World Health Forum

Leon Eisenberg

Preventing mental, neurological and psychosocial disorders

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Prevention

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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

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.

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.

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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MH-7.2

WORKSHOP ON PREPARATION OF TRAINING MATERIALS FOR THE NATIONAL MENTAL HEALTH PROGRAMME

26-27 June, 1989

REPORT

The session began with welcome and introduction by the Director, NIMHANS. He briefly explained the aims and objectives of the National Mental Health Programme. Subsequently other staff members of NIMHANS recounted the genesis of the programme, particularly the development of the training aspect. Details of present training programmes, available training materials and the need for more audio visual materials were discussed. Finally the purpose of this workshop was also elaborated upon.

Apart from reviewing the audio visual material - video and slides, members felt it is important that a guide book/ training manual be prepared. This would help the trainer to use the training material appropriately and effectively. A decision on the content of the training guide should be included in the recommendations of the workshop. The members noted that the audio visual materials would not stand on their own but comprise a part of the total training process which should emphasise participatory learning and include demonstration and field area practice.

1. Review of the video on Rural Mental Health Centre.

1.1 While noting that this video might be good for orienting trainees on the Sakalwara Rural Mental Health Centre. It did not adequately show the integration of mental health into primary health care. This video could just serve as a case study. The need for such a video isnot great. Instead another video should focus on integration.

1.2 Several ways of showing the integration of mental health in primary health care was suggested

- the depiction of work at Solur PHC or Bellary Dist.
- incorporation of mental health into on going National Programmes such as Immunisation, ICDS
- Portrayal of PHC staff carrying on mental health activities.
- Message should be that mental health promotion and treatment can be part of any PHC activity

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- Visuals should show ideal rather than actual
- Team work in the primary health care setting which includes mental health.

1.3 The reviewers felt that the interviews were too directive and suggestive.

1.4 The narration dominated the visuals and there was no synchronisation between the narrations and visuals.

1.5 The visuals could be more effective, colour quality could be improved, captions were difficult to read, visuals should show more of the interactions. The captions could be interspersed with visuals of people.

1.6 To overcome these problems it was suggested that the 'ideal' doctors and patients be chosen for interviews. Certain amount of stage managing is necessary, to get best quality video. e.g. the matter on black board should be written beforehand.

1.7 The video need not emphasise already known facts such as the difficulties of living in rural areas and the video should also not decry or denigrate traditional medicine but high light the positive aspect.

1.8 It is suggested that the video could start in a dramatic manner beginning with the problems faced by mental patients in the rural area or the difficulties doctor faced treating such patients.

1.9 The video needs closer editing, the total duration of the video could be reduced to 60% of the present length.

1.10 To make the video more amenable to wider distribution visuals from other parts of India need to be included.

2. Review of Clinical cases:

Although each case was reviewed separately much of the comments were similar for each case, so, here the comments will be presented together.

2.1 The reviewers agreed that a short introduction to each case would prepare the viewer. It may or may not include details of relevant symptoms. Without this introduction the cases start very abruptly. The doctors introduce patients and give a short case description before beginning the interview.

2.2 The interviews should be less directive and more crisp.

2.3 There is need to evolve a format for interviewing.

2.4 Spontaneity would be lost if actors were employed. Patients rights should be protected by asking their consent on tape or by running a caption throughout the video stating the video is only for professional use.

2.5 In terms of visuals, shots from different angles, more close ups, reactions shots are necessary. For effective communication two cameras are imperative. Later these could be mixed during editing.

2.6 The summaries should also be less didactic and more conversational. Treatments such as psychotherapy should also be included and might also include the effect of treatment and patients recovery. This summary might also include other visuals rather than just doctors such as clips from the interview which illustrate the symptoms or other illustrations and charts, to enhance the points made by the narrator.

2.7 Fine editing is required to make the cases educative and effective. The psychiatrist need to review it to make sure the only information relevant to PHC doctors is included.

2.8 With modifications this material could also be made into self-instruction material.

2.9 One of the major draw backs of these cases are that the heavy representation of middle class, English speaking patients. These cases may not be relevant to the health workers in health professionals in rural PHC's. Effort should be made to include representative cases from rural area. It need be it can be dubbed in English or other regional languages.

2.10 Specifically in the manic depressive psychosis (MDP) case only the information on mania should be presented and the depressive features which are not present at that time should not be included.

Many questions and issues were raised in this session regarding the methodology that needs to be adopted. Concrete suggestions and recommendations should be forthcoming in the final round up session.

The group also viewed video cassettes produced by other agencies, this included two videos on prevention of oral cancer in Kannada and one on mental retardation. The group did not have an opportunity to review these videos as yet.

The group planned to meet in the next day to review slides, epilepsy video and videos produced by other agencies before working out final guidelines.

Tuesday 27-6-1989

3. The session began with the review of slides. The reviewers reviewed slides for one chapter - Mental Retardation.

3.1 Reviewers felt that the slides should be a visual accompaniment to the manual, therefore, there is no need to present much of the written content. They suggested :

- to make the content much more precise by dropping prepositions, adjectives, adverbs
- spacing the words better, three dimensional portrayal of concepts
- including line diagrams, pictures, charts etc. to supplement written words
- using a variety of slides including line diagrams, photographs, graphs, charts etc.
- adding more information than what is present in the manual
- presenting only one idea for each frame
- giving more weightage to visuals which present information not available to the trainer such as pictures of clinical cases, pictures of the anatomy of the Brain etc.

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- the photographs should be present classical, clinical cases
- when content of slides is continued in the following slide a continuation caption should come on top.

3.2 Overall, in producing slides, priority content for communication should be identified. The slide set should form a visual supplement to communicate difficult concepts.

4. Briefly reviewing the manual for the medical officers and multi-purpose workers the reviewers noted that both the manuals were very similar. The manuals did not take in to consideration communication concept in the lay out and design. Particularly, the manual for multi-purpose workers, needs to be specially designed for the educational level of such workers. The manual needs to focus on existing programmes such as family planning, ICDS, immunisation, antenatal care and identify where mental health in-put is needed and how the worker can do this, i.e. the manual needs to be much more skills oriented.

5. Next, the group reviewed the video on epilepsy. Prof. M. Gouri Devi and Dr. Satish Chandra, from the Department of Neurology, NIMHANS, joined the group. This video was reviewed section by section. At the outset there was little agreement whether the same video could be used for both medical officers and multi-purpose workers. The neurologists felt that the medical officers need to know more details and statistics. Public health professionals, however, thought that many medical officers are not conversant with epilepsy and also need to be educated from the beginning.

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5.1 Specific comments on each section:

Section I - Introduction and Types of Epilepsy

There is a need to demonstrate epilepsy or fits, so that the viewer is clear about the content.

- for the PHC scene more community shots are needed

- for explaining grandmal epilepsy, figures (from Netter) need to be enlarged and depicted in an Indian style

- delete - hot water epilepsy is not dangerous

- captions on differentiating hysteria from epilepsy needs to be redrawn

- while mentioning febrile convulsion include the picture of the child with fever.

5.2 Section 3 - Causes and Prevention

- Generally, some viewers felt that cause and prevention should be separated, that the cause should be shown in the beginning and prevention after the follow up section.

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- Life cycle approach to the causal factors of epilepsy may be more meaningful for the community level workers, so factors causing epilepsy - occurring before birth, during the birth, infancy in child hood and adult hood could be shown.
- The visuals should be more oriented to a rural area
- In intoxication only include alcohol as a cause and delete drugs.
- Realistic, actual scenes rather than pictures should be used.
- To show that epilepsy is not contagious, show a patient frothing at the mouth and say that this froth is not contagious.
- In narration X-ray should come before EEG because of the visual order

5.3 Section 4 - Treatment:-

- Abbreviations should not be used in captions.
- In treatment, the drug dosage should be emphasised as most mistakes occur in prescribing
- In showing dosage divide the captions into three parts. (emphasise should be on taking the tablets rather than having the meals).
- Visual of patients sleeping is not necessary
- For showing keep medicine away from children use a actual situation.
- Include section with says : the patient should come back for more drugs; a week or ten days before exhausting the drugs.

5.4 Section 5 - First Aid

- Change the caption "do not hold" to "hold the patient gently do not use force".
- Instead of just roll the kerchief, say roll a small piece of cloth and show other types of cloth also
- It was suggested split screen should be used to for the captions as well as the picture. After status epilepticus show ICU or consultancy
- Often patients know, that they will have an attack, ask them to take precautions.

5.5 Follow up:-

- The patients need to be prepared for the interview
- Show that the patient himself coming rather than the relative.

5.6 Living with epilepsy:

- Again in this section actual scenes need to be depicted.

5.7 Overall participants felt that this video communicated the message adequately with changes as suggested and better synchronisation of the narration and sound with the visuals this video can be produces.

6. The group reviewed towards light and the film and the video schizophrenia produced by SCARF

6.1 Towards Light :-

The group agreed that this is a good introductory video which could be used by all the centres. It raised many issues which could be further discussed. The only change may be to modify the institution based treatment to a more community oriented treatment.

SCARF - Schizophrenia

6.2 Again, thisvideo could be good a introduction to general concepts of psychoses. As it depicts three patients of different social classes, the urban bias is not obvious.

6.3 Over all decision, that the film both technically correct and professionally made so that should be used.

7. Overall round up:

7.1 The group emphasised that the teaching aids should not only provide the content but also improve the teaching process. This is particularly important in psychiatry because approach, and interpersonnel relationship, and communication is critical.

7.2 The non-electronic media such as flip charts, role plays, stimulation games, all can enhance the process the packages on whole should be reviewed. The package also should utilise multi-media approach and depict multi situations. It was suggested that voluntary agencies with social orientation who are involved in media production should to be contacted and their help sought in preparing the media

Letter of follow up sent RN

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7.3 The media should help to integrate the National Mental Health Programme as a part of the overall primary health centre activities which include of the other national health programmes.

7.4 The package should help the trainer to be creative, it should be flexible, so that the trainer can use it as a resource. It should not become the constricting variable for the trainee.

7.5 The synopsis for the video on Integration of Mental Health was briefly reviewed. The group agreed with the content and suggested dramatic approach be adopted to arouse audience interest. Either difficulties of a mental patient or of the health personnel in treating a mentally ill person could serve as a starting point.

7.6 The session concluded with recognition of the invaulable input from the multi-disciplinary team of reviewers. Their thoughtful and practical suggestions would enhance the production of relevant and appropriate education media.

Considering the comments and suggestions given by the expert review panel, decision is to be made on -

1. Finalisation and production of epilepsy video
2. Video on integration of mental health
3. Video on clinical cases

One of the major lessons learnt from this review is that much thought needs to be given to clearly defining objectives and planning the educational material. For each video a small group needs to be set-up which includes specialists and generalists. The group needs to be active in planning the videos. The synopsis and the script have to be approved by the group before production begins.

The group noted several times that much of these training materials will be used in semi-rural areas which have frequent power shortage/cuts. Considering this, and the fact that much electronic and other sophisticated equipment need constant maintenance and repair and are seldom in good working condition, the group suggested that at least 50-60 per cent of the teaching aids should be non-electronic/electric.

So, much thought should be given to preparing relevant and appropriate simple teaching aids such as flip charts, posters, charts, display materials etc. In addition, the trainers should learn to utilise other training methodologies such as role play, simulation games, stories, proverbs to encourage participation and to make the training more responsive to the specific needs of the trainees. Folk media such as songs, dramas, Harikatha could also be effectively employed for this purpose. In this way the trainees can not only be exposed to difficult concepts in a way which makes sense to them, but are also armed with health education methods.

This again underlines the need for preparing a well planned trainers guide book which will educate the trainer on these more interactive methods. In this regard the group also emphasized the need for a section on health education and media in the manual. This should emphasize the need for, and the methodology for planning health education component of the mental health programme, relative merits of each health education method/and media should be considered, and selection of appropriate methodology/strategy tailored to specific problem should be highlighted, and

...11/-

Suggest ways of using them. In addition to the trainers guide book, the training of the trainers in training methodology is essential, only in this way we can ensure that the training material prepared will be adequately and appropriately used.

MH-7-3

VIDEO ON RURAL MENTAL HEALTH CENTRE

Evaluation Proforma

Objectives:

1. To create awareness among the medical and paramedical personnel working in primary health care of the need to integrate mental health care with other PHC services

2. To provide information on one model for integration - The Rural Mental Health Centre - Sakalwara

1. Content : Adequate [ ] Inadequate [ ]

What needs to be added/deleted/modified/clarified/elaborated.

2. Visuals : Good [ ] Fair [ ] Poor [ ] Specify

Camera movements : Smooth [ ] Jerky [ ] Specify

Close ups : Adequate [ ] Inadequate [ ] Specify

Captions : Prefer hand written [ ] Camera captions [ ]

Captions on visual [ ] Specify

3. Duration : Too long [ ] Sufficient [ ] Inadequate [ ]

Specify [ ] Give e.g.

4. Narration: Good [ ] Fair [ ] Poor [ ]

5. General comments & suggestions.

Thank you for helping us evaluate this training video. Your suggestions and comments will be taken into consideration while preparing the final version.

