



ISSN 0971-9962

# INDIAN JOURNAL OF SOCIAL PSYCHIATRY

(Official Publication of Indian Association for Social Psychiatry)

Vol.: 24

Number: 1-2

2008

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# INDIAN JOURNAL OF SOCIAL PSYCHIATRY

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## BURNOUT: A REVIEW OF CONTEMPORARY RESEARCH

Burnout is one of the causes of increasing psychological morbidity among working people and is no more confined to mental health professionals. The hypothesis of specific occupations being more susceptible to burnout did not gain much ground from the research data, instead, stress such as workload, time pressure, or role conflicts correlated more highly with burnout than client-related stressors (such as problems in interacting with clients, frequency of contact with chronically or terminally ill patients, or confrontation with death and dying). Recent research has focused explicitly on emotion-work variables (e.g. requirement to display or suppress emotions on the job, requirement to be emotionally empathic) and has found that these emotion factors do account for additional variance in burnout scores over and above job stressors (Maslach et al, 2001). Studies focusing on other professions support this fact (Chakravorty, 2005; FGIworld, 2005; Hogan & McKnight, 2007; Holcomb, 2007; Seshu, 2003; Siamian et al, 2006; Sudhashree et al, 2005).

Burnout refers to negative psychological response to interpersonal stressors and contains three separate dimensions: emotional exhaustion, depersonalization and reduced personal accomplishment (Cordes & Dougherty, 1993). The early phenomenology of burnout is a study by Menzies titled "A case-study in the functioning of social systems as defense against anxiety" in the 1950s (Menzies, 1975). The burnout phenomenon was first described in the context of job related stress by Freudenberg (1974, 1975) and closely followed by Maslach (1976).

The three core dimensions of burnout:

1. Emotional exhaustion: Represents feelings of fatigue that develop as one's energies become drained. Emotional exhaustion is thus characterized by a lack of energy and a feeling that one's emotional resources are used up.
2. Reduced personal accomplishment: Represents a deterioration of self-confidence, and dissatisfaction in one's achievements. Reduced personal accomplishment thus involves low motivation and self-esteem and is characterized by a tendency to evaluate oneself negatively.
3. Depersonalization: Denotes the development of negative and uncaring attitudes towards others i.e. detachment and an emotional callousness towards clients and peers. It represents the tendency to treat clients as objects rather than people. Individuals may display a cynical, callous,

uncaring and negative attitude toward co-workers, clients and the organization (Cordes & Dougherty, 1993).

### Two Phases of Research

#### *The pioneering phase*

Early studies were qualitative and exploratory and many themes emerged from these early interviews in the human services, suggesting that the burnout phenomenon had some identifiable regularities (Maslach et al, 2001). It was clear that the provision of service or care can be very demanding and involving occupation and that emotional exhaustion is not an uncommon response to such job overload.

The second component of depersonalization (cynicism) also emerged from these interviews, as people described how they tried to cope with the emotional stresses of their work. Throughout this early work was a central focus on relationships, usually between provider and recipient, but also between provider and coworkers or family members.

#### *Empirical phase*

By 1980s, quantitative studies or 'the empirical phase' started, which became the dominant mode of investigating burnout in the last three decades. Among these Maslach's work to develop an inventory remains a pioneering one which saw a third edition within fifteen years (Maslach et al, 1996) and is popularly known as MBI (Maslach Burnout Inventory).

Consequently other scales were also developed such as Burnout Measure (Pines et al, 1981), Oldenburg Burnout Inventory (OLBI) and the Copenhagen Burnout Inventory (CBI). OLBI provided a measure of burnout that can also be used to measure the opposite phenomenon (engagement), and expanded the exhaustion component of burnout and its validity and reliability was tested in English (Halbesleben & Demerouti, 2005). Copenhagen Burnout Inventory (CBI) was developed as a longitudinal study of burnout in human service workers in Denmark (Kristensen et al, 2005). One of the newer developments in burnout research is the extension of the burnout concept by the positive job engagement, so that the full spectrum of workers' wellbeing can be studied (Engelbrecht, 2006).



