices. Brief counselling and, where necessary, referral to social welfare or mental health workers can significantly diminish the number of clinic visits.

Behavioural disorders that are the iatrogenic effect of prolonged or repeated hospitalization can be prevented by minimizing the hospitalization of children, encouraging family participation when hospital care is unavoidable, and introducing certain organizational arrangements in hospitals (e.g., assigning a primary nurse to each child). Mental deterioration in the elderly can also be prevented by avoiding unnecessary hospitalization.

Although measures to prevent dementia must await the results of further research, cognitive impairment resulting from depression and infection can be reversed by prompt treatment. At present, the distinction between dementia and depression in the elderly is not recognized by the family doctor in four out of five cases. A relatively short period of training can enable physicians and other health workers to improve their diagnostic skills in this area.

Minimizing chronic disability

Education of primary care workers in the recognition of sensory and motor handicaps in children, the use of prosthetic devices to minimize handicaps, and the referral of handicapped children to the educational authorities can prevent both cognitive underachievement and social maladjustment. Properly-fitted spectacles and hearing aids can reduce the likelihood of mental and social handicap in children.

Because the incidence of cerebrovascular disease can be reduced by the effective treatment of hypertension, primary care workers should be trained in the diagnosis and treatment of hypertensive disease; similarly, acquired lesions of the central nervous system can be reduced by prompt treatment of, for example, meningitis.

Health workers should be trained to manage febrile convulsions, recognize epilepsy, and control seizures with low-cost anticonvulsant drugs in order to minimize damage to the central nervous system, as well as reduce accidental injury and reduce the psychosocial invalidism and isolation that result when treatment is not provided. An uninterrupted supply of drugs of assured quality is of paramount importance.

Primary care workers should be trained to recognize schizophrenia and to manage it with low-dose antipsychotic drugs, to counsel relatives with a view to minimizing chronicity and avoiding the social breakdown syndrome, and to diagnose and treat patients suffering from depression. Such patients, who commonly present multiple somatic symptoms, may be inappropriately investigated and treated for somatic disorders, and are at risk for suicide. Effective treatment with antidepressants and prevention using lithium salts can be provided at relatively low cost.

Action at community level and in other social sectors

Better day care for children. Retarded mental development and behavioural disorders among children growing up in families that are unable to provide suitable stimulation can be minimized by early psychosocial stimulation of infants and by day-care programmes of good quality, particularly if the parents participate. However, day care must be of adequate quality; child-minding in crowded quarters by people who are too few in number and inadequately trained may retard development, not facilitate it. Among useful measures that could be taken are:

- surveys of existing day-care facilities and assessment of the need for them;
- establishment of quality standards and appropriate regulatory measures;
- setting of targets for quality and for training staff in the psychosocial development and needs of children.

Upgrading long-term care institutions. Although the use of institutions for long-term care can be minimized by providing alternatives in the community, they will continue to be necessary. The quality of the institutional environment is a major determinant of the way the patients function. It is therefore important to subject such institutions to regular evaluation and to improve their architectural design and the content of work programmes where necessary.

Self-help groups and support services. Self-help groups, organized by lay citizens, are effective in reducing the chronicity of certain disorders (e.g., Alcoholics Anonymous), in enabling the handicapped to improve their functional ability (e.g., societies that help epileptics), in educating the community about the nature of disorders, and in advocating changes in

In Australia between 1978 and 1984 a 10% reduction in per capita consumption of alcohol was accompanied by a 30% reduction in deaths caused by alcohol.

legislation, better resource allocation, and satisfaction of the needs of people with specific disorders. Furthermore, community self-organization for local development has been shown to reduce the psychopathology associated with anomie (a state of alienation from the community) and helplessness *(3)*.

Support services provided at community level can enable people to care for relatives with chronic illnesses who would otherwise require more expensive and less satisfactory institutional care. An excellent example is the organization of "home beds" for chronically handicapped mental patients in China: neighbourhood volunteers who are retired workers care for patients while their relatives are away at work. To maintain residual function and to avoid institutionalization, chronic mental patients must be provided with housing, opportunities for sheltered employment, and recreation.

Schools. The progressive extension of compulsory schooling provides new opportunities to broaden people's understanding of how they can protect their health. At the same time it leads to the identification of child health problems not previously known to health authorities.

A variety of risks to mental health and psychosocial development can result from a lack of parental skills and from parents' insufficient knowledge of their children's needs. Urbanization and other social changes result in a growing number of young parents not possessing such skills. Education for parenthood may well have to become a public responsibility. Creches and nursery schools can be sited next to secondary schools, whose students can be assigned to work in them under supervision. Trained leaders for groups of new mothers can guide discussion on child-rearing and thus provide a valuable form of self-help.

Instruction about family planning, sex, child development, nutrition, accident prevention and substance abuse are among the subjects that are most frequently recommended for inclusion in school curricula. A particularly promising way of preventing substance abuse among early adolescents is to encourage them to acquire the behavioural skills necessary to resist pressure to use cigarettes, drugs and alcohol.

If trained properly, teachers can identify children with sensory or motor handicaps or with mental health problems that have not been detected by the health sector. Collaboration between teacher, parent and health worker is central to the rehabilitation of children with chronic handicaps and to the avoidance of social isolation and other untoward consequences.

Public health measures for accident prevention. In view of the high mortality and morbidity resulting from accidents and poisoning, measures for their prevention must be given high priority. Brain damage caused by toxic substances in the workplace can be prevented by imposing strict limits on exposure; untoward effects of shift work can be avoided using the principles of chronobiology; child-proof safety caps on medicine bottles and containers of household chemicals can reduce the ingestion of poisons and consequent damage to the central nervous system; lead poisoning in children can be prevented by prohibiting paints containing lead for household use and by decreasing the lead content of petrol.

The media. Radio, television, newspapers and comic strips can play a major role in public health education—for the better (e.g., by explaining why sanitation is essential for health) or for the worse (e.g., by advertising cigarettes).

Cultural and religious influences. Cultural factors are among the principal determinants of human behaviour. A knowledge of cultural and religious forces can be applied by health workers in their efforts to reduce health-damaging practices.

Government action

Prevention works only if governments want it to work: action must be planned not only in the health sector but in all other sectors important for health, such as education, agriculture, environment, etc. Any country undertaking a prevention programme should have a national coordinating group on mental health with the authority to assign tasks to the appropriate sectors. The coordinating group should have at its disposal an information centre that can collect and feed back data on changes in the nature and trends of problems and on the effects of intervention and task performance. One of the first duties of the centre should be to conduct a comprehensive review of legislation affecting such matters as mental health, family life, health services, drug control and schools.

In the area of prevention, government actions in various spheres may have implications for health; housing projects may worsen mental health because of bad design; industrial development projects may destroy local culture and lead to family disruption, child neglect and substance abuse; and the widespread use of pesticides without safeguards may lead to brain damage.

There is a need for research into the causes and mechanisms of disease in order to develop new and better means for prevention and control. Data on prevalence and the effectiveness of interventions frequently do not exist, particularly in developing countries. The extrapolation of results obtained in one country to another may be entirely misleading. It is therefore important to foster research programmes of two kinds:

— studies on the distribution of problems in specific populations and on changes in the pattern with time;

— investigations to enable assessments to be made in particular countries of measures that have been proposed for large-scale application.

Both types of study should be carried out at the national or subnational level. An urgent task that should be included in programmes of technical cooperation between countries is the development of methods for conducting such studies. The involvement of institutions in developing countries in multi-centre research, research training courses and information exchange should be used to create and/or strengthen the basis for a further growth of knowledge in this field. □

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World Health Forum

Leon Eisenberg

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11/R

Community Approaches to the Treatment of Drug Abuse

MH 1.4

Mrs. Eva Torigue

1. Treatment of environment not individual
2. Away from institutionalisation
3. Personal acceptance of problem & readiness to accept community living rules
4. Community leadership

In USA – Strict regulated lives
Scandanavia – Relaxed regulation, liberty +
Hongkong – Oldest trial – quite succesful
Phillipines – RC influence
Malaysia – Moslem "

Prospects

1. Training of addiction therapists – ex-addicts trained as part of rehabilitation programme
   – ex addicts trained in ← social sciences/soc. work, psychology, Medicine etc
2. Problem of community & in community
   – danger of creating ghettos if contact/exchange of info & outside community not maintained.

(C (DA))

Stages

I Screening (To determine whether pr accepts need for R)
↓
II Medical Examination
↓
III Cold Turkey method → Methadrone 2days

↓
IV Begin community life
Individual/Group therapy
3–6 months

V Re-entry Phase (Family visits) Schooling c 2–3 months

↑ Discharge

VI – Follow up

Follow up

1) Some like to cut of from centre completely to forget what they have gone thru
2) Alumni - known - regular social contact with centre
3) Follow up by social worker - upto 5 yrs

Thailand Model - Culturally accepted Model

Reacceptance of Buddhism (Religious significance) → Symbolic and Literal purgation → Cold Turkey → Religious Life (Community learning) → Reentry into Society

---

Hanbhajan Yogi Mark	Hare Krishna Mark USA/Holland/Canada
TM Meals & Drug addicts	

Psychosocial
Legal
Medical

Youth of Europe 1960 → Came to East - Nepal/India Afghanistan - impressed by Philosophy of life → Took back cannabis but not local culture/food way of life → Shocked the west

Though Alcohol is not considered a problem

Indian/Buddhist religious marks now making impact because of providing a little of the culture

---

Denial Syndrome

Family
Friend
Society
Country

(1)

Drug use in college students

Verma r Dang (PGI)

1. Socio economic variable
2. Drug use variable. of drugs
3. Social desirability.

Methods: Questionnaire

4. Sample – 570 M-270 F-300

	R – U		Mostly Language.	
Sec Sch	104	161	E	H
			106	159
Colleg	0	149	149	0
Univ	6	156	136	0

5. Age – 13-28 group

6. Pearsons 'r' for Degree of Addictive substance usage (Hypothetica 36-96)

8. Drug Abuse

Alcohol most frequent

Tobacco

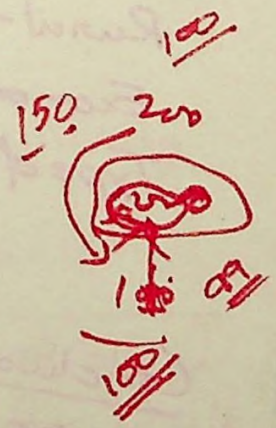
Cannabis

Amphetamines

Cocaine

Hallucinogen.

Other drugs: Tranquillizer, Sedatives, Opium, Inhalants



9. Age at onset

Opium / Tranquillisers — later age group

10. Larger proportion of older age groups used drug

11. Urban population – Tobacco / Alcohol / cannabis used more.

Drug abuse among college students
Sethi / Mandhanda

Prim Research

Drug abuse - indulgence in a drug at least 1/month & out Prescription

Lucknow University - 1513 students

	Arts	Law	Total
History once in a life time.	11.7	8.5	10.4%
History once/twice a year	13.8	10.1	12.2
1/month	10.9	12.3	11.5

Never abused — Remaining

Age - 21-25

Religion -

Place of Residence - off campus residents +

Rural - 49.9 Urban - 50.4%

Economic status - 500-1000↑

Type of drug used — Alcohol - 51.1
Bhang - 40.8
Minor Tra. - 11.5
Mandy - Non. Barb Sed - 75
Amphetamin - 5.2
Charas - 3.4

Conclusions

1. 21-25 use
2. off camp
3. Hindus
4. 501-1000
5. Alcohol / Bhang.
6. Daily users ↓

Limitations of the Questionaire Method

Biosocial Variables — Bhatti / Malhotra

Effects of Cannabis used

Agarwal 1975
Bagade et al 1976
Chopra Chopra etc

Epidemiological Studies -

CPD

Clamp of Registration OP/IP

	1973	1974	1975
DA	0.4	0.6	0.8
AL	2.2	2.4	2.6

Agegroup
DA - 16-29
DL - 30-39

Livers - more
Urban - more
More in Married

Attitudinal Parameters — Verma / Dang.

Approval / Disprove.
Perceived Availability
Social consideration
Perceived harmfulness
Exposure rouse
Perceived parental norms.

Sample = 177
of School / College / Univ. Levels

WHO Study

A SHORT COURSE ON NEUROPSYCHIATRIC PROBLEMS

FOR DOCTORS WORKING WITH

THE UNITED PLANTERS' ASSOCIATION OF SOUTHERN INDIA

AND

THE ANNAMALAI PLANTERS ASSOCIATION

6 - 8 April 1981

VALPARAI.

--ooOoo--

C O N T E N T S

INTRODUCTION

Research carried out in different parts of the world suggests that at any one time about 1% of the population are affected by mental disorder severe enough to require urgent attention and that about 10% would need such attention at least once in their lifetime. Further, no culture or society, urban or rural, is free from the crippling effects of mental illness.

What do we mean when we use the term mental disorder? The term covers a wide range of disturbance of human behaviour, emotion, judgement and thinking - a disturbance serious enough to bother either the person who is undergoing it, or those around him or both. On one hand there are the most bizarre forms of insanity and on the other hand minor anxieties, tensions, depression etc.

It is not too difficult for most of us to admit the importance of disorders in which the patient behaves in a bizarre fashion, suffers from delusions and hallucinations and says things which are ununderstandable - for these disorders can in a very obvious manner incapacitate the patient and to a varying degree those attending to him. But one is less ready to attach much importance to patients whose only problem is that they are excessively anxious or that they tend to get depressed every now and then. However these so called minor disorders can incapacitate the patient in as crippling though more subtle a manner. About 30-40% of the patients who flock every day at medical out patient departments of various hospital, complaining of vague aches, pains, exhaustion and other apparently physical disorders are really the victim of these so called minor psychological difficulties, Anxieties, tensions and depressions contribute to more than half of the industrial absenteeism all over the world. Very often the anxieties and depressions are counteracted by taking alcohol and other drugs which alter consciousness. Very soon alcohol and drugs become the enemy themselves by making the person dependent on them. These drugs act as poison to the nervous system bringing in their wake a variety of physical, psychological and social disabilities.

What are the causes of mental disorder? Human behaviour is a result of a dynamic interaction between brain processes and the environment. The causes of mental disorder

derive from both these sources. The cause may lie in an abnormality of the brain right from birth, at a biochemical, cellular or anatomical level. It may lie in a structural damage to the brain at a later date, a damage due to injury, some physical illness involving brain or a brain tumour. However a cause may equally lie in the environment. Babies brought up in foster homes have been known to develop a permanent emotional callousness because of the absence of a constant affection-giving adult. Many a mental disorder can be traced to a faulty communication in the family. A disorganised society may contribute to emotional illness. It is well known that suicide rate is highest in those areas of the town where the people do not live in cohesive groups.

Are the mental diseases heriditary? A few of them are, but the heridity must interact with environment and in many cases a wholesome environment does successfully counteract the bad effects of the heridity.

The mental disorders can be broadly classified into following categories:

1. PSYCHOSES:

In these conditions, the person loses touch with the surrounding reality, suffers from delusions and hallucinations and/or behaves in a socially unacceptable fashion.

Main sub-categories: (i) Organic Psychosis
(ii) Functional psychosis
(a) Schizophrenia
(b) Manic Depressive Psychosis

2. NEUROSIS:

In these conditions the emotional response to stressful situation is heightened and prolonged resulting in distress and social dysfunctioning.

Main sub-categories: (i) Anxiety Neurosis
(ii) Neurotic Depression
(iii) Hysteria
(iv) Obsessive compulsive neurosis.

3. PERSONALITY DISORDERS:

In these disorders the personality is deviant from early childhood bringing the person in conflict with the community.

4. MENTAL RETARDATION:

In this the intellectual development is poor because of malformation of the brain from birth or due to brain-damage in early childhood.

5. ADDICTIONS:

To various kinds of drugs which alter consciousness.

6. PSYCHOSOMATIC ILLNESSES:

In these there is a structural damage of bodily systems because of heightened emotional (autonomic) activity.

What about treatment? Electric shock treatment which is extremely painless and safe, and the tranquilizing drugs have made it unnecessary to put any restraints on even the most disturbed patients. The present trend is to treat the patients in a general hospital setting, patient continuing to live in his family setting, the supportive effect of which is unquestionable. Even some forms of mental deficiency which till very recently were considered untreatable, can be treated if the patient is brought early enough. Other mentally retarded could be trained and educated to function adequately. In many cases our treatment still consists of talking to the patient, and it is not surprising a disorder arising out of a faulty human interaction can be treated with a therapeutic human interaction.

The understanding of the disorder is increasing at a fast pace; many different scientific disciplines contributing to the knowledge. We know more about the physiology of emotion. We know more about the biochemical basis of emotion. We know more about the psychology of human communication and we know more about the social dynamics of human interaction. But we still have far to go. For example we still have to learn a lot about preventing mental disorder. While early recognition and proper treatment ensure excellent secondary and tertiary prevention, primary prevention is still difficult for most conditions - due to multifactorial aetiology.

MAJOR SYMPTOMS AND SIGNS IN PSYCHIATRY

This list is not exhaustive and contains only the commonly encountered symptoms and conditions.

Amnesia: Disturbances in memory manifested by partial or total inability to recall past experiences.

Anterograde - Loss of memory for events subsequent to the onset of amnesia.

Retrograde - Loss of memory for events preceding the onset of amnesia.

Immediate memory - The reproduction, recognition or recall of perceived material within a period of not more than 5 seconds after presentation.

Short-term Memory (or Recent memory) - The reproduction recognition or recall of perceived material after a period of 10 seconds or longer (a few days) has elapsed after the initial presentation.

Long-term Memory (Remote memory) - The reproduction, recognition or recall of experiences or information that were experienced in the distant past.

Anxiety - It is characterized by unreasonable feelings of fear, tension, or panic or of an expectancy that something unpleasant is going to happen; almost invariably these are physical symptoms, such as palpitations, abdominal sensations (eg, 'butterflies' or a feeling of emptiness) tremulousness, difficulty in breathing, paraesthesiae, chest discomfort, dizziness, or faintness, diarrhoea, frequency of micturition, headache, blurring of vision, sweating, dryness in the mouth and difficulty in swallowing.

Phobia - Persistent pathological, unrealistic, intense fear of an object or situation. The individual may realize that the fear is irrational, but is nonetheless, unable to dispel it.

Attention - Part of higher mental functions, that relate to the amount of effort exerted in focusing on certain aspects of an experience or task. This is also called active

attention. When sustained for sufficient length of time it is termed concentration. Poor attention is characterized by inability to focus on certain aspect of an experience or task on hand; shows itself as distractibility. Also called passive attention.

Catatonic state - A state characterized by muscular rigidity and immobility. It is also known as Catatonia.

Catatonic excitement - Excited uncontrollable motor activity, violence is usually senseless and purposeless.

Delirium - An acute, reversible organic mental disorder characterized by disturbed orientation in relation to time, place or person, (confusion) and some impairment of consciousness. It is generally associated with emotional lability, lack of clarity of thinking, hallucinations, or illusions, and other motor behaviour.

Delusions - A false belief that is firmly held despite objective and obvious contradictory proof or evidence and despite the fact that other member of the culture do not share the belief.

Depression - A mental state characterized by feeling of sadness, loneliness, despair, low self-esteem, and self-reproach. The term refers to a mood that is so characterized. Accompanying signs include, psychomotor retardation, or at times agitation, withdrawl from interpersonal contact, and vegitative symptoms like insomnia, anorexia, loss of libido etc.

Disorientation - Impairment of awareness of time, place and position of the self in relation to other persons.

Elation - Extreme joyful excitement. Associated with jovial mood which is completely unmotivated. There is a general sense of well being, with cheerful thoughts, and a lack of response to depressing influences, so that, everything is seen in the best possible light.

Flight of ideas - Rapid succession of fragmentary thoughts or speech contents which come abruptly and may be incoherent. Association between successive thoughts appear to be due to

chance factors which however can usually be understood.

Grandiosity - An exaggerated feeling of one's importance, power, knowledge or identity.

Hallucination - A false sensory perception occurring in the absence of any relevant external stimulation of the sensory modality involved.

Illusion - Means a perceptual misinterpretation of a real external stimulus.

Hypochondriasis - A somatoform disorder characterized by excessive morbid anxiety about one's health. Individuals exhibit a predominant disturbance in which the physical symptoms or complaints are not explainable on the basis of demonstrable organic findings and are apparently linked to psychological factors.

Insight - Conscious recognition of one's own condition. In psychiatry it more specifically refers to the conscious awareness and understanding of one's own maladaptive behaviour. Loss of insight occurs in psychotic illnesses.

Judgement - Mental act of comparing or evaluating choices within the framework of a given set of values for the purpose of electing a course of action. If the course of action chosen is consonant with reality or with mature adult standards of behaviour, judgement is said to be normal. It is said to be impaired if the chosen course of action is frankly maladaptive.

Mood - Pervasive, and sustained feeling tone that is experienced internally and that in the extreme, can markedly influence virtually all aspects of a person's behaviour.

Obsession - Persistent and recurrent idea, thought or impulse that cannot be eliminated from consciousness by logic or reasoning. Individual is aware that these (idea, thought or impulses) are irrational and silly. He tries to controll them and in the process becomes anxious.

Compulsion - Unacceptable, repetitive and unwanted urge to perform an act which the patient may carry out (ritual).

Stupor - A state of decreased reactivity to stimuli, and less than full awareness of one's own surroundings. As a disturbance of consciousness, it indicates a condition of partial coma, or semicoma. In psychiatry,it is also used synonymously with mutisum , and does not necessarily imply a disturbance of conciousness.

Thought disorder - Any disturbance of thinking that affects language, communication and thought content, Failure to form concepts and follow semantic and grametical rules that is not consistant with person's education, intelligence, or cultural background. Speech may be too much or too little.

Incoherent talk - Though the patient uses ordinary words he uses them out of context. Therefore speech is ununderstandable.

Irrelevant speech - Patient does not answer question to the point though the sentences are understandable in thoughts.

PSYCHOSES

As referred to earlier the psychoses are a group of severe mental illnesses producing gross changes in ones personality. The psychotic looses contact with the surrounding reality, shows extreme deviations in thought, emotions, speech and actions leading to severe changes in behaviour which may ultimately be bizarre and ununderstandable. The behaviour may be dangerous to self or others. There are mainly two types of psychoses:

1. Functional psychoses which includes mainly:
   (a) Schizophrenia
   (b) Manic depressive psychosis (MDP)
2. Organic psychoses.
   (a) Acute
   (b) Chronic

The functional psychoses are major illnesses where the disorder is not directly attributable to impairment in the functioning of any organ systems of the body whereas the organic psychoses are due to the effect of physical illnesses and signs of impairement in the functioning of any of the organ systems will be found.

The various psychoses and their management are now briefly considered.

1. Functional Psychoses:

(a) Schizophrenia is one of the common psychoses and it's symptoms closely correspond to the layman's concept of 'madness'. It is a severe illness which invariably interfers with the individuals function for at least some time. Usually schizophrenia starts rather early in life, often the onset is never identifiable and it may follow either a recurrent or a continuous progressive course. The patient rarely attains the pre-illness status without treatment. In most cases it's severity and course can be modified by regular administration of medications, though in a small percentage of cases, illness does not recur after successful treatment. The psychosis is characterised by disordered thinking resulting in talk that is often not meaningful. There may be wide swings in emotions, initially, ultimately resulting in apaty and 'blunted emotion'. There may be also inappropriateness of emotions, i.e. the person may laugh when the situation would be such that others would expect him to cry and vice versa. Extreme day dreaming may be present. The common presenting complaints are as follows:

- Sleeplessness
- Aggressiveness
- Being quarrelsome and (abusive and assaultive)

- Aimless wanderings.
- Talking or laughing to self.
- Irrelevant talk (What the patient talks does not make sense)
- Not doing routine work properly and failure in discharging ones responsibilities
- Withdrawing from the usual social interactions
- Irresponsible behaviour, at times being destructive
- Neglect of self care.
- Preoccupation, perplexity and unexplained or unaccountable fear.
- Restlessness, often hostility.
- Ideas or firm beliefs that others may be staring at him watching his activites or even plotting against him to harm and destroy him.
- Firm belief that his thoughts and actions are controlled by external agencies through various means.
- Finding special meanings for various things of normal occurance, around him.
- Hearing voices, when there are none - at times accusing him, at times his own thoughts.
- Phases of excitement or extreme withdrawal when patient may remain in uncomfortable and bizarre posture for long periods of time.
- Other odd and ununderstandable behaviour.

It is very essential to remember that in clinical practice, only some of the above features may be present in any given patient. But diagnostically one of the most important finding is that the examining doctor usually finds that he cannot share or understand the patient's experiences.

Both genetic and environmental factors like intrafamily relationships, socio-cultural factors, severe psychological stresses of any kind are important in the causation of schizophrenic. These factors operate in different combinations and degrees to predispose, precipitate or perpetuate schizophrenic illness in an individual. Although it's aetiology is not definitely known, what is certain is that the causation is multifactrial.

MANAGEMENT:

Explanation to the patient and the relatives of the nature of the illness, the need for regular maintanance of medications and of regular follow up reviews are very essential in the management of schizophrenia.

The discovery of chlorpromazine - a phenothiazine drug - (Largactil, Tranchlor) revolutionised the drug treatment of

schizophrenia and brought hope for lakhs of schizophrenics all over the world. Chlorpromazine and various other similar Phenothiazines are the drugs of choice and form the main line of treatment in schizophrenia. The dosage depends upon the severity of symptoms and build of the patient. The treatment of an acute phase of schizophrenia with phenothiazines must be along the same lines as one is expected to treat a case of diabetic coma i.e. starting of treatment with larger, yet safe adequate doses and then gradually adjusting the dose to suitable maintanance levels as symptoms disappear and improvement sets in.

The following guidelines should be followed while managing a schizophrenic patient:

(a) If the patient is excited, start the patient on tablets of Chlorpromazine in daily doses ranging from 50 mg to 300 mg, according to the build of the patient and severity of excitement. If the patient is very excited and unwilling to take oral medications, the initial one or two doses should be given parenterally as Inj. Chlorpromazine (50 mg) intramuscularly.

(b) In patients, who are not excited at the time of examination but who have various other symptoms of schizophrenia and tendency to get excited any time, the same dosage schedule should be followed.

(c) The same dosage is also indicated for patients who are brought with extreme degree of withdrawal and other symptoms associated with it. In such patients, while the Chrorpromazine ensures adequate sleep at night, may also cause excessive and unwanted sleepiness during the whole day. Another type of phenothiazine namely Trifluperazine (Eskazine, Mephazine, Trinicalm, Trankozine, T.F.P) in doses ranging from 10 mg to 20 mg may be given instead of Chlorpromazine to overcome the side effect of excessive drowsiness during the day. However if this phenothazine is not available, Chlorpromazine in the above doses should be given.

(d) The commonest cause of frequent recurrence of symptoms or of failure to respond sufficiently to treatment is the failure on the part of the patient (and his relatives) to take the medicines regularly due to various reasons. In such instances and in cases of long standing schizophrenic illness (chronic schizophrenia) ensuring regularity of medications will be very difficult. For such patients, the newly available, injectable and long acting phenothiazines (depot phenothiazine) are of great help. The patient needs to be given just one injection once in 2 or 3 weeks Fluphenazine deconate (Inj. Anatensol) available in vials of 1 ml. equivalent to 25 mg is used.

(e) Chlorpromazine and other phenothiazines are reasonably safe drugs but have tendency to lower blood pressure. So it is advisable to record the blood pressure of all patients started on Chlorpromazine, initially. Evidence of liver damage is the only contraindication for starting chlorpromazine in a schizophrenic.

(f) It is important to be aware of and look for side effects of the drug when a patient is started on phenothiazines (Chlorpromazine, Trifluperazine and Fluphenazine) The commonest mild side effects are:

1. Drowsiness
2. Giddiness (because of postural hypotension)
3. Extrapyramidal symptoms (because of a drug induced parkinsonism)

The usual extrapyramidal (Parkinsonian) symptoms are:

1. Mask like expressionless face and staring look.
2. Rigidity of the limbs.
3. Tremors of the extremities, tongue
4. Loss of associated movements like swingigg of hands.
5. Shuffling gait
6. Motor retardation.
7. Motor restlessness (called Akathisia. Here the patient manifests an uncontrollable urge to move about and cannot sit quietly at a place. This side effect, may be mistaken, sometimes as a symptom of the illness)
8. Various bizarre movements of the tongue face and neck with excessive salivation (Dystonias). This side effect may get in suddenly in a patient on phenothiazine medication and may present as an acute emergency. This can be very painful and distressing to the patient, and action should be taken to revert it immediately.

(g) If a patient develops any of the above side effects, he and his family should be reassured about these additional symptoms. The following steps must be taken to reduce these undesirable side effects:

1. If excessive drowsiness is the main problem, the dosage of Chlorpromazine could be reduced. Rescheduling the dosage in such a way that most of the otal dose is given at bed time (eg. 50 mg in the morning and 250 mg at bed time) also would be helpful to reduce the day time drowsiness.

2. If mild to moderate extrapyramidal symptoms are present, an antiparkinsonian drug should be introduced into the treatment schedule. The antiparkinsonian drug advised in Tab. Trihexyphenidyl hydrochloride (Pacitane, Parkin, Hexinal) which are available in 2 mg strength. The dose is 2 mg to 6 mg depending on the severity of the extrapyramidal symptoms. This is better given during the day time/in divided doses (eg. 1 tab. in the morning and 1 tab. in the afternoon). It is advisable to continue regularly a minimal dose of antiparkinsonian medication like 2 mgs of Trihexyphenidyl if the patient has tendency to develop extrapyramidal symptoms repeatedly.

3. If any patient develops acute and severe side effects like **bizarre** and uncontrollable movements of the tongue face and neck (to a side), with collection of saliva, rolling up of eyeballs (Distonias, Torticollis, Oculogyric crisis, opisthotonus) he should be given by Promethazine (Phenergan) 1 amp (50 mg) intramuscularly, immediately and started on tablets of Trihexyphenidyl 2 mg three times a day. If patient continues to get severe reactions, the dosage of phenothiazine should be reduced.

(h) A patient started on 300 mg of Chlorpromazine may not show improvement on this dosage. In such cases, the dosage can be steadily increased upto a total daily dosage of 600 mg.

(i) The dosage of medications should be brought down as the symptoms of the patient start disappearing and a maintanance dose decided (usually 50 mg to 200 mg).

(j) The medications should be continued for at least a minimum period of 1 year in all schizophrenics.

(k) It is advisable to follow up the patient initially, once weekly and later when the symptoms have remitted once either fortnightly or monthly.

(l) Refer the schizophrenic under your treatment to a psychiatrist if:

1. His severe excitement is not controlled in 48 hours in spite of using 600 mg of Chlorpromazine per day.
2. If the other main symptoms in a non-excited patient have not come down after 4 weeks of treatment with doses advised.
3. If recurrent and severe side effects (dystonic reactions) occur in spite of taking appropriate measures.

A sympathetic understanding of the patient and his family by the PHC doctor and health worker team is very important and this would facilitate the ultimate complete recovery of the patient. He should be encouraged to staft working routinely as his improvement sets in.

(b) Manic Depressive Psychosis (M.D.P.) is a disorder primarily of the 'mood' of a person. The mood disturbance in M.D.P. is both of quality and quantity ranging from severe depression to elation. The other mental symptoms which appear are secondary to this mood disturbance. A person may get only attacks of mania or only attacks of depression or both alternatively. Complete remissions in between attacks at times (even spontaneously) occur and during these periods the patients would be absolutely normal. Thus MDP is an episodic illness with varying periods of normalcy inbetween.

Clinical features:

Manic state: It has a classical triad of symptoms. Elated but unstable mood, excessive talk and increased motor activity.

The patient is often colourfully dressed, talks easily and humorously. He talks on any matter and builds castles in the air. He boasts of himself and his boasts are not really true. He is warm and very friendly, tries to be very intimate with everybody. He is very active and never seems to tire. But he is easily distractable and never completes any work. He is impatient, becomes restless and irritable if his wishes are not filfilled immediately. His sleep is markedly disturbed. He lacks insight (about his illness).

In severe cases, his talk becomes irrelevant and ununderstandable. He becomes violent and impulsive. At this stage it would be difficult to differentiate between mania and schizophrenia.

II. Depressive State

Retarded Depression: It has the following symptoms - depressed mood, minimal and slow talk, sleeplessness, marked motor retardation, loss of interest in everything around, lack of initiative, hopelessness, worthlessness, unfounded guilt, vague and multiple bodily complaints and inability to perform routine responsibilities.

The patient is usually unconcerned about his dress and appearance, looks dull and dejected. He avoids the company of others and prefers to be alone. He has to put in a lot of

effort to say or do anything. He lacks initiative to even take care of his personal requirements. He feels guilty for trivial or no apparent reasons and at times for his past deeds. His apetite has considerably come down and cannot enjoy eating. His sleep is markedly disturbed especially during the early hours of the day. He entertains ideas of wandering away or committing suicide because of his plight. Some patients may have vague aches and pains all over the body and general weakness predominantly, in addition to some degree of the above complaints. Such patients go from doctor to doctor and find no lasting relief in symptoms. In addition to the various complaints listed above, some patients hear voices saying that they are bad, they are sinners etc. Some of them even have wrong beliefs like only death will solve their problems, they are suffering from the curse of God etc.

Restless depression: (Also called agitated depression) In addition to depression the patient, instead of retardation exhibits irritability and restlessness. Anxiety symptoms and multiple somatic symptoms colour the clinical presentation. This type of depression is more commonly seen in women during the involution (menopausal) periods.

Management:

(i) Mania: The following guidelines should be followed:

(a) If the patient is severely disturbed or excited, he has to be controlled with Inj. Chlorpromazine 50 mgI.M. repeated every half an hour till the patient is sedated. Then change over to tablets of Chlorpromazine 100 to 200 mg given twice or thrice a day.

(b) In less disturbed patients, the treatment can be started with oral medication. Tab. Chlorpromazine in doses of 50 mg to 300 mg per day can be given to start with.

(c) If patient does not improve with the above dosage, a daily dosage of upto 600 mg of Chlorpromazine given in divided doses but (mainly at night) can be attempted

(d) Look for side effects of Chlorpromazine. The various side effects and their management are already mentioned in the section on management of schizophrenia.

(e) The medications should be reduced as improvement in symptoms are noticed but should be continued for a minimum period of 3 months. It should be continued further if symptoms persist.

(f) The guidelines for following up the manic patient and referring him to a Psychiatrist are similar to schizophrenia.

(ii) Depression: The following guidelines should be followed in the management of a depressed patient:

(a) Imipramine hydrochloride (Depsonil , Antidep) - an antidepressant - is the drug of choice for treating depressed patients. It is available as tablets of 25 mgs and a patient is started on 75 mg or 3 tablets per day initially.

(b) Many of the depressives have sleeplessness as a major complaint. In such patients a minor tranquilizer like Diazepam (Valium, Calmpose, Calmod, Tenaril, Paxum) should be given at night, in addition to Imipramine. They are available in tablets of 5 mg and 1 or 2 tablets (10 mg) can be given.

(c) If patients do not start improving in three weeks time, the dose of Imipramine should be stepped up by 1 tab. (25 mg) each weekly upto a total dose of 150 mg per day. This is the maximum daily dosage of Imipramine advised. The diazepam could be stepped upto 15 mg. a day.

(d) It is worthwhile remembering that it takes about 10 days to 2 weeks to notice the beneficial effects of Imipramine.

(e) Many patients on imipramine experience various undesirable side effects and may stop the drug on their own. They should be told about these usual side effects as they are put on this medication. They should also be reassured that these symptoms are transitory and harmless and they will subside in a few days time.

(f) The usual side effects of Imipramine are:

i. dryness of mouth
ii. blurring of vision
iii. constipation
iv. giddiness
v. urinary retention (rarely)

(g) The usual side effects of diazepam are:

i. drowsiness
ii. dulling
iii. hang over effects.

(h) One must be careful in prescribing imipramine to people who have symptoms of enlarged prostrate or increased intra ocular pressure as imipramine can cause acute retention of urine in the former and precipitate severe glaucomatous crisis in the latter

(i) Risk of suicide by the patient must always be kept in mind while treating a depressed patient. This risk is higher when a patient has just recovered from the physical retardation but still feels very sad and depressed. Patients severe suicidal ideation and past history of suicidal attempts increase the risk. The patients family should always be cautioned about this risk and advised not to let the patient be alone at any time.

(j) The dosage of drugs can be reduced after the patient has shown improvement in his symptoms. A maintance dose of 50 mg to 75 mg of Imipramine should be continued for a minimum period of 4 months to prevent recurrence of symptoms.

(k) Refer a depressed patient under your treatment to a psychiatrist in the following situations:

(i) Patient has not shown any improvement in spite of the maximum advisable dosage of medications given for 6 weeks regularly.

(ii) If a patient has developed severe side effects like acute retention of urine

(iii) If it is felt that the family members of a severely suicidal patient, cannot look after the patient adequately and protect him from the risk of suicide.

Note on M.D.P.: (1) Sometimes a patient, on treatment for mania may suddenly start showing symptoms of depression and vice versa. In such cases, the treatment schedules will have to be appropriately changed for either mania or depression.

(2) Lithium carbonate is a new anti-manic drug which is also found to be useful in preventing recurrent manic or manic depressive attacks. But this drug has several serious side effects and needs frequent monitoring of blood levels. This drug should be started only (after the appropriate investigations) by a psychiatrist. Patients who get very frequent attacks of mania or manic depressive attacks could be referred to psychiatrist for consideration of Lithium therapy.

(c) Reactive psychosis: is a brief psychiatric episode brought on by any severe emotional stress. The content of the patients talk and the symptomatology are usually related to the precipitating cause. The illness itself is of short duration and may recover spontaneously after the stress factor disappears. The psychosis itself may resemble schizophrenia, mania or depression in its clinical pcitures and the treatment is decided accordingl The drugs need to be given only for short periods (about 3 months) till the symptoms disappear.

2. Organic psychoses : The organic psychiatric problems are generally classified into (a) Acute organic brain syndrome and (b) chronic organic brain syndrome.

(a) Acute organic brain syndrome is generally due to the effect of physical illnessess and is usually reversible and transient. The clinical picture would predominantly show fluctuating levels of consciousness, with episodes of confusion at which time patient will be disoriented to time place and person. Memory deficits for recent events, frequently fluctuating mood which may range from acute fear and panick to depression and even bursting out into laughter/crying, and hearing and seeing things which do not exist are common features. Many of these symptoms are worse at night and show considerable fluctuation from hour to hour and even minute to minute. The commonest causes of this syndrome are : (1) Drug intoxications including alcohol withdrawal states and alcohol toxicity. (2) Infections - pulmonary, urinary, meningeal, (3) post epileptic (post ictal) confusion, (4) Post head injury confusion state, (5) Myxoedema, (6) Hypoglycemia, (7) Pellagfa and other nutritional deficiency states.

Management: Identifying and treating the primary cause energetically is of utmost importance. If facilities for this are not available, the patient should be referred to a specialist. Management of the symptoms of excitement and other psychiatric symptoms is by the use of Chlorpromazine. It should be used either orally or intramuscularly in smaller doses (50 to 300 mg).

(b) Chronic organic brain syndromes start insiduously and are progressive. They are generally irreversible. The clinical picture would consist mainly of progressive deterioration of intellectual functions like memory loss for recent events, improper judgement, etc. Other symptoms like stereotyped repeatition of words or actions, fabricating lies to make up for the memory loss, quick fluctuations in emotional responses (lability of emotions). As the illness progresses, patient will be unable to take care of his personal needs and may develop symptoms like sleeplessness, restlessness and wandering tendencies.

Patient may also develop neurological symptoms like fits, weakness of the limbs or body, difficulty in speech, vision etc. The various types of senile and presenile dementias present with a clinical picture of chronic ofganic brain syndrome. Sometimes, a slowly growing tumour in certain areas of brain may also present similarly.

Management:- Counselling the family members regarding the nature of the illness is essential for effective management of the various problems. Looking after patients nutritional and hygienic needs are very important. Tablets of chlorpromazine in comparatively smaller doses (25 mg to 200 mg) can be given when sleeplessness, agitation and wandering tendencies are main probles. Tab. Diazepam in doses of 5 mg to 15 mg also can be given.

A patient of chronic organic brain should be referred to a specialist if he develops signs and symptoms of neurological illness like fits, weakness of half of the body(hemiparesis) etc.

Note (on psychoses): When a psychotic patient presents to you in clinic or is referred to you by the health worker, the important steps to be taken are as follows:

1. Determine whether it is an organic state or a functional psychosis.
2. If it is organic, do detailed physical examination to determine the primary physical illness and institute appropriate treatment, in addition to managing the psychiatric symptoms. If facilities are not available for the management of the physical illness, refer patient to a general hospital.
3. If the psychosis is not organic, the type of functional psychosis needs to be established. In any case the patient may

either be excited and restless or withdrawn, quiet, or manageable. The initial treatment is the same immaterial of the type of illness, if excitement is the presenting feature. On the contrary, if patient is withdrawn, determine whether it is a schizophrenic withdrawal or the patient is depressed, start the treatment accordingly.

4. Regular frequent follow up initially (weekly) will give clear picture of the patients symptomatology enabling better drug management. Refer the patient to psychiatrist, when there are difficulties.

5. As a routine all patients and their relatives must be told about the necessity for regularly taking medicines for the advised period of time. They must be told to report any serious side effects or any sudden worsening of the symptomatology either to the health worker or the doctor at the PHC. The family members should be encouraged to let the patient get into his normal routine as soon as possible. The Doctor must, patiently talk to the family about the various misconceptions which they may have regarding either the causation or management of these illnesses.

N E U R O S E S

The term Neuroses is used to a group of specific conditions where anxiety is a predominant feature. Neuroses in general have some common features, some or many of which will invariably be present in any variety of neuroses:

A. A skillfully taken history will reveal that in the past, the patient generally

   (a) has been a very sensitive individual
   (b) has been a worrying kind of individual who tends to worry more than others.
   (c) has been more easily upset by disappointments and set-backs than others.
   (d) has been less confident of himself
   (e) has had one or more symptoms of neuroses in childhood:

      (i) Enuresis beyond 3-4 years age
      (ii) Thumb sucking or nail biting which persist.
      (iii) Recurrent minor attacks of headaches, stomach-aches etc.

B. Common presenting symptoms:

(a) Loss of memory
(b) Excessive generalised weakness
(c) Difficulty in concentrations
(d) Sleep disturbances
(e) Giddiness
(f) Vague tenseness or fears
(g) Irritability
(h) Lack of appetite

C. Common presenting signs:
(Sometimes they may present as symptoms also)
(a) Profuse sweating
(b) Tremors
(c) Palpitations
(d) Dryness of mouth

D. Careful and skillful history will always reveal an event stressful to the patient before the onset of the illness.

Whenever any of the above features are present, it is essential to inquire and verify for the presence or absence of the other features also.

VARIETIES OF NEUROSES:

A. Acute anxiety state:

Predominant feature is a vague sense of anxiety or tenseness of acute onset and short duration. There will be other features of neuroses also.

B. Phobic anxiety state:

Predominant feature is an intense fear that is associated with certain specific situations only. At those times the patient will experience panic: palpitation, trembling, sweating, and even giddiness. The patient may or may not know what his fears are, however he knows that his fear is unfounded, yet cannot help it. There will be other features of neuroses also.

C. Obsessive compulsive neuroses:

Obsession refers to thought, and compulsion refers to action. Usually both of them clinically manifest together. These obsessions and/or compulsions are the characteristic feature of this condition. In case of obsessions, the

patient feels repeated-ly compelled to think about something that he does not wish to think about, or to carry out an action that he does not want to carry out, but he cannot help it. Whenever he resists he becomes extremely anxious.

D. Hysterical conversion reaction:

The predominant feature is that the presenting symptoms mimic a physical illness, but not satisfying criteria for physical illness on detailed history and examination. The patient generally seem apparently happy and unconcerned about the symptoms which from their report appear severe. The physical dysfunction if it exists is very selective. It should be remembered that the patient does not pretend to have the symptoms. He actually experiences it.

E. Hysterical dissociative reaction:

The predominant feature is loss of memory for a very well demarkated, specific recent portion of his life.

F. Neurotic Depression:

Can manifest either independently or with any of the above conditions, but less frequently with the hysterical states. The predominant features are of sadness, severe sleep disturbances, lack of appetite, crying spells, irritability, suicidal ideas or even attempts.

The following are the main differences between neurotic and psychotic depression.

Neurotic depression	Psychotic depression
1. Essential daily activities like eating, drinking, self care not affected.	May be affected
2. Extreme degree of inactivity or restlessness (agitation) absent	Extreme degree of inactivity or agitation (restlessness) may be present.
3. Sleep disturbance more in the form of difficulty in getting sleep and/or disturbed sleep.	Invariably early morning waking will be present. May be associated with other kinds of sleep disturbance also.
4. Patient generally feels lack of confidence.	There will also be feeling of dejection and worthlessness.

Neurotic Depression	Psychotic depression
5. When history of suicidal attempts are present, the methods used are relatively less lethal.	Methods for suicidal attempts will be more lethal.
6. In history personality defects more common	Less common.

NOTE: (i) Often, in a depressive patient it may not be easy to distinguish the neurotic or psychotic variety.

(ii) In either variety, suicidal attempts must always be taken seriously.

Whenever any of the above neurotic conditions are suspected it is always essential to inquire about the following without fail:

(a) Alcohol habits
(b) Drug intake for non-addictive purposes -
  (i) long-term steroids
  (ii) oral contraceptives
  (iii) some antihypertensives.
(c) How much mental and physical activity is still intact.
(d) Any suicidal ideas or attempts
(e) Specific details about the precipitant event, and its meaning to the patient.
(f) Thyroid functioning, anaemia, or other debilitating physical conditions.

The following are the main differences between neuroses and psychoses.

Neuroses	Psychoses
1. Personal care maintained	Neglected
2. Contact with the surrounding reality maintained ie., the patient's behaviour is relatively easily understandable.	Contact with the surrounding reality is deranged and the patient's behaviour is not understandable.

Neuroses	Psychoses
3. Perceptual functioning normal.	Hallucinations will be present in the majority of cases
4. Thought functions are normal	Delusions and other disorders of thought will be present in the majority.

PSYCHOGENIC SOMATIC CONDITIONS:

A. There are clear cut somatic syndromes where psychosocial aetiological factors play a large part. These are called psychosomatic conditions.

Examples of psychosomatic conditions	Percentage of conditions in which psychosocial role was clearly established.
a) Peptic ulcer	57%
b) Urticaria/Angio-neurotic oedema	51%
c) Asthma (after 50 yrs, of age)	46%
d) Thyrotoxicosis	45%
e) Asthma (16 to 45 years of age)	36%
f) Vasomotor Rhinitis	30%

B. There are vague somatic symptoms, which are not associated with any identifiable somatic syndrome, but which are solely caused and maintained by psychosocial stresses:

Examples: Headaches
Body pains
Psychogenic impotency
P.U.O.
Disproportionate breathlessness
Cardiac neuroses

It is essential to note that the patients do not malinger; but genuinely experience the symptoms.

While the clear cut psychosomatic conditions do not offer much difficulty in diagnosis, the more vague psychogenic somatic symptoms are not always diagnosed correctly: the common characteristic features (some or all of them may be present in any given case) identifiable by skillful history are:

1) There is always a stressful event in patients life which precedes the onset of symptoms.

2) Also, during the course of the illness, the severity of symptoms have definite relation to psychosocial setbacks.

3) There will be some or more features of neuroses.

4) The symptoms like headache, body pain etc, are generally reported to be present throughout the day, starting soon after waking up, and also, there will frequently be diurnal variations (more in the morning or more in the evening, or more while facing a specific task etc.)

TREATMENT:

The effectiveness of treatment depends on:

1) The confidence with which the doctor approaches the problem, backed by his knowledge of the case by skillful history.

2) Early diagnosis, and avoidence of iatrogenic factors like numerous investigations, referrals and prescriptions.

3) Early specialist consultation.

MANAGEMENT GUIDELINES:

1) First task is to make it known to the patient, the relationship between the stress and the onset of symptoms according to the history provided by him, and explaining that such things do happen.

2) Second task is to appreciate and encourage the patient's positive strengths and qualities by which he is still managing his life, and assuring him that it should be possible to get well.

3) Seek specialist consultation as soon as possible.

4) Specific conditions:

(a) For acute anxiety state, anxolytics in small or moderate doses are adequate:
Diazepan 5 mg either $\frac{1}{2} : 0 : \frac{1}{2}$ or $0 : 0 : 1$
or $\frac{1}{2} : 0 : 1$.
Phobic anxiety states generally require more adequate doses.
Diazepan $1 : 1 : 1$ or $1 : 0 : 2$.

(b) Neurotic depression respond well to small doses of antidepressants like amitryptiline 25 mg $0 : 0 : 1$
or $0 : 0 : 2$.

(c) Treatment of obsessive compulsive neuroses is best handled by a specialist.

(d) In case of hysterical conditions (both the conversation reaction and dissociative reaction) the 'first-aid' measure is to reassure the relatives that there is no harm or danger to life. The treatment of these conditions are best handled by a specialist.

(e) Clear cut psychosomatic syndromes respond better when conservative treatment is combined with antidepressants iin small or moderate doses. Anitryptiline 25 mg 0:0:1 to 0:0:3.

(f) For the vague psychogenic somatic conditions, simple anxiolytics are sufficient if there are no additional features of depression and small or moderate doses of antidepressants are helpful if there are additional features of depression also.

E P I L E P S Y

Epilepsy can be defined as a paroxysmal stereotyped and recurrent disorder of movement, feeling and/or emotions, these disorders occuring almost always in a background of altered state of consciousness and such disorders being primarily cerebral in origin. The onset is usually sudden, there may be prodroma of headache and uneasiness in the head. If unconsciousness is the first thing to occur before any convulsive movement, then it is known as "major epilepsy" (grandmal, generalised). If any part of the body starts convulsing or if there is any kind of aura before the onset of unconsciousness, then it is called a "focal epilepsy which becomes generalised." If unconsciousness does not develop at all, then it is known as "focal epilepsy."

The focal origins may be at the motor area, sensory area or at the temporal lobe.

The diagnosis of epilepsy would depend entirely on collecting a good history from a person who has witnessed an attack. For all practical purposes, diagnosis of epilepsy is a purely clinical diagnosis. EEG and skull x-rays are not of any value generally. Sometimes epilepsy can be confused with 'hysterical' convulsions. Following are some of the points which can distinguish between the two.

Epilepsy	Hysterical attack
1. Sudden onset, lasts for about a minute or two though relatives may report it as 10-15 minutes.	Dramatic onset, or it may be gradual; usually lasts longer
2. The body becomes stiff and then there are jerks till the whole body relaxes	Bizarre, lashing and flinging type of movement.
3. The pattern is the same always	The pattern differs in every fit
4. Injury to body parts, tongue or lips are common	Injuries are uncommon.
5. After the fit the person remains confused or sleeps off	No confusion or sleep after the fit
6. Occurs in sleep also	Does not generally occurs in sleep
7. Occurs even when alone	Almost always in the presence of other people, the more the audience, the more vigorous is the fit.
8. Pupils are dilated during the attack	Pupils are not dilated
9. Plantars are extensor during the attack	Plantars are flexor

Management: The following guidelines should be remembered in treating an epileptic:

(a) Usually drug treatment is started only after a person gets at least 2 attacks during a period of 6 months. The advise to be given to people with one attack is to watch for further attacks and report, if they occur.

(b) The commonly prescribed drugs for epilepsy are two, namely Phenobarbitone (Gardenal) and Diphenyl hydantoin (Eptoin Mtoin). It is always better to start a patient on a single drug. Add the second one only if the first drug did not control the convulsion.

(c) Phenobarbitone should be started in a single dose of 60 mg per day and increased upto 120 mg per day if the fits are not controlled. Add Diphenyl hydeantoin in dosage of 1 tab. of 100 mg per day and increase it upto 2 tabs (200 mg) when necessary (i.e when fits are not controlled). Do not give more than these doses. It is believed and advised these days that it is sufficient if a single dose of the above drugs are given instead of the old divided dose schedule. Irrespective of the time of fits, these drugs can be given as a single dose at bed time.

(d) The only side effect of phenobarbitone is drowsiness. Dephenyl hydantoins when taken in excessive doses can produce ataxic gait and other cerebellar symptoms. Long consumption of this drug may produce hypertrophy of gums.

(e) The antiepileptic medication should be continued for a minimum period of two years, after the last fit.

(f) It is very essential for the family to cooperative with the management. It is important to remember that certain emotional factors can trigger off an attack. It is necessary to have an attitude towards them as one would have towards any normal person.

(g) Epileptics must avoid, late nights, empty stomach and alcohol as they may bring down the threshold for convulsion. They must avoid driving, being near fire alone, heights or swimming.

(h) Refer the epileptic for treatment to a specialist under following circumstances:

1. When fits are not under control on the advised dosage even after a period of a month
2. When the epilepsy is part of a neurological problem.
3. When a patient develops certain neurological signs of symptoms during the course of his illness.

(i) It is worth emphasising here that in some case both epilepsy and hysterical convulsions may coexist. The epilepsy should then be treated with drugs.

(j) Status epilepticus (patient getting fits continuously without regaining consciousness inbetween) almost always respond immediately to diazepam given as intravenous injection in doses of 5 mg to 10 mg.

Most epilepsies, when correctly diagnosed can be treated and managed by any qualified medical practitioner provided regular and adequate medication is ensured.

MENTAL RETARDATION

Some people are mentally dull and weak right from childhood. The mental retardation first becomes noticed when a child fails to raise his head, sit up, walk and talk, at the usual age (raising head=3 months, sitting up=6 months, walking=1 year, talking=1½ years). His subsequent mental growth and often physical growth remains poor. For example a 10 year old child may behave like a 2 year old child.

These people are not mentally ill. Mental illness occurs later in life in an otherwise normally developed person. However sometimes the mentally retarded person may also show strange or aggressive behaviour. Very severely retarded persons may have physical abnormalities also.

Mental retardation can occur as a result of injury to the brain at birth (as in difficult labour, forceps application) brain fever, fits in early childhood, any serious infection which involves brain Eg: meningitis or fits due to epilepsy. Very often the cause is a chemical abnormality leading to poor construction of the brain while the child is in the womb.

There is no cure for mental retardation. Once the brain is poorly formed nothing can repair it. There are no drugs which increase intelligence. However these children can be trained and learn skills. The parents have to be very patient and repeat instructions many times. With such patient training, many retarded children can train to look after themselves and do simple jobs in the farm. They learn quicker if the training is given with kindness and the children are rewarded every time they learn a skill.

A mentally retarded person may have fits or show symptoms of psychosis - hyperactivity, violence, destructiveness. In such cases, the appropriate medicine to control fits or psychosis should be given.

A L C O H O L

1. Signs of Alcohol dependence:

   (a) Increased frequency and quantity
   (b) Drinking alone
   (c) Alcoholic amnesia (Black-out)
   (d) Morning shakes
   (e) Increase in tolerance
   (f) Personality change and social deterioration.

2. Hazards of Alcohol dependence:

   (a) Poor nutrition
   (b) Delerium tremens
   (c) Korsakoff's Psychosis
   (d) Wernicke's encephalopathy
   (e) Alcoholic hallucinosis
   (f) Delusions of jealousy
   (g) Dementia

3. Signs of Alcohol withdrawl in a 'dependent' case:

(a) Agitation, Hyperactivity, Sweating, Tachycardia

(b) Tremors

(c) Hallucinations - mainly visual

(d) Disorientation, Delerium

(e) Seizure, Fever/diarrhea, dehydration.

4. Treatment of acute alcoholic intoxication:

(a) Let the patient sleep off his stupor

(b) If comatose, pass an endotrachial tube and give 5% glucose. Enough fluids.

5. Treatment of Alcohol withdrawl:

(a) Chlordiazepoxide 20-40 mg a day

(b) In Alcoholic hallucinosis - Chlorpromazine 100 - 300 mg a day.

(c) In D.T's - Fluids, vit. B complex I/V and, chlordiazepoxide. Look out for 'fits' and give anticonvulsants if necessary.

PSYCHIATRIC EMERGENCIES

Psychiatric emergencies are any psychiatric conditions or circumstances of a patient which calls for immediate action. Here, the decision as to what is to be done to the patient, has to be taken soon. A psychiatric condition or circumstances will present as an emergency, usually due to one or more of the following reasons:

(a) The patient may be a source of danger to himself or others because of his mental state.

(b) The patient's relatives may be extremely anxious and worried regarding the patient's condition.

(c) The patient may create disturbance in the community to an intolerable or unmanageable degree

(d) The patient may be in extreme and unbearable distress.

Approach to a psychiatric emergency:

History taking, however brief it may be, is very essential and should preferably be proceeded by the examination of the patient. Inquiry should be made regarding the possibility of any probable precipitating factors. A thorough examination of the patient including measurement of blood preasure should

be done. Examination of the patient can preferably be in private. Avoiding restraint as far as possible will be useful. Do not deny the reality of the patient's experiences. The doctor must try to express his respect for the patient and by direct verbal reassurances, inform the patient of his commitment to the patient's welfare. The doctor can reveal his identity and should try to avoid pretending otherwise to the patient.

A psychiatric emergency may be the acute onset of a new illness or an acute exacerbation of a chronic illness.

The various psychiatric emergencies are the following:

1. Suicidal threats, gestures or attempts: No suicidal threat, gesture, or attempt should be taken lightly. Do not take the assurances of the patient for granted. There are no definite and fixed criteria to differentiate between genuine and spurious attempts.

The following points are worth remembering:

(a) An overdosage of drugs or intake of poisonous substances is seldome accidental and almost always suicidal.

(b) An attempt at suicide when patient is alone is always a serious attempt.

(c) More than one method of attempt, indicates seriousness.

(d) Above themiddle age, attempts are always serious

(e) Farewell note, if found, indicates a serious attempt.

(f) Frank admissions of suicidal intent by the patient can be relied upon, but never his denials.

Management

(a) It is advisable not to take things lightly even if the patient assures that it was not a suicidal attempt or that no further attempts will be made.

(b) It is desirable (and not harmful) to discuss openly about the risk of suicide/suicidal attempt, with the patient and the relatives.

(c) Referral to a psychiatrist and admission under his care is warranted, if family members are not confident to look after the patient.

(d) It is preferably not to leave the patient alone and co-operation of the family members should be sought to ensure sympathetic supervision of the patient.

2. Excitements:

Excitements may be due to (a) Functional psychiatric illness like a schizophrenia or mania (b) Organic brain disorders caused by various CNS or systemic illnesses a state called by the general terms: Acute Brain Syndrome.

When the excitement is due to either schizophrenia or mania, it is rarely the first evidence of these illnesses. Often there will be history dating back to at least few days prior to the onset of excitement, of some behavioural abnormalities and

sleep disturbances. Usually there will be no confusion or other alterations in the state of consciousness.

The clinical picture of acute brain syndrome would consist of fluctuations in level of consciousness, disorientation, inability to concentrate, impairements of memory - in addition to other features like restlessness agitation, disturbances of sleep, slurred speech, irritability, unexplained fear. These symptoms may be more marked in the night.

Management:

(a) Excited patients generally carry the risk also of, self neglect, exhaustion and malnutrition. These have to be taken care of.

(b) If the patient is too excited to be without an escort, it is always advisable to choose an escort who has not physically restrained the patient before, because excited patients generally tend to be uncooperative with those who have physically and forcefully restrained them earlier. However, one should not hesitate to take whatever precautions any situation may demand. For example, when dealing with a physically violent patient, it is wise to be out of his arms' reach except while giving injections and be always facing him.

(c) If the patient expresses hallucinations or delusions, respect it and do not argue.

(d) The primary task in any excitement (except head injury) is sedation. Chlorpromazine (Largetil 100 mg as 1M injection would be an ideal choice and should be given immediately. It can be repeated as injections of 50 mg. at half hourly intervals if necessary to control the patient. Later the injection can be substituted by tablets of 100 mg. Chlorpromazine given orally (400 to 600 mg per 24 hrs may be sufficient). Fall of B.P. as a side effect of Chlorpromazine should always be kept in mind. If the excited patient has jaundice, do not give any drug other than phenobarbitone for sedating the patient. Following head injuries do not give any drug to the patient.

(e) In treating the patient with acute brain syndrome, the underlying physical condition should be determined and energetic treatment for the same should be started as promptly as possible.

3. Side effects of Phenothiazines (Chlorpromazine)/Major tranquilizers like Phenothiazine (Chlorpromazine-Largactil) have many undesirable side effects, some of which may present as an emergency. The commonest side effects are extrapyramidal symptoms

I. Anxiolytics (or, "Minor Tranquilisers")

Anxiolytics are effective for symptomatic relief of neurotic conditions whereever symptoms of anxiety are present; like: sweating, tremors, palpitations; they also facilitate sleep. Their effectiveness as sole curative agents is however very restricted to those conditions where the anxiety symptoms are:

(a) of very recent origin,

(b) the patient has in the past shown ability to cope adequately with stress,

(c) there are no severe and prolonged interpersonal/familial problems.

In all other cases the role of anxiolytics is limited, and the management must necessarily include psychotherapy, family counselling, etc. In such cases, if symptoms of anxiety are severe, anxiolytics can be used with discretion only as adjuncts to other modes of managements.

Pharmacological name of the anxiolytic and tablet strength	Some (proprietory) Trade names	Average dose per day
1. Diazepam 5 mg.	Diazecalm Calmpose Calm-U Paxum Calmood	5 mg O.D. or B.D.
2. Lorazepam 1 mg	Larpose	1 mg O.D., B.D., or T.D.S.
3. Chlordiaze-poxide 10 mg, 25 mg	Librium Equibraum	B.D. or T.D.S. can be given up to 10 mg per day in Tremors due to alcoholism

Diazepam should not be given more than 15 mg per day because of drowsiness, lethargy and ataxia.

Intravenous diazepam is very effective in cases of status epilepticus. The injection must be given slowly. (Intra-muscular injections are ineffective)

II. Hypnotic

Hypnotics are used sparingly to facilitate sleep in conjunction with antidepressants in cases of severe insomnia. The word "sparingly" is deliberately emphasised because (a) prescription merely of an hypnotic to an insomnic person will do nothing to his problems which are causing him insomnia, and there is danger of the individual learning the habit of taking hypnotics instead of "rolling up his sleeves" and dealing with the problems. If this happens we will be contributing to the individual's escape from his healthy and legitimate responsibilities. (b) In majority of instances, insomnia will automatically set itself right either when the underlying problem is adequately dealt with or when his anxiety or depression is relieved.

Pharmacological name of the hypnotic is Nitrazepam, available as Hypnotex, Nitravet, sedomon, etc. available in 5 mg and 10 mg strengths. It is administered only at bed time. Rarely it can cause "hang-over" like symptoms.

Concomitant use of alcohol and hypnotics will cause excessive drowsiness and should be avoided.

III. Antipsychotics (or "Major Tranquillisers")

Antipsychotics are effective either in schizophrenic psychoses or in manic states, or in those cases of depression where addictional psychotic features of hallucinations and delusions are also present, alcoholic psychoses, and when cautiously used in organic and epileptic psychoses.

Pharmacological name and strength	Some trade names	Equi-potent dose	Average therapeutic dose
A. Phenothiazines			
(1) Chlorpromazine 50 mg 100 mg	Largactil tranchlor Promacid Widactil	100 mg	100-300 mg per day
(2) Trifluoperagine 5 mg	Trinicalm Eskazine Trankozine Mephazine T.F.P. Eraine	5 mg	5 - 15 mg per day

(3) Thioridazine 25 mg 100 mg	Mellerich	100 mg	100-400 mg per day
(4) Fluphenazine Deconoate (this is a depot-phenothiazine-parenteral 25 mg/ml)	Anatensol - Deconoale	-	25 mg IM once in 2 weekns to 4 weeks

B. Butyrophenones

Haloperidol 1.5 mg 5 mg	Serenace Depidol Haldol	1.5mg	3-9 mg per day

Note-1: The maximum therapeutic doses mentioned above should not be exceeded in the out-patient setting.

Note-2: In case of Depot phenothiazine:- (a) It is used generally as a maintainance medication for schizophrenic psychoses. (b) The dose is adjusted by altering the interval between injections from 2 weeks to 3 weeks and also by altering the dose between 1 ml and ½ ml.

These antipsychotic drugs have differing degrees of sedative effects, and this can be made use of to meet special clinical requirements like: (a) severe insomnia is a predominant problem, (b) the patient has to attend work during daytime though taking antipsychotics in divided doses. The sedative effect of the drugs is mentioned in decreasing order:

- Chlropromazine - most sedation
- Thioridazine
- Trifluoperazine
- Haloperidol - least sedation.

The following are the side effects of the antipsychotic drugs.

(1) Minor and transient: They usually disappear spontaneously after 2-3 days of treatment:

- dryness of mouth
- blurring of vision
- drowsiness.

(2) Extrapyramidal side effects

(A) Reversible conditions: It is very important to recognise them so as to institute prompt treatment (a) Acute Dystonic

reaction:- sudden muscular contraction, most often in neck, tongue, and pharynx; presenting as occulo-gyric crisis, laryngeal spasm or as protrusion of tongue against clenched teeth. One of the commonly used drugs in general practice, siquil (a phenothiazine) frequently causes, this reaction. Acute dystronic reaction can be quickly relieved by 50 mg of Intra muscular phenergan.

(b) Drug induced parkinsonism: The features are:

Excessive salivation

Tremors

Rigidity

Masklike face.

(c) Akathisia:- It is a condition of motor-restlessness, often accompanied by mental-restlessness; viz: the patient just cannot sit or stand at one place quietly for more than a few seconds, and he is distressed. Though this picture may be seen as a part of agitated depression, there will be history of phenothiazine medication in the last 24 or 48 hours in case of akathisia.

All the three above conditions need antiparkinsonian drugs. If the patient already happens to be on antiparkinsonial drug, the dose will have to be increased. Antiparkinsonian drugs should be continued till these extraphyramidal symptoms disappear. After that, another phenothazine can emperically be substituted for the psychosis.

Thioridazine (Melleril) is least known to cause these extrapyramidal symptoms.

B) Chronic condition: Tardive Dyskinesia

When it does occur, it usually occurs after 5 to 6 years' use of phenothiazines, Buterophenones. This most troublesome iatrogenic condition is difficult to treat. Refer to a psychiatrist. The clinical feature is one of Bucco-oro-facio-lingual movements, almost continuously seen in wakeful state. There can be classical "fly-catching" movements

of the tongue, and grinding of teeth.

3) Jaundice: Commonly seen with Chlorpromazine. Stop drugs and immediately refer to the psychiatrist.

4) Postural Hypotension: If this is severe, the patient should be hospitalised, the drug stopped; and if necessary nor-adrenaline or Isophrenaline drip started. Adrenaline is contraindicated Earliest symptom is giddiness on standing. If so, check B.P., both standing and lying. Commonest offender is Chlorpromazine.

5) Skin sensitivity: Exfoliative dermatitis. Stop drugs and refer to psychiatrist.

6) Rarely, bone marrow depression can take place. Check blood counts when this is suspected.

Thioridazine has high anti-cholenergic side effects, and therefore should be used with caution when prescribing to elderly patients.

IV. Antiparkinsonian Agents: Effective against phenothiazine induced extropyramidal side effects. As mentioned earlier Tardine dyskinesia is one drug induced extrapyramindal condition most difficult to treat and anti-parkinsonian drugs may aggrevate this condition.

Pharmacological name and strength	Some trade names	Average daily dose
1. Trihexyphenedyl 2 mg.	Parkin Pacitane Placidyl Hexinal	2 to 6 mg.
2. Procyclidine Hcl 5 mg	Kemadrine	5 to 15 mg.

V. Antedepressant drugs (tricyclic compounds)

Effective against depression of any cause when the depressive features are predominant.

Pharmacological name ~~and strength~~	Some trade names	Average dose per day
1. Imipramine Hcl	Depsonil Impranil Antidep Restamine	75-150 mg.
2. Trimipramine	Surmontil	75-150 mg
3. Nortryptaline	Sensival	75-150 mg
4. Amitryptaline	Saroxena Tryptanol Amiline	75-150 mg
5. Doxepin Hcl	Doxetar Spectra Sinepan	75-150 mg

Note: A higher or single night dose is preferable, and equally effective if the patient can tolerate.

The therapeutic effect takes on the average about 10-14 days to manifest or to be felt by the patient. Therefore, it is essential to advise the patient to take the drug for a minimum period of at least 3 weeks before considering any change.

Imipramine causes least sedation. The following are the side effects:

- Dryness of mouth
- Blurring of vision
- Constipation
- Rarely, retention of urine and paralytic ileus.

It is essential to advise the patients about these possible transient side effects so that they are prepared if it happens and do not stop the medication.

These antidepressants are to be used with extreme caution and in consultation with the psychiatrist in following conditions:

(a) Glaucoma - Consultation of an ophtholmologist will also become necessary.

(b) Recent Myocardial Ischaemia, because of danger of arrhythmias.

(c) Enlarged prostate, because of danger of retention of urine.

Note: In some families, when there is a death, one or more members may go into a state of normal grief reaction which can resemble depression. If the family members seek consultation, refer to a psychiatrist.

VI. Prophylactic Lithium:

Lithium carbonate is effective in treating cases of mania, and it is widely used in preventing recurrent manic depressive psychoses. The use of the drug may be left to the discretion of a psychiatrist though the GP can effectively conduct the maintainance dose follow-ups.

- Capsule "Litho-carb" 150 mg.
- Tab "Lithium" 250 mg.
- Tab "Lithanate" 250 mg.
- Tab "Licab" 300 mg.

The commonly used dose is 900-1200 mg per day in three divided doses. It is essential to regularly and periodically monitor the required dose by doing serum Lithium Estimations periodically. The effective serum Lithium level is 0.6 to 1.4 m.Eq/Lit (or milli moles/Lt.)

Beyond 1.4 mEq/Lt, toxic effects manifest in the form of:

- Abdominal discomforts
- Nausea
- Vomiting.
- Diarrhoea
- Tremors of hand
- Drowsiness, etc.

A watch must be kept for these early side effects. If they occurs the drugs must be immediately stopped and the patient referred to a psychiatrist or physician.

Caution: Before starting this drug, the renal and cardiac functions must be assertained. The drug should be avoided in 1st trimester of pregnancy and in known epileptics.

VII. Some undesirable interactions which necessiate caution and discretion:

1. Antacids cause delaying of the absorption of the phenothiazines.

2. Both antidepressants and chlorpromazine are liable to potentiate epileptic fits in known epileptics.

3. All the commonly used anti-hypertensive drugs can cause depression, particularly reserpin.

Similarly, oral contraceptives are known to cause psychiatric complications, especially depressive symptamatology.

4.

these drugs	"interact" with	to produce
Tricyclic anti-depressants	Adrenaline and non-adrenaline	→ Hypertension
"	Alcohol	→ Increased depressant effect on CNS
"	Antihypertensive agents	Antagonism to Hypotensive effect
Barbiturates	Alcohol, Anaesthetics and anti histamines	Increased depressant effect on CNS
"	Anticoagulants	Antagonism of anti coagulant effect. In case of phenytoin increased Toxicity of phenytoin
"	Griscofluvin	Reduced Anti-bacterial activity
"	Phenothiazines Tranquillisers Buterophenones	Increased depressant effect of CNS
Phenothiazines	Anaesthetics Alcohol, Barbiturates	Increased depressant effect on CNS
"	Antihypertensive agents	Increased hypotensive effect. Methyl Dopa may cause central excitation
"	Atropine like drugs and Antihistamines	Decreased anti-cholenergic activity

contd...

these drugs	"interact" with	to produce
Hypnotics	Alcohol Anaesthetics Antihistamines Phenothiazines Minor tranquillisers	Increased depressant effect on CNS
Alcohol	Tranquillisers Antihistamines Antidepressants Barbiturates Hypnotics Phenothiazines	Increased depressant effect on CNS
"	Cycloserine	Increased risk of convulsions

Mental Health Services. MH 1.5

Child guidance clinic - Began in Chicago in 1909. At present includes children & adolescents. Looks after juv. delinquents & all the behavioral disorders - antisocial disorders eg stealing, lying, gambling, sexual offences, cruelty & destructiveness.
- Habit disorders eg thumbsucking, nail biting, bedwetting & masturbation.
- Personality disorders eg jealousy, temper tantrums, timidity, shyness, day dreaming, fear & anxiety, un-sociability & hysteria.
- Psychosom. disorders - tiredness, headache depression, asthma, delusions & hallucinations.
- Educational difficulties - backwardness in learning, schoolphobia, frequent failures in exams.