Clinical Case Presentations :

One of the main difficulties of training health professionals in mental health in the primary case setting is the lack of clinical material. It is hoped that these videos will expose them to relevant clinical material

OBJECTIVES:

To help medical officers and other health professionals identify cases by:

a) Providing information on characteristic symptomatology of specific mental illness

b) Giving an idea on how to elicit this information

c) Showing what criteria is used to make a diagnosis

Cases:

1. Anxiety Neurosis
2. Manic Depressive Psychosis
3. Phobia and Depressive Neurosis
4. Paranoid schizophrenia
5. Sexual Neurosis with Hysterical Conversion
6. Chronic Schizophrenia
7. Obsessive Neurosis
8. Hysterical Possession Syndrome

HIT 7.4 MDP (No 2)
Dysphasia Video

DEPARTMENT OF HEALTH EDUCATION
NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES
BANGALORE- 560 029

VIDEO INTERVIEW ASSESSMENT

1. What physical characteristics do you notice ?

Mannerisms/ Expressions — Easily visible ☐ / Not visible ☐

2. Picture:

Clarity : Good ☐ Fair ☐ Poor ☐

Colour : Good ☐ Fair ☐ Poor ☐

Close-ups : Too many close-ups ☐
Sufficient numbers ☐
Too few close ups ☐
Details not clear ☐

3. Focus more on : ☐ Patient
☐ Doctor
☐ Relative

4. Camera movements : Smooth ☐
Jerky ☐

5. Sound : Patient's voice : Clear/Audible ☐
Not audible at times ☐
Inaudible at times ☐

Doctor's voice : Clear/Audible ☐
Not audible at times ☐
Inaudible at times ☐

Patient's relatives voice : Clear/Audible ☐
Not audible at times ☐
Inaudible at times ☐

6. Could the patient/relative communicate well in English : Well ☐
Adequate ☐
Inadequate ☐

7. Did you clearly understand the patient's accent:

Yes ☐ No ☐

8. Duration : Too long ☐
Sufficient ☐
Inadequate ☐

...2/-

9. How does this compare to a live interview ?

Effective [ ]

Not so effective [ ]

(Please elaborate on your opinion)

10. Would you like to have captions.

Yes [ ] No [ ]

Captions : Separate [ ]

As conversations continue [ ]

11. Is a concluding summary necessary

Yes [ ] No [ ]

12. Suggestions/comments

Qualifications. .

Course/Training . .

Date. . . . .

MH-7-4
Duplicate

No 3
Phobia + Depressive Neurosis

DEPARTMENT OF HEALTH EDUCATION
NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES
BANGALORE- 560 029

VIDEO INTERVIEW ASSESSMENT

1. What physical characteristics do you notice ?

   Mannerisms/ Expressions — Easily visible ☐
   Not visible ☐

2. Picture:

   Clarity : Good ☐ Fair ☐ Poor ☐

   Colour : Good ☐ Fair ☐ Poor ☐

   Close-ups : Too many close-ups ☐
   Sufficient numbers ☐
   Too few close ups ☐
   Details not clear ☐

3. Focus more on : ☐ Patient
   ☐ Doctor
   ☐ Relative

4. Camera movements : Smooth ☐
   Jerky ☐

5. Sound : Patient's voice : Clear/Audible ☐
   Not audible at times ☐
   Inaudible at times ☐

   Doctor's voice : Clear/Audible ☐
   Not audible at times ☐
   Inaudible at times ☐

   Patient's relatives voice : Clear/Audible ☐
   Not audible at times ☐
   Inaudible at times ☐

6. Could the patient/relative communicate well in English : Well ☐
   Adequate ☐
   Inadequate ☐

7. Did you clearly understand the patient's accent:

   Yes ☐ No ☐

8. Duration : Too long ☐
   Sufficient ☐
   Inadequate ☐

...2/-

9. How does this compare to a live interview ?

Effective [ ]

Not so effective [ ]

(Please elaborate on your opinion)

10. Would you like to have captions.

Yes [ ] No [ ]

Captions : Separate [ ]

As conversations continue [ ]

11. Is a concluding summary necessary

Yes [ ] No [ ]

12. Suggestions/comments

Qualifications. .

Course/Training . .

Date. . . . . .

MH-74

DEPARTMENT OF HEALTH EDUCATION
NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES
BANGALORE- 560 029

VIDEO INTERVIEW ASSESSMENT

1. What physical characteristics do you notice ?

   Mannerisms/ Expressions : Easily visible [___]
   Not visible [___]

2. Picture:

   Clarity : Good [___] Fair [___] Poor [___]

   Colour : Good [___] Fair [___] Poor [___]

   Close-ups : Too many close-ups [___]
   Sufficient numbers [___]
   Too few close ups [___]
   Details not clear [___]

3. Focus more on : [___] Patient
   [___] Doctor
   [___] Relative

4. Camera movements : Smooth [___]
   Jerky [___]

5. Sound : Patient's voice : Clear/Audible [___]
   Not audible at times [___]
   Inaudible at times [___]

   Doctor's voice : Clear/Audible [___]
   Not audible at times [___]
   Inaudible at times [___]

   Patient's relatives voice : Clear/Audible [___]
   Not audible at times [___]
   Inaudible at times [___]

6. Could the patient/relative communicate well in English : Well [___]
   Adequate [___]
   Inadequate [___]

7. Did you clearly understand the patient's accent:

   Yes [___] No [___]

8. Duration : Too long [___]
   Sufficient [___]
   Inadequate [___]

...2/-

9. How does this compare to a live interview ?

Effective [ ]

Not so effective [ ]

(Please elaborate on your opinion)

10. Would you like to have captions.

Yes [ ] No [ ]

Captions : Separate [ ]

As conversations continue [ ]

11. Is a concluding summary necessary

Yes [ ] No [ ]

12. Suggestions/comments

Qualifications. .

Course/Training . .

Date. . . . . .

MH-7.5

DEPRESSIVE ILLNESS

This is different from "normal" depression by being severe, persistent and disabling.

SIGNS AND SYMPTOMS

(1) Severe feelings of misery and depression - out of character and out of proportion to any stress. Possibly with hopelessness and self blame.

(2) Loss of interest in family, work, hobbies, sexual life. These may be the most obvious signs of depression.

(3) Physical aspects - these can be specifically asked for:-

  (a) regular pattern during each day - for example, much worse during the first few hours of each day and much better by evening;

  (b) sleep disturbance - for example, waking several hours earlier than usual;

  (c) loss of appetite - possibly with weight loss of 5 kg or more;

  (d) depression produced by some drugs - for example, hypotensives, phenobarbitone.

(4) Suicidal thoughts and actions - see separate sheet.

(5) Physical symptoms of emotional distress - for example, palpitations, fatigue, headaches.

TREATMENT

(1) Psychotherapy

listening;
explanation, clarification;
reassurance - after above;
changing patterns of emotional reaction - more difficult;
modifying patterns of thinking which prolong depression.

(2) Physical

Antidepressants

tricyclics (e.g. Tofranil, Tryptizol, Prothiaden);
newer, safer drugs (e.g. Merital, Ludiomil).

Electroconvulsive treatment (E.C.T. electrical treatment).

- artificial fit whilst under an anaesthetic and having muscle relaxant. Used only in severe, drug resistant depression.

(3) Social treatment - changing or helping with problems with spouse, children, parents, work, housing, finance.

PREVENTION

(1) Social treatments above.

(2) Antidepressants can prevent relapse in first few months and possibly later.

(3) Lithium can reduce risk of repeated manic depressive attacks. May need to be taken for years.

ANTIDEPRESSANTS

Tricyclics - Imipramine (tofranil), Amitriptyline (tryptizol).

Imipramine - widely used and proven value in treatment of severe depression and prevention of relapse of depression. Much less effective in depression arising from stress.

Dose: Oral 30-225 mg. per day. Single or divided doses.
Side-effects: Common but not usually serious, e.g. dry mouth, constipation etc. More serious are cardiac arrhythmias, aggravation glaucoma, dangerous in overdosage.

Maybe combined with electroconvulsant treatment (electrical treatment ECT).
Newer antidepressants with fewer side-effects and safer in overdosage, e.g. Mianserin (bolvidon) 30-90 mg. per day.

ANXIOLYTICS (Minor tranquillizers)

Benzodiazepines - Diazepam (valium), Chlordiazepoxide (librium), Oxazepam (serenid, Lorazepam (ativan).
Effective in reducing the symptoms of anxiety but only for a few weeks and merely influencing the underlying cause. Often misused as a solution to personal and social problems. Risks of dependancy, drowsiness, interaction with alcohol. Epidemic increase of use in developing as well as the more developed countries.

Dose: 5-30 mg. per day in divided doses.

ANTI-CONVULSANTS

Eye witness or other evidence of more than one grand mal fit before starting treatment. Community attitudes and social effects important. Problems of patient compliance occur when fits controlled.

Phenobarbitone - effective, cheap, can control 90% of epilepsy.

Dose: 30-180 mg. per day in single or divided doses.
Side-effects: Drowsiness, dangerous in over-dosage, interacts with alcohol.

Phenytoin (epanutin).

Dose: 100-600 mg. per day in single or divided doses.
Side-effects: Ataxia, gum overgrowth.

Primidone (mysoline).

Dose: 750-1500 mg. per day in single or divided doses.
Side-effects: Ataxia common, lessened by slowly increasing dose.

Sodium Valproate (epilim) - a more recent anti-convulsant, effective and well tolerated.

Sulthiame (sultilt) and Carbamazepine (tegretol) of value in the uncommon temporal lobe epilepsy.

PSYCHOTROPIC DRUGS

INTRODUCTION

The discovery of the psychotropic drugs has transformed psychiatric care. There are now treatments for most psychiatric illnesses. The most effective are those for the psychoses and for severe depression. This is important as world-wide studies have shown that serious, incapacitating mental disorders are likely to affect 1% of any population at one time and 10% at some time in their life.

PRINCIPLES OF USE

Provision of psychotropic drugs is only part of a complex process which includes presentation of illness, its recognition by a person trained in diagnosis and drug use, access to stocks of the drugs, the patient understanding instructions and following them, and the monitoring of the effects of the drugs. National decisions have to be made as to which drugs are available, where and who can prescribe them.

Drugs are usually only a part answer to problems. They cannot make decisions for patients, alter the personality or solve interpersonal or social problems. If a drug does not relieve symptoms then the diagnosis should be reconsidered before another drug is started.

NEUROLEPTICS (Major tranquillizers)

Phenothiazines - Chlorpromazine (largactil), Trifluoperazine (stelazine), Thioridazine (melleril), Fluphenazine decanoate (modecate long-acting depot injections).

Thioxanthines - Flupenthixol decanoate (depixol depot injection).

Butyrophenones - Haloperidol (serenace, haldol).

Chlorpromazine - widely used, effective as antipsychotic for treatment of acute illness or prevention of relapse or for symptomatic control of agitation.

Dose: Oral up to 600 mg. per day. Single or divided doses.
Injections: 25-100 mg.

Side-effects: include hypotension, over-sedation, extrapyramidal reactions (akathisia, Parkinsonism, dystonia).

Treatment side-effects: Reduce dose.
Anti-Parkinsonism drugs, e.g. Benzhexol (artane).

Depot injections are absorbed very slowly and have the advantage of needing to be given only two to four weeks, therefore requiring less patient compliance.

Contd.....

COMMUNITY PSYCHIATRY UNIT
DEPARTMENT OF PSYCHIATRY
NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES, BANGALORE.

April 1983.

PROGRAMME OF TRAINING IN COMMUNITY PSYCHIATRY FOR POSTGRADUATES IN PSYCHIATRY, PSYCHOLOGY AND SOCIAL WORK :

(Field experience)

INTRODUCTION:

Organisation of mental health services hasreceived special attention in the country in the last one decade. Notable developments since 1970, have been the various workshops and conferences relating to these matters by the different categories of mental health professionals.

During the last decade two centres, Bangalore and Chandigarh, focussed their attention on developing models for organisation of rural psychiatric service. Research efforts of these two centres have resulted in a number of epidemiological tools and Manuals for training of primary health care personnel. The other important development has been the ICMR multicentred study 'Severe Mental Morbidity' located at Bangalore, Baroda, Calcutta and Patiala. This latter project focussed on the role of primary health care personnel (MPWs and doctors) in mental health care.

A further development in this area of mental health care has been the formulation of a National Mental Health Plan for the country. This plan document was considered by the health policy making body, namely, Central Council of Health and Family Welfare, in August 1982 and recommended for implimentation.

The national plan envisages integration of mental health as part of the general health services by involvement of the existing primary health care infrastructure (GOI, 1982).

Thus, it is likely that in the near future efforts will be directed to achieve the goal of mental health care to all, especially to those living in the rural areas and underprivileged areas,

Internationally too there is growing awareness of these needs and a number of practical approaches have been recommended (WHO, 1975).

It is in this context that the training in Community Psychiatry at NIMHANS has been planned. Being a centre for training a large number of mental health professionals, the Institute has a responsibility to prepare them, as well as suggest how best the different categories of mental health professionals will be trained, so that they are well equipped to play their roles in the broader national planning of mental health care programmes. The following training has been drawn out keeping the above goals in mind.

One guiding principle in planning the objectives and the activities has been the need for all categories of mental health profession to play a multi-faceted role in a flexible manner. This has been brought out most aptly by the WHO Expert Committee Recommendation (No. 10 & 11) as follows: (WHO, 1975).

> "The Committee recommends that specialised mental health workers should devote only part of their working hours to the clinical care of patients; the greater part of their time should be spent in training and supervising non-specialised health workers, who will provide the basic mental health care in the community.....The committee further recommends that the training of mental health professionals should include instruction and supervised experience in this new task of training and supporting non-specialised healthe workers".

It is with this common approach, that a common programme has been drawn up for all the students, with about 25 % time left for the specialised needs of each of the disciplines.

SPECIFIC OBJECTIVES:

1. To provide an orientation to the health and welfare organisation in the rural areas, especially the roles and functioning of the different categories of health facilities and staff and the relevant national policies.

2. To expose the trainees to skills and methodology of psychiatric epidemiology and obtain an understanding of the problems of field studies.

3. To orient to the principles of planning of community mental health services within the existing health and fwelfare infra-structure (decision about priorities, felt needs of the community, role and training of auxilliaries and community involvement).