## Difference between Stress and Burnout (Hart, 2008)

Stress	Burnout
Stress is characterized by over-engagement.	Burnout is a defense characterized by disengagement
In Stress the emotions become over-reactive	In Burnout the emotions become blunted
In Stress the physical damage is primary	In Burnout the emotional damage is primary
The exhaustion of Stress affects physical energy	The exhaustion of Burnout affects motivation and drive
Stress produces disintegration	Burnout produces demoralization
Stress can best be understood as a loss of fuel and energy	Burnout can best be understood as a loss of ideals and hope
The depression of Stress is produced by the body's need to protect itself and conserve energy	The depression of Burnout is caused by the grief endangered by the loss of ideals and hope
Stress produces a sense of urgency and hyperactivity	Burnout produces a sense of helplessness and hopelessness
Stress produces panic, phobic, and anxiety-type disorders	Burnout produces paranoia, depersonalization and detachment
Stress may kill you prematurely, and you won't have enough time to finish what you started	Burnout may never kill you but your long life may not seem worth

## Indian Experience

Despite significant growth and a bright future the Business Process Outsourcing (BPO) industry continues to suffer from high attrition levels for burnout. BPOs mostly cater to customers in the West and the time difference could vary from 8 to 12 hours on an average; never-ending night shifts; high work targets; repetitive nature of work; pressure to work on metrics; non-negotiable metrics; irate customers and insufficient holidays (E-SAT SURVEY, 2005). The BPO industry even has a name for it! BOSS (Burn Out Stress Syndrome) is seen very commonly among young people working in call centers. The symptoms of this syndrome include chronic fatigue, insomnia and complete alteration of 24-hour biological rhythm of the body.

Gastrointestinal problems are inevitable for those working at nights as the body is put under chronic stress. A potentially fatal increase in heart rhythm can result in severe chronic gynecological problems in women and sleep disorders in both men and women (Seshu, 2003). In another study on role of stress in the organizational context among technical and management students in Uttar Pradesh, it was found that the students were experiencing role overload (Agarwal & Chahar, 2007). Indian cricket team's burnout has been a major issue raised by the players (CNN-IBN, 2007). Burnout is common, with 3 out of 10 workers changing jobs every year. One in seven is forced to leave the industry altogether because of stress (Times Online, 2007).

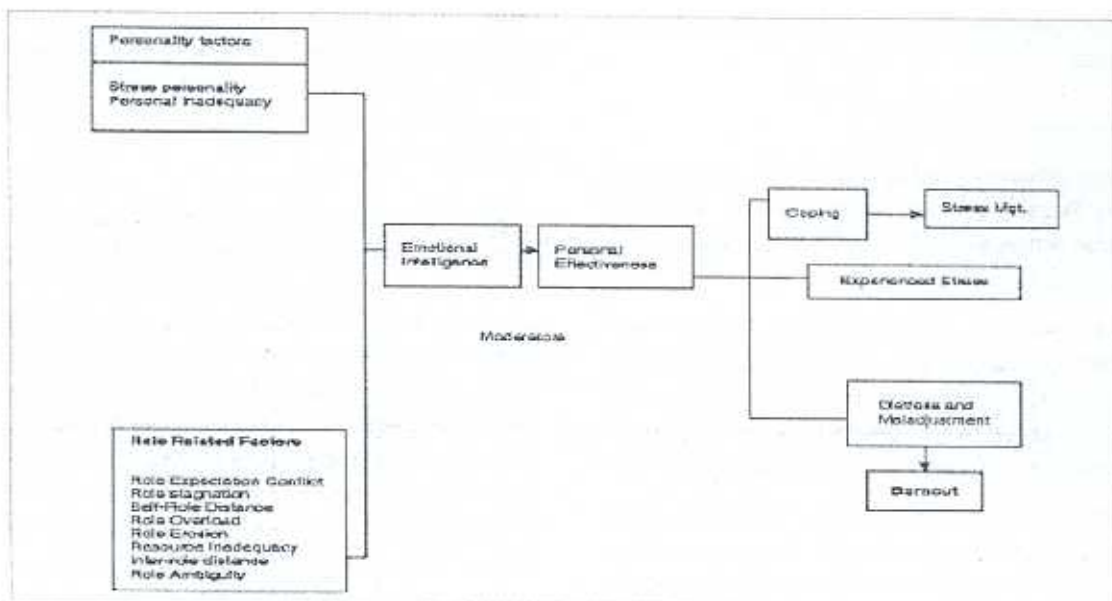


Figure1: Indian Model of Burnout (Adapted from: Sharma, 2007)

### Indian Model of Burnout

Sharma (2007) studied a sample of 300 middle and senior level executives, 75 each from manufacturing and service industry representing public and private sector organizations in India. However, in order to have a nationally representative sample, executives were selected from organizations having an all-India presence, across all the four regions, viz., north, south, east, and west. Sharma found that it was the incessant desire or situational compulsions to achieve more and more which led to burnout among executives.