Child. G. Cl. - a team of personnel children & adolescents from the possibility of becoming psychotic & normalise life.

Team - Psychiatrist, Cl. & educat: psychologist, psychiatric social worker,

PHN, paediatrician, speech therapist, neurologist:
Mode of Therapy → psychoth.
Legislations: to protect children from negligence & harsh Rx, control ale & drug addict', discouraging social crimes, social discrimination, correct adm'. to OLH.

Social welfare Measure
Recreational facilities mat + CH service, ante, intra & post-natal & child care & geriatric welfare services.
Community clubs.
Family effort.
Individual "

Research - in genetics, psychopathology, etiology & epidemiology of disorders,

Social Security

a state of mind & objective reality.
confident of getting certain benefits.
Protection must be adequate in quality & quantity. Ensures min wages, sufficient amenities. Dispel poverty, dis, ignorance, squalor & idleness. These impair a working man who cannot support his fly.
Provided by central, St govts & private organiz'.

< Security of employⁿ.
: of income.
.. " power to work.
Inability to spend, sick, unemployed & unable to work. Since 1935 ILO —
"Security that society furnishes thru' appropriate organiz. against certain risks to which its members are exposed i.e. contingencies against which individual of small means cannot effectively provide by his own ability or foresight alone or even in private comb. with his fellows — viz sickness, invalidity, maternity, old age & death ∴ indispensable for promoting social welfare in an industrial economy.

Social Insurance: covers sickness, maternity, employment, injury, unemployment, old age, dependants & invalidity benefits & pension — always some contribution

Social assistance — a charity — viz non contributory pension, childrens allowance, unemploy. assist, care of handicapped & wounded.

Comprehensive Social Sec. plan — shd cover entire popⁿ. for all contingencies & of med & rehab. services. Benefit

Std Sec commissariat to replace. what is work
& a Tripartite admin — govt, employer
+ employee. Social sec is obligatory social
insurance..

MH1.7

ASPECT OF PREVENTIVE PSYCHIATRY

The expert committee of the W.H.O. on mental defines mental health as the capacity of an individual to form harmonious relationship with others and to participate in or contribute constructively to cange in the social environment. Meninger defines mental health as adjustment of human being to the world and to each other with a maximum of effectiveness and happiness. Mental health is not only absence of mental illness, it is also the development of mature well adjusted personalities. A good adjustment is the core of mental health. Thus the two main aspects of mental health are 1) Promotion of well adjusted stable personalities in society and 2) prevention of mental illness.

Promotion of the development of stable personality:- A personality is the sum total of one's physical, emotional and intellectual faculties which makes one a unique person. The two factors which are important in the development of the personality are early life experiences and genetic factors. Early experiences mould ones personality to a great extent. A well balanced home is important for the development of the personality. Overt rejection, overprotection, perfectionish, inconsistencies and unnecessary strictness on the part of either parent is detrimental to the emotional development of child.

The next place which is important in the development of the child's personality is the school and it is essential that school teachers must be qualified to be of help in the development of the child.

The next critical phase is the adolescent period which is a transitional period, both physically and emotionally and hence a quite vulnerable period. Sex education, vocational guidance, marriage counseling is essential during this period.

Thus, for the promotion of overall personality development a child must have a good emotional climate both at home and school. Social education is the cornorstone of preventive psychiatry. Parents and teachers must be taught about this aspects of mental health.

Prevention of mental health:-

Primary Prevention:- This involves the reduction of new cases appearing in a year. This is the most difficult part of preventive psychiatry since the etiological factors of several types of mental illnesses are not yet specified. But the development of a stable personality will minimize the onset of some types of mental illness. The most important thing is that the home atmosphere in which the children are brought up should provide for their needs which includes security and affection. Child guidance centres, crises therapy to help people in acute crisis in life, marriage counseling centres, and centres to prepare people to meet the demands and frustrations of old age and vulnerable periods of time will serve to minimize many psychiatric disturbances.

Secondary prevention:- Involves reduction in the prevalence rate. Prevalance rate is the measure of the number of mentally ill people at a particular time. Prevalence rate can be reduced by early detection of cases and their effective treatment. The primary role of the general practitioner is in the secondary prevention of mental illness. They should know the fundamentals

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of psychiatry so that they should be able to detect cases of mental illness, treat some of them and refer the rest to a specialist. Indian Mental Health Surveys report that about 20 per 1000 need active psychiatric treatment and as there are only about 400 psychiatrists and 20,000 hospital beds for the treatment of more than 12 million patients, the general practitioners must share a large measure of the load. This makes it imperative that in the undergraduate medical curiculum, psychiatry must be given an important place.

Tertiary prevention:- involves rehabilitation of the patients who have had active treatment and recovered or improved.

The active involvement of the family and the community in the treatment of the mentally ill patients should be encouraged. The psychiatry departments of general hospitals should come to the forefront in treatment of the mentally ill. The mental hospitals should be reserved only for chronic or dangerous patients who need custodial care.

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M. Sc. IN COMMUNITY HEALTH IN DEVELOPING COUNTRIES

MENTAL HEALTH UNIT

TUESDAY 17TH MARCH TO THURSDAY 19TH MARCH, 1987

	9.30 a.m.		11.00 a.m.		2.00 p.m.		3.00 p.m.	
TUESDAY	Introduction Psychiatric concepts	Classification Incidence	Psychotropic Drugs Arraning student speakers	Third World features Burden on the community	Anxiety Neurosis Depression		Schizophrenia Organic States Epilepsy	
WEDNESDAY	Epidemiology of Third World Psychiatry Dr. Paul Williams		W.H.O. Collaborative Study Methods and findings (Harding et al) (Climent et al) (Isaac & Kapur) (WHO Technical Report No.698, 1984)		Priorities in Primary Care (Giel & Harding)	Priorities in treatment (Harding & Chrusciel)	Children's Problems (Giel et al)	
THURSDAY	Auxiliaries & Manuals (Essex & Gosling)	Alcohol Problems Definitions, Problems (especially in the Third World)	Counselling in the Developing World Mr. William Reavley		Mental Handicap Preventive Psychiatry (WHO 1975 & 1981) Innovations		Requested topics Feedback	

Dr. Paul Williams, Epidemiologist, M.R.C. Social Psychiatry Unit, Institute of Psychiatry, London.

Mr. William Reavley, Clinical Psychologist, Dept. of Psychology, Graylingwell Hospital, Chichester, West Sussex.

MENTAL HEALTH PROBLEMS IN DEVELOPING COUNTRIES

INCIDENCE

Seriously incapacitating mental disorders are likely to affect:-

1% of any population at any one time;

10% at some time in their life.

"An estimated 40 million men, women and children in developing countries are suffering from serious untreated mental disorders".

(Reference: WHO 'Organisation of Mental Health Services in Developing Countries'. Technical Report Series No. 564, 1975).

"As many as 20% of all those attending general health care facilities in both developing and developed countries do so because of psychological symptoms. These patients often complain of multiple somatic symptoms".

(Reference: WHO 'Mental Health Care in Developing Countries : a critical appraisal of research findings'. Technical Report Series No. 698, 1984).

PRESENT CARE OF THE MENTALLY ILL

No treatment - wander through towns and villages, often disturbing the community or hidden at home.

Traditional healers - widely available and usually relatives first choice.

Imprisoned - without offending or receiving treatment.

General Medical Services
- Outpatients - wasteful of resources and time of trained staff.
- Inpatients - often disruptive.

Mental Health Services - usually isolated mental hospital or units in major cities - remote from most patients.

Private psychiatric care
- Hospital specialists
- General Practitioners

COMMON PSYCHIATRIC CONDITIONS

Recognition and Management

ANXIETY This can occur alone or as a complication of physical illness.

Anxiety has three aspects:-

1. A feeling of apprehension or unpleasant anticipation.
2. An impulse to action - "fight or flight".
3. Physical effects via the autonomic nervous system especially musoular - chest pain, headache, weakness, tremor; cardio-vascular system - palpitations; respiratory system - over-breathing, difficulty taking deep breath; skin - burning and other sensations; genito-urinary system - impotence, frequency.

In the developing world it is uncommon for patients to present complaining of the feeling aspects of anxiety, the usual complaint is of the physical aspects which doctor and patient may not relate to anxiety but investigate as a symptom of a physical illness.

Management

1. Treatment of the underlying cause, whether this is physical or social.
2. Symptomatic treatment by use of minor tranquillizers, e.g. valium, librium. Expensive, produces only short lived improvements, if any. Phenobarbitone is cheap but also has only short lived benefit.
3. Community, e.g. leaders (secular and religious).
4. Possibly traditional healers.

SCHIZOPHRENIA AND MANIA (Psychosis) Delusions, hallucinations, over-activity, defending themselves against real or imagined threats of others, possibly leading to aggression. Possible social disruption by removal of clothes and damage to property. Locally recognised as "run mad", "quietly mad".

Management

1. Major tranquillizers, e.g. Chlorpromazine (Largactil) - very effective in acute phase. Can help prevent relapse and chronic disability.
2. Possibly electrical treatment.

Cont'd/...

Common Psychiatric Conditions (Cont'd)

DELIRIUM (Acute brain syndrome) The patient has a physical illness in which the function of the brain is impaired. "Clouding of consciousness" - patient disorientated in time, place and person, is very anxious, mental condition varies from the patient being clearly alert to being obviously "not with it".

Causes - almost any physical illness but particularly alcohol, (both intoxication and withdrawal effects), infections (e.g. typhoid, cerebral malaria, encephalitis, meningitis, typhus, trypanosomiasis, septicaemia, pneumonia). Epilepsy. Heart disease, brain disease.

Management

1. Treatment of the underlying physical illness.
2. Major tranquillizers, e.g. Chlorpromazine (Largactil).

SEVERE DEPRESSION Commonly presenting as withdrawal, inactivity, loss of usual interests, though may complain of persistent misery out of proportion to any stress. Hypochondriasis. Danger of suicide.

Management

1. Antidepressant drugs, e.g. Imipramine (Tofranil).
2. Possibly electrical treatment.

EPILEPSY Major fit with unconsciousness, tonic and clonic movements, tongue biting, incontinence of urine, other injuries. Temporal lobe epilepsy much less common with "clouding of consciousness", multiple psychiatric symptoms. Adequate dosage of phenobarbitone controls 90%. Problems of compliance, maintaining stocks. Cultural attitudes with fears of infection and community rejection can lead to lifelong disability.

SELECTING PRIORITIES IN MENTAL HEALTH CARE

WHICH CONDITION?	e.g. excited states, epilepsy, chronic psychoses.
WHO TREATS IT?	e.g. basic primary health worker, rural nurse and midwife, medical assistant, medical officer, consultent physician.
WHERE?	e.g. village, rural aid post, health clinic, health centre with beds, district hospital.
WITH WHAT DRUGS?	e.g. phenobarbitone, chlorpromazine, imipramine or amitriptyline, anti-parkinsonian drug, depot major tranquillizer, another major tranquillizer.

Common symptoms of mental disorders

Disorders of cognition:- Cognition is the act of knowing and it involves attention, perception, memory and thinking.

Attention:- Attention is a preliminary step for observation. One may have difficulty in arousing attention or sustaining it.

Perception:- is the process of getting to know the objects in the environment. The common disorders of perception are imperfections, illudiond and hallucination.

Imperception is a condition in which stimulation and sensation fail to produce a correct and complete perception. Hypoesthesia Anaesthesia, paraesthesia are examples of imperception.

Illusion is a misinterpretation of real sensory experience arising from stimulus outside the body. Illusions can occur in normal people. Illusion are frequently associated with delirium and twilight states.

Hallucination is a vivid perceptual experience in the absence of a stimulus. There is no stimulus to stimulate the sensory organs, but the experience of perception occurs and is quite real to the person involved. Hallucinations can be auditory, visual, olfactory, gustatory or tactile. Auditory hallusinations are common in schizophrenia, usual hallucinations are common in acute alcoholism. Tactole hallucinations occur in cocaine poisioning.

Memory:- Memory is the capacity to register, retain and recall the objective reality in the form of images, concepts or ideas. The commonest disorder of memory is amnesia which is inability to remember. It may be partial or total. It may be specific like difficulty in remembering numbers, names etc or it may be general. It may be temporary or permanent. It can be with regard to immediate events, recent or remote events.

Hypomnesia is a partial loss of capacity to recall. Retrograde amnesia occurs after a brain trauma involving loss of consciousness where the person is unable to recall what preceded the events. Antrograde amnesia, is the difficulty in remembering the events immediately following the trauma. The gap left by memory is sometimes filled with fabricated stories, this is called confabulation or paramnesia.

Thinking involves the organization of symbols which may be words, images or gestures which involves subjective representation of some object or situation whose meaning depends upon the past experience of an individual.

Speech is an expression of thought process and disorders of thinking can manifest in the form or content of speech. In manic excitement associative bonds form with great rapidily, resulting in several thoughts and mental images is called pressure of speech. Logical connection between thoughts is lost in schizophrenics and this is called loosening of association. Sometimes a patient joins together unconnected concepts and images and utters a jumble of words without meaning, this is called word salad.

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preservation involves persistent verbal repetition of a thought in response to repeated external stimulation. Obsessions are repetitive and persistent intrusions into consciousness of an unwanted thought, desire or impulse when obsession is associated with persistent unrealistic affect of fear, it is known as phobia.

Delusion is a dirorder of the content of thinking. Delusions are false opinions or beliefs which do not correspond with reality, one's level of knowledge, and the cultural beliefs of the social group and which cannot be dispelled by any correcting influence. Persecutory delusions are common in schizophrenia. Delusions of grandeur occur in manic state. Delusions of inferiority, of hypochondriacal delusions and that some organ is absent (Nihilistic delusion) are common in depression. Paranoid delusions, are well systemalized on a false presumption but have a formally correct pattern of reasoning.

DISORDERS OF EMOTION:- The pathology of emotions can be judged on three criteria; (1) duration (2) intensity (3) appropriateness.

Fear implies impending danger or disaster and is related to an external object. In phobia the fear is irrational. Anxiety is apprehension and uneasiness in anticipation of some danger the nature of which is not known.

Elation or euphoria: can be pathological when incongruous either with the patients surrounding or with his physical state. Depression is the lowering of mood, inconsistent with the actual state of affairs. Emotional liability occurs in organic psychosis where the patient crys and laughs without adequate external stimulii. Incongruity of emotion is commonly seen in schizophrenia when the patients feelings are in appropriate with their careser. Emotional apathy is shallowness of mood or inadequate mood.

Disorders of Volition:-

Volition is our will. Stupor where in psychic inhibition, partial or general especially in reference to deadened sensibility occurs. In catatontic stupor there is marked retardation of movement and speech.

Negativism where the patient refuses to obey commands, automatism where all commands are passively obeyed are disorders of volition. passivity phenomenan where the patient feels that he is controled by external forces beyond his control is a common disturbance of voilition in schizophenia.

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1. COMMUNITY INDICATORS OF MENTAL HEALTH

Although the need for developing indicators is a well accepted area of study developing indicators as such has received little attention. Indicators in any component of health are a basic prerequisite at all levels (from needs assessment to measuring effectivness) to effectively design appropriate and relevant programmes. Already well established indicators are in usuage for many of the communicable diseases.

In the present context of National mental health programme, development of indicators assumes greater significance as the programme is in its early stages. At the moment, when all attempts are being made to integrate mental health with total health, developing indicators from inception will aid in monitoring & evaluation of programmes.

Both indicators of health & illness are important for any health programme and this becomes slightly difficult in the field of mental health because of practical difficulties in the definition of mental health and illness at the level of community. In the field of mental health, the indicators usually involve morbidity, disability, services, provisions of care etc. as there is enormous difficulty in deriving the definition of well being, happiness etc.

2. PROPERTIES OF INDICATORS

Indicators are usually based on direct or indirect measurements or observations. These are an indication of a given situation or a reflection of that situation. Indicators are usually defined as "variables which help to measure changes". Being measures of a situation, when employed over a period of time, they help in indicating direction and speed of change and also guide in comparison of different areas, groups or components of a programme. Hence, indicators are the yardsticks to assess changes in the development phase of a given situation.

Indicators, objectives and targets are a times considered synonymous. Objectives are desired aims while targets are objectives that have been made more specific in quantifiable terms or in terms of time and indicators are used as markers of progress towards achievement of objectives and targets.

Any indicator or a set of indicators (indices) which are applied to a given situation must be valid, objective, sensitive, specific simple to collect, inexpensive and easy to apply. Choice of indicators must be decided based upon the usefulness of their application. No one indicator can give a complete picture of the situation and hence a set of indicators are essential.

Finally indicators are unidimensional summary statistics referring to a particular situations.

3. USES OF INDICATORS IN MENTAL HEALTH

Every Mental health programme passes through the phases of planning, organisation, implementation, surveillance, monitoring and evaluation when systematically thought about. Indicators will be of greater help in planning, monitoring and evaluation by providing a continuous feedback. Among the several uses, a few notable ones are

- for needs assessment
- for prioritisation of problems
- to predict or document a given situation
- for equitable allocation of scant resources
- for identification of risk groups in need of immediate services
- to help decision makers in initiating appropriate action
- to make timely changes for the improvement of programmes

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- to effectively organise specific types of institutional services
- for comparison purposes
- for policy development at higher level
- for monitoring and evaluation of programmes
- for further research activities.

Some indicators serve a single purpose while several others serve multiple purposes.

4. SELECTION OF INDICATORS IN MENTAL HEALTH PROGRAMMES

Indicators exist at all levels viz. national, regional, PHC and even at community levels. A set of indicators at the national level or at any higher level may not be suitable to local levels because of the direction in which they are sought. They need to be changed, refined, added or deleted to suit the local situation and also depending upon the characteristics of programmes, and also with changing emphasis over a given period of time. Several aspects need to be considered before construction, selection and application of indicators, these are :

- characteristics of catchment area
- availability of resources
- availability of health services (General & Specific)
- level of community development
- characteristics of mental health programmes in terms of aims, objectives, coverage etc.
- status of record maintenance
- purpose of indicators

Expression of indicators also needs to be a given thought. Indicators can be qualitative (yes - No) or quantitative (percentages, numbers, ratios) depending upon the level. For most of the community mental health programmes, quantitative indicators are widely employed.

5. SITUATION-SOURCE-DATA-INDICATORS

Situation - source - data - processing - analysis - conclusions form the back bone of any indicator. In the field of mental health this task becomes difficult due to the complexities involved in definition - diagnosis - classification procedures (problems at field level in terms of various barriers existing for utilisation of services). Determination of source of information, frequency of data collection, personnel involved in this task are vital for the formulation of indicators in mental health. Regular, systematic, continuous and centralised collection of data is essential which could be analysed to develop indicators which can throw light on past, present and future trend of mental health and illnessess in the community for which effective programmes could be designed. Both the data that is currently available and additional data which needs to be procured should be considered at the beginning itself.

The type of data at different levels and different phases of a community programme should be given a serious thought. At present, due to lack of uniformity and coordination among different agencies concerned with mental health various sources will have to be utilised. The data available could be of a direct nature or an indirect one.

Several sources of information at the community level could be census data, health service data (hospital records, PHC records, programme records), records of other agencies (other sectors of government), records of voluntary and other social welfare agencies, work dairies of health personnel (if maintained? and how well), Panchayat records, from police files, court files,

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remand homes (if any) and data from any specialised institutions working in the field of health and mental health in particular.

Apart from official records in many of these agencies direct interviews with principle members of community, traditional healers, village health guides, Anganwadi workers, Traditional birth attendants, teachers may yield a wide variety of information which would be useful in framing indicators.

Apart from these sources, periodically conducted community surveys on the total population or a sample of population will be a very useful way of gathering additional data periodically.

The time interval for collecting information could vary from annual verification of records to monthly visit to study areas & is determined chiefly by the purpose of indicators.

Major mental health problems of community, amount - nature - type of data, personnel involved in collecting information, time interval and purpose of obtaining information are some of the key issues involved in developing indicators.

6. CATEGORIES OF INDICATORS

- indicators could be qualitative or quantitative
- expression of indicators could be Yes - No, numbers, percentages, ratios etc.
- indicators could be of direct or indirect relevance to mental health programmes
- source of information - personnel involved - nature of data - periodicity should be considered at the beginning.
- suitable modifications needs to be made to develop applicable indicators at the community level.
- importance must be given for both numerator & denominator

6.1 SOCIO ECONOMIC - DEMOGRAPHIC INDICATORS

The use of this set of indicators is of special importance to the field of mental health. For needs assessment, prioritisation of problems, risk group identification, resource allocation and community involvement these indicators might be important. Based on social area analysis this category of indicators serve better where no other information is available.

- Age, sex characteristics of population - especially children & elderly
- social rank indicators based on economic status, educational status and social status
- % of population below poverty line according to national standards
- % of families in poverty
- median income of families
- aged dependancy ratio
- % of aged persons living in isolation
- literacy rates of population
- % of school dropouts
- % of employed persons, male & female
- % of women in labour force
- % of houses occuped by > 1 person/room (for overcrowding)
- divorced/widowed families
- rate of population growth
- % of population seeking help/not seeking help within the catchment area

6.2 SOCIAL DISRUPTION INDICATORS

- Suicide rates
- Crime rates
- accident rates
- % of Juvenile delinquents for corresponding total population

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- % entry into correctional institutions
- frequency of communal riots
- number of lunatics outside homes
- % of child abuse
- % Marital separations

6.3 MENTAL HEALTH RESOURCE INDICATORS

- Personnel/population ratios
  1. Professionals
  2. Para professionals
  3. Non-professionals
- % of doctors & health workers with training and without training in mental health
- number of health centres where help for mentally ill is available
- mental health, budget as % of total health budget
- % of population residing at specific distance from where they could reach for help in mental health problems within catchment area/outside catchment area
- number of G.C/H.C.O where different patterns of care are available
- expenditure v/s allottment in budgetary terms
- number of bed available for mentally ill patients/1,000 population (ch. area chs)
- bed occupancy ratios (Ch. area chs.)

6.4 MENTAL HEALTH SERVICE PERFORMANCE INDICATORS

- number of organisations involved in mental health care
- % of referrals (to the centre & from the centre)
- mean time of travelling to the centre
- cost of travelling to the centre
- KAP of catchment area residents
- % of people knowing about services
- % of people knowing how to obtain services at times of help
- proportion of population served by each centre
- ratio of actual outcome to planned outcome

Service performance is usually considered through availability. Accessibility, Acceptability, Awareness, efficacy and effectiveness and the choice of indicators depends upon the focus of measure.

6.5 MENTAL MORBIDITY INDICATORS

- Prevalence of mental morbidity within specific area
- disease - specific rates
- number of admissions to mental hospitals (on their own, referral)
- number of identified cases in each illness category who are on treatment or not on treatment
- prevalence of M.R. children to total children population
- number of M.R. Children attending medical institutions
- number of referrals by different categories of personnel
- % of children who are users of alcohol, drugs and tobacco
- duration of illness before seeking help (Mean number of days)
- inpatient/outpatient ratios
- % admissions with specific problems
- % disabled persons
- measures of intervention and outcome like recovered, improved, deaths, on maintenance etc.

6.6 UTILISATION INDICATORS

A certain degree of overlapping does occur between indicators mentioned above while trying to assess the utilisation indicators

- % population knowing about availability of mental health services in catchment area
- % of population seeking help from different sources (organised and unorganised sectors)

- % of population knowing how to obtain services.
- number of other organisations from where cases are referred
- % of population living within an area of ≤ 12 hrs. travelling time
- % of users and nonusers of mental health services
- change in the utilisation of services over a period of time
- % patient on specific patterns of care
- cost involved per patient management through different approaches
- % dropouts from a specific programme

6.7 OUTCOME INDICATORS

- number of patients counted based on expected outcome

6.8 INDICATORS ON COMMUNITY PARTICIPATION IN MENTAL HEALTH PROGRAMMES

- participation in programmes
- inclusion of mental health in different activities (qualitative or quantative)
- KAP of the community
- indirectmeasures
- Contribution in cash or other methods (Place, manpower, supportive measures)
- preventive/promotive programmes in community

6.9 POSITIVE INDICATORS OF MENTAL HEALTH

- Temporal changes in terms of increased awareness and programmes
- Subjective well being
- Social adjustment
- Disability free life
- Activities of daily living
- Satisfaction in life

These indicators are predominantly qualitative. As these basically reflect on the quality of life and considered as a total measure of physical, mental and social well being and hence it is an exhaustive task because of defining these terms. A number of aspects will have to be selected and then a final assessment has to be made. Mental health as perceived by an individual being a part of total environment should be evaluated. The on going work at NIMHANS should be able to throw more light in this area.

6.10 MORTALITY INDICATORS

- Disease specific death rates
- Suicide/poisoning statistics
- Accidents rate

A detailed list of various categories of indicators has been given and this is not an end in itself. As mentioned earlier, choosing a set of indicators is determined primarily by the use of that indicator and the suitability of adopting the same to the given situation. An attempt has been made to list out various items which could be used as indicators in each category.

7. PROBLEMS TO BE OVERCOME

- emphasis must be given for collecting information at community levels as this is a neglected area
- coordination mechanisms will have to be strengthened at community levels as there is considerable overlapping, duplication or neglect
- mental health programmes must become totally operational at lower levels of health care delivery system.

- suitable legislative measures
- prioritisation of mental health problems must be done and relevant minimal data must be collected at lower levels.
- simple methods of case identification and good referral service need to be established.
- adequate manpower with basic training in mental health needs to be made available
- data wastage should be avoided

8. FOR FUTURE WORK

From the list of mentioned indicators, a few selected ones depending upon the focus of measure could be utilised in any one of the ongoing or forthcoming projects and then evaluated. Selection of area - source of information - obtaining information - ... personnel involved - periodicity of obtaining information - composition of indicators - further application could be tried.

9. QUESTIONS TO BE ANSWERED

9.1 What should be the definition of mental health and illness at the level of community for the purpose of developing indicators ?
9.2 How should the information be collected at the level of community ?
9.3 What should be the minimal amount of data tobe collected ?
9.4 Keeping in mind the existing systems of record maintenance at the community, how could this be improved ?
9.5 For what purposes should the data be utilised ?

10. READING LIST

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ELECTRICAL TREATMENT (E.C.T.)

A psychiatric treatment found to be effective in severe depression and in some excited states. The patient is given an artificially induced fit whilst under a brief general anaesthetic and receiving a muscle relaxing drug. It is usually given as a course of two or three a week to a total of four to eight. The patient is usually in hospital. The development of effective antidepressants and major tranquillizers has markedly reduced but not eliminated its use.

The risks are those of a short anaesthetic. The side-effects are anticipatory fearfulness, post treatment headache, and short lasting forgetfulness. There is no permanent damage to the brain or the memory in the brief courses given nowadays.

There is much misunderstanding and unnecessary hostility towards the use of this treatment. The patient gives written consent to the anaesthetic and the electrical treatment. In the United Kingdom, in the uncommon circumstances of refusing treatment when urgently required, the patient would need to be detained under the Mental Health Act 1983. In addition there would need to be the supporting opinion of an independent Consultant Psychiatrist appointed by the Mental Health Commission.

The use of electrical treatment without premedication, an anaesthetic and a muscle relaxant, exposes the patient to a frightening experience, the risk of cardiac irregularities and the muscular spasms and occasional fracture associated with a major fit. In a developing country, where some parts of the medical services lack resources and personnel, it will be necessary to balance these hazards against the undoubted benefits of electrical treatment in psychiatric conditions which are seriously disabling and at times fatal.

Etiology of Mental Illness

The relative importance of various causative factors of nervous and mental illness is difficult to evaluate. There is no specific relationship between cause and effect such as exists in physical illness, but rather we are called upon to deal with a constellation of causes of an hereditary constitutional or personality nature plus an almost bewildering variety of environmental stresses.

Psychiatric disturbance is a result of a persons failure in coping with his responsibilities - a failure in carrying his loads in life (Verghese) This load refers to a series of psychosocial stresses. The failure to carry the load can be either due to the size of the load or due to the inherent weakness of the personality. A stable personality can breakdown if the load is too much. On the other hand, unstable personalities who show adjustment difficulties and interpersonal problems may breakdown even with a very small loads in life.

Breifly, the etiology of mental illness can be studied under 3 groups. They are 1) Biological 2) Psychosocial and 3) Socio-cultural.

There are five categories of biological factors that seem particularly relevant to an understanding of the development of maladoptive behaviour- a) Genetic factors b) Constitutional liabilities c) Physical deprivation, d) disruptive emotional processes e) brain pathology.

Chromosomal aberrations, faulty gives and inherited predispositions are defects of major concern.

Downs (a type of mental retardation) syndrome is an example of chromosomal investigations have discovered trisomy in chromosoms 2%.

The role of hereditary in the transmission of mental illness is very important, though difficult to study. Kallman's (1958) study showes a condordance rate of 86.2 among indentical twins for Sehzophrenia as apposed to general population where it is only 85. Hereditary factors in mental illness have goven rest to a lot of controversy. As a, consequences most investigations now take the position that only a predisposition to mental illness can be inherited. Many genes, rather than just one may be involved, in such a predisposition. Here it is presumed that certain certain individuals are especially prone to develop mental disorders if placed under severe stress. Given a favourable life situation the individual's inherent vulnerability may never show up.

The term constitution is used to denote the relatively enduring biological Make up of the individual resulting from both genetic and environmental influences (coleman) physique, physical handicaps and vulnersbility to stress are among the many traits included, in this category. While physique is not a primary cause of psychopathology, but it does presumably influence of type of disorder the individual is likely to develop under stress.

Physical handicaps, too play a role in the causation of mental illnesses. Robert Burton (1579-1640) in his Anatomy of Melancholia whole these poignant words "Deformities and insperfections of our bodies, as lameless

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deafness, blidness be they innate or accidental torture many men". The common and undesirable reactions to physical handicaps are feeling of inferiority, self-pity and hostility. As a consequence of such obstacles, the individual, whether child, adolescent or adults may develop psychological handicaps that are much more disabling than his physical impairment. A wide range of physical deprivations may act as predisposing or precipitating causes in mental illness, the most of these are malnutritions, sleep deprivation and fatigue.

Prolonged emotional mobilization produces physiological changes which are harmful to the organism like psychosomatic disorders like asthama, peptic ulcers, psoriasis etc.

Brain pathology wither temporary as in the delirium a fever or drug intoxication or permanent as in the case of syphilitic infection of the brain may result in precipitating mental abnormalities.

In comparison with the variables associated with biological causes of maladaptive behaviour, those associated with psychosocial causes are less understood and more elusive. However, a good deal has been learned about psychological and interpersonal factors that appear to play significant roles in maladaptive behaviour. These factors in brief are

a) meternal deprivation
b) Pathogenic family pattern
c) early psychic truma
d) disordered interpersonal relationships and
e) key stresses of modern life.

Faulty development has been observed in infants deprived of maternal stimulation of "mothering" as a consequence of either (a) separation from the mother and placement in an institution or (b) lack of adequate "mothering at home".

In institutions compared to an ordinary home, there is likely to be less warmth, and physical contact, less intellectural, emotional and social stimulation and a lack of encouragement and help in positive learning studies show that institutionalized children show a general impairment in relationship to people. Affectionless psychopathic characterized by inability to form close interpersonal relationships and often by antisocial behaviour - is a syndrome commonly found among children who have been institutionalized at an early age.

By far the greatest number of infants subjected to maternal deprivation are not those separated from their mothers, but rather the ones who suffer from inadequate or distorted maternal care. Here the mother neglects the child, devotes little attention to them and in generally rejecting.

Faulty parent child relationships like parental rejection over protectiveness and restrictiveness (or "Momism"), over permissiveness and indulgence have undesirable consequences. Some parents place excessive presures on their children to live upto unrealistically high standards.

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Faulty discipline, communication failure and undesirable parental models appear with great regularity in the background of children who show emotional disturbances.

Certain family typologies have detrimental influence on child development. These are the (1) inadequate family where the family is characterized by inability to cope with the ordinary problems of family living.

2) The disturbed family where the parents because of personal instability interact with other people in a way that is distructive to other as well to themselves.

3) The antisocial family where the parents are overtly or covertly engaged in behaviour that violets the standards and interests of society.

4) The disrupted family where the families are incomplete either as a result of that divorce, separation or some other condition.

These family patterns have been labelled "pathogenic" because of the high pregnancy with which they are associated with problems in child development and later psychopathology. It is relevant to note here that pathogenic interpersonal relationships and interactions are by no means confined to the family, but may involve the peer group and other individual outside the family.

Pathogenic interpersonal relationship especially maretal instability plays an important role in maladaptive behaviour. Besides there certain other common sources of stress in our society which appear directly relevant to understanding maladaptive behaviour.

In contemporary life there number of frustrations that lead to self-devaluation and hence are particularly difficult to cope with. Among these are failure, losses, personal limitations and lack of resources, guilt and lonliness.

Values play a key role in determining over "choice". If our value assumptions are unclear or contradictory or if we have little faith in them, we are likely to experience difficulties in making choices and directing behaviour.

Some core conflicts of modern life that frequently lead to tension and inner turmoil are conformity Vs nonconformity, caring Vs noninvolvement, avoiding Vs, facing reality, fearlessness Vs positive action, integrity Vs self advantage, sexual desires Vs restraints.

Further each person faces his own unique pattern of pressures, but in a general way, most of us face pressures of modern living such as competition, meeting educational, occupational and marital demands and coping with the complexity of rapid face of modern living.

Socio-cultural factors:- In addition to the biological, and psychosocial factors, conducive to abnormal behaviour they are certain other conditions specially characterisitc of our time and place in history that put stress directly or indirectly on most of us. Among these are problems of war and violence, group prejudice and discrimination, economic and employment

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problems, rapid social change and existential anxiety.

Accelerating technological and social change in contemporary world as played hovac with established norms and values with many peoples assumption and meaning of human existance. The rate and pervasiveness of change and the new adjustments demanded by these changes with a source of considerable stress. Infact Toffler proposed the term "future shock" to describe the profound confusion and emotional upset resulting from social change. that has become too rapid. As a result many people are groping about bewildered and bitter unable to find satisfying values to guide their lives. In essence, they are alienated from broader society and suffering from "exis - tential anxiety" - from doubt and concern about their ability to find meaningful and fulfilling way of life.

These biological, psychosocial and socio-cultural factors interact in the causal pattern of abnormal and maladaptive behaviour.

Classification of Mental disorders.

Classification of mental disorders according to ICD - 9 is as follows:-

Organic psychotic conditions (290-294) 290. Senele and presenele organic psychotic conditions.
291. Alcoholic psychoses
292. Drug psychoses
293. Transient organic psychotic conditions
294. other organic psychotic conditions (chronic)
Other psychoses
295 Sehizophrenic psychoses
296 Affective psychoses
297 peranoid states
298 Other non organic psychoses
299 Psychoses with origin specific to childhood

Nemotic disorders, personality disorders and other nonpsychotic mental disorders

300 Neurotic disorders
301 Personality disorders
302 Sexual deviations and disorders
303 Alcohol dependence syndrome
304 Drug dependence
305 Nondependent abuse of drugs
308 Acute reaction torturs
309 Adjustment reaction
Mental Retardation
317 Mild mental retardation
318 Other specified Mental retardation
319 Unspecified mental retardation.

MENTAL RETARDATION

Mental retardation or deficiency is subnormal mental development at birth or early development which is characterized by low intelligence. It is estimated that about 1% of school children are mentally retarded, the majority belonging to the borderline and mild groups.

General Characteristics:- The physical growth may be stunted, poor sensorimotor development is common. Physical stigmata such as large head or small head, narrow forehead widening of nasal bridge, slanting of epicanthal fold, high arching of palate; polydactgily and congenital abnormalities in the various systems are usually present. Intellectual faculties are retarded. Difficulty in social adjustment results from physical, intellectual and emotional deficits.

Classification:- Mental retardation can be classified in 2 ways. According to the IQ and according to the etiological factors IQ or (intelligent Quotient is the ratio: mental age X 100

Chronological age.

The maximum chronological age is taken as 16 years. IQ is determined by the use of psychological tests. ICO 9 - makes the following classification of IQ

3A. Mild mental retardation - Feeble minded moron IQ 50-70.
318, Moderate MR
Imbecile IQ 35-49
3181 Severe MR IQ 20-34
3182 Profound MR IQ 10-20 (Idiocy)

Etiological classification:- The common causes of mental retardation are

1. Parental causes:
a) Metabolic: Aminoacids eg. phenylketonuria
Fats: eg. Taysach's disease, carbohydrates.
Carbohydrate: eg. Galactosemia, Mucopolysachysacharides: eg. Gargoylism or Hurler's disease.

b) Endocrinal: eg- Cretin
c) Chromosomal: eg. Mongolism. Sex-chromosomes: eg. Klinefelters (XXY); Turner (XO).
d) Abnormal development: Autosomal dominant: eg. Epiloia; Sturgewebers; Marfans; Achondroplasia; Craniostenosis. Autosomal recessive: eg. Microcephaly: Anencephaly etc.,
e) Maternal infections; X-rays; drugs.
2. Natal causes: eg. Trauma; Asphyxia
3. Postnatal: Trauma; infections; deficiencies; neoplasm; sensory deprivation (deafness); lack of parental care and affection (eg. Merasmus).

Diagnosis:- Recognition of mental retardation in infancy and childhood is very important. It is mainly done by getting details of the developmental milestones. Delayed milestones may indicate mental retardation. While taking history details of delivery and the condition of the baby immediately after birth are important. Eg. whether delivery was difficult and whether asphyxia, convulsions, drowsiness, sucking difficulties, birth injuries etc were present. Backwardness in school is another important diagnostic information. Difficulty in social relationships, irrational fears, physical stigmatas of mental dificiency are also of diagnostic importance.

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Management:- 1) Prophylactic :- Where genetic factors are strongly involved Eugenics may help children with phenylketonuria, if diagnosed early enough c. can be treated by giving food which does not contain phenylalanine. Congenital syphilis can be treated with penicillin. Children with cretinism can be treated with thyroid substitution. Regular anticonvulsant medication must be given to children with epilipsy. These measures must be taken early.

2. Mentally retarded children who are trainable should be admitted to special schools for sub-normal children or special training centres. They should be employed in some industries etc., for routine type of work. The community should take the responsibility of looking after them.

The psychological and social implications of having a mentally retarded child is great indeed. The marked social stigma attached to mental retarded and their immediate families make it very difficult to seek professional counsel or openly discuss the problem. The psychological problems seem greater because of their deep emotional involvements that is guilt feelings, disappointments and underlying, frustrations, The child's condition may lead to marital dissentions, self recriminations and considerable anxiety about the child's future. Moreover the child's immediate relatives may be nonacceptable in the circle of acquaintance.

Counseling the parents, of mentally retarded children should focus upon the world of the parents and attempt to resolve the anxieties which retarded children bring to the family structure. This also involves genetic counseling and management of the child, methods of training etc.

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NEUROSES

Neurotic forms of reaction are the commonest kinds of manifestations of psychological ill-health. They are the faulty responses to the stresses of life and especially to those tensions that come about from confused and unsatisfactory relationship with other people which hinder adaption.

The individual is said to exhibit neurotic behaviour if he frequently misevaluates adjustive demands, becomes anxious in situations that most people would not regard as threatening and tends to develop behaviour patterns aimed at avoiding rather than coping with his problems. The individual, may realize that his behaviour is maladaptive it does not involve gross distortion of reality. Rather neurotics are anxious, unhappy, ineffective and often guilt ridden individuals who do not ordinarily require hospitalization.

The main type of neuroses are

1. Anxiety neuroses which involves diffuse but often severe anxiety not specially referable to a particular situation or threat.
2. Hysterdal neuroses which consists of 2 types (a) conversion type in which symptoms of physical illness that are not caused by organic pathology such as paralysis or loss of hearing and
   b) dissociative type includs such reactions as amnesias and multiple personalities.
3) Obsessive compulsive neurosis which involves thoughts and actions the individual recognises as irrational but which still persist
4) Phobic neurosis involves varied fears which the individual realizes as irrational but from which he cannot free himself.
5) Depressive neurosis involve, abnormally prolonged dejection associated with internal conflict, interpersonal loss or environmental setback.

ANXIETY NEUROSIS

Anxiety Neurosis is the commonest of neuroses constituting 30-40% of all neurotic disorders. Anxiety may occur as a symptom in almost any psychiatric syndroms - here it is the leading and predominant feature.

Anxiety is defined as a diffuse, highly unpleasant, often vague feeling of apprehension, uneasiness, uncertainity or helplessness, accompanied by one or more badily heaviness of head, palpitation etc.

There is usually anticipation of danger. Anxiety is vague and objectless in contrast to fear which is a emotional response, consciously recognised, specific and often to external threat or danger.

Clinical features:- Symptoms of morbid anxiety commonly develop in people of anxious personality - tense, timid, self-doubting worrying people who tend to expect the worst to happen and "to cross their bridges before they come to them".

The symptoms of anxiety neurosis are both mental and physical.

The mental symptoms take the form usually of a state of persistent anxiety, tension, apprehension and worry, lack of concentration, forgetfulness and general feeling of tiredness. An anxious person has difficulty falling asleep because worries crowd his mind, night mares and unpleasant dreams may disturb his sleep.

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The somatic symptoms of anxiety are diffuse and involve several systems. Palpitation, shortness of breath, dryness of mouth, chest pains, abdominal pains, excessive sweating, headache, heaviness of head, dizzness and steadiness frequency of micturation diahorrea and disturbance of sleep are some of the common symptoms of anxiety. Elevation of blood presure, tachycardia, increased respiratory rate, sweating and hyper reflexia are common signs. Investigation of different symptoms will not show any structural changes. The patient may show some of somatic signs of anxiety - dilated pupels, tremors, clammy and cold hands, a raised systolic blood pressure and a very brisk tendon reflexes. There may be some loss of weight.

A person with anxiety state has a tense, anxious apprehensive appearence.

Increased muscular tension is showed in his facial expression and posture. He usually sets on the edge of his chair during an interview and jumps at any sudden noise.

In acute attacks of anxiety (panic) the physiological changes are more obvious and in chronic anxiety, the psychological changes are more obvious.

Etilogy and psychopathology:-

Though there may be a genetic predisposition to develop anxiety in many cases, environmental factors are more important in the etiology of anxiety state. Early emotional conflicts in life interfere with the normal development of personality and contribute to the development of anxious type of personality which under the influence of stresses of life breaks down into attacks of anxiety neurosis. The life stresses may include any source of dissatisfactions, whether in personal relationship, domestic, sexual, social or in connection with employment or financial stress.

Differential Diagnosis:- In acute attacks of anxiety, Pheochromocytoma should be ruled out. Chronic anxiety state should be differentiated from thyrotoxicoses.

Further anxiety neurosis must be differentiated from other psychiatric symptoms like agitated depression. A patient who develops symptoms of morbid anxiety for the first time in middle or late life should be suspected of suffering from depression rather than anxiety. Anxiety neurosis must be differentiated from early schizophrenia.

Treatment:- Patient with anxiety neurosis can be treated as an outpatient.
1. Mild tranquilizers eg- diazepan 3 mg. meprobamate 100 mg. tds are some of the commonly used antianxiety drugs. Psychothcrapy to help the patient to cope with the difficult environmental factors is necessary.

HYSTERIA

Hysteria has been known since antiquity. The term "Hysteria" is derived from the Greek work meaning 'Uterus'. It was thought by Hippocrates and other ancient Greeks that this disorder was restricted to women and that it was caused by sexual difficulties particularly by the wandering of a frustrated uterus to various parts of the body because of sexual deseires and a yearning for children. Thus the uterus might lodge in the throat and cause choking sensations or in the spoen, resulting in temper tautums etc. Hippocrates considered marriage the best remedy for the affliction.

The concept of the relationship of sexual difficulties to hysteria was later advanced by freud. According to him symptoms of hysteria were an expression of repressed and deviated sexual energy.

In contemporary psychopathology, the symptoms of hysteria are usually seen as serving a defensive function enabling the individual to escape or avoid a stressful situation.

Hysteria is more common among women in the age group of 15-25 years, among those who belong to a low-socio-economic group in rural areas and in the developing countries.

Hysteria can be manifested as conversion reaction or dissociative reaction.

In hysterical conversion reaction the symptoms of physical illness appear without any underlying organic pathology. Here the mental conflict is converted into a physical symptom.

Clinical features:- The patients who develop hysterical symptoms have what has been called the hysterical or histrionic personality. Such people tend to be highly egocentric and immature. They are dramatic, emotional, dependent, seductive, unpredictable, suggestible and attention seeking.

The symptoms of hysterical conversion reaction closely mimic those of organic diseases and greater the patients medical knowledge the closer the resemblance. The particular symptom chosen depend on a number of factors and have symbolic meaning.

The conversion symptoms involve involuntary sensorimetor systems. The motor symptoms may involve complete or partial incapacity involving the voluntary musculature including paresis, mutism aphonia tremors and ties. Sensory symptoms may mimic anesthesias, paraesthesias, hyperaesthesia etc. Common visceral symptoms are anorexia, bulina, vomiting, hiccough, flatulence airswalloing etc.

The conversion symptoms cannot be explained by any organic lession. Usually the patients indulge in dramatising the complaints but appear to be indifferent to them. This is called La Belle Indifference. Here the patient makes his complaints in a matter of fact way with little of the anxiety and fear that would be expected in a person with the symptom. Very often the symptoms are exaggerated when people are around and very seldom do the symptoms produce any serious injuries. Usually the symptoms have some symbolic meaning to the original unconscious conflict and thus have a communicative significance.

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Hysterical dissociative reactions:-

In dissociative reaction, the symptoms are mainly mental amnesias (forgetfulness of a part event or series of events which occured during a particular time), fugue where a person suddenly leaves his previous activity and goes on a journey which has no apparent relation to what he has just been doing and for which he has complete amnesia, somnambulism or sleepwalking and multiple personalities. Here the patient manifests two or more complete systems of personality each system distinct from one another. The individual may change from one personality to another. Thus personalities are usually dramatically different and the main personality is unaware of the secondary personalities. (eg. Dr. Keykell and Mr. Hyde, 3 Faces of Eve).

The so called possession syndrome is an example of dissociative state. This has aroused great interest among Indian psychiatrist as an epidemic of it was seen in Ranchi in 1966 and in north Karnataka this year (Bananati). Though epidemics of possession are rare the possession syndrome itself is very common in our country particularly among females.

Differential diagnosis:- In every case a careful physical examination is essential to exclude physical diseases. Hysteria is often mistaken for physical diseases and physical disease is often called hysteria. In many cases physical diseases and hysterical overlay may be present together. Central nervous system diseases may be misteken for hysteria. Hysterical symptoms are of dramatically sudden onset and or common among young people. Hysteria like symptoms occuring for the first time in middle or old age should always be suspected of being organically determined.

Hysterical fits may be difficult to distinguish from epileptic fits. A careful discription of the fit is essential.

Hysterical symptoms should be distinguished from malingering. A malingerer pretends to have a symptom but will find it difficult to maintain consistency of symptom for a long time.

A hysterical type of personality presence of emotional conflicts, sympolic nature of the symptoms, absence of organic lesions, and la Belle indifference are diagnostic points. Hysteria and organic lesions can coexist and this has to be taken to to account for treatment.

Treatment:- The patient must be helped to make a more rational solution of his problems by means of psychotherapy. Sometimes situational readjustment and social measures may help.

The general practitioner can diagnose hysteria and refer the patient to a specialist as the patient may need specialized therapeutic procedure to deal with the symptoms and conflicts. It is usually unwise to make a driect attack on the conversion symptom because this may lead to very disturbed behaviour. In many cases the conversion symptom is a cry for help and if the symptom is removed, the patient becomes helpless. In some cases, however symptomatic treatment such as mild tranquilizers, and behaviour therapeutic methods like relaxation, aversion therapy and negative practice can be used.

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Obsessive Compulsive Neurosis:- Obsessions are persistant, recurring ideas accompanied by a subjective feeling of compulsion, which the patient tries to resist, but cannot get rid of compulsions are irresistible urges to carry-out meaningless and irrational activities. The patient cannot prevent these obsessions and compulsions. The more he tries to prevent them, the more the tension mounts which will be released only by yielding to the obsessions or compulsions. The patient knows that it is silly to have the symptoms, but he cannot prevent them. The three elements of obsessive compulsive neurosis are the feeling of subjective compulsion, the resistance to it and the retention of insight.

Clinical features:- Obsessive compulsive neurosis is the least common of neurotic reactions, comprising less than 5% of the total cases.

The majority of those who develop an obsessional neurosis have shown personality traits which have been discribed as constituting the obsessive personality. These traits are an unusuall conscientiousness and adherence to method, order and cleanliness. These people are fastidious, meticulous, fussy, tidy, punctual, hardworking prone to recheck rigorously what they do and persistant.

Lady Macbeth persistently washing her hands is a classical illustration of obsessive compulsive neurosis. Majority of patients are under 40 years and this illness is more common in women.

Obsessive ideas are disturbing and they may be frightening, blasphemous disgusting or obscene. The thoughts are persistent and the patient tries to fight them. Obsessive rumination is a continous pre-occupation with some topic or group of topics to the exclusion of most other interests, commonly **religious**, philosophical or metaphysical.

The third group of symptoms are compulsive acts like washing hands, checking locks etc. The patient feels compelled to carry them out and gets anxious if he resists them.

Differential diagnosis:-Obsessive compulsive neurosis should be distinguished from **schizophrenia**, very often obsessions can be a symptom of **schizophrenia.** A **schizophrenic** patient does not consider the obsessive symptom as silly whereas in ocw the patient knows that the symptom is silly and actively tries to prevent it. Further obsessive symptoms can be present in depressive psychosis and organic brain damage.

Treatment:- Obsessive compulsive neurosis is difficult to treat tranquilizers such as chlordiazepoxides give symptomatic relief. Psychotherapy is useful in early stages. Behaviour therapy especially systematic desensitisation gives good results. In very severe chronic cases, prefrontal leucotomy may be considered. The G.P should refer Ocw cases to the specialist as it needs specialized treatment.

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Phobia

A phobia is a recurrent intense, unreasonable fear associated with some situation or object or idea. The patient realizes that his fear is irrational but is dominated by it. If he enters the fear producing situation acute anxiety or panic assaits him. The list of phobias is very long. The common phobias are

Aerophobia - fear of high places
Clanstophobia - fear of closed places
Agorophobia - fear of open places
Pyrophobia - fear of fire places.

Phobias constitute about 8 to 12% of all neurosis. Phobic reactions occur more commonly among young adults and are much more common among women than men.

In some cases, phobic reactions may be obsessive as when a persistent obsessive fear of contamination dominates the neurotic conxciousness.

Phobias occur in a wide range of personality, patterns and abnormal syndromes. Traditionally, phobias have been thought of as attempts to cope with internal or external dangers by carefully avoiding situations likely to bring about whatever is feared. Phobias most often are learned reactions to previous trauma.

Treatment:- The treatment of choice for phobia is behaviour therapy Anxiolytics may help.

Organic Mental States

Organic mental disorders are a result of anotomical and physiological disturbance in the central nervous system caused by physical disease, intoxication or degeneration.

Organic pathology should be suspected where psychiatric symptoms occur in the presence of the following.

1. First onset of psychiatric symptoms in old age.
2. No positive emotional factors in etiology.
3. History of trauma, toxic factors and familial degenerative deseases.
4. Abnormal neurological signs.
5. Atypical psychiatric symptomatology.
6. Certain characteristic psychological changes.

7. (a) Drowsiness, constriction in the level of consciousness. Impairment of orientation, especially for time.

(b) Sudden or progressive deteriocation for intellectual powers eg. memory loss especially for recent events. Stereotyped repetition (perseveration)compensatory fabrication (confabulation) difficulty in abstract thinking.

(c) Emotional fluctuations, eg. crying in one moment and laughing in the next moment.

(d) Changes in character eg; A person who had a strict and orthodox code of ethics becomes lex in his sexual behaviour.

Clinical descriptions:-

1. Acute; Delirium; Stupour.
2. Chronic; Dementias.

Classification (etiological)

1. Infective, Encephalitis neurosyphilis (GPI) Typhoid, and malaria.

2. Trauma; Head injury, Brain damage, subdural haematoma; post-concussional syndrome.
3. Neoplastic example frontal lobe tumour.
4. Cerebrovascular; Arterioscelerotic dementia; Polyarteritis nodosa; disseminated lupus; temporal arteritis; hypertensive encephalopathy.
5. Metabolic and nutritional: a) Carbohydrate: e.g. hypoglycemia.
   b) Proteins: Porphyria.
   c) Vitamin deficiency:
Thiamine: Korsakoff's Psychosis; Wernicke's encephalopathy. Nictotinic acid; Pellagra. B12: pernicious anaemia.
   d) Hypo and Hyper thyroidism; parathyroid, both hypo and hyper.
   Adrenal: Addision's disease; Cushing's syndrome.
   Pituitary: Simmond's disease.
6) Intoxications: Exogenous: Alcohol, drugs, lead.
   Endogenous: Uremia; Hepatic coma.
7) Degenerative disorders:
   Senile dementia.
   Arterio Sclerotic dementias.
   Presenile demintias.
   (Alzheimers' disease; Pick's disease; Huntington's chorea).
8) Epilepsy: Postepileptic confusion;
   Psychomotor epilepsy.

Delirium:- Characteristic features 1. Varying degrees of clouding of consciousness, usually associated with a disorientation for time, place or person.
2) Attention is disturbed and is difficult to sustain it.
3) Percetual disorders such as illusions and hallucinations particulary visual.
4) Mood varies from mild unease to perplexity. Fear and suspicion are the predominant aspects.
5) Thinking may be disconnected and speach incoherent.
6) Misidentification of people.
7) Symptoms become more marked as darkness falls.
8) sleep is disturbed. Patient is drowsy during the day and keeps awake at night. Restlessness may be present.
9) On recovery from delirium, patients memory for the period is vague or absent.

Dementia:- Dementia denotes a loss of mental capacity due to organic damage of the brain. It is characterized by a) failure of memory mainly for recent events at first, and subsequently for remote events.
2) Difficulty to grasp and comprehension.
3) emotional instability with emotional outbrusts on minor provocation.
4) difficulty in forming judgements.

Disorientation, delusions, neglect of personal hyhine with incontinence may be present.

Senile dementia:- is characterized by progressive deterioration of memory, thinking and stability, by blunting and lack of responsiveness in emotional reactions and reduction in interest and initiative. This occured in senescence. The onset is gradual and later becomes more rapidly progressive. Delusions of persecution are common. The failure of memory for recent events tends to recede progressively backwards until ultimately it involves early life.

Treatment:- Treatment of acute brain syndromes consists of specific and supportive measures. The specific measures depend on the etioloy eg. antibiotics for tumor etc. Suppative treatment is aimed at minimising confusion, restlessness, dehydration, malnutrition and attending to bowel and bladder functions and care of skin in bed patients. Phenothiazine are effective to control agitation and restlessness.

Treatment of chronic brain syndromes mainly consists of nursing care. If there are associated secondary psychiatric symptoms such as depression paranoid ideas specific.drugs should be given occupational thereby will be useful if the patients are physically able to participate.

PERSONALITY DISORDERS

Personality is the sum total of ones psychological and physical characteristics which makes one a unique person. Physical constitution emotional temperament, the intellectual abilities and general character give a person his uniqueness. Early life experiences and genetic or constitutional factors contribute to the development of personality. Personality disorders or character disorders are developmental defects or pathological trends in personality structure with mitimal objective anxiety and little a no mark of distress. There is usually a life long pattern of action or behaviour which are deviant from the accepted norms of society without the presence of disorder of perception, intellectual functions or affect.

They are classified as
1) Personality pattern deviations such as inadequate personality, schizoid personality, cyclothymic personality, paranoid personality, hysterical personality, regid and obsessive personality, aggressive personality and obsessive personality.

2) Psychopathy:- is characterized by irresponsible and antisocial behaviour in the absence of mental retardation, psychosis, neurosis and cerebral injury or disease. Absence of guilt or remorse, no response to punishment, inability to accept blame, shallow and impersonal relationships, self-centredness, no regard for others, and immediate satisfaction of desires, are some of the common features of psychopathy. A psychopath from an early age indulges in antisocial behaviour without due regard to the consequences. There is usually a genetic predisposition. Environmental factors such as parental deprevation broken homes, abnormal parentchild relationships, unhealthy physical environment are commonly associated with psychopathy.

Treatment:- Drug treatment is of limited value in the treatment of psychopathic disorder. Psychotherapy especially group therapy gives better results.

Sexual disorders

These disorders can be discussed as (1) disorders of Heterosexual functioning eg. Impotence premature ejaculation in men vaginimus and dyspareunia in women regidely.

Frigidity:- emotional disturbence is the common cause for frigidity among women. Emotional disturbance can range from phobic anxiety leading to dyspareunia to revulsion towards heterosexual experiences due to ignorance or lesbian tendenceis. Treatment should concentrate on sex education and excuseling of husband and wife.

Importence:- The most important cause for impotence in the young male is emotional factors, though systemic diseases like diabetis, local lesions or intake of drugs and aging process can produce impotence. Emotional factors like adjustment problems, frigidity in wife, stressfactors in the life situation guilt feeling over visit to prostitutes, extramarital affairs and guilt feeling associated with masturbatim are common causes of impotence

Dhat syndrome, wherein the individual attributes a number of somatic complaints, like weakness, loss semen is a very common in young adults, This is due to a popular belief that one chop of semen is equivalent to several ounces of blood and young men who are ignorant of real factors can get

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frightened of their sexual adequacy and this fear usually produces functional impotence.

Psychotherapy should be educative and directive. Sexual counseling is useful in impotency and premature ejaculation behaviour therapeutic techniques like relaxation and masters and tetuson techniques will be effective.

2) Disorders in which the aim of sexual activity deviates from the normal èg. Homosexuality, exhibitionism , Trasuestism, Beastiality, Fetichism, Voyeurism, Sadism, Masochism etc.

Treatment:- Psychotherapy behaviour therapentic techniques like systematic desensitization, relaxation, aversion therapy are useful.

Alcoholism and Drug Dependence:- Alcoholism refers to a state when an individual develops a physical and emotional dependence on alcohol. The disease is characterized by (a) a pathological desire for alcohol after ingestion of small quantities which act as a trigger dose.
b) Black-out during intoxication with alcohol.
c) Physical dependence on alcohol after withdrawal following a drinking bout.

Etiology:- Social pressures, economic trends and cultural attitudes psychological exert influence on the pattern of drinking and alcoholism. Personality too is an important factor. Many alcoholics start drinking to alliviate personality problems, to drown worries etc. Alcoholism is common in psychopathic personality disorder.

Clinical features:- The common neuropsychiatric manifestations of alcoholism are a cute alcoholic psychosis, Delirium, Tremens, Chronic alcoholism, Wernicke's encephalopathy, and Korsakoff's Psychosis.

Acute accoholic psychosis is an acute psychotic reaction precipitated by ingestion of alcohol as a result of direct effect of alcohol on the brain . Visual hallucinations, usually of small colourful animals, auditory hallucinations of an accusatory type, excitement, sleeplessness and voilent behaviour are the common features.

The onset of Delirium Tremens is usually when alcohol is withdrawn,, though it can also appear during an alcoholic episode. Delirious talk with confusion and incoherence, frightened look, excessive perspiration, generalized and diffuse tremor; coated tongue and parasthesias are the common manifestations.

In chronic alcoholism there is slow and gradual personality deterioration characterized by lack of judgement carelessness at work, antisocial activity paranoid ideas and unreliable and undependable behaviour.

Wernicke's encephalopathy is characterised by clouding of consciousness ophthalmoplegia and ataxia. Korsakoff's psychosis is characterised by polyneuritis, gross memory disturbance mainly of retention, and confabulations. These two conditions are the results of degenerative changes in the brain most probably due to Vitamin B_1 (Thiamine) deficiency.

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Treatment:- Acute alcoholic psychosis and delirium Tremens are emergencies and have to be treated as such after admitting the patient. Heavy doses of phenothiazines and non-barbiturate sedatives such as Doriden are useful in acute alcoholic psychosis. Heavy doses of chlordiazepoxide are useful in Delirium Tremens.

Since Wernicke's encephelopathy and Korsakoff's psychosis are both produced by chronic degenerative changes, no treatment will have and curative value.

Patients with chronic alcoholism need continious, long term psychotherapy. This can be supplemented by aversion therapy which uses mall electric shocks, or drugs as emetine, apomorphine or antabuse or antabuse with a view to produce an aversion in the patient. Belonging to groups such as alcoholic anonymous will be useful and should be encouraged.

Drug Dependence

Drug addiction may be defined as a state of periodic or persistent intoxication, detrimental to the individual to society or both and characterized by the following features.

1) a strong need, drive or compulsion to continue taking the drug
2) The development of tolerance, with a tendency to increase the dose to produce desired effects.
3) Physical and emotional dependence.

Physical dependence results from an altered physiological state, which necessitates continued administration of the drug in order to prevent the appearance of a characteristic series of symptoms referred to as the abstinence syndrome or withdrawal state.

The term drug habituation has been applied to the person who has a strong drive or need or compulsion to continue taking the drug on which he is emotionally dependent, but he does not develop the withdrawal state characteristic of addiction.

WHO has suggested that the term drug dependence should be applied to both drug addiction, drug habituation and all types of drug abuse.

Drug dependence is defined as a state arising from repeated administration of a drug on a periodic or continous basis. It is characteristics will vary with the agent involved.

All addictive drugs have powerful actions on the CNS. The nature of the effects varies according to the class of drugs. All addictive and dependence - producing drugs create emotional dependence. Physical dependence varies in type and severity according to the class of drugs. It is marked with apiate drugs and less marked with drugs such as marijuana and amphetamines.

Deterioration in the patients physical and mental health with consequent effects family and society are the main features. Drug dependence can be a symptom of other mental diseases such as anxiety state, depression or schizophrenia. It may be a manifestation of personality disorder and the result of personality difficulties like unstable personalities or of environmental factors.

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Psychotherapy and methodone substitution are useful in treatment of drug addiction. Where drug addiction is a sympton of an illness, the underlying illness should be treated.

Preventive measures should concentrate on educative measures about the dangers and effects of various drugs with a view to influencing the attitudes of teenagers, young adults and society generally to drug usage. Early diagnosis, treatment and rehabilitation of the addict is needed. Legal measures such as making the unauthorised possession of drugs illegal would help to control traffic in drugs. Medical measures could include care in prescribing depending producing drugs. Early diagnosis, treatment and rehabilitation of the addict is needed.

PSYCHIATRIC EXAMINATION

Diagnosis in psychiatry depends mostly on a good history. A psychiatric history taking differs from history taking in other medical desciplines. Here the intimate details of patients life, experiences during childhood, schooling adolescence, marital life, waking situation etc have to be obtain and critically evaluated patients personality, the methods of coping with difficult situations, interpersonal relationships become part of the history. To get a good history from the patient, the doctor requires to establish a relationship with the patient, wherein the patient comes to trust in the doctor. Hence the first step in history taking is building up a rapport with the patient. This requires the doctor to have a proper attitude towards the patient. These attitudes include an unconditional positive regard which the doctor should have towards the client. Moreover the doctor should have "amphathic understanding that is a kind of ability to sense the feelings which the client is experiencing in each moment. The doctor should be able to focus his attention actively on what the patient is saying and doing. He should become a participant observer. Though he should not become involved in patients' feelings, he should at all times demonstrate respect for the other person and awareness of the other person's feeling and need for security. The doctor should be able to communicate in a number of different ways, he should be able to communicate and express his ideas fluently. The patient must be understood completely. Thus a psychiatric history taking becomes a therapentic process also.

Further a psychiatric history has to depend quite a lot on the information given by close relatives of the patient and other who come into contact with him.

Psychiatric history taking should not be rushed. The room must be quiet with no interruptions. Note taking during interview should be avoided as it interfers with understadning of the patient. Questions should be so framed that they suggest a desired answer.

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Mental Examination:- is another diagnostic tool in psychiatry. Mental examination tries to assess the functioning of the various mental faculties at the time of the interview. General appearance and behaviour, talk, mood, thinking, perception, orientation, memory, attention and concentration, intelligence, judgement and insight should be tested.

Physical Examination:- A thorough medical examination must be performed. Neurological signs should be looked for.

It is better to interview the patient first and relatives next in neurotic patients where as in psychotics it is better to see the relatives first.

A guide to history taking and mental examination is given below:-

Psychiatric History:-

Main Complaint: The patient must be encouraged to describe his symptoms in his own way. 'What are your main complaints?' 'What made you come to the hospital?'. These are some questions which will help the patient to begin his story. Interruptions must be minimum. Leading questions must be avoided. A chronological order of symptoms must be obtained. He must be encouraged to go back to the time when he was quite free of symptoms. Once the patient finishes giving the symptoms, an attempt must be made to find out what the symptoms mean to him. What does the patient think his symptoms are due to? In what way do the symptoms interfere with his normal life.

Personal History:- The biographical aspects of history taking should then be started.

Place and date of birth; mother's condition during pregnancy. Full term birth. Normal delivery. Breast or bottle fed. Encourage the patient to talk about his parents, sibs and others in the family. This will give a chance to know about the family dynamics. Emotional relationships between members of the family should be assessed. What sort of childhood did you have? Was it a happy one? The patient should be allowed to described the early life experience. What is the social position of the family. Has any member of the family been treated for psychiatric problems?

Details about developmental milestones and neurotic symptoms in child - hood(terror; temper tantrum, wetting bed after 4-5 years of age; thumb sucking, nail biting, stammering, walking in sleep are the examples) will be useful. How was the physical health during childhood. Infections? Convulsions? Details of schooling. Age of beginning and finishing. Standard reached. vidence of backwardness; special abilities; hobbies and interests; relationship to teachers and school mates; was he a leader or follower.

Details of work adjustment: Nature of job. Is the work record stable or have there been several changes of jobs? Is the patient happy in the present job? Relationship with colleagues.

Menstrual history: age of first period, how did the patient regard.it. Regularity, duration and amount, emotional changes before period. Climacteric symptoms.

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Sexual inclinations and practices; details about masturbation, sexual phantasies, homosexuality, extramarital sex:

Marital history: arranged marriage? acquaintance before marriage, age, occupation and personality of spouse; sexual satisfaction? Is marital life happy. Details about children.

Some of the above questions are too personal to be asked in the first interview. They can be taken up subsequently, unless they are raised by the patient during the first interview.

Medical history: detail previous illness, accidents, operations. Did he have any psychiatric illness? What type treatment did he have?

Personality before illness: (premorbid personality)

In this description of the personality prior to the beginning of the illness, do not be satisfied with a series of adjectives and epithets, but give illustrative anecdotes and detailed statements. Aim at a picture of an individual, not a type. The following is merely a collection of hints not a scheme:

1. Social relations: To family (attachment, dependency). To friends. To work and workmates (leader, follower, organiser, aggressive, submissive).

2. Intellectual activities, hobbies and interests: books, plays and pictures preferred.
3. Mood: Cheerful and despondent; strung up or calm and relaxed; worrying or placid; optimistic or pessimistic; self-depreciative or satisfied or over-confident; Stable or fluctuating (with or without any occasion); Controlled or demonstrative.
4. Character.
(a) Attitude to work and responsibility: Welcomes or is worried by responsibility; makes decisions easily or with difficulty; haphazard or methodical and meticulous; regid or flexible; cautious, foresightful and given to checking or impulsive and slipshod; persevering and determined or easily bored and discouraged.

(b) Interpersonal relationships: Self confident or shy and timid; insensitive or touchy and sensitive to criticism; trusting or suspicious and jealous; emotionally controlled or quick tempered and irritable, tactful or outspoken; enjoys or shuns self display; quiet and self restrained expressive and demonstrative in speech and gesture; interests and enthusiasms sustained or evanescent; tolerant or intolerant of others; adaptable or unadaptable.

c) Standards in moral, religious, social and health matters:
Level of aspiration high or low; perfectionistic and self critical or complacent and self approving in relation own behaviour and achievement; steadfast in face of difficulties or intolerant of frustration; selfish and egoistic or unselfish and altruistic; given to much or little concern about own health.

(d) Energy and initiative: Energetic or sluggish; output sustained or fitful; fatiguability;

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5. Fantasy life: day dreaming-frequency and content.
6. Habits: eating (fads), sleeping, excretory functions; alcohol consumption, self medication with drugs or other medicines; specify amounts taken recently and earlier; tobacco consumption.

Mental Examination:

General behaviour:- Description as complete, accurate and life-like as possible. (The following points may be considered, though not exclusively). How does he come into the office. Is he suspicious? Any abnormality about the dress and general appearance? Does the patient look ill? Is he in touch with his surroundings in general and in particulars? Gestures, grimaces or other motor expressions? Tics, mannerisms? Much or little activity? Is it constant or abrupt or fitful? Free or constrained? Slow, stereotyped, hesitant or fidgety? Tenseness, scratching or rubbing. Do movements and attitudes have an evident purpose or meaning? Do real or hallucinatory perceptions seem to modify behaviour? Does the patient, if inactive, resist passive movements, or maintain an attitude, or obey commands, or indicate awareness at all? If the patient does not speak, the description of his mental state may be limited to a careful report of his behaviour.

Talk:. The form of the patient's utterances rather than their content is here considered. Does he say much or little; talk spontaneously, or only in answer, slow or fast; hesitantly or promptly; to the point; coherently; appropriately; sudden silences; changes or topic; comments on happenings and things at hand; using strange words or syntax, rhymes, puns? How does the form of his talk vary with its subject?

Sample of talk: Conversation should be recorded, with physician's remarks on left side of page and patient's on right. It should be representative of the form of his talk, his response to questioning and his main preoccupations. In later sections of the mental state, it will be desirable to record the patient's reported experiences in his own words, but the sample required at this point need not aim at being comprehensive.

Mood:- The patient's appearance may be described so far as it is indicative of his mood. His answers to 'how do you feel in yourself?' 'What is your mood?', 'Are you in good spirits'?, or some similar inquiry should be recorded. Many varieties of mood may be present not merely happiness, or sadness but such states as irritability, suspicion, fear, unreality worry, restlessness, bewilderment, and many more which it is convenient to include under this heading. Observe the constancy of the mood; the influences which change it; the appropriateness of the patient's apparent emotional state to what he says.

Delusions and misinterpretations:- What is the patient's attitude to the various people and things in his environment? Does he misinterpret what happens, give it special or false meaning, or is he doubtful about it? Does he think anyone pays special attention to him, treats him in a special way, persecutes or influences him bodily, or mentally, in ordinary or scientific or super natural ways? Laughs at him? Shuns him? Admires him? Tries to kill, harm, annoy him? Does he depreciate himself in any regard- his morals, possessions, health? Has he grandiose beliefs? These matters may be complicated or concealed and may need much inquiry. If a whole conversation dealing with them is reported here, resume the main points at the end.

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Hallucinations and other disorders of perception:-
Auditory, visual olfactory, gustatory, tactile, visceral, The source, vividness, reality, manner of reception, content and all other circumstances of the experience are important. Its content, especially if auditory or visual, must be reported in detail. When do these experiences occur: at night, when falling asleep, when alone? Any peculiar bodily sensations: feeling of deadness? Unreality?

Compulsive Phenomena: Obsessional thoughts, impulses, or acts. Are they felt to be from without, or part of the patient's own mind? Does their insistence distress him? Does he recognise their inappropriateness? Relation to his emotional state? Does he repeat actions such as washing unnecessarily?

Orientation: Record the patient's answers to questions about his own name and identity, the place where he is, the time of day, and the date. Is there anything unusual to him in the way in which time seems to pass?

Memory: This may be tested by comparing the patient's account of his life with the given by others, or examining his account for intrinsic evidence of gaps or inconsistencies. There should be special inquiry for recent events. Where there is selective impairment of memory for special incidents, periods, recent or remote happenings, this should be recorded in details, and the patient's attitude towards his forgetfulness and the things forgotten specially investigated.

Record the patient's sucess or failure in grasping, retaining, and being able to recall three or five minutes later a number, a name and address, or other data. Give the patient a story to read and ask him to repeat it in his own words. Record his repetition of the story, verbatim if possible and say whether he sees the point of it. Give him digits to repeat forward and then others to repeat backwards and record how many he can repeat immediately after being told. In describing the state of the patient's memory do not merely record the conclusions reached but give the evidence first, in full, and describe at appropriate length such factors of behaviour as seem to indicate whether he was attending, trying his hardest, being distracted by other stimuli, etc.