4. To get an overview of the importance of the rural environment on the presentation of mental health problems, their response to treatment and course of the illness.

5. To develop an awareness and familiarity with ongoing programmes and research projects in the unit.

ACTIVITIES PLANNED:

1. Teaching by the staff of the Unit, in regard to the theoretical aspects of community psychiatry, in the form of lectures, seminars and journal club.

2. Visits to the health and welfare facilities (PHC, PHU, Sub-centre, Anganwadi centre, schools) to be familiar with their structure and functioning including the roles of environment on causation, treatment and outcome.

3. Follow up, over the period of training, a set number of families with mental health problems to obtain an under-standing of the role of environment on causation, treatment and outcome.

4. Observation of the ongoing monthly training programmes for health workers, medical officers and other mental health professionals.

5. Examination of the research designs, the epidemiological tools utilised for the various projects of the Unit to gain first hand knowledge about their use.

6. Initiate efforts to carry out a simple field work to obtain experience of epidemiological work. Some of the activities can be (Optional)

(1) Screening of the clinic population for mental disorders
(2) Identification of ill persons in a virgin area (Community survey)
(3) Preparing teaching programmes for the non-specialists
(4) Management of 'problem families' with mental disorders,
(5) Study of attitude of population
(6) Training family members of mentally ill and handicapped persons.
(7) Preparation of health education material.

7. Discussions with the staff members of the Unit.

The training programme is planned for a duration of one month. The weekly time table is given in Appendix-I.

DETAILS OF THE VARIOUS ACTIVITIES:

1. Seminar-Discussion: One of the students will review for discussion by the group.

(i) Primary Health Care in India
(ii) Organisation of mental health services in developing countries. WHO (1975) TRS 564.
(iii) Epidemiological studies in India (One study in detail)
(iv) Public attitude to mental disorders

2. Lectures:

1. Selection of priorities
2. National Mental Health Plan
3. Selection of essential drugs
4. Principles of training of non-specialists.

3. Case Conferences: Each student in rotation will present any one of these cases namely (i) one of the families followed up by the student, (ii) an intervention/treatment experience and (iii) patients from OPD with clinical symptomology of interest.

4. Field work: Each student on joining the posting, will be given 5 families (two with a psychotic patient, two with a mentally handicapped person, and one with epilepsy) for care during the four weeks of training. Students will visit these families weekly to obtain a detailed understanding of the impact of the illness, the coping styles of the families, effect on social life and community attitudes as well as provide help that is needed.

This activity will provide the student an opportunity to know the way mental illness affects family and community life, along with an opportunity to experience field work. Detailed records will be maintained by the students for submission to the respective faculty members for discussion and guidance.

5. Health Education: The trainees besides observing the health education activity, will carry out at least one 15-20 minute health education work in the OPD of Sakalawara or at Anekal. This would include preparation of the text and illustrations with the help of the staff members.

6. Journal club: Each staff member of the unit will in turn review a chosen article from journals and discuss the methodology and relevance to ongoing work.

7. Visit to the health and welfare organisations: This will be organised by a faculty member and the aim is to provide an understanding as to the structure and functioning of health and welfare services in the rural areas. It is hoped that this practical experience will provide the student a background to the community psychiatry programmes. Adequate background material regarding these will be made available.

8. Training programmes for non-specialists: Due to the limited time available it is unlikely that the students will take an active part in the training. They will be observers to some of the sessions, they will review the manuals and they will prepare some model lectures and deliver it in front of the unit members.

9. Epidemiological tools: Each student will develop familiarity with at least one instrument in terms of its construction, its use, its translation. If possible they will administer to a small number of subjects.

10. Assessments: All the students will be assessed about their competence in knowledge and skills in a chosen number of areas at the end of the training. Feed back about the training will also be obtained.

Students who do not know Kannada: Field work and interaction with the non-specialists will be less satisfactory for those students who do not have a working knowledge of Kannada. These students will take part in all academic programmes and the guided field work. In addition they will be given greater expertise in the following areas:

1) Translation of research/epidemiological tools
2) Preparation of health education material and presenting to the staff members.
3) Preparation of lectures and presentation to the staff members.
4) Review a topic of epidemiological work of interest to the speciality with the help of the faculty member.
5) Work in the Sakalawara OPD, where more faculty staff are available for help and guidance.

Govt. of India (1982) National Mental Health Programme for India. Director General of Health Services, Nirman Bhavan, New Delhi (Mimeo)

WHO (1975) Organisation of Mental Health Services in developing countries. tTechnical Report series No. 564. Geneva.

	Estimated Monthly/recurring expenses Type	No	Phase 1 @	Amount
1	Psychiatrist	1	3000.00	3000.00
2	Behaviour therapist (p.time)	0	750.00	0.00
3	Psy. Social workers (p.time)	0	1500.00	0.00
4	Nurses	4	700.00	2800.00
5	Occupational therapists	1	1000.00	1000.00
6	Nursing Aides	4	500.00	2000.00
7	Cook	1	800.00	800.00
8	Catering assistant	2	500.00	1000.00
9	Gardener	1	500.00	500.00
10	Security guards	2	500.00	1000.00
11	Miscellaneous	1	1700.00	1700.00
12	Rent,city centre,steno,food,water,e	1	3000.00	3000.00
13	Maintenance	1	1000.00	1000.00
14	Drugs	1	1000.00	1000.00
15	Equipment	1	500.00	500.00
				19300.00

	Estimated Monthly/recurring expenses Type	No	Phase 1 @	Amount
1	Psychiatrist	2	3000.00	6000.00
2	Behaviour therapist (p.time)	1	750.00	750.00
3	Psy. Social workers (p.time)	1	1500.00	1500.00
4	Nurses	4	700.00	2800.00
5	Occupational therapists	1	1000.00	1000.00
6	Nursing Aides	4	500.00	2000.00
7	Cook	1	800.00	800.00
8	Catering assistant	2	500.00	1000.00
9	Gardener	1	500.00	500.00
10	Security guards	2	500.00	1000.00
11	Miscellaneous	1	1700.00	1700.00
12	Rent,city centre,steno,food,water,e	2	3000.00	6000.00
13	Maintenance	1	1000.00	1000.00
14	Drugs	1	1000.00	1000.00
15	Equipment	1	500.00	500.00
				27550.00

St John's Medical College, Bangalore 560034
Directorate of Rural Health Services and
Training Programmes

Mental Health and Mental Illness

CONTENTS:

prepared by professor s.v. rama rao
director of rural health services and training programmes

1. WHO IS A MENTALLY HEALTHY PERSON?

One who is well adjusted as regards his emotions or feelings, thoughts and behaviour in his day to day activities.

Most workers concentrate on the physical health of the person. You should be aware that emotional problems that burden a patient will affect his physical health also and may result in changes in his behaviour. Eg: young child's mother died; it refuses to eat; its health deteriorates; gets a feeling of abandonment, loss of love, loss of security.

2. ROLE OF CHWs in MENTAL HEALTH SERVICES

a. To teach individuals and informal groups about mental health and to correct common misconceptions about mental illness;

b. To recognise the common situations of stress which have the potential of upsetting mental health of individuals;

c. To identify and refer persons who have signs and symptoms of emotional maladjustment or mental disease.

d. Assistance to problem patients who are mentally ill.

3. WHAT YOU SHOULD KNOW ABOUT HUMAN BEHAVIOUR AND MENTAL HEALTH

a. There is a reason behind all human behaviour (even if it appears irrational to others). The person finds that it is not safe or possible in a specific situation to show his feelings of anger, fear, embarassment or worthlessness. Suddenly he behaves in a very unexpected way.

   Eg: Whole day the husband has been working hard in the office/bank. His boss was very inconsiderate--criticised, commented and abused and humiliated him. He comes home finds that his child is crying for something. He releases his anger on his child and gives it a good beating.

   So it is important for such people to find ways of releasing their feelings of stress, anxiety etc., without hurting anyone. Eg: by strainous exercise (physical activity), listening to music, or talking about his feelings, with a person who is hill well wisher and friend.

b. When a person is deeply troubled - eg., looses all money in race, gambling etc., and becomes bankrupt--his thinking may be affected. He is unable to cope with the problem. In such a situation a loving husband/wife/brother/sister/well-wisher/friend can give emotional support. HOW?

   i. by listening;
   ii. by helping him to look at the problem from a different angle;
   iii. by pointing out alternate solutions;
   iv. by avoiding telling him what to do.

c. Any help offered to someone who is in trouble must arise from a person who can understand him, who is genuinely concerned for him, otherwise assistance will not be effective.

.....3

d. Every person needs love, affection, respect of others who are important to him - for mental health and for leading a well adjusted life.

MENTAL ILLNESS IS DUE TO:

ABSENCE OF OR DISTURBED HUMAN RELATIONSHIPS OVER A PROLONGED PERIOD OF TIME.

e. Planning the daily life is important : relaxation to reduce stress which can lead to maladjustment should be avoided.

AS A CHW, you must be aware of the many kinds of human behaviour which are common to most people and are rooted inthe culture of the family, community and religion. Before you label a behaviour as unexpected, different, unfamiliar or abnormal or maladjusted BE VERY VERY CAREFUL.

f. Physical ailment in a person could be due to a feeling of anxiety or tension, Eg: head-ache, diarrhoea, vomiting etc., often are temporary. If they are persistant they need referral.

g. Any person who has threatened to comit suicide must be taken seriously and not ignored. IT IS HIS WAY OF ASKING FOR HELP. WITHOUT TREATMENT, HE MAY KILL HIMSELF.

4. EDUCATION FOR MENTAL HEALTH

You should TEACH : individuals, families of patients, informal groups in the community about how they can practise simple mental health concepts in their daily life.

You should also CORRECT their misconceptions about mental illness

You should TELL THEM ABOUT PREVENTION AND TREATMENT OF mental illness.

(a) Prevention of maladjustment and mental illness

i. Tender, loving care and genuine concern from members of the family and others especially at times of emotional stress and crisis.

ii. Individuals and families can learn to recognise signs and symptoms of maladjustments and mental disease.

iii. A loving mother care is absolutely essential for a healthy personality growth and development of child.

iv. A loving-substitute to child must be provided if mother dies or deserts.

(b) Correcting common misconceptions

i. Mental illness is like any other illness. It is not due to evil spirits, bhutas, witch craft etc.

ii. Marriage is not a cure for mental illness. Stress of married life for people who are not mentally adjusted may even aggravate.

.....4

iii. If someone in the family is mentally ill or mentally retarded, it is not a shame.

iv. Any person who has threatened to comit suicide should not be ignored. He must be treated.

v. Mental illness can be cured. Recovery can be rapid and complete if treatment begins very early.

(c) Management of the mentally ill and mentally retarded

i. Treatment of mental illness is often prolonged and must be continued according to medical advice sometimes even after patient becomes apparently normal.

ii. There is no cure for mental retardation. Parents and well wishers should avoid unrealistic expectations. A retarded person can be trained to carry out simple tasks and with supervision he can take care of himself.

iii. Mentally disturbed or mentally retarded patient must be kept busy with whatever activity he can perform. Keeping them idle will worsen the condition.

iv. One must not make fun of mentally ill or retarded persons; it makes the condition worse.

v. Patient's family and others have an important role to play in assisting mentally ill and retarded. Their interest and support is very essential in overcoming illness and to recover.

5. SITUATIONS OF HIGH RISK FOR MENTAL HEALTH

CHWs should make systematic efforts to identify families in their area who are undergoing severe emotional stress or have had crisis in family so that they may be referred early. These are the families prone to develop physical ailments as well as symptoms of emotional maladjustment. Eg;-

IRRITABILITY FOR NO REASON;

SUDDENLY AVOIDING CONTACT WITH FRIENDS;

INABILITY TO SLEEP FOR SUCCESSIVE NIGHTS.

COMMON TYPES OF PREDICTABLE CRISIS-PROVOKING SITUATIONS

a. A death in the family (an only male child, bread winner, mother, both parents etc)

b. Birth of a defective or mentally retarded baby or birth of another female child when male child was needed.

c. A suicide/attempted suicide in the family.

d. Sexual assault/rape.

e. Permanent physical changes in the body/deformity due to accident (surgical removal of breast, genital organs, amputation of a limb etc).

f. Sudden unemployment.

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g. Difficulties in one's work situation.

h. Break up of a marriage (divorce/annulment/separation)

i. Sudden forced migration (due to dam construction, exodus, earthquake etc).

j. Imprisonment/jail term.

k. Retirement.

l. Marriage or addition of family members.

6. MANAGEMENT OF PERSONS FACING CRISIS SITUATIONS

a. Listen and offer sympathy. Avoid false reassurance.

b. Help them to focus their thoughts and feeling on something positive (mother if child is dead vice versa, compare with situations or persons who are worse off).

c. After building up rapport, friendship and trust, you may be able to answer questions, clarify doubts on sexual matters, diseases etc.

d. Encourage close and important members of family to talk to them about their sense of loss, feelings, anxiety, worry etc.

e. Demonstrate/suggest alternatives for their day-to-day work.

f. Guide them to seek and use all avoidable resources.

g. Explain to family that the person behaves as he does for reasons which makes sense to him though it does not to others.

h. Help the family to learn and accept the person's right to feel as he does.

SHARING FEELINGS ABOUT CRISIS SITUATION WITH CLOSE MEMBERS OF THE FAMILY OR TRUSTED FRIENDS IS A HEALTHY WAY TO PROVIDE EMOTIONAL SUPPORT NEEDED.

i. Plan for a second visit within a week.