He developed a scale called Sharma Burnout Scale (SBS) for an Indian sample and standardized for screening and identifying the cases of burnout or those that are prone to burnout among executives. He found that executive burnout is marked by persistent feelings of inadequacy, ambiguity, dissatisfaction, and powerlessness accompanied by behavioural manifestations of apathy and indifference (depersonalization) and physical and emotional exhaustion. He formulated a model that explains the contributing factors and moderators of executive burnout.

### Prevention

Various methods have been developed for prevention of burnout which can be simply summarized as (Bhargava & Acharya, 2006)

#### Measures at Individual Level

- You are dispensable
- Learn to relax
- Give time to family
- Shoulders to cry on
- Love your job
- Vacations are for taking
- Exit if you must

#### Measures at Organizational Level

- Create a fun culture
- Empower each employee
- Sense of belonging
- Job rotation
- Incentives and rewards
- Selection process review
- Exit interview

Research findings published by Bittman et al (2003) demonstrated that drumming could significantly reduce burnout and improve mood using a six-week program of Recreational Music-making (a protocol that included group drumming complemented by a Yamaha Clavinova keyboard). According to Bittman and his colleagues, this is the first study to address the practical human-resource applications of recreational music-making in a specific and quantifiable manner. The

study showed the following results:

Significant reduction in burnout based upon the Maslach Burnout Inventory (MBI)

Significant reduction in Total Mood Disturbance by 46 percent based upon the Profile of Mood States (POMS)

Sustained effect six weeks after sessions ended, with an increased reduction in Total Mood Disturbance of 62 percent

Estimated annual cost savings to institution of \$89,100 by reducing staff turnover

I would like to conclude that burnout still remains a less researched area in mental health in India and both post graduate trainees and their teachers should take initiative to develop a good database on burnout in the twenty-first century.

### Acknowledgement

This editorial is based on the introductory article in my forthcoming edited book *Understanding Burnout*. Hyderabad: ICFAI University Press, and my presentation at 34th Annual Conference of Indian Psychiatric Society, Eastern Zonal Branch on 18-19 Oct 2008 at Hotel Residency, Bodhgaya.

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## RESPONSE, REMISSION & RECOVERY: NEED TO REVIEW OUTCOME MEASURES FOR SCHIZOPHRENIA

Amresh Shrivastava<sup>1</sup>, Nilesh Shah<sup>2</sup>

### ABSTRACT

Schizophrenia is a complex neurobehavioral disorder known to be associated with poor outcome. It causes significant disability in patients and burden of care amongst relatives. Outcome in developing countries has been reported to be far better than western world, which has come into scientific scanner recently. Wide gap exists between expectations of outcome amongst patients, relatives, caregivers and professionals, which is possibly because of limitations in measurement tools. Significant number of patients remain marginalized without improvement in social & occupational functioning preventing their integration into mainstream of society despite 'clinically reported good outcome' and significant advancement in treatments. The contemporary outcome measure does not capture real-life situations. The concept of response, remission and recovery is being revisited scientifically. There is a strong need to develop culture specific, comprehensive and reliable outcome measures for schizophrenia, which reflects clinical and social outcome in multidimensional measures.

**Key words:** Schizophrenia, outcome measures

### INTRODUCTION

Patients with schizophrenia consistently show poor course and outcome than patients with other psychotic and nonpsychotic psychiatric disorders (Jobe & Harrow, 2005). A significant difference in the concept of outcome among patients, family members & clinicians has been observed (McCabe et al, 2007; Kooyman et al, 2007). Recently, outcome measures have evolved and now outcome is measured in domains of psychopathology, quality of life & level of functioning (Burns, 2007).