Attention and Concentration: Is his attention easily aroused and sustained? Does he concentrate? Is he easily distracted? Pre-occupied? To test his concentration ask him to tell the days or months in reverse order, to do simple arithmetical problems.
General information:-

Tests for general information and grasp should be varied according to the patient's educational level and his experiences and interest. For eg. the following can be asked: Names of the President and his immediate predecessors; of the prime minister of India; Capitals of Pakistan, Ceylon, Burma, U.S.A., Russia. Dates of Indian Independence and India becoming a republic; six large cities of India.

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Intelligence: Assess the patient's intelligence. Use his history, his general knowledge, problems of reasoning, his educational background.

Insight and judgement:- What is the patient's attitude to his present state? Does he regard it as an illness, as 'Mental' or 'nervous' as needing treatment? Is he aware of mistakes made spontaneously or in response to tests? How does he regard them and other details of his condition? How does he regard previous experiences, mental illness etc?

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PSYCHIATRIC GLOSSARY

ABREACTION A process by which repressed material, particularly a painful experience of a conflict, is brought back to consciousness. In the process of abreacting the person not only recalls but relives the repressed material, which is accompanied by the appropriate emotions.

AFFECTIVE DISORDERS Illness in which a persisting and severe mood change is the dominant feature.

AGORAPHOBIA A phobia is an intense and unreasonable dread of an object or situation. Agoraphobia is often used for fear of open spaces but actually includes social phobias - fear of people or crowded situations. Most severe when there is little opportunity to escape, e.g. public transport, busy shops. Often associated with panics. Can be severely disabling. Simple phobias, e.g. of spiders - extremely common.

ALCOHOLICS Those persons whose drinking interferes with their physical or mental health, their personal relationships or their working ability. This definition includes, but is not restricted to, those persons physically dependent on alcohol. "Alcoholic" is falling out of use, a preferable term is "problem drinker". The use of the term "alcoholism" distracts attention from the much larger problem of "heavy drinking" which causes many more physical, psychological and social problems. Measures to reduce "heavy drinking" in a community are probably more productive than the treatment of the smaller number who are physically dependent on alcohol.

AMBIVALENCE Presence of strong and often overwhelming simultaneous contrasting attitudes, ideas, feelings and drives, towards an object, person or goal.

AMNESIA Disturbance in memory manifested by partial or total inability to recall past experiences.

ANOREXIA NERVOSA A distorted attitude to body weight and fatness with deliberate restriction of eating with the aim of drastic slimming. Often associated with secret disposal of food and vomiting and excessive use of laxatives. Episodes of over-eating and vomiting may occur (bulimia). Problems of emotional maturation and relationships with parents. Usually takes fluctuating course over several years and may leave long-lasting abnormal eating habits. May endanger life especially by depression and suicide.

AUDITORY HALLUCINATIONS False auditory sensory perception, i.e. without external stimulus. "The voices".

AURA The warning sensations that a person with epilepsy may feel just before a seizure.

AVERSION Stimuli leading to undesirable responses are linked with an unpleasant experience, e.g. snapping an elastic band on the wrist, or imagining being arrested. A form of self regulation.

BEHAVIOUR A series of responses which are observable (e.g. talking, touching, waving).

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BEHAVIOUR THERAPY A type of therapy which focuses on overt and objectively observable behaviour rather than on thoughts and feelings. It aims at symptomatic improvement and the elimination of suffering and maladaptive habits. Various conditioning and anxiety-eliminating techniques derived from learning theory are combined with didactic discussions and techniques adapted from other systems of treatment. The additional use of the relationship between therapist and patient, a behavioural analysis of past events and dynamic factors have led to the current term "Behavioural Psychotherapy".

CHILD PSYCHIATRIC DISORDER Abnormalities of behaviour, emotions or relationships sufficiently severe and prolonged to cause persisting suffering or handicap to the child himself or distress and disturbance in the family and community.

CLINICAL PSYCHOLOGIST A graduate psychologist with further training in diagnosis and treatment of psychiatric illness, emotional problems and mental handicap. May use psychotherapy and/or behavioural treatments and specialised assessment techniques. Not medically qualified and does not prescribe drugs. May be part of a mental health team or work independently. Often skilled in design of research studies.

CLOUDING OF CONSCIOUSNESS Consciousness is the awareness of the self and the environment. Grasp is the ability to integrate and give meaning to the experiences of self and the environment. Clouding of consciousness can include disorientation, difficulties in concentrating, thinking and grasp and there may be visual or auditory hallucinations and anxiety. Clouding occurs when physical illness interferes with brain function.

CONFLICT Clash of two opposing emotional forces.

CONFUSION This term is used by different people to mean "clouding of consciousness", disorientation, being muddled or perplexed. Its use can therefore be misleading. It is suggested that these terms be used instead of "confusion".

CONTRACTING The person negotiates a formal agreement with another party (e.g. spouse) in which each party contracts to make specific changes in their behaviour as desired by the other party. These exchanged behaviours should be clear, simple, active and frequent.

DEFENCE MECHANISMS A specific defensive process, operating outside of and beyond conscious awareness. It is automatically and unconsciously employed in the endeavour to secure resolution of emotional conflict, relief from emotional tension and to avert or allay anxiety. It is an attempt to cope with an otherwise consciously intolerable situation. (Examples are Repression, Denial, Rationalisation, Compensation, Displacement, Projection).

DEJA VU Illusion of visual recognition in which a new situation is incorrectly regarded as a repetition of a previous experience.

DELIRIUM (Acute Brain Syndrome) A disturbance in the state of consciousness that stems from an acute organic illness affecting brain function, characterised by "clouding of consciousness", restlessness, disorientation, bewilderment, agitation and rapidly changing emotions. It is associated with fear, hallucinations and illusions.

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DELIRIUM TREMENS (D.Ts.) An acute delirium occurring when alcohol is withdrawn from a person who is physically dependent. There is anxiety, "clouding of consciousness", terrifying hallucinations (e.g. snakes) and sometimes fits.

DELUSION A false, unshakeable belief, which is out of keeping with the patient's personal, social and cultural background.

DEMENTIA (Chronic Brain Syndrome) Global deterioration of mental functioning due to physical changes in the brain, characterised by loss of recent memory, poor comprehension, emotional lability and tendency to self-neglect.

DEPRESSIVE ILLNESS Distinguished from the normal experience of depression or misery by being severe, persistent and disabling. Reactive depression is related to external stresses and/or a vulnerable personality. It is usually understandable. Endogenous depression has little or no external stress, comes "out of the blue" and usually affects weight, sleep, drive and sexual life. Assessment of suicidal risk is essential in depression.

DISTRACTABILITY When a person's attention is taken up by every new stimulus instead of the normal filtering of stimuli.

DRUG DEPENDENCE A state, psychic and sometimes physical, resulting from the interaction of an organism and a drug, characterised by behaviour and other responses which always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

DYSPAREUNIA Physical pain in sexual intercourse. Can affect either sex. The cause is commonly physical but may be emotional.

ELECTROCONVULSIVE THERAPY (ECT) A form of treatment empirically found to be of value in severe depression and some forms of schizophrenia. The patient is anaesthetised and muscles are relaxed. An electrical charge then induces a controlled epileptic fit. The main side-effect is transient memory disturbance. Used less frequently as more antidepressant drugs become available. Helpful with severe, drug resistant depressions.

ELECTROENCEPHALOGRAM (EEG) A paper recording of the electrical activity of the brain obtained by a painless procedure in which electrodes are attached to the scalp.

EMOTIONS (Affects) Consist of feelings (e.g. anxiety, anger), physical aspects (e.g. palpitations, churning stomach), and changes in behaviour ("fight or flight"). An individual with disturbed emotions may complain only of the physical aspects.

ENCOPRESIS Passage of stools by children at inappropriate times and places. May be due to physical illness, poor training or emotional upsets. It may be associated with retention of faeces.

ENURESIS Involuntary micturition by day (diurnal) or night after an age when control would be expected. Primary - failure to acquire control - usually familial and probably in part due to slow physical maturation. Secondary - loss of acquired control - may be emotional.

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EXTINCTION Planned ignoring of specific undesirable behaviour.

FADING Gradual reduction of prompts to the patient to carry out targeted behaviour. Prompts are diminished in frequency or volume, or in other ways, as the patient acquires competence.

FLOODING Prolonged exposure in vivo to the worst feared situation, continued until distress reduces. Requires clear explanations, consent and reasonable physical fitness.

GRADED EXPOSURE Facing the feared situation in preplanned steps of increasing difficulty ("hierarchy"). This can be in fantasy or "in vivo". Progress to a new step is normally delayed until the previous step can be performed with relative ease.

GUIDED MOURNING Reduction of abnormal grief by bringing the person into repeated, prolonged contact with cues concerning the deceased, both in imagination and in real life.

HABIT CONTROL Methods to disrupt or adapt habits, such as stuttering, bed-wetting etc. These include "massed-practice" (deliberate repetition to the point of extinction); "habit-reversal" (deliberately performing the opposite manoeuvre before and after each habit event); feed-back (e.g. bell and pad for enuresis). The setting in which each habit occurs requires careful attention and different techniques (e.g. graduated social exposure for stammerers whilst practising their speech, reward for enuretics the morning after dry nights).

HALLUCINATIONS Perceptions without an adequate external stimulus.

HOLISTIC The study of an individual as a distinctive entity rather than as a collection of various characteristics.

HYPERKINETIC SYNDROME Disorder of childhood with distractability and a diminished ability to sustain attention. Associated with overactivity.

HYPOCHONDRIASIS Excessive concern with health or functioning of part of the body (or sometimes mind). May be secondary to depression or other mental disorder.

HYPOMANIA A prolonged change in mood when the patient is overactive, elated, feels very well and may have grandiose ideas, spend excessively and be sexually disinhibited. The mood is out of keeping with the circumstances.

HYSTERIA Mental disorders in which motives (of which the patient seems unaware), produce a restriction of the field of consciousness or disturbance of motor or sensory function. These may seem to have a psychological advantage or symbolic value. May present as conversion symptoms without obvious physical cause, e.g. paralysis, tremor, blindness, aphonia, fits. May present as dissociation, e.g. selective amnesia. The underlying cause of hysteria may be a psychological stress or a physical illness. The term is falling out of use as it can be seriously misleading when considered a final diagnosis.

ILLUSIONS Misinterpretations of stimuli arising from an external object (e.g. noisy central heating interpreted as an intruder).

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INSTITUTIONALISATION Effects of prolonged living in a regulated community with little opportunity for individual choice in daily life, possessions, clothes, activities etc. The person is over-dependent on staff, loses initiative and is increasingly unable to cope with life outside the institution. Patients with schizophrenia are very susceptible to this complication.

LABILE Unstable; characterized by rapidly changing emotions.

LEUCOTOMY An operation to cut some of the nerve fibres passing to the frontal lobes of the brain. Used in severe, intractable and disabling tension states. Falling out of use because of irreversibility, replacement by other treatments and danger of permanent personality change.

MAJOR TRANQUILLIZERS (Neuroleptic) Used in treatment of psychotic illness and severe agitation, e.g. Chlorpromazine (Largactil).

M.A.O.I.s (Mono-Amine Oxidase Inhibitors) A group of antidepressant drugs. Less commonly used because of serious interactions with certain drugs and foods (e.g. cheese), e.g. Phenelzine (Nardil).

MINOR TRANQUILLIZERS (Anti-anxiety, anxiolytic drugs) Used as part of treatment of anxiety, e.g. Diazepam (Valium). Ineffective after a few weeks of use. High risk of dependency.

MODELLING A behaviour is demonstrated then the person is asked to copy it. The aim is coping rather than perfect behaviour, with some reward for the new activity. Use brief natural components. The person practises immediately and is guided on progress and rewarded for good performance.

NEUROSIS Problems of definition despite wide use of this term. No organic cause. Presents as anxiety, depression, phobias, hysterical symptoms, obsessional symptoms. The person can distinguish between his subjective experiences and external reality. Behaviour may be greatly affected but usually remains within socially accepted limits. The psychodynamic explanation is conflict, perhaps unconscious. The learning theory explanation is that it is a learned habit in a susceptible individual who has been exposed to stress and therefore had the opportunity to learn the neurosis.

NORMALITY A number of different concepts: (1) the average; (2) the ideal; (3) the statistical normal curve; (4) the absence of signs and symptoms of abnormality; (5) the continuous process of adjustment and adaptation (and possibly development). All concepts used in Psychiatry and can be misleading.

OBSESSIONAL PERSONALITY Feelings of doubt and insecurity lead to excessive conscientiousness, perfectionism, repeated checking, caution and possibly stubbornness. There may be insistent and unwelcome thoughts or impulses. The obsessional personality is reliable and can be very productive particularly where meticulous activity is required. Indecisiveness carries the risk of being unproductive.

OBSESSIONS Unwanted thoughts which are perceived by the person as inappropriate. Efforts to dismiss the thoughts may lead to anxiety. Certain actions or rituals may be performed to relieve anxiety, e.g. washing hands, counting, checking.

OPERANT CONDITIONING Desired behaviour is rewarded and so increases. Whereas undesirable behaviour is not rewarded or is punished and so decreases. Also known as instrumental conditioning.

Contd.....

PARADOXICAL INTENTION Reduction of anxiety by encouraging the patient to deliberately practice the feared behaviour, e.g. a patient afraid of fainting in public is asked to deliberately faint in front of others.

PERSONALITY The unique, sum total of a person's psychological and physical characteristics. The established and largely unchanging patterns of relating to, perceiving, thinking and feeling about the environment and oneself. Abnormal personalities have patterns which are severely maladaptive and impair functioning and may have an adverse effect upon the individual and/or society. Psychopathic personality is an extreme form of abnormal personality.

PHOBIA Anxiety inappropriately linked with an object or situation.

PREVENTION (After Caplan) Primary - involves lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before they have had chance to produce illness. Secondary - aims at reducing the disability rate due to a disorder by early diagnosis and effective treatment. Tertiary - aims to reduce the rate in a community of defective functioning due to mental disorder.

PRIMARY GAIN The reduction of tension or conflict through neurotic illness.

PSYCHIATRIST Medical graduate with higher training in the assessment and care of the mentally ill. Treatments are physical (drugs and ECT), psychotherapy, behaviour therapy and social care.

PSYCHOANALYSIS Term used for both Freud's method of psychic investigation and a form of psychotherapy. As a technique for exploring the mental processes, psychoanalysis includes the use of free association and the analysis and interpretation of dreams, resistances and transferences. Uses Freud's libido and instinct theories and ego psychology, to gain insight into a person's unconscious motivations, conflicts and symbols. Requires specially trained therapists and involves extremely prolonged treatment.

PSYCHOSIS Problems of definition despite wide use of this term. Impairment of mental function particularly in loss of contact with reality. Lack of ability to distinguish subjective experience from external reality. Presents as hallucinations, delusions, abnormal thinking processes, odd behaviour, reduced ability to cope with ordinary demands of life, loss of drive and inability to recognise is ill when this is obvious to others.

PSYCHOTHERAPY "Talking treatment" The treatment by psychological means of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient/client with the object of (1) removing or modifying symptoms (supportive psychotherapy); (2) modifying disturbed patterns of behaviour (re-educative psychotherapy); or (3) promoting development of the full potential of the personality (reconstructive psychotherapy, psychoanalytic treatment). See behavioural psychotherapy under behaviour therapy.

PSYCHOTROPIC DRUGS Those drugs having powerful effects on the central nervous system and used in psychiatric treatment.

REHEARSAL RELIEF An exposure method to reduce nightmares by talking and writing about them repeatedly and giving them a triumphant ending.

REINFORCEMENT Reward.

Contd.....

RESPONSE PREVENTION Prolonged exposure to ritual-evoking cues whilst asking the person to refrain from carrying out the rituals. Continued until the urge to perform rituals fades.

SCHIZOPHRENIA A group of mental disorders with no coarse brain damage. Cannot be understood as arising emotionally or rationally from affective states, previous personality or current situation. There is characteristic interference with thinking, emotions, drive and motor behaviour. May include hallucinations, delusions, thought disorder and thought broadcasting. Sense of being controlled by alien forces, emotions out of keeping with external reality and severe withdrawal. Schizophrenia is one form of psychosis. The layman's association of schizophrenia with chronic madness and hospitalisation is outdated. With modern treatments approximately one quarter recover completely, one quarter have mild disability, one quarter moderate and one quarter continue with severe disabilities.

SECONDARY GAIN The obvious advantage that a person gains from his illness such as gifts, attention and release from responsibility.

SELECTIVE INATTENTION An aspect of attentiveness in which a person blocks out those areas which generate anxiety.

SELF REGULATION (self treatment) The person is taught to monitor, record, evaluate and reward or punish his current behaviour and also practice new behaviours.

SICK ROLE Allocated by society though may be formally supported by doctors. (1) Exemption from normal social responsibilities. (2) Person not responsible for the illness and cannot recover by own unaided action. (3) Person must want to become well again. (4) Must seek and co-operate with treatment.

SOCIAL SKILLS TRAINING Stepwise training in how to show assertion, warmth, interest, etc. by use of voice, eyes, posture, gesture and key phrases. Components are demonstrated and practised in role play with feedback. This is linked to graduated real life practice. The person finds it helpful and reassuring when the demonstrator is not perfect in social skills.

THERAPEUTIC ATMOSPHERE All therapeutic, maturational and growth supporting agents - cultural, social and medical.

THERAPEUTIC COMMUNITY Ward or hospital treatment setting where frequent and regular meetings of patients and staff aim to improve awareness in patients of their effects on others, to encourage communication, to lessen the hierarchical authority of staff over patients and to share responsibility for each other's care. In practice may tolerate and help some personality disorders not influenced by other forms of psychiatric care.

THOUGHT STOPPING The person deliberately has the unwanted thought in order to learn how to stop it. A loud noise or the snapping of an elastic band on the wrist is an adequate aversive unpleasant experience.

TIME-OUT Immediately after highly undesirable behaviour the patient is placed somewhere alone for a few minutes without access to rewards.

TRANS-SEXUALISM Fixed belief that the overt physical sex is wrong. Associated with desire to dress and behave as opposite sex. May request sexual hormones or operations. Distinct from transvestism.

TRANSVESTISM Sexual gratification by wearing clothes of the opposite sex. Distinct from and not necessarily associated with homosexuality.

Contd.....

TRICYCLICS, TETRACYCLICS Commonly used and effective groups of anti-depressant drugs, e.g. Imipramine (Tofranil), Mianserin (Bolvidon).

UNCONSCIOUS Thoughts, feelings, impulses, which are not immediately available to the attention but nevertheless influence behaviour. Evidence for this in everyday life from verbal lapses, dreams and forgetting, indicating a part of the personality not immediately accessible to consciousness.

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Psychiatric disorders associated with pregnancy:-

Depressive symptoms are common during 3-4 month of pregnancy especially if its the first one, and if its an unwanted pregnancy. Psychotherapy and mild tranquilisers should be helpful.

Psychiatrid disorders associated with pnerperium:- Post partum psychosis usually occurs during the first 4 weeks after delivery. Onset is usually sudden and clinical features consist of florid symptoms, more often schizophrenic with a confusional colouring. Preexisting psychosis tend to get exacerbated during this time. These patients need to be admitted and treated by a specialist. Depressive symptoms are common during postpartum period.

Psychiatric Emergencies:

A psychiatric emergency may be a new illness with an acute onset or an acute exacerbation of a chronic illness. These are emergencies, because of the possibility of harm done either to the patient or to others.

The main psychiatric emergencies are:-

1. Attempted suicide and suicide:- The most common psychiatric cause for suicide is depression, especially of the indogenous type. The common causes for suicide in schizophrema are hallucinations and impulsive behaviour. The methods adopted are quite brizzare and cruel.

In hysterical patients, attempted suicide is an acting out behaviour to get attention. This indicates that the person is in emotional destress.

2. Acute Psychotic states:-
a) Schizophrenia: Catatonic excitement or stupor; paranoid excitement with homicidal tendencies.
b) Depressive illness: Gross degree of depression with self-destructive ideas.
c) Manic excitment which becomes a problem for management.
d) Postpartum psychoses.
e) Post epileptic excitement with assaultive and destructive tendencies
f) Nonspecific acute psychotic excitement.

3) Acute brain syndromes: Intoxication with alcohol or drugs.
4) Chronic brain syndrome: Explosive outbursts of rage and temper tantrum.
5) Acute anxiety and panic, usually in reaction to some crises in life; transient situational reactions; hyperventilation syndrome.
6) Toxic confusional states.
7) Side effects of psychotropic states.

It is better to admit these patients in psychiatric wards and treated by specialists.

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Psychiatric disturbances in Children

The psychiatric disturbances in children can be classified as follows:-

1. Habit disorders:- Thumb sucking, nail biting, enuresis, masturbation, loss of appetite, insomnia, night terrors, Dyslalia.
2. Bahavioural disorders:- stealing truancy, temper tantrums, delinquent behaviour.
3. Neurotic disorders:- Anxiety state, hysterical reaction, obsessive compulsive reaction, depressive reaction.
4. Psychosomatic disorders.
5. Psychosis: Autism and childhood schizophrenia.
6. Miscellaneous: Deplexia, backwardness in school, postencephalitic syndrome, Mental retardation.

Enuresis is repeated involuntary micturition occuring after the fourth year in the absence of any organic disease. Insomnia, night terror, and sleep walking are common disturbances of sleep. In night terros, the child gets up in a state of great fear, while still asleep. There will be intense persperation and the child will go back to sleep after a while. The nightmare on the other hand is a terrifying dream which usually wakes up the child. Sleep walking is a dissociative state wherein the child walks about in his sleep without being conscious about it.

Dyslalia is a defect in articulation. Here there is a tendency to ommission, substitution and distortion of sounds. Dyslalia or word blendness is a condition in which a child is unable to read words inspite of adequate vision and intelligence. Backwardness in school can be due to emotional problems or mental retardation. School phobias wherein the child is anxious about being separated from the mother is also common.

Most of the emotional disturbances in childhood are caused by environmental factors such as faulty parental attitudes, parental rejection, over protection, broken homes, problems in the schools.

Psychotherapy is very effective in the treatment of functional psychiatric disturbances in children. Family therapy, play therapy and group therapy and individual psychotherapy are useful techniques. A child guidance clinic where a team consisting of a child psychiatrist, clinical psychologist a social worker and a paediatrician is a ideal place for the treatment of the emotional problems of children.

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PSYCHIATRIC SERVICE NEEDS OF DEVELOPING COUNTRIES

CLINICAL PRIORITIES

Based on judgements of local needs.
Emphasis on problems which are:-

common)
disabling) See reference 1
disturbing)
treatable)

The following list of groups to be rearranged in a local order of priority.

excited and overactive states)
epilepsy)
chronic withdrawn behaviour following excited states) See reference 2

abnormal behaviour in the puerperium
senior civil servant/privileged clinic
student/senior school children problems
excess drinking/drug abuse problems
depressive illness
symptoms without signs in general medical clinics
shanty town populations
prison population
migrants

References

1. Developed from Morley, D. (1973). "Paediatric Priorities in the Developing World". Published by Butterworth.

2. First three priorities decided jointly by W.H.O. psychiatric experts and local communities in W.H.O. Collaborative Study for Extending Mental Health Care in Primary Care in Columbia, India, Senegal, Sudan, Brazil, Egypt and the Philippines. Reported in Climent, C.E. et al. (1980). "Mental Health in Primary Health Care". W.H.O. Chronicle, 34, 231-236.

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PSYCHIATRY

INTRODUCTION

With the Bhore Committee recomendations (1946), Diploma courses in Psychiatry were started at All India Institute of Mental Health (now NIMHANS), Bangalore. Later, Post Graduate (M.D.) courses were introduced in 1966 at National Institute of Mental Health and Nuero Sciences (NIMHANS).

Mental Health, ignored till recently, is now seen as a major component of general health services. The mind and the body cannot be seen separately and thus, while treating, the whole person needs to be understood. Good physical health contributes to good psycological or mental health and vice versa. Thus were born professionals working with the mentally ill, one of the earliest being the Psychiatrist.

Psychiatry is the science of recognition and treatment of diseases of emotions and the mind.

COURSES OFFERED

There are two courses in psychiatry which can be taken after a basic M.B.B.S. degree.

1) Diploma in Psychiatric medicine (DPM) : This is the basic degree to practice psychiatry and the duration is 2 years.

2) Doctorate in Medicine (M.D. in Psychiatry) : With an M.D. degree, apart from practising there are openings for teaching too, as the University eligibility rules makes it mandatory for a person to have an M.D. degree to become an examiner and a teacher. Duration is 3 years.

NIMHANS is the only Deemed University offering both these courses. A list of psychiatry departments of the Medical colleges in India offering the MD courses are listed in Annexure D.

FUTURE PROSPECTS

Earlier, psychiatry was taught only at intitutions attached to the Mental Hospitals. Later psychiatry units were started at General Hospitals. A newer trend is that private hospitals are also having Psychiatry units.

Today however, there is shift of emphasis from large public psychiatric hospitals to community based psychiatric care. Community psychiatry aims at working at the district, taluk and sub-taluk level, reaching out to the villagers at their village itself. With the forms of care moving to the community, there is a greater need for psychiatrists in India.

MEDICAL AND PSYCHIATRIC SOCIAL WORK

INTRODUCTION

The concept and practice of social work is as old as the human race itself. But it acquired its professional recognition only recently in India. On the recommendations of the Bhore Committee (1946), it was felt that a psychiatric social worker should be included in the medical health team. Subsequently, Tata Institute of Social Sciences started the Medical and Psychiatric social work specialisation in M.A. Social Work programme in 1946. Following this model, other schools of social work introduced this specialisation in their Masters in Social Work programme. At present there are about 15-20 schools of social work offering this specialisation (see Annexure C). Many of these schools also offer other specialisations apart from Medical and Psychiatry, like Family & Child Welfare, Community Development, Criminology and Correctional Administration.

TYPES OF COURSES

Medical and Psychiatry specialisation is included in the M.A. Social Work programme. Apart form this a two year M.Phil course is offered in India by two institutes namely, Central Institute of Psychiatry, Ranchi and National Institute of Mental Health and Nuero Sciences (NIMHANS), Bangalore. In NIMHANS, facilities are provided to do Ph.D in Psychiatric social work.

FUTURE PROSPECTS

Those who specialise in Medical and Psychiatric social work, get employment in General Hospitals, Psychiatric Clinic, Rehabilitation centres, Child Guidance clinic, Mental Hospitals, Marriage and Family Counselling centres, School of Social work, Research Project etc.

In addition, there is a recent trend in Industries to employ Psychiatric social workers as social counsellors. Of the 42 mental hospitals only 22 mental hospitals have employed psychiatric social workers. The State and Central Government need to be persuaded to fill up the vacancies. Likewise, there is proposal to start District Mental Health programme in each State. One or two posts will be created in each of these District Mental Health programme.

In the educational institutions, there is an increasing awareness about the needed importance of professionally trained social workers in schools and colleges. In this way the medical and psychiatric social work has a bright future in India.

ANNEXURE C

1. College of Social Work,
   Red Hills, Hyderabad 500 004.

2. Department of Social Work,
   Madras Christian College,
   Tambaram, Madras 600 059.

3. Department of Social Work,
   Loyala College of Social Sciences,
   Sreekariyam, P.O.,
   Trivandrum 695 017.

4. Madurai Institute of Social Sciences,
   Alagarkoil Road, Madurai 625 002.

5. Rajagiri College of Social Sciences,
   Rajagiri P.O., Kalamassery 683 104,
   Kerala.

6. Karve Institute of Social Service,
   Hill Side, Karve Nagar,
   Pune 411 052,
   Maharashtra.

7. Department of Social Work,
   Jnanabharati, Bangalore 560 056.

8. Tata Institute of Social Science,
   P.B. No. 8313, Sion-Trombay Road,
   Deonar, Bombay 400 088.

9. Department of Social Work,
   Karnataka University,
   Pavate Nagar, Dharwad 580 003,
   Karnataka.

10. Department of Social Work,
    Loyala College, Nungambakkam,
    Madras 600 034.

11. The Madras School of Social Work,
    32,Casa Major Road,
    Madras 600 008.

12. Department of Social Work,
    P.S.G. College of Arts and Science,
    Coimbatore 641 014.

13. School of Social Work,
P.B. No.521, Roshini Nilaya,
Mangalore 575 002.

14. Department of Social Work,
Gulbarga University,
Gulbarga 585 106,
Karnataka.

15. Department of Social Work,
Andhra University,
College of Arts and Commerce,
Visakapatnam 530 003,
Andhra Pradesh.

15. Indore School of Social Work,
14, Sea Shore Road, Indore 452 001,
Madhya Pradesh.

16. Department of Social Work,
D.N.R. College, Bhimavaram 534 202,
Andhra Pradesh.

17. Department of Social Work,
S.P. Mahila Viswa Vidyalayam,
Tirupathi 517 502,
Chitoor District,
Andhra Pradesh.

18. Department of Social Work,
Bishop Heber College,
Tiruchirapalli 620 017,
Tamil Nadu.

19. Department of Social Work,
Stella Maris College,
17, Cathedral Road,
Madras 600 086.

20. Department of Social Work,
Institute of Social Sciences,
Agra University, Agra 282 004.

21. Department of Social Work,
Viswa Bharati, SriNiketan,
Bhirbhum District 731 236,
West Bengal.

22. Department of Social Work,
Guru Nanak Khalsa College,
Yamuna Nagar 135 001,
Haryana.

23. Department of Social Work,
Dwaraka Doss Goverdhan Doss Vaishnav College,
E.V.R. Periyar High Road,
Arumbakkam, Madras 600 106.

24. Bosco Institute of Social Work,
Sacred Heart College, Tirupattur 635 601,
Tamil Nadu.

25. Department of Social Work,
Gujarat Vidyapith,
Ahmedabad 380 014,
Gujarat.

26. Department of Social Work,
University of Delhi,
3, University Road,
Delhi 110 007.

27. Institute of Social Work,
West High Coast Road,
Bajaj Nagar, Nagpur 440 010.

28. Department of Social Work,
Udaipur School of Social Work,
Udaipur 313 001,
Rajastan.

29. Department of Social Work,
M.S. University of Baroda,
Baroda 390 002,
Gujarat.

30. Department of Social Work,
National Institute of Social Work
and Social Sciences,
Surya Nagar, Bhubaneshwar,
Orissa.

31. Department of Social Work,
Chatrapathi Shahu Central Institute
of Business Education and Research,
University Road, Kolhapur 416 004,
Maharashtra.

32. Department of Social Work,
Tirpude College of Social Work,
Civil Lines, Sadar, Nagpur 440 001,
Maharashtra.

33. Department of Social Work,
Kasi Vidyapeeth, Varanasi 221 002.

34. Department of Social Work,
Kurukshetra University,
Kurukshetra 132 119,
Haryana.

35. Department of Social Work,
Hindu College, Guntur,
Andhra Pradesh.

36. Department of Psychiatric Social Work,
Central Institute of Psychiatry,
Kanke, Ranchi 834 006.

37. Department of Social Work,
University of Mysore,
Manasagangotri, Mysore 570 006.

PSYCHIATRY AND GENERAL PRACTICE

The wide gap that existed Psychiatry and general Medicine is being bridged and it may be hoped that in the not too distant future psychiatry in its preventive aspects will become a part of general medical practice. Psychiatry ofcourse, has specialist aspects but our aim is to train the practitioners so that they may become as interested in and as able to treat their psychiatric patients as those who are physically involved. The psychic and the soematic constantly react on one another and cannot be completely separated. That is why the treatment of the whole man is stressed and not merely the part disease from which he may be suffering. To do so effectively we must know his background , his personality structure plus his environmental situation and the biological manner in which he is able to adopt to the various exigencies of the physical or psychological nature to which he has been called upon to meet. The general practitioner therefore must be as expert in conducting a psychological examination of his patient as a physical one and in the long run he can be rest assured that he will have time than he wastes. He will acquire a more comprehensive viewpoint, he will inspier greater confidence, he will be able to exercise a stronger influence, he will be able to go to the core of the situation. Among other things he will find that many of the bodily states which have not responded to surgery or pharmocology will disappear miraculously. Once the underlying psychological factors have been disclosed. Hence the body and the mind work in harmony and are delicately balanced and must be handled with the greatest care. The one is complementary to the other.

Psychology is the septematic study of the mind. It is defined as the study of human behaviour. The important faculties of the mind are cognition or knowledge connation or will and feeling or emotion.

Psychiatry is the branch of medicine which deals with the recognition, treatment and prevention of mental abnormalities and disorders. Thus Psychology deals with normal behaviour while Psychiatry deals with abnormal behaviour. What physiology is to general medicine, Psychiology is to psychiatry.

It is estimated that nearly half of the hospital beds in western countries are occupied by psychiatric patients. About 30% of the patients

who attend general practitioners' clinic suffer primarily from psychiatric symptoms. In India various surveys report about 20% per 1000 in a community suffer from gross degrees of psychiatric morbidity. Moreover a recent study done in Bangalore shows that 30% of the patients who attend general practioners clinic show purely psychiatric symptoms. (Sham Sundar et al) This gives a rough estimate of about 12-million patients in the whole country who need psychiatric treatment. Against this need, there are only 20,000 hospital beds for psychiatric patients and there are only about 400 qualified psychiatrists in our country. This emphasizes the need for general practioners to be more equipped with the ability and knowledge to treat the more simple calls and refer the others to specialists.

PSYCHOSIS

Psychosis involves a realm of symptoms that typically includes delusions, hallucinations and various kinds of bizzare behavioural manifestations. The distinctions between neuroses and psychosis are symptomatic psychopathological and therapeutic.

A psychosis involves a change in the whole personality of the subject in whom it appears, while in neurosis it is only a part of the personality thtt is affected. Furthermore in a psychosis reality is changed qualitatively and comes to be regarded in a way very different from the normal and the patient behaves accordingly. In neurosis reality remains unchanged qualitatively, although its value may be quantitatively altered.

In neurosis language as such is never disturbed, whereas in psychosis it often undergoes distortion from the psychoanalytical point of view, the unconsious comes to direct verbal expression in the psychosis whereas in neurosis it never attains more than symbolic expression in some physical or localized mental disturbance. The reactions in a psychosis are much more primitive type on the whole than in neurosis. There is often a refression to an infantile level of activity in the psychotic, for eg. wetting and soiling without shame are not found in neurotics in the presence of clear consciousness.

The main type of psychosis are (1) Sechizophrenia (2) affective disorders and (3) Paranoid disorders.

SCHIZOPHRENIA

Schizophrenia is one of the common psychosis. It can be defined as a psychosis characterised by disturbances in the thinking, emotional, and volitional faculties in the presence of clear consciousnes which usually to social withdrawal.

Epidemiology:- Schizophrenia is a common disease found in all cultures in all parts of the world. Several community surveys show that 3 to 4 per 1000 in any community suffer from schizophrenia. About 1 per cent of general population stand the risk of developing the disease in their life time. About 15 per cent of new admissions to a mental hospital are schizophrenic patients. Women are more prone to develop schizophrenia. About 2/3 of the cases are in the 15-30 year age group though the paranoid type has a later age of onset. It is commonly found that the majority of schizophrenic patients are from the lower social classes whether schizophrenic patients drift down the ladder of social cause, because of the disease or whether the social stresses associated with a lower social class produce the disease, is not finally proved. The former appears to be a more probable explanation.

Etiology:- Both genetic and environmental factors are important in the etiology of schizophrenia. Family studies show that nearer the blood rala - tionship, greater the chances of getting schizophrenia. Several twin studies show that among manozygotic twins, the concordance rate is about 60 per cent where as among the dizyotic twins the concorance rate is only 10 per cent. Another piece of evidence for the genetic causation of schizophrenia comes from adoption studies. An examination of adults who

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were separated from their natural mothers from the first few days of life and adopted by others show that those who are born to schizophrenic mothers manifest more commonly the symptoms of schizophrenia. In some types of schizophrenia, there is a genetically determined biochemical abnormality, which in some situations produces abnormal metabolites which in turn causes changes in behaviour. Though the genetic basis of schizophrenia is established, there is no agreement as tothe mode of transmission. The important environmental factors attributed to the genesis of schizophrenia are intrafamily relationships and sociocultural factors. All the above theories need more substantiation But it is a common finding that physical illness, childbirth and psychosocial stresses precipitate schizophrenic reactions..

Clinical features:- Schizophrenic patients usually have a particular type of personality characterised by a tall and lean body structure (aesthenic body build) and a withdrawn, aloof, serious and impulsive type of temperament (schizoid).

The various mental faculties are disorganised in varying degrees.

Disorders of thinking:-

Their thinking is usually bizarre. It is very difficult to follow their reasoning, since there is a disturbance in the association of ideas. Patients sometimes complain that their stream of thinking suddenly stops and the mind becomes blank. This is called 'thought block'. Sometimes the ideas rush through the mind producing a confusion and chaos of thinking. Various types of delusions are common. Delusions of suspicion are characteristic of paranoid type of schizophenia. Over-thinking refers to an inability to preserve conceptual boundaries with the result that distantly related and irrelevant ideas are regarded as essential parts of a concept. There is a loosening of associations. The schizophrenic patient coins new words (neologism)

Disorders of emotion:- Apathy is usually seen in schizophrenia. This interferes in social relationships. The patient often complains that he has lost the ability to feel. Sometimes the emotions become incongruent and the patient will say something and behave in a different way.

Disorders of volition: Many patients manifest different degrees of weakness of willpower or volition. They would say that some change has happened to them and that their behaviour is controlled by some external forces. This is called passivity phenomenan. Some will obey any command however inconvinient or dangerous it is. This is called automatic obedience often patients do not have the power to do the normal activities of life, even though they try hard to do. This is often mistaken for laziness by relatives

Disorders of perception:-

Additory hallucinations are commonly seen especially in chronic cases.

Miscellaneous:- Catalonic refers to abnormality of movement, awkwardness, grimacing and posturing. Some patients adopt very inconvenient postures for a long time, as though they are made of wax. This is called wasy flexibility. Sometimes patients show motor excitement, sometimes motor retardation, even gross degree of stupor.

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Sleep is usually disturbed. All the schizophrenic symptoms are present in the absence of any disturbance of consciousness. The presence of coma would suggest an organic pathology and would be against a diagnosis of schizophrenia social withdrawal is a common manifestation of schizophrenia especially in chronic cases. The patient retreats to his own shell and lives in his own world.

Clinical sub-groups:- According to differences in clinical manifestations, there are four main clinical sub-groups of schizophrenia.

The hebephrenic group has a very vague and insiduous onset late in the teenage period. The early symptoms are perplexity, poor concentration, vague vagueness, day-dreaming , self-consciousness, moodiness, apathy, indiscriminate concern with pseudophilosophical-religious ideas, feeling of inferiority and inadequacy. Thinking disturbances and emotional incongruity are very marked, thus giving rise to a silly and impulsive behaviour. Inappropriate giggling and unpredictable temperament are characteristic of hebephrenic schizophrenia. Chronic cases show a marked degree of mental deterioration

The simple group has also a very insiduous onset during early adolescence and the diagnosis is usually missed. Emotional blunting is the characteristic feature. Patients drift from social groups and lead solitary lives. They thus will settle down into lives of poverty, petty crimes prostitution and vagrancy. These patients will not have delusions, hallucinations or thought.

The catatonic type shows a less insiduous onset during any age group and usually manifest disturbances in motor behaviour such as excitement, restlessness, stereotyped behaviour, negativism, posturing immobility, waxy flexibility and stupor.

The paranoid group is characterized by well systematised delusions of persecution and auditory hallucinations. The onset is later in life, the body build is usually pyknic and mental deterioration is not marked.

In clinical practise it is difficult to do a clear sub-typing. The same patient may show the features of different groups. There are no well-degined criteria of diagnosis of schizophrenia which are agreed upon by different investigations from different parts of the world.

Some psychiatrists believe that there are two types of schizophrenia. One is called the process or nuclear schizophrenia, which is characterized by a schizoid, premorbid personality, family history of schizophrenia, inciduous onset during adolescence, gross hebephrenic features and a poor prognosis. Such patients are more leptomorphic in body build and more commonly demonstrate abnormalities of immunological and autonomic responses.

The other group is called reactive schizophrenia or schizophreni form psychosis or symptomatic schizophrenia. In contrast to the nuclear type, this group is characterised by less insiduous onset in any age group predominance of precipitating factors and change in motor behaviour and a better response to treatment.

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TREATMENT:-

1. Drugs: Phenothiazines are the drugs of choice and form the main line of treatment in schizophrenia. The dossage depend upon the severity of the symptoms and the body weight. The following phenothiazines are usually used chloropromazine (Largactil) 300mgm per day. Trifluoperazine (Eskazine) 15mgm per dayThioridazine (Melleril) 300 mgm perday. Newer drug such as Haloperidol and Thiozanthines may be used. If the severity of symptoms continue, these drugs can be given in a reduce to a maintenance dosage and continued for thelo long time. The drug treatment must be supervised by specialist. Long acting phenothiazines such as Anatensol Decancate are recently introduced and are very useful for chronic schizophrenic patients.

2 Electro Convulsive Therapy:-
This is usrful in selected cases. It is indicated in catatonic type of schizophrenia with excitement or stupor. If the response to drugs is very slow in other types of schizophrnia, a course of E.C.T. may be tried. The usual course of treatment is between 10 tol5 number of treatments. There are many individual variations and the treatment must be under the supervision of a specialist.

3. Social Therapy: A sympathetic understanding of the patient by the team of psychiatrists, psychologists, social workers, occupational therapists and nurses is very important. This total push programme of treatment as inpatients is very helpful in the rehabilitation of the patients and the prevention of relapses. Individual supportive psychotherapy will help the patient to have more confidence. The involvement of the family members in the treatment will imporve the intrafamily relationships and facilitate regular follow up.

4. Prefrontal Leucotomy: This is useful in selected cases where the other conservative treatments have failed, and the patient shows aggressive, impulsive behaviour which makes management difficult.

Course and Prognosis:- A family history of schizophrenia, schizoid type of premorbid personality, early onset, insidious onset, long duration and absence of precipitating factors, are bad prognostic factors. In other words process schizophrenia has a bad prognosis and reactive schizophrenia has a better prognosis.

It is estimated that about 10 per cent of patients show spontaneous recovery, even without treatment. About 60 per cent show various degrees of recovery with treatment. About 20 per cent show gradual deterioration in spite of treatment.

AFFECTIVE DISORDERS

Affective disorders are illnesses in which mood changes form the dominant and primary features.

Depression is the most common affective illness. Depression usually follows an unhappy life event. Grief reaction or mourning is one example Depression can also be associated with any physical illness.

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Neurotic depression or reactive depression is commonly precipitated by environmental stresees.

Endogenous depression or psychotic depression is not causally related to any major traumatic situation and are more constitutional or genetic.

Neurotic depression or Reactive depression:- Here the primary characteristic is a change in mood consisting of a feeling of sadness which may vary from mild depression to a gross degree of despair. This may last for days weeks or even months and produces changes in behaviour, attitude, thinking, efficiency and physiological functioning.

Depression, is precipitated by environmental factors. Reactive depression usually lifts when the precipitating factor is removed.

Clinical features:-

Feeling of insomnia especially sadness, difficulty in falling asleep, decreased appetite, lack of concentration and confidence, lack of interest in work and people, vague fears are main features. Somatic complaints such as heaviness of head, chestpain feeling of weakness are common . Suicidal ideas may be present. Neurotic depression differs from endogeneousdepression in several ways. Neurotic depression is precipitated by environmental factors whereas endogeneous depression is not usually precipetated by extraneous factors. The neurotic depressive usually finds it difficult to go to sleep (early insomnia) whereas in endogenous depression there is early morning awakeing. The neurotic depressive feels worse towards evening whereas in endogenous depression the patient feels better towards evening and worse in the morning. The neurotic depressive feels better in company, whereas endogenous depressive shuns company. Delusions and hallucinations may be present in endogenous depression but are absent in reactive depression.

Treatment:- Psychotherapy is the main line of treatment. Antidepressants and minor tranquillisen may be helpful

MANIC DEPRESSIVE PSYCHOSIS (MDP)

Ganetic constitutional factors are more important in etiology. Hereditory factors are important here.

MDP is a circular illness, which compresis of a series of attacks of elation and depression with periods of normality inbetween and generally favourable prognosis.

Some individuals evidence only manic reactions and others only depressive reactions, still others show both types of reactions, either alternating between two or showing a combination of manic and depressive reactions at the same time.

The premabid personality is usually of cyclothymic type- extraverted and outgoing people liable to mood changes and have a pyknic type of body build (short and thick)

Depression:- Depression phase of MDP, which is currently known as Bipolar depression is characterized by depressive features of an endogenous type.

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The depression is not usually triggered by environmental factors and is quite intense. The patient has morbid guilt feelings feelings of unworthiness and suicidal preoccupation. Loss of vitality, weakness, loss of libido is common. Anorexia, constipation, weight loss and amenorrhea, are the other common physical symptoms.

Elation:- In the manic phase, the patient has great feeling of wellbeing and his mood is euphoric. There is increased mental and physical activity. Flashes of irritability may be present. Thinking is marked by flight of ideas i.e. ideas rush through the mind one after another, and he jumps from one point to another. Gross degree of extravagance may be present. The patient may express grandiose delusions. His attention may be difficult to sustain. He is easily distractible. Libido may be increased during a manic phase.

The depressive phase has to be differentiated from early schizophrenia and organic cerebrovascular conditions such as cerebral tumour, arteriosclerosis, and general paresis of insane. The manic phase has also to be differentiated from cerebral tumour, general paresis of insane, GPI, drug addiction and catatonic excitement.

Treatment:-
Drugs:- The common antidepressant drugs are imipramine, amitryptylene and trimipramine. The dosage is usually 75 mg per day which can be gradually reduced to 50 mg.

In recent years Lithium carbonate has been found to be effective for manic excitement and recurrent attacks of endogenous depression.
E.C.T. Endogenous depression especially withsuicidal preoccupation is an indication for E.C.T.

Involutional Melancholia:-

Involutional melancholia is differentiated from other depressive reactions by the initial appearence of the disorder during the climacteric. The involutional period in women is usually considered to be from 40 to 55 and in men 50 to 65.

Here the depression is similar to that of the depressive phase of MDP but is usually coloured by paranoid delusions and hypochondriacal features. Restless and agitation is very common. Nihilistic delusions may be present. (intestines are missing etc.,).

The premorbid personality is characterized by rigidity, obsessive tendencies, exaggerated concern with health and perfectionism.

Treatment comprises of E.C.T. and antidepressant drugs. Suicidal risk among these patients in very high and have to be admitted and treated by a specialist.

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PARANOID PSYCHOSIS

Paranoid psychoses are psychotic states which are characterized mainly by paranoid delusions. These are paranoia, paranoid state, paraphrenia and paranoid schizophremia. Paranoid ideas and preoccupations can be associated with other conditions as secondary symptoms eg. frontal lobe tumors, endogenous depression, myxodema, toxic psychosis etc.

Paranoia:- Here there is a gradual development of an unshakable delusional system. This usually occurs late in life. Here the personality is well preserved and social functioning is not usually handicapped prognesis is poor.

Paranoid states:- These too have a later age of onset (usually during the involutional period). There are florid symptoms, paranoid delusions not as systematised as in paranoia, sleeplessness, fear and anxiety are present. The onset is sudden. Phenothiazenes and ECT are the lines of treatment and the response may be good.

Paranoid schizophremia is characterized by gross personality changes such as paranoid delusions, brizzare thinking, lack of personal care and auditory hallucinations.

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PSYCHOSOMATIC DISORDERS

Psychosomatic disorders refers to a group of diseases where structual lesions are produced in organs supplied by the autonomous nervous system by the prolonged influence of emotional factors. The psychological factors have a definete relationship to the onset and perpetuation of the symptoms.

The word 'psychosomatic' has another connotation. This emphasises the importance of psychological factors in medicine and the need for treating a patient as a total personality as psychological factors are relevant in all disease. If they are not the primary importance in the causation of disease they can be the results, eg. reaction to chronic illnesses, pain etc.

Etiology:- The important etiological factors are the personality type and presence of life stresses. The personality of psychosomatic patients is described as "Conscientious" regid, ambitious, sensitive and uncompromising. They usually repress their emotions such as anger and resentement and have a high motivation to achieve success.

Emotional stresses produce anxiety which brings about disturbances in hypothalamus and limbic areas, which in turn, through the autonomic nervous system and endocrinal glands, produce changes in different systems.

Why a patient gets a illness in a particular system is difficult to answer. It may be because psychosomatic tension take the least line of resistance. The organs which are weaker because of inherent weakness or because of injury to he organ by physical disease, generally become the targets for psychosomatic lesions. The person with a weak gastro intestional tract may develop pepticulcer when exposed to emotional stress for a long time. Thus a predisposed personality, organ vulnerability and prolonged emotional stresses in life are the main factors involved in the production of psychosomatic disorders.

Clinical features:- Common psychosomatic disorders are

1. Skin disorder:- Neurodermatitis cezema, acne, urticaria, some cases of hives etc.
2. Musculoskelital disorders such as backaches, muscle cramps, tension head-, aches, Rhumatoid artritis
3. Respiratory disorders such as browchial asthama, hiecoughs rhinitus etc.
4. Cardiovascular disorders include essential hypertension, migraine, Vascular spasms.
5. Gastro intestinal disorders such as peptic ulcers, ulcerative colitis muscous colitis.
6. Genitourinary disorders like amenorrhoea, oysmenhorrea premenstrual tension, impotency, frigidity, sterility.
7. Endocrinal disorders like hyperthyroidism obesity etc.

Diagnosis:- Emotional factors can be demonstrated to be significant in the production or perpetuation of the disorder. The course of the illness tends to be phasic with periods of exacerbations, remissions and relapses.

Treatment:- involves both symptomatic treatment for the structural lesion and psychotherapy. Psychotherapy must be aimed to help him to cope with the life stresses. Life stresses should be minimized where ever possible. The treatment of psychesomatic disorders need good collaboration between the psychiatrict and the internist.

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occupational therapy etc.

The point of consideration here is not the ideal set-up, but the minimum that is required and could be organised with the available personnel. Equal emphasis should be paid to training and service. If training is not adequate, the growing rate of psychiatric clientele would result in poor standards of service. Such a growth in psychiatric clientele can be expected as shown from assessment of many general hospital units (Jindal, RC,1980).

If properly planned and organised, one professor, one assistant professor and a lecturer or tutor would be sufficient personnel for administration, training and rendering of services in the hospital and at the periphery. In addition, a senior house-officer could be appointed, who would manage day to day ward care, while being simultaneously trained to become a specialist.

With regard to paraclinical staff, the need for a psychologist is under-rated by most centres. If a psychologist is available, most of the psychological testing, behavioural methods of treatment and long-term psychotherapy can be taken care of by him, giving the doctor more time for other duties.

The social worker is perceived as a hospital-based person involved in casework and day-to-day treatment programmes. He can also be utilised in promoting tertiary care and organising rehabilitatory and placement programmes in co-operation with voluntary and governmental services that exist in the catchment area. In this way, the individual's organisational ability is tapped along with his capacity for direct intervention, although today's teaching programmes in psychiatric social science emphasise the latter.

The inclusion of a trained nurse in this unit will improve the standard of patient care and promote a positive attitude towards psychiatry and its patients (Wig, NN,1978).

A statistician whose services will be required only occasionally, could be shared with other faculties.

The above would form the basic outlay for the staffing of a General Hospital Psychiatric Unit. As and when the need for more personnel arises, staff may be co-opted on a temporary or permanent basis.

To Rwi MH1.29
From M.J.

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ON PLANNING A GENERAL HOSPITAL PSYCHIATRIC UNIT

India has achieved impressive levels in the control of communicable diseases and has improved her sanitation and nutritional levels, thus increasing the longevity of life. However, a deplorable status exists in the quality of life Indians lead. Mental health has remained a low priority in our health planning.

The country has about 20,000 psychiatric beds for its 5.4 million psychiatric patients in 1973. Only 163,000 of these patients were given psychiatric facilities annually, with one psychiatrist catering for approximately a million population (Neki, J.S., 1973). Psychiatric units in various medical colleges were either illequipped or non-existent. These figures expose the quality of our mental health services. The conditions have not changed much today.

There have been infrequent studies on the planning of general hospital psychiatric units. This has resulted in the isolation of these units into small mental hospitals within the framework of consultation liasion psychiatry. The teaching units of such hospitals have seldon imparted knowledge to the many medical graduates trained in our country. If we have to take care of the psychiatric morbidity prevalent in this country, the general hospital psychiatric units have to be reorganised and their teaching units activated.

NEED FOR GENERAL HOSPITAL PSYCHIATRIC UNITS

Review of mental hospital statistics from all parts of India indicates that more than 90% of the patients in mental hospitals are psychotics (Khanna, BC, 1974), while the prevalence rates according to epidemiological surveys show a high incidence of neuroses. Psychoneuroses and personality disorders, many of which present with somatic symptoms, make up the bulk of the mental disorders in the rural and urban communities. However, they are not conspicuous since this population is often not perceived as mentally disturbed. A large number of them is hidden among the masses attending the general hospital services, where prevalence rates as high as 20% have been reported (Neki, JS, 1973). As primary health services are developed, increasing numbers of these patients are expected to seek help. T They could be mismanaged, prescribed expensive drugs and investigations. The teaching units of the general hospitals are in a position to train medical personnel to recognise these symptoms and manage them adequately.

The planning of a general hospital psychiatric unit can be divided into three broad categories:

1. Staffing
2. Services
   A. Hospital Services
   B. Peripheral Services
3. Undergraduate teaching and research.

Some of these units may also serve as post-graduate training centres. If so, an appropriate programme should be chalked out and integrated with the above.

STAFFING

The existing staffing pattern, bed strength and services of psychiatric teaching units in general hospitals vary considerably. There is insufficient guidance on the pattern of staffing required and on the services that should be made available at these centres.

The Tripartite Committee in the United Kingdom suggested the following staff for a district general hospital with a teaching psychiatric unit of 25 to 30 beds (British Medical Association, 1972).

Professor	1	
Assistant Professor	1	
Lecturer	1	
Senior Registrar	1	
Registrar (In training)	1	
Social Workers	2	
Occupational Therapist	1	
Psychologist	1	(Part-time)
statistician	1	(Part-time)

The WHO recommended that in countries currently developing their psychiatric services, a team comprising of one or two psychiatrists, two social workers, a nurse with some training in psychiatry and a psychologist may well form the basic psychiatric service, while provisions are being made for the development of more elaborate facilities.

Arising from the need for uniformity, the National Academy of Medical Sciences has laid down minimum requirements for psychiatric units before they can be recognised as training centres for MNAMS examinations. These include 20 inpatient beds, daily out-patient service, a minimum of two consultants and special services such as child psychiatry,

occupational therapy etc.

The point of consideration here is not the ideal set-up, but the minimum that is required and could be organised with the available personnel. Equal emphasis should be paid to training and service. If training is not adequate, the growing rate of psychiatric clientele would result in poor standards of service. Such a growth in psychiatric clientele can be expected as shown from assessment of many general hospital units (Jindal, RC,1980).

If properly planned and organised, one professor, one assistant professor and a lecturer or tutor would be sufficient personnel for administration, training and rendering of services in the hospital and at the periphery. In addition, a senior house-officer could be appointed, who would manage day to day ward care, while being simultaneously trained to become a specialist.

With regard to paraclinical staff, the need for a psychologist is under-rated by most centres. If a psychologist is available, most of the psychological testing, behavioural methods of treatment and long-term psychotherapy can be taken care of by him, giving the doctor more time for other duties.

The social worker is perceived as a hospital-based person involved in casework and day-to-day treatment programmes. He can also be utilised in promoting tertiary care and organising rehabilitatory and placement programmes in co-operation with voluntary and governmental services that exist in the catchment area. In this way, the individual's organisational ability is tapped along with his capacity for direct intervention, although today's teaching programmes in psychiatric social science emphasise the latter.

The inclusion of a trained nurse in this unit will improve the standard of patient care and promote a positive attitude towards psychiatry and its patients (Wig, NN,1978).

A statistician whose services will be required only occasionally, could be shared with other faculties.

The above would form the basic outlay for the staffing of a General Hospital Psychiatric Unit. As and when the need for more personnel arises, staff may be co-opted on a temporary or permanent basis.

SERVICES

HOSPITAL SERVICES

The services of a general hospital unit have to be diversified into hospital care and outreach programmes. The latter involves more of training than direct patient care and will be discussed separately.

Daily out-patient service in the hospital is an essential requirement. Studies pertaining to the inpatient population showed that 80% of these patients could be managed on an out-patient basis, and that only 0.4% of them had to be transferred to mental hospitals. Of the remaining number who were treated as in-patients, 60% had hospitalisation for less than one month (Khanna, BC; 1974). These statistics give us an idea of the in-patient requirements. One of the largest general psychiatric units in the country, the K E M Hospital, Bombay, has 3% of the total beds allotted to psychiatry (Vahia, NS; 1974). Although the American Psychiatric Association recommends 15% of total beds in general hospitals for psychiatry, which is one of the highest percentages recommended (Kaufman, MR,1965), in our country with other important priorities, approximately 2-3% of the general hospital beds would suffice.

Out-patient services should also include special clinics of importance, which are the Child Guidance Clinic, in which management of the mentally subnormal group would also be taken care of and the Student Counselling Centre. Most general hospital services do not include these special clinics. The first is mostly forgotten, and the second never thought of. The overall frequency of psychiatric morbidity among medical students appears to be nearly one-third of the student population, with 13.5% of these cases belonging to the severe category of grading (Agarwal, AK, 1973). As compared to many western countries, the geriatric group constitutes a smaller number of psychiatric patients in India, and therefore, may not need a separate programme (Varma, VK, 1979). Similarly, alcoholics were not found in large numbers, to justify a separate programme. However, the need for this may arise in later years (Wig, NN, 1978).

The tertiary care should preferably start within the hospital and from there extend to the community. Decision as to the placement and rehabilitation of the individual is made and the agency is contacted by the social worker during hospitalisation or active treatment. Once rehabilitated,

follow up of these cases and management of relapses have to be carried out from the hospital. Apart from these duties, the trained nurse and the social worker can promote attitudinal changes in the relatives of patients towards mental illness.

PERIPHERAL SERVICES

Perpheral services run by hospitals cater to only a minority of the needy people. Hence, the emphasis should be on training health personnel located at the peripheral, in detection and management of common cases. The priority of services in our rural areas must be extended to three groups. Firstly, the psychoneuroses and the personality disorders, many of which present with somatic symptoms. Crosscultural studies have shown that physical symptoms and hypochondriasis are more common in Indian psychiatric patients (Neki, J.S.1973). The psychiatric aspect of the patient's illness gets clouded by the physical nature of his complaints, hence he approaches the general physician more frequently than the psychiatrist (Malhotra, HK, 1975). Reports on non-psychiatrists' use of psychotropic drugs show that antidepressants were often not used when indicated. The major reason for their non-use was the physicians' lack of recognition of affective disorders (Raft,D,1975). Predominance of somatic symptoms would increase the possibility of this error. Training physicians at the Primary Health Centre and private practioners would reduce the number of patients being erroneously managed. The second priority would be the chronically mentally handicapped group of patients. This population is often neglected as they do not by themselves come to the hospital. They are also more susceptible to other illnesses which need attention. Thirdly, epilepsy, though not a psychiatric illness, can be easily managed with minimal training and cost.

Training of private practioners and of the doctors at the Primary Health Centre can be achieved in a short time by the psychiatric teaching units of general hospitals. They could could undertake this programme in collaboration with the department of community medicine.

The social worker plays a major role in peripheral services in activating programmes for attitudinal changes, identification of cases, using traditional healers in health care (Carstairs, GM, 1973), and promoting tertiary care in these areas. In addition, periodic filed camps by psychiatric teams would increase the awareness of psychiatric ■ care among the local physicians.

CURRICULUM AND TEACHING

Psychiatric teaching in general hospitals includes three different areas, namely, teaching of undergraduates, exchange of ideas between the psychatrist and other medical disciplenes, and research. The Medical Council of India gives periodic recommendations to medical colleges on the requirements of their curriculum. However, most institutions fall short of these guidelines. A separate examination in psychiatry or inclusion of questions on the subject, as well as a satisfactory internship programme would reduce the prevailing ignorance. It is preferable to begin teaching the behavioural sciences, namely, psychology and sociology in the preclinical years, and introduce clinical psychiatry when the student enters his clinical training.

An attitudinal survey on psychatry's image amongst other medical professionals and students revealed that psychatrists were viewed different from other physicians, because, they did not satisfy their identity as physicians and also isolated themselves from the rest of the medical community. The meaning and use of psychotherapy was little known (West, ND, 1975). Some of these attitudes have to be changed before psychiatrists can become efficient teachers. There is also an emotional barrier between psychiatry and other hospital services, which retards the scope for combine work and teaching programmes.

Diagnosis of psychiatric illness and use of psychotropic drugs by other physicians are far below expectations. In a study of psychiatric referrals in general hospitals, only 25% of the referral diagnosis corresponded with the actual psychiatric diagnosis (Jindal, RC, 1980.). The organisation of inter-departmental seminars and discussions would improve psychiatric awareness in other physicians.

The general hospital units are specially suited for research on psychosomatic illnesses, neuroses and variants of depression. Patients with these disorders prefer to attend general hospitals. In an evaluation of twenty-five years of psychiatric research in India, the (Wig, NN, 1974), made the following observations. There was an extreme lack of up-to-date laboratory research, which is probably the result of financial incapacity and insufficienty of sophisticated equipments. They noted that there have been very few prospective studies pertaining to the natural history of mental illnesses, as they exist in India.

Scant attention has been paid to psychotherapy in this country. There have been no assessment of the efficacy of undergraduate education programmes and present-day pattern of mental health services.

CONCLUSION

Several seemingly contradictory tendencies that characterised mental health services in the past two decades have found their resolution in the last few years. Controversies on the relative priority of research and services have also been resolved by the recognition of effective, economically acceptable techniques in treatment and prevention of psychiatric illness (Sixth Report on the World Health Situation, 1980). Although institutional treatment still remains necessary for selected conditions at certain stages of their development, community-oriented services now have universal support.

Today, the general hospital psychiatric unit holds a key position in mental health services. It is, therefore, of vital importance to strengthen these units and put them into more effective use.

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newsletter

Federation for the Welfare of the Mentally Retarded (India)

VOL II | ISSUE XI | NOVEMBER 1976

SPECIAL ISSUE ON THE NATIONAL DAY FOR THE MENTALLY RETARDED 8 DECEMBER, 1976

A PROFILE IN COURAGE

The parents of a retarded child are most directly and cruelly affected by their child's handicap. From the first awful moment of discovery, and the feeling of utter despair which slowly gives way to resignation and through gradual stages reaches an attitude of acceptance, these courageous souls survive an ordeal by fire. The bravest of them all, rise above their personal misery to accept and embrace a larger world of handicapped children. They start institutions which cater for many like their own child and help to alleviate the sufferings of other parents. They refuse to be beaten, they revolt against defeatism.

To these courageous parents we dedicate this special issue.

ANNOUNCEMENT

There will be no separate issue of our Newsletter in December. Your January issue will come to you in the first week of the New Year.

FWMR wishes all its readers a very happy New Year.

AN APPEAL

Considering the magnitude of the problem of Mental Retardation in India today, the services to help them are pitifully inadequate. Worse still, a fog of misconceptions and misunderstanding about the nature of the problem separates them from an unenlightened public.

Mental retardation is not a medical problem. The condition is determined before birth, exists at birth or develops in early infancy. It is a life long condition and as such the question of cure does not arise. Improvement can be effected but this too with prompt diagnosis, assessment and proper education and training.

The 8th of December of every year has been set apart as the National Day for the Mentally Retarded. Institutions—dealing with the Mentally Retarded—all over the country, have programmes to highlight the activities of the retarded and raise funds to better existing services.

The FWMR is a national body which helps to co-ordinate the working of all affiliated institutions and encourages the initiation of new services. We need financial help for our projects and many schemes have not been implemented solely due to shortage of funds.

Your donation will help us to :

1. Fund sheltered workshops
2. Initiate farm—oriented programmes for the adult retarded
3. Start a Foster Parent Scheme
4. Build Residential Homes for the adult retarded
5. Build Holiday Homes for all ages and categories of the retarded
6. Build up a Trust Fund
7. A multi-category service home in Hauz Khas, New Delhi is our immediate dream project.

May I count on you to help our efforts and donate generously towards the cause of the Mentally Retarded ?

Yours faithfully,

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE 560 001

(Mrs. Vasanthi A. Pai)
President, FWMR.

ELECTRICITY TO THE FORE IN THE SERVICE OF MANKIND

Electricity has come to permeate our life as probably nothing else does. It serves mankind right from the cradle to the grave in a way which is truly fascinating.

Let us take the case of those who are mentally retarded or physically handicapped. Electricity becomes a major factor in their rehabilitation too. The electrical process is a 'must' in the manufacture of medicines for them. Even when the scene shifts to the operation theatre, electricity it is which keeps the show going.

No less positive is the role of electricity in creating avenues of self-employment for such afflicted people. For it is through electrically operated producing, processing or manufacturing equipment that diverse types of ventures can be started with a view to finding gainful employment for them.

While always at their service, the BIHAR STATE ELECTRICITY BOARD assures them of its unstinted co-operation.

Issued by

Director, Public Relations,

BIHAR STATE ELECTRICITY BOARD

PATNA.

PSYCHOSOCIAL CARE *for* COMMUNITY LEVEL HELPERS

SUPERCYCLONE

INFORMATION MANUAL 2

PSYCHOSOCIAL CARE *for* COMMUNITY LEVEL HELPERS

SUPERCYCLONE

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BfC BOOKS for CHANGE
Dedicated to Development
A Unit of ActionAid Karnataka Projects

FOREWORD

Disasters pose a monumental challenge to the total community. The worst affected are the people whose lives are disrupted severely by the enormity of the tragedy. Their recovery capacities are stretched beyond normal human limits. Equally disturbing is the disruption by the social, economic and political structures.

For too long, psychosocial consequences have been neglected. It is only since 1984, after the Bhopal Disaster, that both professionals and administrators have awakened to the need to focus on mental health care of survivors of disasters.

The ORISSA Disaster like all disasters, poses the enormous challenge of REBUILDING THE PEOPLE, RECONSTRUCTION NOT ONLY OF SHELTERS AND LIVELIHOOD but OF THE HUMAN SPIRIT. This information manual is part of a major initiative in the overall relief and rehabilitation programme, to organise mental health care. It is the joint effort of ActionAid India and NIMHANS, Bangalore, going beyond the initiative of OXFAM, India, after the National Workshop held in December 1998.

The information booklet is unique because:

1. It addresses mental health care;
2. It is made available soon after the disaster;
3. It is user-friendly;
4. It is a collaborative effort of professionals, voluntary agencies and people – both survivors and concerned.

We sincerely appreciate the contributions of all the authors, Suresh M B, the artist and the Books *for* Change team for the editorial and production assistance.

Dr Srinivasa Murthy R
Prof. Psychiatry Dept
NIMHANS, Bangalore

Harsh Mander
Country Director
ActionAid India

Generally from the same local area, these people take up the task of helping as a priority. They include – lay volunteers, basic health workers, anganwadi workers, gramsevakas, National Social Service (NSS) volunteers, civil defence personnel, and other groups.

Role of the CLH

CLHs are a vital link between the affected population and the helping agencies (individuals, Non-Governmental Organisations, Governmental Organisations) arriving from outside the community. They are likely to know the community and area well and have close ties with several people in the locality.

Psychological problems following disasters often tend to be neglected. This happens because they are relatively invisible when compared to the damage to life, physical health and property. But it is important to remember that psychological problems occur very commonly. Hence, early identification of this problem followed by intervention help the survivor to recover. The distress is intense and leads to helplessness, isolation and apathy. No one who witnesses a disaster is untouched by it.

It is sometimes difficult to draw a line between rescue, relief work and psychological interventions. An awareness of psychological consequences leads to a frame of mind of being sensitive to mental health needs of the affected population. Actions can arise from such a sensitivity.

At the early stages following disaster, most survivors are psychologically open and willing to talk about their experiences. This may change later into a defensive, non-cooperative attitude if time passes without attempts at providing help. Therefore, it is of utmost importance that survivors are encouraged to seek help and talk about their psychological problems as early as possible. As already mentioned, this intervention will prevent the persistence of problems and development of further complications.

In general, people do not readily/directly talk about their psychological problems. Even during their visits to the health centres, they generally report physical problems. Psychological problems may be reported, but indirectly manifested as vague aches, pains, headaches, tiredness, etc. **Remember, people do however talk** about themselves when given an opportunity to do so.

Psychological intervention can be provided to the family in the daily visits by monitoring and noting down information – all by the CLHs. Such visits are to be utilised for talking about the survivor's feelings and experiences, imparting health education, discussion of health problems, motivating individuals to hold group meetings, and organising educational activities.

Principles of emotional support

Need for emotional support for survivors of a supercyclone disaster is based on the following broad principles:

- ***No one who experiences the event or witnesses the event is untouched by it***

Disaster, depending on the nature and magnitude can cause enormous loss to life, property and the environment of the area. Grief, sadness, anxiety, anger are common in such situations. Individuals find comfort and reassurance when told that their reactions are normal and understandable in every way. **Therefore, CLHs help to educate the survivors about common disaster stress reactions, ways to cope with stressors and available resources to respond to their needs.**

- ***Disaster results in two types of trauma***

Disaster-affected population have **individual** and **collective trauma.** Individual trauma manifests itself in stress and grief reactions, while collective trauma can severe the social ties of survivors with each other. These ties could provide important psychological support in times of stress. The loss of these natural buffers in the community is less visible and thus mental health interventions, such as outreach, support groups and community organisations which seek to re-establish linkages between individuals and groups are essential.

- ***Most people pull together and function during and after a disaster but their effectiveness is diminished***

A disaster survivor is confronted with multiple stressors. In the initial phases there is much energy, optimism and altruism. There is often a high level of activity

with low level of efficiency. As the reality of losses becomes more clear, frustrations and disillusionment set in, leading to more stress symptoms. **This can impair the survivor's ability to make sound decisions and take necessary steps towards recovery and reconstruction.**

- ***Disaster stress and grief reactions are normal responses to an abnormal situation***

  Stress reactions and grief responses are common in disaster survivors. Almost all the individuals who are part of this event experience such reactions. Relief from stress, ability to talk about the experience and passage of time usually lead to the re-establishment of equilibrium. **Public information about normal reactions, education about ways to handle them, and early attention to symptoms that are problematic can hasten recovery and prevent long-term problems.**

- ***Many emotional reactions of disaster survivors stem from problems of living caused by the disaster***

  Disaster disrupts all aspects of daily life resulting in practical problems like finding temporary housing, food, clothing, etc. **Timely and appropriate relief and support measures are very vital to help survivors handle the disruption.**

- ***Disaster mental health service must be uniquely tailored to the communities they serve***

  Mental health interventions should be based on the demography and characteristics of the population. It is also essential to consider the ethnic and cultural groups in the community, so as to provide help in a manner which is culturally relevant and in the language of the people. **Hence the emphasis is that such programmes are effective if workers indigenous to the community and to its various ethnic and cultural groups are integrally involved in service delivery.**

- ***Survivors respond to active interest and concern***

  Survivors will usually be eager to talk about what happened to them when

approached with warmth and genuine interest. Workers should not hold back from talking with survivors out of fear of intruding or invading their privacy.

- *Interventions must be appropriate to the phase of disaster*

  It is of paramount importance to recognise different phases of the disaster and varying emotional reactions of each phase. In the initial phase it is listening, supporting, ventilation, catharsis and grief resolution. While in the latter phase it involves handling frustration, anger and disillusionment.

- *Support systems are crucial for recovery*

  The most important support group for individuals is the family. Workers should attempt to keep the family together and the members encouraged to be involved in each other's recovery. For those who are orphaned or have become single, support from other groups can be helpful.

- *Attitude of the CLH*

  The Community Level Helpers need to set aside traditional methods, avoid use of mental health labels like 'neurotic', 'counselling', 'psychotic', 'psychotherapy', etc., and use an active outreach approach to intervene successfully in disaster.