7. IDENTIFICATION OF EARLY MALADJUSTMENT AND MENTAL ILLNESS IN THE COMMUNITY

You are neither qualified or are you expected to treat. It requires special skill and training. But you should be able to recognise signs and symptoms so that you can promptly refer.

Signs and symptoms: Sudden loss of appetite, weight--no physical complaints.
Sleeplessness which is persistant;
usual daily activities not attended to;
no concern for personal hygiene, personal appearance;
carelessness in: job, looking after children, cooking etc.

Sexual problems (refusing to sleep with wife/husband, dyspaerunia.

Difficulty in talking, expression, disorientation of time, day of the week, relationship etc.

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Anti-social behaviour--stealing, lying, abusing, cursing.

Distressing feelings - over-excitement, anger, inferiority, depression, guilt, laughing, crying.

Morbid fears - obsession/phobias/illusions, hallucinations.

Neglect of school, work etc.

Excessive use of alcohol/drugs.

Injury to self or to others.

Peculiar mannerisms - running away, excessive bathing, exaggerated gestures.

ON CHILDREN:

i. wetting the bed at night/stools in clothes.
ii. extensive cruelty to other children/pets/animals etc.
iii. disobedience of a high order.
iv. developing sudden strong dislike towards one or more members of the family.
v. saying that no one cares for him.
vi. unable to get along with others.

CHARACTERISTIC SIGNS AND SYMPTOMS OF MENTAL ILLNESS

IN THINKING	IN FEELING	IN BEHAVIOUR
Uses words, says things cannot be understood, mutters. Hears voices, sees things. Claims that he is possessed by evil spirits. Concerned very much about his body pains/ aches with no basis. Threatens to commit suicide. Lost his memory or is loosing. Disoriented, confused, pre-occupied. Difficulty in understanding others.	Become very quiet. Avoids people. Does not talk to people. Become unusually cheerful. Says he is a big man. Becomes sad; cries; suddenly laughts. Very suspicious of people around him. Claims that they are all against him.	He is aggresive. Violent without apparent reason. Behaves strangely in a socially unacceptable manner. Attempts suicide. Drinks alcohol excessively.

8. MANAGEMENT OF PATIENTS WHO HAVE SIGNS AND SYMPTOMS OF MENTAL ILLNESS

Refer patients to appropriate doctors/institutions. Offer only first aid or emergency aid to the extent possible (ensure that a family member stays with patient when you are giving first aid or transporting patient to institutions or doctor). Explain to patient that he is being taken to the doctor for his own safety and treatment.

CIRCUMSTANCES WHEN YOU SHOULD OFFER YOUR ASSISTANCE

(a) Very excited patient: Patient may have been brought tied up since he turns violent. Violent behaviour is the result of his fear that others may harm him. Tying up only increases his fear.

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i. reassure relatives and those accompanying. Release the bonds of patient and free him after speaking directly to him and getting his verbal response.

ii. try and calm the patient and his relatives. Talk to patient smoothly. Instill confidence.

iii. Offer food and fluids.

iv. observe patient carefully. Supervise any request such as use of toilet, to move about, to go to bed etc.

v. create quiet surroundings.

vi. remove harmful objects (knife, rope etc.)

vii. ensure that his clothes are not tight.

viii. recognise your own limitations and have sufficient help at hand and of members of family.

(b) Very dull patient:

i. talk to patient continue even if he does not respond. Use a natural sincere voice.

ii. gently coax him to eat and drink and feed him if necessary.

iii. Ask family to help you in cleaning him up.

v. ask family to ensure that he is taken to toilet regularly if referral is delayed.

vi. accompany patient with responsible members of the family when he is taken to doctor/institution.

(c) Suicidal patient: Take threats seriously.

i. patient should have always somebody with him.
ii. remove all objects which can be used on himself--knife, match box, blade, rope, fire, electricity, water, towel etc.
iii. While at home do not tie him up. He can move about and his energies can be diverted to constructive activities.

(d) Person is drunk: He may be irritable; he may use abusive language; he may become violent.

i. let him sleep
ii. do not agitate him. Do not restrain him physically.
iii. do not put him into a dark room because his mental confusion will increase.
iv. observe closely (no harm should come on him).

(e) Patient with other signs and symptoms of mental illness.

If the signs and symptoms have appeared immediately or soon after : CHILD BIRTH; HIGH FEVER; HEAD INJURY; FITS OF DOG BITE accompany patient along with a family member to the nearest doctor/institution/primary health centre.

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MH-7.9

WORKSHOP ON PREPARATION OF TRAINING MATERIALS FOR THE NATIONAL MENTAL HEALTH PROGRAMME

MINUTES

The session began with welcome and introduction by the Director, NIMHANS. He briefly explained the aims and objectives of the National Mental Health Programme. Subsequently other staff members of NIMHANS recounted the genesis of the programme, particularly the development of the training aspect. Details of present training programmes, available training materials and the need for more audio visual materials were discussed. Finally the purpose of this workshop was also elaborated upon.

Apart from reviewing the audio visual material - video and slides, members felt it is important that a guide book/ training manual be prepared. This would help the trainer to use the training material appropriately. It was felt that the content of the training material should form a part of recommendations of the workshop. The members noted that the audio visual materials would not stand on their own but when comprise a part of the total training process which should emphasise participatory learning and include demonstration and field area practice.

1. Review of the video on Rural Mental Health Centre.

1.1 While noting that this video might be good for orienting trainings on the Sakalwara Rural Mental Health Centre. It did not adequately show the integration of mental health into primary health care. This video could just serve as a case study. The need for such a video is not great. Instead another video should focus on integration.

1.2 Several ways of showing the integration of mental health in primary health care was suggested

- the depiction of work at Solur PHC or Bellary Dist.
- incorporation of mental health into ongoing National Programmes such as immunisation
- Portrayal of PHC staff carrying on mental health activities.
- Message should be that Mental-Health Promotion and treatment can be part of any PHC activity
- Visuals should show ideal rather than actual
- Team work in the primary health care setting which includes mental health.

...2/-

2.5 In terms of visuals, shots from different angles, more closeups, reactions shots are necessary. For effective communication to cameras are imperative. Later these could be mixed during editing.

2.6 The summaries should also be less didactic and more conversational. Treatments such as psychotherapy should also be included, might also include the effect of treatment and patients recovery. This ~~is the~~ summary might also include other visuals rather than just doctors such as clips from the interview which illustrate the symptoms or other illustrations and charts, to enhance the points made by the narrator.

2.7 Fine editing is required to make the cases effective. The psychiatrist need to review it to make sure the only information is relevant to PHC doctors is included.

2.8 With modifications this material could also be made into self-instruction material.

2.9 One of the major draw backs of these cases are that the heavy representation of middle class, English speaking patients. These cases may not be relevant to the health workers in health professionals in rural PHC's. Efort should be made to include representative cases from rural area. If need it can be dubbed in English or other regional languages.

2.10 Specifically in the manic depressive psychoses case only the information on mania should be presented and the depressive features which are not present at that time ~~of~~ should not be included.

Many questions and issues were raised in this session regarding the methodology that needs to be adopted. Concrete suggestions and recommendations should be forthcoming in the final round up session.

The group also viewed video cassettes produced by other agencies this included to videos on prevention of oral cancer in Kannada and one on mental retardation. The group did not have an opportunity to review these videos as yet.

The group planned to meet in the next day to review slides, epilepsy video and videos produced by other agencies before working out final guidelines.

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...2/-

1.3 The reviewers felt that the interviews were to directive and suggestive

1.4 The narration dominated the visuals and there was no synchronisation between the narrations and visuals.

1.5 The visuals could be more effective, colour quality could be improved, captions were difficult to read, visuals should show more of the interactions. The captions could be interspersed with visuals of people.

1.6 To overcome these problems it was suggested that the 'ideal' doctors and patients be chosen for interviews. Certain amount of stage managing is necessary, to get best quality video. e.g. the matter on black board should be written before-hand.

1.7 The video need not emphasise already known facts such as the difficulties living in rural areas and the video should also not decry or denigrate traditional medicine but high light the positive aspect.

1.8 It is suggested that the video could start in a dramatic manner beginning with the problems faced by mental patients in the rural area or the difficulties doctor faced treating such patients.

1.9 The video needs closer editing, the total duration of the video could be reduced to 60% of the present length

1.10 To make the video more amenable to wider distribution visuals from other parts of India need to be included.

2.Review of Clinical cases:

Although each cases was reviewed separately much of the comments were similar for each case so here the comments will be presented together.

2.1 The reviewers agreed that a short introduction to each case would prepare the viewer. It may or may not include details of relevant symptoms. Without this introduction the cases start very abruptly. The doctors introduce patients and give a number of descriptions before beginning the interview.

2.2 The interviews should be less directive and more crisp

2.3 There is need to evolve a format for interviewing.

2.4 Spontaneity would be lost if actors were employed. Patients rights should be protected by asking their consent or by running a caption throughout the video stating the video is only for professional use.

...3/-

2.5 In terms of visuals, shots from different angles, more closeups, reactions shots are necessary. For effective communication to cameras are imperative. Later these could be mixed during editing.

2.6 The summaries should also be less didactic and more conversational. Treatments such as psychotherapy should also be included, might also include the effect of treatment and patients recovery. This is the summary might also include other visuals rather than just doctors such as clips from the interview which illustrate the symptoms or other illustrations and chats, to enhance the points made by the narrator.

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MH-7.10

INTEGRATION OF MENTAL HEALTH CARE WITH THE EXISTING GENERAL HEALTH CARE SYSTEM

It is estimated that 1% of the population suffer from severe mental disorders, 2-3% from mental retardation, 5-10% from neuroses and 1% from Epilepsy (Visuals)

Since 80% of our population living in rural areas, most of the mentally ill people live in our villages. The facilities available to treat these patients are located in big cities in the form of mental hospitals, psychiatric departments. They are few in number and more than 90% of the mentally ill do not get a modern treatment. (Visuals)

It is also known that most of these patients are taken to tradition healing places for care. If they do not become better they are neglected and they become chronic patients. (Visuals)

It is found that people do not make use of the existing mental care facilities available because of poverty, long distance, ignorance, social stigma. (Visuals)

The alternative approaches to delivery mental health care to patients in the rural areas were designed and developed in centres like Bangalore (Rural Mental Health Centre - Sakalwara) Chandigarh (Raipurani block), Vellore and Jaipur etc. One of the feasible method is to integrate mental health care into existing general health care facilities, the primary health care doctors and para-medical workers giving basic mental health care to the needy. (Visuals)

Pilot studies in the above centres have revealed that

1. Mentally ill can be easily identified by para medical workers, village leaders or any volunteers
2. 50-60% of this identified mentally ill can be treated effectively with 5-6 drugs, counselling and rehabilitation in their own home ~~city~~ Setting
3. Home care is better than hospital care in terms of cost, and rapid improvement.
4. Rehabilitation is faster and easier in the community set up using the available resources in the community (Visuals)

National Mental Health Programme for India which was approved by Government of India in 1982 as the following objectives:-

1.
2.
3.

The approaches are:

1. Integration of mental health care into general healthcare system.
2. Task orieinted training to PHC personnel ~~and~~ in delivering mental health care.
3. Referral system i.e., PHC - general hospitals - district hospitals- psychiatric consultation hospitals, mental health institutions.
4. Multi Sectoral approach involving the departments of social welfare education, labour, etc (Visuals)

1. Mental Health Care envisaged at the sub-centre level by the paramedical workers (visuals)
   Identification, referral, follow up, education
2. At primary health care through the doctors and his team
   a. Management of tipical cases of psychoses, epilepsy, neuroses, and mental retardation
   b. Rerer difficult cases to higher centres
   c. Followup education.
3. At district hospitals by trained psychiatrist and his team, inpatient care for difficult cases and monitoring of the programme (visuals)
4. At department of psychiatry and mental health institutions - investigations inpatient care and long term care to the needy patients, training of various personnel in mental health care (visuals)

Sensitisation and involvement of Anganwadi workers and other staff of ICDS programme, school ~~xxxx~~ teachers, voluntary agencies and is also envisaged in educating mental health care into community (visuals)

Conclusions:

With visuals it is shown how mental health care occurs at different levels ~~of~~ department of health, it is demonstrated that it is possible to integrate mental health care into existing general care system. Different levels of appropriate ~~xxxx~~ care will be made available by establishing good referral system.

In a recent meeting of the National Advisory Group on the National Mental Health Programme of India, the immediate need for a Mental Health Training Educational Package for trainers of PHC personnel was identified. This package should help trainers to conduct training in mental health for PHC doctors and paramedical workers in an organised and systematic manner through-out the country. At present, the community mental health unit of Department of Psychiatry has developed the following teaching and educational materials for this purpose.

1. Manual of Mental Health for Medical Officers
2. Manual of Mental Health for Health Workers
3. Case history taking proformae for doctors and health workers
4. Case records for doctors and health workers
5. Monthly report forms for PHC
6. Review proforma for PHC doctors and health workers
7. Poster on mental disorders
8. Video film on Schizophrenia (Towards Light)

PROPOSAL FOR TRAINING PACKAGE

In addition to the materials already available the package should contain the following items :

A. A set of colour slides for each chapter of the manuals. The slides contain written materials or diagrams or pictures or photographs.