It is repeatedly observed that outcome shown in research studies does not reflect real-life outcome status or a state observed in naturalistic clinical settings. It is also reported that poorly defined cohorts and weak study designs have hampered cross-cultural comparisons of course and outcome in schizophrenia. Best outcome from different countries vary between 34 and 62%. By and large at ten years the outcome is not more than 40-50%. In fact a ten year follow up study from the National Institute of Mental Health, USA concluded good outcome to be around 20%. Outcome in schizophrenia is a multidimensional measure; therefore it needs to be performed on different parameters (Faerden et al, 2008). The measurement of outcomes has risen in prominence over the past 30 years (Ellwood, 1988; Lohr, 1988). Standardized instruments have been developed which measure clinical aspects of illness, and more recently 'patient based measures' have been developed. In schizophrenia, standardized instruments traditionally define disease severity and change in clinical status by counting the number and severity of symptoms and signs - such as delusions and hallucinations ('symptom based measures' - e.g. Brief Psychiatric Rating Scale (Overall &

Gorham, 1962)). Patient based measures, however, assess the impact of illness on the individual (Jenkinson, 1994). These are often referred to as health status, health related quality of life (HRQoL) or functional status measures (Bowling, 1997). They measure more than just clinical symptoms, since they incorporate combination of the following domains: 1) physical health, 2) mental health, 3) social functioning, 4) role functioning, 5) general perceptions of health and well-being, 6) cognitive capacity and 7) patient satisfaction. Outcome measures have come to be used for a number of purposes, which include: 1) the evaluation of the clinical and cost-effectiveness of interventions in experimental situations such as trials, 2) the monitoring of population health, 3) clinical audit and 4) facilitating clinical decision making in routine practice and patient care (Faden & Leplege, 1992; Fitzpatrick et al, 1992; Fitzpatrick, 1994; Ware, 1995).

### NEED FOR RE-EXPLORATION OF 'OUTCOME MEASUREMENTS'

The use of the term 'recovered' in outcome studies of schizophrenia has for a long time been problematic because of the many different definitions in use. While using the term (recovery) in the field of schizophrenia, a distinction should be made between symptomatic and functional recovery in order to place it in line with other fields of medicine particularly in long-term patients. It is suggested that the outcome needs to be measured on multiple dimensions, at least to reflect functional and symptomatic domains. There is wide consensus among researchers and clinicians that psychopathological domain alone does not reflect social situation. This attempt needs to be strengthened to capture real-life situations of patients in order to understand the factors, which prevent their social integration.



## INDIAN CONTEXT

It was generally accepted that outcome of schizophrenia in developing countries is more favorable though reasons for the same were far from clear (Thara & Eaton, 1996). In Indian situation acute psychosis in short term has been found to have excellent course and outcome; however the belief that psychotic symptoms in schizophrenia are not just temporary states and have long-term impact was also supported. There is no clear evidence if such patients were able to gain social integration or not. Currently, this evidence also has been challenged and it appears that schizophrenia outcome is not as good as shown in several studies in the past, particularly in developing countries (Drake et al, 2006; Meltzer, 1995; Priebe, 2007). A possible selection against the most severe forms of schizophrenia could account for greater occurrence of better-outcome phenotypes (Kulhara, 1994). It is crucial to identify patients experiencing their first episode of psychosis who are likely to have an unfavorable long-term outcome. It is often seen that the outcome seen in clinical trials is reflected in clinical situation less frequently because of a variety of reasons. There is a wide variation observed in outcome status in different cultures and geographical regions as well.

## LIMITATIONS

Clinical experience does show that patients suffering from schizophrenia continue to remain marginalized. They are seldom integrated in mainstream of society. A wide variety of outcome measures are used. The most frequent are clinical symptoms, hospitalization and mortality (direct indicators), and social/occupational functioning, marriage, social support and burden of care (indirect indicators). Areas such as cognitive function, duration of untreated psychosis, quality of life and effect of medication have not been studied in low and middle-income countries. Outcome in schizophrenia has many undesirable facets, longevity is reduced by 15 to 25 years, and mortality is high. About 40% of them die due to suicide and 60% die due to medical comorbidity; fewer than 10% remain in full-time productive employment. While documenting the heterogeneity in outcome and the generally poorer outcomes of patients with schizophrenia, studies also alert us to the danger of suicide and early death. In addition, they expose problems in clinical management and treatment and also help us anticipate the possibility of intervals or periods of recovery, some of which appear spontaneously and may be tied to individual patient factors such as resilience (Thara & Eaton, 1996). The routine measurement of outcome has not been without its critics (Crombie & Davies, 1997), and concerns have been raised that outcome measures are un-interpretable, unwieldy and a bureaucratic hindrance to successful patient care (Gilbody et al, 2002). One way in which the success or usefulness of outcome measures in everyday routine care might be judged is by evaluating