Understanding the impact of the supercyclone disaster

Disaster-affected population experience various kinds of trauma. Physical injuries, fractures and infections are common during the actual event, either due to direct effects of the cyclone or as part of survival efforts used by the victims. Psychological trauma immediately follows the event while socio-economic trauma like unemployment, homelessness, environmental distraction and disorganisation emerges as a consequence following the devastation caused by the disaster.

DISASTER TRAUMA

PHYSICAL	PSYCHOLOGICAL	SOCIO-ECONOMIC
■ fractures	■ bereavement	■ unemployment
■ burns	■ anxiety	■ homelessness
■ injuries	■ depression	■ environmental destruction
■ infections	■ alcohol abuse	■ disorganisation
	■ drug abuse	
	■ stress reactions	

After a disaster, the psychological reactions among members of a community may vary and this also usually undergoes change over time. Therefore, post-disaster psychological interventions should be flexible and based on an ongoing assessment of needs, which depend on certain factors and their variables. The factors relating to this are the following: the nature and severity of the Disaster, the supportive nature, the

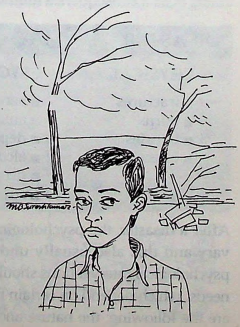
preparedness, previous experience of the Community, the age, character (strong- or weak-willed), single, widowed, married, personal losses of the survivor, etc. These are:

The DISASTER:	■ occurrence ■ magnitude ■ suddenness ■ type
The COMMUNITY:	■ level of preparations ■ social support ■ leadership ■ past experience
The SURVIVOR:	■ age ■ level of education/exposure ■ marital status ■ physical health ■ personality ■ coping skills ■ losses ■ social support

Types of emotional reactions to disasters

It is only in recent years that the importance of emotional and psychological reactions to disasters has been recognised. It is now clear that these reactions:

- are common and universal (no one who witnesses a disaster is untouched by it)
- manifest differently at different periods of time after the disaster
- may continue for long periods of time causing suffering and disability.



The different types of psychological reactions to disasters can be broadly categorised under 4 phases:

1. **Immediate reactions** *(i.e. within hours to few days)*

   Affecting almost all the population immediate to the disaster, these reactions can be considered normal to a traumatic experience and are generally temporary or short-lived:

   - Tension, anxiety, panic

- Stunned, daze, disengagement
- Relief, elation, euphoria among some survivors
- Flight from the situation
- Restlessness, confusion, sleeplessness, repeated experiences of the events, 'flash-backs', nightmares, arousal symptoms
- Disorientation, wandering, loss of identity
- Extreme forms of reaction with agitation, aimless wandering, talking excessively, crying and withdrawal from others.
- Survivor's guilt.

2. Immediate post-disaster reactions *(one month to six months)*

Reactions mentioned earlier tend to reduce with time, but may give way to other symptoms, or they may persist. The new reactions that may appear include:

- Grief
- Apathy
- Lack of response to others
- Inhibition of outward activity
- Physical symptoms of anxiety
- Early symptoms of grief, and post-traumatic stress disorder (described later) may appear during this period.

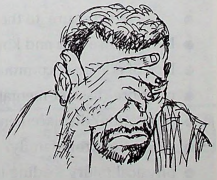
These are observed in about 40–50 per cent of the population.

3. Delayed reactions *(after 6 months)*

These may appear after a few months or may manifest as an intensification of reactions seen earlier (in about 30% of the population):

- **Grief:** Grief is the response of the survivor to loss – loss of close relatives, home, possessions and property. People experiencing grief develop:

  sadness, distress, depression, yearning for what has been lost, anger, guilt, sleeplessness, loss of appetite, severe irritability, suicidal tendencies, being acutely upset and disturbed by anything which reminds them of the loss.



- **Post-traumatic Stress Disorder:** This is a response of an individual having exposure to a severely traumatic event. It manifests in the form of:
  - **reliving the trauma** in intrusive memories or dreams
  - **avoidance** of all activities and situations reminiscent of the traumatic event
  - **numbness,** emotional blunting, and detachment from other people
  - **hypervigilance** (i.e. inability to relax, being always tense), jumping at the slightest noise, fearfulness, palpitation
  - **inability to enjoy** anything
  - **panic reactions**
  - **acute outbursts** of violence may also be present.

4. Other delayed reactions

These are:

- loss of productivity
- family problems
- excessive dependency on external help – alcohol and other substance abuse
- increased vulnerability to stress
- poor physical health
- suicide.

Chances of developing serious psychological reactions can increase because of the following factors:

- 'dose of exposure' to the disaster.
- loss of close kith and kin and valuable property.
- lack of adequate community, social support.
- poor pre-disaster mental adjustment.
- separation/displacement from locality.
- separation from family/primary support group.
- physical injury leading to disabilities.
- absence of emotional support.

EMOTIONAL SUPPORT – PRACTICAL GUIDELINES FOR PSYCHOSOCIAL INTERVENTION

Losses due to the death of a near and dear one, separation from loved ones and material losses are an inseparable part of human existence. Under normal circumstances, everyone goes through this process without much difficulty because the family as a whole joins together to understand the losses. Support from friends, relatives and neighbours occur automatically. Rituals are initiated soon after the death, e.g.: family temporarily suspends some activities, prayers are offered to the deceased, arrangements are made for cremation and rituals are completed on a particular day by conducting the 'shradh' ceremony. All these helps the individuals to understand the personal meaning of loss, and come to terms with reality and to carry on with their lives.

However, in a disaster situation, normalcy of the social structure is lost because each one in the area has been affected. The family as a unit no longer exists for many. This leads to a sense of isolation, helplessness and despair. Therefore, the normal process of mourning and the related rituals do not occur automatically. This means that they have to be provided emotional support.

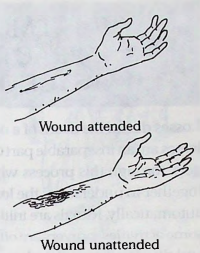
It is important to realise that rebuilding of an individual's life and reconstruction of the entire community following the disaster depend upon the survivor's ability to accept the losses as early as possible. It will help him/her to understand and emotionally accept current reality and thereby work towards reconstruction of life both at the individual, family and community level.

How does this intervention work to heal psychological trauma?

Let us now examine an analogy of a person with an injury. An injury in any part of the body will heal over a period of time because the body has the ability to repair damage. The natural repair process takes some time.

However, if this person gets immediate first aid for his injury (e.g. cleaning the wound with uncontaminated water and covering the wound with sterile or clean cloth) the healing process will be hastened, thereby pain and discomfort will gradually reduce. But on the other hand, imagine a situation where this help is not available and the wound is unattended. The wound is likely to be infected and healing will be delayed, leaving a bad scar. This might even cause some limitation in the normal functioning of that part of the body.

It is important to note that in either case the scar remains but in the former situation the scar is light and does not produce a limitation. In the latter situation the scar is dense and will produce limitation for a longer time.



Similarly, grief due to loss and death requires help to facilitate ventilation/reliving and reprieving. This works similar to a sterile cloth preventing infection, allowing the body to work and heal. Non availability of such help to grieve or neglecting the need to grieve, leaves a scar in the mind. Therefore, it is absolutely essential for every survivor to share grief and to come to terms with the loss. This can be facilitated by contacting survivors and helping them to relive and grieve the losses...

Relationship with people and the community

The supercyclone disaster struck the population who were normal people handling their problems and coping with them in the best way possible. Stress consequent to the disaster results in certain emotional reactions which are natural and normal. Relationship with survivors depends on your rapport with them. Rapport refers to feelings of understanding, interest and concern among two or more people. This can be facilitated by:

- **making sure** that each person understands what the other is saying
- **having genuine respect** and regard for the other
- **being nonjudgmental** and accepting another even if he has different attitudes and feelings
- **establishing trust** by promising only what you can do, not what you would like to do
- **listening several times** to an account of the same disaster
- **recognising** that quite often what is actually said may be a cover for vastly different feelings underneath.

Helping people help themselves

Under normal circumstances most people can take care of their problems. The supercyclone disaster being an abnormal situation, equilibrium is temporarily upset because of emotional reactions. Till such time the survivors apply successful coping strategies and handle their lives competently, they need emotional support and help to identify, define, evaluate and implement a problem-solving strategy to reconstruct their lives. It is like extending help to a person who has fallen on the ground. Extend your hand to help the person sit. Then slowly make him/her stand and walk few paces with him/her. Gradually he/she will walk independently.

Listening

Listening is an important skill to help and provide emotional support. Listening skills can be effective by using the following methods.

- **Look at the person while he/she is talking** : This indicates being interested in what is being said.
- **Respond occasionally while listening:** This makes the person speaking feel that what he/she is saying is being understood and taken seriously. Sometimes it helps to paraphrase what has been said, often giving the speaker another viewpoint.
- **Avoid interruptions:** Let the other person finish his/her thoughts. Do not interrupt unless there is confusion and the details are jumbled.
- **Be tolerant:** Do not prejudge or moralise or condemn. There may interpret how the other person should feel.
- **Empathise:** Share the experiences of the other person as if they are your own. It is based on the sensitivity and ability to recognise when the other person is going through certain feelings or emotional experiences.

Interventions

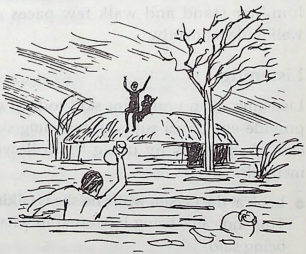
Interventions can be planned at three levels, namely – individual, family and community.

INDIVIDUAL LEVEL

Ventilation: This process involves release of emotions and feelings. It is a very important intervention and should be used as soon as possible after the supercyclone.

■ *STEP ONE:*

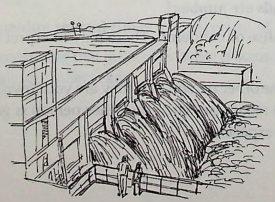
Show the picture of the supercyclone and its fury – destruction and damage



Talk about the picture: This picture is so familiar and vivid in your minds. It must be so painful and traumatic for every one of you to be in this unfortunate situation. Your life has changed so much after this event. Some of you have lost personal assets, house, property, etc. Much worse is the loss of your loved ones like parents, siblings, children, spouse, grandparents and grandchildren. It is so distressing to know that they are gone forever. What remains now are only their memories. Life appears meaningless, full of pain and suffering because the loss is too much to bear. It is understandable that you are sad, grief stricken and preoccupied about your losses.

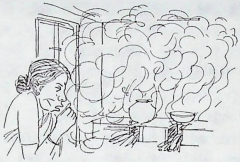
■ *STEP TWO:*

Feelings and emotions associated with loss: unspoken bottled emotions:



Flood Gate: Catharsis

Grief: Need for support



Relief from Suffocation –
Ventilation : Release Pressure

Open your mind to
help healing

To facilitate reliving or re-experiencing of the painful events: While making the survivors talk, the following can happen:

- **Some of the survivors will talk immediately:** Listen attentively. Acknowledge that you understand his/her pain and distress by leaning forward. Look into the survivor's eyes; console him/her by patting on the shoulders or touching. Also keep reminding him/her, "I am with you; be courageous. Its good you are trying to release your distress by crying. It will make you feel better."

WHAT SHOULD YOU DO?

- Listen carefully and attentively.
- Maintain eye contact.
- Acknowledge distress.
- Do not interrupt.
- Support by patting on the shoulders/hold the hand as they cry.

  CAUTION: be sensitive to community norms about touching members of opposite sex.
- Do not ask them to stop crying.

- **Some survivors may not talk/they may be very angry or remain mute and silent:** Do not get upset that they are not talking. Remind them that you understand how they feel, and the pain and suffering they are going through. "It is true that pain is so much that you will feel that there is no point in talking about it. I can imagine how much you miss your spouse/siblings/parents/children/relatives/friends/teacher/neighours/house/cattle/school/roads, etc. Memories of good days you spent with each one must be alive in your mind and coming to your mind again and again. You must be tense inside! Try and let the steam out, I am sure you will feel better."

WHAT YOU CAN DO?

- Do not get upset or anxious.
- Maintain interaction by reminding them about
  - memories of the loved ones
  - pain of separation
  - distress of being alone
  - helplessness
  - isolation.

- **Do the following:** Do not panic or feel rejected. Remain calm; tell them you are here to help them in the best possible way. Acknowledge that you understand their distress; the frustration, emptiness and also the subsequent anger because of the vacuum created by the loss. Share in their grief and console them that losing someone dear is terrible and unfortunate. Also make them understand that they are not to blame for the tragedy and need not feel guilty.

  In case the person does not wish to talk, tell him /her that you will return the next day or in a couple of day. Also tell him/her that you are not upset or angry because he/she did not talk. Meanwhile ask him/her to think about whatever has been told.

- **Use the Destiny Story:** When the survivor is the only one alive, with all others dead, he/she must be feeling angry and guilty. This is when you should use the destiny story to convey that whatever is destined will happen.

"Is zindagi mein hum do din ke mehman hain. Yeh to hakeekat hai. Idhar kabhi hasna aur kabhi rona hota hai. Is sachhai ko man lene mein hi hamari bhakai hai".

(The truth is that each one of us is a visitor in this world. During our stay here there are some moments of joy and some of sorrow. This truth cannot be altered.)

As an example you can narrate a story from an epic like the *Ramayana*: *Lord Rama had gone into the forest and had instructed his brother Laxman to stay in the hut and keep a watch over Seetha Devi. But when the attractive golden deer was seen outside the hut, she insisted that Laxman should go out and bring it to her. He did so and just at that time a mendicant came by. Seetha realised that she should not cross the 'Laxman Rekha' but at the same time she could not refuse him alms. But the mendicant refused to accept the alms with her across the threshold. Hence, Seetha crossed over and was kidnapped by the mendicant who transformed into Lord Ravana. This is destiny. Despite Lord Rama's instructions, Laxman left Seetha all by herself; despite Laxman's caution, Seetha was overcome by her hospitality and ignored the warning. She crossed the threshold and therefore had to undergo a lot of agony.*

> ***Remember:*** *whatever is destined to happen will happen. No matter what we do, we have no control over that. Therefore, let us accept reality.*

Similar stories can be identified from the community and used appropriate to the community – something from the *Koran*, the *Bible*, etc.

To continue interaction, explain further:

Our life is a mixture of joy and sorrow. All of us have our share of both and have to experience this kind of sorrow some day or the other. It's unfortunate that your turn of sorrow has come so early. Tomorrow it could be me. Please remember, all of us will have to go through some experience of loss.

> ***Be alert:*** *Throughout the interview remember to acknowledge that you can understand his/her pain. Keep reminding him/her that the responsibility for whatever has happened does not rest with him/her. For having survived, he/she may feel ashamed and blame him/herself. But this is understandable and normal to the situation. Getting angry on this account is natural.*

Advise the person that:

- Happy memories about the dead makes us remember them more: Trying to remember happy memories can sometimes help in a vivid recollection of the deceased which in turn may lead to an acute sense of loss, sorrow and an emotional outburst of tears. This recollection would include shared past activities, soft loving words, and everything he/she did when he/she was alive.

- Every moment in our life is stressful. Such situations make us feel that life has come to a standstill, feeling all alone. However, the fact is that life should go on.
- The more he/she gives, the more he/she achieves. Once the person has started talking about the loss and personal grief, he/she feels better. It becomes easier to take stock of his/her life and understand the vacuum (a feeling of emptiness) created by the loss. This will facilitate more support to rebuild his/her life.

Hence, the more he/she releases the pent up feelings, the lighter you feel.

To address the other needs of the survivors attempt to do the following:

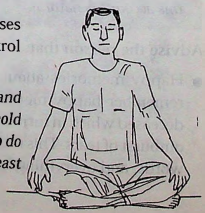
Once the survivor is willing to talk, maintain conversation using the following format:

- How is his/her life and also that of the other family members after the supercyclone?
- Focus on various kinds of loss – details about all the losses he/she and the family have experienced.
- Feelings associated with loss. How does he/she feel about the loss? – Personal meaning of loss, etc.
- Details about the support/help received immediately after the event from friends/neighbours/relief workers, etc.
- How has he/she been recovering? – details about how he/she is handling this situation. (e.g. some individuals become very religious and pray more).
- Effects of the event on health, like physical problems or problems like aches/pains, decreased sleep, decreased appetite, fear, loss of interest.
- How is the future visualised?
- What is the help/support needed? – Should the CLH visit frequently, talk about the event, to understand and solve life problems, etc.?

- **Relaxation Exercises**

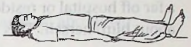
Encourage survivors to undertake relaxation/yoga exercises regularly several times a day. This helps them gain control over their agitation and anxiety.

Instructions: *The person should sit in a squatting posture and place his/her hands on the knees. Then take a deep breath, hold it for a few seconds and slowly exhale. Encourage him/her to do it for 5-10 minutes steadily and slowly. Repeat this at least twice a day.*



The family can undertake this exercise in a group.

Another similar technique very useful for relaxation is:



Instructions: *The individual should lie on the floor and relax his/her entire body. Ask him/her to close the eyes and take a deep breath, and slowly exhale. This exercise should be done for 5 minutes several times a day. Concentrate on incoming fresh air and outgoing warm air.*

Note: **These activities can also be repeated at the end of group meetings in the community settings.**

Practical help for the individual:

- ✔ **Listen** to **authentic information** about the supercyclone.
- ✘ **Do not** believe in rumours that go around during such times.
- ✔ Be **together** with family members.
- ✘ **Do not** send women, children and the aged to far off places for the sake of safety as this separation can cause a lot of anxiety to them and you.
- ✔ **Be with** people from the same village, i.e. people you are familiar with, even if you are in temporary dwellings.
- ✔ **Get back** to a **daily routine** as soon as possible to make you feel that you are in control of the situation.
- ✔ Make it a point to **talk about the supercyclone, share your experiences and feelings with** your family, your parents, friends, spouse, siblings, acquaintances. This will help ventilate/release your emotions.

- ✔ **Restart** activities that are special to your family like having meals together, praying, playing games, singing, etc.
- ✔ **Keep touching and comforting** your parents, children, spouse and the aged in your family. This will not only make you feel good but also make the other person feel the same.
- ✔ **Initiate and participate** in rituals like collective grieving, prayer meetings or group mournings if you have lost a near and dear one. This will help you come to terms with the loss of the person.

- ✔ **Take part in rescue, relief and rehabilitation operations** if you are not hurt or only slightly injured. **Work is a good tonic for healing.**
- ✔ **Keep in constant touch** in case of a member of the family having to be shifted to a far off hospital or residence. Update him/her about yourself as well as find out about him/herself. This gives a feeling of being cared for.
- ✔ **Take time of everyday to relax and have a good time** by gathering together at a central place, playing kabbadi, reading, listening to music, visiting shrines, singing hymns, chanting prayers, reading scriptures.
- ✔ **Make time for yourself** and acknowledge and admit that you will not be always functioning at your usual level of efficiency for a few weeks/months.

Help and seek-help behaviours

Following is a list of behaviour patterns you can use as a guideline to identify individuals or families with whom you can work and probably help: Some out of these may be in a state of mind where they may require the help of a mental health specialist or other professional assistance.

CAUTION: Referring a person to a mental health specialist will require tact and sensitivity because of factors like social stigma, etc. Help may be essential but the individual may not readily accept referral for a variety of reasons. However, the first task is to be able to recognise when it may not be within your own capabilities and skill to help a person and thus you have to refer him/her for professional attention. Such cases should be discussed with the trainer.

Considering alertness and awareness:

The CLH can handle the situation if the client is:

- aware of who he/she is, where he/she is, and what has happened
- only slightly confused or dazed, or shows slight difficulty in thinking clearly or concentrating on a subject.

Consider referral to a mental health agency if the client:

- is unable to give his/her own name or names of people with whom he/she is living
- cannot recollect the date or state where he/she is from or even tell what he/she does
- cannot recall events of the past 24 hours
- complaints of memory gaps.

Considering actions

The CLH can handle if the client:

- wrings his hands or appears still and rigid or clenches his/her fists
- is restless, mildly agitated, and excited

- has sleep difficulty
- has rapid or halting speech.

Consider referral to a mental health agency if the client:

- is depressed and shows agitation, restlessness, and paces up and down
- is a pathetic, immobile, unable to move around
- is discontent
- mutilates him/herself
- uses alcohol or drugs excessively
- is unable to care for him/herself, e.g., does not eat, drink, bathe, change into fresh clothes
- repeats ritualistic acts.

Considering the Speech

The CLH can handle if the client:

- has appropriate feelings of depression, despair, discouragement
- has doubts of his/her ability to recover
- is overly concerned with small things, neglecting more pressing problems
- denies problems or states he/she can take care of everything himself
- blames his/her problems on others, is vague in planning, and bitter with anger that he/she is a victim.

Consider referral to a mental health agency if the client:

- hallucinates – hears voices, sees visions, or has unverified bodily sensations
- states the body feels unreal and fears he/she is losing his/her mind
- is excessively preoccupied with one idea or thought
- has the delusion that someone or something is out to get him/her and the family
- is afraid he/she will kill him/herself or another
- is unable to make simple decisions or carry out everyday functions
- shows extreme pressure of speech – talk overflows.

Considering emotions

The CLH can handle if the client:

- is crying, weeping, with continuous retelling of disaster
- has blunted emotions, hardly reacts to what is going on around him/her right now

- shows high spirits, laughs excessively
- is easily irritated and angered over trifles.

Consider referral to a mental agency if the client:

- is excessively flat (not wanting to move), unable to be aroused and completely withdrawn
- is excessively emotional and shows inappropriate emotional reactions.

Referral Care Centres

The first referral centre for you would be the Primary Healthcare Centre (PHC). The doctor at this centre would be able to provide appropriate care.

However, if you feel that visiting a Psychiatrist is more beneficial and if there is a facility in the neighbourhood, then refer the individual.

FAMILY LEVEL

Practical help for the family

In addition to individual specific interventions, the family as a whole can also be helped simultaneously. This depends on the number of individuals surviving in the family. If some family members are present, encourage them to practise the following activities:

- the Family **as a group** to share the losses
- **Encourage** family members to contact relatives. This will help mobilise support and facilitate recovery.
- **Rituals** like prayers, keeping the dead persons photographs, preserving the belongings of the dead person or persons.
- **Encourage** the survivors to engage in meaningful activity as a family.
- **Recreation** like listening to Radio, TV or visiting melas.
- **Resume normal activities** of the pre-supercyclone days with the family
- **Support each other** at home. Emphasise that the family should regularly undertake activities together at home.

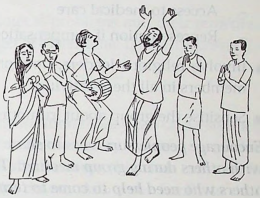
COMMUNITY LEVEL

The following activities help in rebuilding of community life:

- ***Group mourning:*** Grief resolution should occur at the personal, family and the community levels. Group Mourning is a process of mass grieving. It expresses solidarity of the grief-stricken community and facilitates unity and collective action. Such activities should be initially organised on a weekly basis, gradually on a monthly basis, and later annually.

- ***Group meetings:*** Group meetings are important activities where the community as a whole participates. This stimulates the people to think, and brainstorm about various themes for rebuilding the community. This not only helps the community to come to terms with the reality of loss and emptiness but also helps them to initiate collective action and rebuild their lives. It is also an important technique of DISTRACTION.

- ***Folk songs:*** Singing of folk songs about the supercyclone tragedy, its impact and then mourning. This helps people gather in a common place and share their grief. There is a sense of commonality in grief that increases the cohesiveness of the community and motivates them to initiate collective action.



- ***Devotional songs:*** Singing devotional songs like hymns/bhajans, etc. is helpful.

- ***Rally:*** Organise a rally to sensitise the administration regarding delays in implementation of action for restoration, rebuilding, relocation, compensation, etc. It is also a powerful expression of solidarity, "All for one, one for all", show of strength and action to fight for a just cause.

If family members are not available or if he/she is the only survivor with children or is alone or is old, then the interventions at the individual level should continue in addition to these activities.

If the survivor is a child or a minor, encourage others in the village to take care of the child. If there are no takers, think of relocating him in *Mamtha Gruha* (Home for children without parents and women who have lost their families).

Remember:

- **Encourage** the family or the survivor to get back to the routine kind of activities done by him/her/them during pre-supercyclone days.

- **Group participation** for rebuilding facilitated by *'Shramadhan'*, for e.g.: clearing bushes to create a playground for children, putting up a temporary hut for a school; providing food for those who are the only survivors or those who are disabled or dependent.

- **Encourage** survivors to discuss about local problems and initiate collective action like:
  - Rebuilding schools
  - Roads
  - Restoration of power/water
  - Rebuilding houses
  - Access to medical care
  - Representation if compensation payments are delayed.
- Involve religious leaders, opinion leaders, professional mourners, panchayat members in all these activities.
- Sensitise the group about 'rumours' and ways to handle this as a group.

Encourage people/survivors to share their success stories (recovering from the loss) with others during group meeting. This will make them feel good and also benefit others who need help to come to terms with reality.

Issues likely to come up during your work in the field:

Rumours may become rampant following disasters and they often have a negative effect on the mental health of the affected population. The daily visits described earlier can be utilised for rumour control and clarification. Also information meetings can be organised to communicate available, authentic information.

It is advantageous to speak to the families (including children) in their own homes (temporary or permanent), about their mental health problems. During these visits it is important that the CLH **accepts hospitality of any family (like drinking water, juice, coffee/tea, etc. if offered). This will help to build a rapport.**

The local community on its own, starts responding appropriately and effectively to the disaster by using healthy coping strategies. So, one important task of the CLH is to encourage, initiate, sustain and guide such local community action. The CLHs can take the initiative to organise community-based actions specific to the local culture in order to alleviate mental suffering. These activities could involve: chanting prayers, singing hymns and folksongs, group celebration of rituals/ceremonies, group rituals/ceremonies, group celebration of religious activities, performing street plays, folksongs, skits etc.

It is natural to have many misgivings about the encounters with survivors: "Will they be cooperative? Will they reject me? Will they not get angry with me for making them talk about painful things? Am I doing something wrong by focussing their mind on something which is best forgotten? How am I different from crowds who visit places of disaster just out of morbid curiosity?" Also, the fear of facing the affected people, feelings of helplessness in the face of the magnitude of the problem may also be experienced by the CLH.

Note: What has to be constantly remembered is that one's own genuine concern and care about human suffering and the need to contribute one's efforts to alleviate suffering should be the overriding factor.

Some workers may fear that one might lose control and start crying while speaking to affected people. It is perfectly normal to have this fear and there is nothing wrong in crying along with people.

Like any problem, early detection of psychological problems and their remedies/ alleviation can prevent them from growing bigger at a later time. This is the preventive aspect of mental healthcare.

Compensation

Sometimes issues like who should handle compensation money can cause conflicts, e.g. a young widow might feel that she should handle the money, whereas the mother- or father-in-law or brothers-in-law could take offense about this. It is common for parents of the deceased to feel helpless and let down. Allow the family to think through the problem and come to consensus themselves. It is important to make the family feel together and cohesive and take consensus decisions.

***Note:** Best way to deal with the above issues - you should not take sides or decide for the family about any issue. Be non- judgmental and neutral.*

Other supports

Practical help for the individual and the family:

After contacting the survivor, establish a rapport, facilitate reliving and grief resolution, look for or enquire about the need for any specific help which could be:

- Compensation
- Guidance to get compensation
- Help in filling forms/opening a bank account or post office account.
- Practical help like getting forms/accompanying survivors to the office or helping the individual open a bank account, etc.
- Medical help if need be.
- Request/Mobilise help from neighbours/others to support the single young survivor or old destitute survivor, etc.
- Help with agricultural work
- Food-for-Work Programme
- House building, fishing, etc.

Coordination with other agencies:

As part of psychosocial interventions, in addition to providing help for emotional difficulties, help to network and coordinate with other agencies is also important. For e.g., coordinating with NGOs working on specific rehabilitation and reconstructing activities or other governmental agencies.

Tips to make you an effective community worker

DOs

- ✔ Visit families regularly
- ✔ Accept food or drinks like coffee or tea if offered
- ✔ Help survivors to get medical care or other help if needed.
- ✔ Provide clear guidance about compensation or ways of getting it.
- ✔ Provide practical help whenever necessary.
- ✔ Facilitate networking among survivors.
- ✔ Contact relatives (e.g. writing letters) and appeal to them to meet and support survivors.

DON'Ts:

- ✘ Do not promise things you cannot do or things beyond your control.
- ✘ Do not take decisions for them for e.g., marriage or money handling, etc.
- ✘ Do not get upset with the behaviour of survivors. Sometimes they are unreasonably angry/blame you for causing trouble to them by your frequent visits, or at times they might be very demanding.
- ✘ Do not miss appointments.
- ✘ Do not overburden yourself with lot of work.
- ✘ Do not take sides in family conflicts.

> ***Attention***
>
> *Community level helpers need to take extra care when providing help to certain special groups in the affected population. This group may not volunteer for help readily, for example, children may not talk freely or remain withdrawn. Similarly, marginalised persons may not come forward for help because of discrimination by the local community. It is important therefore, to note that disaster has a quality of 'equity' in all humans and therefore the healing process automatically should have equity.*

Conclusion

This section has outlined the various ways of understanding the behaviour of the disaster-affected population and measures that you can take at the level of individual, family and community.

The Appendix Section which follows has the following information:

1. the **group activities** you can use to facilitate psychological understanding.
2. **illustrative situations.**
3. **how to care for yourself?**

SUMMARY

Levels of Intervention

Family
- Support each other
- Stay together
- Contact relatives
- Display photo/ belongings of the dead person
- Family grieving

Community
- Group mourning
- Folk songs
- Group meeting
- Voluntary work
- Rally

Individual
- Ventilation
- Catharsis
- Coming to terms with loss
- Seek support/ Network
- Resume routine
- Avoid conflicts

Administration
- Compensation
- Help for reconstruction
- School
- Hospital
- Home

NGOs
- Networking
- Coordination
- Relief & Rehabilitation
- Schools
- Homes
- Innovative agricultural initiatives

Activities of the CLH

APPENDICES

Appendix 1

GROUP WORK

Group work is a powerful activity to initiate collective action. Experience suggests that in a disaster population survivors have different needs. Responding to such needs on an individual basis can sometimes be controversial, for e.g. in a disaster population, the community consists of various strata of people. It is common for people to demand for a particular type of help. Some might even refuse to participate in community building activities because of their social status before the disaster. This can be barrier for forward movement. Hence it is imperative to maintain equity in rebuilding activities and not allow people to bring in their individual bias because of their social status. Such a delicate issue can be handled by encouraging the survivors to participate in games focussing on problem-solving techniques.

The knot game is one such game that can be useful in such activities.

How to play:
Knot game is a creative way of generating or stimulating a problem. Select even number of participants, i.e. 10 or 12 members, and create separate male and female groups. Give them the following instructions:

1. Stand in a circle close to your neighbouring partners on the left and right.
2. The knot can be created by each holding the other's hand gently but firmly.
3. Do not hold the hand of the person who is standing on to your immediate right or the left. Also instruct them not to hold both hands of the same person.
4. Do not leave the shake hand grip till the end of the game.

What do you expect?
Formation of one circle or more, with participants holding hands and facing the inside of a circle.

What is the conclusion?
After completion of the game encourage the participants to talk about the various steps/processess involved in formation of the circle. It will invariably be found that the final result of forming the desired circle was achieved because of the following:

1. Cooperation of the group
2. Leadership
3. Hardwork
4. Examining alternatives
5. Some problems can be solved, while some cannot.
6. Managing stress
7. Working in a goal directed manner
8. Thinking creatively, etc.

Following rules correctly
Commitment to participate and learning to solve problems.

It is important to link up this issue as the problem and encourage group members to collectively apply their

mind to find common solutions to rebuild their lives. The topics that can be used to understand and work upon problem-solving methods for the community as a whole follow:

Issue	Action
Reconstruction	A way to move forward
What next	Examine alternatives
Now or Never	Need for collective action
Religious meaning	Grief resolution
Working with NGOs	Networking
Working with Administration	To make administration/assertively demand action, etc.

Appendix 2

ILLUSTRATIVE SITUATIONS

Illustration 1:

Mr A was a very hard working, successful diesel mechanic and he owned a small workshop. He was earning about Rs500-800 per day and lived with his family consisting of his old father, wife and 2 sons. On the fatal day he was in the village and was very apprehensive about the consequences of the storm and rising water level. He lost his father, wife and 2 sons during the cyclone. He also lost his prosperous business, which was located in Erasama. Since then he is withdrawn, does not mix with others in the village; even when someone talks to him he hardly speaks, cries silently from time to time, feels that his life is not worth living and feels that it would be better if he was dead. His sleep is disturbed and he wakes up in the middle of the night because of the dreams of that fateful night. Even after 8 weeks of the cyclone, Mr A continues to be withdrawn, looks dull and grief-stricken. As our team was talking to him he reported that the most distressing aspect of the entire episode was his helplessness in that situation. He could not save and protect anyone of his family members. He, however, was able to save his brother's son. But this makes him feel very guilty that he could not do the same for both his sons.

Mr A feels depressed and cries very often. He feels ashamed that he is alive while all his family members are no more. He was hoping that at least his younger son will survive, but God has not been kind - his younger son succumbed to pneumonia. Mr A feels his life has no meaning and finds it extremely difficult to handle loneliness. He however works in the 'Food-for-Work' Programme and earns Rs10/- + $2\frac{1}{2}$kgs of rice. He finds it very difficult to accept this option and quality of life. Nevertheless he feels that he should work atleast to feed himself.

Key aspects of this illustration:

- A middle class well settled individual who was a successful business man.
- Multiple losses of all his family members and business.
- Feels guilty that he is alive while others in the family are no more.
- Feels depressed, cries often, and questions himself whether he is a weak person because of this
- Though slow and withdrawn he has decided to work in the 'Food-for-Work' Programme because he has to survive.
- Haunted by recurrent memories of the traumatic event.

Illustration 2:

Ms S is an 18-year-old lady who had completed 10 years of schooling. She was married to a man who was the most educated in that village. She had dreamt of a beautiful life ahead and was happy that God has given her a very understanding, highly qualified and caring husband. Little did she realise that all her dreams would be

shattered by nature's fury on 29 October 1999. Ms S reported that she has not heard from her husband since 29 October and hopes that he will return some day. She however saw the bodies of her father-in-law and two of her brothers in-law.

Ms S has a faint smile of hope on her face and still entertains the idea that her husband will return some day. This attitude of hers amuses her neighbours in the village and her own relatives. They often think that there is something wrong with her because she believes that the death of her husband may not be true. She continues to wear a *bindi*, bangles and adorns her hair with flowers.

As we spoke to her about the traumatic event she did not seem distressed. Most of the people around remarked that she is totally indifferent because she smiles whenever people talk to her about her husband. As we continued to talk to her about her marriage, husband and what she had thought about their future, tears started rolling down her cheek slowly and steadily. She said that her husband had completed MA in arts and was due to appear for the Orissa administrative service shortly. She remarked, "How can I believe that this will not happen?" and continued to weep. She also reported feeling less energetic, sleepless, and was eating less. She told us that her mother-in-law, brother-in-law and other relatives had decided about the 'Shraadh' ceremony about a month later. They have planned this because otherwise they will have to wait for at least 90 days to presume that her husband is no more. Ms S continued to weep and said, "If this is what God has destined for me what can I do? I have to accept His verdict and I will do something meaningful in my life". She plans to assist teachers in the school and help volunteers to take care of children in *Mamtha Gruha*.

Key aspect of this illustration:

- A young responsible woman, loved and admired by her husband and in-laws.
- Multiple losses of her house, her husband, father in-law and several relatives.
- Did not show any feelings or grief about the loss initially.
- As the interaction continued she wept continuously.
- Reported feeling weak, sad, and hoped for another cyclone and wished that she be swept away.
- Wants to assist school teachers in the care of children, and volunteers to take care of orphaned children and destitute women.

Illustration 3:

Mr P is 40-years-old and was a happily married man with three children. He lived with his father and mother. He worked as a labourer and was contended with this life, despite poverty. Little did he realise that his satisfied life and feeling of contentment would soon lead to helplessness and despair after the cyclone. He says he is devastated by nature's fury. He cannot tolerate anymore – his house was washed away and his entire family disappeared in a short time. The trauma has caused such a deep hurt in him that he has migrated to a village 12 kms away from his native village. His new friends are very concerned about him because he remains dull and preoccupied most of the time. They describe him as a man who walks and follows commands but has no life in him. They also say that he does not express any feelings like sadness or anger even though others with similar trauma show it. When we interacted with him he answered in monosyllables. He admitted nodding that he cannot handle loneliness and is unable to accept the devastation in his life. He wonders why he was given such a harsh punishment by God and thinks he does not deserve it. Even though he was verbalising very little he was able to speak out his mind expressing no feelings about the event. He feels that he has reached a point of no return and does not know what to do about it. His friends in the new village keep talking to him, support him, they give him food and encourage him to get involved in some activities, while constantly reminding him that he should talk about what and how he feels.

Mr P responds by nodding that he remains awake most of the night, feels very tired and disinterested, eats less and moves around slowly. He does report feeling sad but does not elaborate.

Key aspect of this illustration

- A middle aged man who lived a contended life despite poverty.
- Devastated by multiple losses of his house, three children, wife and parents.
- Remains withdrawn, dull, preoccupied and talks very slowly in a low tone voice.

- Does not show any feelings
- Migrated to another village and is receiving support from friends who did not know him before the cyclone.
- Has not been working for his living since the event but passively responds to instructions from his friends.

Illustration 4:

Mrs M is a 30 year old married lady who lived happily with her fisherman husband. They had two children and the family was reasonably well off financially. Since she had two daughters, Ms M longed for a male child and is currently pregnant. The recent cyclone has devastated her life completely. Both her children and father in-law were washed away by the massive tidal waves and her husband who went to sea never returned. Ms M sits alone wondering what has happened to her and her family. She feels isolated and helpless all the time. She recollects all her family members. All her belongings have been washed away and there is no trace of her house. She says that her tears have dried up and asks why God has been so cruel. She wonders why disaster struck her at this stage of her life and is worried as to who will take care of herself and her unborn child. She currently lives in a family of all widows who have lost their husbands. The head of the family, Ms N has accepted her as another daughter-in-law and has been caring for her since the disaster struck Ms M's family.

Ms M reports feeling sad, cries all the time, has not been in good health and traumatic memories keep hounding her. She says she would have killed herself but for the support she received from Ms N. Ms M has not been working in the 'Food-for-Work' Programme, does not want to live in the temporary shed likely to be put up as a measure of relief because she feels extremely scared. She has to be forced to eat on a regular basis.

Ms M is unsure about her future, has lost direction in her life and is totally dependent on the foster family. She also says that her parents who lived in another village with her brother are also no more and feels this entire life ahead looks dark for her. She continues to bear her chest and cry.

Key aspects of this illustration:

- 30 year old housewife from lower middle class.
- Currenty pregnant and with multiple losses of her house, husband, children, parents.
- Suffers from depression, sleeplessness, constantly preoccupied with loss and has recurrent traumatic memories.
- Has not been working and refuses to live in a temporary house erected as part of the relief programme.
- Lives with her neighbours where 4 ladies have lost their husbands.
- Helps in household activities as and when necessary.

Illustration 5:

Mr A M, a 45-year-old married belonging to the upper middle socio-economic strata, lived with his wife and two children. The family lived in a good house with reasonable comforts. Following the disaster, he says his house does not exist and all his valuables have been washed away. He reports that the entire family lived on wet rice for three days and they had to be content with 2 pairs of soiled clothes which they could salvage. Though the structure of his house exists there are no doors or windows and he feels miserable to live in such conditions. He feels that he and his family members have to accept this verdict of God and he has no complaints. He does report feeling tense, anxious, and has headaches from time to time. He also feels like crying but he feels that by crying, he will let his family down and cause more grief to his wife and children. He also thinks that his family members will consider him a 'weak man' and lose hope for the future. He thinks that the best remedy for him and his family is to forget this entire episode and look at life positively. Despite 8 weeks after the disaster Mr A M has not talked about this event with his family members. After he goes home the entire family consisting of wife and two children form three isolated islands of their own, and remain silent and look at the floor.

Key aspects of this illustration:

- Upper middle class family.
- Material losses.

- Feels tensed, angry, worried, sleepless and has recurrent memories of the trauma.
- Feels like crying but never did so.
- Feels that if he talks about this event, he might cause more grief.

Illustration 1:
How can you help this person:

The illustration clearly reveals multiple losses, sadness and grief consequent to that, guilt that he is alive while others are no more and feeling of not being in control of the situation.

- Firstly help him ventilate his feelings and emotions.
- Reassure him that crying over the loss is not a sign of weakness.
- Help him understand that often as human beings we can be in situations, e.g., supercyclone where we feel we are not in control of what is happening around us.
- Emphasise that it would be better for him to share his feelings with friends, relatives, and others.
- Reassure him that he is not responsible for what has happened in his life and that it is only human to feel helpless and guilty. Help him understand that he has done his best to his save children.
- Meet him regularly at least once a week.

Illustration 2:
How can you help the person:

Hope of return remains strong when survivors do not see the dead person's body and acceptance of death is very hard. Therefore do the following.

- Contact her on a weekly basis and encourage her to ventilate her feelings
- Help her understand that chances of her husband being dead are very high and therefore emphasise the need to grieve.
- Involve family members and others in the village to support her and to talk to her.
- Positively reinforce her ideas to get engaged in helping other children or destitute women in *Mamtha Gruha.*
- Inform family members to maintain a close watch on her because such individuals can become 'suicidal'.
- Refer her to the doctor if she continues to be in the same state despite meeting her regularly.

Illustration 3.
What can you do?:

- Meet him regularly and help him talk about his loss.
- Facilitate ventilation and catharsis using the destiny story.
- Help him relive and regrieve as often as possible.
- Emphasise that he should resume work and mix with people.
- Help him understand that he is not responsible for the calamity in his life in any way.
- Encourage him to participate in group activities/bhajans and mass grieving activities.
- If he continues to be the same despite regular visits after 2 weeks, suggest him to see a doctor or personally you can take him to the doctor for further evaluation.

Illustration 4:
What can you do?:

- Meet her regularly, preferable with a lady CLH.
- Help her relive and grieve.
- Facilitate ventilation/catharsis.
- Emphasise the need for adequate nutrition and regular ante-natal check ups and encourage her to have the baby at the hospital rather than at home.

- Encourage her resume normal activities like cooking, working, mixing with people, talking about her feelings and future.
- Encourage her to participate in group activities at the community level.

Illustration 5:

- Encourage him to ventilate his feelings and emotions.
- Help him recognise that crying or showing emotions is not a sign of weakness.
- Clarify that by talking about the loss to his wife and children, he will enable them to ventilate their feelings also.
- Encourage him to understand, accept the loss rather than forget the loss.

Appendix 3

HOW TO CARE FOR YOURSELF?

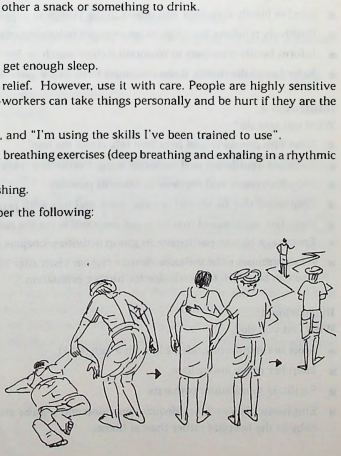
Be it the logistic help or the emotional support, the Community Level Helpers (CLH) do heavy and demanding work. The day in and day out stressful work does pose a threat to their personal mental health. They need every day mental health care as well as specific interventions like debriefing to stay clear of excessive stress and burnout.

The following are suggestions to manage your stress during disaster work:

- Develop a 'buddy' system with a co-worker. Agree to keep an eye on each other's functioning, fatigue level, and stress symptoms. Tell the buddy how to recognise when you are getting stressed - ("If I start doing so-and-so, tell me to take a break"). Make a pact with the buddy to take a break when he/she suggests it, if the situation allows it.
- Encourage and support co-workers. Listen to each other's feelings. Do not take anger too personally. Avoid criticism unless it is essential. Keep telling each other, "You are doing great"; "Good job", etc. Give each other a touch or pat on the back. Bring each other a snack or something to drink.
- Try to get some physical exercise.
- Listen to music, read books, etc.
- Try to eat frequently, in small quantities and get enough sleep.
- Humour can break the tension and provide relief. However, use it with care. People are highly sensitive during disaster situations, and victims or co-workers can take things personally and be hurt if they are the brunt of 'disaster humour'.
- Use positive 'self-talk' like, "I'm doing fine", and "I'm using the skills I've been trained to use".
- Practise relaxation techniques frequently, e.g., breathing exercises (deep breathing and exhaling in a rhythmic fashion).
- Take breaks if you find effectiveness diminishing.

On long assignments away from home, remember the following:

- **Make your living accommodations as personal, comfortable, and homely as possible, unpack bags and put out pictures of loved ones.**
- Make new friends. Let off steam with co-workers.
- Stay in touch with people at home. Write or call often. Send pictures. Have the family visit you if possible and appropriate.
- Avoid alcohol and tobacco as much as possible.
- Keep a diary of your activities and experiences.



INFORMATION MANUAL 2

PSYCHOSOCIAL CARE *for* COMMUNITY LEVEL HELPERS

SUPERCYCLONE

Disasters pose a monumental challenge to the total community. For too long, psychosocial consequences have been neglected. The ORISSA Disaster like all disasters, poses the enormous challenge of REBUILDING THE PEOPLE, RECONSTRUCTION NOT ONLY OF SHELTERS AND LIVELIHOOD but OF THE HUMAN SPIRIT.

The information booklet is unique because:

1. It addresses mental health care;
2. It is made available soon after the disaster;
3. It is user-friendly;
4. It is a collaborative effort of professionals, voluntary agencies and people – both survivors and concerned.

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INFORMATION MANUAL 1

PSYCHOSOCIAL CARE *for* INDIVIDUALS

SUPERCYCLONE

INFORMATION MANUAL 1

PSYCHOSOCIAL CARE *for* INDIVIDUALS

SUPERCYCLONE

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FOREWORD

Disasters pose a monumental challenge to the total community. The worst affected are the people whose lives are disrupted severely by the enormity of the tragedy. Their recovery capacities are stretched beyond normal human limits. Equally disturbing is the disruption by the social, economic and political structures.

For too long, psychosocial consequences have been neglected. It is only since 1984, after the Bhopal Disaster, that both professionals and administrators have awakened to the need to focus on mental health care of survivors of disasters.

The ORISSA Disaster like all disasters, poses the enormous challenge of REBUILDING THE PEOPLE, RECONSTRUCTION NOT ONLY OF SHELTERS AND LIVELIHOOD but OF THE HUMAN SPIRIT. This information manual is part of a major initiative in the overall relief and rehabilitation programme, to organise mental health care. It is the joint effort of ActionAid India and NIMHANS, Bangalore, going beyond the initiative of OXFAM, India, after the National Workshop held in December 1998.

The information booklet is unique because:

1. It addresses mental health care;
2. It is made available soon after the disaster;
3. It is user-friendly;
4. It is a collaborative effort of professionals, voluntary agencies and people – both survivors and concerned.

We sincerely appreciate the contributions of all the authors, Suresh M B, the artist and the Books *for* Change team for the editorial and production assistance.

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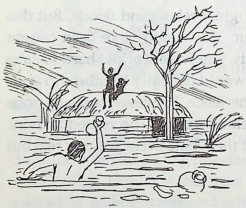
SUPERCYCLONE AFFECTED INDIVIDUAL - DISASTER AND MENTAL HEALTH INFORMATION

Dear Friend,

You, your family and community have recently experienced the most distressing disaster, i.e. the supercyclone. The horrific effect of this supercyclone will be still fresh in your mind as well as in that of others affected like you. Help has been coming in from different quarters, to as many people as possible. The painful experience and its consequences are personal.



The people around you would be reacting to this unexpected event in different ways. Many a time you will find yourself alone, not even able to talk about the disaster to others, especially since several of them too are not in a position to either help or comfort. In this hour of need, we the mental health professionals from the National Institute of Mental Health and Neurosciences (NIMHANS) recognise the feelings and emotions in you and others around you. We feel it is imperative and vital for you to recognise these feelings and personally make an attempt to recover in a healthy and positive manner.

Towards achieving this, the following information, which has been compiled from the experiences of people who have undergone various types of disasters in the past, would be helpful. The fact is that there is commonality between those affected people and yourself. Knowing this should reassure you. The information given will provide you a better understanding of the difficulties you could face in future in your efforts to reorganise/rebuild your own life and that of your family. Here are suggested ways to recover and rebuild your life:

Immediate (at the time of disaster)

It is necessary to be aware of the various reactions during and after the cyclone. This will help you understand your emotions, your behaviour and the recovery methods adopted by yourself. The main aim of this understanding is to help you and others recover in a healthy and positive manner. During the cyclone each one of you has experienced the massive loss of either human lives or property or shelter or cattle, or all. The emotional reactions to the supercyclone and the loss are often not recognised and understood by many as being natural and expected. Let us examine the immediate reactions of people to the supercyclone:

- ***Shock and or Disbelief***

Orissa has often faced natural calamities like drought, cyclone and floods. But this supercyclone struck at the most unexpected hour. You would have been caught unawares – totally unprepared. But, in spite of this, you have worked hard to save your life as well as that of others. Similarly, there would certainly be others in your community who have gone through the same experience. However, some persons in the community would have reacted with shock and shown decreased activity. Another common emotional reaction is to feel that the whole event was not real but a bad dream, i.e. one of total disbelief.

- ***Panic***

Panic at the time of undergoing very severe stress is common and normal. Hence for people to panic at the time of a cyclone is normal. Just as an example, imagine a large number of people entrapped by the surging floods of water in a small space. It would only be natural that all of them will panic and try to get out at the same time causing a stampede.

After the Cyclone

- ***Shock***

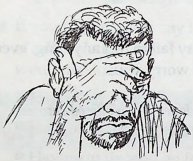
You find it difficult to believe that the disaster has actually happened – that the cyclone has ripped through leaving behind so much death and destruction. All routine activities have come to a standstill due to the supercyclone and this adds to feeling lost. The all round confusion further intensifies this.

• *Vigilance*

You will find yourself hyper alert - responding to each and every sound and/or light in the surrounding, constantly on vigil for signs of further disasters. This can prevent you from sleeping. Sometimes you can become irritable and angry. Let not this disturb you. It is only a protective behaviour which usually decreases gradually over a period of time (few weeks).

• *Despair*

In spite of the major disaster being over, often you may feel helpless and abandoned and look forward for some form of rescue. Even in a crowd you can feel lonely. You can feel like going away to a place of refuge. But the safety of your children, old parents and family overtake you and become more important than your personal safety. People in disasters try and stay together giving and taking from each other help, support and drawing strength from this.



• *Elation*

Often you can feel very happy that you have survived. But at the same time this feeling puzzles and disturbs you. You keep wondering, "How is it that I am feeling happy and relieved instead of feeling depressed when I have `lost' a near and dear person? What right do I have to survive when others have suffered so much of loss?" But do not feel guilty about feeling so. It is a normal feeling of survivors.

• *Guilt*

Feelings of guilt and repeatedly blaming yourself for having survived keep coming back ("I did not save my family/friends") especially if other near and dear ones have been injured or have lost their lives in the supercyclone.

Reliving the experience and flashbacks

Several times hereafter, you can remember and re-live/ experience the disastrous supercyclone repeatedly including the raging wind, swirling of the trees in the gale, gushing sound of the floods, thundering sounds of trees getting uprooted, shrieking of people. Small sounds may trigger these experiences. This can happen more at nights. Being involved in relief work can also trigger off 'these attacks'. Having to remove mutilated bodies or identify dead relatives, may send you into a state of panic.

Different ways of reacting

You may find others being 'numb and empty'. They may fail to feel anything, even the loss of a near and dear one. This may surprise and worry you.

Krishna, a 40-year-old man, had lost his mother in the cyclone. When offered kerosene to burn her he said, "I would rather use it to cook food for my family".

A few others may withdraw into themselves totally. They may not eat or sleep for many days.

Poor physical health

It is common for people to feel physically weak, easily exhausted, have symptoms like headache, chest pain, rapid heart beating, sweating, poor appetite for a few weeks/months after the disaster.

However, in some:

1. There may be repeated images and recall of the cyclone, decreased sleep, reduced appetite, lack of concentration and intense irritability or fatigability may continue or increase over time. This could interfere with daily functioning and prevent them from re-organising/rebuilding their lives. These people need professional help from mental health practitioners.
2. Very few can have a more severe reaction – excited, confused, wandering, saying same things over and over again.

They need to see a doctor or a mental health professional.

Future

Some of the difficulties you/others may face in future:

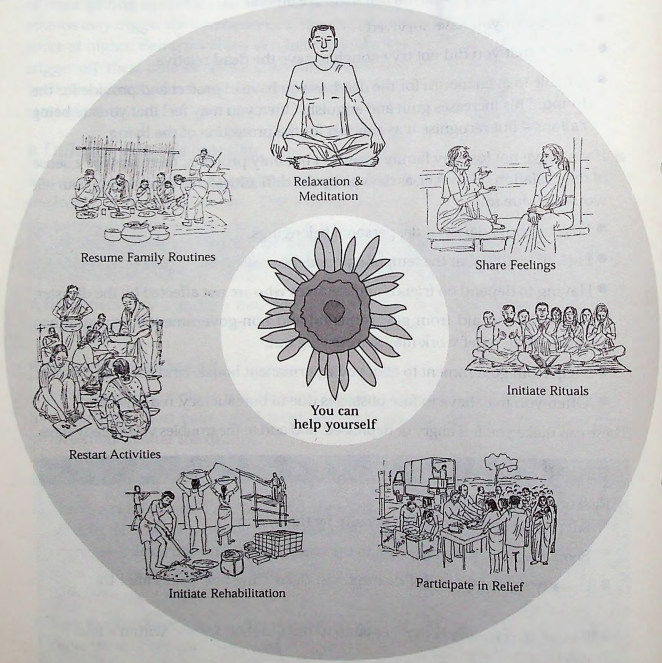
- If you have lost a near and dear one like spouse, child, parent or sibling you will feel:
  - Why me and my family, when there are others?
  - Guilty that you have survived.
  - Guilty that you did not try enough to save the dead relative.
  - Unable to even mourn for the dead, as you have to protect and provide for the living. This increases guilt and anguish. Often you may feel that you are being callous – but recognise it as concern for the protection of the living.
- If you have not lost any family members but only property, there may be a sense of relief, elation. However, as days go by, the difficulties in re-establishing yourself would be due to:
  - Loss of house, land, cattle, personal belongings.
  - Lack of facilities, at the temporary residence.
  - Having to depend on friends and relatives who are not affected by the disaster.
  - The help and aid from governmental and non-governmental organisations involved in relief work may start drying out.
  - Help from government to allot you a permanent house, land, job may be slow.
  - Often you may have to face obstacles due to bureaucracy, red-tape, etc.

These can make you feel angry or depressed, and add to the troubles you already have.

RECAP

Reactions to a Cyclone

- All people are affected emotionally by the cyclone.
- People react in different ways to the crisis, loss and the survival.
- Usually the symptoms of distress start decreasing few weeks after the cyclone.
- People start feeling better – enough to rebuild their lives – within a few weeks.
- Those who continue to be affected and are unable to rearrange their lives, need professional help.


Relaxation & Meditation
Resume Family Routines
Share Feelings
You can help yourself
Initiate Rituals
Restart Activities
Initiate Rehabilitation
Participate in Relief

RECOVERY MECHANISMS

Symptoms start decreasing in most people in a few weeks when they initiate some actions to reorganise and rebuild themselves. After a few weeks/ months, even though the memories of the disaster remain, they do not stop you from going ahead with your life.

HOW CAN YOU RECOVER?

To promote recovery we suggest the following to be done:

At a Personal Level:

- ✔ **Listen** to **authentic information** about the supercyclone.
- ✘ **Do not** believe in rumours that go around during such times.
- ✔ Be **together** with family members.
- ✘ **Do not** send women, children and the aged to far off places for the sake of safety as this separation can cause a lot of anxiety to them and you.
- ✔ **Be with** people from the same village, i.e. people you are familiar with, even if you are in temporary dwellings.
- ✔ **Get back** to a **daily routine** as soon as possible to make you feel that you are in control of the situation.
- ✔ Make it a point to **talk about the supercyclone, share your experiences and feelings with** your family, your parents, friends, spouse, siblings, acquaintances. This will help ventilate/release your emotions.

- ✔ **Restart** activities that are special to your family like having meals together, praying, playing games, singing, etc.
- ✔ **Keep touching and comforting** your parents, children, spouse and the aged in your family. This will not only make you feel good but also make the other person feel the same.
- ✔ **Initiate and participate** in rituals like collective grieving, prayer meetings or group mournings if you have lost a near and dear one. This will help you come to terms with the loss of the person.

- ✔ **Take part in rescue, relief and rehabilitation operations** if you are not hurt or only slightly injured. **Work is a good tonic for healing.**
- ✔ **Keep in constant touch** in case of a member of the family having to be shifted to a far off hospital or residence. Update him/her about yourself as well as find out about him/herself. This gives a feeling of being cared for.
- ✔ **Take time everyday to relax and have a good time** by gathering together at a central place/point, playing kabbadi, reading, listening to music, visiting shrines, singing hymns, chanting prayers, reading scriptures.
- ✔ **Make time for yourself** and acknowledge and admit that you will not be always functioning at your usual level of efficiency for a few weeks/months.

At the Community level:

Immediate

- ✔ **Disseminate authentic information** about the disaster and the help available either by going around personally or using loudspeakers or posters/placards.

- ✔ **Organise groups for rescue operations. Help** to remove debris, shift people to a safe place, help the disabled, and share food, water and medicines. **Identify** groups for each activity and a leader for each group. The whole village should be involved in planning rescue, relief and rehabilitation operations.

- ✔ **Listen to and encourage** other people talking about the disaster, etc.
- ✔ **Encourage** the group to focus on the special groups like the children, women, disabled and elderly.
- ✔ **Organise** people to present their **needs** and **difficulties** to the administrators in a collective manner.
- ✔ **Bring together** people of the community for **sharing of grief/community mourning.**
- ✔ **Organise self help groups** to procure aid and to discuss emotions associated with the disaster. Self-help groups should have people with similar needs. For example, people who have lost family members could join together to grieve and later work on it.

- ✔ **Organise weekly meetings** to **share information** and sing together.
- ✔ **Prepare yourself** for delays and difficulties.

In Future

- ✔ **Seek information** about help extended and organise groups to represent your village to seek help/aid.
- ✔ Actively **mobilise action** for reconstruction and rehabilitation work. Take care that this includes all aspects of a community to be disaster proof, where agriculture, electricity, health care, education, etc. are concerned.
- ✔ **Continue dialoguing** with government officials and NGOs for a persistent effort on relief and rehabilitation.

SPECIAL GROUPS

Children, women, old people and the disabled are special groups of people who need special attention. Let us first talk about children.

YOUNG CHILDREN

The child's mind and emotional state are not yet developed enough to solve problems as an adult. A child needs to discuss and sort out his/her fears with an adult because he/she probably does not realise there are other options. He/she becomes dependent on adults physically and emotionally. Often the child cannot comprehend the consequences of any disaster – leave alone even this supercyclone. There is a sense of losing his/her identity. However, events that take place during a disaster, like darkness, loud noises, commotion, loss of shelter, separation from caring persons like mother, father and siblings, deprivation of food, and drink, experiencing the cold, and so on, do impact the child much more than it would an adult.

- Very young pre-school children react by:
  - Crying
  - Clinging to adults, especially known people.

Later, often they are known to:

- Cry and excessively cling on to some family member due to the fear of once again losing whatever security they have.
- Become listless and apathetic, especially if they do not get warmth and a feeling of security from the surviving adults.
- Have disturbed sleep and unhealthy feeding problems.
- Behave like a smaller child much younger than his/her age. For example, a child of three years may stop talking and may insist on being carried and fed like a one-year-old child or an eight-year-old and restart wetting the bed at night.

SCHOOL GOING OLDER CHILDREN

Following are the experiences these children can show:

- Have nightmares or talk about the cyclone repeatedly. They are unable to get a sense of control over what has happened.
- Regress and develop bed-wetting or thumb sucking.
- Refuse to go to school or even separate for a short while from the remaining family members for fear of losing them.

- Decline in scholastic performance due to preoccupation with and reliving constantly the disaster scenes.
- Physical symptoms like abdominal pain, headache, movements of the body, which is one way of communicating distress.
- Feel responsible for the death of the near and dear one(s) and become depressed and withdrawn, with reduced sleep and appetite.
- Disturbed and angry over what has happened and retaliate with difficult behaviour, like irritability, quarrels, lying, disobedience and at times stealing.

Sumitra, a 9-year-old impish girl, after the cyclone seems to be coping well – doing her routine, going to school and helping other children in the family. However, her interest in studies has suddenly decreased. She no longer shows interest in doing her homework given by the teacher. The teacher thought it was natural, with the children having gone through a lot. To her surprise, Sumitra continued to be disinterested in studies after many months and later dropped out of school, though her father was keen to send her to school as he felt she was very intelligent. But nobody realised that Sumitra's friend in class, Sarada had been washed away in the cyclone along with her family. Sumitra used to compete with her for the first position.

How to help

Often the child does not understand why he/she behaves in a particular manner and cannot articulate the reasons for the behaviour clearly. It is necessary for the parents/adults to understand these changes and take certain measures to help the child get over the stress. The goal is to improve the feeling of security and bonding between them.

- Leaving children with known adults, i.e. mother, siblings, known neighbours.
- Re-establishing at the earliest possible a routine like eating, playing, studying, sleeping, etc.
- Actions that are security-giving
  - Touching, hugging the child often
  - Reassuring them verbally.
  - If possible giving a favourite toy, or piece of cloth (mother's sari) which the child had used earlier as a soother.
  - Keeping a small light on while the child is sleeping.
- Activities which will provide a sense of control over the disaster.
  - Allowing the children to talk about the incident and listening without advising.

- Encouraging play activities which are related to the incident. For example, Children can make paper boats and put then in water. The boats may be rocked, creating a turbulence in the water. The difficulties of people in the boat can be discussed.
- Story telling, singing songs pertaining to the cyclone.
- Giving attention to and approving of the child's coping behaviour, e.g., praising him/her for going back to school and following a routine, etc. Routine also gives a sense of control over oneself.

- Liaisoning with the teacher to also help in the recovery of the child.
- Paying more attention and spending more time with them on their studies.

AGED PEOPLE

Aged people like children may not be in total control of situations. This makes them also very vulnerable to the trauma. They take a longer time and more effort to recover with the disaster.

When faced with the death of many young people, the aged can become very depressed. They may:

- Withdraw, cry and groan repeatedly, for many months.
- Suffer from sleeplessness and refuse food.
- Be agitated, feel hopeless and have suicidal tendencies
- Fall ill as psychologically they are affected and their resistance is low and are susceptible to all types of illness.

Binay Panda's (aged 64) only companion was his ailing wife who was bed-ridden since the last few years. She died when their hut came down in the cyclone. Others thought that her death was a blessing in disguise to Panda; he also felt so. However, over the following weeks, Binay was found to be apathetic, confused and complaining of memory loss. People thought that it was due to his advanced age. But it was, one health worker who realised that Binay was mourning his wife's death in this manner.

How to help

- Keep them with the near and dear ones as much as possible.
- Convey to them positive news without fail and repeatedly.
- Touch them and allow them to cry.
- Re-establish their daily routine.
- Give them responsibility which they can carry out without much difficulty, like for e.g, take care of children for short periods, distribute food for a small number of people, etc.
- Consult them in relief activities.

  (Note: the above two give them a feeling of control over the situation.)
- Attend to them with immediate medical attention when necessary.
- Conduct prayers in small and large groups, focussing on religious matters.

WOMEN

Women feel more vulnerable than men in disaster situations. The poor physical condition of an average Indian woman and the oppressive social conditions in a patriarchal society are some of the reasons for this. Women are more emotional than men and a supercyclone causing such a magnitude of human suffering affects them significantly. However, women also respond to stress differently from men, which can be manifested in:

- λ Exhibiting more emotional symptoms like weeping and later on becoming depressed.
- λ Exhibiting symptoms like 'fainting'.
- λ Experiencing physical symptoms like aches and pains, weakness as a response to conflict.
- λ Showing more 'resilience' than the other group to care for the young.

Among them, more affected are women who are young, single, widowed, orphaned, disabled, have lost children, etc. Specific attention has to be given to the affected women during and following a disaster, like:

Helping women help themselves

- λ Similar to the aged and children, women should stay together in nearby safe places rather than move to faraway places.
- λ Obtain information about the safety of family members especially spouses, offsprings, siblings and parents.
- λ Involve actively in routine activities of the family pertaining to caring of the young, old, sick members of the family, etc.
- λ Involve in community level activities, which are familiar, like preparing food, caring of the sick.
- λ Involve actively in relief activities of social relevance, like maintenance of cleanliness of the surroundings, etc.
- λ Form self-help groups among yourselves to deal with, share the loss, and suffering, and participate in the rehabilitation activities.

- Create private physical spaces for yourself and other women for bathing, changing clothes, etc.

- Mobilise resources to help other affected women in innovative ways like asking women who have lost children to adopt orphaned children, suggesting widowed women to start a new life.

- Spend time in singing and other activities that give you happiness.

DISABLED PEOPLE

People who are disabled like the visually impaired, hearing impaired, orthopaedically handicapped, mentally ill and mentally handicapped are also affected by the cyclone. The disability often may stretch their recovery skills. In the face of disasters like the supercyclone, they need assistance from others to adjust and recover, without which they can become quite ill.

Amit, is a 40-year-old visually impaired person, who has so far been totally independent, able to walk freely within the village and to his job as a music teacher. During the cyclone, Amit was totally helpless as he did not know where and how to reach a place of safety. He could not even help his elderly father to a place of safety.

This is to be remembered and recognised.

How to help the disabled

- Explain to and update them of the situation. This gives a feeling of being involved and not ignored.
- Remove them to any place of safety where they can recover.
- Focus on specific tasks which they can perform within the limitations of their handicap. Focus on what they can do.
- It is better to have groups comprising differently abled people and some people without disabilities.

RECAP

- Special groups like children, old people, women and disabled can react differently to the supercyclone.
- Their distress also starts decreasing after a few weeks.
- Specific efforts can help recovery.
- In some this may not happen and therefore need recognition and intervention.

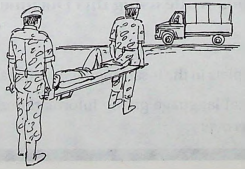
PERSONNEL INVOLVED IN GIVING HELP/AID IN A DISASTER

Immediate (at the time of disaster):

- Local administrative officers – District Commissioner, Tahsildar, Panchayat members, Block Development Officer.

- Local health authorities: District Health Officers, Primary Health Doctors, Nurses, Health Workers, Anganwadi Workers, Mental Health Professionals.

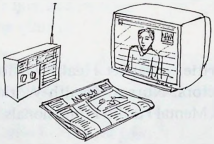
- Fire brigade



- Army

- Voluntary organisations

- Media



After the disaster

- Local Administrative Authorities
- Block Development Authorities
- Agricultural Officers
- Veterinary – Animal husbandry officials
- Public Works Department (PWD)
- Local Health Authorities
- District Education Authorities.

Suggestions while using this Document

- Translate into local language.
- Narrate stories and couplets in the local language while talking of recovery.
- Perform skits in the local language giving information about the disaster and also encouraging recovery.

INFORMATION MANUAL 1

PSYCHOSOCIAL CARE for INDIVIDUALS

SUPERCYCLONE

Disasters pose a monumental challenge to the total community. For too long, psychosocial consequences have been neglected. The ORISSA Disaster like all disasters, poses the enormous challenge of REBUILDING THE PEOPLE, RECONSTRUCTION NOT ONLY OF SHELTERS AND LIVELIHOOD but OF THE HUMAN SPIRIT.

The information booklet is unique because:

1. It addresses mental health care;
2. It is made available soon after the disaster;
3. It is user-friendly;
4. It is a collaborative effort of professionals, voluntary agencies and people – both survivors and concerned.

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MENTAL HEALTH

A loss of moral values!

A decrease of true spiritual strengths resulting in a weakening personality seems to be the order of the day!

Can we remedy this state before it is too late ?

A Booklet for Educators

by

MARIE MIGNON MASCARENHAS

EVERY 10 MINUTES ONE INDIAN ENDS LIFE

Express News Service 1988

Trivandrum, March 6 : One person commits suicide every 10 minutes in India, while in the United States someone commits suicide or attempts to commit suicide every minute.

According to the papers presented at the 17th annual conference of the Indian Society of Criminology, on an average out of every 1,000 suicides in the world a day, 100 are in India.

Available figures say that over 50,000 people in the country commit suicide every year and majority of them are men. Studies on suicidology undertaken by various sociologists show that physical illness, mental disorder, economic need, psychic causes and dowry menace are among the reasons for the rising trend in suicides in the country.

Though India is still far behind Japan, which has the highest suicide rate in the world, despite its affluence, or Switzerland, which is ranked seventh, suicide is on the increase in India as in the case of many affluent Western countries. The studies have revealed that persons in the age group of 18-30 are more prone to suicide. Suicide is less among married couples and theists.

Let us bring Mental and Spiritual health into our Homes and Institutions !

Mental Health

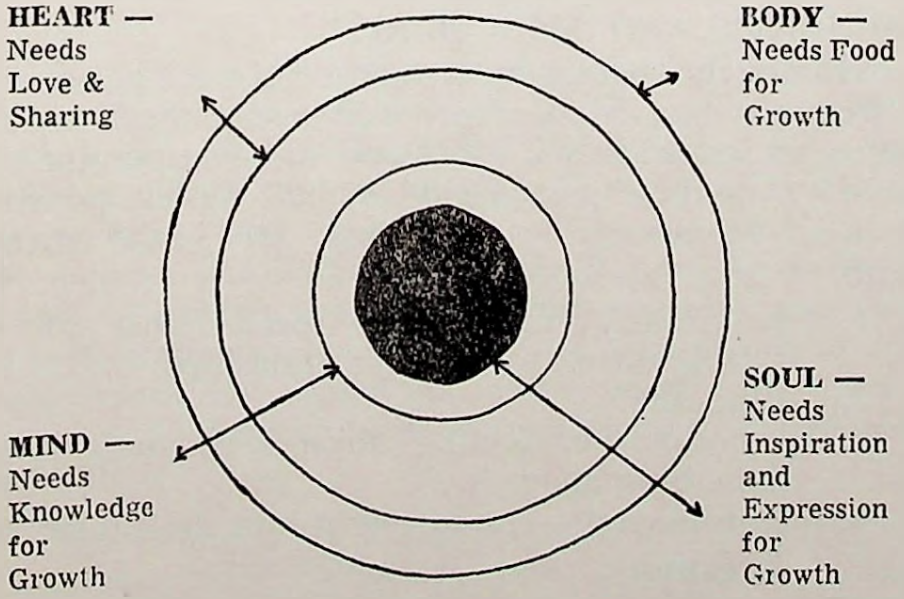
MENTAL HEALTH AND MENTAL HYGIENE

Mental Health is an integral part of general health. It can be promoted by *mental hygiene* which is the practice and use in daily life of specific convictions and behaviour that is conducive to the following :

a) dealing satisfactorily with the daily events of life.
b) working out certain roles relating to different events and persons in stressful situations with least distress
c) resolving conflicts in a self-confident manner
d) seeking help in the above situations whenever indicated.

Mental Hygiene is in other words a " personality development " effort which grows with the person promoting " personhood " or maturity of emotions and actions. *In the diagram below one can note the components of the human person, or the anatomy of self.*

ANATOMY OF SELF



MENTAL HEALTH PROGRAMME

The conviction and belief of a positive self-image and self-acceptance, the behaviour that is consistent with

self-worth and dignity, the understanding that one has to fit into different roles without much distress, the belief that one has to be responsible for ones actions, and that conflicts are a part of life that must be faced are all part of a positive mental health programme.

Freud defined mental health as the "ability to love and to work." To love is to be able to enter into a relationship of mutuality, that is giving and receiving love.

A mentally healthy person, he said is one who is strong enough to resolve conflicts between *impulses* and *morals,* that is, he can choose between expressing feelings and withholding such expression, and between pursuing gratification of needs and postponing such a quest for gratification.