B. Video tapes on

1. History taking and mental state examination
   2 cases of psychosis
   2 cases of neurosis (15 minutes for each case)

2. Different signs and symptoms of mental disorders (40-60 minutes)

3. 10 minutes tapes on
   i) Schizophrenia (4 cases)
   ii) Mania (2 cases)
   iii) Depression (2 cases)
   iv) Organic psychosis (3 or 4 cases)
   v) Neurosis (6 cases)

4. Mental Retardation
   6 cases (each case 5 minutes)

5. Epilepsy
   different types (10 minutes)
   difference between epilepsy and hysterical fits (5 minutes)

6. Childhood problems
   Interviewing a child with its parents (15 minutes)
   Hyperactivity (2 minutes)
   Neurosis (10 minutes)

7. Management of an excited patient (10 minutes)

8. Severe side effects of neuroleptics (10 minutes)

9. ECT modified (5 minutes)

10. Inpatient care (closed/open/family) (10 minutes)

11. Home care of the patient (10 minutes)

12. Rehabilitation (15 minutes)

13. First aid in Epilepsy, Suicidal attempt, excited patient (15 minutes)

14. Treatment of status epilepsy (5 minutes)

15. Do's and Don't in epilepsy (15 minutes)

16. Management of febrile fits (5 minutes)

17. Counselling techniques (3 cases) (60 minutes)

18. Mental retardation training for different stages (30 minutes)

19. Case identification and referral in the village (15 minutes)

20. Follow-up (15 minutes)

21. Mental health clinic at a PHC (10 minutes)

22. Monitoring of the programme at PHC (15 minutes)

23. Group health education (10 minutes)

C. Posters/flip charts on M.R. and epilepsy (already designed and being finalised in the unit)

D. A guide book regarding how to use the kit.

WORKSHOP ON PREPARATION OF TRAINING MATERIAL FOR NATIONAL MENTAL HEALTH PROGRAMME

AGENDA

Monday 26th June '89

9.30 to 10.00	Welcome and Introduction Dr. G.N. Narayana Reddy
10.00 to 10.30	National Mental Health Programme Dr. R. Srinivasamurthy
10.30 to 10.45	Coffee Break
10.45 to 11.15	Purpose, Aims and Objectives of Training Material and of the Review Session Dr. Jayashree Ramakrishna & Dr. C.R. Chandrashekar
11.15 to 1.00	Review of Video on Community Care of Mental Illness Presentation and Discussion
1.00 to 2.00	L u n c h
2.00 to 4.00	Psychiatric Case Presentation, Video Review and Discussion
4.00 to 4.15	Coffee
4.15 to 5.00	Review of Slides

Tuesday, 27th June 1989

9.00 to 11.00	Epilepsy Video Review
11.00 to 11.15	Coffee
11.15 to 12.00	Educational videos produced by other agencies (Schizophrenia and Mental Retardation)
12.00 to 1.30	Round Up - Preparation of Guidelines for Preparing Training/Educational Package for NMHP

Community Health Cell

From: N.N. Shantha <shanta@ncbs.res.in>
To: <Undisclosed recipients:;>
Sent: Friday, February 21, 2003 9:37 AM
Subject: Colloquium_21_2_03_ 4 p.m.

NATIONAL CENTRE FOR BIOLOGICAL SCIENCES
TATA INSTITUTE OF FUNDAMENTAL RESEARCH
GKVK CAMPUS, BANGALORE

LECTURES IN SCIENCE, PHILOSOPHY & HISTORY

Madmen and specialists: The history of psychiatry in India and the lunatic asylum, Bangalore

by

Professor Sanjeev Jain
Department of Psychiatry
National Institute of Mental Health and Neurosciences

at 4.00 p.m. on Friday, 21st February, 2003

in the Ground Floor Lecture Hall (LH 1)

The advent of Asylum based psychiatry two centuries ago began the influence of the Western systems of classifying, and caring, for the mentally ill. Modern psychiatry in India is a combination of Western medical practice grafted onto an older medical and social tradition. Diagnoses and methods of care, as practised in Britain and Europe at the time were employed in most instances. At the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, medical records reveal a close congruence to classification used in the UK. In the early part of the 19th century, infections, intoxicants and injury were considered important causes of insanity. At the end of the century, it was specifically recommended that future medical care follow Western models in the Kingdom of Mysore. Analysis of records of the Hospital, during the first half of the 20th century, indicates a steady change in the description of psychopathology, methods of diagnosis and treatment practice. These suggest a rapid spread of ideas and technologies in psychiatry. As the only Asylum maintained by a Native Kingdom, it was designed with particular attention. The need for specialists was felt, and doctors were sent to the UK for training. However, at the same time, concerns were also voiced about the need to develop more locally relevant models. The need to reform the Asylums and to improve the professional standards was acutely felt from time to time. The growth of this hospital, and the medical and social history of Bangalore, is a microcosm of the larger British-Indian encounter. Analysing the records at this hospital, and other sources, we have been

RNJ for info
- Lib - Mental Health Resource file
21/2

able to trace the contrasting influences on the development of psychiatry at this institution, and in India. This subsequently became the first post-graduate training facility in independent India, and has played an important role in the development of psychiatry in the country.

Prof. Sanjeev Jain is an Additional Professor at the Department of Psychiatry at the NIMHANS. He completed his M.B.B.S. at Delhi University, and his MD from NIMHANS. He has been a Visiting fellow at the University of Cambridge, and at the Wellcome Institute of history of Medicine in London. His research includes molecular genetics of psychiatric disorders, and the history of psychiatry in India.

Tea at 5.15 p.m.

ALL ARE WELCOME

P.S. : Mazda leaves from the parking lot in front of the Main Library in IISc. 3.30 p.m.

****

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MH-7.

10/7/04

VISION INDIA

WORLD MENTAL HEALTH DAY

10th October 2004

WORKSHOP

Theme: Current trends in Mental Health

PROGRAMME SCHEDULE

Time	Session	
09.30 to 10.00	Arrival & Registration	
10.00 to 10.30	Welcome Address	Dr. James Joseph
	Inauguration Address	Dr K.T Thomas
	Lightning the Lamp Releasing Souvenir	
	Tea	
10.30 to 11.15	Mental Retardation & Rehabilitation	Dr.Romate John
11.15 to 12.00	Mental Illness & Rehabilitation	Ms Sapna C.B
12.00 to 01.00	Panel Discussion -	Ms. Sunaina Sreedharan & Ms.Gayathri.S
01.00 to 02.00	**Lunch**	
02.00 to 02.45	Mental Illness & Legal Dimension	Ms Anuroopa
02.45 to 03.45	Myth & Miracle	Mr. Hulikal Nataraj
03.45 to 4.00	**Tea**	
04.00 to 04.30	Valedictory Session	
	Closing Remarks Vote of Thanks	Mr. Thulasinathan Mr. Emerson Samuel

MH-7.

International Symposium on Cultural Psychiatry

12th & 13th December 98

At
Seminar Hall,
(Near Director's Office)
Nimhans

PROGRAMME

DAY ONE

12-12-98

8.30 AM To 9 AM Registration

9 AM To 10 AM INAUGURATION

Welcome

Dr.R.Raguram, Organizing Secretary, ISOCP

Inauguration of the symposium & Inaugural Address

Dr. M.Gourie Devi, Director, Nimhans

Chief Guest's Address

Dr.A.Venkoba Rao

Cultural Psychiatry: A Clinician's Musings

10 AM To 11AM KEYNOTE ADDRESS

Cultural Psychiatry;

Past, Present & Future

Professor Roland Littlewood

11 To 11.30 AM Coffee Break

11.30 AM To 1.30 PM SESSION ONE

Perspectives in Cultural Psychiatry

Chairperson: Dr.R.L.Kapur

***Why* cultural psychiatry?**

Dr.R.Raguram

Approaches to the study of folk models in psychiatry

Dr.Sushrut Jadhav

A third world perspective on mental health: view from Africa

Dr Yemi Olloyodi

1.30 To 2.30 PM Lunch

2 PM To 4.30 PM SESSION TWO

Cultural Psychiatry in Clinical Practice

Chairperson: Dr.S.M.Channabasavanna

Cultural formulation in clinical psychiatry

Prof Mitchell Weiss

Clinical Case Discussion

Resource Person: Dr.Sekhar Seshadri

•Case Presentation (video)

• Small group discussion and development of cultural formulation

• Plenary discussion of small group deliberations

PANELLISTS

Prof Mitchell Weiss Prof Roland Littlewood, Dr Raguram & Dr.Sushrut Jadhav

7.30 PM DINNER

At Rudraksha Centre For Performing Arts

Preceded By Yakshagana : "Kamsa Vadhe"

DAY TWO

13-12-98

9.00 AM To 11.30 AM SESSION THREE:

Research methods in cultural psychiatry

Chairperson: Dr. Jayashree Ramakrishna

Introduction to methodologies in Cultural Psychiatry
Prof Mitchell Weiss
Cultural study of depression at NIMHANS:
Dr.Raguram
Cultural study of depression among the white British
Dr.Sushrut Jadhav

11.30 AM To 12 PM Coffee Break

12 To 1 PM SESSION FOUR

Issues of training and practice in Cultural psychiatry*: *A North-South Dialogue

Chairperson: Dr. A. Venkoba Rao
SPEAKERS:
Dr. Gerdje Van Hoecke BELGIUM
Dr. M.V.Ashok INDIA

1 TO 2 PM Lunch

2 To 3.30 PM SESSION FIVE: Panel Discussion

Domains of Influence of Cultural Psychiatry: The Emerging Scenario

Moderator: Prof Roland Littlewood

SPEAKERS

•Dr. Mohan Isaac: Cultural psychiatry and psychiatric epidemiology
•Dr.R.L. Kapur: Cultural issues in Psychotherapy
•Dr.Chittaranjan Andrade: Culture and Psychopharmacology
•Dr.Bhargavi Davar : Gender, culture and mental health

3 To 3.30PM Coffee

4 PM SESSION SIX

Valedictory Function

Chairperson: Dr. Ajit Bhide
Feedback from participants
Vote of Thanks: Dr.R.Raguram

The decision to seek medical consultation is a request for interpretation.. Patient and doctor together reconstruct the meaning of events in a shared mythopoesis. Once things fall in place, experience and interpretation appear to coincide; once the patient has a coherent 'explanation' which leaves him no longer feeling the victim of the inexplicable and the uncontrollable, the symptoms are usually exorcised..

Leon Eisenberg *(1981)*

CULTURAL FORMULATION OF PSYCHIATRIC DISORDERS..

Over the years, advances in psychiatric nosology have been quite considerable. Increasing attention to precision in the description clinical phenomena will hopefully redress the issue of poor reliability of diagnosis that has plagued psychiatry for a long time.

At the same time, professionals in the field also recognize that symptoms constitute only one dimension of expression of psychological suffering. The manner in which people perceive, categorize and respond to distress is also governed by cultural notions concerning the body in health and disease. Symptoms invariably are interpreted within a particular context of individual life situation. In addition, cultural orientation influences our perceptions about how to understand and treat illnesses. Illness experiences are therefore undeniably culturally shaped.

In some manner can we attempt to incorporate this perspective in the arid landscape of psychiatric nosology?

Indeed, attempts have been made to evolve a cultural description of psychiatric illnesses. The guidelines outlining one such approach are enclosed with this document.

In the afternoon session on the 12th let us explore in an interactive manner, the issue of culturally configuring psychological distress of Pt K according to these guidelines.

Unexamined worlds of patients
Often reflect
Our unexamined thoughts

Cultural Formulation for DSM-IV

- ### Description of cultural identity of the patient

This involves specifying the patient's cultural reference group or groups. Important cultural elements are language abilities, use and preferences as well as multilingualism, if present. This should be understood within the larger frameworks of acculturation and biculturalism. For migrants and ethnic minorities, degrees of involvement with the culture of origin and the host culture should be separately appraised.

- ### Cultural explanatory model of the patient's illness

An attempt should be made to clarify: 1) The predominant illness idioms through which symptoms are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune, etc.), 2) the relation of the patient's signs, symptoms, and illness experience to both relevant cultural norms and standard diagnostic categories and criteria, 3) any local illness category used by the patient's family and community to identify the condition at hand, (See Appendix G for definitions of cultural terms and syndromes,) and 4) the perceived causes that the patient and the reference group employ to explain the illness, and the current preferences and past experience with various professional and non-professional sources of help.

- ### Stressors and supports in the social and cultural environment

Addressed here should be the personal meaning and cultural context of social stressors, of available social resources and emotional, instrumental, and informational supports (including familial, religion, and community-at-large), and of forms and levels of disability. Examples may include the personal meaning of familial losses and legal norms.

- ### Intercultural aspects of the relationship between the clinician and the patient

The formulation should conclude with an examination of the differences in culture and status between clinician and patient (e.g., difficulty in communication, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological, etc.).

CLINICAL HISTORY FOR CULTURAL FORMULATION

PATIENT IDENTIFICATION

Mr.Kariyappa, a 52 year old farmer was brought by his son and son-in-law on to Nimhans for consultation. Kariyappa lives in the village of Machenahalli, in Hosadurga taluk of Karnataka. He was brought with the complaints that he has been overactive, restless for the previous two months and the villagers who were quite upset with his behaviour suggested that he be taken to a 'mental hospital'. He was brought tied up to the hospital and looked disheveled and untidy. He was pleading with his relatives to 'free' him and when the doctor advised admission, did not protest. Later in the day when seen in the ward, he looked fresh after a bath, had applied the holy vermillion on his forehead and was eager to talk to the doctor. He told the doctor that he wonders why he was brought to the hospital, even though he has no objections to being admitted here. Added that the God 'Jinjappa' is inside his body, though people do not believe in this anymore. He went to the other beds in the ward and blessed the patients saying that they would recover from their illness quite soon.

HISTORY OF PRESENT CONSULTATION:

Over the past twenty years, the patient has been periodically 'possessed' by the God 'Jinjappa'. The first such episode occurred in 1978 during the *suggi* (harvest) season. The patient had let the cattle for grazing one night and they accidentally strayed into the neighbouring field. The owner of the land got angry and took custody of the cattle. When the patient protested, he was assaulted with bamboo sticks and he sustained injuries over his head and back. The next morning the village elders met in the temple of the local Goddess (Golimaradamma) and decided that grazing of cattle in the night was an offence. The patient was admonished, fined Rs 5 and was asked to offer a coconut with betel leaves to the Goddess. The cattle were released immediately.