of the degree to which their adoption improves the outcome and quality of care. The results of research in other specialties has generally not been positive in this respect nor has the use of these measures been shown to improve the management of common psychiatric disorders in non-psychiatric settings (Gilbody et al, 2001). The measurement of outcome in the context of individual patient care is not without cost. Instruments must be developed, administered, coded, stored and retrieved - all of which have resource implication in terms of time, direct cost and opportunity cost. There is also a danger that outcome measurement triggers resource intensive interventions which are of no proven benefit to patients, and which might actually harm them. Perhaps, more subtly, there is also a danger that the uptake of outcome measurement in this context represents a marketing ploy, in which measurement is used to demonstrate an institution's 'customer orientation', but which does not inform the provision of care (Fitzpatrick, 1994).

## EVOLVING CONCEPT OF OUTCOME

Concern has been raised in the way we measure the outcome status. It has been widely recommended that outcome should be at least measured on two dimensions, clinical and social. Much work on quality of life, global assessment of functioning and assessment of disability has been in this direction. Long-term and short-term studies do measure outcome of different dimensions; however, clinical practice and routine assessment still does not incorporate these measures. A recent expert panel has proposed consensus criteria for remission in schizophrenia. They distinguished remission from recovery, noting that the latter outcome was likely to require not only remission of symptoms, but also improvement in cognitive and psychosocial functioning. The panel deferred the task of establishing operational criteria for recovery since there was insufficient research on the topic (McEvoy, 2008). Treatment success in schizophrenia is multifactorial. These factors can be conveniently grouped into 3 categories: treatment-related factors, patient-related factors, and environment- or system-related factors (Buckley, 2008). Description of the long-term outcome of schizophrenia cannot be summarized with just one outcome variable. Recovery is now a widely discussed concept in the field of research, treatment, and public policy regarding schizophrenia. It has increasingly become a focus in mainstream psychiatry. However, it has also become clear that the concept is often used in multiple ways, and lacks a strong scientific basis. Recently some important questions have been raised in the literature: 'Do patients of schizophrenia ever recover?' and 'What do we mean by recovery?'. The use of the term 'recovered' in outcome studies of schizophrenia has for long been problematic because of many different definitions in use. While using the term in the field of schizophrenia, a distinction should be made between symptomatic and functional recovery in order to place it in line with other fields of



medicine (Ng et al, 2008). 'Recovery' is now a widely discussed concept in the field of research, treatment, and public policy in schizophrenia. As it has increasingly become a focus in mainstream psychiatry, it has also become clear that the concept is often used in multiple ways, and it lacks a strong scientific basis. A scientific basis is necessary for the concept of recovery to have a significant long-term impact on the way that schizophrenia is understood and treated. This scientific agenda for recovery includes (Cohen et al, 2008):

- 1) Differences in definitions of recovery and the implications of studying recovery processes and outcomes
- 2) Key research questions
- 3) The implications of data from outcome studies for understanding what is possible for people diagnosed with schizophrenia
- 4) Factors that facilitate recovery processes and outcomes, and methods for studying these issues
- 5) Recovery-oriented treatment, including issues raised by peer support. The role of hospitals in recovery-oriented treatment remains unexplored. Consideration of these issues may help organize approaches to the study of recovery, and in doing so, improve the impact of recovery-based initiatives.

'Response' in strict terms is defined as 'Often a response is the result of a stimulus'. 'Remission' is defined as 'the state of absence of disease activity in patients with a chronic illness, with the possibility of return of disease activity'; while 'Recovery' may be seen within the model as a personal journey requiring hope, a secure base, supportive relationships, empowerment, social inclusion, coping skills, and finding meaning'. It is quite clear that recovery for schizophrenia is a state, which has not been given enough thought in terms of measurement. Parameters for recovery need to be scientifically defined based upon categories and dimensions that consist of the world of an individual suffering from schizophrenia.

#### MULTIDIMENSIONAL MEASUREMENT OF OUTCOME

A related development has been the introduction of formal 'needs assessment' tools in the care of those with severe and enduring mental illnesses, such as schizophrenia. Such needs assessment tools are intended to define health and social needs both at population level and, ideally, at an individual level (Thornicroft et al, 1992), so that healthcare provision might be more rational, responsive and 'appropriate' (Stevens & Gillam, 1998; Wright et al, 1998). Examples of individual patients' needs assessment tools for use in severe mental illness include the Camberwell Assessment of Need (CAN) (Phelan et al, 1995) and the MRC Needs for Care Assessment (Brewin & Wing, 1993).