He|She can thus make a healthy rational choice and control any tendency to compulsive behaviour. Repression ignores this and thus consumes energy which could go into productive behaviour.

According to Jung, a mentally healthy person is a responsible person who has found a meaning for his existence and has integrated conflicting elements of his personality into a unique and harmonious pattern.

FEMININITY AND MASCULINITY

Having the correct understanding of one's personality i.e. Feminity and Masculinity will ensure that men and women understand each other and more important that they develop their personality to their fullest potential which is an essential requirement for sound mental health.

1. Femininity implies the special charisma of affiliation or forming relationships.
2. Empathy.
3. Emotion i.e. feeling strongly enough to do something about it.
4. Intuitiveness — a foresight into the future-and Creativity.

Masculinity on the other hand has the special character of

1. Being direct
2. Logical

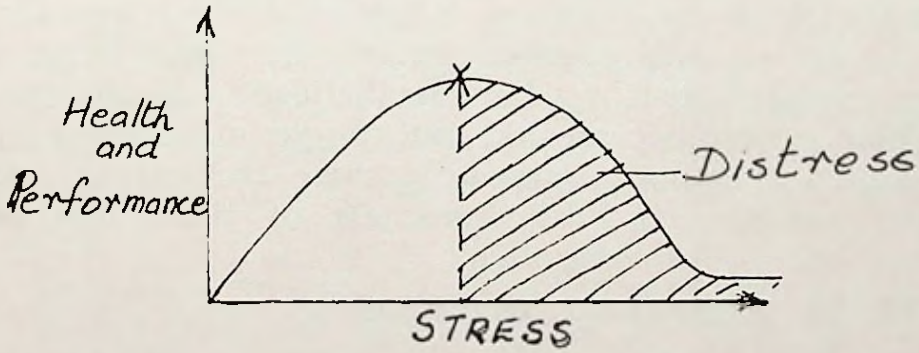
3. Rational
4. Aggressive
5. Physical

Hence the ancient Greek symbols to represent man was the arrow and for women the mirror reflecting her feelings in her countenance.

ANXIETY

Modern psychologists have done an admirable service in studying anxieties, revealing a phase of human nature which has been to some extent closed to us. But the course of anxiety is deeper than the psychological.

Optimal Stress in Relation to Overload



One of the favourite psychological descriptions of modern man is to say that he has an anxiety complex. Psychology is more right than it suspects, but for a more profound reason than it knows. There is no doubt that anxiety has been increased and complicated by our metropolitan and industrialised civilisation. An increasing number of persons are afflicted with neuroses, complexes, fears, irritabilities and ulcers they are perhaps not so much "run down" as "wound up," not so much set on fire by the sparks of daily life as they are burning up from internal combustion.

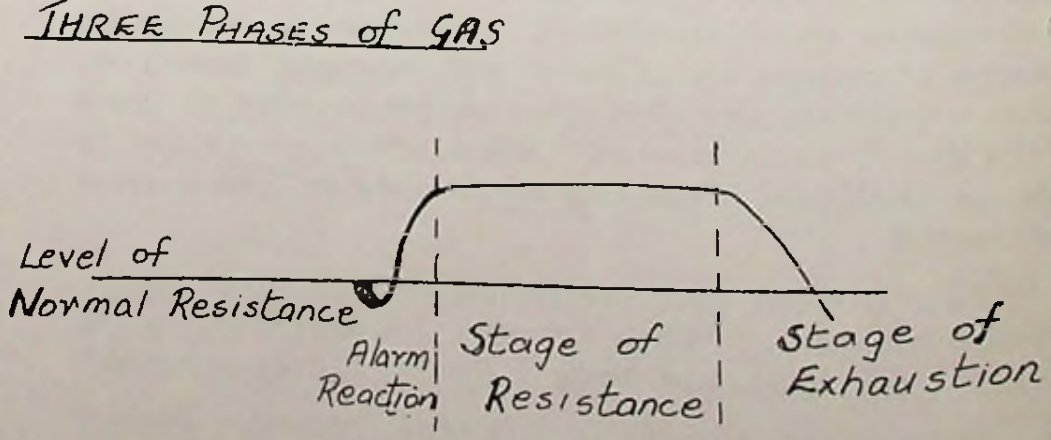
Few of them have the felicity of the good Negro woman who said, "When I works, I works hard, when I sits, I sits loose, and when I thinks, I goes to sleep."

But modern anxiety is different from the anxiety of previous and more normal ages in two ways. In older days men were anxious about their souls, but *modern*

anxiety is principally concerned with the body. the major worries of today are economic security, health, the complexion, wealth, social prestige, and sex. To read modern advertisements one would think that the greatest calamity that could befall a human being would be to have pimples or a cough in the T-zone. This over emphasis on corporal security is not healthy, it has begotten a generation that is much more concerned about having life belts to wear on a sea journey than about the cabin it will occupy and enjoy. The *second characteristics* of modern anxiety is that it is not fear of objective, a vague fear of what one believes would be dangerous if it happened. That is why it is so difficult to deal with people who have today's types of anxiety, it does no good to tell them that there is no outside danger, because the danger that they fear is inside of them and therefore is abnormally real to them. Their condition is aggravated by a sense a dispropotion between their own forces and those marshalled by what they believe to be the enemy. These people become like fish caught in nets and birds trapped in a snare, increasing their own entanglements and anxieties by the fierceness of their disorderly exertions to overcome them.

STRESS. EUSTRESS. DISTRESS.

Hans Selye has done the most work in the effect of Stress on man in the University of Montreal. He has described the '*Gas,*' General Adaptation Syndrome in three phases (1) the alarm reaction (2) the stage of resistance and (3) the stage of exhaustion.



Most illnesses occur in stage three, which is when repair fails. When the diet is adequate, a person can

go for years withstanding tremendous stress with little apparent harm. If the raw materials are insufficient to meet the needs, there comes the stage of exhaustion, disease develops and eventually death threatens. During every illness we are in one of these three phases of stress, and to regain our health, our diets must be planned accordingly. Diet is not only for the body, but also for the mind, since body and mind work in close harmony. A disturbance in one, disturbs the other.

EUSTRESS AND DISTRESS

Stress is good and needed for people to grow to their full potential. So when we talk of stress management, we do not mean eliminating all stress. The primary stress response is the fight or flight response. A response helps to ensure our survival and any threat, physical or symbolic can bring about this response. Now while physical arousal to physical threat is appropriate, physical arousal to symbolic or emotional threat is inappropriate. It is longer in duration, is not easily dissipated and is physically detrimental to the body.

Hans Selye says that stress is a process that enables the body to resist the stressor in the best possible way by enhancing the functioning of the organ system best able to respond to it.

He calls optimal stress levels eustress, and this reaches a maximal point where stress increases health and performance. He calls overload, distress, where stress increases, but health and performance decrease."

DISTRESS OR NEGATIVE REACTIONS TO STRESS — MANIFESTATION

1. Mood and Disposition Signs

Worry, over-excited, insecure, insomnia, confused, forgetful, uncomfortable, ill at ease, and nervous.

2. Visceral Signs

Stomach, upset, heart palpitations, profuse sweating, moist hands, feeling faint or light headed, face hot or flushed, experience of cold chills.

3. **Musculoskeletal Signs**

Fingers and hands shake or tremble, cannot sit or stand still, twitches, headache, tense, stiff muscles, stuttering, stammering, stiff neck.

Selye Says that our problems evolve quickly, but our bodies evolve slowly, very slowly. People like to assume that the body always works intelligently. But this is not so. The body is like the mind, it too, gets confused and makes mistakes.

Where stress is concerned, what usually happens is that mind and body make the same mistakes together. Selye says that stress is the non-specific response of the body to any demand made upon it; it can be pleasant or unpleasant. Stress is not something to be avoided. Complete freedom from stress is death.

All illnesses have a psychosomatic component. All disorders are psychosomatic, in the sense that both mind and body are involved in their aetiology."

COMMON SYMPTOMS OF EMOTIONAL ORIGIN

1. Exhibiting *nervous mannerisms,* e.g. biting nails, jittery speech, shivering.
2. *Overeating.* Some people eat a lot more than usual when they are under stress.
3. *Excessive talking.* Sometimes a person may become unusually talkative and literally feels compelled to talk at all times.
4. *Escaping into drugs,* alcohol or work.
5. *Ignoring it,* hoping that denial will help get rid of it.
6. *Withdrawal.* A person may withdraw within himself or to some other refuge to cope with stress. He may become anti-social and adopt an ascetic life style.
7. *Give-up* . Many who attempt or commit suicide are those who have decided to give up fighting their stresses and seek permanent release.

HEALTHY MANAGEMENT OF STRESS OR EUSTRESS

This is a good or positive response to stress.

a) Talking it over with a friend who is sympathetic and understanding.

b) Taking an inventory of the stress factors in our lives.

c) Emotional innoculation. By this we mean preparing oneself mentally and emotionally for the stressful event. A person taking an examination can prepare himself by ensuring that he studies, as well as working out alternatives should he fail. Because he is prepared for the worst possible outcome, he may be able to take it better. In this way he|she avoids *"stressor" factors.*

MEASURES TO PROMOTE EUSTRESS

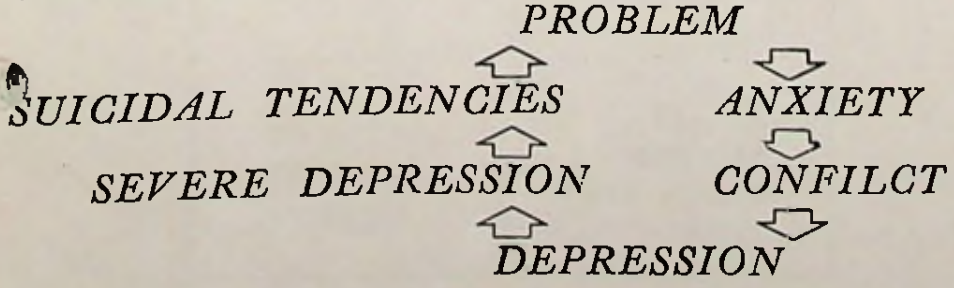
d) Relaxation and body awareness exercises.

e) Making changes in diet, life style etc.
Being assertive. Center. Imaging and focussing on self.

g) Seeking professional help.

Depression is to give into the pressures or stresses of life and go below the normal and healthy feeling of well being. It is a negative and self destructive reaction and if unchecked can have serious implications for the individual.

VICIOUS CIRCLE



Only counselling can break this vicious circle. At the stage of Severe Depression, professional and psychiatric help and even hospitalization may be necessary. Hence we can see how important mental hygiene is, since it can convert stress into eustress and solve the problem or resolve the conflict.

It is here that spiritual counselling is essential to give the individual belief in him|herself and that God cares and loves them, even if all others have disappointed them.

CASE STUDY

Ramesh's father had a quick temper and Ramesh was often his target. At first Ramesh bitterly resented this injustice and felt humiliated. He tried to react by staying long hours out of the house and this resulted in poor results in studies and worsening relations at home. Ramesh blamed all this on his father. Ramesh went to a Counsellor who helped him to understand that his father loved him and though he had a quick temper he forget about his anger soon after. Ramesh realised his own reaction was childish and that he harmed himself most. He started staying home more and whenever his father lost his temper he would wait till he had cooled down and then tell him his side of the story. This happened over a period of 6 months and they are now good friends much to the relief of Ramesh's mother and the entire family, who had all been adversely affected.

AWARENESS IN INTERPERSONAL RELATIONS

I AREA OF FREE ACTIVITY	**II** BLIND AREA
III AVOIDED OR HIDDEN AREA	**IV** AREA OF UNKNOWN ACTIVITY

In quadrant 1 are the behaviours and feelings known to an individual and also to other people. In quadrant II called the blind area, are aspects of the individuals of which he is not aware but which are known to other people. The avoided or hidden area, quadrent III, involves personal characteristics which the individual

knows about but does not wish to reveal to others. In quadrant IV, the area of unknown activity are aspects of behaviour and motivation unknown to the individual and also unknown to others.

It is very helpful for each person to do this EXERCISE and then discuss what is listed in each area with a friend or counsellor *(LUFT)*.

CLASS ACTIVITY

1. Exercise in Emotional Status.
2. Do you have Self Confidence ?
3. Do you have will power ?

AN EXERCISE IN EMOTIONAL STATUS

List 1	List 2
Suspicion	Peace
Frustration	Confidence
Discouragement	Exhiliration
Fear	Hope
Disappointment	Friendliness
Anger	Joy
Guilt	Enthusiasm
Hostility	Relief
Jealousy	Trust
Loneliness	Affection
Inferiority	Contentment
Rejection	Curiosity
Envy	Satisfaction
Impatience	Pride
Boredom	Excitement
Sadness	Acceptance

Pick out an emotion from List 1 and 2 and describe to other group members a recent experience which you had which makes you feel that emotion. Let the other members of the group respond to you. Try to talk in depth about the feeling.

Complete the following statements

1. When I join a new group I_____
2. I feel most comfortable in a group when _____

3. I like people who .....
4. Helping others make me feel .....
5. I feel angry when .....
6. I feel happy when .....

Now let the listener or listeners complete this statement :

" Towards you right now I feel....."

Now let all share with each other what they felt about this exercise, what they feel about each other, what they have gathered from this experience.

Discuss how best you could have adjusted to stressful feelings. Decide on how to act in the future.

A TEST FOR PERSONALITY DEVELOPMENT

2. DO YOU HAVE SELF-CONFIDENCE ?

Here is a test you may like to try. Answer " YES " or " NO " to the questions before you turn to the key at the end.

1. Do you believe that you are wanted ? *Yes|No*
2. Do you take success and failure without becoming unduly elated or depressed ? *Yes|No*
3. Are you good at coping with emergencies ? *Yes|No*
4. Do you regard yourself as a pleasant personality ? *Yes|No*
5. Are you seldom at a loss for words ? *Yes|No*
6. Are you rarely worried about what others think of you ? *Yes|No*
7. Do you seldom feel the urge to justify ? *Yes|No*
8. Is it difficult for people to embarrass you ? *Yes|No*
9. Can you laugh at your own mistakes ? *Yes|No*
10. Can you apologize gracefully without feeling embarrassed or uncomfortable ? *Yes|No*
11. Can you discuss without getting upset ? *Yes|No*
12. Would you stand up and ask questions in class ? *Yes|No*
13. Do you enjoy the company of the opposite sex ? *Yes|No*

14. Do you look forward to meeting new people ? *Yes|No*

15. Is it easy for you to talk to strangers and get to know them ? *Yes|No*

16. Can you remain calm when people are uncooperative ? *Yes|No*

17. Do you think that you are loved ? *Yes|No*

18. Can you be relied upon to cope with most situations? *Yes|No*

19. Do you seldom stammer or blush ? *Yes|No*

20. Would you be thrilled to chair a meeting or lead a discussion ?

KEY TO QUIZ

Count 5 marks for every yes. Above 75 is very good. 65 - 75 is good. Below 65 can improve.

How to Gain Self Confidence and improve your score.

DO YOU HAVE SELF-CONFIDENCE ?

Many people feel that problems and difficulties are often more than they can cope with. They feel beaten by life and constantly weighed down by problems. They lose faith in themselves and their ability to make a success of their lives. There is no worse experience than losing one's self-confidence. If a person doesn't believe in himself he is frustrated and beaten at every turn.

TO GAIN SELF-CONFIDENCE — REMEMBER

1. You are different from everyone else because you are unique. This means that you are important. If you were important, how would you dress, how would you walk, how would you feel ? When you have pictured these things, put them into practice.

2. Choose for yourself some goal which is within the bounds of possibility. This is what you must try to achieve.

3. Having fixed your aim, proceed towards it gradually. Plan for it and arrange your life in such a way as to fit in with your aim.

4. Learn from your mistakes, but never let them deflect you from your goal.
5. If you lack faith in yourself it is essential that you set out to be interested in other people. We are only hesitant to meet people because we are more interested in ourselves. Make a hobby of people, and remember all people are interesting to those who are prepared to find out where their interest lies.
6. Learn more about other people. Begin to care about them and as you lose yourself in caring passionately for them you will find your self-confidence restored.
7. One of the greatest causes of loss of self-confidence is tension. This means we must learn to relax. Practice letting go. Have a few minutes every day when you consciously let go of life and its problems. These short "vacations" mean so much and it's surprising the difference it makes.
8. Always do the best you can in facing a situation and then leave the issue to God. If you have done your best you can do no more.

3. DO YOU HAVE WILL POWER ?

1. Can you *convince* yourself of your strength of will ? Your possibilities are greater than you think. This is true on the natural plane alone. From the religious point of view, your certainty is still greater. God has a task for you to do, and he will give you all you need to do it well.
2. Can you *conform* your exterior behaviour to your interior ideal ? Your exterior behaviour greatly influences your thinking. Make your exterior calm, firm and virile. Cultivate a healthy, straight posture. Don't lounge or drag your feet.
3. Can you *profit* by every occasion to exercise energetic action ? You must repeat voluntary acts of energetic effort. A practical method is the following.

   Determine a certain number of wilful acts to be accomplished daily for a period of ten days. Do not relent till you have accomplished them all.

4. Can you take *pleasure* in work and hardship ? This may sound impossible, but work can be as enjoyable as play, and the satisfaction it can bring you is far deeper than the pleasure you get from fun.

5. Can you *polarize* your energies through an apt slogan ? A good slogan is an effective stimulant. Invent your own personal formula and repeat it especially in times of discouragement. Examples, *"I shall overcome." God gave me life to conquer"* etc.

6. Can you seek *perfection* in all you do ? "What is worth doing is worth doing well" : Few things help will-power more than applying a maximum of concentrated energy to simple tasks.

7. Can you leave a job half-done ? First draw up a definite plan of action; then, stick to it. This will also save you undue worry and loss of time. What tires you most is not what you have done, but what you should have done and did not do. Are you convinced of this truth ?

8. Can you not give into the first feeling of *tiredness ?* Do not underestimate your working power. If you give in to the first temptation to stop working real fatigue will soon develop and you will lose the day. So react promptly.

9. Can you be flexible, but tenacious ? If you want to succeed in any walk of life, you need tenacity, a certain ' gentle stubbornness." As that great soldier, Marshal Foch said, *"Nothing resists tenacity, But if you accept the very thought of defeat, you are vanquished beforehand. Victory belongs to the man who remains firm longer than his opponent," and "Nothing ventured, nothing gained"*

To every Question the Answer should be 'Yes'

* Know what you want-and clear-cut decisions will follow.
* Energetic action is the next requisite.
* Follow through with continuous effort.

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1998 UPDATE
ABNORMAL PSYCHOLOGY AND MODERN LIFE

TENTH EDITION

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Such therapy is concerned with verbal and nonverbal communication, social roles, processes of accommodation, causal attributions (including those supposedly motivating the behavior of others), and the general interpersonal context of behavior. The therapy situation itself can be used as a vehicle for learning new interpersonal skills. In recent years, major progress has been made in documenting the effectiveness of interpersonal psychotherapy in the treatment of disorders such as depression and bulimia, an eating disorder discussed in Chapter 8 (Fairburn et al., 1993; Klerman et al., 1994).

Although the interpersonal approach of Sullivan and others lacks a fully adequate scientific grounding, it has generated considerable enthusiasm among researchers in recent years and has far more potential in this regard than does the humanistic approach, which does not promote empirical testing of its basic ideas. The major impact of the interpersonal perspective has been its focus on the key role a person's close relationships play in determining whether behavior will be effective or maladaptive.

Summary

Each of the psychosocial perspectives on human behavior—psychodynamic, behavioral, cognitive-behavioral, humanistic, and interpersonal—contributes to our understanding of psychopathology, but none alone can account for the complex variety of human maladaptive behaviors. Each perspective depends on generalizations from limited observations and research. In attempting to explain a complex disorder such as alcoholism, for example, the psychodynamic viewpoint focuses on intrapsychic conflict and anxiety; the behavioral viewpoint focuses on faulty learning and environmental conditions that may be exacerbating or maintaining the condition; the cognitive-behavioral viewpoint focuses on maladaptive thinking, including deficits in problem solving and information processing; the humanistic viewpoint focuses on the ways in which a person's struggles with values, meaning, and personal growth may be contributing to the problem; and the interpersonal viewpoint focuses on difficulties in a person's past and present relationships.

Thus adopting one perspective or another has important consequences: It influences our *perception* of maladaptive behavior, the *types of evidence* we look for, and the *way in which we are likely to interpret data*. In the following section we will discuss a range of psychosocial causal factors which have been implicated in the origins of maladaptive behavior. We will also illustrate how some of these different viewpoints would provide contrasting (or sometimes complementary) explanations for how they exert their effects. In later chapters, we will discuss relevant concepts from all these viewpoints as they relate to different forms of psychopathology, and in many instances, we will contrast different ways of explaining and treating the same disorder.

PSYCHOSOCIAL CAUSAL FACTORS

We begin life with few built-in patterns and a great capacity to learn from experience. What we do learn from our experiences may help us face challenges resourcefully and resiliently. Unfortunately, some of our experiences may be much less helpful in our later lives, and we may be deeply influenced by factors in early childhood over which we have no control. In this section we will examine the psychosocial factors that make people vulnerable to disorder or that may precipitate disorder. Psychosocial factors are those developmental influences that may handicap a person psychologically, making him or her less resourceful in coping with events.

We begin this section with a brief examination of the central role played by our perceptions of ourselves and our world which derive from our schemas and self-schemas. Then we will review specific influences that may distort the cognitive structures on which good psychological functioning depends. We will focus on four categories of psychosocial causal factors that exemplify the range of factors that have been studied: early deprivation and trauma, inadequate parenting, pathogenic family structures, and maladaptive peer relationships. Such factors typically do not operate alone. They interact with each other and with other psychosocial factors, with particular genetic and constitutional factors, and with particular settings or environments.

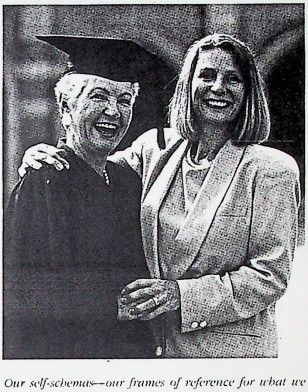
Schemas and Self-Schemas

Fundamental to determining what we know, want, and do are some basic assumptions that we make about ourselves, our world, and the relationship between the two. Using terminology from the cognitive perspective, these assumptions make up our frames of reference—our *schemas* about other people and the world around us, and our *self-schemas* or ideas that we have about our own attributes. Because what we can learn or perceive directly through our senses can provide only an approximate representation of "reality," we need cognitive frameworks

to fill in the gaps and make sense out of what we can observe and experience. A **schema** is an organized representation of prior knowledge about a concept or about some stimulus that helps guide our processing of current information (Alloy & Tabachnik, 1984; Fiske & Taylor, 1991). Our schemas about the world around us and about ourselves are our guides, one might say, through the complexities of living in the world as we understand it. We all have schemas about other people (for example, expectations about their traits and goals), as well as schemas about social roles (for example, expectations about what appropriate behaviors for someone in that role are) and about events (for example, what appropriate sequences of events are for particular situations) (Fiske & Taylor, 1991). Our **self-schemas** include our views on what we are, what we might become, and what is important to us. Other aspects of our self-schema concern our notions of the various roles we occupy or might occupy in our social environment, such as woman, man, student, parent, physician, American, older person, and so on. The various aspects of a person's self-schema also can be construed as his or her *self-identity* (similar to Rogers' self-concept and Sullivan's self-system). Most people have clear ideas about at least some of their own personal attributes, and less clear ideas about other attributes (Fiske & Taylor, 1991).

Schemas about the world and self-schemas are vital to effective and organized behavior, but they are also sources of psychological vulnerabilities. This is because some of our schemas or certain aspects of our self-schema may be distorted and inaccurate. In addition, some schemas—even distorted ones—may be held with conviction, making them resistant to change. We are usually not completely conscious of our schemas. Although our daily decisions and behavior are largely shaped by these frames of reference, we may be unaware of the assumptions on which they are based—or even of having made assumptions at all. We think that we are simply seeing things the way they are and often do not often consider the fact that other pictures of the "real" world might be possible or that other rules for "right" might exist.

On the one hand, the self-schema can be seen as a set of rules for processing information and for selecting behavior alternatives; on the other hand, it can be seen as the product of those rules—a sense of selfhood, or self-identity (Vallacher, Wegner, & Hoine, 1980). Deficiencies or deviations in either aspect of the development of the self can make one vulnerable to disorder. For example, if a person's information-processing rules differ in major respects from those of his or her peers, then that person's "reality" will be correspondingly different and may lead to rejection, isolation, despair, and disorder.



Our self-schemas—our frames of reference for what we are, what we might become, and what is important to us—influence our choice of goals and our confidence in being able to attain them. A key element of this older woman's self-schema was that she could accomplish her lifelong goal of obtaining a college education once her children were grown in spite of the fact that she was nearly 40 years older than the average college student.

As Vallacher and colleagues (1980) have put it, we look *through* the rules of the self—rarely at them. For this reason, the rules, once established, may be hard to identify, and it may be difficult to change them deliberately. New experiences tend to be worked into our existing cognitive frameworks, even if the new information has to be reinterpreted or distorted to make it fit—a process known as **assimilation.** We tend to cling to existing assumptions and reject or change new information that contradicts them. **Accommodation**—changing our existing frameworks to make it possible to incorporate discrepant information—is more difficult and threatening, especially when important assumptions are challenged. Accommodation is, of course, a basic goal of psychosocial therapies—explicitly in the case of the cognitive and cognitive-behavioral variants, but deeply embedded in virtually all other approaches as well. This process makes major therapeutic change a difficult task.

A person's failure to acquire appropriate principles or rules in cognitive organization can make

him or her vulnerable to psychological problems later in life. Mischel (1973, 1990, 1993) has identified five learning-based differences that become apparent early in childhood: (a) children acquire different levels of competency in different areas; (b) they learn different concepts and strategies for encoding and categorizing their experiences, and they thus "process" new information differently; (c) although they all learn that certain things follow from certain others, what they learn to expect is quite different, depending on their unique experiences; (d) they learn different subjective values and goals, which lead to their finding different situations attractive or disagreeable; and (e) they learn different ways of coping with impulses and regulating their behavior—they develop a characteristic "style" of dealing with life's demands. Differences in these general areas continue through childhood and into the adult years and help shape later learning.

These learned variations make some children far better prepared than others for further learning and personal growth. The ability to make effective use of new experience depends very much on the degree to which past learning has created cognitive structures that facilitate the integration of the novel or unexpected. A well-prepared child will be able to assimilate or when necessary accommodate new experience in ways that will enhance growth; a child with less adequate cognitive foundations may be confused, unreceptive to new information, and psychologically vulnerable. It is mainly for this reason that most theories of personality development, and all of the psychosocial viewpoints of abnormal behavior just described, emphasize the importance of early experience in shaping the main directions that a person's coping style will take.

A good example is afforded by modern research on the cognitive antecedents of psychological depression. As discussed in Chapter 6, the onset of many cases of depression, including severely incapacitating depression, has been linked repeatedly with the prior occurrence of negative life events, such as illness, divorce, or a serious financial setback. Some evidence shows that people who respond to such events with clinically diagnosable depressions are in some sense "primed" to respond in this way because of the ways in which they process the negative happenings. Although the details of such a negative "set" are still being studied, they seem to involve a kind of overreaction to and overgeneralization of the meaning of negative events, one that was learned much earlier and may have remained dormant for many years (Beck 1967, 1987). Some evidence suggests that traumatic experiences, such as the death of a parent in childhood, may encourage the acquisition of such maladaptive self-schemas (Bowlby, 1980).

The example just given reminds us that the events making up one child's experiences may be vastly different from those of another, and that many such events are neither predictable nor controllable. At one extreme are children who grow up in stable and lovingly indulgent environments, buffered to a large extent from the harsher realities of the world; at the other extreme are children whose experiences consist of constant exposure to frightening events or unspeakable cruelties. Such different experiences have corresponding effects on the schemas about the world and about the self of adults: Some suggest a world that is uniformly loving, unthreatening and benign, which of course it is not; others a jungle in which safety and perhaps even life itself is constantly in the balance. Given a preference in terms of likely outcomes, most mental health professionals would opt for the former of these sets of experiences. However, these may not be the best blueprint for engaging the real world, because it may be important to encounter some stresses and learn ways to deal with them in order to gain a sense of control (Seligman, 1975) or self-efficacy (Bandura, 1977a, 1986).

Exposure to multiple uncontrollable and unpredictable frightening events is likely to leave a person vulnerable to *anxiety,* a central problem in a number of the mental disorders to be discussed in this book. For example, Barlow's (1988) and Mineka's (1985a) models acknowledge some biological vulnerability to stressful circumstances in creating anxiety, but they also stress the importance of experience with negative outcomes perceived to be unpredictable and uncontrollable, based on a review of pertinent research (see also Mineka & Zinbarg, 1991; in press-b). A clinically anxious person is someone whose schemas include strong possibilities that terrible things over which he or she has no control may happen unpredictably, and that the world is a dangerous place. It is not difficult to imagine developmental scenarios that would lead a person to have schemas with these elements as prominent characteristics.

Finally, it appears that some uncontrollable experiences to which children are subjected are so overwhelming that they do not develop a coherent self-schema. This situation is perhaps seen most clearly in cases of dissociative identity disorder, where separate personalities have developed separate self-schemas that may be completely walled off from one another. We have learned in recent years that dissociative identity disorder (formerly called "multiple personality disorder"; see Chapter 7) may be associated with repeated, traumatic sexual and physical abuse in childhood. The main point here is that a

fragmented sense of identity, whatever its origin—and it is frequently traumatic—invites the development of abnormal behaviors. On this the psychosocial viewpoints all concur; they differ primarily in the mechanisms through which they hypothesize these abnormal behaviors develop.

Early Deprivation or Trauma

Fortunately, experiences of the intensity and persistence just noted, although more common than was thought only a decade ago, are nevertheless relatively rare. There are, however, other kinds of experiences that, while less dramatic and chilling, may leave children with deep and sometimes irreversible psychic scars. The deprivation of needed resources normally supplied by parents or parental surrogates is one such circumstance.

Parental deprivation refers to an absence of adequate care from and interaction with parents or their substitutes during the formative years. It can occur even in intact families where, for one reason or another, parents are unable (for instance, because of mental disorder) or unwilling to provide for a child's needs for close and frequent human contact. The most severe manifestations of deprivation are usually seen among abandoned or orphaned children who may either be institutionalized or placed in a succession of unwholesome foster homes.

We can interpret the consequences of parental deprivation from several psychosocial viewpoints. Such deprivation might result in fixation at the oral stage of psychosexual development (Freud); it might interfere with the development of basic trust (Erikson); it might retard the attainment of needed skills because of a lack of available reinforcements (Skinner); it might preempt self-actualizing tendencies with maintenance and defensive requirements (Rogers, Maslow); or it might stunt the development of the child's capacity for relatively anxiety-free exchanges of tenderness and intimacy with others (Sullivan). Any of these viewpoints might be the best way of conceptualizing the problems that arise in a particular case, or some combination of them might be superior to any one. From the cognitive perspective, which we have been focusing on, we see the victims of such experiences as acquiring dysfunctional schemas and self-schemas in which relationships are represented as unstable, untrustworthy, and without affection.

Institutionalization In an institution, compared with an ordinary home, there is likely to be less warmth and physical contact; less intellectual, emotional, and social stimulation; and a lack of encouragement and help in positive learning. A much-referenced study by Provence and Lipton (1962) compared the behavior of infants living in institutions with that of infants living with families. At one year of age, the institutionalized infants showed general impairments in their relationships to people, rarely turning to adults for help, comfort, or pleasure and showing no signs of strong attachments to any person. These investigators also noted a marked retardation of speech and language development, emotional apathy, and impoverished and repetitive play activities. With more severe and pervasive deprivation, development may be even more retarded.

Success at school—such as winning a spelling bee—may be a protective factor that helps a child overcome disadvantages such as parental deprivation or institutionalization.

The long-range prognosis for children suffering early and prolonged parental deprivation through institutionalization is considered unfavorable (Quinton & Rutter, 1988; Quinton, Rutter, & Little, 1984; Rutter, 1990; Rutter & Quinton, 1984a; Tizard & Hodges, 1978). It is clear that many children deprived of normal parenting in infancy and early childhood show maladaptive personality development and are at risk for psychopathology. Institutionalization later in childhood in a child who has already had good attachment experiences is not so damaging (Rutter, 1987). However, even among those institutionalized at an early age, some show resilience and do well in adulthood. One important protective factor found to influence this was whether the child went from the institution into a harmonious family or a discordant one, with better outcomes among those who entered harmonious homes (Rutter, 1990). Another influential protective factor was having some good experiences at school, whether in the form of social relationships, or athletic or academic

success; these successes probably contributed to a better sense of self-esteem or self-efficacy (Quinton & Rutter, 1988; Rutter, 1985, 1990).

Deprivation and Abuse in the Home Most infants subjected to parental deprivation are not separated from their parents, but rather suffer from inadequate care at home. In these situations parents typically neglect or devote little attention to their children and are generally rejecting. Parental rejection of a child is closely related to deprivation and may be demonstrated in various ways—by physical neglect, denial of love and affection, lack of interest in the child's activities and achievements, harsh or inconsistent punishment, failure to spend time with the child, and lack of respect for the child's rights and feelings. In a minority of cases, it also involves cruel and abusive treatment. Parental rejection may be partial or complete, passive or active, or subtly or overtly cruel.

The effects of such deprivation and rejection may be very serious. For example, Bullard and his colleagues (1967) delineated a "failure to thrive" (FTT) syndrome that "is a serious disorder of growth and development frequently requiring admission to the hospital. In its acute phase it significantly compromises the health and sometimes endangers the life of the child" (p. 689). The problem is fairly common in low-income families, with estimates at about 6 percent of children born at medical centers serving low-income families (Lozoff, 1989). Some have suggested that it may occur in a child who has become severely depressed (because of the deprivation and/or abuse) and has developed a neuroendocrine problem stunting growth (Ferholt et al., 1985), but it is also now clear that this syndrome often has prenatal origins, with a disproportionate number having had low birth weights (Lozoff, 1989).

Outright parental abuse of children has also been associated with many other negative effects on the development of its victims, although some studies have suggested that, at least among infants, gross neglect may be worse than having an abusive relationship. Abused children often have a tendency to be overly aggressive and prone to impulsive behavior (Emery, 1989). Researchers have also found that maltreated children have difficulties in linguistic development and significant problems in emotional and social functioning, including depression and impaired relationships with peers (Cicchetti, 1990; Emery, 1989). In addition, abused children are at heightened risk for later aggressive behavior (Dodge, Bates, & Pettit, 1990). Abused and maltreated infants and toddlers are likely to develop a pattern of disorganized and disoriented style of attachment (Crittenden & Ainsworth, 1989), characterized by bizarre, disorganized, and inconsistent behavior with the mother. A recent review of research in this area concluded that "maltreatment by the primary caregiver in early childhood appears to jeopardize the organization and development of the attachment relationship, the self, and the regulation and integration of emotional, cognitive, motivational, and social behavior" (Masten et al., 1990, p. 437).

Nevertheless maltreated children—whether the maltreatment comes from abuse or from deprivation—can improve when the caregiving environment improves (Crittenden, 1985; Farber & Egeland, 1987; Masten & O'Connor, 1989; Rutter, 1979). Yet even though subsequent experiences may have a moderating influence, for some children the detrimental effects of such early traumas may never be completely overcome, partly because experiences that would provide the necessary relearning may be selectively avoided. A child whose schemas do not include the possibility that others can be trusted may not venture out toward others far enough to learn that some people in the world are in fact trustworthy. This idea is supported by the findings of Dodge and colleagues (1990) who found that abused children tend to attribute hostile intent to negative interactions with peers. Moreover, this tendency to attribute hostile intent seemed to mediate the development of aggressive behavior. That these effects may be enduring is supported by a recent review of the long-term consequences of physical abuse (into adolescence and adulthood) which concluded that childhood physical abuse predicts both familial and nonfamilial violence in adolescence and adulthood, especially in abused men (Malinosky-Rummell & Hansen, 1993). Physical abuse was also found to be associated with self-injurious behaviors and suicidal behavior, as well as anxiety, depression, and psychosis, especially in women.

A significant proportion of parents who reject or abuse their children have themselves been the victims of parental rejection. Their early history of rejection or abuse would clearly have had damaging effects on their schemas and self-schemas, and probably resulted in a failure to internalize good models of parenting. Kaufman and Zigler (1989) estimated that there is about a 30 percent chance of this pattern of intergenerational transmission of abuse (see also Widom, 1989). Those who were least likely to show this pattern tended to have one or more protective factors, such as a good relationship with some adult during childhood, higher IQ, positive school experiences, or physical attractiveness, among others.

Childhood Trauma Most of us have had one-time traumatic experiences that temporarily shattered our feelings of security, adequacy, and worth and influenced our perceptions of ourselves and our environment. The term **psychic trauma** is used to describe

In February 1994 during a drug raid, Chicago police discovered 19 children in this freezing, squalid cockroach-infested apartment. The stove in the kitchen did not work, and children were found sharing food with dogs off the floor. The six adults in the apartment were charged with child neglect, and child abuse charges were also considered. Growing up in such a setting may predispose children to later psychological problems.

any aversive (unpleasant) experience that inflicts serious psychological damage on an individual. The following illustrates such an incident:

> I believe the most traumatic experience of my entire life happened one April evening when I was 11. I was not too sure of how I had become a member of the family, although my parents had thought it wise to tell me that I was adopted. That much I knew, but what the term adopted meant was something else entirely. One evening after my step-brother and I had retired, he proceeded to explain it to me—with a vehemence I shall never forget. He made it clear that I wasn't a "real" member of the family, that my parents didn't "really" love me, and that I wasn't even wanted around the place. That was one night I vividly recall crying myself to sleep. That experience undoubtedly played a major role in making me feel insecure and inferior.

Traumas of this sort are apt to leave psychological wounds that may never completely heal. As a result, later stress that reactivates these wounds may be particularly difficult for an individual to handle; this often explains why one person has difficulty with a problem that is not especially stressful to another. Psychic traumas in infancy or early childhood are especially damaging because children have limited coping resources and are relatively helpless in the face of threat. They are therefore more readily overwhelmed by traumas than an older person would be. Conditioned responses, which in cognitive terms are acquired expectancies that a particular event will follow from another, are readily established in situations that evoke strong emotions; such responses are often highly resistant to extinction. Thus one traumatic experience of almost drowning in a deep lake may be sufficient to establish a fear of water that endures for years or a lifetime. Conditioned responses stemming from traumatic experiences may also generalize to other situations. For example, the child who has learned to fear water may also come to fear riding in boats and other situations associated with even the remotest possibility of drowning. Young children are thus especially prone to acquiring intense anxieties that remain resistant to modification even as their coping resources develop over time.

Bowlby (1960, 1973) has summarized the traumatic effects for children from two to five years old of being separated from their parents during prolonged periods of hospitalization. First, there are the short-term or acute effects of the separation, which can include significant despair during the separation and detachment from the parents upon reunion; Bowlby considers this to be a *normal* response to prolonged separation, even in securely attached infants. Children who undergo such separations may develop an insecure attachment. In addition, there can be longer-term effects of early separation from one or both parents. For example, such separations can cause an increased vulnerability to stressors in adulthood, making it more likely that the person will become depressed (Bowlby, 1980). As with other early traumatic experiences, the long-term effects of separation depend heavily on the support and reassurance given a child by parents or other significant people, which is most likely if the child has a secure relationship with at least one parent (Lease & Ollendick, 1993; Main & Weston, 1981).

Many psychic traumas in childhood, although highly upsetting at the time, probably have minor long-term consequences. Some children are less vulnerable than others and show more resilience and ability to recover from hurt (Crittenden, 1985). For example, not all children who experience a trauma—even a parent's death—exhibit discernible long-term effects (Barnes & Prosen, 1985; Brown, Harris, & Bifulco, 1985; Crook & Eliot, 1980; Rutter, 1985).

Inadequate Parenting

Even in the absence of severe deprivation, neglect, or trauma, many kinds of deviations in parenting can have profound effects on a child's subsequent ability to cope with life's challenges, and thus create vulnerability to various forms of psychopathology. Therefore, although their explanations vary considerably, the psychosocial viewpoints on abnormal behavior all focus attention on the behavioral tendencies a child acquires in the course of early social interaction with others—chiefly parents or parental surrogates.

You should keep in mind that a parent-child relationship is always bidirectional: As with any continuing relationship, the behavior of each person affects the behavior of the other. Some children are easier to love than others; some parents are more sensitive than others to an infant's needs. In occasional cases, we are able to identify characteristics in an infant that have been largely responsible for an unsatisfactory relationship between parent and child. A common example occurs in parents who have babies with high levels of negative emotionality. For example, Rutter and Quinton (1984b) found that parents tended to react with irritability, hostility, and criticism to children who were high in negative mood and low on adaptability. This in turn may set such children at risk for psychopathology because they become "a focus for discord" in the family (Rutter, 1990, p. 191). Because parents find it difficult and stressful to deal with babies who are high on negative emotionality, many of these infants may be more prone to developing avoidant styles of attachment than are infants who are not high on negative emotionality (Rothbart & Ahadi, 1994). Although these examples illustrate that characteristics of an infant can contribute to unsatisfactory attachment relationships, in most cases the influence of a parent on his or her child is likely to be more important in shaping a child's behavior, as we will see in the following sections.

Parental Psychopathology In general, it has been found that parents who have various forms of psychopathology, including schizophrenia, depression, antisocial personality disorder, and alcoholism, tend to have children who are at heightened risk for a wide range of developmental difficulties. Although some of these effects may have a genetic component, many researchers believe that genetic effects cannot account for all of the adverse effects that parental psychopathology has on children. For example, the children of seriously depressed parents are at enhanced risk for disorder themselves (Downey & Coyne, 1990; Gotlib & Avison, 1993), at least partly because depression makes for unskillful parenting—notably including inattentiveness to a child's needs (Gelfand & Teti, 1990). Not only do depressed mothers rate their children as having more psychological and physical problems than do nondepressed mothers, but independent observers also rate infants of depressed mothers as more unhappy and tenser than infants of nondepressed mothers. Slightly older children of depressed mothers have also been rated as having a wide range of problems (see Gotlib & Avison, 1993). In addition, children of alcoholics have elevated rates of truancy and substance abuse and a greater likelihood of dropping out of school, as well as higher levels of anxiety and depression and lower levels of self-esteem (Chassin, Rogosch, & Barrera, 1991; Gotlib & Avison, 1993), although many children of alcoholics do not have difficulties. Although most research on this topic has focused on the effects of disordered mothers on their children, recently attention has been drawn to the fact that disordered fathers also make significant contributions to child and adolescent psychopathology, especially to problems such as conduct disorder, delinquency, and attention deficit disorder (Phares & Compas, 1992).

In spite of the profound effects that parental psychopathology can have on children, it should also be noted that many children raised in such families do just fine because of a variety of protective factors that may be present. For example, a child living with a parent with a serious disorder who also has a warm and nurturing relationship with the other parent, or with another adult outside the family, has a significant protective factor. Other important protective factors that promote resilience include having good intellectual skills and being appealing to adults (Masten et al., 1990).

Although not associated with any particular form of parental psychopathology, several specific patterns of parental influence appear in the backgrounds of children who show certain types of faulty development that may increase their risk for psychopathology. Some of these patterns will be discussed in the following sections.

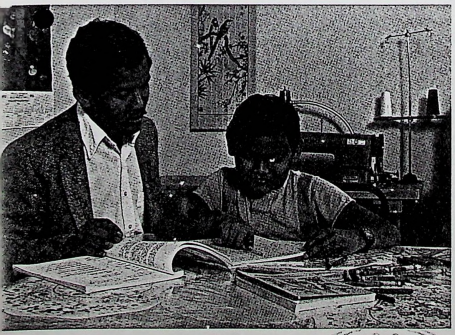
Parental Warmth and Control In the past, discipline was conceived of as a method for both punishing undesirable behavior and preventing or deterring such behavior in the future. Discipline is now thought of more positively as providing needed structure and guidance for promoting a child's healthy growth. Such guidance provides a child with schemas similar to outcomes actually meted out by the world, contingent on a person's behavior. The

person thus informed has a sense of control over these outcomes and is free to make deliberate choices. When coercion or punishment is deemed necessary, it is important that a parent make clear exactly what behavior is considered inappropriate. It is also important that the child know what behavior is expected, and that positive and consistent methods of discipline be worked out for dealing with infractions. In general, a child should be allowed independence in keeping with his or her level of maturity. As competent parents would doubtless agree, this judgment is not always easy to make.

Researchers have been interested in the degree to which *parenting styles*—including their disciplinary styles—affect children's behavior over the course of development. Four different types of parenting styles have been identified that seem to be related to different developmental outcomes for the children: authoritative, authoritarian, indulgent, and neglecting. These styles vary in the degree of *parental warmth* (amount of support, encouragement, and affection versus shame, rejection, and hostility) and in the degree of *parental control* (extent of discipline and monitoring versus being largely unsupervised) (Maccoby & Martin, 1983). First, the *authoritative style* is one in which the parents are both very warm and very careful to set clear limits and restrictions regarding certain kinds of behaviors, but also allow considerable freedom within certain limits. This style of parenting is associated with the most positive early social development, with the children tending to be energetic and friendly and showing development of general competencies for dealing with others and with their environments (Baumrind, 1967, 1975, 1993). When followed into adolescence in a longitudinal study, children of authoritative parents continued to show positive outcomes. This parenting style was particularly predictive of competence in sons (Baumrind, 1991).

Parents with an *authoritarian style* are high on control but low on warmth, and their children tend to be conflicted, irritable, and moody (Baumrind, 1967). When followed into adolescence these children had more negative outcomes, with the boys doing particularly poorly in social and cognitive skills. If such authoritarian parents also use overly *severe discipline* in the form of physical punishment—as opposed to the withdrawal of approval and privileges—the result tends to be increased aggressive behavior on the part of a child (Eron et al., 1974; Faretra, 1981; Patterson, 1979). Apparently, physical punishment provides a model of aggressive behavior that the child emulates and incorporates into his or her own self-schema.

A third parenting style is the *permissive-indulgent style*, in which parents are high on warmth but low on discipline and control. This style of parenting is associated with impulsive and aggressive behavior in children (Baumrind, 1967; Hetherington & Parke, 1993). Overly indulged children are characteristically spoiled, selfish, inconsiderate, and demanding. In a classic study Sears (1961) found that much permissiveness and little discipline in a home were correlated positively with antisocial, aggressive behavior, particularly during middle and later childhood. Unlike rejected and emotionally deprived children,



This father, who is helping his child with homework, has an authoritative parenting style. He has a warm and supportive relationship with his son, but also sets clear limits and restrictions—for example, about how much homework must be done before his son is allowed to watch TV.

indulged children enter readily into interpersonal relationships, but they exploit people for their own purposes in the same way that they have learned to exploit their parents. Overly indulged children also tend to be impatient, and to approach problems in an aggressive and demanding manner (Baumrind, 1971, 1975). In short, they have self-schemas with significant "entitlement" features. Confusion and adjustive difficulties may occur when "reality" forces them to reassess their assumptions about themselves and the world.

Finally, there are parents who are low both on warmth and on control—the *neglecting-uninvolved style*. This latter style of parental uninvolvement is associated with disruptions in attachment during childhood (Egeland & Sroufe, 1981), and with moodiness, low self-esteem, and conduct problems later in childhood (Baumrind, 1991; Hetherington & Parke, 1993). These children of uninvolved parents also have problems with peer relations and with academic performance (Hetherington & Parke, 1993).

When just examining the effects of restrictiveness (ignoring the warmth variable), research has shown that restrictiveness can serve as a protective factor for children growing up in high-risk environments, as defined by a combination of family occupation and education level, minority status, and absence of a father (Baldwin, Baldwin, & Cole, 1990). Among high-risk children, those who did well in terms of cognitive outcome (IQ and school achievement) tended to have more restrictive and less democratic parents. Indeed, restrictiveness was positively related to cognitive outcome only among high-risk children and not among low-risk children. Restrictiveness was also particularly helpful for families living in areas with high crime rates.

Inadequate, Irrational, and Angry Communication Parents sometimes discourage a child from asking questions and in other ways fail to foster the information exchange essential for helping the child develop essential competencies. Inadequate communication may take a number of forms. Some parents are too busy or preoccupied with their own concerns to listen to their children and to try to understand the conflicts and pressures they are facing. As a consequence, these parents often fail to give needed support and assistance, particularly when there is a crisis. Other parents have forgotten that the world often looks different to a child or adolescent—rapid social change can lead to a communication gap between generations. In other instances, faulty communication may take more deviant forms in which messages become completely garbled because a listener distorts, disconfirms, or ignores a speaker's intended meaning.

Not uncommonly children are exposed to high levels of anger and conflict. The anger can occur in the context of marital discord, abuse, or parental psychopathology, and is often associated with psychological problems in children (Emery, 1982; Porter & O'Leary, 1980; Schneider-Rosen & Cicchetti, 1984). That there are psychological problems is not surprising given findings that children experience such background anger, like abuse, as emotionally arousing and distressing (Cummings, 1987; Emery, 1989).

Pathogenic Family Structures

The pathogenic parent-child patterns so far described, such as parental rejection, are rarely found in severe form unless the total familial context is also abnormal. Thus pathogenic family structure is an overarching risk factor that increases an individual's vulnerability to particular stressors. We will distinguish between intact families where there is significant marital discord and families that have been disrupted by divorce or separation.

Marital Discord In some cases of marital discord, one or both of the parents is not gaining satisfaction from the relationship. One spouse may express feelings of frustration and disillusionment in hostile ways such as nagging, criticizing, and doing things purposely to annoy the other person. Whatever the reasons for the difficulties, seriously discordant relationships of long standing are likely to be frustrating, hurtful, and generally pathogenic in their effects on the adults and their children.

In more severe cases of marital discord, one or both of the parents behave in grossly eccentric or abnormal ways and may keep the home in constant emotional turmoil. Such families differ greatly, but it is common to find (a) parents who are fighting to maintain their own equilibrium and are unable to give children the love and guidance they need, (b) grossly irrational communication patterns, and (c) entanglement of children in the parents' emotional conflicts. In all these cases, the children are caught up in an unwholesome and irrational psychological environment and as they grow up they may find it difficult to establish and maintain marital and other intimate relationships.

Divorced Families In many cases a family is incomplete as a result of death, divorce, separation, or some other circumstance. Due partly to a growing

cultural acceptance of divorce, more than a million divorces now occur yearly in the United States (U.S. Bureau of the Census, 1989). Estimates are that about 20 percent of children under the age of 18 are living in a single-parent household—some with unwed parents and some with divorced parents. About 40–50 percent of marriages end in divorce and about 60 percent of these divorces involve children (Hetherington & Parke, 1993). Unhappy marriages are difficult, but ending a marital relationship can also be enormously stressful for the adults, both mentally and physically. Divorced and separated persons are overrepresented among psychiatric patients, although the direction of the causal relationship is not always clear. In their comprehensive review of the effects of divorce on adults, Bloom, Asher, and White (1978) concluded that it is a major source of psychopathology, as well as physical illness, death, suicide, and homicide.

Divorce can have traumatic effects on children, too. Feelings of insecurity and rejection may be aggravated by conflicting loyalties and, sometimes, by the spoiling the children receive while staying with one of the parents. Not surprisingly, some children do develop serious maladaptive responses. Temperamentally difficult children are likely to have a more difficult time adjusting than are temperamentally easy children (Hetherington, Stanley-Hagan, & Anderson, 1989). Somewhat ironically, these also may be the children whose parents are more likely to divorce, perhaps because having difficult children is likely to exacerbate marital problems (Block, Block, & Gjerde, 1986). Delinquency and other abnormal behaviors are much more frequent among children and adolescents from divorced families than among those from intact families, although it is likely that a contributing factor here is prior or continuing parental strife (Rutter, 1971, 1979). Moreover, given that both broken homes and delinquency are more common among families in lower socioeconomic circumstances, it may be that disrupted homes and childhood deviance are both largely caused by the stresses of poverty and exclusion from society's mainstream. Finally, Amato and Keith (1991; Amato, 1988) also note that there may well be long-term effects of divorce on adaptive functioning in early adulthood in as much as some studies have found lower educational attainment, lower incomes, increased probability of being on welfare and having children out of wedlock in young adults from divorced families.

Nevertheless, many children adjust quite well to the divorce of their parents. Indeed, a recent quantitative review of 92 studies conducted on 13,000 children since the 1950s on parental divorce and the well-being of children concluded that the average negative effects of divorce on children are actually quite modest (Amato & Keith, 1991). They also found that the effects seem to be decreasing over the past four decades (particularly since 1970), perhaps because the stigma of divorce is decreasing. The domains of well-being that were examined included school achievement, conduct problems, psychological and social adjustment, self-concept, and parent-child relations. Children in the middle-age range (grade school to high school) had slightly worse outcomes than preschool-age and college-age children (Amato & Keith, 1991).

The effects of divorce on children have been compared with the effects of remaining in a home torn by marital conflict and dissension, and the effects of divorce are often more favorable (Hetherington et al., 1989). The Amato and Keith review (1991) also demonstrated that children who were in intact but high-conflict families were worse off than children in divorced families. At one time it was thought that detrimental effects of divorce might be minimized if a successful remarriage provided an adequate environment for child rearing. Unfortunately, however, the Amato and Keith review revealed that such children living with a stepparent were no better off than children living with a single parent, although this was more true for girls than for boys. Indeed, some studies have found that the period of adjustment to remarriage may be longer than that for divorce (Hetherington et al., 1989). Other studies have shown that children—especially very young children—living with a stepparent are at increased risk for physical abuse and even death by the stepparent, relative to children living with two biological parents (Daly & Martin, 1988).

Maladaptive Peer Relationships

Another important set of relationships outside the family usually begins in the preschool years—those involving age-mates, or peers. Normally, these neighborhood or school relationships involve a much broader range of possible experiences than do the more constrained and established relationships within families. When a child ventures into the world independently, he or she is faced with a number of complicated and unpredictable challenges. The potential for problems and failure is considerable.

Children at this stage are hardly masters of the fine points of human relationships or diplomacy. Empathy—the appreciation of another's situation, perspective, and feelings—is at best only primitively developed, as can be seen in a child who turns on

and rejects a current playmate when a more favored candidate arrives. The child's own immediate satisfaction tends to be the primary goal of any interaction, and there is only an uncertain recognition that cooperation and collaboration may bring even greater benefits. A substantial minority of youngsters seems somehow ill-equipped for the rigors and competition of the school years, most likely by virtue of constitutional factors and deficits in the psychosocial climate of their families. A significant number of them withdraw from their peers; a large number of others (especially among males) adopt physically intimidating and aggressive lifestyles. The neighborhood bully and the menacing schoolyard loner are examples. Neither of these routes bode well for good mental health outcomes (e.g., Coie et al., 1992; Coie & Cillessen, 1993; Hartmann et al., 1984; Kupersmidt, Coie, & Dodge, 1990).

Fortunately, there is another side to this coin. If peer relations have their developmental hazards, they can also be sources of key learning experiences that stand an individual in good stead for years, perhaps for a lifetime. For a resourceful youngster, the give-and-take, the winning and losing, the successes and failures of the school years provide superb training in coming to grips with the real world and with his or her developing self—its capabilities and limitations, its attractive and unattractive qualities. The experience of intimacy with another, a friend, has its beginning in this period of intense social involvement. If all has gone well in the early juvenile years, a child emerges into adolescence with a considerable repertoire of social knowledge and skills. Such an adolescent can effectively adapt his or her behavior to the requirements of a situation and communicate, as appropriate, his or her thoughts and feelings to others. Practice and experience in intimate communication with others makes possible a transition from attraction, infatuation, and mere sexual curiosity to genuine love and commitment. Such resources can be strong protections against frustration, demoralization, despair, and mental disorder.

Although the scenario just outlined seems reasonable, it lacked until recently a strong empirical research foundation. In fact, the developmental period it addresses had been largely ignored by the major personality theorists, Erikson and Sullivan being notable exceptions. In the last 20 years, however, research into risk factors associated with children's peer relations has been accelerating. Some of the more important of these findings are briefly summarized in the following section.

Sources of Popularity Versus Rejection What determines which children will be popular and which will be rejected? By far the most consistent correlate of popularity among juveniles is being seen as friendly and outgoing (Hartup, 1983). The causal relationship between popularity and friendliness is indeterminate and probably complexly involved with other variables, such as intelligence and physical attractiveness.

Far more attention has been devoted to identifying why some children are persistently rejected by their peers. One large factor is an excessively demanding or aggressive approach to ongoing peer activities, but this factor by no means characterizes the behavior of all children rejected by their peers. A smaller group of children is apparently rejected because of their own social withdrawal. The remaining large group is rejected for unknown reasons; evidently some reasons are quite subtle (Coie, 1990).

Many rejected children have poor entry skills in seeking to join ongoing group activities: They draw attention to themselves in disruptive ways; make unjustified aversive comments to others; and frequently become the focal point of verbal and physical aggression (Coie & Kupersmidt, 1983; Coie & Dodge, 1988; Putallaz & Gottman, 1983). Indeed, approximately half of rejected boys are highly aggressive (Coie & Cillessen, 1993). More generally, Dodge and colleagues (1980; Dodge & Newman, 1981; Dodge & Frame, 1982; Dodge, Murphy, & Buchsbaum, 1984) have described these children as taking offense too readily and as attributing hostile intent to the teasing of their peers, escalating confrontations to unintended levels. They also tend to take a more punitive and less forgiving attitude toward such situations (Coie et al., 1991). In the end, rejection leads to social isolation, often self-imposed (Dodge, Coie, & Brakke, 1982; Hymel & Rubin, 1985; Ladd, 1983). Coie (1990) pointed out that such isolation is likely to have serious consequences because it deprives a child of further opportunities to learn the rules of social behavior and interchange, rules that become more sophisticated and subtle with increasing age. Repeated social failure is the usual result, with further damaging effects on self-confidence and self-esteem. Kupersmidt and Coie (1990) reported that boys who were rejected by their peers in the fifth grade were more likely to have nonspecific negative outcomes seven years later than were average, popular, or neglected boys. Aggression toward peers in the fifth grade was the best predictor of juvenile delinquency and school dropout seven years later (see also Coie et al., 1992; Coie & Cillessen, 1993). One causal pathway for this association has been supported by Patterson, Capaldi, and Bank (1991; see also Dishion, 1994). Building on the finding that aggression is the best predictor of

Juvenile socializing is a risky business in which a child's hard-won prestige in a group is probably perceived as being constantly in jeopardy. Actually, reputation and status in a group tend to be stable, and a child who has been rejected by peers is likely to continue to have problems in peer relationships.

peer rejection (Coie et al., 1990), they found that peer rejection often leads a child to associate with deviant peers several years later, which in turn is associated with a tendency toward juvenile delinquency.

A child's position in a group tends, in the absence of intervention, to remain stable, especially by the fifth grade and beyond. On average, "stars" tend to remain stars and "rejects," rejects. For example, in one study almost half of the fifth graders who were rejected by their peers continued to be rejected over the next five years (Coie & Dodge, 1983). Some of this happens because other children tend to explain the behavior of the rejected child in terms of stable characteristics of the child. Because they have negative expectations of the rejected child, they act more negatively toward the child, thus setting up a kind of self-fulfilling prophecy for the interaction between the rejected child and his peers.

In summary, both logic and research findings lead to a similar conclusion: A child who fails to establish a satisfactory relationship with peers during the developmental years is deprived of a crucial set of background experiences and is at higher-than-average risk for a variety of negative outcomes in adolescence and adulthood (Kupersmidt et al., 1990). Peer social problems in childhood have been linked to a variety of breakdowns in later adaptive functioning, including schizophrenia, school dropout, and crime. Although these correlational data do not in themselves permit strong causal inferences, they constitute important links in a highly plausible causal chain.

THE SOCIOCULTURAL VIEWPOINT

By the beginning of the twentieth century, sociology and anthropology had emerged as independent scientific disciplines and were making rapid strides toward understanding the role of sociocultural factors in human development and behavior. Early sociocultural theorists included such notables as Ruth Benedict, Ralph Linton, Abram Kardiner, Margaret Mead, and Franz Boas. Their investigations and writings showed that individual personality development reflected the larger society—its institutions, norms, values, ideas, and technologies—as well as the immediate family and other groups. Studies also made clear the relationship between sociocultural conditions and mental disorders—between the particular stressors in a society and the types of mental disorders that typically occur in it. Further studies showed that the patterns of both physical and mental disorders in a given society could change over time as sociocultural conditions changed. These discoveries have added another dimension to modern perspectives on abnormal behavior.

Uncovering Sociocultural Factors Through Cross-Cultural Studies

The sociocultural viewpoint is concerned with the impact of the social environment on mental disorder, but the relationships between maladaptive behavior and sociocultural factors such as poverty, discrimination, or illiteracy are complex. It is one thing to observe that a person with a psychological disorder has come from a harsh environment. It is quite another thing, however, to show empirically that these circumstances were either necessary or sufficient conditions for producing the disorder. Part of the problem relates to the impossibility of conducting controlled experiments. Investigators cannot ethically rear children with similar genetic or biological traits in diverse social or economic environments in order to find out which variables affect development and adjustment.

Nevertheless, natural occurrences have provided laboratories for researchers. Groups of human beings have been exposed to very different environments, from the Arctic to the tropics to the desert. These societies have developed different means of economic subsistence and different types of family structures. Accordingly, highly diverse social and political systems have developed. Nature has indeed

done social scientists a great favor by providing such a wide array of human groups for study.

In the earliest cross-cultural studies, Western-trained anthropologists observed the behavior of "natives" and considered those behaviors in the context of Western scientific thought. One of the earliest attempts to apply Western-based concepts in other cultures was the classic study of Malinowski (1927), *Sex and Repression in Savage Society.* In this work, he attempted to explain the behavior of "savages" through the use of the then-dominant principles of psychoanalysis. Malinowski found little evidence among the Trobriand Islanders of any Oedipal conflicts as described by Freud. He concluded that the sexually based behavior postulated by psychoanalytic theory was not universal but rather was a product of the patriarchal family structure in Western society.

Shortly thereafter, Ruth Benedict (1934) pointed out that even the Western definitions of abnormality might not apply to behavior in other cultures. Citing various ethnographic reports, she indicated that behavior considered abnormal in one society was sometimes considered normal in another. For example, she noted that some cultures valued trancelike states. Thus she concluded that normality was simply a culturally defined concept.

Early research also found that some types of abnormal behavior occurred only in certain cultures. Several of these "culture-related" behaviors are described in HIGHLIGHT 3.6. These and other early anthropological findings led many investigators to take a position of cultural relativism concerning abnormal behavior. According to this view, one cannot apply universal standards of normality or abnormality to all societies. In fact, for a time many people accepted the anthropologist's veto: Any general principle could be rejected if a contrary instance somewhere in the world could be demonstrated. For example, schizophrenia would no longer be viewed as abnormal if its symptoms were somewhere accepted as normal behavior.

This extremely relativistic view of abnormal behavior is not widely held today (Strauss, 1979). It is generally recognized that the more severe types of mental disorder described in Western psychology are found and considered maladaptive in societies throughout the world. When people become so mentally disordered that they can no longer control their behavior, perform their expected roles, or even survive without special care, their behavior is considered abnormal in any society.

Research supports the view that many psychological disturbances are universal, appearing in most

Margaret Mead (1901–1978), the world-famous anthropologist, spent years studying other societies and amassing cross-cultural data. Her Coming of Age in Samoa *(published in 1928) gave a favorable picture of many aspects of life in a "primitive" society and was influential in establishing an attitude of cultural relativism among many scientists and thinkers. Here she is pictured meeting with schoolchildren in New Guinea.*

cultures studied (Al-Issa, 1982; Carpenter & Strauss, 1979; Cooper et al., 1972; Murphy, 1976; World Health Organization, in press). For example, although the incidences and symptoms vary, the behaviors we call schizophrenia (Chapter 12) can be found among almost all peoples, from the most primitive to the most technologically advanced. Recent studies have also shown that certain psychological symptoms, as measured by the Minnesota Multiphasic Personality Inventory (MMPI-2; see Chapter 15), were consistently found among similarly diagnosed clinical groups in other countries (in Turkey by Savacir & Erol, 1990; in China by Cheung & Song, 1989; Butcher, 1995).

Nevertheless, although some universal symptoms appear, cultural factors do influence abnormal behavior. Human biology does not operate in a vacuum; cultural demands serve as causal factors and modifying influences in psychopathology. Sociocultural factors often create stress for an individual (Al-Issa, 1982; Sue & Sue, 1987). For example, children growing up in an oppressive society that offers few rewards and many hassles are likely to experi-

TABLE 3.6

Unusual Patterns of Behavior Considered to Be Culture-Related Disorders

Name of Disorder	Culture	Description
Amok	Malaya (also observed in Java, Philippines, Africa, and Tierra del Fuego)	A disorder characterized by sudden, wild outbursts of homicidal aggression in which an afflicted person may kill or injure others. This rage disorder is usually found in males who are rather withdrawn, quiet, and inoffensive prior to the onset of the disorder. Stress, sleep deprivation, extreme heat, and alcohol are among the conditions thought to precipitate the disorder. Several stages have been observed: Typically in the first stage the person becomes more withdrawn; then a period of brooding follows in which a loss of reality contact is evident. Ideas of persecution and anger predominate. Finally, a phase of automatism or Amok occurs, in which the person jumps up, yells, grabs a knife, and stabs people or objects within reach. Exhaustion and depression usually follow, with amnesia for the rage period.
Anorexia nervosa	Western nations (particularly the U.S.)	A disorder occurring most frequently among young women in which a preoccupation with thinness produces a refusal to eat. This condition can result in death (see Chapter 8).
Latah	Malay	A fear reaction often occurring in middle-aged women of low intelligence who are subservient and self-effacing. The disorder is precipitated by the word *snake* or by tickling. It is characterized by echolalia (repetition of the words and sentences of others) and echopraxia (repetition of the acts of others). A disturbed individual may also react with negativism and the compulsive use of obscene language.
Koro	Southeast Asia (particularly Malay Archipelago)	A fear reaction or anxiety state in which a person fears that his penis will withdraw into his abdomen and he will die. This reaction may appear after sexual overindulgence or excessive masturbation. The anxiety is typically very intense and of sudden onset. The condition is "treated" by having the penis held firmly by the patient or by family members or friends. Often the penis is clamped to a wooden box.
Windigo	Algonquin Indian hunters	A fear reaction in which a hunter becomes anxious and agitated, convinced that he is bewitched. Fears center on his being turned into a cannibal by the power of a monster with an insatiable craving for human flesh.
Kitsunetsuki	Japan	A disorder in which victims believe that they are possessed by foxes and are said to change their facial expressions to resemble foxes. Entire families are often possessed and banned by the community. This reaction occurs in rural areas of Japan where people are superstitious and relatively uneducated.
Taijin kyofusho (TKS)	Japan	A relatively common psychiatric disorder in Japan in which an individual develops a fear of offending or hurting other people through being awkward in social situations or because of an imagined physical defect or problem. The excessive concern over how a person presents himself or herself in social situations is the salient problem.

Based on Kiev (1972), Kirmayer (1991), Lebra (1976), Lehmann (1967), Simons and Hughes (1985), and Yap (1951).

ence more stress and thus be more vulnerable to disorder than children growing up in a society that offers ample rewards and considerable social support. Growing up during a period of great fear, such as during a war, a famine, or a period of persecution, can make a child vulnerable to psychological problems.

Sociocultural factors also appear to influence what disorders develop, the forms that they take, and their courses. A good example of this point is a comparison study of psychiatric patients from Italy, Switzerland, and the United States carried out by Butcher and Pancheri (1976). Patients grouped according to diagnostic categories produced similar general personality patterns on the MMPI. However, the Italian patients also showed an exaggerated pattern of physical complaints significantly greater than that of the Swiss and the American patients, regardless of clinical diagnosis. This finding was consistent with earlier work by Opler and Singer (1959) and Zola (1966). Zola attributed this difference to a defense mechanism, which he called dramatization, that led the Italian patients, once identified as ill, to exaggerate or dramatize their physical problems to a greater extent than the Irish patients.

In another example, Kleinman (1986) traced the different ways that Chinese people (in Taiwan and in the People's Republic of China) deal with stress compared with Westerners. He found that in Western societies depression was a frequent reaction to individual stress. In China, on the other hand, he noted a relatively low rate of reported depression. Instead, the effects of stress were more typically manifested in physical problems, such as fatigue, weakness, and other complaints. Moreover, Kleinman and Good (1985) surveyed the experience of depression across cultures. Their data show that important elements of depression in Western societies—for example, the acute sense of guilt typically experienced—do not appear in other cultures. They also point out that the symptoms of depression (or dysphoria), such as sadness, hopelessness, unhappiness, lack of pleasure in the things of the world and in social relationships, have dramatically different meanings in different societies. For Buddhists, seeking pleasure from things of the world and social relationships is the basis of all suffering; a willful disengagement is thus the first step on the road to salvation. For Shi'ite Muslims in Iran, grief is a religious experience, associated with recognition of the tragic consequences of living justly in an unjust world; the ability to experience dysphoria fully is thus a marker of depth of personality and understanding.

Fascinating issues are also raised by recent studies of childhood psychopathology in different cultures. In certain cultures like that of Thailand, adults are highly intolerant of undercontrolled behavior such as aggression, disobedience, and disrespectful acts in their children. Children are taught to be polite and deferential and to inhibit any expression of anger. This raises interesting questions about whether childhood problems of undercontrolled behavior would be lower in Thailand than in the United States where such behavior is tolerated to a greater extent. Conversely it also raises the question of whether overcontrolled behavior problems such as shyness, anxiety, and depression would be overrepresented in Thailand relative to the United States. Two recent cross-national studies (Weisz et al., 1987, 1993) have confirmed that Thai children and adolescents do indeed have a greater prevalence of overcontrolled problems than do American children. Although there were no differences in the rate of undercontrolled problems between the two countries, there were differences in the kind of undercontrolled behavior problems reported. For example, Thai adolescents had higher scores than American adolescents on indirect and subtle forms of undercontrol not involving interpersonal aggression, such as having difficulty concentrating or being cruel to animals; American adolescents on the other hand had higher scores than Thai adolescents on behaviors like fighting, bullying, and disobeying at school (Weisz et al., 1993). Related findings have also emerged from studies comparing Jamaican and American children. Jamaicans come from an Afro-British tradition that is also intolerant of acting out behavior and that promotes politeness and respectfulness. Accordingly, it is not surprising that Jamaican children were more likely to be referred to a clinic for overcontrolled behavior than were American children, whereas American children were more likely to be referred for undercontrolled behavior than were Jamaican children (Lambert, Weisz, & Knight, 1989).

All of these findings illustrate an important point—the need for greater study of cultural influences on psychopathology. This neglected area of research may yet answer many questions about the origins and courses of behavior problems (Draguns, 1979; Marsella et al., 1985). Yet even with strong evidence of cultural influences on psychopathology, many professionals may fail to adopt an appropriate cultural perspective when dealing with mental illness. Clark (1987) notes a reluctance of "mainstream" psychologists and psychiatrists to incorporate the cross-cultural perspective in their research and clinical practices even when their patients or

subjects are from diverse cultures. In a shrinking world, with instant communication and easy transportation, it is crucial for our sciences and professions to take a world view. In fact, Kleinman and Good consider cultural factors so important to our understanding of depressive disorders that they have urged the psychiatric community to incorporate another axis in the DSM diagnostic system to reflect cultural factors in psychopathology.

Sociocultural Influences in Our Own Society

As was noted in Chapter 1, the study of the incidence and distribution of physical and mental disorders in a population (as in the research just cited) is called epidemiology. The epidemiological approach implicates not only the social conditions and high-risk areas that are correlated with a high incidence of given disorders, but also the groups for whom the risk of pathology is especially high—for example, refugees from other countries (Vega & Rumbaut, 1991). Throughout this text we will point out many high-risk groups with respect to suicide, drug dependence, and other maladaptive behavior patterns. This information provides a basis for formulating prevention and treatment programs; in turn, the effectiveness of these programs can be evaluated by means of further epidemiological studies.