Three days after this event, while lying down in the bed in the afternoon, patient suddenly got up, went outside the house apparently searching for the persons who assaulted him. He was saying in a loud voice, " Why did you assault Kariyappa, who is my greatest devotee? I Jinjappa is now in Kariyappa's body and will punish those people who abused him." All the villagers came and 'begged' Jinjappa to calm down and forgive the persons who have been disrespectful to him. Kariyappa calmed down after this, but Jinjappa stayed on him for six weeks. During this period of time, every morning , villagers used to visit him, do puja to him and offer cow's milk, fruits, sweets etc. They also requested his assistance in solving their personal problems. Patient used to offer advice and occasionally would give money and other valuables to the needy and poor. He was also found to be working for long hours in the field, grazing cattle for times at stretch. Over the course of six weeks, these activities slowly came down and as the patient started feeling tired he felt that Jinjappa was leaving him.

Since then once in a year or two, patient used to get similar 'episodes', often after any insult or threat to his family or himself. Over a period of time, villagers used to ask for more and more favours from Jinjappa. Consequently, Kariyappa had been instrumental in settling land disputes, marital problems, alcohol dependance and minor medical problems

of children and problems involving the cattle. He also used to forecast about the rainfall and seasonal changes. Whenever he walks in the streets, people used to prostrate themselves before him, seeking his blessings.
During the last five years, these 'episodes' have occurred on the background of land disputes involving him and his paternal cousin's family. He was primarily angry with his cousin for his attempts to sell a part of the ancestral land. The cousin who is also the village leader currently, did not heed to his request. The patient was also angry with the villagers for supporting his cousin. Prior to the current consultation, patient heard from others, that his cousin is in the process of finalizing the land deal. He went to his house and challenged him to complete the deal without his consent On his return to his home, he started talking like Jinjappa. This time he was restless, verbally abusive towards the people who were supporting his cousin and was abusing them in public. He also threw stones at these peoples houses. Hence, he was tied up and brought to the hospital with the help of the police.

PREVIOUS 'TREATMENT'
Two years before these episodes started, a Golla (cowherd) came to the patient's village as a migrant worker. Patient asked him to look after his lands and keep a watch over it. He had brought with him two idols of Jinjappa and Beerlinga in a brass pot. These two were immersed in the holy water of Kenchamma inside the pot. He installed these three gods near a anthill under the neem tree in Kariyappa's field. After a year the Golla wanted to leave the job and he advised the patient to worship these Gods as they would protect him and his family. He also added that if Kariyappa did not follow his advice, adverse consequences might follow for the family. Since then the patient has been worshiping the Gods everyday and has also appointed his nephew to do regular pujas.
On this background, the family did not view the patient's behaviour as a problem and were offering pujas to him every time he got possessed. It was only during the last five years when they noticed Kariyappa to get more angry during the episodes, the family had sought help from other faith healers. On their recommendations, pujas and offerings were made to the main temple in the next village whose main deity was Jinjappa (Krishna). They had also arranged for a massive poor feeding and distributed money and clothes to the poor people in the village. They also consulted many temple priests who used to get possessed and one of them advised the family to transfer the idols from their lands to the main temple. Even after this, the patient continued to have the episodes. Since the current episode was more disruptive, people in the village advised consultation at Nimhans.

SOCIAL & DEVELOPMENTAL HISTORY
Kariyappa was born in a joint family. His father was the eldest in a family of six sons. And Kariyappa was his eldest son. They belong to the Kuruba (shepherd), community, which is considered as a backward caste in Karnataka. They are devotees of Lord Krishna and are primarily non-vegetarians.
Patients paternal grand father had thirty acres of wet lands in Machenahalli and also had large herd of cows and buffaloes. Towards the end of his life, he divided this property into six equal parts. Each son had five acres of arable land, which they have been cultivating for many years. Kariyappa himself has two brothers and hence the five acres of his family, was

in turn divided among the three of them. Kariyappa's uncles had also divided their land among their family. The particular cousin with whom Kariyappa has been having problems, is the only son to his father and hence has been 'enjoying' the benefit of having five acres of land. This includes a portion to which Kariyappa is immensely attached, as it has a small pond where he had spent many hours with his grandfather. As Kariyappa's cousin had taken a large loan after pledging his land and was not in a position to repay it, he has been keen that the lender take away his land in lieu of the money he owes to him. Moreover, since he is actively involved in politics, he has not been keen on cultivating and looking after the land. This has angered Kariyappa as he is against the selling of the ancestral property.

Kariyappa never attended the school and has been working in the lands since an young age. He got married at the age of 21 and has two sons, who assist him in farming. The interpersonal relations between him and his wife as well as his son is reportedly very cordial. His wife is reported to be a very quite, soft-spoken, hard-working woman. Whenever Kariyappa has these episodes, he sends his wife away to her parent's house as he feel that he has to maintain his 'purity' during these episodes.

Between these episodes, Kariyappa has been functioning well. He has no major monetary problem, nor does he have any debts.

FAMILY HISTORY

Within the community, Kariyappa's family has always been respected. They have been the community leaders for many decades. The patient's father was the village leader (gowda) and later Kariyappa himself assumed this position for a long time. Since the past six years, his cousin has taken over his position.

Kariyappa's paternal grand uncle also had 'possession' attacks, the nature of which is not very clear.

No other history of any other illness in the family.

COURSE & OUTCOME

After his admission in the hospital, Kariyappa was found to be cheerful, talking freely with all the inmates of the ward. Sometimes he would bless them, wishing them a faster recovery from their illness. He was a popular figure in the ward and many patients and their attendants enjoyed talking to him. He slept poorly during the initial few days, waking up often in the night.

During the interview, he was found to be dressed immaculately, wearing flowers over his ears and with a prominent vermillion mark over his forehead. He was smiling all through and was gesticulating with his hands to emphasize his narration. His speech output was increased. He was talking spontaneously and would continue to do so unless stopped. He was telling that it was not he but Jinjappa who was talking and described at length about his powers, " I could do the work of many people without feeling tired. I can face any number of people who come to control me. I can tell you when it will rain. And I can cure people of their illnesses." When queried about his powers as to when and how he got them, he replied " it is not Kariyappa who is talking to you. I am Jinjappa, Lord Krishna. I have immense powers to help and assist people." He had no perceptual anomaly and his cognitive functions were within normal limits. He did not feel that he had any illness and rejected the suggestion that he could be mentally ill.

12/12/98

Roland Littlewood

1. National traits — Italian - Irresolute, procrastinator
   British - Depressive - melancholy
2. Culture & nature
3. culture vs nature (industrial capitalist m.
4. European vs colonial people interact.
5. Form & Content
6. Russian Doll Model — core similarly voiced by layers
7. Artichoke (no core similarly)
8. Wrong model of culture — not similar core but diverse realities and interrelatedness
9. Psychiatric imposition of categories — need to be challenged
10. Doctors concentrate on biology - follow out
    — if same culture — following is easy
    — if not same " Non confusion!
    e.g. Brit Psych blame confusions of Indian pts
11. Recognition of social/cultural differences of doctors manifestations/expectations/ to be taken into account
12. Medicalising social/political problems

13. Exaggerated cultural norms -
eg Dhat syndrome

14. More you look at things sexual,
more you unravel — more you get
uncomfortable with models we have
taken for granted

15. Study - Religion / Sickness / Health - Sexual
— But interpretations problem — Anthropology
— limitations

16. Normality and abnormality — is a power relation
between observer
and observed

17 Freud / Sex Biologist / Marxist
Postmodernism / Universal Scheme
Few will accept ⟶
What explains difference — Evolutionary
Culture

18 Psycho-analysts in some countries
are given new interpretation - way children
brought up and breast feed —
— All somehow use deductive + abstract
modes of thoughts (difference) Construct

19. Now focus on Why? Not How? — Porkers know
Big Gap between Porkers + how

20 Colonial Hubris / Academic analysis

What is not universal — European Viewpoint
appropriate
has limited meaning

21. Psychiatry & Imperialism

- Scientific objective — People as chattels/slaves
- No Higher value → personal exp

22. Mental Health and Development in Africa

→ People can't cope

23. Colonisation not change

24. Colonial Psychiatrists — marginal / non ideological
very little practical contribution to ethnic

25. French Psychiatrist — were involved with
cultural resistance (Haiti)

26. Now all illness is culturally conceived

27. mythical
Cannibal syndrome / Missionary excesses

28. Voodoo / Exotic curiosity

29. Post dilemmas continue

- Historic origins of disease

- Archive of Mental Illness within a cultural context
- Build approach
- Not as exotic but fundamental

Raghuram — Why Cultural Psychiatry

1. Is Psychiatry inescapably cultural?
   Every interaction — takes place
   on a background/social/context

2. Road less travelled
   Outside of People
   Too complex to enquire
   Beyond the Ambit of clinical concern — Myths legends
   Not scientific enough (conflict between 'rational' psych and irrational' psychiatry)
   Unappealing pursuit economically
   (every context — shared limit of psychiatry)

3. Schisms between
   Lay folk + professional/scientific knowledge, Symptoms
   Personal with Political

   Exclusion
   unfamiliarity/fear of unknown
   Control
   of the irrational
   Commodification
   of distress
   Promotion
   of marketable identity

4 A subtle alienation of the professional framework from the lived world of the patients
(Western textbook / western models)

unsettling of clinicians →
— attuning to local culture

- goes undocumented
- goes unexamined
- goes untaught

5 Indians by becoming intellects.
— renounce local cult..

6 Psychiatry — Post-colonial derivat.

7. Professional framework change over time
incorporate influences that are dominant
socially, economically,

Influence of colonialism..
British American Boundaries

Monoculture of the Mind

Genetically determined seeds → can affect agricul.

8. Lancet Editorial — Crisis in Psychiatry,
knowledge base drawn from
North American / European populations
Applied to 80% of population outside this system

9. Psychiatry

A Product of western - Biomedicine

(i) The infectious model paradigm
Agent -- Host · Response

(ii) Predominant Attention on the host
Vulnerability. Biological char

(iii) Tangible Determinants of Distress
Influence of the market forces

10. Emergent emphasis on Diagnosis
- Search for Reliability
Tyranny of the Kappa
- Focus on classifying and typing Human distress
without attempting to portray it
- Formation of Accessible, empirically
verifiable, marketable abstraction
of clinical reality

11. Bio-Psycho-Social Model
Layers of Knowledge
Each one autonomous
What lies at the core? - Biology?

Choice between

Russian Doll and Onion

Do we have to unravel to reveal.

↳

Reach across to layer to address

Human Suffering

12. OCD - obsessive compulsive disorder

Elderly widow cleaning rituals and order

- An uncommon disorders

(Suchubai syndrome)

- Culture bound

- More patients than ever before seeking help

- Availability of effective treatment

- Does the Biology operate outside the individual

13. Role of environment

Biological

Milieu interior + Milieu exterior

Relation to Pollution of in the environment

Psychosocial

Urbanisation of Economy

Information explosion

Need for control of Stressful events

14. Role of cultural Defences
Findings of using influence on
Ritualization in Daily life

15. Conceptual Shift

Aetiology (form) to Teleology (Function)

Stratigraphic Approach (Biomed paradigm) to Synthetic approach

↓

Need data from experience/narratives with patient

↓

A Research methods to collect socio cultural situation in daily life

←

Need for integration of different Domains:

Illness ideology ⇕ Disorder ideology ⇕ non western healing

Work of culture – Sensitive to social suffering

16. Not 'laws' but meaning

1983
(Murchel

Sworut Approach to Folk models

'Cultural Psychology' (Apology)

Roghun Roland

↓

Psychology must intervene culture

1998

↓

dejargonise | power of words!

1. They have beliefs we have knowledge
(Psych Subjects) (professional)
2. Organisation of Knowledge — C in culture

Ethnoscience — Folk epidemiology

Cognitive (Psychological)	Anthropological (Symbolic)	Integrated
Attitudinal	Propositional	Emic
Lay Models	Narrative	
Health Beliefs	Grounded Theory	
What People Say	What People do	
Attitudinal Conceptual internal mental mod	~~How~~ Lay Models in Society	

Cognitive — Symbolic

Don't explain — Limited how

why people

do what they do

Pre structured Questionnaire | All Leaders

Attitude studies

↓

Lay Models — Narrative

Health Belief — Grounded Theory

Ethnos representa — Ethnographic depth

Coherence — Semantic Network

Prototypical — Inferential

↓

Self propositional

stance

(less individual attitude propositions) → Depression

(Std vignettes similarly framed) → Sadness (like)

Folk categorisation — like sort of — low esteem (sort of

milder disorders not common

Prototypal
(Fuzzy logic)
Subsets + supersets
relation
Ren = Reag.

informants vs
ethnographic prejudice

Contagion + vs Bacterial
Semantic appm.
97%
(Sontag – USA)

Ethnographic

semantic network

informants judgement
over salient proposition

cultural vs professional
reference vs reference

McKnight

Proposition → Make you Ven

		Yes	No
can	Yes	depress	chronic fatigue
lose			
joy	No	anxiety phob.	—

"Chunks of retrieval"

Narrative
- literary fiction
- factual authoritative accounts
- ? invisible narrator
impartial observer ??