Recently an expert panel has proposed consensus criteria for

remission in schizophrenia. They distinguished remission from recovery, noting that the latter outcome was likely to require not only remission of symptoms, but also improvement in cognitive and psychosocial functioning. The panel deferred the task of establishing operational criteria for recovery since there was insufficient research on the topic (Patel et al, 2006). Schizophrenia is different than mood disorder in course and outcome and any definition of remission in schizophrenia should reflect these characteristic differences. Schizophrenia has always been historically considered as an illness with no hope of recovery. It has been argued that refinement of knowledge regarding the clinical course of schizophrenia, improvements in psychotherapeutic techniques, and the introduction of antipsychotic medications began to alter this view, with consideration of possible parameters to define recovery appearing in the literature as early as 1983 (Ng et al, 2008). Psychosocial interventions including vocational therapies, family therapy, cognitive behavioral therapy, and rehabilitation have played a critical role in improving long-term outcome. Assertive case management has helped in preventing and resolving major social needs and crises in many western countries. Short-term outcome has been better in comparison to long-term outcome. Data also indicates that outcome deteriorates with time. In other words, there is a swing from recovery to non-recovery with passage of time, not necessarily relapse. Relapse is often accompanied by noncompliance with treatment or suboptimal treatment, which results in incomplete or uncontained symptom remission. Such condition may subsequently lead to chronic illness characterized by substantial morbidity and persistent deficits in cognition and psychosocial function. Some patients develop downhill course while others experience a relatively circumscribed deterioration (Issac et al, 2007).

It has also been reported that patient's perspective of outcome and recovery is far more different than clinician's and professional's perspective. In a study about stigma and discrimination in city of Mumbai more than 70% patients and more than 65% relatives expressed dissatisfaction about status of recovery in a group consisting of recovered patients with minimum 5 years of treatment and clinically classified as remitted by their respective physicians. It could not be ascertained whether these patients had the benefit of comprehensive pharmacological and psychosocial management involving a multidisciplinary team or not as they belonged to different clinical settings (Flyckt et al, 2006).

This discrepancy is a matter of concern for patients, care givers, relatives, researchers as well as service providers. It also needs to explore why such a gap in perception exists. It seems likely that if the individuals suffering from schizophrenia are integrated in main social stream at the end of the day, their expectations would be fulfilled and the gap would become narrow. In-depth analysis indicates that focus



of clinical setting often remains limited to response or remission in target symptoms and psychopathology while patients and caregivers wish to focus and aspire for family life, marriage, childbearing, employment, income generation and becoming free from liability of illness. It is in this direction that outcome measures need to be redefined in cultural context.

Recently there have been few attempts to look at this aspect scientifically, particularly from the working group of American Psychiatric Association (APA) on defining criteria for remission. Routine outcome measurement has been advocated as an adjunct to patient care within psychiatric services (Marks, 1998); where measures of psychiatric symptomatology might be applied in order to measure therapeutic response and to inform management decisions. In addition, broader measures of health related quality of life might also be usefully adopted. In the case of schizophrenia, impairments in quality of life and health status are often unrelated to the number or severity of symptoms (such as delusions and hallucinatory experiences) (Anthony & Rogers, 1995; Becker et al, 1993). This is especially important, since it is the level of symptomatology which forms the major focus of clinical consultations and practice, and is the major criterion by which the success or failure of treatment is judged in both practice and research (Revicki & Murray, 1994). Consequently, clinicians' perceptions of these wider problems are often poor and it has been empirically demonstrated that clinicians underestimate the health status or health related quality of life of patients when patients' and clinicians' ratings are compared (Becker et al, 1993; Lehman, 1983; Sainfort et al, 1996). The use of more comprehensive outcome measures, which capture both symptoms and wider health-related quality of life, might therefore be useful in identifying needs, monitoring clinical response and making clinical decisions in those with severe mental illness. The adoption of routine outcome measurement has also become central to government policy formulations. For example, in the UK, there have been a number of initiatives in recent years aimed at the introduction of outcome measurement tools into routine mental health practice, as part of a government health strategy to 'improve significantly the health and social function of mentally ill people'. In response, the Health of the Nation Outcome Scale (HoNOS) has been developed with a number of uses in mind, including the assessment of local service requirements and psychiatric morbidity at a population level (Wing, 1994). However, a key aim of the developers of the HoNOS is that it should be useful to clinicians in actual individual care planning, since without this feature it would not be widely used and the data which would ultimately inform decisions made at a population level would not be collected (Stein, 1999).