With the gradual recognition of sociocultural influences, what was previously an almost exclusive concern with individual patients has broadened to include a concern with societal, communal, familial, and other group settings as factors in mental disorders. Sociocultural research has led to programs designed to improve the social conditions that foster maladaptive behavior and to community facilities for the early detection, treatment, and long-range prevention of mental disorder. In Chapter 18 we will examine some clinical facilities and other programs—both governmental and private—that have been established as a result of community efforts.

SOCIOCULTURAL CAUSAL FACTORS

We will begin our discussion of the sociocultural causal factors that increase our vulnerability to the development of abnormal behavior by considering the role of culture in determining an individual's behavior patterns. For reasons of temperament, conditioning, and other individual factors, not all people adopt the prevailing cultural patterns. This situation is especially common in Western society, where we are exposed to many competing values and patterns. We will also examine the particular factors in the social environment that may increase vulnerability: low socioeconomic class, disorder-engendering social roles, prejudice and discrimination, economic and employment problems, and social change and uncertainty.

The Sociocultural Environment

In much the same way that we receive a genetic inheritance that is the end product of millions of years of biological evolution, we also receive a sociocultural inheritance that is the end product of thousands of years of social evolution. The significance of this inheritance was well pointed up by Aldous Huxley (1965):

> The native or genetic capacities of today's bright city child are no better than the native capacities of a bright child born into a family of Upper Paleolithic cave-dwellers. But whereas the contemporary bright baby may grow up to become almost anything—a Presbyterian engineer, for example, a piano-playing Marxist, a professor of biochemistry who is a mystical agnostic and likes to paint in water colours—the paleolithic baby could not possibly have grown into anything except a hunter or food-gatherer, using the crudest of stone tools and thinking about his narrow world of trees and swamps in terms of some hazy system of magic. Ancient and modern, the two babies are indistinguishable. . . . But the adults into whom the babies will grow are profoundly dissimilar; and they are dissimilar because in one of them very few, and in the other a good many, of the baby's inborn potentialities have been actualized. (p. 69)

Because each group fosters its own cultural patterns by systematically teaching its offspring, all its members tend to be somewhat alike—to conform to certain basic personality types. Children reared among headhunters become headhunters; children reared in societies that do not sanction violence learn to settle their differences in nonviolent ways. In New Guinea, for example, Margaret Mead (1949) found two tribes—of similar racial origin and living in the same general geographical area—whose members developed diametrically opposed characteristics. The Arapesh were a kindly, peaceful, cooperative people, while the Mundugumor were warlike, suspicious, competitive, and vengeful. Such differences appear to be social in origin.

The more uniform and thorough the education of the younger members of a group, the more alike they will become. Thus in a society characterized by a limited and consistent point of view, there are not the wide individual differences typical in a society like ours, where children have contact with diverse, often conflicting, beliefs. Even in our society, however, there are certain core values that most of us consider essential.

Subgroups within a general sociocultural environment—such as family, sex, age, class, occupational, ethnic, and religious groups—foster beliefs and norms of their own, largely by means of social roles that their members learn to adopt. Expected role behaviors exist for a student, a teacher, an army officer, a priest, a nurse, and so on. Because most people are members of various subgroups, they are subject to various role demands, which also change over time. In fact, an individual's life can be viewed as a succession of roles—child, student, worker, spouse, parent, and senior citizen. When social roles are conflicting, unclear, or uncomfortable, or when an individual is unable to achieve a satisfactory role in a group, healthy personality development may be impaired—just as when a child is rejected by juvenile peer groups.

The extent to which role expectations can influence development is well illustrated by masculine and feminine roles in our own society and their effects on personality development and on behavior. In recent years, a combination of masculine and feminine traits (androgyny) has often been claimed to be psychologically ideal for both men and women. Many people, however, continue to show evidence of having been strongly affected by traditional assigned masculine and feminine roles. Moreover, there is accumulating evidence that the acceptance of gender-role assignments has substantial implications for mental health. In general, studies show that low "masculinity" is associated with maladaptive behavior and vulnerability to disorder for either biological sex, possibly because this condition tends to be strongly associated with deficient self-esteem (Carson, 1989). Baucom (1983), for example, has shown that high-feminine-sex-typed (low masculinity) women tend to reject opportunities to lead group problem-solving situations. He likens this effect to learned helplessness, which, as we have seen, has in turn been suggested as a causal factor in anxiety (Barlow, 1988; Mineka, 1985a) and depression (Abramson et al., 1978). Given findings like these, it should not be too surprising that women show much higher rates of anxiety and depressive disorders (see Chapters 5 and 6).

Pathogenic Societal Influences

There are many sources of pathogenic social influences, some of which stem from socioeconomic factors, and others of which stem from sociocultural factors regarding role expectations and the destructive forces of prejudice and discrimination. Some of the more important ones will be examined in the following sections.

Low Socioeconomic Status In our society, an inverse correlation exists between socioeconomic status and the prevalence of abnormal behavior—the lower the socioeconomic class, the higher the incidence of abnormal behavior (e.g., Eron & Peterson, 1982). The strength of the correlation seems to vary with different types of disorder, however. Some disorders may be related to social class only minimally or perhaps not at all. For example, the incidence of schizophrenia is inversely correlated with social class, while that of mood disorders bears a less distinct relationship to class.

We do not understand all the reasons for the more general inverse relationship. There is evidence that some people with mental disorders slide down to the lower rungs of the economic ladder and remain there because they do not have the economic or personal resources to climb back up (Gottesman, 1991). These people will often have children who also show abnormal behavior for a whole host of reasons, including increased risk for prenatal complications leading to low birth weight. At the same time, more affluent people are better able to get prompt help or to conceal their problems. In addition, it is almost certainly true that people living in poverty encounter more, and more severe, stressors in their lives than do people in the middle and upper classes, and they usually have fewer resources for dealing with them. As Kohn (1973) pointed out, the conditions under which lower-class children are reared tend to inhibit the development of the coping skills needed in our increasingly complex society. Thus the tendency for some forms of abnormal behavior to appear more frequently in lower socioeconomic groups may be at least partly due to increased stress in the people at risk (Gottesman, 1991). Nevertheless, findings from a longitudinal study of inner-city children in Boston showed that in spite of coming from high-risk socioeconomic background, many of the boys did very well and showed upward mobility. Resilience here was best indicated by childhood IQ and having adequate functioning as a child in school, family, and peer relationships (Long & Valliant, 1984; Felsman & Valliant, 1987).

In our society the lower the socioeconomic class, the higher the incidence of abnormal behavior. The conditions under which lower-class youngsters are reared tend to inhibit the development of coping skills. Many individuals, however, emerge from low socioeconomic environments with strong, highly adaptive personalities and skills.

Disorder-Engendering Social Roles An organized society, even an "advanced" one, sometimes asks its members to perform roles in which the prescribed behaviors either are deviant themselves or may produce maladaptive reactions. A soldier who is called upon by his superiors (and ultimately by his society) to deliberately kill and maim other human beings may subsequently develop serious feelings of guilt. He or she may also have latent emotional problems resulting from the horrors commonly experienced in combat and hence be vulnerable to disorder. As a nation, we are still struggling with the many problems of this type that have emerged among veterans of the Vietnam War (Kulka et al., 1990). The diagnosis of posttraumatic stress disorder was added to DSM-III (1980) largely in response to the problems of Vietnam veterans. Although this condition can occur following a range of highly traumatic events (such as rape, torture, and natural disasters), as discussed in Chapter 4, the feeling of guilt over atrocities committed were especially pronounced in Vietnam veterans.

Militaristic regimes and organizations are especially likely to foster problematic social roles. Military and civilian officials in Germany during the Nazi Holocaust and in the Soviet Union during Stalin's collectivization of rural areas in the 1930s (Conquest, 1986) willingly participated in history's most heinous and cold-blooded mass murders. Some American street gangs demand extreme cruelty and callousness on the part of their members. Well-organized terrorist groups, feeling that the world is ignoring their just claims, train their members for taking hostages, mass destruction, and murder.

There is, of course, no easy answer to the problems of violence and coercion in the modern world; people will often resort to force when other remedies fail. As long as such actions are taken, many people will be subjected to conditions of extraordinary stress and will feel compelled to enact difficult and painful social roles. In some cases, the end result will be psychological disorder.

Prejudice and Discrimination Vast numbers of people in our society have been subjected to demoralizing stereotypes and overt discrimination in areas such as employment, education, and housing. We have made progress in race relations since the 1960s, but the lingering effects of mistrust and discomfort among various ethnic and racial groups can be clearly observed on almost any college campus. For the most part, students socialize informally only with members of their own subcultures, despite the attempts of many well-meaning college administrators to break down the barriers. The tendency of students to avoid crossing these barriers needlessly limits their educational experiences and probably contributes to continued misinformation about, and prejudice toward, others.

We have also made progress in recognizing the demeaning and often disabling social roles our society has historically assigned to women. Again, though, much remains to be done. As already

noted, many more women than men seek treatment for various emotional disorders, notably depression and many anxiety disorders. Mental health professionals believe this is a consequence both of the vulnerabilities (such as passivity and dependence) intrinsic to the traditional roles assigned to women, and possibly of the special stressors with which many modern women must cope (being full-time mothers, full-time homemakers, and full-time employees) as their traditional roles rapidly change. However, it should also be noted that working outside the home has also been shown to be a protective factor against depression under at least some circumstances (e.g., Brown & Harris, 1978).

Economic and Employment Problems Economic difficulties and unemployment have repeatedly been linked to enhanced vulnerability and thus to elevated rates of abnormal behavior (Dew, Penkower, & Bromet, 1991; Dooley & Catalano, 1980). Recession and inflation coupled with high unemployment are sources of chronic anxiety for many people. Unemployment has placed a burden on a sizable segment of our population, bringing with it both financial hardships, self-devaluation, and emotional distress. In fact, unemployment can be as damaging psychologically as it is financially. Research on the effects of unemployment was intense in the 1930s (Eisenberg & Lazarsfeld, 1938), but during the period of economic prosperity following World War II interest in the topic waned. However, interest was rekindled in the 1970s and 1980s when severe economic recessions were experienced worldwide and moderately high rates of employment became a seemingly permanent part of modern society. We certainly have not come close to solving the human problems such major economic shifts entail. The philosophies of free enterprise and rugged individualism run deep in American culture and politics, and they are shared by many unemployed people. The result is self-blame and personal demoralization.

Periods of extensive unemployment are typically accompanied by adverse effects on mental and physical health. In particular, rates of depression, marital problems, and somatic complaints increase during periods of unemployment, but usually normalize following reemployment (Dew et al., 1991; Jones, 1992). These effects occur even when mental health status before unemployment is taken into account; thus, it is not simply that those who are mentally unstable tend to lose their jobs. The psychological and physical health problems are more severe in lower socioeconomic groups (Jones, 1992). It also seems that physical violence among couples is associated with unemployment, although the causal direction is unclear (Dew et al., 1991). Not surprisingly, the wives of unemployed men also are adversely affected, with higher levels of anxiety, depression, and hostility. These effects appear to be mediated by the distress of the unemployed husband (Dew, Bromet, & Schulberg, 1987). In addition, children can be seriously affected. In the worst cases, the unemployed fathers engage in child abuse, with many studies documenting an association between child abuse and father's unemployment (Dew et al., 1991). In one prospective study, all the children born on Kauai, Hawaii, in 1955 were followed until age 18 (Werner & Smith, 1982). One of the best predictors distinguishing children (especially boys) who experienced significant problems with mental health or delinquency from those who did not was whether the father had lost his job when his children were small.

Social Change and Uncertainty The rate and pervasiveness of change today are different from anything our ancestors ever experienced. All aspects of our lives are affected—our education, our jobs, our families, our leisure pursuits, our finances, and our beliefs and values. Constantly trying to keep up with the numerous adjustments demanded by these changes is a source of constant and considerable stress. Simultaneously, we confront inevitable crises as the earth's consumable natural resources dwindle and as our environment becomes increasingly noxious with pollutants. Certain neighborhoods have increasing problems with drugs and crime. No longer are Americans confident that the future will be better than the past or that technology will solve all our problems. On the contrary, our attempts to cope with existing problems increasingly seem to create new problems that are as bad or worse. The resulting despair, demoralization, and sense of helplessness are well-established predisposing conditions for abnormal reactions to stressful events (Dohrenwend et al., 1980; Frank, 1978).

UNRESOLVED ISSUES

on Theoretical Viewpoints and Causation of Abnormal Behavior

The viewpoints described in this chapter are theoretical constructions devised to orient psychologists in the study of abnormal behavior. As a set of hypothetical guidelines, each viewpoint speaks to the importance and integrity of its own position to

the exclusion of other explanations. Most psychoanalytically oriented clinicians, for example, value those traditional writings and beliefs consistent with Freudian or later psychodynamic theory, and they minimize or ignore the teachings of opposing viewpoints. They usually adhere to prescribed practices of psychoanalytic therapy and do not use other methods, such as desensitization therapy.

Theoretical integrity and adherence to a systematic viewpoint has a key advantage: It provides a consistent approach to orient one's practice or research efforts. Once mastered, the methodology can guide a practitioner or researcher through the complex web of human problems. Theoretical adherence has its disadvantages, however. By excluding other possible explanations, it can blind researchers to other factors that may be equally important.

The fact is that none of the theories to date addresses the whole spectrum of abnormality—each is limited in its focus. Two general trends have occurred as a result. The first involves revisions of an original theoretical doctrine by expanding or modifying some elements of the system. The second involves making use of two or more diverse approaches in a more general, eclectic approach. We will now examine how effectively each of these trends brings order to theoretical complexity.

1. *The revision of theoretical viewpoints.* The emergence of diverse viewpoints to explain abnormal behavior has led to criticisms of each viewpoint and thus to attempts to accommodate these criticisms. There are many examples of such corrective interpretations, such as Adler's or Jung's modification of Freudian theory or the more recent cognitive-behavioral approach in behavior therapy. But many of the early Freudian theorists did not accept the neo-Freudian additions, and many classical behavior therapists today do not accept the revisions proposed by cognitive behaviorists. Therefore, theoretical viewpoints tend to multiply and coexist—each with its own proponents—rather than being assimilated into previous views. In effect, at least some "revisions" of an original doctrine tend to survive as new, alternative interpretations of psychopathology. The result is a cumbersome backdrop of many theoretical viewpoints from which to study abnormal behavior. This situation also complicates communication among psychologists who may adhere to different perspectives, and with so many different perspectives, it is nearly impossible to have a clear grasp of them all.

2. *The eclectic approach.* As already noted, explanations based on single viewpoints are likely to be incomplete. In practice, many psychologists have responded to the existence of many perspectives by adopting an eclectic stance—that is, they accept working ideas from several existing viewpoints and use whichever they find to be useful. For example, a psychologist using an eclectic approach might accept causal explanations from psychoanalytic theory while applying techniques of anxiety reduction derived from behavior therapy. Another psychologist might combine techniques from the cognitive-behavioral approach with those from the interpersonal approach. Purists in the field—those advocates of a single viewpoint—are skeptical about eclecticism, claiming that the eclectic approach tends to lack integrity and produces a "crazy quilt" of activity with little rationale and inconsistent practice. This criticism may be true, but the approach certainly works for many psychologists.

Typically, those using an eclectic approach make no attempt to synthesize the theoretical perspectives. Although the approach can work in practical settings, it is not successful at a theoretical level because the underlying principles of many of the theoretical perspectives are incompatible as they now stand. Thus the eclectic approach still falls short of the final goal, which is to tackle the theoretical clutter and develop a single, comprehensive, internally consistent viewpoint that accurately reflects what we know empirically about abnormal behavior. It may be unrealistic to expect a single theoretical viewpoint to be broad enough to explain abnormal behavior in general and specific enough to accurately predict the symptoms and causes of specific disorders. Nevertheless, such a unified viewpoint is the challenge for the next generation of theorists in the field of abnormal psychology.

At present the one attempt at such a unified viewpoint is called the *biopsychosocial viewpoint.* This viewpoint acknowledges the interaction of biological, psychosocial, and sociocultural causal factors in the development of abnormal behavior. The biopsychosocial model was first articulated in order to account for the effects of psychological and sociocultural factors in physical health and has now become the dominant viewpoint in the fields of health psychology and behavioral medicine (see Chapter 8). However, it has also now been extended to the study of many other disorders as well.

The biopsychosocial viewpoint fits well with the conclusion that most disorders, especially beyond childhood, are the result of many causal factors—biological, psychosocial, and sociocultural. Moreover, for any person the particular combination of causal factors may be relatively unique, or at least not widely shared by large numbers of people with the

same disorder. For example, some children may become delinquents because of having a heavy genetic loading for antisocial behavior, while others may become delinquent more because of environmental influences such as living in an area with a large number of gangs. Nevertheless, we can still have a scientific understanding of many of the causes of abnormal behavior even if we cannot predict such behavior with exact certainty in each individual case. However, there may also remain a rather large array of "unexplained" influences.

SUMMARY

In most instances the occurrence of abnormal or maladaptive behavior is the joint product of a person's vulnerability (diathesis) to disorder and of certain stressors that challenge his or her coping resources. Such vulnerabilities may be necessary or contributory causal factors, but they are not generally sufficient to cause disorder. Some of the major contributory causal influences are reviewed in this chapter. We also distinguished between relatively distal causal factors and more proximal causal factors. There are also a variety of protective factors that can promote more positive developmental outcomes even in persons who have the diathesis for a disorder.

Both the distal and the proximal causes of mental disorder may involve biological, psychosocial, and sociocultural factors. These three classes can interact with each other in complicated ways. At present there are many different points of view on the interpretation and treatment of abnormal behavior. We discussed biological, psychosocial, and sociocultural viewpoints, each of which tends to emphasize the importance of causal factors of the same type.

The early biological viewpoint focused on brain damage as a model for the understanding of abnormality. Modern biological thinking about mental disorders has focused more on the biochemistry of brain functioning, as well as other more subtle forms of brain dysfunction. In examining biologically based vulnerabilities, we must consider genetic endowment (including chromosomal irregularities), physical deprivation, primary reaction tendencies, and temperament. Investigations in this area show much promise for advancing our knowledge of how the mind and the body interact to produce maladaptive behavior.

The psychosocial viewpoints on abnormal behavior, dealing with human psychology rather than biology, necessarily are more varied than the biological perspective. The oldest of these perspectives is Freudian psychoanalytic theory. For many years this view was preoccupied with questions about libidinal energies and their containment, but more recently it has shown a distinctly social or interpersonal thrust under the direction of object-relations theory. Psychoanalysis and closely related approaches are termed *psychodynamic* in recognition of their attention to inner, often unconscious forces. An integration of psychodynamic and interpersonal perspectives (as suggested by Sullivan's work) would seem possible as we move into the future.

The behavioral perspective on abnormal behavior, which was rooted in the desire to make psychology an objective science, was slow in overcoming a dominant psychodynamic bias, but in the last 30 years it has established itself as a significant force. Behaviorism focuses on the role of learning in human behavior. It views maladaptive behavior either as a failure of learning appropriate behaviors, or learning maladaptive behaviors. Its therapeutic methods have achieved excellent results, and its ability to accommodate itself to the current dominance of cognitive thinking in psychology ensures its continued growth and importance.

Initially a spinoff from (and in part a reaction against) the behavioral perspective, the cognitive-behavioral viewpoint attempts to incorporate the complexities of human cognition in a rigorous, information-processing framework. This viewpoint attempts to alter maladaptive thinking and improve people's abilities to solve problems and to plan. As we will discuss in Chapter 17, the treatment procedures incorporating cognitive processes are highly effective in treating a variety of disorders.

The humanistic perspective does not chiefly concern itself with the origins and treatments of severe mental disorders. Rather, it focuses on the conditions that can maximize functioning in individuals who are just "getting along." It views abnormality as a failure to develop individual human potential. As such, it has to do with personal values and personal growth.

The originators of the interpersonal perspective were defectors from the psychoanalytic ranks who took exception to the Freudian emphasis on the internal determinants of motivation and behavior. As a group, interpersonal theorists have emphasized that important aspects of human personality have social or interpersonal origins. This viewpoint sees unsatisfactory relationships in the past or present as the primary causes of maladaptive behaviors.

For psychosocially determined causes or sources of vulnerability, the situation is somewhat more complicated than for biological causes. It is clear,

however, that people's schemas and self-schemas play a central role in the way that they process information and in the kinds of attributions and values concerning the world that they have. The efficiency, accuracy, and coherence of a person's schemas and self-schemas appear to provide an important protection against breakdown. Sources of psychosocially determined vulnerability include early social deprivation, severe emotional trauma, inadequate parenting, and dysfunctional peer relationships.

Any comprehensive approach to the study of human behavior—normal or abnormal—must take account of the sociocultural context in which a given behavior occurs. Cultural influences on psychopathology are important in understanding the origin and course of a behavioral problem. The sociocultural viewpoint is concerned with the social environment as a contributor to mental disorder because sociocultural variables are also important sources of vulnerability, or, conversely, of resistance to it. The incidence of particular disorders varies widely among different cultures. Unfortunately, we know little of the specific factors involved in these variations. In our own culture, certain prescribed roles, such as those relating to gender, appear to be more predisposing to disorder than others. Low socioeconomic status is also associated with greater risk for various disorders, possibly because it is often difficult for economically distressed families to provide their offspring with sufficient coping resources. Additionally, certain roles evolved by given cultures may in themselves be maladaptive, and certain large-scale cultural trends, such as rapid technological advance, may increase stress while lessening the effectiveness of traditional coping resources.

Finally, we are still a long way from the goal of a complete understanding of abnormal behavior. The many theoretical perspectives that exist have given us a start, and a good one at that—but they fall short. To obtain a more comprehensive understanding of mental disorder, we must draw on a variety of sources, including the findings of genetics, biochemistry, psychology, sociology, and so forth. The biopsychosocial approach comes closest, but in many ways it is merely a descriptive acknowledgment of these complex interactions rather than a clearly articulated theory of how they interact. It is the task of future generations of theorists to devise a general theory of psychopathology, if indeed one is possible.

KEY TERMS

etiology (p. 64)
necessary cause (p. 64)
sufficient cause (p. 64)
contributory cause (p. 64)
diathesis-stress models (p. 65)
protective factors (p. 66)
resilience (p. 66)
neurotransmitters (p. 69)
hormones (p. 69)
genotype (p. 71)
phenotype (p. 71)
temperament (p. 75)
id (p. 79)
libido (p. 79)
pleasure principle (p. 79)
primary process thinking (p. 79)
ego (p. 79)
secondary process thinking (p. 79)
reality principle (p. 79)
superego (p. 79)
intrapsychic conflicts (p. 79)
ego-defense mechanisms (p. 79)
psychosexual stages of development (p. 81)
Oedipus complex (p. 81)
castration anxiety (p. 81)
Electra complex (p. 81)
introjection (p. 82)
classical conditioning (p. 84)
extinction (p. 84)
spontaneous recovery (p. 84)
operant (or instrumental) conditioning (p. 84)
reinforcement (p. 84)
generalization (p. 85)
discrimination (p. 85)
cognitive-behavioral perspective (p. 87)
attributions (p. 88)
humanistic perspective (p. 89)
self-actualizing (p. 92)
interpersonal perspective (p. 92)
social-exchange view (p. 94)
interpersonal accommodation (p. 94)
schema (p. 96)
self-schema (p. 96)
assimilation (p. 96)
accommodation (p. 96)
psychic trauma (p. 99)

IMH-1.

Beyond Erwadi

The mentally challenged people rescued from Erwadi are in no better a state in their new surroundings. A review of the mental health care scene in Tamil Nadu.

ASHA KRISHNAKUMAR

[illegible] the rescued [illegible] ple rescued from the 15 so-called mental homes in Erwadi in Tamil Nadu's Ramanathapuram district in August 2001.

They had come under the Tamil Nadu government's care after all the "mental homes" in Erwadi were closed down following a fire in the Moideen Badusha Mental Home on August 6, which killed 28 inmates who were chained to their positions. Of the 571 persons who were rescued, 152 were sent to the Government Institute of Mental Health (IMH) in Chennai, while 11 patients who had violent tendencies were admitted to the Ramanathapuram Government Hospital. The rest were returned to the care of their families. (Some have returned to their families from the IMH.)

But nothing has changed for them – they continue to live in misery, stripped of dignity and shunned by their families and society. Most of those who were forced back onto their families have been sent to 'faith healing' centres attached to various temples or dargahs. The rest, who remain with their families, are mostly isolated and ostracised.

For instance, Raghu, from one of Erwadi's "mental homes", was sent back to his family in Sikkil in Thanjavur district in August 2001, since the government doctors who examined him soon after the Erwadi incident found him "fit for discharge". But his father, Raghavan, did not know what to do with the "mentally ill" son. Neither did he have the means to rehabilitate Raghu in a private hospital nor could he bear the stigma of having a mentally ill person at home. He had two daughters to be [illegible] February 2002, Raghu was [illegible] ling centre closer home.

[illegible] s like Gowri, who had [illegible] an Erwadi mental home [illegible] allegedly in an attempt to [illegible] dispute, and Murugan, who [illegible] in Erwadi to separate him from his girlfriend, are back at the 'faith-healing' dargah at Erwadi. While the privately run mental homes in Erwadi were ordered closed on August 13, 2001, patients who stayed within the precincts of the dargah were allowed to remain there, provided each had an attendant.

Even for the 152 patients brought to the IMH, the only government hospital for the mentally challenged in Tamil Nadu, life is no different except that they are no longer in chains. Also, according to a psychiatrist at the IMH (who prefers to remain anonymous), "because of the media attention, the Erwadi patients at the IMH get some special treatment".

The patients who were already in IMH, numbering over 1,500, were in a situation hardly better than at Erwadi. The death of some inmates in October 2001 owing to diarrhoea, the collapse of the main building a month later, and some incidents of violent inmates killing each other, brought to light the abysmal conditions at the IMH.

Shunned by family and society, most IMH inmates live without dignity and basic human rights. The plight of some 600 of them who have been in the IMH for decades is especially bad. For them, death may well be the only means of deliverance. For instance, Thangam and Noyola Mary, who had been there for 60 and 50 years respectively, died last year (but no one claimed the bodies). Viswanathan, who has been at the IMH for 20 years, says, "I look forward to the day (of my death)."

Says an IMH psychiatrist: "The IMH follows the 18th century concept of the mental asylum. It is like a concentration camp. Patients are checked once in 15 days. They are paraded outside their wards while a psychiatrist checks each one quickly. There are no doctors. Patients with physical complications are referred to other government hospitals. Some of the 21 wards do not have toilets." The abysmal level of crisis management at the IMH was revealed by the diarrhoea deaths there last year.

According to the psychiatrist, the system followed at the IMH is similar to that followed in jails: lunch is served at 1 p.m. and dinner at 4 p.m. At 5 p.m. all patients are locked in their wards until 8.30 a.m. the next morning, when they are given breakfast. Says the IMH psychiatrist: "Most patients skip dinner as it is too early. Thus most patients eat at 1 p.m. and then only 8.30 a.m. the next day. This is particularly bad for the diabetic, the old and the infirm."

Says the psychiatrist: "Ward 21 is the de-addiction ward. But several patients in this ward abuse heroin and cannabis regularly."

There is no emergency room or an intensive care unit at the IMH. Patients in serious condition are exam-

V. GANESAN

Women patients who were brought to the Institute of Mental Health in Chennai following the Erwadi fire incident of August 2001. Life is no different for the 152 patients brought to the IMH except that they are no longer in chains.

ined just outside the ward. Most often the 'golden hour' is lost by the time these patients are taken to an ICU of a government hospital.

Says another IMH psychiatrist: "Treatment at the IMH is not holistic. Addressing the social context – environmental and social stress – is not considered important. The focus is narrow, and is limited to neuro-transmitters and genetics. Rehabilitation, occupational therapy and social integration are poor. That is why most inmates remain there for decades." There seems to be no protocol for drug treatment. The mentally challenged seem to be dumped at the IMH for life.

V. GANESAN

Mentally challenged patients brought from [illegible] at Chennai last year.

When this correspondent approached the IMH Director for comments, he refused to talk and denied her permission to visit the hospital premises.

According to an administrative staff member, the IMH is plagued by many problems. Many inmates, though cured, continue to remain at the IMH as the addresses given at the time of admission are false. The arrears that "old" patients owe the IMH add up to over Rs.3 lakhs. Although the number of in-patients (1,654) is lower than the sanctioned bed strength of 1,800, maintenance has become difficult, with several 'basic servant' posts remaining vacant for long. For instance, of the sanctioned 202 posts of warders, 47 are vacant, while 20 of the 79 sanctioned posts of ayahs are vacant. Of the 91 sanctioned posts of male sanitary workers, 28 remain vacant, as do 12 of the 20 sanctioned posts of dhobis.

WITH just one bed for every 40,000 patients and one psychiatrist for every one million patients, India's infrastructure for treating the mentally ill is abysmal. The only comprehensive report on the 37 mental hospitals in the country, brought out by the National Human Rights Commission (NHRC) in 2001, points to the scanty availability of facilities such as beds, medicines and toilets; insufficient professional help; and inadequate treatment and rehabilitation facilities. Lack of awareness and infrastructure forces families of the mentally challenged to resort to witchcraft, black magic and faith-healing. Professional help is hardly sought. The NHRC report also points to the deprivation of human rights to the mentally ill.

The mental health care system in Tamil Nadu has been in a deplorable state, with successive governments failing to act on the various reports and studies on the plight of the mentally ill. The Erwadi tragedy, which caught the attention of even the international media, forced the State government to act. It decided to implement, after 14 years, certain sections of the Mental Health Act, 1987, and announce some measures to deal with the situation. The State Human Rights Commission, which studied the cause of the Erwadi incident, came up with 19 recommendations including penal action against private mental homes operating without a licence.

Among the immediate measures announced by the State government were the closure of all "mental homes" functioning in thatched sheds and the "unchaining" of all inmates. The government also made it mandatory for anyone setting up such a home to obtain a licence, as stipulated by the Mental Health Act, 1987. It also ordered the setting up of a monitoring cell under the Collector in every district to make sure that the homes conform to norms. The government also launched the District Mental Health Programme (DMHP) in Ramanathapuram and Madurai districts, with help from such rehabilitation centres as Shristi in Madurai run by the M.S. Chellamuthu Trust under the guidance of the psychiatrist Dr. C. Ramasubramanian. The IMH is to be the nodal agency for the programme. The basic idea of the DMHP is to provide primary mental health services on a sustained basis and to put in place a system for early detection of mental disabilities and treatment.

Under the DMHP, the Ramanathapuram district administration conducted a survey of the district, identified over 25 handicapped and mentally challenged persons and provided them with a rehabilitation package that included treatment and vocational training. According to Ramanathapuram Collector S. Vijayakumar, this programme will establish [illegible] centres for rehabilitating handicapped people, including the mentally challenged, are to be set up in the State soon.

In August 2001, soon after the Erwadi incident, the Supreme Court *suo motu* issued notices, on the basis of media reports on the tragedy, to the State and Central governments asking them to submit a "factual report" and ordered the mapping of all faith-healing homes in the country. This process is under way. The Centre also ordered the implementation of the guidelines for maintaining minimum standards in mental homes.

Says Dr. Ramasubramanian: "A piecemeal approach will not help the millions of hapless mentally ill people and their families. Treating the mentally ill does not stop with medicines. It involves a multi-dimensional approach including rehabilitation and integration into the family and society." This should be the approach of all mental hospitals, including the IMH. The complex problem of mental health care can be addressed only through a sustained programme of education and awareness generation, along with improving the infrastructure for treatment. It is important to expand, encourage and push community-based treatment and rehabilitation. The system of "care givers" started by the government early this year, by which youth in the rural areas are trained to take care of the mentally ill in the local areas, needs to be expanded. While the government seems to have taken some steps in the right direction, a lot depends on sustaining them. ■

MH-1.

MENTAL HEALTH

Deliverance in Erwadi

The death by fire of 28 persons while still in chains in a 'mental home' in a Tamil Nadu town draws attention to the lack of facilities for humane and scientific treatment of the mentally ill in the country.

ASHA KRISHNAKUMAR
in Erwadi

THE chain is blackened and the ring is horribly twisted but still fastened to the charred stump – of a leg. Mentally challenged and physically shackled he was, yet Murugaraj had desperately tried to save himself. Twenty-seven more mentally ill people died with him in the early hours of August 6 when a fire engulfed the thatched roof of the Moideen Badusha Mental Home at Erwadi, a fishing village 27 km south of Ramanathapuram town in southern Tamil Nadu. They were stripped of dignity when they lived – chained, confined and ill-treated. The manner of their death was even worse.

Their death highlights the deplorable state of mental health care in the country and the need for the government to reach out to the mentally ill. Caught up in economic, social, cultural, religious and legal problems, most of the mentally ill persons are deprived of the right kind of treatment. Many of them end up being exploited at homes that are set up illegally. They are denied even the basic human rights.

Such homes proliferated at Erwadi because of the dargah of Syedina Sheikh Shaheed Valiyullah. Valiyullah, who came to India to propagate Islam, legend has it that Sheikh Valiyullah, who died in 1198, appeared in the dream of his descendant Naila Ibrahim Valiyullah and told him to build a mosque for him at a particular place and maintain it. Thus the dargah was built and it is looked after by the descendants of Naila Ibrahim. It is believed that Vijaya Reganatha Sethupathy, the Raja of Ramanathapuram, got an heir to his throne after he offered prayers and drank the water at the dargah, which is considered to be holy, for 41 days. The king endowed over 6,000 acres (2,400 hectares) to the dargah. This apparently is at the root of the belief that the holy water and the oil from a lamp in the dargah can cure all ailments.

People have been coming to the dargah for the last 200 years in search of a cure, mostly for mental disorders. About 1,000 pilgrims, belonging to different religious groups, visit the dargah every day. When the flow of cure-seekers increased, 'homes' came up to take care of the mentally ill.

According to dargah committee manager Murad Ibrahim, these homes proliferated in the last 10 years. Ironically, many of them are run by persons who were brought to Erwadi 15 to 20 years ago for a cure, or by those who came here with their wards. The person who ran the Moideen Badusha Mental Home had come to Erwadi from Tuticorin 15 years ago with a mental illness. His home had 43 inmates as on August 6 (28 of them died, nine survived with minor burns and six are missing). Similar is the case of the Darbar Mental Hostel, whose owner Bashir came from Kerala 20 years ago for treatment. The home, run by Bashir and wife Najima, has 15 inmates.

The 17 homes around the dargah together have about 550 inmates, and some 100 patients are kept in the dargah compound. Most of them are chained. They go to the dargah in the evening, drink the water and dab themselves with oil from the lamp. They wait for the "divine command" in their dream to go back home. For the "command" to come it may take anything from two months to several years.

Men and women are kept separately in the dargah. There are a few toilets, and these are used by the pilgrims also. The tank near the dargah is like a cesspool, but many inmates bathe in it. A few go to the sea. While some inmates seem to have been there for long, many come on the "divine call" and stay for a few months. Lakshmi of Chennai has been visiting the dargah for 17 years, and has stayed for periods ranging from six months to a year depending on the "divine command". (Some names of

PICTURES: K. GANESAN

Charred remains of the victims and the Moideen Badusha Mental Home at Erwadi.

same period. Agricultural imports into developing countries increased by nearly 4 per cent during this period compared to less than 2 per cent for developed countries. The U.S.-based Institute for Agriculture and Trade Policy complained in a recent note to the U.S. Trade Representative that American agribusiness corporations were "dumping" their products across the world because of the "export credit, insurance and transportation subsidies" that they receive from the U.S. government at the expense of the taxpayer.

ENFORCEMENT of intellectual property rights is an emotive issue that is threatening to assume serious proportions in the Third World. At the very least, developing countries want compulsory licensing of patents so that they are able to address their public health priorities. The development and availability of drugs for the treatment of Acquired Immune Deficiency Syndrome (AIDS) is among the most significant issues. African governments are under pressure to ensure that the drug monopolies are not allowed to override the need for treatment of life-threatening epidemics. Although some individual companies have offered concessions, developing countries would like the WTO to provide a more durable arrangement.

On the issue of trade in services, developing countries have time and again called for more liberal provisions for the "movement of natural persons" so that they could benefit from selling labour skills, priced cheaper, in advanced countries. This has met with stiff resistance although the value of trade in the "movement of natural persons" amounted to a mere $30 billion, compared to $820 billion in the case of the services trade via commercial presence. Developing countries also favour a more transparent and equitable dispute settlement mechanism at the WTO.

Although trade in textiles is of significant export interest to developing countries, very little has been done to remove the barriers to trade. Although member-countries are to remove all restrictions by 2005, till date only a fraction of such restrictions have been removed in the developed countries.

The Like-Minded Group (LMG), an informal group that includes India, Pakistan and other developing countries, has categorically rejected a new round. Srinivasan Narayanan, the Indian Ambassador to the WTO, said recently: "We are not ready for it (a new round). We will lose more than we gain."

India also articulated its concerns in its communique to the G-77 in mid-June. Union Minister for Commerce and Industry Murasoli Maran pointed out that the Uruguay Round, which laid the basis for the establishment of the WTO, had "resulted in serious imbalance and asymmetry to the detriment of the developing countries." He also pointed out that although the WTO's General Council had decided in May 2000 that all "implementation issues" would be resolved before the Doha Conference, developed countries now insist that these issues will be settled as part of a new round.

The LMG insists that the "implementation-related concerns are a hangover from the pre-WTO days. The group claims that developing countries have already paid heavily by undertaking obligations arising out of deviations from the standard agenda of trade negotiations under the auspices of the General Agreement on Tariffs and Trade (GATT), the forerunner of the WTO. These obligations included those relating to intellectual property rights and Trade Related Investment Measures (TRIMS). Developing countries now demand that implementation issues be settled "upfront", before other issues are taken up for negotiations.

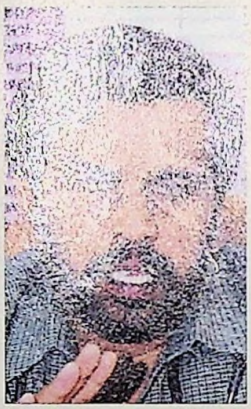
Indeed, Uganda's Ambassador to the WTO Nathan Irumba has argued that the demand for a new and extended round is flawed. "There is a systemic issue here," he said. Arguing that "the whole notion of rounds was before the WTO was created," Irumba claimed that the WTO is "supposed to be a continuous negotiating forum". Developing countries have called for a "realistic assessment"incorporating their concerns. They warn that if this does not happen, the "level of ambition will have to be lowered".

A confidential memo circulated among member-countries before the Geneva meet admitted that the "entrenched nature" of the differences among member-countries did not augur well for starting a new round at Doha. Mike Moore, Director-General of the WTO, could barely conceal his own position in favour of a new round, when he warned that another failure, at Doha, "would certainly condemn us to a long period of irrelevance". He asked member-countries "to get real" on the agenda for Doha. ■

'State intervention is important'

Interview with Dr. C. Ramasubramanian.

Shristi is a cluster of homes at Musundagiripatti, 20 km from Madurai, where the mentally challenged are treated after initial medical care. It is more like a resort. The inmates are not chained or manacled. Each one is assigned a task – gardening, cleaning the cowshed, packing soap powder, making greeting cards, cooking, and so on. The premises, with a beautiful two-acre garden, are spic and span.



The basic objective of Shristi, run by the M.S. Chellamuthu Trust and Research Foundation under the guidance of its founder-trustee Dr. C. Ramasubramanian, a well-known psychiatrist based in Madurai, is to enhance the quality of life of the mentally challenged and reintegrate them into society. Started in 1992, Shristi now offers de-addiction therapy, helps the mentally retarded, organises community support groups, and provides vocational and skill-development training. To meet the recurring expenditure and to help impart skills to the inmates, Shristi runs a printing press, small industrial units making chalk, soap and agarbathi, a dairy farm and a computer centre.

Shristi was chosen as the best non-governmental organisation (NGO) by the Tamil Nadu government in 1996-97. It is recognised as a research institution in the field of mental health by the Department of Science and Technology, Government of India. The Rehabilitation Council of India recently recognised Shristi as a training institute. Dr. Ramasubramanian was a member of the Regulatory Committee set up by the Tamil Nadu government last year to look into the condition of the homes in Erwadi.

Dr. Ramasubramanian spoke to **Asha Krishnakumar** at his Madurai clinic. Excerpts from the interview:

▶ *What is the incidence of mental illness in India and how do people deal with the problem?*

There are today an estimated 70 million mentally ill in the country. The degree of their illness ranges from marginal to severe, yet they all need treatment. There are hardly 10,000 hospital beds for the mentally ill and a few doctors to treat them.

The stigma associated with mental illness, the fear of social ostracism, unaffordable treatment and the myths that mental illness is contagious or incurable force many to resort to crude methods before seeking psychiatric help. Often they try magico-religious methods. This is prevalent in villages and is closely associated with cultural beliefs cutting across religious divides. This method, usually adopted by priests, makes use of hypnotism. Minor problems arising from pressure and fatigue, such as fainting spells, chest pain and breathlessness can probably be cured using this method. But major problems cannot be addressed.

Another method is shock treatment. This is usually a painful procedure in which some special herbs and leaves are made into a paste and administered through the nose, mouth and eyes. Or, the patient is suddenly pushed into a deep well.

If all this fails, they are taken for 'religious', 'divine' or 'faith' healing in Erwadi, Gunaseelam (near Tiruchi), or Courtallam (Tirunelveli district). Here, most often the patients are chained. They are beaten when they become violent. Faith-healing has no role to play in treating the mentally ill. It is a waste of valuable time.

Most patients stop with faith-healing; only some take the next step – of going to a psychiatrist. Unfortunately, by the time they come to us their situation would have become chronic.

▶ *What should be the nature of the treatment for the mentally challenged?*

Total cure is possible. Mental illness, like any other illness, is curable, treatable and preventable. Most important is early detection, followed by effective treatment and appropriate rehabilitation. Treatment is incomplete if the patient is not integrated into society. He needs to be accepted by the family and then society. Vocational training and skill development are crucial for the patient to develop self-esteem, to be independent and to live with dignity. Follow-up and continuing medicines are a must.

▶ *Has pharmacology kept pace with the increase in the incidence of mental illness?*

A silent revolution has been on in psychiatry. Some wonder drugs have been developed in the last five years. Drugs such as lithium have revolutionised treatment. Several medicines that do not make patients drowsy have also been developed.

But, even the rich and educated do not accept mental illness as a disease that can be cured. There is an urgent need to change society's attitude towards mental illness. For this, educating the people and creating an awareness is very important.

▶ *How expensive are the treatment and the medicines?*

Right now the medicines are expensive. But the prices will come down. State intervention is important. Drugs should be subsidised. There should be community-based rehabilitation and self-help groups to deal with such problems.

▶ *Is the Mental Health Act, 1987, implemented in Tamil Nadu?*

Only a few States have implemented the Act. Tamil Nadu has not. Had the Act been implemented, the Erwadi problem would have never happened. As, according to the Act, no home could have been set up.

But under the Act, it is an elaborate and cumbersome process before a patient can be given treatment. A 'Magistrate' and an 'Inspection Committee' need to approve a case for treatment. There is a need to simplify these procedures before implementing the Act, for which there is an urgent need.

▶ *What needs to be done immediately to help the hapless people who fall into the trap of "faith-healers" and quacks?*

Inmates of all faith-healing homes in Tamil Nadu should be given immediate medical attention. There should be an outpatient psychiatric department in every taluk. There should be a well-equipped van (with a psychiatrist) to visit every taluk at least once a week. Generating awareness that the disease is totally curable and even preventable, and educating people on the various treatment opportunities and the availability of drugs can go a long way in addressing the problem. The success of the programme would, however, depend on how well the NGOs and the community are involved. ■

(From left) A woman patient in chains; one of the survivors of the tragedy, outside a home for the mentally ill; chained together, at a home in Erwadi.

patients in this article have been changed, in order to respect their privacy.)

Those who run the homes pay a rent of Rs.500-700 for the thatched sheds, which do not even have basic amenities. They charge between Rs.500 and 1,500 a month for each inmate, apart from taking an initial deposit. Each home has between 15 and 125 inmates. Some even engage touts who wait at the bus station and the railway station to lure relatives of the mentally ill.

For at least some people, putting their kin in the homes has become an easy way out of family disputes, often relating to property; in some cases even mentally healthy people are admitted to the homes in order to settle scores. For instance, Gowri (22), who was doing her B.Sc. in Psychology in Coimbatore, was left in Erwadi two years ago by her brothers after a property dispute among them made her depressed and moody. She gets a money order from her brothers every month. Murugan (25) was forced to stay in a home so that he is separated from his lover who comes from an influential family. Sundar (38), abandoned in Erwadi, is not sure where he is from. He stays chained and is made to beg.

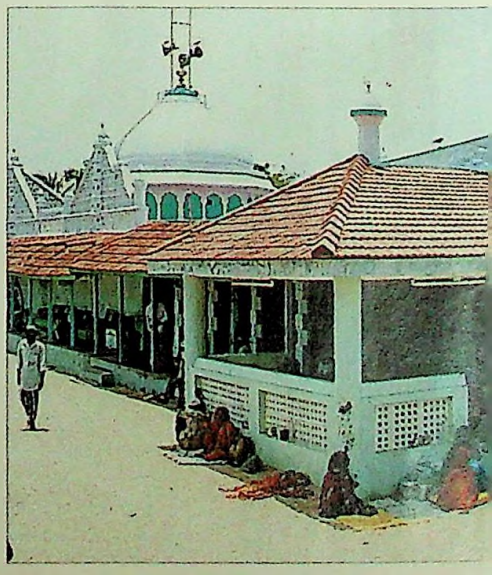
The only records the homes maintain are the addresses of the patients' kin, to make sure that the money order arrives every month. Some relatives are prompt in sending the money, perhaps just to ensure that their wards do not return home. Defaulting in payment is common, especially by the relatives of inmates from poor families. In such cases the inmates are made to beg, with the binding chains intact so that they do not escape.

No distinction is made among the inmates depending on the nature of their illness or its intensity. They are all chained – mostly six or seven of them together and at times individually – day and night. The plight of those chained together is especially heart-rending. If one needs to answer the call of nature, all the others have to accompany him. It is worse when one of them suffers from diarrhoea or gets an attack of epilepsy, or is violent or has an abnormal sexual orientation.

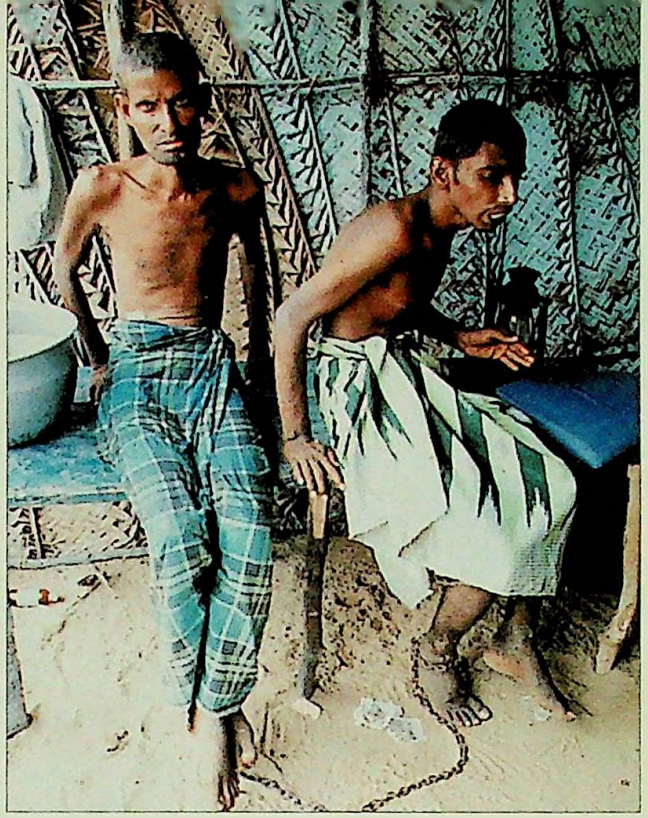
The inmates huddle together in small thatched sheds, which are mostly left open in the sides. A typical home, measuring 100 sq ft, houses about 20 persons. In some homes, men and women are kept together. Fungal infections and skin diseases are common among them as they do not wash themselves regularly. They are allowed to bathe in the tank once in two or three weeks. The inmates get no medical attention; beating is the only treatment.

Few homes have kitchens. The inmates are malnourished and weak. Most of them get only the food offered by the pilgrims. It is hardly an environment to treat the mentally ill. Yet people come to Erwadi, believing stories of people having been cured.

IT is not as if the condition of the homes was not known earlier. Only, successive governments have failed to act. In July 1998, I.Nazneen, Principal of the Women's Arts College at Ramanathapuram, brought to the government's notice the inhuman treatment of the mentally ill at the Sultan Alayudeen Dargah at Goripalayam in Madurai and asked the authorities to look into the affairs of all faith-healing centres, including Erwadi. The District Collector dismissed



The Erwadi dargah. People have been coming to the dargah for the last 200 years in search of a cure, mostly for mental disorders.



her findings as a "gross exaggeration". Nazneen then made a representation to the National Human Rights Commission.

The NHRC, under the chairmanship of Justice M.N. Venkatachaliah, urged the State government to address the issue urgently. As nothing was done in spite of repeated reminders, the NHRC deputed D.R. Karthikeyan, who was Director General (Investigations) then, to probe the state of affairs at the homes in Goripalayam and Erwadi. Karthikeyan confirmed Nazneen's findings.

The dargah management committee and the Society for Community Organisation Trust, a Madurai-based non-governmental organisation, also made representations to the NHRC. The NHRC set up a committee under the chairmanship of Prof K.S. Mani of the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, to study the condition of the mentally ill at Goripalayam and Erwadi. The NHRC sent the committee's report to the State government along with its recommendations. The State government took no action.

It was only when eight inmates of the Erwadi homes died owing to diarrhoea in April 2000 that the State government set up a District Mental Home Regulatory Committee. The committee recommended that the homes should register themselves with the respective local bodies; inmates should not be chained; basic amenities such as toilets should be provided; nutritious and hygienic food should be offered; the sheds should be made pucca; and the inmates should be admitted to hospitals through the dargah haqdar management committee. These recommendations were not implemented. The Dargah Committee has also been urging the Collector to close down the homes.

The only fallout of the recommendations, according to Dr. A. Ganesan, Deputy Director, Health, Paramakudi, who was on the Regulatory Committee, was that a primary health centre (PHC) was set up at Erwadi and Health Department personnel started visiting the homes once in two weeks. Health Department personnel, who had only monitorial powers, could not do much beyond recording in the inspection books their observations about the poor hygiene and the absence of infrastructure at the homes.

The PHC is of little help. According to S. Paneerselvam, who runs the New Limras Mental Home which has 120 male inmates, it is practically impossible to take inmates who require quick medical attention to the PHC, which is 3 km away. But, according to S. Vijayakumar, District Collector of Ramanathapuram, although a psychiatrist was posted at the PHC and the inmates were given slips that would facilitate treatment at the Government Hospital in Ramanathapuram, none from the Erwadi homes visited the hospital.

In September 2000, People's Watch, a Madurai-based human rights organisation, sought the NHRC's intervention in the case of Murugan after verifying a complaint that he was forcibly lodged at a home in Erwadi. K.R. Venugopal, the NHRC's Special Rapporteur, conducted a probe and the Commission issued a notice to the Chief Secretary to the Tamil Nadu government and the State's Director-General of Police on October 3, 2000.

Governmental inaction is glaring. But its greatest blunder is the failure to implement the Mental Health Act, 1987. Section 4(1) of the Act states: "The State government shall establish an Authority for Mental Health with such designation as it may deem fit... to be in charge of regulation, development and coordination of mental health services... and supervise the psychiatric hospitals and mental homes (including places where the mentally ill may be kept or detained)." Section 6(1) prohibits the running of a home for the mentally ill with-

out a licence. According to Section 11(1b), the licensing authority can revoke the licence if the maintenance of the "home is being carried on in a manner detrimental to the moral, mental or physical well-being of the inpatients." None of the homes in Erwadi meets the standards set by the Act.

THE August 6 fire, which is believed to have been caused by an overturned kerosene lamp (though sabotage is not ruled out and an investigation is on) seems to have galvanised the administration at last. The District Collector has sent a report to the State government with suggestions to improve the conditions of the homes and regularise them.

On August 10, the government announced a series of measures to regulate the functioning of homes for the mentally ill. It has ordered the immediate closure of all homes functioning in thatched sheds. Other homes should obtain a licence within a month and no home can be set up without a licence. A cell will be set up in every district under the chairmanship of the Collector to ensure that the homes conform to norms. The government has also ordered that the inmates of all homes be "unchained" immediately and those prone to violence be admitted to government hospitals. It has decided to take the inmates of all the homes at Erwadi into its care; those who are "actually mentally ill" will be moved to government hospitals and the others sent back to their families, or to old-age/destitutes homes run by the government or reputed non-governmental organisations (NGOs). Those who are not mentally ill but are abandoned by their families will get an old-age pension (regardless of their age) under the category of destitutes.

The District Mental Health Programme, sanctioned last year by the Centre, will be implemented immediately in Ramanathapuram and Madurai districts. Each district will get Rs.1 crore. According to Health Minister S. Semmalai, Rs.57 lakhs has been released by the State government for the programme in the two districts. Psychiatrists will be posted at all the 25 district headquarters hospitals. Only 14 have psychiatrists now.

In the wake of the Erwadi tragedy, the Centre has ordered the mapping of all "faith-healing" centres for the mentally ill in the country. Union Health Minister C.P. Thakur has ordered the implementation of the guidelines for maintaining minimum standards in homes for the mentally ill. The Centre also plans to modernise all mental health hospitals in the country.

Thulkarni Badsha, former secretary of the dargah committee, said that the dargah management was ready to participate in any programme initiated by the State government to improve the condition of the homes. Some home-owners, who maintain the infrastructure and keep the conditions of hygiene at reasonably good levels, have appealed to the Collector not to close down the homes. Says Paneerselvam of the New Limras Mental Home: "After the district administration issued strictures (unofficially, following the death of eight inmates in April 2000), I spent Rs.4 lakhs to upgrade all amenities to conform to the standards set by the District Mental Homes Regulatory Committee. The government should differentiate between homes."

S. Vijayakumar, District Collector, Ramanathapuram.

On August 9, Dr. K. Balagurunathan, Deputy Director in the District Health Department, examined the inmates in all the homes in Erwadi and ordered the transfer of 10 patients (by August 11, the number rose to 20), who were prone to violence, to the Government Hospital in Ramanathapuram. A clinic has been set up in a room given by the dargah committee to treat the others. The government plans to create a separate ward for the mentally ill at the Ramanathapuram hospital. Says State Health Secretary Syed Munir Hoda: "The government is looking at the social, legal and medical issues to deal with the problem. A comprehensive programme for the mentally ill will soon be put in place." The Departments of Health, Social Welfare and Law would be involved in the programme.

Various political parties are conducting independent inquiries into the Erwadi incident. There is, however, a general sense of caution as the issue involves "religious faith".

Immediately after the incident on August 6, the police arrested Moideen Badusha, his wife Suraiya Begum and relatives Badsha and Mumtaj. The government announced a solatium of Rs.50,000 each to the families of the 28 people who died (Rs.15,000 from the National Calamities Fund and Rs.35,000 from the State Relief Fund); Rs.15,000 to the families of the inmates with major burn injuries; and Rs.6,000 for the families of those with minor burns. While the families of 15 of the inmates who died claimed the *ex-gratia* payment, money has been disbursed to only seven families as in the case of others the legal heirs of the victims could not be ascertained. (Only the amount from the National Calamities Fund was disbursed; the rest would be distributed later.) The Collector has asked the relatives of the inmates of the other homes to take back their wards. Only a fourth of the inmates have been taken back by their families.

The families hesitate to take their kin back because, according to Dr. C. Ramasubramanian, a psychiatrist and a member of the District Mental Home Regulatory Committee, many of them consider the homes a convenient place to abandon their mentally ill wards in order to escape the stigma attached to mental illnesses (see interview). Myths that mental illnesses are incurable and contagious and the lack of proper medical infrastructure for the treatment of such diseases are also fac[illegible] that have influenced the decision of the relatives of the inmates of these homes. As a result, such homes have proliferated. There are about 35 of them around various temples and dargahs in Tamil Nadu.

According to Dr. Ramasubramanian, some 70 million people are mentally ill in the country. According to the publication *Mental Health in India 1950-2000*, 2 per cent of the population is affected severely and 20 per cent in varying degrees. But, according to estimates, there are hardly 10,000 hospital beds in India for the mentally ill. The only mental hospital in Tamil Nadu is the Institute of Mental Health in Kilpauk, Chennai, with 1,800 beds.

Dr. Ramasubramanian said that in recent times the treatment for mental illnesses has made rapid advances. The condition of most inmates of the homes for the mentally ill can be improved with the right medicines. But with their families unwilling to take them back and with a dearth of hospitals to treat them, what is the choice before them? Says Dr. Ramasubramanian: "Treating the mentally ill does not stop with medicines. It involves a multi-dimensional approach including rehabilitation and integration into the family and society."

According to Nazneen, this complex problem can be addressed only through a sustained programme of education and awareness generation, along with improving the infrastructure for treatment and providing medicines free or at subsidised rates. Says Nazneen: "We hope the martyrs of Erwadi will open the eyes of the people and the authorities." ■

Frankie Castillo, 15
Charlie Inguanzo, 11

HOMETOWN: Laredo, Texas

BIO: Brothers by blood and disorders, Frankie and Charlie are both on meds. Less than three years ago, Frankie was found to have ADHD and depression; he is taking a three-drug cocktail. Charlie, disruptive in class since age 4, takes one drug for ADHD

and attention-deficit/hyperactivity disorder (ADHD)—a decidedly lousy trifecta. If that was what eighth grade was, ninth was unimaginable.

But that was then. Andrea, now 18, is a freshman at the College of St. Catherine in St. Paul, Minnesota, enjoying her friends and her studies and looking forward to a career in fashion merchandising, all thanks to a bit of chemical stabilizing provided by a pair of pills: Lexapro, an antidepressant, and Adderall, a relatively new anti-ADHD drug. "I feel excited about things," Andrea says. "I feel like I got me back."

So a little medicine fixed what ailed a child. Good news all around, right? Well, yes—and no. Lexapro is the perfect answer for anxiety all right, provided that you're willing to overlook the fact that it does its work by artificially manipulating the very chemicals responsible for feelings and thought. Adderall is the perfect answer for ADHD, provided that you overlook the fact that it's a stimulant like Dexedrine. Oh, yes, you also have to overlook the fact that Adderall has left Andrea with such side effects as weight loss and sleeplessness, and both drugs are being poured into a young brain that has years to go before it's finally fully formed. Still, says Andrea, "I'm just glad there were things that could be done."

Those things—whether Lexapro or Ritalin or Prozac or something else—are being done for more and more children the world over. In the U.S., they are being done with such frequency that some Americans have justifiably begun to ask, "Are we raising Generation R_X?"

Just a few years ago, psychologists couldn't say with certainty that kids were even capable of suffering from depression the same way adults do. Now, according to PhRMA, a pharmaceutical trade group, up to 10% of all American kids may be suffering from some mental illness. Perhaps twice that many have exhibited some symptoms of depression. Up to a million others may be suffering from the alternately depressive and manic mood swings of bipolar disorder (BPD), one more condition that was thought until recently to be an affliction of adults alone. ADHD rates are exploding too. According to a Mayo Clinic study, American children between the ages of 5 and 19 have at least a 7.5% chance of being found to have ADHD, which amounts to nearly 5 million kids. In Japan, the Asian country most attuned to psychological problems in children, a survey of more than 40,000 elementary and middle school kids—the first such large-scale study by the government—revealed that 2.5% were suffering from ADHD, which translates into one child in every schoolroom. Kwai Chung Hospital in Hong Kong, which runs one of the five main child psychiatric centers in the territory, has seen a doubling of ADHD cases since 1998 and an even bigger jump in kids diagnosed with schizophrenia. Other maladies affecting children: obsessive-compulsive disorder, social-anxiety disorder, post-traumatic stress disorder, pathological impulsiveness, sleeplessness, phobias and more.

Has the world simply become a more destabilizing place in which to raise children? Probably so. But other factors are at work, including sharper-eyed parents and doctors with a rising awareness of childhood

"OUR USAGE EXCEEDS BE USED FOR, BUT LET'S

Photographs for TIME by Steve Liss

Joel Flynn, 14

HOMETOWN Jefferson City, Missouri

BIO He might not look it, but Joel feels the drug he takes for his ADHD has flattened his personality some. That's a price the straight-A student is willing to pay, given that when his conditi· was diagnosed, at age 6, his fidgeti· s made it impossible for him to play baseball, much less do schoolwork. The drug that calms him is, paradoxically, a stimulant

mental illness and what can be done for it. "While we don't know exactly why the incidence of psychopathology is increasing in children and adolescents, it probably has to do with better diagnosis and detection," says Dr. Ronald Brown, professor of pediatrics at the Medical University of South Carolina.

Also feeding the trend for more diagnoses is the arrival of whole new classes of psychotropic drugs with fewer side effects and greater efficacy than earlier medications, particularly the selective serotonin reuptake inhibitors (SSRIs), or antidepressants. While an earlier generation of antidepressants—tricyclics such as Tofranil—didn't work in kids, SSRIs do. According to a study by Professor Julie Zito of the University of Maryland School of Pharmacy, use of antidepressants among children and teens increased threefold between 1987 and 1996. And that use continues to climb.

Nobody, not even the drug companies, argues that pills alone are the ideal answer to mental illness. Most experts believe that drugs are most effective when combined with talk therapy or other counseling. Nonetheless, the American Academy of Child and Adolescent Psychiatry now lists dozens of medications available for troubled kids, from the comparatively familiar Ritalin (for ADHD) to Zoloft and Celexa (for depression) to less familiar ones like Seroquel, Tegretol, Depakote (for BPD), and more are coming along all the time. There are stimulants, mood stabilizers, sleep medications, antidepressants, anticonvulsants, antipsychotics, antianxieties and drugs to deal with impulsiveness and posttraumatic flashbacks. A few of the newest meds were developed or approved specifically for kids. The majority have been okayed for adults only but are being used "off label" for younger and younger patients at children's menu doses. The practice is common and perfectly legal but potentially risky. "We know that kids are not just little adults," says Dr. David Fassler, professor of psychiatry at the University of Vermont. "They metabolize medications differently."

Within the medical community—to say nothing of the families of the troubled kids—concern is growing about just what psychotropic drugs can do to still developing brains. Few people deny that mind pills help—ask the untold numbers who have climbed out of depressive pits or shaken off bipolar fits thanks to modern pharmacology. But in America, few deny that a quick-fix culture exists, and if you offer a feel-good answer to a complicated dilemma, people will use it with little thought of long-term consequences. "The problem," warns Dr. Glen Elliott, director of the Langley Porter Psychiatric Institute's children's center at the University of California, San Francisco (UCSF), "is that our usage exceeds our knowledge base. We're learning what these drugs are to be used for, but let's face it: we're experimenting on these kids."

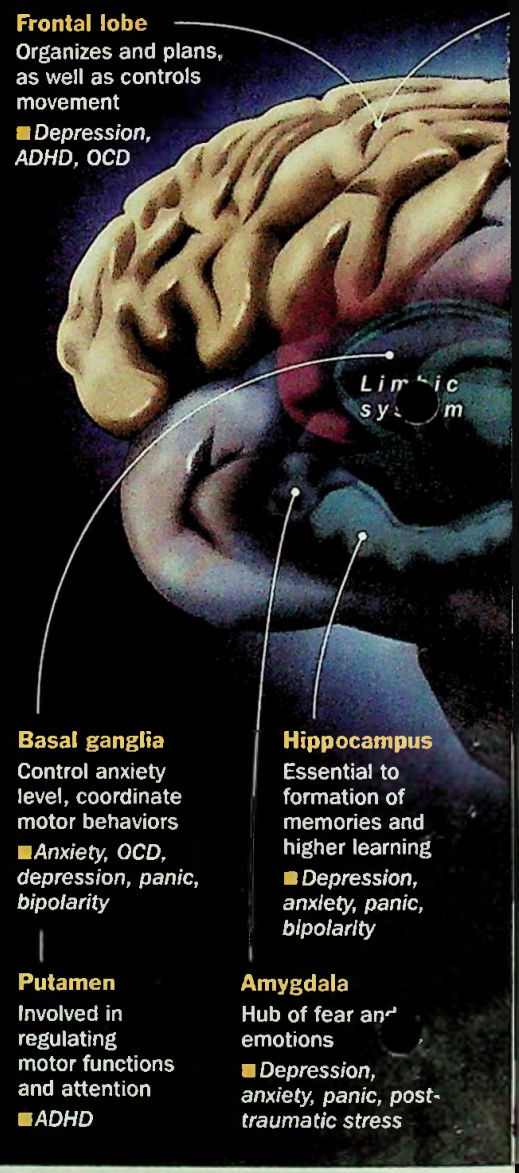
OUR KNOWLEDGE BASE. WE'RE LEARNING WHAT THESE DRUGS ARE TO FACE IT: WE'RE EXPERIMENTING ON THESE KIDS."

—DR. GLEN ELLIOTT, University of California, San Francisco

PILLS FOR CHILDREN: HOW THEY WO

	HOW IT WORKS	SIDE EFFECTS	TESTED/ APPROVED
 ADDERALL	A once-a-day amphetamine, it puts the brake on areas of the brain responsible for organizing thoughts	Rapid heartbeat, high blood pressure and, in rare cases, overstimulation. It can also become addictive	✓ Approved in the U.S. to treat ADHD in children of age 3 and older
 CONCERTA	It keeps neurons bathed in norepinephrine and dopamine, which reduce hyperactivity and inattention	Headache, stomach pain, sleeplessness and, in rare cases, overstimulation	✓ Approved in the U.S. to treat ADHD in kids of age 6 and older
 STRATTERA	Approved in the U.S. a year ago, it's the first nonstimulant for ADHD; enhances norepinephrine levels in the brain	Decreased appetite, fatigue, nausea, stomach pain	✓ Approved in the U.S. to treat ADHD in children of age 6 and older
 RITALIN	Its active agent, methylphenidate, stimulates the brain to filter and prioritize incoming information	Headache, lack of appetite, irritability, nervousness, insomnia	✓ Approved in the U.S. to treat ADHD in children of age 6 and older
METHYPATCH	The patch form of the stimulant methylphenidate, it delivers continuous low doses through the skin	Similar to those for oral methylphenidate	Developed to treat ADHD, but the FDA has deemed drug "unapprovable" in the U.S. until more studies completed
 PROZAC	Approved in the U.S. in 1987, it's the first antidepressant aimed at regulating serotonin, a brain chemical involved in mood	Insomnia, anxiety, nervousness, weight loss, mania	✓ Approved in the U.S. for depression and OCD in kids of age 7 and older

Inside the brain



Frontal lobe
Organizes and plans, as well as controls movement
■ *Depression, ADHD, OCD*

Basal ganglia
Control anxiety level, coordinate motor behaviors
■ *Anxiety, OCD, depression, panic, bipolarity*

Hippocampus
Essential to formation of memories and higher learning
■ *Depression, anxiety, panic, bipolarity*

Putamen
Involved in regulating motor functions and attention
■ *ADHD*

Amygdala
Hub of fear and emotions
■ *Depression, anxiety, panic, post-traumatic stress*

IS ASIA CATCHING UP?

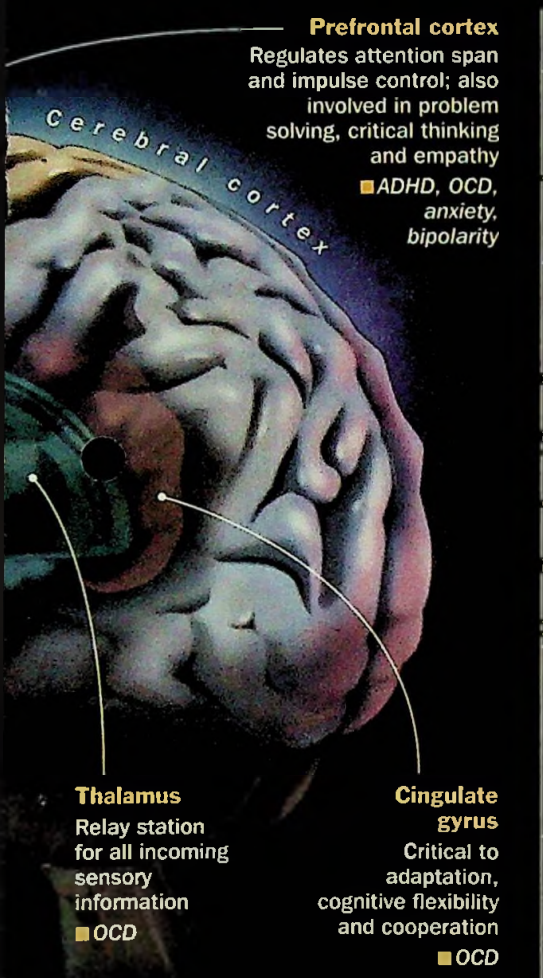
SHOHEI ASAKURA WAS A RESTLESS AND TROUBLED child since he was several months old. He didn't respond normally to his peers, and his language development lagged behind other kids' in his neighborhood in Japan's Fukushima prefecture. At age 3, Shohei was diagnosed with ADHD and pervasive development disorder, but for a year his parents refused the doctor's offer of a "miracle drug," Ritalin. When they finally relented in 1999, Shohei's behavior changed almost overnight. He was more comfortable around his mother, Rei, and could concentrate for extended periods of time. But Rei is still apprehensive about her son's dependence on drugs and is sometimes criticized by people who respond to her website, which chronicles her son's struggle. "I could tell them only that I got him to take it because it was absolutely necessary," she says.

Asia is far behind the West in diagnosing kids with mental illness. "A gross number of children and teenagers who really need help are untreated," says Dr. Ahn Dong Hyun, president of the Korean Academy of Child and Adolescent Psychiatry. In all of India, for example, there are only a dozen child psychiatrists. In China, most parents have never even heard of conditions such as ADHD. "They tend to think their kids are misbehaving, disobedient, or that they don't like going to school," says Du Yasong, director of the department of child and adolescent behavior at the Shanghai Mental Health Center. "Their reaction is to blame the children, scold them, even beat them." And from that foundation of ignorance springs many more problems. Ritalin, for example, isn't approved in Japan for treating hyperactivity (although it is for severe depression and narcolepsy). The drug isn't officially sanctioned for any condition in China (although it is available to doctors there). Ritalin's manufacturer, Novartis Pharmaceuticals, doesn't even bother marketing the drug in Asia. But ADHD, the ailment for which Ritalin is most frequently prescribed, is at least starting to be diagnosed in Asian kids—far more than depression, BPD or OCD. "The problem here," says

"WE KNOW THAT FRONTAL LOBES, WHICH MANAGE FEELINGS AND

RK

Children are just as vulnerable as adults to mental illness. But though the pharmaceutical pantry is filling up with more medications designed and tested for kids, in some cases they still have to settle for smaller doses of drugs made for adults



THE HUMAN BRAIN does not reach full cognitive and emotional maturity until a person reaches his or her 30s

Source: Brainexplorer.org

TIME Graphic by Lon Tweeten

	HOW IT WORKS	SIDE EFFECTS	TESTED/ APPROVED
ZOLOFT	It enhances the levels of serotonin in the brain to maintain feelings of satisfaction and stability	Upset stomach, dry mouth, agitation, decreased appetite	Not approved for kids but prescribed pediatrically based on adult data for depression, anxiety, OCD and others
PAXIL	Like Prozac and Zoloft, it elevates levels of serotonin in the brain	Nausea, drowsiness, insomnia	Not approved for kids but prescribed pediatrically based on adult data for depression, anxiety, OCD and others
EFFEXOR	It targets two brain chemicals—serotonin and norepinephrine—to regulate mood	Nausea, constipation, nervousness, loss of appetite, drowsiness	Not approved for kids but many doctors prescribe it for childhood depression based on adult data
DEPAKOTE	This antiseizure medication is particularly effective in treating the grandiose, hyperagitated state of mania	Liver and white blood cell abnormalities, headache, nausea, drowsiness	Not approved for kids but many doctors use it to treat childhood bipolar mania and seizures
ZYPREXA	It's a mood stabilizer designed to balance levels of serotonin and dopamine in the brain	Weight gain, drowsiness, dry mouth, seizures	Not approved for kids but many doctors use it to treat childhood bipolar mania and schizophrenia
LITHIUM	It stabilizes the episodes of elated, intensely joyous moods associated with mania	Nausea, loss of appetite, trembling of the hands	Not approved for kids but many doctors use it to treat childhood bipolar mania

Dr. Angeline Chan, a child psychiatrist in Hong Kong, "is *undermedication*."