3rd Person Accts are amenable to distortion

↓

Coauthorship — Subject
— Narrator

Grounded Theory (Sociologist) Bottom up perspective (Qualitative)

vs

Ethnographic Theory (Anthropologist)

↓

Rich descriptions of specific episodes (organised by interest of research

↓

Researcher live in community
- Participant observation
- Take everything into Acct

Marginal Field — Rural Ghanians

Sheldon? — Women attending Temple (Manukthar) - Depression, Suicidal Tendencies - Love sickness

R. Littlewood

Udon Kalon applied lovers in North India

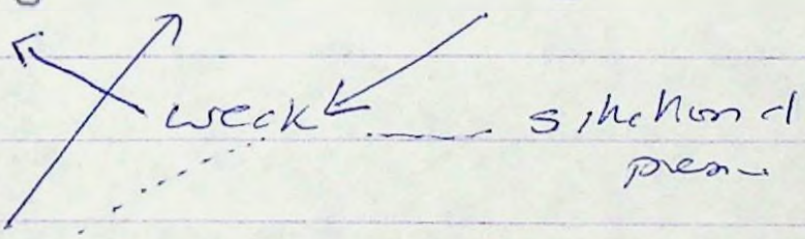
Semantic Network - Causal Reasoning

↓ Folk etiological constructs

Causality Questioning

USA — Hongkong — Morelle Rahe 1984

Busy — Appetite — Busy



emotion → Sleeping ⟷ Emotion

Problem: Rchard approach to causality

Inferential - Dynamic-Path model

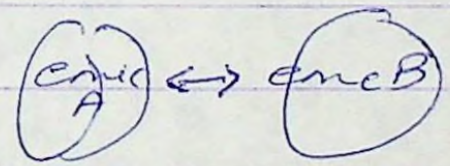
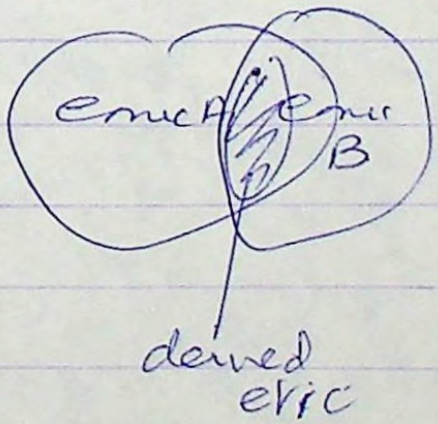
Implication - Equal Contrast | Potentially → Always → Can contribute

EMIC

Qualitative & Qualitative — Explanatory Model — Interactive — Catalogue

Phonemic — emic — indigenous — subjective — Dhehu Tchenke

Phonetic — etic — Professional — outsider

Steps	Research Activity	Culture A (our)	Culture B (other)
1.	Begin research in our cultr	emic A	
2	Transport to other cult.		
3	Discover other culture		
4	Comparison ~~from~~ culture		
5-1	comparison not possible	emic A	emic B
5-2	comparison possible		

Third World view from Africa

Africa

↓

Nigeria

↓

Yoruba understanding epilepsy.

(one of three largest ethnic group)

↓

Seizures → attributed to Demons | Illicit sexual relations

→ Jealous spirit

Cause

Esu - embodiment of evil (devil) | provokes encourages dishonesty

↓

IFA - Divination process

↓

OLORUN - GOD

Divination Priest Babalawo - local healer

Bo - wash / scarify to Gods

Iwin - Ancestral scarify

Appease Esu

Epilepsy

↓

curse

↓

revelation of evil doing

Locals - Why not How

interested in

Healing process - desire to get ochre

perhaps the of esu. is

↓

- Slaughtering of Goat
- Alms to Poor
- Going to Market on special days for 7 weeks

Psychiatrist — How to cure epilepsy

Mokes — Why my child epilepsy

MAGUN - Magical medicine laid in the path of the person (walks over) → Seizure — Punished for Adultery

Disease as cultural symbolisms of why?

Yoruba illness is a cultural construct

↓

Other system - Reading

- Breaking of taboo

Aim:- To understand why pt dont comply why some need

ISCCP

18/12/98

Mother Issue

1. Problems of Cross cultural Sh.

- Standardisation of methods of assessment of diagnosis
- rigorous methods
- not sensitive to cultural variables
- not possible to compare studies

2. Ethnographic studies

- Small scale, descriptive
- comparably
- Long term follow up not there
- not so useful for policy formulation

3 WHO/NIH Joint project on diagnosis and classification

- Classifications
- Assessment instruments
- Lexica, Glossary

Chapter V of ICDs
↓
were extensively reformulated

General Instrument for Dx of 4 major disorders
- CIDI
- SCAN
- IPDE

Cross cultural terms

- Clinical Diagnosis
- Diagnostic criteria For Research
- Diagnostic criteria For PHC
-

Symptom, checklist

personality disorder

× International Multicentric Field trials

Took into account cultural nuances | 14 languages

NIMHANS Centre

Multicentre Field Trials — Different Geography Language/culture Group
- Different schools of thought in Psych (Psychoanalysis

Translation of Assessment Instruments

- Translatability of the instrument
- Language barriers
  - Structure and form (Grammatical rules/pattern of vocabulary)
  - Availability of discriminatory words to express subjectivity experiences and affective states
  - Socio cultural factors
  - Dimensions of equivalence & methods of equivalence check
    - content
    - semantic
    - conceptual
    - criterion
  - Back Translation
  - Bilingual technique
  -

(I) Vega. Sept 98 issue of Archives of Psych

Incorporated culturally and linguistically sensitive elements

(II) Room R. et al (1996)

Addiction

- Cross cultures
- Cross cultural applicability of diagnostic criteria for substance use disorders
- Qualitative & Quantitative methods
- Translation difficulties at the levels of item, criterion, concept

includes probes on idiomatic expressions of psychological disorders

"Normal drinking"

III Culture and Common Mental disorders of Sub-Saharan Africa — V. Patel

- Review of explanatory models of Mental illness in Sub-Saharan Africa.
- Ethnographic study
- Short Symptom questionnaire
- Phenomenology
- Case control survey

Demonstrated association b/w gender, mental health and econ deprivation.

Chitra Andrade

- Cultural issues in Psych P
- Psych Ph issues across cultures

Drugs and cultural variations

- Pharmacodynamics and pharmacokinetics — Body does to drugs
- Benefits — Drugs does to body
- — Absorbs, Tolerance, Dependence

Race Culture Ethnicity

Genetic
Biological
Surface identity

Cultural variations

- Seizure approaches during ECT (variations in S. India)
- Clozapine Agranulocytosis — Indian Chinese very few cases reported
- Response to Schizophrenia vs Neuroleptics

Cultural variations

- Dosing difference Haloperidol – Euro & Japan
- " Eu countries
- Dose blood level relationships — blood level
- Dose response relationships

— Primary & Secondary variables

Complicated variable – The Patient

Physician

Effect of patient care
interests
opinions and attitudes
Fashions

- illness behaviour
- Attitudes, compliance
- placebo effects
- intrinsic religiosity

Nurses

- Therapeutic expectations
- patient
- Nursing staff

Drug companies

- Availability of drugs
-

Environment

Stress
Family support
Social support

Others

- Sociocultural
- Late presentation for treatment
- clients
- Concurrent illness

Caution

1. Greater variations in culture
2. No convention
3. Geographic units culture entities
4. Interacting may complicate clinical picture

Bhargava Davar

Between Feminism & Psychiatry

- gender- social category < those t power. those t out power
- ideas and practices

Priorities

- violence and victimization
- valid bodies experiences
- poverty, homelessness and social exp of severely ill women
- human dignity in all life stage
- motherhood and widowhood

Aims

1. Codify clinical strategies < empowering disempowering
2. making women better negotiators in their own care
3. Strengthening self help skills by drawing from women diverse coping skills

Gender is an analytical formulation

- People as 'Masculine or feminine' in a power relationship

Feminist discussions

- How psy sciences received in India
- Who were interested parties
- In what terms were these sciences received

Hindu/caste issue/mental health problem

- Hinduism - caste issues - mental health
- Public Health discourse - upper caste discourse
  Hygiene - caste / purity
  ↓
  reformulation of upper caste rules
- "Married Spinster" - De 1946
- Feminist suspicion about cultural perspectives
  women's side of story is left out

1. Possession states

Interpretation	What is left out
- Hysteria - Infantile sexuality - weakness - suggestibility	women's experience of body women's experience of power (Ram, 1992, 1998)

2. Somatization

Inability to verbalise

women's experience of the body [in pain]

women's experience of social powerlessness (Dover, 1998)

3. "Hysteric"

This is not dissociation

Inability to verbalise

women's experience of the body (in pain)

women's experience of social powerlessness (Dover, 1998)

- Infantile sexuality
- maladjustment / neurotic state

reality of child sexual [illegible]

Skultans, 1991

Recent concerns

- Study re x between psychiatry colonialism, caste, gender
- Document ethnographies
- Collect cultural stories about women's distress esp depression
- Feed into CH-Care

SCHIZOPHRENIA RESEARCH FOUNDATION (INDIA)

WORLD HEALTH ORGANISATION

COLLABORATING CENTRE

FOR MENTAL HEALTH RESEARCH & TRAINING

Towards a better future for the mentally disabled

SCHIZOPHRENIA

A MALADY OF THE MIND

" The eldest son of a temple priest, he was brilliant at school and nurtured great ambitions about becoming an engineer. His family shared his dream, and not withstanding the great financial stress they were facing were prepared to make any sacrifice to enable him to join the IIT. All went well for a year and a half at I.I.T. until he started hearing voices accusing him. His friends began to feel that he was a different person and no longer enjoyed his company. His family sought the advice of astrologers, magicians and faith healers, but he seemed to move further and further away from them - a pale shadow of his exuberant, flashy self. Why did this bright youngster stop attending classes, start failing in his exams and ultimately drop out from the course itself crushing the fond hopes of his family?"

" She used to get up everyday at 5 in the morning and go about her work with the precision of a clock. She was an ideal mother and wife, friendly and helpful. Gradually her husband noticed that she was becoming moody, temperamental and given to periods of intense preoccupation and silence. She did not seem to enjoy anything, be it his company or the children's or cooking her favourite dishes and neglected her self care. She became irritable, suspicious, kept awake the whole night and insisted on all doors and windows closed all the time in mortal fear of an enemy who she thought was going to attack her. She felt that everybody was looking at her and talking about her and slowly stopped cooking, and looking after the home. Why did this loving wife and mother decide to end her life unable to bear the inner pain and agony?"

These are not born out of a writer's imagination, but true descriptions of tragic transformations in people's lives, changes so painful to those near and dear and hard to understand and fathom. What is the common feature in these stories?

Both these people suffered from an illness called Schizophrenia, an illness afflicting the mind in the most productive years of people's lives. They are not alone in this.

Nearly 6 - 7 million Indians suffer from this disorder variously described as the "cancer of the mind" and the "greatest disabler of youth". Cosmopolitan in its occurrence, it cuts across barriers of gender, educational and socio - economic classes. Although the causes of this disorder are not clearly established, significant advances have been made in its treatment and rehabilitation.

SCARF

However in order to reduce or prevent the disability caused by schizophrenia, it is essential to identify it early and treat it vigorously.

How does one identify this illness and what is the treatment?

Does it run in families? Does it have a total cure?

These and several questions which plague the minds of families have an answer. You just have to write to SCARF and get all the information you require, all the support you need and the professional expertise to tackle this challenge.

But what is SCARF?

SCARF is the acronym for the Schizophrenia Research Foundation, a non-governmental, non-profit organisation in Madras, India which since 1984 has committed itself to schizophrenia care and research. Founded by a group of philanthropists and mental health professionals, SCARF has established itself as a centre of repute in rehabilitation of the illness and research.

What does SCARF offer to patients suffering from this illness?

SCARF offers a comprehensive treatment package comprising of :

* Out patient care manned by a multi - disciplinary team of psychiatrists, social workers and psychologist.
* Free medication for those who cannot afford it
* A well worked out, individually tailored rehabilitation programme consisting of occupational therapy, group therapy, social skills training and cognitive training.
* A special emphasis on the family by

EARLY SIGNS AND SYMPTOMS

* Lack of concentration in work, studies.
* Confused thinking; strange or grandiose ideas.
* Prolonged severe depression; apathy; mood changes Excessive anxieties, fears, or suspiciousness.
* Withdrawal from society, friend lessness; appears lost in thoughts, brooding a lot.
* Denial of obvious problems; Strong resistance to help.
* Thinking or talking about suicide.
* Numerous, unexplained physical ailments; marked changes in eating or sleeping patterns.
* Anger or hostility out of propor tion to the situation.
* Delusions, hallucinations, hearing voices.
* Abuse of alcohol or drugs; neglect of self care.
* Growing inability to cope with problems and daily activities such as school, job or personal needs.

OBJECTIVES

the family cell to support, counsel them and involve them in treatment programmes.

* An employment bureau which seeks to find jobs for the disabled.

And above all SCARF sees in each client a human being disabled in various ways, but yet deserving the self respect, dignity like his brethren.

RESEARCH

SCARF has forged research links with several national and international bodies of repute.

* Has completed over 20 research projects
* Published over 80 scientific papers in national and international jour nals.
* Organised 4 international and 18 national conferences
* Brought out books and training manuals.
* Trained over 50 students of social work and psychology.
* Has been recognised by the M.G.R. Medical University as a centre for PhD training.
* Has had some of its faculty trained in certain special programmes such as cognitive retraining.

AWARENESS, EDUCATION

SCARF has been equally active in the field of awareness and education. Myths and misconceptions abound in the understanding of mental illness leading to delay in seeking treatment. SCARF therefore identified this as an important area of work and has organised several awareness programmes not only in urban areas, but in rural pockets using indigenous modes of communication. Video films, Audio visual materials have been produced on the illness and its management.