## MELTZER'S CRITERIA

Meltzer defined 13 necessary outcome criteria for assessment of schizophrenia (Meltzer, 1995)

- 1) Psychopathology (positive symptoms, negative symptoms & disorganization,
- 2) compliance,
- 3) hospitalization,
- 4) suicidality,
- 5) extrapyramidal symptoms,
- 6) interpersonal social function,
- 7) cognition (six subtests),
- 8) work and employment,
- 9) social burden,
- 10) independent living,
- 11) aggression,
- 12) quality of life,
- 13) family burden

However no study replicated to measure outcome of all these criteria. Attempts are required to successfully integrate this measure into composite scale for easy understanding to define how different parameters can be converted to point out meaningful measures of outcome. In a recent study we reported a global recovery rate of 62% as per Clinical Global Improvement Scale (CGI) at the end of ten year period; however when we applied all 13 multidimensional outcome criteria by Meltzer's the recovery rate dropped to 55% in a group of clinically recovered patients and to 32% in the main cohort available at ten years for follow up. Further, even the recovered patients had significant disability. Large number of patients (between 30-45%) were living with one or the other positive or negative symptoms, varying degree of suicidality, neuroleptic side effects, limited social and personal functioning and family burden in Mumbai, contrary to earlier reports (Shrivastava & Thakkar, 2008). Several international studies of long-term outcome show a variable rate of remission between 33% to 50% from developed countries.

## THE AMERICAN PSYCHIATRIC ASSOCIATION (APA) INITIATIVE

APA working group on remission criteria for schizophrenia has been a welcome move and much more is expected to be done. However in Indian conditions we require a culturally specific, sensitive, reliable, multidimensional outcome measure, which can be easily administered in wide variety of clinical setting by mental health professionals. Some of the important and relevant features of APA working groups highlighting conceptual framework, background and consensus criteria listed below are helpful in understanding the process of developing such a tool.



1. There now exists a range of pharmacological and non-pharmacological interventions with proven effectiveness, but with variable effect on specific disease features; pharmacological treatments are also characterized by substantial differences in the nature and severity of adverse effects. This variability highlights the need for and importance of establishing criteria for clinical improvement that can be applied across multiple treatment modalities and specific therapies (Andreasen & Olsen, 2005).
2. Although schizophrenia exhibits substantial heterogeneity with respect to severity and course over time, typical features of disease course have been summarized, with support from models presenting schizophrenia as a neurodevelopmental disorder with a substantial hereditary component. Attempts at early treatment have highlighted the significance of duration of untreated psychosis in first-episode schizophrenia (Kordy et al, 2002).
3. Although most patients improve significantly after their first episode is treated, the majority experience subsequent episodes, with only a small fraction being able to regain premorbid levels of functionality.
4. The APA practice guidelines reports a three-phase model of schizophrenia disease course, with the recognition that these phases merge into one another without clear boundaries. In this model, the 'acute phase', characterized by florid psychosis and severe positive and/or negative symptoms, is followed by a 'stabilization phase', during which symptoms recede and decrease in severity, and a subsequent 'stable phase' with reduced symptom severity and relative symptom stability.
5. According to these guidelines, 'the majority of patients alternate between acute psychotic episodes and stable phases with full or partial remission' although the operational criteria for remission remain undefined. Also unclear is the extent to which symptomatic remission must occur in order to achieve improved functioning and ultimately recovery and autonomy (Fallon, 1999).
6. Regardless of clinical course, it can be argued that current treatment perspectives are designed for, regrettably, preventing relapse, in contrast to therapy goals for which long-term symptom remission serves as a foundation for building functional gains.
7. The importance of defining a remitted state is highlighted by the observation that psychosocial therapies and rehabilitation are most effective when positive and negative symptoms are adequately controlled. The working group concluded that progress toward an operational definition of remission in schizophrenia is warranted at this time because of: a) The emergence of nuanced insights into the etiology, pathophysiology, and disease course in schizophrenia, b) the availability of effective psychotherapeutic and pharmacological options, c) the need to facilitate standardized comparisons across treatments and therapeutic modalities, and d) the opportunity that such a definition provides to elevate and more clearly articulate expectations on the part of patients, caregivers, and mental health providers for positive long-term outcome in schizophrenia.
8. Although the symptom-based criteria used in most of the studies represent a marked improvement over the generalized descriptions, the lack of consistent definitions prevents cross-study comparison and limits the generalization of results. Recent efforts to describe remission in schizophrenia have been based on longitudinal symptom evaluation combined in early-episode. However, most of these studies were not designed with the goal of establishment of operational remission criteria (Lieberman et al, 2001; Liberman et al, 2002).
9. The working group concluded that any definition of remission in schizophrenia should include a significant time component and be applicable to patients across stages of disease course. Categorical and dimensional approaches have important conceptual differences. Although categories divide patients into groups, dimensions divide symptoms into groups. Categorical approaches tend to have the problem that patients' disorders often do not present in classic "pure" forms. Dimensional approaches recognize the fact that symptom groups overlap in individual patients (Prevoo et al, 2003). It appears better to rest the definition of symptomatic remission on dimensional approach. The working group explicitly considered the incorporation of symptomatic, functional (activities of daily living, social relationships, employment, quality of life), and cognitive outcomes into the definition of remission. That is, functional improvement can occur in some patients in parallel with ongoing moderate symptoms, with some individuals developing coping mechanisms that enable them to function despite their illness.
10. Criteria: Three measurement scales were selected based on consensus: Schedule for Assessment of Positive Symptoms (SAPS), Schedule for Assessment of Negative Symptoms (SANS), Positive and Negative Syndrome Scale (PANSS) and Brief Psychiatric Rating Scale (BPRS). The SAPS, a 34-item scale used to assess positive symptoms in schizophrenia, is designed for use in conjunction with the 25-item SANS, which is used to assess negative symptoms (Yen et al, 2002). The Positive and Negative Syndrome Scale, is a 30-item inventory assessing the absence or severity of schizophrenia symptoms across three subscales (Andreasen & Olsen, 1982; Kay et al, 1987). The BPRS is an 18-item scale which is routinely used as screening tool (Overall & Gorham, 1962).
11. Based on an examination of these scales, the working group