Which suggests that Asian kids are impervious to the dangers of these drugs—but that's not true either. School performance—often the first thing to be affected in a child with mental illness—is an obsession with middle-class Asian parents, and a whole lot of kids are hauled off to unqualified physicians who can dispense a pharmacopoeia of potentially dangerous drugs. Varkha Chulani, a Bombay-based child psychologist, saw a seven-year-old boy with ADHD last year who had suffered problems at school. His parents had brought him to a doctor who prescribed a slew of medications, including Valium and Alprax. "The child was on so many drugs, he had become a zombie," she says. In South Korea, school-obsessed teens self-medicate on powerful over-the-counter drugs, including amphetamines (to concentrate) and opiates (to counter anxiety and depression). "When we see these kids at the hospital," says Kim Hun-Soo, a psychiatrist at Seoul Asan Hospital, "it's because these drugs have changed their behavior so much that their previously nonchalant parents finally were able to notice a difference." Once the kids get off the street drugs, Kim says, some are found to have undiagnosed mental illness such as ADHD, depression and social-anxiety disorder, which should have been treated with entirely different drugs.

THE CASE FOR MEDICATION

WHEN A CHILD IS SUFFERING OR SUICIDAL, is it fair not to turn to the prescription pad in conjunction with therapy? Is it even safe? Untreated depression has a lifetime suicide rate of 15%—with still more deaths caused by related behaviors such as self-medicating with alcohol and drugs. Kids with severe and untreated ADHD have been linked, according to some studies, to higher rates of substance abuse, dropping out of school and getting into trouble with the law. Bipolar kids have a tendency to injure or kill themselves and others with uncontrolled behavior such as brawling or reckless driving. They are also more prone to suicide.

Which is why Teresa Hatten of Fort

THOUGHT, DON'T FULLY MATURE UNTIL AGE 30.77

—STEPHEN HINSHAW, University of California, Berkeley

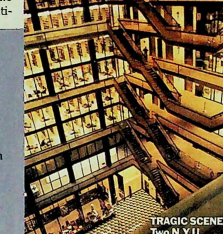
Wayne, Indiana, hesitated little when it came time to put her granddaughter Monica on medication. Hatten's grown daughter, Monica's mom, suffers from BPD, and so does Monica, 13. To give Monica a chance at a stable upbringing, Hatten took on the job of raising her, and one of the first things she had to do was get the violent mood swings of the BPD under control. It's been a long, tough slog. An initial drug combination of Ritalin and Prozac, prescribed when Monica was six years old, simply collapsed her alternating depressed and manic moods into a single state with sad and wild features. By the time she was eight, her behavior was so unhinged that her school tried to expel her. Next, Monica was switched to Zyprexa, an antipsychotic, that led to serious weight gain. "At 12 years old she had stretch marks," says Hatten.

Now, a year later, Monica is taking a four-drug cocktail that includes Tegretol, an anticonvulsant, and Abilify, an antipsychotic. That, at last, seems to have solved the problem. "She's the best I've ever seen her," says Hatten. "She's smiling. Her moods are consistent. I'm cautiously optimistic." Monica agrees, "I'm in a better mood." Next up in the family's wellness campaign: Monica's eight-year-old cousin Jamari, who is on Zyprexa for a mood disorder.

All along the disorder spectrum there are such pharmacological success stories. In the October issue of the *Archives of General Psychiatry*, Dr. Mark Olfson of the New York State Psychiatric Institute reports that every time the use of antidepressants jumps 1%, suicide rates among kids 10 to 19 years old decrease, although only slightly. But that doesn't include the nonsuicidal depressed kids whose misery is eased thanks to the same pills.

ARE WE MEDDLING WITH NORMAL DEVELOPMENT?

FOR CHILDREN WITH LESS SEVERE PROBlems—children who are somber but not depressed, or antsy but not clinically hyperactive, or who rely on some repetitive behaviors for comfort but are not patently obsessive-compulsive—the pros and cons of using drugs are far less obvious. "Unless there is careful assessment, we might [inadvertently] start medicating normal variations [in



TRAGIC SCENE: Two N.Y.U. students died to their deaths in this library

Marano she wouldn't dream of telling peers about her darker fears because she saw them as rivals, scrambling for the same grades and grad-school slots. "For many in this generation," says Marano, "there is a sense that you can't show any vulnerability." Pruett wonders if the reliance on medication to handle the blues hasn't weakened some students' nonpharmaceutical coping skills. "Sometimes we need to value our ability to solve and work through problems," he says. "Prescribing a drug sometimes deprives these young people of that age-old human ability."

The prescriptions may be saving lives, though. As the rate of their use on campus has gone up, overall reported U.S. college suicide rates, despite the cluster at N.Y.U., have fallen noticeably, from a total of 122 in 2000 to 80 in 2001. "It's the Prozac payoff," says Marano. That and the determined efforts of campus mental-health professionals to diagnose depression early, treat it aggressively and reassure students who [illegible] an ideal and not always a reality.

By Kathy Kiely, [illegible] and Sarah Childress/[illegible]

Sarah Childress/[illegible]

ON CAMPUS

University Blues: a Crisis

Going away to college isn't the same these days. Once upon a time—at least in the U.S.—mom and dad unloaded the station wagon as their starry-eyed scholar surveyed the campus with a heart full of hope and a mind on fire with plans. The mood was wistful and optimistic; the future looked bright despite the tearful farewells. But a shadow has fallen among the ivory towers. A growing number of students arrive on U.S. campuses suffering from depression and other emotional disorders—some diagnosed, some hidden. So that traditional moment of new beginnings is haunted by deep anxiety and gloom.

A rapid-fire trio of student suicides at New York University this fall has focused attention on the problem. On Sept. 12, a day after celebrating his 20th birthday, Jack Skolnik of Evanston, Illinois, leaped to his death from the 10th-floor inner balcony of the campus library. A month later, Stephen Bohler, 18, of Dayton, Ohio, made the same fatal dive. And on Oct. 16, Michelle Gluckman, 19, a sophomore from Brooklyn, New York, threw herself from the sixth-floor window of an off-campus apartment.

Behind these deaths lurk an array of grim statistics that show how prevalent mental disorders have become on campus. Data from a 2001 survey of college mental-health counselors, when compared with past findings, revealed that the percentage of students treated at college counseling centers who have had psychological problems diagnosed and are taking psychotropic drugs increased from 7% in 1992 to 18% in 2001, according to Greg Snodgrass, director of the counseling center at Texas State University. The survey also found that during the previous five years, 85% of North American student counseling centers reported an increase in students with "severe psychological problems."

Colleges have responded by beefing up their mental-health services, including suicide-watch programs. Harvard set the standard in 1998—after a widely publicized campus murder-suicide case—by increasing staff 25%. "One huge issue was access," explains Dr. Richard Kadison, who heads mental-health services there.

Are today's students more emotionally fragile than their predecessors? No one can say, though some point to grueling pressures to succeed in an era of economic uncertainty and heightened parental expectations. Hal Pruett, director of student psychological services at UCLA, recalls a tense freshman who became so distracted by inner turmoil that he couldn't study. "He kept saying, 'I can't afford to get a C.' I asked why, and he said, 'I won't get into medical school, and my parents will disown me.'"

Hara Estroff Marano, an editor at *Psychology Today* who has interviewed college counselors and their students about depression, wonders what happened to sharing one's worries with roommates and friends. A depressed student told

45%

Percentage of college students who said they had difficulty functioning owing to depression at least once in the past year

behavior]," says Stephen Hinshaw, chairman of psychology at the University of California, Berkeley.

The world would be a far less interesting place if all the eccentric kids were medicated toward some golden mean. Besides, there are just too many unanswered questions about giving mind drugs to kids to feel comfortable with ever broadening usage. What worries some doctors is that if you medicate a child's developing brain, you may be burning the village to save it. What does any kind of psychopharmacological meddling do, not just to brain chemistry but also to the acquisition of emotional skills—when, for example, antianxiety drugs are prescribed for a child who has not yet acquired the experience of managing stress without the meds? And what about side effects, from weight gain to jitteriness to flattened personality—all the things you don't want in the social crucible of grade school and, worse, high school.

Adding to the worries is a growing body of knowledge showing just how incompletely formed a child's brain truly is. We now know from imaging studies that frontal lobes, which are vital to executive functions like managing feelings and thought, don't fully mature until age 30," says Hinshaw. That's a lot of time for drugs to muck around with cerebral clay.

For that reason, it may not always be worth pulling the pharmacological rip cord, particularly when symptoms are relatively mild. Child psychologists point out that often nonpharmaceutical treatments can reduce or eliminate the need for drugs. Anxiety disorders such as phobias can respond well to behavioral therapy—in which patients are gently exposed to graduated levels of the very things they fear until the brain habituates to the escalating risk.

Depression, too, might respond to new, streamlined therapy techniques, especially cognitive therapy—a treatment aimed at helping patients reframe their view of the world so that setbacks and losses are put in less catastrophic perspective. "The therapist teaches relaxation skills and positive thinking," says Denise Chavira, clinical psychologist at the University of California at San Diego. "It goes beyond talk therapy." Unfortunately, medical insurance pays more readily for pills than for these other treatments for adults and children alike.

For kids with more serious symptoms, experts are worried that undermedicating is a bigger risk than overmedicating. "Say you've got a kid who's severely obsessive and literally can't leave the home because of the fears and rituals he's got to perform," says UCSF's Elliott. "Think about what anyone age 2 to age 16 has to learn to function in our society. Then think about losing two of those years to a disorder. Which two would you choose to lose?" Also on the side of intervention is the belief that treating more kids with mental illness could reduce its incidence in adulthood.

HOW CAN WE MEASURE THE RESULT?

PREVENTING SYMPTOMS, OF COURSE, IS NOT everything. A sleeping child is completely asymptomatic, for example, but that's not the same as being fully functioning. If the drugs that extinguish symptoms also alter the still developing brain, the cure might come at too high a price, at least for kids who are only mildly symptomatic. To determine if this kind of damage is being done, investigators have been turning more and more to brain scans such as from magnetic resonance imaging (MRI). The results they're getting have been intriguing.

MRIS had already shown that the brain volumes of kids with ADHD are 3% smaller than those of unafflicted kids. That concerned researchers because nearly all those scans had been taken of children already being medicated for the disorder. Were the anatomical differences there to begin with, or were they caused by the drugs? Attempting to answer that, Dr. F. Xavier Castellanos of the New York University Child Studies Center took other scans, this time using only kids with ADHD and comparing those who were taking medication with those who were not. Reassuringly, he discovered that they all shared the same structural anomaly, a finding that seems to exonerate the drugs.

Dr. Steven Pliszka, chief of child psychiatry at the University of Texas Health Center in San Antonio, went further. He conducted scans that picked up not just the structure but the activity of the brains of untreated ADHD children, and compared these images with those from afflicted children who had been medicated for a year or more. The treated group showed no signs of any deficits in brain function as measured in blood flow. In fact, he says, "we saw hints of improvement toward normal."

Monica Moore, 13

HOMETOWN
Fort Wayne, Indiana

BIO Monica, whose mother has BPD and whose cousin might too, needs a four-drug regimen to control her own BPD. It took much trial and error to hit on the right mix, and that meant a lot of side effects and discomfort. Now, however, her symptoms are under control. "She's smiling," says her grandmother

"A GROSS NUMBER OF CHILDREN AND TEENAGERS WHO REALLY NEED HELP ARE UNTREATED."

—DR. AHN DONG HYUN, Korean Academy of Child and Adolescent Psychiatry

The news was less positive when it came to BPD. Dr. Kiki Chang of Stanford University has looked at the brains of kids treated with Depakote, and while his study is as yet unpublished, he says he noticed some anatomical differences that could have resulted from treatment—and he wasn't necessarily happy with them. "We are seeing that medications do affect the brain acutely," he says. "Is that a good thing, a bad thing? We just don't know."

What nobody denies is that more research is needed to resolve all these questions—and that it won't be easy to get it started. The first problem is one of time. It was only in the early 1990s that the antidepressant Prozac exploded into pharmacies. It's hard to do a lifetime of longitudinal studies on a drug that's been widely used for just over a decade. And each time the industry invents a new medication, the clock rewinds to zero for that new pill.

The pharmaceutical companies could be doing better in research, too—and if they don't, governments must push them to do it. There is a lot of money to be made in developing the next Prozac, but there is less profit if you test it for longer than the law demands. The U.S. Food and Drug Administration (FDA) doesn't require long-term studies that follow patients over decades. Its only requirement is toxicity trials that span six to eight weeks. In an effort to entice companies to conduct lengthier studies, the agency now grants an extension of six months of exclusive marketing rights to any firm engaging in studies of a drug's effects on a minimum of 100 children for more than six months. "It's a relatively small amount of data," acknowledges Dr. Thomas Laughren, a psychiatrist with the FDA's psychopharmacology division, "but it's better than what we had before, which was nothing."

Until all these things happen, the heaviest lifting will, as always, be left to the family. Perhaps the most powerful medicine a suffering child needs is the educated instincts of a well-informed parent—one who has taken the time to study up on all the pharmaceutical and nonpharmaceutical options and pick the right ones. There will always be dangers associated with taking too many drugs—and also dangers from taking too few. "Like every other choice you make for your kids," says Chang, "you make right ones and wrong ones." When the health of a child's mind is on the line, getting it wrong is something that no parent wants. —*With reporting by Dan Cray/Los Angeles, Chaim Estulin and Austin Ramzy/Hong Kong, Meenakshi Ganguly/Bombay, Mingi Hyun and Kim Yooseung/Seoul, Susan Jakes/Beijing, Kathie Klarreich/Miami, Alice Park/New York City, Michiko Toyama/Tokyo and Leslie Whitaker/Jefferson City*

LIFE ON MEDICATION

"I Am a Different Person"

I've had ADHD for 10 years now. I was diagnosed with it in kindergarten. Truthfully, I don't remember every detail of my life before ADHD, but there are some things I can't help remembering. For example, in kindergarten I was sent to the "time-out chair" about two or three times daily. The reason? I would say things that would hurt the other kids. Why did I say these mean things? Because I'd never think about what I was going to say or the consequences. Another thing I'll never forget is how antsy and talkative I was. Every day after lunch, there was a competition to see whose table was quietest. Of course, I could never stop talking or moving, so my table was always last.

I have taken two medications to treat my ADHD. From first through fifth grade, I took Ritalin, which was not very good for me. Ritalin took away my appetite completely, so I lost dramatic amounts of weight. My teachers had to inspect my lunch to see if I ate it! Now I take Adderall. It has worked for me, but it has taken so long to find the right dosage.

I guess you could say my life changed a good deal after the treatment, because I had a lot more focus. But to tell you the truth, I could not see the difference until the seventh grade. By then, I was a straight-A student because of it. I may be naturally smart, but I never could have applied myself as much without it. Nowadays, I know when I need my medicine because it lets me perform to my full ability.

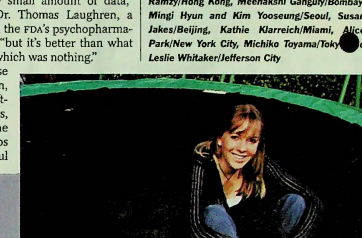
Recently I've become aware of the side effects of my medicine, which are a problem. I am a totally different person on it than off it. This is called emotional lability. While on the medicine in school, I rarely ask my friends what there is to do on the weekend. At lunch, I literally sit at the table without saying a word, and because of that, I have lost a whole bunch of friends. I drift from table to table, but I don't have one true group that I belong to. This gets me depressed at times. But when I am off my medicine, I am this outgoing, spontaneous, hilarious person. When I go to parties, I do not take my medicine, and I go absolutely wild. I will dance the entire night, walk up to anyone and start talking. People who know me say, "Jessi, you're so different at parties and outside of school." Truly, they are right. I do not like suffering from emotional lability, and it sometimes makes me cry.

It also affects how I am with my family. When I am off my medication, I am hysterically funny with my parents and a lot more imaginative in playing with my younger sister and brother. But I also have a shorter temper, which leads to conflicts with my sister. We make each other cry. So my condition and treatment have definitely affected my family for good and bad.

Feeling different from other kids has never been an issue for me. I just see myself as someone who has to have medicine to concentrate better. I will tell my friends straight off that I have ADHD; if they don't like that, well, then too bad. In eighth grade, we were given nicknames ("most likely's," actually) and mine was Miss Hyper! It didn't bother me. I think it showed my classmates are cool with it. My teachers are very accepting of my condition, but I find it difficult when a teacher does not know I am allowed extra time on tests. I used to feel guilty about getting extra time, but now I accept it because I know I need it.

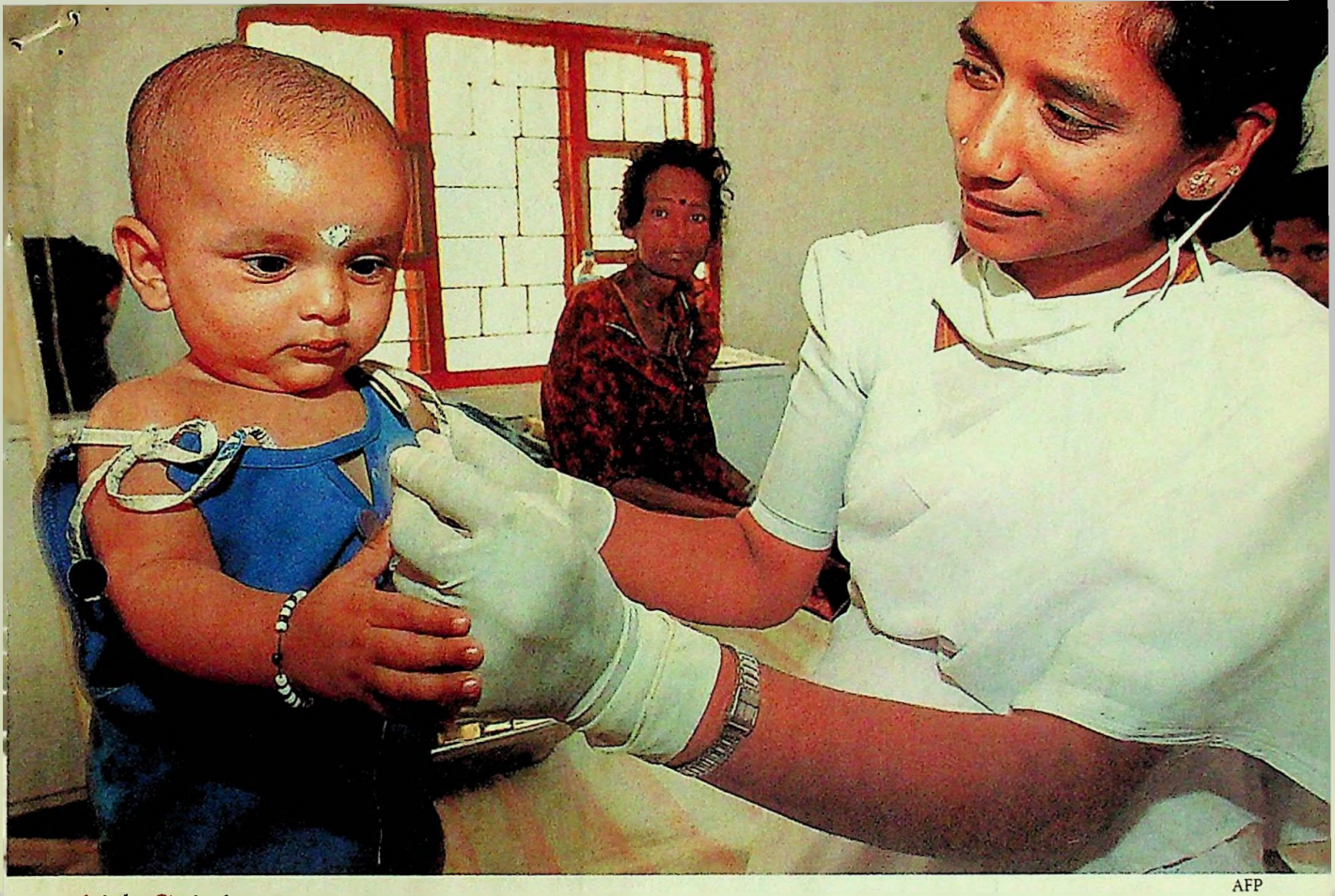
I'll never know what the future holds for me, but I do expect to remain on the medication, because I want to. I enjoy how I can focus and apply myself. Maybe my parents want me to stay on it as well, but it's not their choice. It is my choice. And from now on, it will always be my choice. —*By Jessi Castro*

Jessi Castro, a high school [illegible] how to [illegible] be a successful [illegible], a soccer



ANDREW NEWMAN—CONTACT PRESS IMAGES FOR TIME

OVERCOMING ADHD: The author, 15, has straight A's in school



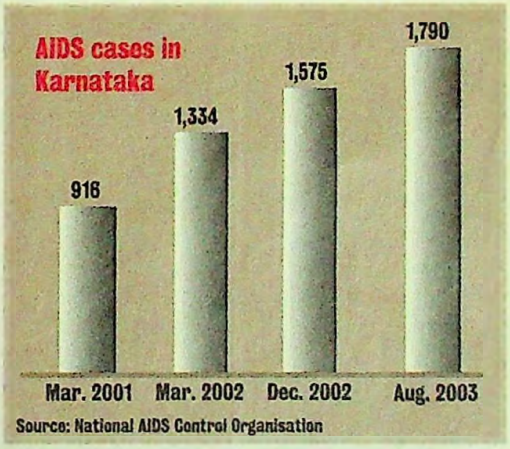
AFP

NURTURING HOPE: A nurse with an HIV-positive orphan at the Freedom Foundation in Bangalore

AidsCrisis

Growing pains

Karnataka has the most number of HIV cases among pregnant women



Graphics/B. MANOJKUMAR

By N. BHANUTEJ

Latha's little sons tug at her lean frame for attention. But what is shaking her inside is the thought that she and her three-year-old son are HIV positive. Her husband, a driver, who was HIV positive died of a TB relapse when Latha was seven months pregnant with her second child. She is now awaiting the six-month-old infant's blood report.

Latha was married to Lokesh when she was 12. She had a child at 15, but the baby did not survive. They lived in a rented house belonging to Lokesh's relative in Bagalkot in north Karnataka. "My husband looked after me well," she said. "But he has left us nothing." Two years ago when Lokesh's health began to fail, he was treated for tuberculosis before the doctor detected something more in the blood report. He was referred to the HIV/AIDS centre run by the Freedom Foundation in Bangalore.

Dr Nirmala Skill of the HIV/AIDS centre told them about the disease and how it spreads. That did not, however, stop the couple from having a second child. Lokesh died at the HIV centre less than a year ago. "When he died, I needed Rs 300 to come to Bangalore," said Latha. "I worked as a coolie to raise the money." Now, Latha has nowhere to go and no means of earning an income. "I can't go back to my maternal home in Bagalkot because my brother's family does not want us there and we were also turned out of our rented house," she said.

The foundation gives her the cotrimoxazole medication to prevent infections, but it is yet to find anyone to sponsor the expensive anti-retroviral drugs that can delay the onset of AIDS. "We are hoping to find a job for her," said Nirmala. "We will also try to convince her family to look after her."

Karnataka is a "high prevalence"

N. BHANUTEJ

Experts stress the importance of education. (Above) A street play at a Bangalore slum on World AIDS Day.

state in HIV graphs. National AIDS Control Organisation figures say that 5 per cent or more in the high-risk groups are testing positive for HIV. On World AIDS Day on December 1, a random HIV test in Bellary by an NGO showed that 10 out of the 110 persons tested were HIV positive.

More worrying, experts have detected a shift in demographic patterns in the incidence of infection. Earlier, sex workers, intravenous drug users and truck drivers were the main high-risk groups. Gradually, middle-class housewives are becoming part of the statistics.

"Hundreds of men visit red-light areas," said Christopher Skill of the Freedom Foundation. "And they are not just truck drivers. They are businessmen or office workers and they transmit HIV to a population that was hitherto considered low-risk." The National AIDS Control Organisation's 2001 report indicates that two-thirds of sex workers' clients are married men or those with partners.

It was a statistic waiting to be revealed. Now, Karnataka has the highest number of HIV cases among pregnant women. That is 1 per cent, or more, of women who attend antenatal clinics during pregnancy. The sudden increase may be partly due to education, detection and follow-up, but that does not mean the situation is not serious, said Christopher.

Programmes like the Prevention of Mother to Child Transmission Project in Karnataka have increased the awareness among women. "Now, almost 99 per cent of women who come to antenatal clinics voluntarily go for the HIV test," said Hepzibah Sharmila, the project's director.

Source: National AIDS Control Organisation

Vandana Gurnani, project director of the Karnataka State AIDS Prevention Society, said the incidence of HIV among those who visit antenatal clinics was a worrisome indicator of its prevalence in the general population.

There are differences of opinion on statistics and their interpretation, but experts unanimously stress the importance of education, counselling and community support. To educate a rural population of which, according to a National AIDS Control Organisation report, only 30 per cent know about condoms, is a challenge, but the government and NGOs have set up counselling centres across the state. The Karnataka State AIDS Prevention Society itself runs 33 centres.

But, like most women's issues, HIV is linked inextricably with empowerment. While the millions of dollars of donations flowing into India to check HIV/AIDS can only help educate and counsel, little can be achieved until the larger issue of socio-economic empowerment of women is addressed. But in keeping with third world logic, something is better than nothing.

THE DREAM GIRLS

The success of Uma Bharati, Vasundhara Raje and Sheila Dikshit could trigger a search for more charmers in other states

By SACHIDANANDA MURTHY

Digvijay Singh is no Laloo Prasad Yadav. The irrepressible Bihar leader had promised roads which would be smooth as the cheeks of dream girl, Hema Malini, and yet won a re-election on horribly potholed roads.

But the Dream Girls of the BJP—Uma Bharati in Madhya Pradesh and Vasundhara Raje in Rajasthan—proved to be too powerful for Digvijay and Ashok Gehlot. They became heartthrobs by narrating heart-rending tales of poor development in their states. The fact that one was a sanyasin representing the backward castes and the other was a princess foraying into a man's world helped in a big way.

The BJP had gone wrong in 1999 by projecting Sushma Swaraj just six weeks before the Delhi Assembly elections. This time they began projecting Uma and Vasundhara a year in advance. As Chief Minister Sheila Dikshit romped home to a massive victory, BJP strategists rued the fact that they did not think of a feminine alternative to Dikshit. Only Chhattisgarh was the male bastion.

It was a big gamble for the BJP to project two women, but the gamble paid off because of their natural appeal and because they touched the rural womenfolk in search of a better life.

Uma was at her best in selling dreams to women voters. During campaigning she would ask whether they wanted a life of drudgery or the comforts of development. She promised them a life of dignity in a feudally ossified society. Her biggest punch line was on unemployment under Digvijay and how her party would create millions of jobs. Vasundhara struck an emotional chord with rural women by wearing their traditional dress and eating from their humble plates.

Sheila Dikshit scored because she was the neighbourhood aunt. She addressed the public's ire against an erratic power supply by ensuring they got the best service this summer, coupled with uninterrupted water supply. She won the hearts of young mothers by organising periodic and compulsory polio drop camps in schools. She accepted every invitation and sat among the audiences without fanfare.

Does the success of the three mean there will be more women leaders to come? The only other woman who has won a comfortable majority in recent times is Tamil Nadu Chief Minister Jayalalithaa.

The BJP thinks it can experiment further by projecting more women. The parliamentary board, which met on

Illustration/HADIMANI

COMMUNITY HEALTH CELL

Society for Community Health Awareness Research and Action
No. 367, Srinivasa Nilaya, Jakkasandra I Main, I Block
Koramangala, Bangalore - 560 034.

BUDGET ESTIMATES 2003 - 2004

EXPENDITURE

Sl No.	Head of Account	Budget 2003-2004 (as per 3 year Budget)	Budget 2003-2004 (Revised)	Remarks
01.	Funds for Capital Purchase	160,000.00	160,000.00	Additional Office and Storage Furniture - Computer & Accessories will be purchased
	Total	160,000.00	160,000.00	
RECURRING				
A. Peoples Health Watch Unit [now Global People's Health Movement (PHM) Secretariat] Inclusive of Information Centre				
I	Programme Costs			
01.	Papers / Periodicals / Journals	48,400.00	48,400.00	
02.	Postal Document Service	4,800.00	4,800.00	
03.	CHC Reports, Pamphlet and Newsletter	26,100.00	100,000.00	Three to four publications based on the work done in the past will be brought out, this year being the 20th milestone of CHC. Besides, the cost of printing has gone up. Hence the increase.
04.	Books	42,400.00	42,400.00	
05	Telephone (including Fax, Email, Internet etc.)	26,400.00	35,000.00	Telephone No. 5525372 - This telephone is being used as Telephone, Fax & Internet dial-up. Hence the increase.
06.	Photocopying	13,200.00	13,200.00	
07.	Travel / Conveyance	13,200.00	13,200.00	
08.	Contingency	8,700.00	12,900.00	5% of Items A 1 to 7 and rounded off
II	Salaries and Allowances :			
01.	CH Adviser and Coordinator PHM	250,600.00	268,500.00	* RN (from PHM Secretariat)
02	Associate / Assistant (Fellowship) - One person	129,600.00	120,000.00	Fellowship being negotiated (from RTT). This is of one year duration at Rs. 10,000 per month.
03.	Secretary to Adviser / Convenor	108,100.00	92,000.00	DGS (from PHM Secretariat)
04	Library / Documentation Officer	122,500.00	82,800.00	VNR - Presently this position is occupied by a part-time official. Hence the difference.
05.	Information Assistant	82,800.00	91,800.00	* HRM
06.	Office Cum Media Assistant	78,200.00	82,200.00	* CJ (50% from PHM Secretariat)
07.	Staff Welfare Fund	3,600.00	3,600.00	
08.	Provision for Provident Fund	54,000.00	51,600.00	7% of items AII 1 to 6 and rounded off
09.	Provision for Gratuity	27,000.00	25,800.00	3.5% of items AII 1 to 6 and rounded off
10.	Internship (2 persons)	129,600.00	60,000.00	Shortterm internship being negotiated (from RTT). This is for two persons for a duration of 6 months each per year at Rs. 5,000 per month. (Rs.5,000X6monthsX2)
	Total	1,169,200.00	1,148,200.00	

* Increase is due to upward revision of salary

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TIME

LOST LIVES

A TIME special report on Asia's mental-health crisis

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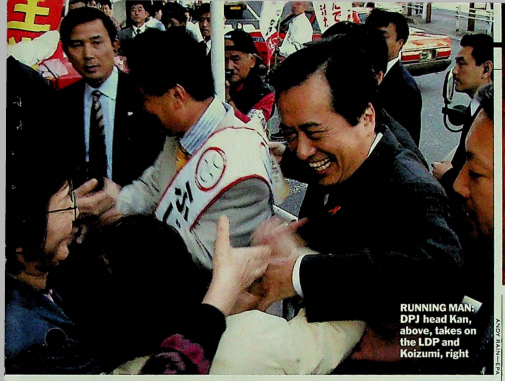


RUNNING MAN: DPJ head Kan, above, takes on the LDP and Koizumi, right

ASIA

Get This Party Started

After nearly five decades in power, Japan's LDP faces an election surprise: credible competition

By JIM FREDERICK TOKYO

OVER A FEW ROUNDS OF THE BOARD game Go earlier this summer, Japanese political veterans Naoto Kan and Ichiro Ozawa brokered an alliance that could forever alter their country's political landscape. For years, these rivals had led Japan's two major opposition parties, each a sworn enemy of the Liberal Democratic Party (LDP) that has ruled the country almost continuously for 48 years. Alone, neither had been able to mount more than a token challenge. But Kan and Ozawa agreed that the LDP's once fearsome power base was eroding. Even its popular leader, Prime Minister Junichiro Koizumi, was having trouble keeping its squabbling factions in line. Suddenly, they reasoned, the LDP seemed vulnerable to an opposition party with real clout. The answer: to join forces. So Ozawa agreed to let his Liberal Party be acquired by Kan's Democratic Party of Japan (DPJ). "There has never been a major political power shift between the ruling party and the opposition party," Ozawa told TIME shortly before the merger. "Japan needs that power transfer to establish a true parliamentary government."

Since that epochal decision, a genuine two-party democracy has begun to emerge in Japan. For the first time in the country's history, a political party is putting unprecedented power in the hands of voters by mounting a serious challenge to the LDP directly at the polls, rather than cobbling together an opposition parliamentary majority through alliances of previously unaffiliated parties. Old-fashioned Japanese politics—including backroom deals and rule by faction—won't disappear overnight. But "aside from the random Communist running around, it's a two-party system now," says Steven Reed, professor of modern government at Chuo University in Tokyo. And that's what makes the run-up to the Nov. 9 general election such an intriguing—and heartening—spectacle.

It's already one of the most hard-fought, liveliest Japanese elections in memory. Taking a cue from the charismatic Koizumi, who has hung onto his job largely by charming the masses, the DPJ has fielded younger, more telegenic candidates to battle the LDP gerontocracy. The DPJ recently hired U.S. public relations giant Fleishman-Hillard as image consultants, and its candidates received a booklet of tips on wooing voters—particularly women. Among other advice, candidates were told that bad breath, dirty fingernails and poorly knotted ties are all electoral turnoffs.

The DPJ's chances of capturing the 104 seats necessary for a majority in the powerful lower house (thus catapulting Kan into the Prime Minister's seat) remain slim. But at the very least, DPJ candidates are generating unusually robust political debate. Besides zealously portraying the opposition as corrupt and anachronistic, the DPJ took the unorthodox step of publishing a 60-page manifesto that's rich in specifics, from slashing government spending on large public works projects by 30% by 2006 to decreasing the size of grade school classes.

In the past, politicians tended to avoid taking detailed stands on issues, fearing they could later be held accountable for broken promises. But now the LDP has been compelled to release a manifesto of its own. Among its pledges: to privatize the postal service within four years and increase tourism from today's 5 million visitors per year to 10 million by 2010. "This is without a doubt the most policy-oriented election campaign in postwar Japanese history," says Ellis Krauss, professor of Japanese politics at the University of California, San Diego.

Kan himself admits only to modest expectations for the upcoming election. He says his goal is to take 63 seats, far short of a majority but enough to embarrass the LDP and wound Koizumi. Kan has already succeeded in convincing many Japanese citizens and businesses that a strong second party is essential to economic and political rejuvenation. For example, a coalition of executives led by Kyocera's Kazuo Inamori recently took out newspaper ads spelling out the benefits of a two-party system. "I want Japan to be like the U.S., England, Taiwan or South Korea, where we can have a change in government every five or ten years," Kan said during a recent election rally. Considering the Japanese government has barely changed in half a century, shaking things up even once would be progress. —*With reporting by Ilyn Garger, Tako Sekiguchi and Gregory Turk/Tokyo*

Hidden Away

Stigmatized, abandoned, often locked up, Asia's mentally ill are left to inhabit a living hell. A TIME special report **By Hannah Beech**

PHOTOGRAPHS FOR TIME BY JOHN STANMEYER—VII

HUMAN STAIN
Mentally ill inmates at the Panti Bina Laras Cipayung Center in east Jakarta are left to lie on the soiled floor of the latrines

IF A BOY DISAPPEARS AND NOBODY notices, is he really gone? Hisaki Fujishiro's withdrawal had been almost imperceptible, as hard to gauge as the ebb of a high tide. Even his mother failed to see the signposts, Fujishiro recalls: the elementary-school bullying that broke one of his fingers, the obsession with computer games, the increasing hours spent cloistered in his cluttered bedroom. These were, it seemed, the normal teethings of a preteen in postindustrial Tokyo, just another geeky kid wandering awkwardly through childhood. But gradually Fujishiro retreated completely.

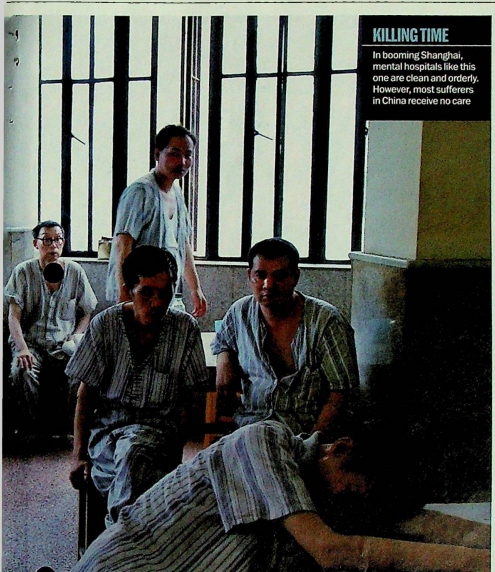
The first tangible danger sign was an obsessive-compulsive disorder that manifested in Fujishiro when he entered junior high. He would write a character, erase it and rewrite it hundreds of times. Or he would frenetically wash his textbooks, as if the act of scrubbing them would somehow cleanse his troubled mind. Despite his eccentricities, Fujishiro managed to enter Tokyo's Chuo University in the mid-1990s. But soon he had withdrawn almost completely into the safety of his little room in student housing. Most days he would go to bed early and sleep through the morning, only venturing outside for exams or to buy a stash of junk food at the local 7-Eleven. He had no friends, preferring to spend his time with car magazines, which were stacked to the ceiling. "My curtains were always closed," recalls Fujishiro, now 29. "I didn't feel like I had a place where I belonged."

Fujishiro was hardly alone in his terrifying isolation. A generation of Japanese youngsters has dropped out of society entirely, unable to cope, it seems, with the rapid syncopation of life in Asia's most developed nation. The phenomenon has been dubbed *hikikomori*, or social withdrawal, by psychiatrist Tamaki Saito, who estimates that one in every 40 Japanese households has such a loner. That's an astounding 1 million social dropouts, most of whom are male. For Fujishiro, a support group at his university coaxed him out of his room, and he has now started reintegrating into society after eight years of seclusion. Today, he runs an online outreach program for other *hikikomori* slowly emerging from their shells. So far the disease has been diagnosed only in Japan, except for a handful of cases in South Korea. But these alienated youngsters might be a harbinger of what's to come for the rest of Asia, emblems of a continent hurtling so quickly into the future that its citizens have few tools to cope with the dizzying speeds.

Asia's mental health is, more than ever, in a perilous state. The Global Burden of Disease study commissioned jointly by the World Bank, the World Health Organization (WHO) and Harvard University predicts that by 2020 depression will be the leading cause of disability in Asia, measured by the number of years a person lives with a debilitating health condition. Already, mental illnesses account for five of the 10 leading causes of disability in Asia, including disorders such as depression and schizophrenia. That's a bigger health burden to the continent than cancer. A WHO study found that as many as one-quarter of all Indians currently suffer from some sort of mental illness. The region also boasts some of the highest suicide rates in the world. In China, for instance, suicide is the No. 1 cause of death among those aged 18-34, according to the Beijing Suicide Research and Prevention Center. At least 250,000 Chinese have fallen themselves each year since the mid-1990s.

Yet only a small percentage of these troubled individuals ever seek help—or even possess the opportunity to do so. In Asia's more developed countries, ordered,

MENTAL ILLNESSES ACCOUNT FOR FIVE OF THE



KILLING TIME

In booming Shanghai, mental hospitals like this one are clean and orderly. However, most sufferers in China receive no care

Confucian cultures are loath to confront mental illness. Its victims commonly endure workplace discrimination, receive scant family support and feel obliged to hide their symptoms for fear of unsettling the people around them. Du Yasong, a psychiatrist at the Huashan Hospital in Shanghai, estimates that as many as one-third of all people who go to general practitioners in China are actually suffering from mental-health problems expressed psychosomatically through symptoms such as headaches or insomnia. Yet 95% of those with depression in China are untreated, according to Ji Jianlin, a medical professor at Shanghai's Fudan University who advises the central government on mental-health policy. Japan has the highest number of hospitalized, mentally ill patients in the world, yet psychiatry is still considered a crackpot discipline by many doctors there. "There is so much stigma when it comes to mental health," says Osamu Tajima, a leading psychiatrist in Tokyo. "The perception that it's a personality weakness prevails not just among 'normal' people. I've heard many doctors tell patients to stop complaining and tough it out."

Even when the severity of the problem is acknowledged, treatment is hampered by a disastrous lack of resources. This is especially true in Asia's poorer countries, where conditions for the mentally ill are often horrific. Many patients are locked up in hospitals no better than prisons. At the Panti Bina Laras Cipayung mental-health center in east Jakarta, just 10 minutes off a modern expressway, the air is thick with flies and the stench of feces. Originally intended for 200 patients, the government-run facility is crammed with 305 inmates. Most are naked, some are shackled or chained to window bars. Others, emaciated or showing oozing lesions, curl up on the soiled floor of the latrines. A doctor stops by the center only once a week for two to three hours; he has numerous other similar institutions to attend to. Though the center's number of patients has nearly doubled since 1996, its funding has not increased because of the weak economy—less than $1 is spent on each patient per day.

Indeed, most Asian nations spend tragically small amounts on mental-health care. In Cambodia, for instance, the country's entire mental-health budget is far less than what it would take to fund one topflight mental hospital in the U.S. In Pakistan, the government has all but given up on caring for the mentally ill and private donors have had to pick up the slack. More than 1,000 mentally ill patients live jammed together in the privately funded Karachi commune called Edhi Village, run by the prominent social worker Abdus Sattar Edhi. Iron gates lock the inmates in, some of whom, stark naked, slam their heads against the walls of their dark cells. "Our center is becoming a dumping ground for people who consider mentally ill people as the dirt of society," says Ghazanfar Karim, the complex's overburdened supervisor.

The grim irony of Asia's mental-health crisis is that it seems to be escalating even while much of the region is getting richer. Some experts see the continent's transformation as a profoundly mixed blessing, carrying with it dreams of cell phones and cable for all but also exacting an immense psychological toll on those who are struggling to keep up with the manic pace of change. Tradition and a sense of security have given way to upheaval and uncertainty. A farmer born of farmers, the father of future farmers, would work from dawn to dusk like everyone else he knew. Because he entertained no hope of an alternative lifestyle, he didn't agonize over one. But

10 LEADING CAUSES OF DISABILITY IN ASIA

NO WAY OUT?

Children at Karachi's Edhi Village for the mentally ill, below. Cambodian Kum Kim sees a witch doctor for her schizophrenia, right

today the characteristics of a modern existence—the potential to get ahead, the rat race, even the crushing traffic—mean that Asians feel more psychological pressure than ever before. Psychiatrists in China, for instance, estimate that the rate of anxiety disorders is higher now than it was during the chaotic years of the Cultural Revolution. This, then, is the dark side of Asia's economic miracle.

Money Disorder

BORN TO PEASANTS IN CHINA'S SOUTH central province of Sichuan, Song L. had wanted to go to Shanghai for as long as he could remember. For him, China's biggest city was where dreams were made, where farmers morphed into millionaires. In truth, Shanghai is also where thousands of migrants lose their way in a pell-mell rush to riches. Fudan University professor Ji estimates that the incidence of mental illness among China's 100 million migrants might be twice as high as in the rest of Chinese society, due to the pressures of existing on the margins both economically and socially. But when Song headed to the big city, in 2000 for construction work, he knew only of Shanghai's possibilities. At first, things went well for the then 19-year-old, but an altercation with a co-worker who accused him of shoddy workmanship cost him his job. "I couldn't eat, I couldn't sleep and I felt dizzy all the time," Song recalls. "When I closed my eyes and tried to sleep, I had nightmares where everything was spinning."

Song soon landed another job, but the dizziness didn't subside—a dangerous condition for a man who was supposed to make his living scrambling up the half-built skeletons of Shanghai's skyscrapers. He was quickly fired again. After 19 years in a tightly knit village, he was now alone in the city. "No one could help me," says

IN CAMBODIA, THERE IS NOT A SINGLE

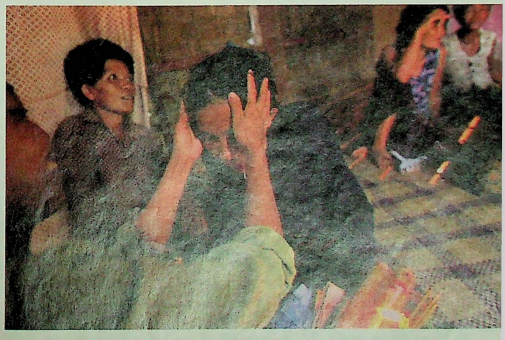
Song. "All I had to keep me company were my thoughts, but my thoughts were already bad." Details of events after his second sacking are jumbled in Song's clouded mind: there was a desperate 16-hour, standing-room-only train ride up to Beijing, where he had heard of a job opening; a curt foreman who wouldn't take Song because he didn't look sturdy enough; and—the final blow—a robbery that stripped him of most of his savings. After that, Song wandered the streets for days—or was it months? He doesn't remember. Everywhere he went, the dizziness followed, even to the jail where Song was locked up for 30 days as a vagrant. "Sometimes I would see other people like me, alone, walking the streets, and I wondered if they had problems too, and wanted to make friends," he says. "But when I would go up to them, they would turn away."

One morning last spring, Song decided he wanted to die. He gathered his final pennies, bought some pesticide and swallowed it. When he woke up in a hospital, a nurse derided him for being cowardly and a drain on medical resources. "The nurse told me not to waste her time," says Song. "She said I was so stupid that I couldn't even kill myself correctly." Upon finding out that Song had no money, she forced him to check out of the hospital the next day, even though his throat still burned from the poison. No one came to pick him up, because no one knew he was there. Even today, Song does not know what to call the dizziness and bad thoughts that continue to haunt him. He has never heard of the word depression. All he knows is that he is a failure. "I cannot go home now," he says. "I would be an embarrassment to my parents and they would lose face in our village."

The vast majority of China's burgeoning mental-health patients suffer in silence. The nation's psychiatrists have seen a remarkable upswing in the kinds of mental disease linked to fast-paced societies, particularly depression and anxiety disorders. But, says Professor Ji, "Outside the big cities, most doctors have never heard of things like anxiety disorders or obsessive-compulsive disorders or even depression. So most people are never treated." According to the Global Burden of Disease survey, mental health constitutes only 2% of China's health budget, but psychiatric disorders account for 20% of the nation's health burden. The situation is particularly acute for serious mental diseases. The same study asserts that although 60% of schizophrenics are treated in hospitals in the U.S., 90% of China's schizophrenics remain hidden at home without access to medication or therapy. "Many people in China just want to hide the mentally ill person at home," says Du of Huashan Hospital. "They don't want outside people to see their crazy relative and think they are crazy too." Not that most could afford the cost of treating such major illnesses. Only about 15% of mainlanders currently have health insurance, and in most places expensive antipsychotic medicine is not subsidized.

The continuing stigma of mental disease in China—and, indeed, in much of Asia—is so pervasive that even the caregivers fall prey to misconceptions. Nurses who worked with Canadian psychiatrist Michael Phillips in the town of Shashi in central China confided to him that they didn't tell their families the true nature of their work, because it was widely believed that mental illness is contagious. Such ignorance isn't surprising given that many nursing schools in China don't even offer courses on psychiatry—it only became a formal discipline in mainland universities in 1995. There are only 2,000 fully qualified psychiatrists for a country of 1.3 billion people, compared with 10.5 psychiatrists per 100,000 in the U.S. The majority of China's psychiatrists never chose their field: they were assigned to it by their medical school.

Nevertheless, there are hopeful signs that China is trying to combat its growing mental-health scourge. The country recently passed a law that tries to address the basic rights of victims through education and increased funding for mental-health care. But as is often the case in China, the law has been implemented fully only in the big cities. In Shanghai, mental hospitals are clean, safe and orderly. But several Western-trained Chinese psychiatrists in the metropolis wonder whether overmedication is the cause of the eerily quiet halls. Indeed, the country still combats mental health by focusing on control—a fundamental difference with the West, where psychiatric disorders are recognized as a medical condition that often can be treated with therapy as well as drugs. By contrast, in East Asia social deviance is an issue typically addressed by the law. In China, it is the Ministry of Public Security that oversees many of the country's mental-health policies, not the Ministry of Health. Until recently the security bureau was also in charge of the



INPATIENT MENTAL HOSPITAL. THE NATION HAS ONLY 20 PSYCHIATRISTS

nation's suicide statistics—and did not make them public. "We are still not facing up to our mental-health problem fully," says Du. "Unless all of us face up to the crisis, things will not change enough. We will be rich, but we will be sick."

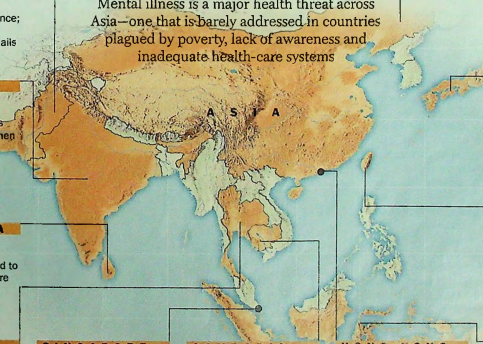
War Wounds

PERHAPS NO COUNTRY IN ASIA NEEDS MENtal-health care more than Cambodia, a tormented nation where the scars of the 1975-79 Khmer Rouge regime are still fresh even a quarter-century later. According to a survey conducted by the Transcultural Psychosocial Organization (TPO), an NGO with ties to the WHO, 75% of adult Cambodians who lived through the Khmer Rouge era suffer from either extreme stress or post-traumatic stress disorder. Children born to this broken generation haven't fared much better. Aid workers estimate that 40% of young Cambodians suffer from stress disorders caused by growing up in a

STUART FRETT

Brain Damage

Mental illness is a major health threat across Asia—one that is barely addressed in countries plagued by poverty, lack of awareness and inadequate health-care systems



PAKISTAN
Awareness of mental illness is almost nonexistent. With only 360 psychiatrists, most of Pakistan's estimated 1.5 million mentally ill suffer in silence; others are locked up in asylums that resemble jails

INDIA
Domestic violence and sexual abuse are major causes of mental illness and suicide among women in this male-dominated society. Depression is little understood and rarely diagnosed

SRI LANKA
Two decades of civil war plus widespread political violence have contributed to a suicide rate that is more than three times higher than the global average

THAILAND
With some 1 million Thais suffering from mental illness and only 400 psychiatrists in state-run health-care institutions, Thai officials recently admitted that they are ill-equipped to deal with this mounting "social crisis"

SINGAPORE
The worst job market in 17 years has seen depression and anxiety disorders on the rise, yet mental illness remains deeply stigmatized. In a 2002 survey, 60% of surveyed Singaporeans said those suffering depression could snap out of it if they wanted to

CAMBODIA
An estimated 75% of adults who lived through the Khmer Rouge era suffer from extreme stress or post-traumatic stress disorder. Poverty and ongoing political instability have intensified the problem

HONG KONG
Job-related stress is rampant in the workaholic SAR. High unemployment contributed to a record suicide rate in 2002; almost half of the 1,100 victims were jobless

INDONESIA
In a country with a disastrously low budget for health care in general, the mentally ill are all but discarded. Almost no other Asian nation offers less care, with just two psychiatrists per 1 million people

CHINA
Because of rapid economic change and social dislocation, anxiety disorders are more common now than during the Cultural Revolution. China is the only country with more female schizophrenics and more female suicides than male

JAPAN
Best known for its depressed salarymen, Japan has also been hit by a rash of *hikikomori* cases of younger Japanese withdrawing from daily life. Still, few other Asian countries spend as much on mental-health care

TAIWAN
Psychiatrists estimate that more than a fifth of Taiwan's 23 million populace might be suffering various degrees of mental illness. A recent survey found that a quarter of fourth-grade students in Taipei had thought about suicide

TIME Map by Dennis Wong; Text by Nick Papadopoulos

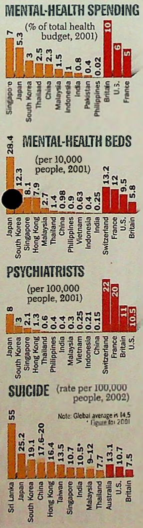
DON'T DO IT

Japanese authorities installed mirrors above Tokyo's Chuo line tracks to dissuade people from jumping to their deaths

tattered social network. Yet in all of Cambodia there is not a single inpatient mental hospital. The nation of 11 million has only 20 psychiatrists. Mental-health funding didn't even figure into the national budget until nine years ago. "The mental-health situation is bad in many countries," says Muny Sothara, a psychiatrist at an outpatient clinic at Preah Bat Norodom Sihanouk Hospital in the capital, Phnom Penh. "But I don't know of any place worse than Cambodia."

Every day, hundreds of bedraggled citizens line up from dawn at the Preah Bat hospital's mental-health clinic. Most have traveled for hours by oxen-drawn cart or packed bus to reach the venue. Chan Muoy, a gaunt, 41-year-old snack vendor, has not been able to sleep soundly for years. Images of past torture creep into her mind before slumber does. Now, though, things have got even worse. Cambodia has just gone through dangerously polarizing parliamentary elections, and many fear that violence might erupt once again. So nervous is Chan Muoy that she has lost her appetite and the tortured flashbacks are beginning to blur the line between reality and hallucination. While speaking to a psychiatric nurse, Chan Muoy's eyes bulge out and dart wildly as she recounts her trauma: how her father, brother and sister were killed by the Khmer Rouge, the latter for the crime of stealing a potato; how a troop of machete-wielding child soldiers came to get her one night when she was 18 and lashed her to a post in crucifixion pose before inexplicably releasing her hours later; how she wandered the streets for years after that, suffering rapes and beatings. "Everyone has gone through hard times here," says Chan Muoy, who was diagnosed with post-traumatic stress disorder by the nurse. "I'm not unusual. We all relive bad memories that make us shake and cry."

JOHN GREIM—SCIENCE PHOTO LIBRARY; ADAM HART-DAVIS—SCIENCE PHOTO LIBRARY



It's in Your Mind

An estimated 450 million people worldwide—200 million in Asia alone—suffer from a mental or behavioral illness. The major disorders include:

DEPRESSION

(Unipolar Depressive Disorder)

What it is: An illness characterized by lackluster energy and a general lack of interest in life. Often recurrent or even chronic

Symptoms: Poor self-esteem; a sense of sadness, dejection or hopelessness without any clear cause; suicidal thoughts

How it's treated: With antidepressant medications such as Prozac and/or psychotherapy, through which patients can learn to overcome—among other things—their negative self-image

MANIC DEPRESSION

(Bipolar Affective Disorder)

What it is: Alternating bouts of mania and depression

Symptoms: Feeling dramatically more active, confident and sociable, then depressed or intensely irritable; delusions

How it's treated: Mainly by mood-stabilizing drugs such as lithium or anticonvulsants such as sodium valproate (Depakote) and carbamazepine (Tegretol)

SCHIZOPHRENIA

What it is: A psychotic disorder that severely alters the way a person usually thinks and behaves

Symptoms: Hallucinations; delusions; confusion; withdrawal; agitation; emotional numbness

How it's treated: Therapy, along with antipsychotic drugs. Success rate is fairly high—about 50% of patients can expect a full and lasting recovery

POST-TRAUMATIC STRESS DISORDER

What it is: A delayed psychological reaction after witnessing or experiencing a highly traumatic event, like a war, natural disaster or a violent physical assault

Symptoms: Anxiety; flashbacks; recurring nightmares; emotional numbness; chest pain

How it's treated: Therapy, in which patients talk through the traumatic event, helping them accept the incident and regain control. New antidepressant drugs can also relieve symptoms

OBSESSIVE-COMPULSIVE DISORDER

What it is: Repeated, unwanted thoughts, or unnecessarily repeating actions such as washing hands or counting

Symptoms: Extreme anxiety or depression. Obsessions and compulsions

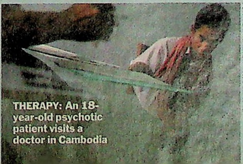
How it's treated: Drugs are effective, enabling some 75% of patients to recover. Therapy helps the sufferer confront the problem and alter his or her behavior

PANIC DISORDERS

What it is: Sudden and recurrent attacks of intense fear or panic

Symptoms: Palpitations; chest pain; shortness of breath; hyperventilation. Fear of being alone or of dying

How it's treated: Therapy involves repeated exposure to the patient's anxiety or fear in order to change his or her thinking patterns and actions. Medication might also be prescribed



THERAPY: An 18-year-old psychotic patient visits a doctor in Cambodia

JOHN STANMEYER—VII FOR TIME

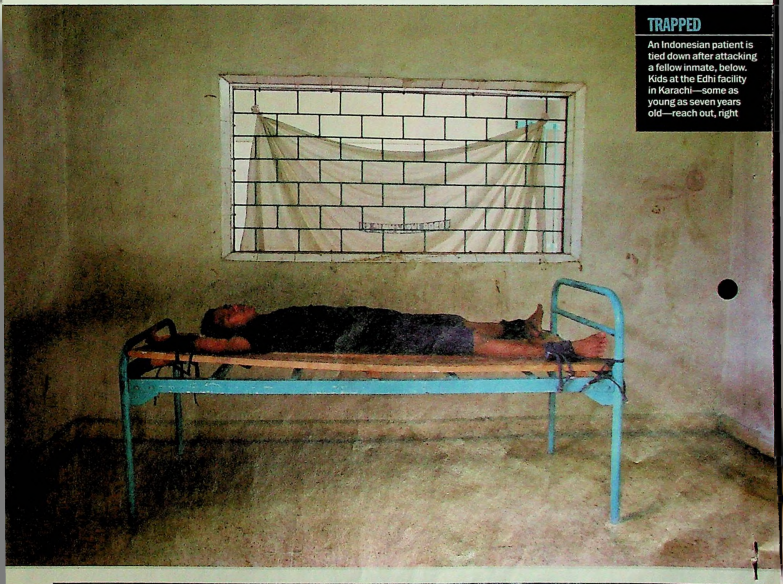
Sources: Atlas: Country Profiles on Mental Health Resources, World Health Organization; Merriam-Webster's Medical Dictionary; Sharon Glick, director of St. John's Counseling Service, Hong Kong; TIME Research

The lack of mental-health infrastructure gives Cambodians few options to treat their woes. Kum Kim, a 47-year-old from Kampong Thom province, was diagnosed as a schizophrenic by a health worker from TPO earlier this year. She says evil spirits poke sticks through the floor slats sometimes when she is resting in her wooden, stilted house. She says she must hop around her home to avoid the sharp jabs. Desperate for help, she goes to a *krukmai*, or witch doctor, named Son Mao. The *krukmai's* house—the only one in the village whose owners can afford a corrugated iron roof—has been prepared for Kum Kim's visit. There is an offering of fruit on the floor and whirls of incense meant to lure the village spirits in for a chat. As pigs squeal nearby, the *krukmai* touches Kum Kim's forehead and conjures up the spirits. They tell her that Kum Kim has been possessed by evil spirits. The reason? While Kum Kim's husband was commune chief many years ago, he promised to build a road for the village. Yet he never did. Now, the spirits are out to punish the whole family. "If the spirits are angry, you have to soothe them," explains Son Mao. "Once they forgive you, your craziness is gone."

Despite the *krukmai's* ministrations, Kum Kim's craziness has not disappeared. The spirits in her house still jab her with pointed sticks. Other families in the village have begun shunning her family, worried that the spirits might haunt them, too. In Cambodia, though, the haunted seem too numerous to avoid. "So many people are sick in the head here," says Chea Dany, a nurse at the Preah Bat hospital. "But no one wants to be with them. Our society is divided into two: people who are sick, and people who are O.K. and want to ignore the sick. We cannot grow up as a country if we are divided like this."

Suicide Nation

THE PLACID POSTWAR HISTORY OF JAPAN has little in common with the devastation Cambodia has endured. In Japan the streets are neat, and the government coffers are full despite more than a decade of economic stagnation. And yet there is a melancholy in the country that has caused more than 30,000 Japanese to commit suicide every year since 1998, compared with fewer than 15,000 a year in the 1970s. That's the highest suicide rate in East[illegible]a,



TRAPPED

An Indonesian patient is tied down after attacking a fellow inmate, below. Kids at the Edhi facility in Karachi—some as young as seven years old—reach out, right

"OUR CENTER IS BECOMING A DUMPING GROUND FOR PEOPLE WHO

and one of the highest in the world. In part, the malaise that is gripping Japan seems to be a product of a hypercommercial society where so many feel the need to compete—and so many fall apart when they slip behind. "We are very developed economically, but Japanese are still intent on getting ahead," says Yukio Saito, who runs a suicide-prevention hot line headquartered in Tokyo. "That pressure makes it very hard to sustain a healthy life."

To its credit, Japan has tried to heal its perennially depressed populace. Already, the nation has the most inpatient psychiatric beds in the world, and recent regulations have raised standards at private hospitals where care was often substandard. Government bureaucrats have also loosened stringent regulations on imports of Prozac and other badly needed medication. There has been a push to allocate more money for outpatient care and community-based education through posters. And on the Chuo train line, a well-known final destination for terminally depressed, local authorities have installed mirrors in the train tunnel because studies show that looking at one's own reflection helps check suicidal impulses.

Yet, for all its efforts, Japan's suicide statistics remain desperately high. The phenomenon strikes most frequently among middle-aged men, precisely the same group most affected by Japan's long economic downturn and ensuing corporate restructuring. Among government bureaucrats, for instance, suicide is the second leading cause of death. "These people, who were used to lifetime employment, have seen a huge shift in the social system," says Saito. "But they can't admit to themselves that they're depressed, and they don't see any other noble way out." Even suicide itself is a shameful topic—ironic for a nation weaned on tales of kamikaze pilots and hara-kiri samurai. Saito remembers talking to a widow who couldn't admit to her family and friends that her husband had committed suicide. "She told everyone he died of a heart attack," he recalls. "That was the best way not to embarrass the family and his company."

In Japan, as in many other East Asian nations, such avoidance of social humiliation guides people's lives. "In America, people talk about going to the psychiatrist like going to the grocery store," says Tokyo-based psychiatrist Osamu Tajima. "But here, it's still quite taboo." Even after several nationwide education campaigns, mental illness is still widely seen in Japan as largely incurable. And though mental-health spending is higher in Japan than in other Asian nations, the country's legislation allows mental hospitals to have up to 48 patients per doctor, while regular hospitals are limited to just 16 patients per physician.

In tackling Asia's mental-health crisis, perhaps the most important task is to make smart spending a priority. Eight years ago, South Korean government officials tried just that, shifting resources from full-fledged mental institutions to community mental-health centers. The majority of patients who visit the 40 nationwide centers suffer from severe mental illnesses such as schizophrenia and bipolar disorder. But with rehabilitation courses and occupational training, many can reintegrate into a society that once shunned them. "Helping patients realize that they can manage their illness without being institutionalized is my duty," says Hong Joo Eun, who heads the Sungdong district community mental-health center in Seoul. Still, Hong notes that staff at such centers are paid half of what those in general hospitals earn, and the turnover rate among center workers is high.

The weight of battling on the front line of Asia's mental-health epidemic seems to hang heavy on psychiatrist Tajima. Sitting in his claustrophobic, fluorescent-lit consulting room in Tokyo, he rubs his eyes and cups his head in his hands. He has a bad headache that simply will not go away. Then, Tajima looks up and smiles a peculiarly Japanese smile—half apology, half wistfulness, without a hint of humor in it. "You know, I fit the profile of a high-risk suicide candidate in Japan," he says, massaging his temples. "I am a middle-aged man who is overworked and can't see that situation changing anytime soon." And with that thought, Tajima bows his head ever so politely and walks slowly out of the room. *—With reporting by Bo Hou/Shanghai, Juliane Han/Seoul, Hanno Hitte/Tokyo and Owais Tohidi/Karachi*

CONSIDER MENTALLY ILL PEOPLE AS THE DIRT OF SOCIETY." —GHAZANSAR KARIM, Edhi Village supervisor

LIFE OF THE PARTY

One of India's richest men, liquor baron Vijay Mallya has houses, racehorses, fancy

By **ARAVIND ADIGA** BANGALORE

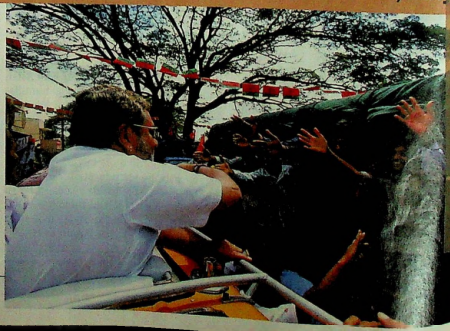
VIJAY MALLYA, CHAIRMAN OF THE UB Group, India's largest liquor conglomerate, is getting a touchup. The businessman and flamboyant socialite—whose toys include racehorses, sports cars and soccer teams—lounges beside the swimming pool of his seaside mansion in Goa while a makeup artist brushes dye into his beard. The hues perfectly match the copper tints already gleaming in Mallya's hair. Rifle-toting security guards keep watch while his wonderstruck guests sip beer and wander about the pleasure dome's grounds.

His new highlights suitably dry, Mallya—known inside his palace as "Boss"—makes for the pool. Wearing red-tinted sunglasses, diamond studs and thick gold bracelets, he wades into the cool turquoise water, lights up a cigarillo and bellows out a limerick that begins, "There once was young man from Madras, whose balls were made of brass ..."

After a sumptuous lunch served by uniformed waiters, the Boss heads for the Goa airport, where his private Boeing 727 is prepped for take-off. Is the destination Monaco, Gstaad or any number of other international playgrounds befitting the 47-year-old glamour boy of Indian business? Hardly. Vijay Mallya is hitting the campaign trail.

Already a member of India's upper house of Parliament, he's also a new and improbable leader of the Janata Party, a socialist outfit famous for its commitment to farmers and the downtrodden. Mallya is campaigning hard to establish himself as a political force in his home state of Karnataka. He's already spent time and money stumping for candidates from an affiliated party in a recent election for the state assembly, and he says he plans to field candidates of his own in future elections. Emulating his heroes—American tycoon-turned-politician Ross Perot and Italian media magnate-turned-Prime Minister, Silvio Berlusconi—Mallya is pushing hard to break down the barrier traditionally separating business from politics in his country. "This is the first time a major businessman has officially entered politics in India," says P.S. Jayaramu, a professor of political science at Bangalore University. For many, Mallya could be the welcome harbinger of a new kind of reformer ready to storm Indian poli-

THE "BOSS": Mallya at his home in Goa and campaigning in Karnataka, below



All the President's Men

Corruption scandals involving some of Roh Moo Hyun's closest aides and supporters have undermined his election pledge to end dirty politics. Key players include:

CHOI DO SUL
Former presidential secretary, high school chum and one of Roh's closest aides who is known as the eternal butler"
Status Arrested in October for allegedly receiving an illegal donation of more than $900,000 from the SK

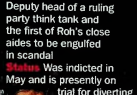
conglomerate. He resigned, but denies the charges

KANG KEUM WON
Textile businessman and longtime Roh supporter
Status Barred from leaving the country; his offices

were raided in an investigation of alleged illegal contributions to Sun Bong Sul and to Roh's election camp last year. He denies any wrongdoing

SUN BONG SUL
Roh's longtime friend, business partner, and former chauffeur
Status Brought in for questioning in relation to the SK bribery case, but denies any wrongdoing. Prosecutors allege he received about $195,000 of the money they say the SK Group gave to Choi Do Sul

AHN HEE JUNG
Deputy head of a ruling party think tank and the first of Roh's close aides to be engulfed in scandal
Status Was indicted in May and is presently on trial for diverting funds from the now defunct Nara Merchant Bank to the think tank (which he denies doing)



YANG GIL SEUNG
Former personal secretary to the President, he resigned in August after he was videotaped with a nightclub owner under investigation for tax evasion, pimping and instigation of murder
Status Prosecutors are investigating the club owner, Lee Won Ho, to determine whether he tried to bribe Yang. The National Assembly

passed an independent counsel bill requesting an investigation into the Yang case, vetoed by Roh last week. Both Lee and Yang deny any wrongdoing

ing bribes, and Ahn Hee Jung, a presidential aide who is currently on trial for allegedly funneling $166,000 from a faltering commercial bank into a private political research institute set up by Roh. Meanwhile, investigators from the Supreme Public Prosecutors' Office recently raided offices at Samsung Electro-Mechanics, part of the Samsung Group, the country's largest conglomerate; Hyundai Capital, the auto finance arm of automaker Hyundai Motor; and LG Shopping, an online shopping subsidiary of Korea's No. 2 conglomerate. Prosecutors are seeking evidence that the companies made contributions illegally to political campaigns, including Roh's. A spokesman for Samsung said the group was "not involved with the election process illegally." The other companies declined to comment.

South Koreans have seen corruption crackdowns before. The country's traditional ties between government and industry breed an incestuous system of mutual back scratching that is rife with under-the-table payouts. Winning office is expensive—political analysts estimate that Roh's campaign cost at least $125 million, more than that of U.S. President George W. Bush—but tough campaign-financing laws limit the money that can be raised legally from deep-pocket contributors to $208,000 each. Says Roh Kwan Kyu, budget and accounting committee chairman for the Millennium Democratic Party (under whose banner Roh ran for the presidency): "It would be extremely difficult to get elected within the legal amount of money that is allowed."

The current campaign-financing investigation is different from past scandals, however, because it is the first to take aim at a sitting President. Touched off this year when auditors looking into possible accounting fraud at SK's trading arm, SK Global, uncovered a multimillion-dollar political slush fund and bank accounts linked to both Roh's campaign and those of the opposition Grand National Party (GNP), the probe is unprecedented in scope and scale. Political pundits are comparing the dragnet to Italy's "Clean Hands" crackdown of the early 1990s, when reform-minded investigators sent hundreds of businessmen, bureaucrats and prominent politicians to jail. GNP members are also under investigation: GNP lawmaker Choi Don Woong has already admitted to taking $8.3 million from SK.

If Roh is feeling the heat, he has only himself to blame. In the past, the Blue House could sway—or kill—sensitive investigations by putting pressure on senior prosecutors, analysts say. But Roh's promise to clean up South Korea's dirty politics has given a freer hand to law-enforcement officials. At a town-hall-style meeting in March, Roh told a gathering of prosecutors that "there will be no phone calls" from the Blue House squashing investigations. And the public is squarely behind a cleanup drive. The lead prosecutor for the campaign-financing investigation, Ahn Dae Hee—known to be fearless in pursuing politically sensitive cases—even has an Internet fan club. Under the circumstances, the Blue House "can't make the phone call even if they want to," says Kim Young Ho, an expert on Korean politics at Inha University in Inchon.

Smelling blood, the GNP is working overtime to keep investigators focused on the administration. The centerpiece of the strategy was the bill that Roh vetoed last week. GNP chairman Choi Byung Yul immediately protested the veto by launching a hunger strike and ordering GNP lawmakers to boycott the National Assembly. The GNP wants to prove that after the elections, Roh's aides accepted illegal donations with the President's knowledge. "If we find that Roh's involved, we'll impeach him," says GNP lawmaker Hong Joon Pyo. Another GNP legislator, Won Hee Ryong, remarks, "To put it in football terms, this is about who can stay on offense until the April [legislative] elections."

Offense, in this case, means looking less guilty than the other guy. Roh strategists figure the President will triumph because the prosecutors' probe will likely show the GNP, whose candidate was the favorite to win last fall's presidential elections, took in more illegal contributions. But incalculable damage to Roh's once clean image has already been done. One of the biggest embarrassments came in July when a national television network ran a videotape of Roh's personal secretary Yang Gil Seung cavorting in a sleazy nightclub south of Seoul with the club's owner—a man who has been under investigation for tax evasion, pimping and instigation of murder.