CARE AND REHABILITATION

* Out patient treatment at Anna Nagar for nearly 4,000 mentally ill.
* Cared for 1,200 rural patients at Karnambut and Thiuporur and 200 from urban slums.
* Found jobs for 82 mentally disabled.
* In recognition of outstanding services for the welfare of the handicapped, SCARF received the "National Award to Outstand ing Employer 1995" from the President of India Dr. Shankar - Dayal Sharma on December 3, 1995 at New Delhi.
* Reintegrated 165 women into their families after rehabilitating them.
* Provided free transport to patients reaching our centre.
* Assisted 210 children of the mentally ill with their education.
* Engaged over 300 patients in work units.

PROGRAMMES

TRAINING

Training various levels of health workers in the basic principles of detection and management of mental health problems and promotion of positive mental health is another important area of activity. In fact, with the development of manuals, training aids and kits, SCARF is well poised to become a focal agency for training in psychosocial rehabilitation techniques.

COMMUNITY MENTAL HEALTH

Work has been confined not just to institutions, but has been taken to the community as well. Thiruporur in Chingelpet district, Karnambut in North Arcot District, Thiruverkadu and the urban slums at Vyasarpadi have all benefitted from SCARF's community based programmes, a rubric of activities including treatment, rehabilitation, awareness etc. A key element in these programmes has been the extensive participation of the community in all our activities.

RESIDENTIAL CARE

Recognising that the path of rehabilitation is long and tedious and involves several levels of intervention, SCARF has established two residential centres at Thiruverkadu and Mahabalipuram. Manned by a professional, multi - disciplinary team, these centres offer varying, need based periods of stay and intensive efforts at improving the skills lost by the patients.

The centre at Thiruverakadu was built in 1991 (on land donated by the temple trust with donations from Helpage India, IDBI, Madras Round Table I) and houses 55 mentally disabled women and elderly. Just outside the town of

SCARF'S COLLABORATORS, SPONSORS

* World Health Organisation, Geneva ; WHO SEARO, New Delhi.
* World Association For Psychosocial Rehabilitation (WAPR)
* Johns Hopkins University, U.S.A.
* International Development Research Centre (IDRC) Canada.
* Royal Crichton Hospital, Dumfries, Scotland.
* Royal Perth Hospital, Australia.
* Oxfam.
* Helpage.
* Tata Institute of Social Sciences.

TOP PRIORITY

Mahabalipuram is the centre for men on land donated by Sri Sankaracharya of Kanchi with Sri Sugalchand, Jindal Trust & Sri G.N. Damani being the major donors for the construction of buildings. People from all over the country have availed of these facilities.

POLICY & LEGISLATION

SCARF has also gone beyond microlevel planning and has been actively engaged in influencing legislation and welfare programmes for the mentally disabled at the level of the state and central governments.

All this has been possible because of

* A high degree of commitment to the cause of mental illness.
* An excellent multi - disciplinary team
* Support from the public, donors, governments of Tamil Nadu and India.
* A great number of beneficiaries who have reposed faith and trust in us.

OUR OWN HOME

Our next mission is to have a building on land donated by the Govt. of Tamil Nadu. This will house the following :

* Out patient clinic
* Limited inpatient beds
* Day Care Centre
* Vocational units for men and women
* Research wing with a computer cell, library and auditorium
* Training and education centre
* Special services for women and elderly mentally disabled.
* Administration and accounts
* Guest rooms

FUND RAISING FOR THIS IS ON A WAR FOOTING SINCE AN AMOUNT OF A CRORE OF RUPEES is required to complete the COMPREHENSIVE MENTAL HEALTH FACILITY Which will be a centre of excellence and repute in all aspects of mental health care and research, a centre which will do the country proud and bring solace and comfort to the mentally disabled and their families.

At this point in time, we make a special and specific appeal to help us complete our centre. The various ways in which you can contribute towards this are detailed in this brochure.

Since its humble beginning in 1984, SCARF has established itself as an

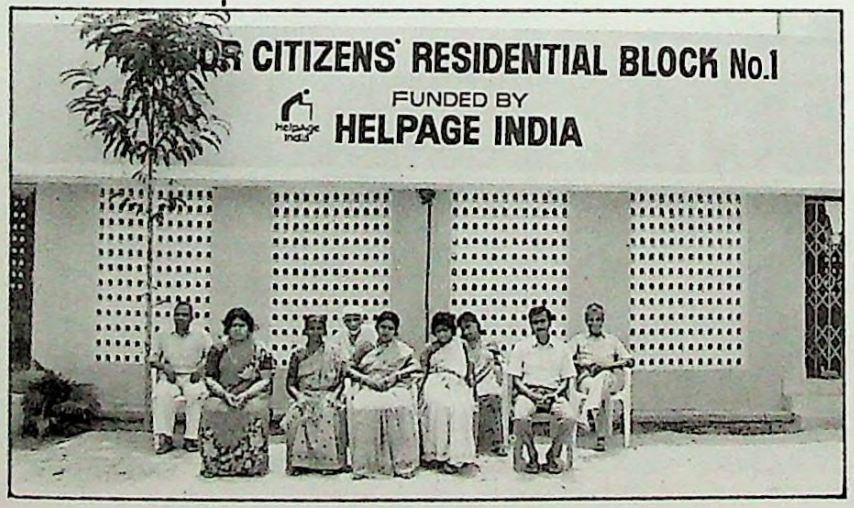
Fund raising programme organised by 'Friends of SCARF' & hosted by the Prince of Arcot. 1996

Research Seminar 1989

SCARF residential centre for men at Mahabalipuram.

International Collaborators of Scarf

Senior Citizen's Residential Block at Thiruverkadu



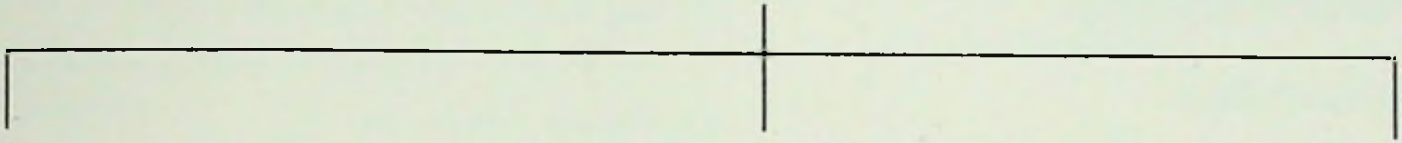
Public Awareness Programmes 1993.

unique and nodal centre for mental helath care and provided relief to thousands of mentally disabled and their families. It is only with your support and encouragement that we can continue and expand these activities into the 21st century. The following are some of the ways in which you can help us do this :

* Make donations to SCARF and avail of a 100% tax relief under 35 (i) (ii) of the I.T.Act.
* Become a life member / institutional member of SCARF.
* Sponsor the education of the children of patients, especially if they are the bread winners of the family.
* Help generate employment for our improved clients.
* If your communication skills are good, you can write in the general press about schizophrenia and SCARF and improve awareness.
* Above all you can be a friend and well wisher and be part of us in our mission to work for a brighter future for the mentally ill.

SCARF has been designated as a World Health Organisation Collaborating Centre for Mental Health Research & Training - the first Indian NGO dealing with Mental Health to be accorded this status.

SCARF



REHABILITATION

1. Out Patient Care
2. Community Homes
3. Residential Facilities
4. Rehabilitation Package
5. Employment
6. Education of Children
7. Family support
8. Community Based Work

RESEARCH

1. Intramural Projects
2. Collaborative Projects
3. Seminars & Symposia
4. Publications
5. Books, Manuals
6. Recognised PhD Centre
7. Influencing Policy & Legislation

AWARENESS & TRAINING

1. Awareness Programmes
2. Mental Health Awareness Week
3. Audio - Visual Aids
4. Films
5. Training
6. Training Package for Health Workers & PSR Personnel

PEOPLE BEHIND SCARF

Patron-in-Chief : Honourable Sri K.R.Narayanan, Vice President of India, **President** : Mr. V.T. Somasundaram
Vice-Presidents : Mr. M.A. Vellodi, Dr. M.S. Valiathan, Mr K.P. Mahalingam **Secretary** : Dr. R. Thara
Founder & Adviser : Dr. M. Sarada Menon , **Members** : Mr. K.R. Baliga, Dr. S. Rajkumar, Dr. T.R. Govindachari, Mrs. C.K. Gariyali, Dr. Subash Phaterpekar, Mr. Rajiv Raj, Mr. Habibullah Badsha, Dr. S.M. Channabasavanna, Mr. Jayaram Rangan

FUNDING OPTIONS

A. For the Proposed New Building

1. Sponsoring one particular room or wing (This will be named as per the wishes of the donor)	Rs.	3,00,000

2. Furniture for the Acute Care Ward

a) 2 Accaire Air Conditioner 1 tonne each for Computer Rooms with Voltage Stabiliser (2 x 35,000)	Rs.	70,000
b) 4 Cots for acute care ward (4 x 1,500)	Rs.	6,000
c) 4 Cupboards for acute care ward (4 x 2500)	Rs.	10,000
d) 4 Mattresses, Pillows, Pullover etc. (4 x 1000)	Rs.	4,000
e) 4 Cupboards (big size) for acute care pharmacy (4 x 5,000)	Rs.	20,000
f) 4 of tables and Chairs for Doctors and Nurse in acute care ward (4 x 3,000)	Rs.	12,000
g) Medical Equipments	Rs.	25,000
h) 1 Petrol driven Autorickshaw for transporting acute patients to other hospitals in emergencies (1 x 70,000)	Rs.	70,000
		2,17,000

3. Furniture & Fittings

a) P.V.C Chairs (12 sets) for the lobby and acute care ward.	Rs.	16,200
b) P.V.C. Chairs (50 sets) for the conference hall.	Rs.	1,45,000
c) Head Table and Chair for the Conference hall	Rs.	21,000
d) Executive Table and Chair	Rs.	15,000

4. Fans and Tube Lights

a. Fans for I and II floors (50 Nos)	Rs. 46,500.00
b. Box type tube lights for I and II floors (50 Nos)	Rs. 28,100.00
	74,600.00

B. Client Support for one year

1. Cost of Medicine Rs.800/- x 12	Rs. 9,600.00
2. Cost of Food Rs.800/- x 12	Rs. 9,600.00
3. Cost of other support services Rs. 200/- x 12	Rs. 2,400.00
	Rs. 21,600.00

Sponsoring a poor client for life in one of our residential centres Rs.1,50,000.00

C. Support to Research Activities

1. A Research Fellowship endowment for one research staff.	Rs.2,00,000.00

Please note that all donations to SCARF are exempted fully (100%) from taxable income under Section 35 (i) (ii) of the Income Tax Act.

JOIN SCARF (INDIA) in the c[illegible]ade. Donations to SCARF are fully exempted u[illegible]r sec 35 (I), (II) of the I.T. Act.

To
The Secretary
Schizophrenia Research Foundation (India)
C-46, 13th Street, East Anna Nagar,
Madras - 600 102.
INDIA.

Tick where applicable

☐ Kindly enroll me as a Life / Institutional member.

☐ I wish to support the activities of your Foundation. Please accept my enclosed contribution

Name .....

Address .....

.....

.....

.....

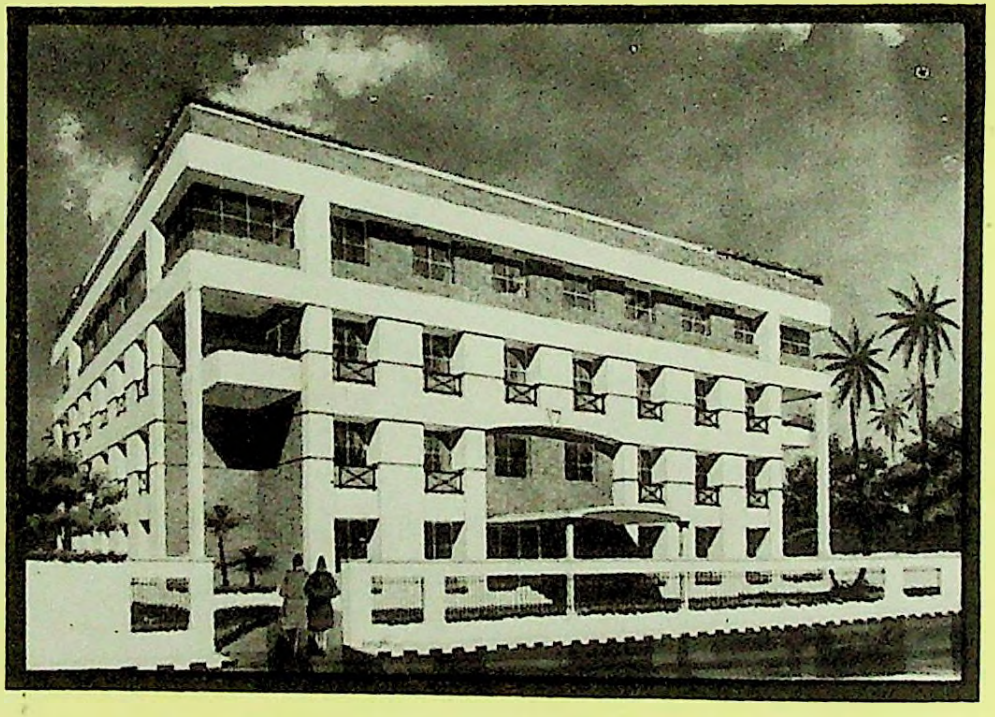
Cheque / Demand Draft No. : ..... Drawn on .....

Date : .....

Cheques may be drawn in the name of

SCHIZOPHRENIA RESEARCH FOUNDATION (INDIA).

* Life Member Fee Rs. 2,000/-
* Institutional Member Fee Rs. 10, 000/-



Proposed building for SCARF Centre at
Anna Nagar