Yang resigned. But GNP members are pushing hard to continue the investigation, hoping to show that he accepted bribes from the nightclub owner, Lee Won Ho, in exchange for political help with his legal troubles. (Yang denied accepting bribes.) A key unanswered question: Was Lee involved in illegal fund raising for Roh's campaign? Lee, who is under arrest but denies any wrongdoing, has testified that he helped round up voters for Roh during primary elections. He even got a certificate of appreciation from Roh campaign officials, according to his lawyer. With friends like these, Roh might have all the enemies he needs to lose the public's trust—and his job. *—With reporting by Juliane Han and Kim Yooseung/Seoul*

By HANNAH BEECH XINMIN

UNHAPPY RETURNS

China's public-health system was told to make its way in the free market. Now, the underfunded network can't cope with re-emerging diseases

DEAD MAN STANDING: Farmer Wang's distended belly is a symptom of schistosomiasis

XINMIN IS A VILLAGE ON THE VERGE OF extinction. Nearly every resident of this swampy, 1,000-strong hamlet in the central Chinese province of Hunan is infected by the parasitic worm *Schistosoma japonicum*. It spreads through the bloodstream, lays eggs in the liver and bladder, wriggles into the brain or embeds itself in the spine. Renal failure and paralysis may follow; death is painful and untimely. That is the grim fate awaiting Xinmin villager Wang Zengkun. The 45-year-old rice farmer first experienced the stomach cramps and bloody diarrhea that signal schistosomiasis three years ago. For a while, Wang fought the disease by spending his life savings, some $4,830, on medication and operations that removed calcified egg deposits and polyps from his body. But earlier this year, when doctors told Wang that he needed more surgery, he had to forgo it. He had no money left. Wang is not alone. Four of his neighbors who lived along the fetid stream that oozes with microscopic *Schistosoma* worms—the vectors are freshwater snails—have died in recent months. "The government does not care about us farmers, only about economic development," says Wang, cradling his distended belly with gnarled hands. "There's no one to protect us anymore."

Half a century ago, Chairman Mao Zedong, himself a native of Hunan province, declared war on the diseases ravaging China's countryside. One of his major battles was against the fearsome *Schistosoma* fluke, which infected 12 million Chinese in 1949 and, according to the World Health Organization (WHO), is still the world's second-most-debilitating parasitic disease, after malaria. Employing troops of pesticide-wielding workers to eradicate snails and offering free health checkups and medicine for all those living in the schistosomiasis-prone Yangtze River region, China slashed the number of victims to 2.5 million in 1975. By 1988, that had shrunk even further, to 400,000. So proud was the Great Helmsman that he wrote a poem, called "Sending Away the God of Plague," commemorating the People's Republic's fight against a tiny worm.

But beginning in the 1980s, as China's drive to capitalism kicked into higher gear, Beijing extended market reforms to health care—with disastrous consequences. Local health bureaus were stripped of their government funding and forced to become financially self sufficient. To survive, many local clinics eschewed public-minded immunization drives for more profitable ventures, like selling medicine and services at inflated prices. The social pitfalls of this system were laid bare in a 1998 United Nations–led survey, which found that almost half of those who had fallen below China's poverty line did so only after suffering from a major disease. Today, just 15% of Chinese have health insurance. The nation's recent SARS crisis served as another reality check; crucial weeks were lost because only a trickle of funding had gone to important but money-losing services, such as outbreak response and epidemiological research. Despite the lessons learned during SARS, the nation's 4,000 local centers for disease control (CDCs)—key institutions on the front lines of China's battle against disease—still must privately finance more than 50% of their budgets, according to the WHO, whereas similar institutions in most other nations are government funded. Says Lisa Lee, a medical officer with the WHO in Beijing: "China's health care focuses on how to maximize revenue, not coverage."

Many infectious diseases that were nearly tamed during Mao's era are now rebounding or, at the very least, the battle against them has stalled. Schistosomiasis is just one example. Diseases like tuberculosis and hepatitis B, which could have been curbed by a more public-minded health-care system, are now spreading largely unchecked. China has had a cheap vaccine for hepatitis B available since 1985. But local health bureaus were loath to offer it free of charge, because the vaccine was a crucial source of income. As a result, 10% of Chinese are now carriers of the potentially fatal liver disease, compared with less than 1% of Americans. Even today, China is the only one of the 37 nations in the WHO's western-Pacific region that requires its citizens to pay for routine childhood immunizations. "During the past 20 years of reform, the government only focused on economic development," says Song Wenzhi, a professor at the Peking University Public Health Institute in Beijing. "It neglected social issues, such as health." No surprise, then, that a 2000 WHO study ranking the health systems of 191 member countries placed China 144th, behind Indonesia and Bangladesh.

Such chronic neglect has decimated villages like Xinmin. By the early 1990s, local health workers no longer had a budget to spray antisnail pesticide around Dongting Lake, where Xinmin is located. Free schistosomiasis checkups and medicine stopped as well. Now funding for local clinics once proudly designated as "antisnail-fever bureaus" has also dried up; to make ends meet, many have opened up moneymaking clinics for sexually transmitted diseases and osteopathy. Consequently, just as China was proudly announcing that it had defeated snail fever, the mollusk began returning. Last year, according to statistics from the Ministry of Health, 810,000 people contracted schistosomiasis, more than double the number of cases in 1988. But experts caution that the real figure is much higher and could spiral further upward upon completion of the Three Gorges Reservoir, which might cause the snails to spread eastward. Jiang Changzao, a former official at China's largest reed plantation, which supplies pulp for paper, says that almost every reed cutter working the fields near Dongting Lake is now infected with schistosomiasis. He charges staff at the local health bureau with consistently underreporting the number of people infected in recent years in order to meet quotas on snail-fever prevention and to land year-end bonuses. "The local government is lying about the number of people with the disease to make itself look good," says Jiang, who has contracted schistosomiasis himself. "But I am a member of the Communist Party, and I feel it is my duty to report the truth."

Underreporting is also rampant among China's 100 million–strong migrant population, which relies on health care from unlicensed fly-by-night clinics that rarely report epidemiological figures to local CDCs. The WHO estimates that one-third of China's measles and tuberculosis cases are never reported, in part because they disproportionately affect migrant workers. Without access to proper health care, these itinerant communities are virtual petri dishes of disease. Recent outbreaks of measles and Japanese encephalitis in the southern province of Guangdong—where SARS first appeared—are believed to have originated in this so-called "floating population." An article this year in the U.S.-based *Journal of Infectious Diseases* reported that the number of people getting measles in migrant populations was almost eight times higher than in resident communities, largely because migrants are either too broke or too disenfranchised to get routine childhood immunizations. Indeed, two of China's poorer neighbors, Vietnam and Mongolia, boast higher rates of routine childhood immunization than China, because of their greater public-health commitment. "All of the international organizations in China have sent clear signals that the public-health system needs to be reformed," says the WHO's Lee. "But so far, we've had almost no response."

Back on Dongting Lake, a reed cutter surnamed Song is resigned to the worms invading his body. During the colder months he serves as the plantation's caretaker, living in a makeshift lean-to made of reeds. One of the few ornaments inside his cramped quarters is a portrait of antidisease crusader Chairman Mao. Outside, the ground is littered with the shells of snails whose worms infect workers in warmer weather. Song's drinking and washing water, drawn from a brackish pit by his hut, also teems with *Schistosoma* worms in the summer. Naturally, Song has been diagnosed with snail fever. He doesn't feel the symptoms yet, but he knows they will come—as they have for nearly everyone he knows. "I will get sick," says Song, who cannot afford proper treatment. "But I have no other choice for a job. The God of Plague has returned to Man's home province with a vengeance." ■

THE PLAGUES

China is reeling from an onslaught of communicable diseases

■ HEPATITIS B

Viral infection of the liver spread by contact with infected blood or through sexual contact. Can cause cirrhosis and liver cancer

SUFFERERS: 130 million

ANNUAL DEATHS: 250,000

■ SCHISTOSOMIASIS

◀ Caused by parasitic worms carried by freshwater snails. Leads to liver, urinary, lung and nervous-system disorders

SUFFERERS: Nearly **1 million**

ANNUAL DEATHS: Unknown

■ TUBERCULOSIS

A chronic bacterial infection spread through the air. Leading killer of adults worldwide

SUFFERERS: 1.3 million new cases annually on average

ANNUAL DEATHS: 250,000

■ AIDS

▶ Caused by the Human Immunodeficiency Virus (HIV), which can be passed from one person to another through infected blood and sexual contact

SUFFERERS: 1–1.5 million

ANNUAL DEATHS: 30,000*

■ MEASLES

▼ Highly contagious viral disease characterized by high fever, cough, runny nose and rash

SUFFERERS: 58,341**

ANNUAL DEATHS: 7,000

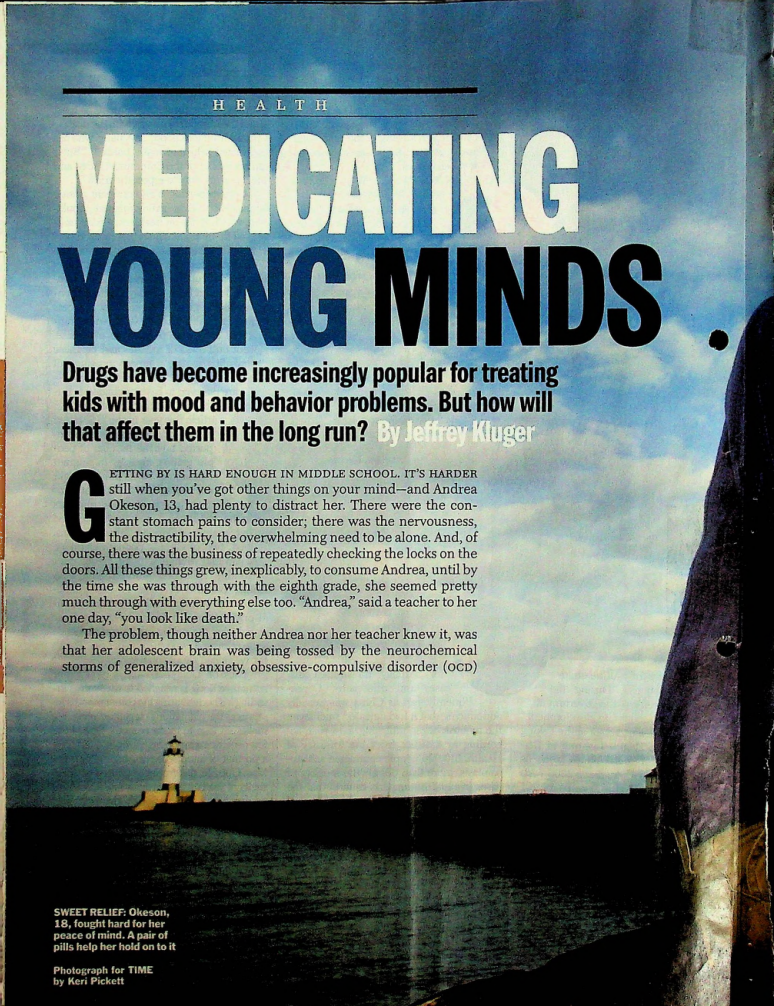
*Figure for 2001 **Figure for 2002
Sources: World Health Organization; World Bank; Chinese Ministry of Health; Institute of Development Studies

MEDICATING YOUNG MINDS

Drugs have become increasingly popular for treating kids with mood and behavior problems. But how will that affect them in the long run? By Jeffrey Kluger

GETTING BY IS HARD ENOUGH IN MIDDLE SCHOOL. IT'S HARDER still when you've got other things on your mind—and Andrea Okeson, 13, had plenty to distract her. There were the constant stomach pains to consider; there was the nervousness, the distractibility, the overwhelming need to be alone. And, of course, there was the business of repeatedly checking the locks on the doors. All these things grew, inexplicably, to consume Andrea, until by the time she was through with the eighth grade, she seemed pretty much through with everything else too. "Andrea," said a teacher to her one day, "you look like death."

The problem, though neither Andrea nor her teacher knew it, was that her adolescent brain was being tossed by the neurochemical storms of generalized anxiety, obsessive-compulsive disorder (OCD)



SWEET RELIEF: Okeson, 18, fought hard for her peace of mind. A pair of pills help her hold on to it

Photograph for TIME by Keri Pickett

MH-1.

ಮಹಿಳೆಯರ ಮಾನಸಿಕ ತೊಂದರೆಗಳು

ಹುಟ್ಟಿನಿಂದ ಸಾವಿನವರೆಗೂ ನಾವು ಬಾಲ್ಯ, ಯೌವ್ವನ, ಮುಪ್ಪು ಮುಂತಾದ ಹಂತಗಳನ್ನು ದಾಟಿ ಮುನ್ನಡೆಯುತ್ತೇವೆ. ಈ ಬದುಕಿನುದ್ದಕ್ಕೂ ಹಲವು ಸಮಸ್ಯೆಗಳು/ ಹೋರಾಟಗಳು ನಡೆಯುತ್ತಿದ್ದು, ನಾವುಗಳು ಅದಕ್ಕೆ ಸಮಯೋಚಿತ ಪರಿಹಾರ ಹುಡುಕಿಕೊಳ್ಳಬೇಕಾಗುತ್ತದೆ. ದೊಡ್ಡವರು, ಚಿಕ್ಕವರು, ದಲಿತರು, ಮೇಲ್ವರ್ಗದವರು ಯಾರೇ ಆದರೂ ಈ ಹೋರಾಟ ಪರಿಹಾರ ಸಹಜ.

ಇಲ್ಲಿ ನಾವು ಚರ್ಚಿಸಿ ಹೊರಟಿರುವುದು ಪುರುಷ ಮತ್ತು ಮಹಿಳೆಯರ ಮಾನಸಿಕ ಹೋರಾಟಗಳ ನಡುವಿನ ಭಿನ್ನತೆ ಆದರಲ್ಲಿಯೂ ಮುಖ್ಯವಾಗಿ ಮಹಿಳೆ ತನ್ನ ಸಮಸ್ಯೆಗಳಿಗೆ ಪರಿಹಾರ ಹುಡುಕಬೇಕಾದ ವಿಧಾನಗಳ ಬಗೆಗೆ.

ಜೀವನದಲ್ಲಿ ಸುಖ / ದುಃಖ, ಆರೋಗ್ಯ / ಆನಾರೋಗ್ಯ, ನೋವು / ನಲಿವು ಎಲ್ಲವೂ ಇರುತ್ತದೆ. ನಮ್ಮ ಮನಸ್ಸು ಸುಖವನ್ನೇ ಅಪೇಕ್ಷಿಸಿದರೂ, ದುಃಖವನ್ನು ಬೇಡವೆನ್ನುವಂತಿಲ್ಲ. ಯಾವುದೇ ಪರಿಸ್ಥಿತಿ ಬಂದರೂ, ಅದನ್ನು ಎದುರಿಸಲು ದೈಹಿಕ ಆರೋಗ್ಯ ಮನೋದಾರ್ಢ್ಯ ಎರಡೂ ಬೇಕು.

ದೈಹಿಕ ಆನಾರೋಗ್ಯ ಆದರೆ, ಕೆಲವು ಲಕ್ಷಣಗಳನ್ನು ಗುರುತಿಸಿ, ಕೂಡಲೇ ವೈದ್ಯರಲ್ಲಿಗೆ ಕರೆದೊಯ್ಯಬಹುದು. ಆದರೆ, ಮಾನಸಿಕ ಸಮಸ್ಯೆಗಳನ್ನು ಗುರುತಿಸುವುದು ಕಷ್ಟ. ಅದರಲ್ಲಿಯೂ ಮಹಿಳೆಯರ ಮಾನಸಿಕ ಸಮಸ್ಯೆಗಳನ್ನು ಗುರುತಿಸುವುದು ಮತ್ತೂ ಕಷ್ಟ. ಕಾರಣ, ಸಮಾಜದಲ್ಲಿ ಮಹಿಳೆಗಿರುವ ಸ್ಥಾನ, ಅವಕಾಶ ಇತ್ಯಾದಿ, ಇದನ್ನು ಮುಂದಿನ ಚರ್ಚೆಗಳಲ್ಲಿ ತಿಳಿಯಬಹುದು.

ಮಹಿಳೆಯ ಮಾನಸಿಕ ಆರೋಗ್ಯ ಬಹಳ ಮುಖ್ಯ. ಸಮಾಜ ಮಹಿಳೆಯಿಂದ ಬಹಳಷ್ಟು ನಿರೀಕ್ಷಿಸುತ್ತದೆ. ಗಂಡಿಗೆ ಇರುವುದಕ್ಕಿಂತ ಮಹಿಳೆಯರ ಮೇಲೆ ಕಟ್ಟುಪಾಡುಗಳು ಹೆಚ್ಚು. ಬಾಲ್ಯದಲ್ಲಿ ತಂದೆಯ, ಯೌವ್ವನದಲ್ಲಿ ಗಂಡನ, ಹಾಗೂ ಮುಪ್ಪಿನಲ್ಲಿ ಮಕ್ಕಳ ಅಧೀನಳಾಗಿಯೇ ಇಲ್ಲಿಯವರೆಗೆ ಮಹಿಳೆ ಬಾಳಿದ್ದಾಳೆ. ಈ ಪುರುಷ ಪ್ರಧಾನ ಸಮಾಜದಲ್ಲಿ, ಮಹಿಳೆಗೆ ಮಾತನಾಡುವ ಅವಕಾಶ ಕಡಿಮೆ ಇರುವುದರಿಂದ, ಮಹಿಳೆಯ ಮಾನಸಿಕ ಆರೋಗ್ಯ ಇಂದು ಚರ್ಚೆ ಮಾಡುವುದು ಹಿಂದೆಂದಿಗಿಂತಲೂ ಪ್ರಸ್ತುತವಾಗುತ್ತದೆ. ಮೇಲೆ ಹೇಳಿರುವ ವಿಷಯಗಳನ್ನು ಗಂಡಸರಷ್ಟೇ ಮಹಿಳೆಯರೂ ಒಪ್ಪುತ್ತಾರೆ ಎಂಬುದು ವಿಪರ್ಯಾಸ. ಗಂಡು ಶೋಷಣೆಗೊಳಗಾಗುವ ಸಂಭವಗಳು ಕಡಿಮೆ, ಆಲ್ಲದೇ ಪುರುಷರಿಗೆ ಸಾಮಾಜಿಕವಾಗಿ ಕಟ್ಟುಪಾಡುಗಳು ಕಡಿಮೆ. ಹೆಣ್ಣು ತನ್ನ ಜೀವನದುದ್ದಕ್ಕೂ ಪ್ರತಿ ಹಂತದಲ್ಲೂ ದೌರ್ಜನ್ಯ, ತಿರಸ್ಕಾರಗಳಿಗೆ ಗುರಿಯಾಗುತ್ತಾಳೆ.

- ಹುಟ್ಟುವ ಮೊದಲೇ - ಹೆಣ್ಣು ಭ್ರೂಣ ಹತ್ಯೆ.
- ಹುಟ್ಟಿದ ಕೂಡಲೇ - ನವಜಾತ ಹೆಣ್ಣು ಶಿಶುವಿನ ಹತ್ಯೆ
- ಬಾಲ್ಯದಲ್ಲಿ - ಲಿಂಗ ತಾರತಮ್ಯ (ಗಂಡು ಮಗನಿಗೆ ಓದು, ಹೆಣ್ಣು ಮಗಳಿಗೆ ಅಡುಗೆ ಕೆಲಸ ಇತ್ಯಾದಿ)
- ಯೌವ್ವನದಲ್ಲಿ - ಲಿಂಗ ತಾರತಮ್ಯ, ಲೈಂಗಿಕ ಶೋಷಣೆ (ಮನೆ ಕೆಲಸ ಮಾಡುವ ಜಾಗ, ಅಥವಾ ಹೊರಗೆ ಎಲ್ಲಾದರೂ ಆಗಬಹುದು).
- ಪ್ರೌಢದಲ್ಲಿ - ಲಿಂಗ ತಾರತಮ್ಯ, ಲೈಂಗಿಕ ಶೋಷಣೆ, ಗಂಡನಿಂದ ಹೊಡೆತ, ವರದಕ್ಷಿಣೆ ಶೋಷಣೆ ಇತ್ಯಾದಿ.
- ಮಧ್ಯ ವಯಸ್ಸಿನಲ್ಲಿ - ಲಿಂಗ ತಾರತಮ್ಯ, ಲೈಂಗಿಕ ಶೋಷಣೆ ಇತ್ಯಾದಿ.
- ಮುಪ್ಪಿನಲ್ಲಿ - ವೈಧವ್ಯ, ಒಂಟಿತನ, ತಿರಸ್ಕಾರ ಇತ್ಯಾದಿ. ಇವುಗಳಲ್ಲದೆ, ಬಲವಂತದ ಮದುವೆ, ಆಪಹರಣ, ಸ್ವಾತಂತ್ರ್ಯ ಹರಣ ಇತ್ಯಾದಿಗಳೂ ನಡೆಯುತ್ತವೆ.

ಕೆಲಸದ ಸನ್ನಿವೇಶಗಳು

- ಮಹಿಳೆಯರಿಗೆ ಹೆಚ್ಚು ಲಾಭವಿಲ್ಲದ ಕೆಲಸಗಳೇ ಹೆಚ್ಚು. ಗಂಡು ಧನಾರ್ಜನೆಗಾಗಿ ದುಡಿಯುತ್ತಾನೆ ಎಂಬ ನಂಬಿಕೆಯೊಂದಿಗೆ, ಮಹಿಳೆ ಮನೆಯಲ್ಲಿ ಮಾಡುವ ಕೆಲಸಕ್ಕಾಗಿ ಯಾವುದೇ ಮೌಲ್ಯ ನಿರ್ಧಾರ ಮಾಡುವುದಿಲ್ಲ.

- ಮಹಿಳೆಯರು ಮಾಡುವಂತಹ ಕೆಲಸಗಳು, ಬೇಸರ ತರಿಸುವಂತಹವು, ಎಂದರೆ ಕಸ ಗುಡಿಸುವುದು, ಬಟ್ಟೆ ಒಗೆಯುವುದು ಇತ್ಯಾದಿಗಳನ್ನು ಪುರುಷ ಮಾಡುವುದಿಲ್ಲ. ಅಲ್ಲದೇ ಇದೇ ಕೆಲಸಗಳನ್ನು ಮಹಿಳೆಯು ಜೀವನಪೂರ್ತಿ ಮಾಡುತ್ತಿರಬೇಕಾಗುತ್ತದೆ.

- ಗಂಡು, ಹೆಣ್ಣು ಇಬ್ಬರೂ ಒಂದೇ ಸಮ ದೈಹಿಕ ಶ್ರಮ ಇರುವ ಕೆಲಸ ಮಾಡಿದರೂ, (ವ್ಯವಸಾಯ, ಕೂಲಿ ಇತ್ಯಾದಿ ಕೆಲಸಗಳಲ್ಲಿ) ಇಬ್ಬರಿಗೂ ಕೂಲಿ ಹಣದಲ್ಲಿ ವ್ಯತ್ಯಾಸ ಇರುತ್ತದೆ.

- ಮಹಿಳೆ ತಾನು ದುಡಿದ ಹಣವನ್ನು ತಂದೆ, ಗಂಡ ಯಾರಿಗಾದರೂ ಕೊಡಬೇಕಾಗುತ್ತದೆ. ಒಂದು ವೇಳೆ ಹೀಗಾಗದಿದ್ದರೂ, ಮಹಿಳೆ ತನ್ನ ದುಡಿಮೆ ಹಣವನ್ನು ತನಗಿಷ್ಟ ಬಂದಂತೆ ಖರ್ಚು ಮಾಡಲು ಅವಕಾಶಗಳು ಬಹಳ ಕಡಿಮೆ / ಇಲ್ಲವೇ ಇಲ್ಲ.

- ಮಹಿಳೆಯರು ಗರ್ಭಿಣಿ / ಬಾಣಂತಿಯರಾದಾಗಲೂ ತಮ್ಮ ದೇಹ ವಿಶ್ರಾಂತಿಯ ಕಡೆ ಗಮನ ಹರಿಸದೆ ದುಡಿಯಬೇಕಾಗುತ್ತದೆ.

ಸಮಾಜ ಅಪೇಕ್ಷಿಸುವ ಹೆಣ್ಣಿನ ಗುಣಗಳು

- ಪರಹಿತಕ್ಕಾಗಿ ಜೀವನ ಸವೆಸಬೇಕು. (ತನ್ನ ಬಗ್ಗೆ ಸ್ವಲ್ಪಯೋಚಿಸಿದರೂ, ಆಂತಹ ಮಹಿಳೆ ಸ್ವಾರ್ಥಿಯೆನಿಸಿಕೊಳ್ಳುತ್ತಾಳೆ) ಇದೇ ಸಮಾಜದ ಇಬ್ಬಂದಿ ಧೋರಣೆ.

- ತನ್ನ ಕುಟುಂಬದವರ ಹಿತವನ್ನೇ ಸದಾ ಯೋಚಿಸಬೇಕು.

- ತನ್ನ ಭಾವನೆಗಳನ್ನು ಹೊರಗೆ ತೋರ್ಪಡಿಸಬಾರದು.

- ಹೆಣ್ಣು "ಕ್ಷಮಯಾ ಧರಿತ್ರಿ", ಕೇವಲ ಕ್ಷಮಿಸಬೇಕಷ್ಟೇ. ತಾನು ಒಂದು ತಪ್ಪನ್ನೂ ಮಾಡುವಂತಿಲ್ಲ. ಮಾಡಿದರೂ ಶಿಕ್ಷೆ ಅನುಭವಿಸಬೇಕಷ್ಟೇ ವಿನಃ ಕ್ಷಮೆ ದೊರೆಯದು.

- ನೋವುಗಳನ್ನು ತನ್ನೊಳಗೆ ನುಂಗಿಕೊಳ್ಳಬೇಕು.

- ಎತ್ತರದ ಧ್ವನಿಯಲ್ಲಿ ಮಾತನಾಡಬಾರದು (ಗಂಡು ಮಾತನಾಡಿದರೆ ಆತ್ಮವಿಶ್ವಾಸವುಳ್ಳವನು, ಹೆಣ್ಣು ಮಾತನಾಡಿದರೆ ಗಂಡು ಬೀರಿ)

- ಸ್ವಂತ ವ್ಯಕ್ತಿತ್ವ ಬೆಳೆಸಿಕೊಳ್ಳುವ ಪ್ರಯತ್ನ ಮಾಡಬಾರದು.

- ಆನಾರೋಗ್ಯವನ್ನು ಬಹಿರಂಗ ಪಡಿಸಬಾರದು (ಬದಲಿಗೆ ಅನಾರೋಗ್ಯ ಇದ್ದರೂ ಕೆಲಸ ಮಾಡಬೇಕು)

- ರಾಜಕೀಯ ಪ್ರಕ್ರಿಯೆಗಳಿಂದ ದೂರ ಇರಬೇಕು.

ಮನೆಯ ಒಳಗೆ ಮಹಿಳೆ

- ಮನೆಯಲ್ಲಿ, ಲೈಂಗಿಕತೆ ಹಾಗೂ ಮಕ್ಕಳ ಬಗ್ಗೆ ವ್ಯೆಯಕ್ತಿಕ ಧೋರಣೆ ವ್ಯಕ್ತಪಡಿಸಕೂಡದು.
- ಸಂಸಾರದ ನಿರ್ಧಾರಗಳಲ್ಲಿ ಸಮಭಾಗಿಯಲ್ಲ.
- ಯಾವುದೇ ಸಂಕಷ್ಟವಿದ್ದರೂ ಸಂಸಾರ ಸರಿಯಾಗಿ ನಿಭಾಯಿಸಬೇಕು.
- ಗಂಡ ಬಿಟ್ಟ ಹೆಣ್ಣು, ವಿಧವೆಯರು ಹಾಗೂ ಮದುವೆಯಾಗದವರು ಸಮಾಜದಲ್ಲಿ ಅವಗಣನೆಗೊಳಗಾಗುತ್ತಾರೆ.
- ಹೆಣ್ಣು ದುಡಿದು ತಂದರೂ, ಆದನ್ನು ಖರ್ಚು ಮಾಡಬೇಕಾದ ನಿರ್ಧಾರ ಗಂಡನದು.
- ಗಂಡು ಮಗುವನ್ನು ಮಾತ್ರ ಹೆರಬೇಕಾಗಬಹುದು ಎಂಬ ಆತಂಕ.
- ಹಿರಿಯರು ಹೇಳಿದಂತೆ ಕೇಳಿಕೊಂಡು ಇರಬೇಕಾದ ಪರಿಸ್ಥಿತಿ. ಅವರು ತಪ್ಪು ಹೇಳಿದರೂ ಒಪ್ಪಬೇಕು.
- ಹೆಣ್ಣು ಮ ಕ್ಕಳು ಋತುಮತಿಯಾದ ಕೂಡಲೇ ಅವರ ಚಲನವಲನಗಳ ಮೇಲೆ ನಿರ್ಬಂಧ.
- ಗಂಡಸರಿಗೆ, ಮಕ್ಕಳಿಗೆ ಆಹಾರ ನೀಡಿದ ನಂತರ ಮಹಿಳೆ ಊಟ ಮಾಡಬೇಕು.
- ಹೆಣ್ಣು ಮಕ್ಕಳಿಗೆ ಮೂಲ ಶಿಕ್ಷಣದಲ್ಲೂ ತಾರತಮ್ಯ.

ಲಿಂಗ ತಾರತಮ್ಯ ಏಕೆ ಕಂಡು ಬರುತ್ತದೆ ?

- ಪುರುಷ ಪ್ರಧಾನ ಸಮಾಜದಲ್ಲಿ ಮಹಿಳೆಯ ಮೇಲೆ ಕಟ್ಟುಪಾಡಿನ ಹೊರೆ ಇದು ಸಮಾಜದ ಇಬ್ಬಂದಿ ನೀತಿ.
- ಗಂಡು ಮತ್ತು ಹೆಣ್ಣುಗಳಿಂದ ಸಮಾಜ ನಿರೀಕ್ಷಿಸುವ ಪಾತ್ರಗಳು, ಜವಾಬ್ದಾರಿಗಳು ಭಿನ್ನವಾಗಿವೆ.
- ಒಂದೇ ರೀತಿಯ ಕ್ರಿಯೆ ಮಹಿಳೆ ಅಥವಾ ಪುರುಷ ಮಾಡಿದರೆ ಸಮಾಜ ತೋರುವ ಇಬ್ಬಂದಿ ಧೋರಣೆ (ಗಂಡು - ಆತ್ಮವಿಶ್ವಾಸ, ಹೆಣ್ಣು - ಅಹಂಕಾರ, ಗಂಡು - ನಿರ್ಧಾರಕ, ಹೆಣ್ಣು - ಸ್ವಾರ್ಥಿ) ಇತ್ಯಾದಿ.
- ಇದನ್ನು ಕುಟುಂಬದಲ್ಲಿಯೂ ಸಹ ಕಾಣಬಹುದು. ಹೆಣ್ಣು ಮಗು ಬೆಳೆಯುತ್ತಿರುವಾಗಲೇ ಈ ಭೇದ ಕಂಡು ಬರುತ್ತದೆ.
- ಗಂಡಿನ ವಿವಾಹೇತರ ಸಂಬಂಧಗಳನ್ನು ಒಪ್ಪಿಕೊಂಡಂತೆ, ಹೆಣ್ಣಿನ ಸ್ವಲ್ಪ ತಪ್ಪುಗಳನ್ನೂ ಸಮಾಜ ಕ್ಷಮಿಸುವುದಿಲ್ಲ.
- ಹೆಣ್ಣಿನ "ಶೀಲಕ್ಕೆ" ಈ ದೇಶದಲ್ಲಿ ಕೊಟ್ಟರುವ ಪ್ರಾಮುಖ್ಯತೆಯಿಂದ ಹೆಣ್ಣಿಗೆ (ಮುಖ್ಯವಾಗಿ ಯೌವ್ವನದಲ್ಲಿರುವ ಒಂಟಿ ಹೆಣ್ಣು) ಯಾವಾಗಲೂ ಅಸುರಕ್ಷತೆಯ ಭಾವ ಕಾಡುತ್ತದೆ.

ಮಹಿಳೆಯ ಮಾನಸಿಕ ಸಮಸ್ಯೆಗಳು

ವಿಸ್ಮತಿ : ಇದು ಮುಖ್ಯವಾಗಿ ಜೀವನದಲ್ಲಿ ಯಾವುದಾದರೂ ಮೈಲಿಗಲ್ಲು ಉಂಟಾದಾಗ ಆಗುತ್ತದೆ (ಉದಾ. ಗರ್ಭಧಾರಣೆ, ಇತ್ಯಾದಿ)

ಕೀಳರಿಮೆ : ಇದಕ್ಕೆ ಮುಖ್ಯ ಕಾರಣ, ಸಮಾಜದಲ್ಲಿ ಮಹಿಳೆ ಎರಡನೇ ದರ್ಜೆ ಪ್ರಜೆ ಎಂಬ ಧೋರಣೆ ಇರುವುದು. ಆಲ್ಲದೇ ವಿದ್ಯಾಭ್ಯಾಸ, ಆರ್ಥಿಕ ಸ್ವಾತಂತ್ರ್ಯ ಇವುಗಳಿಗೂ ಮಹಿಳೆಯ ಅವಕಾಶ ಕಡಿಮೆಯಾದ್ದರಿಂದ ಸಹಜವಾಗಿ ಕೀಳರಿಮೆ ಬೆಳೆಯುತ್ತದೆ. ಇದರಿಂದಾಗಿ, ಮಹಿಳೆಗೆ ಅವಕಾಶಗಳು ದೊರೆತರೂ, ಆಕೆ ಸರಿಯಾಗಿ ನಿರ್ವಹಿಸಲಾಗುವುದಿಲ್ಲ.

- ಅವ್ಯಕ್ತ ಭಯ, ಕಾತುರ, ಇದು ಹಲವು ಕಾರಣಗಳಿಂದ ಉಂಟಾಗುತ್ತದೆ, ಎಂದರೆ , ಕೀಳರಿಮೆ, ಖಿನ್ನತೆ ಇತ್ಯಾದಿ.
- ಹೊಂದಾಣಿಕಾ ಸಮಸ್ಯೆಗಳು : ಉದಾ : ಗಂಡನ ಮನೆಗೆ ಹೋಗುವ ಸಂದರ್ಭ.
- ಜೀವನದಲ್ಲಿನ ಪ್ರಮುಖ ಘಟನೆಗಳು ಋತುಮತಿಯಾಗುವುದು, ಗರ್ಭಿಣಿಯಾಗುವುದು, ಇತ್ಯಾದಿ (ಇದು ಮುಖ್ಯವಾಗಿ ಇವುಗಳ ಬಗ್ಗೆ ಅರಿವಿಲ್ಲದಿರುವುದಿರುವುದರಿಂದ ಆಗುತ್ತದೆ)
- ಲೈಂಗಿಕತೆ, ಗಂಡನೊಂದಿಗೆ ಸಂಪರ್ಕ ಇತ್ಯಾದಿ (ಇದೂ ಸಹ ಸರಿಯಾದ ಅರಿವಿಲ್ಲದಿರುವುದಿರುವುದಿಂದ ಆಗುತ್ತದೆ)
- ಉನ್ಮಾದ ಅಥವಾ ಹಿಸ್ಟೀರಿಯಾ (ಇದು ಮಹಿಳೆಗೆ, ತನ್ನ ಬಗ್ಗೆ ಬೇರೆಯವರ ಗಮನ ಕಡಿಮೆಯಾಗುತ್ತಿದೆ ಎನಿಸಿದಾಗ ಉಂಟಾಗುತ್ತದೆ. ಇವುಗಳು ಬೇರೆ ಬೇರೆ ರೂಪಗಳಲ್ಲಿ ಕಾಣಿಸಿಕೊಳ್ಳುತ್ತದೆ. ಉದಾ. ಮೈಮೇಲೆ ದೇವರು, ದೆವ್ವ ಬರುವುದು ಇತ್ಯಾದಿ.
- ಬಾಣಂತಿ ಸನ್ನಿ

ಮಾನಸಿಕ ತೊಂದರೆಗಳ ನಿವಾರಣೆ (ಕುಟುಂಬ, ಸ್ನೇಹಿತರು, ಇತರರ ಪಾತ್ರ)

- ಮಾನಸಿಕ ತೊಂದರೆಗೊಳಗಾದವರಿಗೆ, ಮುಖ್ಯವಾಗಿ ಪ್ರೀತಿ, ವಿಶ್ವಾಸ ವಾತ್ಸಲ್ಯಗಳ ಅಗತ್ಯವಿರುತ್ತದೆ. ಅವರು ತಮ್ಮ ಭಾವನೆಗಳನ್ನು ವ್ಯಕ್ತ ಪಡಿಸುವಂತೆ ನಯವಾಗಿ ಪ್ರಚೋದಿಸಬೇಕು.
- ಅವರು ಮಾತನಾಡುವಾಗ, ಮತ್ತೊಬ್ಬರು ಹೆಚ್ಚು ಮಾತನಾಡಬಾರದು. ಹಾಗೆ ಮಾಡಿದರೆ, ರೋಗಿಗಳ ಭಾವನೆ/ ಮಾತುಗಳು ತುಂಡರಿಸಿ ಹೋಗುತ್ತದೆ.
- ಅವರು ತಮ್ಮ ಸಮಸ್ಯೆಗಳನ್ನು ವ್ಯಕ್ತಪಡಿಸದಿದ್ದಲ್ಲಿ ಬಲವಂತ ಮಾಡಬಾರದು.
- ಅವರು ಸಮಸ್ಯೆ ಹೇಳಿಕೊಳ್ಳುವಾಗ, ಬೇರಾರೂ ಇರಬಾರದು. ಗುಂಪಿನಲ್ಲಿ ಇಂತಹ ವಿಷಯಗಳನ್ನು ಹಂಚಿಕೊಳ್ಳಲು ಯಾರೂ ಇಷ್ಟ ಪಡುವುದಿಲ್ಲ.
- ಅವರ ಸಮಸ್ಯೆಗಳನ್ನು ಗುಟ್ಟಾಗಿಡಬೇಕು. ಬೇರಾರ ಮುಂದೆಯೂ ಹೇಳಬಾರದು. ಹಾಗೇನಾದರೂ ಹೇಳಿದರೆ, ಅವರು ನಮ್ಮ ಮೇಲಿಟ್ಟಿರುವ ನಂಬಿಕೆಗೆ ದ್ರೋಹ ಬಗೆದಂತಾಗುತ್ತದೆ. ಆಲ್ಲದೆ, ನಮ್ಮ ಸಮಸ್ಯೆ ಹೇಳಿಕೊಳ್ಳುವಾಗ ನಾವು ಅಪಹಾಸ್ಯ ಮಾಡುವುದಾಗಲೀ, ಬೇರೆತ್ತಲೋ ನೋಡುವುದಾಗಲೀ ಮುಂತಾದುವು ಮಾಡಬಾರದು.
- ಅವರಿಗೆ ಉತ್ತಮ ಸ್ಥಾನ / ಅವಕಾಶ ದೊರೆಯುವಂತೆ ಮಾಡಬೇಕು.
- ಆರ್ಥಿಕ ಸ್ವಾತಂತ್ರ್ಯ ದೊರೆಯುವಂತೆ ಮಾಡಬೇಕು. (ಸಾಧ್ಯವಾದಲ್ಲಿ)
- ಮಹಿಳೆಯರ ಬಗ್ಗೆ ಹೀನಾಯ ಧೋರಣೆ ಹೋಗುವಂತೆ ಮಾಡಬೇಕು.
- ಅವರ ಸಮಸ್ಯೆಗಳಿಗೆ, ಪರಿಹಾರ ಸೂಚಿಸುವ ಜವಾಬ್ದಾರಿ ಅವರಿಗೇ ಬಿಟ್ಟು, ನಾವು ಕೇವಲ ಮಾರ್ಗದರ್ಶಕರಾಗಬೇಕು. ನಮ್ಮ ನಿರ್ಧಾರಗಳನ್ನು ಭಾವನೆಗಳನ್ನು ಅವರ ಮೇಲೆ ಹೇರಬಾರದು.
- ಉತ್ತಮ ಶಿಕ್ಷಣ ದೊರೆಯುವಂತೆ ಮಾಡಬೇಕು.
- ಅವರಿಗೆ "ನೀವು ಸಹಾಯ ಮಾಡಬಲ್ಲಿರಿ" ಎಂಬ ಭಾವನೆ ಬರಬೇಕು. ಇಲ್ಲವಾದಲ್ಲಿ ನಿಮ್ಮ / ನಿಮ್ಮ ಚಿಕಿತ್ಸೆಯ ಬಗ್ಗೆ ವಿಶ್ವಾಸ ಕಳೆದುಕೊಳ್ಳುತ್ತಾರೆ.

ಮಾನಸಿಕ ತೊಂದರೆಗೊಳಗಾದವರು ಅನುಸರಿಸಬೇಕಾದ ಮಾರ್ಗಗಳು

- ಮನಸ್ಸನ್ನು ಹೆಚ್ಚು ಚಿಂತೆ ಮಾಡಲು ಬಿಡದೆ, ಶಾಂತ ರೀತಿಯಲ್ಲಿಟ್ಟುಕೊಳ್ಳಬೇಕು.
- ಒಳ್ಳೆಯ ಹವ್ಯಾಸಗಳು (ಸಂಗೀತ, ಒಳ್ಳೆಯ ಪುಸ್ತಕ ಓದುವುದು, ಇತ್ಯಾದಿ) ಬೆಳೆಸಿಕೊಳ್ಳಬೇಕು.
- ಮನಸ್ಸಿನ ತೊಂದರೆಗಳನ್ನು ಯಾರಾದರೂ (ನಂಬಿಕಸ್ಥ) ಆತ್ಮೀಯರ ಬಳಿ ಹೇಳಿಕೊಳ್ಳುವುದು.
- ಮನಸ್ಸಿಗೆ ಕಿರಿಕಿರಿ ಉಂಟು ಮಾಡುವ ವಾತಾವರಣದಿಂದ ದೂರ ಇರುವುದು.
- ಪುಷ್ಟಿಕರವಾದ ಆಹಾರ, ವ್ಯಾಯಾಮ ಸಹ ಮನಸ್ಸನ್ನು ಉಲ್ಲಾಸಗೊಳಿಸುತ್ತದೆ.

ಅಬ್ರಹಾಂ ಮಾಸ್ಲೊ ನ ಪ್ರಕಾರ ಆತ್ಯುತ್ತಮ ವ್ಯಕ್ತಿತ್ವದ ಗುಣಗಳು

1. **ವಾಸ್ತವಿಕ ಪ್ರಜ್ಞೆ :** ಹಗಲುಗನಸು, ಭ್ರಮೆಗಳನ್ನು ಬಿಟ್ಟು ತಮ್ಮ ಸಾಮರ್ಥ್ಯಕ್ಕೆ ತಕ್ಕ ಸಾಧನೆ ಮಾಡುವ ಹಂಬಲ ಬೆಳೆಸಿಕೊಳ್ಳಬೇಕು. ಹಾಗೂ ಸತ್ಯವನ್ನು ಅರ್ಥ ಮಾಡಿಕೊಳ್ಳುವುದು.

2. **ವೇಷರತ್ ಸ್ವೀಕಾರ :** ತಾವಿರುವ ಹಾಗೆ ತಮ್ಮನ್ನು ಮತ್ತೊಬ್ಬರು ಇರುವ ಹಾಗೆ ಅವರನ್ನು ಒಪ್ಪಿ ಕೊಳ್ಳುವ ಮನೋಭಾವ

3. **ಸಮಯಕ್ಕೆ ತಕ್ಕ ನಿರ್ಧಾರ :** ಸಮಯ, ಸಮಸ್ಯೆ ಸಂದರ್ಭ, ಸನ್ನಿವೇಶಕ್ಕೆ ತಕ್ಕ ನಿರ್ಧಾರ ತೆಗೆದುಕೊಳ್ಳುವ ಸಾಮರ್ಥ್ಯ.

4. **ಕಾರ್ಯಕ್ಕೆ ಮಾನ್ಯತೆ :** ಅಹಂಕಾರ, ಸ್ವಪ್ರತಿಷ್ಠೆಗಳನ್ನು ಪಕ್ಕಕ್ಕಿಟ್ಟು ಮುಂದಿರುವ ಕಾರ್ಯದ ಬಗ್ಗೆ ಯೋಚಿಸುವ ಗುಣ

5. **ಆತ್ಮಾವಲೋಕನ :** ತಾನು ಯಾರು, ತನ್ನ ನಡೆ ಸರಿಯೇ, ತಪ್ಪೇ ಎಂಬುದರ ಬಗ್ಗೆ ಆಗಾಗ ಆತ್ಮವಿಮರ್ಶೆ ಮಾಡಿಕೊಳ್ಳಬೇಕು.

6. **ಸ್ವತಂತ್ರರಾಗಿ ಆಲೋಚಿಸುವ ಮನೋಭಾವ :** ಸಂಪ್ರದಾಯಬದ್ಧ ವಾತಾವರಣದಲ್ಲಿ ಬೆಳೆದರೂ ಸಹ, ತಮ್ಮ ನಿರ್ಧಾರಗಳನ್ನು, ಭಾವನೆಗಳನ್ನು ಮುಕ್ತವಾಗಿ ಹೊರಗೆಡಹುವ ಸ್ವಭಾವ.

7. **ಸಮತ್ವ :** ಸುಖ, ದುಃಖ, ನೋವು, ನಲಿವುಗಳೆಲ್ಲವೂ ಒಂದೇ ನಾಣ್ಯದ ಎರಡು ಮುಖಗಳು. ಒಂದನ್ನೊಂದು ಹಿಂಬಾಲಿಸುತ್ತವೆ ಎಂದು ಅರಿತು ಎಲ್ಲವನ್ನೂ ಒಂದೇ ರೀತಿ ಸ್ವೀಕರಿಸುವ ಮನೋಭಾವ.

8. **ಸರ್ವರ ಅಭ್ಯುದಯ :** "ಸರ್ವೇ ಜನಾ ಸುಖಿನೋ ಭವಂತು" ಎಂಬ ಮಾತಿನಂತೆ ಎಲ್ಲರಿಗೂ ಒಳ್ಳೆಯದಾಗಲಿ, ಎಲ್ಲರೂ ಸುಖವಾಗಿರಲಿ ಎಂಬ ನಿಸ್ವಾರ್ಥ ಮನೋಭಾವ.

9. **ಸ್ನೇಹಪರ – ಕರುಣಾಪೂರಿತ :** ಎಲ್ಲರೊಂದಿಗೂ ಹೊಂದಿಕೊಂಡು ಬೆರೆಯುವ ಹಾಗೂ ಎಲ್ಲ ಜೀವಿಗಳ ಬಗೆಗೂ ಕಾಳಜಿ ತೋರುವ ಮನೋಭಾವ.

10. **ಎಲ್ಲರ ಅಭಿಪ್ರಾಯಗಳಿಗೂ ಮನ್ನಣೆ :** ಸರ್ವಾಧಿಕಾರಿ ಮನೋಭಾವ ಎಲ್ಲ ತನಗೆ ಗೊತ್ತು ಎಂಬ ಅಹಂ ಬಿಟ್ಟು ಎಲ್ಲರನ್ನು ಆವರ ಅಭಿಪ್ರಾಯಗಳನ್ನು ಗೌರವಿಸುವ ಮನೋಭಾವ ಬೆಳೆಸಿಕೊಳ್ಳಬೇಕು.

11. **ನೈತಿಕತೆ :** ಹೇಗಾದರೂ ಮಾಡಿ ಗುರಿ ಸಾಧಿಸಲೇಬೇಕು ಎಂಬ ವಿಷಯ ಮುಂದಿಟ್ಟುಕೊಂಡು ನೈತಿಕತೆ ಕಳೆದುಕೊಳ್ಳಬಾರದು.

12. **ಹಾಸ್ಯ ಪ್ರಜ್ಞೆ :** ಸಮಯೋಚಿತ, ಸಮಯಸ್ಫೂರ್ತಿಯಿಂದ ಕೂಡಿದ ಸದಭಿರುಚಿಯ ಹಾಸ್ಯ ಪ್ರಜ್ಞೆ ಬೆಳೆಸಿಕೊಳ್ಳಬೇಕು. ಇದು ಎರಡು ಮನಸ್ಸುಗಳನ್ನು ಜೀವಿಗಳನ್ನು ಬೆಸೆಯುವ ವಿಧಾನ.

13. **ಸೃಜನ ಶೀಲತೆ :** ಕ್ರಿಯಾತ್ಮಕತೆ, ದಕ್ಷತೆ, ಎಲ್ಲವೂ ಸೇರಿದೆ.

14. **ಉತ್ತುಂಗ ಅನುಭವ :** ಬದುಕಿನಲ್ಲಿ ಆಗಾಗ ಜೀವನದ ಪರಮಾನಂದ (ಶಾಂತತೆ, ಸಮಾಧಾನ, ಇತ್ಯಾದಿ) ಗಳನ್ನು ಅನುಭವಿಸಬೇಕು.

MH-1.

Escape from Erwadi

The State government comes to the rescue of the mentally ill lodged in Erwadi's faith-healing homes, but a lot more needs to be done for their complete cure and integration into society.

ASHA KRISHNAKUMAR

SHANTI shuffles along, dragging her feet, as if she were chained. She is not, but she is yet to realise fully that she is free of the fetters that bound her for eight years. Shanti is one among the many mentally ill persons who were transferred to the Institute of Mental Health (IMH) in Chennai following the closure of the "mental homes" at Erwadi in Tamil Nadu's Ramanathapuram district. Such has been the treatment meted out to her at the mental home that even if she were to be cured of her illness, the trauma of having been chained, confined and ill-treated is sure to haunt her.

Yet Shanti is lucky at least to be alive, and she owes her "freedom" to the 28 chained inmates of the Moideen Badusha Mental Home who died on August 6 unable to escape the fire that engulfed the thatched shed that housed them (*Frontline*, August 31, 2001).

The mental health care system in Tamil Nadu has remained in a deplorable state, with successive governments failing to act on various reports and studies on the plight of the mentally ill at the various faith-healing centres. The Erwadi tragedy, which caught the attention of even the international media, has forced the State government to act. It has decided to implement, after 14 years, certain sections of the Mental Health Act, 1987, and has announced some immediate measures to deal with the situation. However, this will be done without addressing the larger issues of treatment, care and rehabilitation of the mentally ill.

The measures announced on August 10 to regulate mental homes include the immediate closure of all such homes functioning in thatched sheds and the "unchaining" of all inmates. Inmates of all "faith-healing" homes in the State are to be examined by doctors, and those with violent tendencies will be admitted to government hospitals. Those found to be normal are to be reunited with their families; those abandoned will be given an old-age pension and sent to homes for destitutes run by the government or reputed non-governmental organisations (NGOs).

All 15 mental homes at Erwadi were closed on August 13 and their 571 inmates taken under the government's care. As stipulated by the Mental Health Act, all inmates were produced before the District Magistrate, and a team led by Dr. M. Soundararajan, Professor of Psychiatry at the IMH, the Secretary to the State Mental Health Authority and the coordinator of the District Mental Health Programme (DMHP), examined them. Many are now being treated for schizophrenia, cerebral palsy, epilepsy and mental retardation. While 11 inmates, who had a tendency to become violent, were admitted to the Ramanathapuram Government Hospital, 152 were sent to the IMH and the rest back to their families. According to Tamil Nadu Health Minister S. Semmalai, all government hospitals and primary health centres (PHCs) in the State will provide medical attention to the inmates who have been sent home.

V. GANESAN

Mentally ill patients who were brought from Erwadi to the Institute of Mental Health in Chennai on August 16.

Twenty families have so far received the *ex gratia* payment of Rs.50,000 announced by the State government to the families of those who died in the Erwadi fire. The Tamil Nadu Medical Supplies Corporation has sanctioned Rs.5 lakhs to procure drugs for the 152 inmates admitted to the IMH, while the government has sanctioned another Rs.15 lakhs to improve the basic amenities at the IMH to accommodate the new patients.

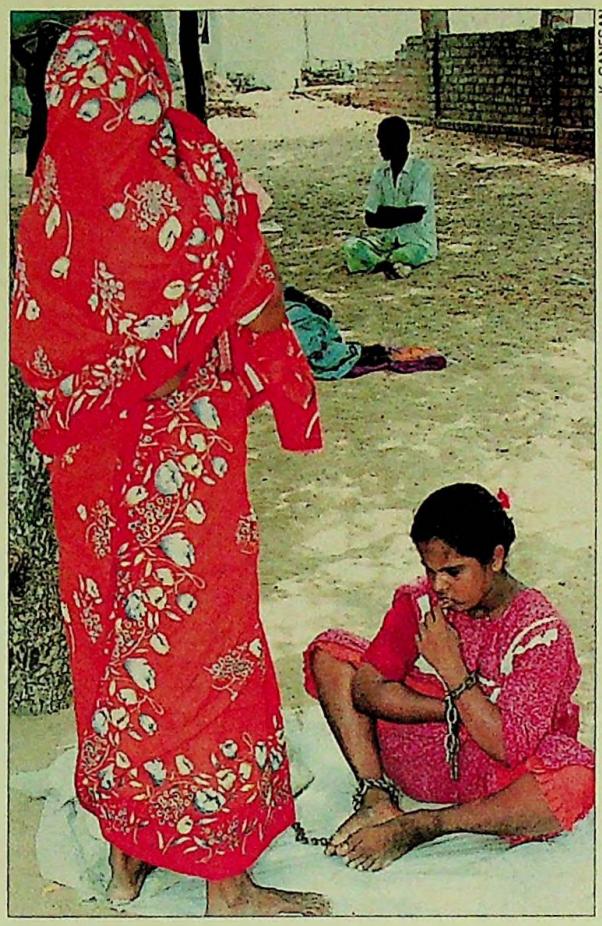
Ramanathapuram Collector S. Vijayakumar has set up a monitoring committee comprising the Village Administrative Officer, the Revenue Inspector, the Health Inspector and the Erwadi village panchayat president to prevent the setting up of any more mental homes and to ensure the monitoring of the mentally ill who are staying with their families within the premises of the Erwadi dargah.

THE belief that "holy water" from the dargah and oil from the lamp burning there have the power to cure all illnesses, particularly mental disorders, had people flocking to Erwadi in search of

a cure. The situation worsened with some people (mostly those who themselves had come to Erwadi in search of a cure) setting up "homes" for the mentally ill.

The government has now made it mandatory for anyone setting up such a home to obtain a licence as stipulated by the Mental Health Act, 1987. It has also ordered the setting up of a monitoring cell in every district, under the Collector, to make sure that the homes conform to norms.

On August 7, a five-Judge Bench of the Supreme Court, comprising Chief Justice A.S. Anand, Justices K.T. Thomas, R.C. Lahoti, N. Santosh Hegde [redacted] S.N. Variava, *suo motu* issued, on the basis of media reports on the Erwadi tragedy, notice to the State and Central governments asking them to submit a "factual report" of the incident. The Bench observed that the issue "raises important questions concerning human rights of inmates of the mental asylum, who could not escape the blaze as they had been chained to poles or beds". The Centre has ordered the mapping of all faith-healing homes for the mentally ill in the country. Union Health Minister C.P. Thakur has ordered the implementation of the guidelines for maintaining minimum standards in mental homes. The Centre also plans to modernise all government mental hospitals.



K. GANESAN

A chained mentally ill person in the premises of the Erwadi dargah.

[redacted] On August 20, the Tamil Nadu government launched the DMHP in Ramanathapuram and Madurai districts with an initial fund of Rs.27 lakh each (the total project cost is Rs.1 crore). The programme consists of three components – health care, training, and education and communication. According to Collector Vijayakumar, the main objectives of the programme are to provide basic mental health services on a sustained basis and to put in place a system for early detection and treatment.

The IMH in Chennai will be the nodal agency, and its Director the officer in charge of the programme. The five-year programme, sanctioned in 2000 by the Centre under the National Mental Health Programme (NMHP), is to reach every taluk in the two districts. According to Semmalai, a team of doctors and paramedical staff will visit every taluk regularly, screen people for mental illness, and provide treatment for those who are ill. Those needing hospitalisation would be referred to government hospitals.

Tamil Nadu, which implemented the DMHP four years ago in Tiruchi (the other three States that have the programme are Assam, Andhra Pradesh and Rajasthan) as part of the NMHP, has made some success; 42,000 patients have come for review and 2,700 have been identified as needing medical attention. The thrust of the programme has been on training village and community leaders, providing medical help at the taluk level, and generating awareness, particularly in the rural areas. This success, according to Dr. Soundararajan, is largely because of the massive strides made in public education, and this will be replicated in Ramanathapuram and Madurai districts.

The State government is planning to build a 10-bed hospital exclusively for the mentally ill in every district. An awareness programme that will cover the symptoms, treatment and management of mental illnesses, is also to be initiated in every district. A training programme for doctors and paramedics is also planned. Psychiatrists are to be posted at all district headquarters hospitals; 14 of the 25 such hospitals do not have psychiatrists now.

WHILE something is happening in the case of the mentally ill who have been taken under the government's care, what of those sent back from the 'homes' to their families? Raghu, an inmate of a home in Erwadi, has been sent back to hsi family in Sikkil (Thanjavur district), but his father, Madhavan, does not know what to do with him. With two daughters to be married, Raghu is a burden. Madhavan neither has the money to have Raghu treated in a private hospital nor can he bear the stigma of having a mentally ill person at home. The important question is: What happens to the millions of such families with mentally ill persons to take care of, and, more important, what happens to these patients?

The State government has responded to the situation, but central to addressing the problem is the care of the patients and their integration with their families and society. According to Dr. C. Ramasubramanian, a Madurai-based psychiatrist and the founder-director of the M.S. Chellamuthu Trust and Research Foundation, changing public apathy and attitude to the mentally ill is crucial to addressing the problem. Given the enormity of the problem – considering that it has cultural, religious, economic, social and medical ramifications – the government cannot tackle it on its own. Only community-based rehabilitation, with the active participation and help of NGOs and philanthropists, can offer a lasting solution.

Medical help, vocational training, and rehabilitation with family and community support are essential for the complete treatment and cure of the mentally ill. For this, society at large should participate. This requires a mass awareness campaign – to break the myths and to educate people on the curability of the diseases. Says Dr. Ramasubramanian: "It is imperative that the government initiates the next step soon as it is an instance of now or never for the millions of the hapless mentally ill persons and their families." ■

MH-1.

EMBARGOED 18 March, 2004, 1600 CET

Neuroscience of Psychoactive Substance Use and Dependence report: Key conclusions

A complex disorder

- **Substance dependence is a complex disorder** with biological mechanisms affecting the brain and its capacity to control drug use. It is not only determined by biological and genetic factors, but psychological, social, cultural and environmental factors as well. Currently, there are no means of identifying those who will become dependent – either before or after they start using drugs.

- **Dependence is not a failure of will or of strength of character,** but a disorder that could affect any human being. Dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions. Given the long term alterations in brain functioning, it is unknown to what extent it is curable, but there are effective treatments.

- **Significant co-morbidity of substance dependence with mental disorders** indicates that these two conditions should not be treated as entirely separate entities, and that treatment and research would be most effective if an integrated approach were adopted. Treatment and prevention insights from mental illness or substance use disorders can be used to inform treatment and prevention strategies in the domain of the other.

- **Use of psychoactive substances might be expected** because of their effects on the brain as well as peer pressure and the social context of their use. Experimentation does not necessarily lead to dependence, but the greater the frequency and amount of substance used, the higher the risk of becoming dependent.

- **Investments in neuroscience research must continue and expand** to include investments in social science, prevention, treatment and policy research. The reduction in the burden from substance use and related disorders must rely on evidence-based policies and programmes which are the result of research and its application.

- **Harm to society is not only caused by individuals with substance dependence.** Significant harm also comes from non-dependent individuals, stemming from acute intoxication and overdoses, and from the form of administration (e.g. through unsafe injections). There are, however, effective public health policies and programmes which can be implemented and which will lead to a significant reduction in the overall burden related to substance use.

Intervention and treatment

- **Effective treatments and interventions for substance dependence do exist,** and involve both pharmacological and behavioural interventions:

- **Treatment for substance dependence is not only aimed at stopping drug use** – it is a therapeutic process, which involves behaviour changes, psychosocial interventions and, for opioid dependence, the use of substitute psychotropic drugs. Dependence can be treated and managed cost-effectively, saving lives, improving the health of affected individuals, their families and reducing costs to society.

- **Treatment is more effective if supported by reintegration/rehabilitation** - the dynamics of substance dependence are such that treatment is less likely to be effective if it does not also include efforts to encourage and facilitate rehabilitation and social reintegration.

- **Harm reduction approaches are not synonymous with legalizing all drugs.** Harm reduction includes a range of interventions to reduce the risk to health of substance dependent individuals, some of which have been proven to be effective in reducing public health threats, and some of which have no evidence of effectiveness. This includes access to clean needles and syringes and needle-exchange programmes, among others.

- **Treatment must be accessible to all in need** and the most cost-effective treatments need to be provided by the health care sector. Effective interventions exist, are not costly, and can be integrated into health systems, including primary health care.

- **All psychoactive substances can be harmful to health,** depending on how they are taken, in which amounts and how frequently. The harm differs between substances and the public health response to substance use should be proportional to the health-related harm that they cause.

- **One of the main barriers to treatment and care** of people with substance dependence and related problems is the stigma and discrimination against them. Regardless of the level of substance use and which substance an individual takes, they have the right to health, education, work opportunities and reintegration into society. We should empower individuals to recognize their problem and seek help, and provide full access to care and treatment.

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SUBSTANCE DEPENDENCE TREATABLE, SAYS NEUROSCIENCE EXPERT REPORT

Psychosocial, environmental, biological and genetic factors all play significant roles in dependence, says new report published by WHO

The World Health Organization (WHO) today launched *Neuroscience of Psychoactive Substance Use and Dependence*, an authoritative report summarizing the latest scientific knowledge on the role of the brain in substance dependence. The report*, released in Brasilia, Brazil, is the first of its kind produced by WHO, and cites an explosion of advances in neuroscience to conclude that substance dependence is as much a disorder of the brain as any other neurological or psychiatric disorder.

Substance dependence is multifactorial, determined by biological and genetic factors, in which heritable traits can play a strong part, as well as psychosocial, cultural and environmental factors, says the report. It has been known for a long time that the brain contains dozens of different types of receptors and chemical messengers or neurotransmitters. The report summarizes new knowledge on how psychoactive substances are able to mimic the effects of the naturally occurring or endogenous neurotransmitters, and interfere with normal brain functioning by altering the storage, release and removal of neurotransmitters.

The report discusses new developments in neuroscience research with respect to craving, compulsive use, tolerance and the concept of dependence. The report shows that psychoactive substances have different ways of acting on the brain, though they share similarities in the way they affect important regions of the brain involved in motivation and emotions. The report discusses how genes interact with environmental factors to sustain psychoactive substance-using behaviours. This knowledge is the basis of novel diagnostic tools and behavioural and pharmacological treatments.

The report urges increasing awareness of the complex nature of these problems and the biological processes underlying drug dependence. And it supports effective policies, prevention and treatment approaches and the development of interventions that do not stigmatize patients, are community based and cost-effective.

"The health and social problems associated with use of and dependence on tobacco, alcohol and illicit substances require greater attention by the public health community and appropriate policy responses are needed to address these problems in different societies," says WHO Director-General Dr Jong-wook LEE. "Many gaps remain to be

filled, but this important report shows that we already know a great deal about the nature of these problems."

United Nations Office on Drugs and Crime (UNODC) data estimates about 205 million people make use of one type of illicit substance or another. The most common is cannabis, followed by amphetamines, cocaine and the opioids. Illicit substance use is more prevalent among males than females, much more so than cigarette smoking and alcohol consumption. Substance use is also more prevalent among young people than in older age groups. UNODC data shows that 2.5% of the total global population and 3.5% of people 15 years and above had used cannabis at least once in one year between 1998 and 2001.

"Substance dependence is a chronic and often relapsing disorder, often co-occurring with other physical and mental conditions," said Dr Catherine Le Galès-Camus, WHO's Assistant-Director General, Noncommunicable Diseases and Mental Health. "While we still do not know to what extent it is curable – given the long-term alterations in brain functioning that result from substance abuse – we do know that recovery from dependence is possible through a number of effective interventions."

The Global Burden of Disease (GBD) from the use of all psychoactive substances, including alcohol and tobacco, is substantial: 8.9% in terms of DALYs (Disability Adjusted Life Years). However, GBD findings re-emphasize that the main global health burden is due to licit rather than illicit substances. Among the 10 leading risk factors in terms of avoidable disease burden cited in *The World Health Report 2002*, tobacco was fourth and alcohol fifth for 2000, and remains high on the list in the 2010 and 2020 projections. Tobacco and alcohol contributed 4.1% and 4.0%, respectively, to the burden of ill health in 2000, while illicit substances contributed 0.8%. The burdens attributable to tobacco and alcohol are particularly acute among males in the developed countries (mainly Europe and North America). Measures to reduce the harm from tobacco, alcohol and other psychoactive substances are thus an important part of the public health response, says WHO.

"The explosive growth in knowledge in neuroscience in recent decades has contributed new insights into why many people use psychoactive substances even though it causes them harm," says Dr Benedetto Saraceno, Director of WHO's Department of Mental Health and Substance Abuse. "The need for this report comes from these advances, which have shown that psychoactive substances, regardless of their legal status, share similar mechanisms of action in the brain, can be harmful to health and can lead to dependence. The public health impact is enormous and requires a comprehensive approach to policy and programme development."

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* *The* Neuroscience of psychoactive substance use and dependence *report is a product of three years work involving the contributions of many experts from around the world. The project began in 2000 with a consultation in New Orleans, USA, during the Congress on Neuroscience. A meeting convened by WHO was attended by representatives of international societies and selected experts in the field. Twenty-five reviews were commissioned, completed and submitted and these formed the basis of the final report. Meetings were held in Geneva and Mexico to discuss the outline of the report and the background papers.*

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Neuroscience of Psychoactive Substance Use and Dependence report

QUESTIONS + ANSWERS

1. Is substance dependence a disease?

Before answering this question it is important to clarify certain terms. Psychoactive substance use refers to any form of self-administration of any substance that has the potential of altering the way we behave or think. It is a broad term which is sometimes used to encompass all levels of drug involvement from occasional use to prolonged involvement with the substance. The terms substance abuse and substance dependence are technical terms with specific meanings. Abuse refers to a maladaptive pattern often involving continued use despite social, occupational, psychological or physical problems associated with the use of the substance. Dependence refers to a cluster of physiological, behavioural and cognitive phenomena and implies the need for repeated use of the drug to feel good or avoid feeling bad.

Substance dependence is classified in the tenth edition of the International Classification of Diseases (ICD-10) among other mental and behavioural disorders, such as depression and schizophrenia, and those who are substance dependent should enjoy the same rights to treatment as any other individuals. Some people do not like the term disease because it seems too biological and may give the impression that dependence is not related to social factors, so we often use the term disorder in this particular case as a synonym for disease, and acknowledge that environmental factors do play a role in its etiology. It should, however, not be forgotten that most psychoactive substance use (especially alcohol consumption) is not associated with dependence.

2. Is smoking a disease too?

Tobacco dependence is a disease and the majority of people who smoke are dependent on nicotine from tobacco. But strictly speaking, smoking is a way of using tobacco and not a disease.

3. What does the report say about harm reduction interventions?

In the context of substance use, the term harm reduction describes policies and programmes that focus on reducing the social and health consequences resulting from the use of substances, without necessarily eliminating the underlying behaviour of substance use.

WHO supports harm reduction strategies proven to be effective, e.g. substitution therapies, needle exchange programmes, condom distribution, drunk driving laws and seat belt use. But harm reduction has been a term sometimes used to mean legalisation of all psychoactive substances, and a whole range of unproven strategies. We need to be careful about what we are talking about and to recommend what is evidence-based.

4. What can we learn from the report about the medical use of cannabis?

Delta-9-tetrahydrocannabinol (THC), the active principle in cannabis, is potentially effective for some health conditions (e.g. as anti-emetic agent in cancer chemotherapy) and medications containing THC are available for treating them. Some patients find relief of their symptoms through smoking cannabis, although it is difficult to control the dose. There is limited evidence of the effectiveness of smoking cannabis, given the difficulties of conducting controlled trials of this nature. Delivery of THC through cannabis smoking presents problems, as it carries the negative effects of the elements which are present in the cigarette.

5. Are methadone and other substitution drugs harmful to the brain? If so, why are they prescribed?

Despite the fact that substitution drugs do act on the brain, as other psychotropic medicines, they actually have the capacity to normalise some disrupted brain functions. Being involved in substitution maintenance therapy, patients actually can have normal lives, take a job, drive a car, etc, while avoiding withdrawal symptoms. Substitution medicines are prescribed for the treatment of heroin dependence to improve health and social functioning of the patients.

6- What is the WHO position on legalization of cannabis?
WHO is mostly concerned with the negative health consequences of cannabis use and how they can be prevented and treated.

7. Is WHO recommending vaccines against nicotine and cocaine? Who should be vaccinated?

WHO does not have sufficient scientific evidence about their efficacy to have a position on their usefulness. Vaccines or immunotherapies are in their early stages of development and there are many issues to be resolved. They appear to help in the recovery from dependence, but their potential use to prevent cocaine use among non-users (e.g. children, adolescents) has not been investigated and it would likely raise very important ethical questions that would have to be addressed first.

8. Where should countries invest their resources to reduce the burden of drug use?

There is a great need to invest in a comprehensive public health response, which includes epidemiology, prevention, treatment and reintegration/rehabilitation. Each of the four pillars is important and the resources should be distributed according to the effectiveness of available interventions.

9. Are the public health messages of the report compatible with law enforcement and control over the supply of drugs? Is WHO in favour of revising the UN Conventions?

Investment in public health measures to reduce the burden of substance use can be compatible with and supplement law enforcement and control. WHO supports the UN Conventions and any potential revision of the UN Conventions is beyond the mandate of WHO.

10. Why is khat not discussed in the report? Why is khat not controlled?

Khat is a mild stimulant which has not been well studied, although its use is widespread in Africa. There are reports of a variety of medical problems, including cancers and mental disorders. It is less well understood to what extent dependence occurs and whether withdrawal syndromes exist as a result of prolonged use. A comprehensive review of all its consequences to health is needed in order to make appropriate recommendations about the need for its control under the UN Conventions.

11. What will WHO do in relation to alcohol?

The WHO Executive Board meeting in January 2004 accepted a draft resolution for World Health Assembly 2004, which urges Member States to give attention to the prevention of alcohol-related harm and promotion of strategies to reduce the adverse physical, mental and social consequences of alcohol, especially among young people and pregnant women, in the workplace and when driving.

12. What does WHO recommend that countries do to reduce alcohol problems?

According to their levels of per capita consumption and patterns of alcohol consumption, a mix of effective policies can be implemented, ranging from increases in price/taxation; regulation of the physical availability of alcohol, including increase in minimum legal purchase age; drinking-driving countermeasures; treatment and early interventions. Depending on the social, political, economic and cultural environment, other strategies such as prevention programmes, community projects and harm reduction efforts, can also play an important role.

13. What is WHO expecting from launching of this report?

To raise awareness of public health officers, Ministries of Health, and relevant policy makers, to the need to include the health sector in policy making in these areas. There are effective policies and interventions which work and can decrease the health burden of substance abuse, but there is an urgent need to invest human and financial resources to prevention, policy implementation and treatment.

14. What are the major implications of this report?

Substance dependence is a multifactorial disorder, which has several implications for prevention and treatment. First, that all substances need to be considered in the framework of a comprehensive public health approach, regardless of their status. Second, ,that all levels of use should be addressed: experimentation, harmful use, and dependence. Third, that policies and programmes should be tailored to the needs of the population, the threats to health and safety, and adapted to the culture and values of the particular society. All countries can do better in relation to substance abuse problems, both developed and developing ones.

15. What should be the role of the public health sector in managing psychoactive substance use problems?

Substance abuse and dependence are public health problems and they contribute significantly to the global burden of disease. The public health sector, including the World Health Organization, is concerned about this and should work towards reducing the burden. Adopting a public health approach, which goes beyond issues of security and control, allows us to widen the range of options and possible interventions. The public health approach involves the use of a variety of approaches and strategies involving the participation of stakeholders from all relevant sectors. As the leading global public health organization, WHO is active in providing the evidence necessary for the development and implementation of prevention and treatment strategies, and policies.

16. What is the role of prevention in reducing the burden attributable to substance abuse and dependence?

It is common knowledge that prevention is better than cure. This is even more true with substance use problems, where cure is difficult, although treatment can be effective. We have learned a lot over the years about how we can make prevention more effective than it is at present. What we have learned includes the following: that teaching young people to say 'no' to drugs in the classroom is not enough, though it is good practice; that prevention programmes should be broadly based enough to include skills to resist drugs; that the community (parents, churches, etc.) as a whole should be involved; and that prevention programmes should be part of an overall strategy of changing societal attitudes towards the use of psychoactive substances.