identified appropriate criteria to serve as the basis for defining symptomatic remission in schizophrenia. In addition, the working group proposed that remission criteria might be described separately for positive and negative symptoms, to allow primary consideration of these symptom groups independently in the assessment of symptomatic remission. Specific items selected for consideration as criteria for remission in schizophrenia were chosen to map the three dimensions of psychopathology identified by factor analyses 1) Psychotism, 2) Disorganization & 3) Negative symptoms. With regard to severity, the working group consensus defined a score of mild or less (Positive and Negative Syndrome Scale item scores of  $\leq 3$ ; BPRS item scores of  $\leq 3$ , using the 1-7 range for each item; SAPS and SANS item scores of  $\leq 2$  simultaneously on all items) as representative of an impairment level consistent with symptomatic remission of illness.

12. Given the long-term course and intrinsic character of schizophrenia, the working group consensus defined a period of 6 months as a minimum time period of remission. Working group consensus provided that, in addition to meeting the criteria, individuals may remain in remission while experiencing minor changes in symptoms, in the absence of appreciable effects on daily function or subjective well being.
13. It was argued that data on cognitive dysfunction is less than adequate to incorporate it in outcome criteria.
14. Ongoing or emerging thoughts regarding self-harm or harm of others were considered to be a critical focus for clinical care. Implementation of these criteria should provide researchers and clinicians with a robust, well-defined outcome goal in the long-term treatment of schizophrenia, facilitating comparisons of effectiveness across therapeutic modalities.

Though these consensus criteria are very helpful, these have some limitations. The criteria address the features of symptomatic remission only, which is far from adequate. Social outcome has not been included possibly because research data on culture and region specific issues are not very robust. Similarly, cognitive dysfunction also does not find a place in outcome measures. It is being strongly argued to include cognitive dysfunction as a criterion for diagnosis in future diagnostic systems, DSM V and ICD-11. In this working group no consensus could be achieved regarding inclusion of cognition as outcome measure despite significant research data. Perhaps the data has not yet gained universal acceptance and rightly so. In a study we did not find significant cognitive impairment in a cohort of chronic schizophrenia with mean duration of 4.6 years (Shrivastava & Rao, 1995).

## Summary Implications for practice

The use of outcomes measurement in the context of routine care of those with schizophrenia is unsupported by robust clinical evidence of the clinical and cost effectiveness of this strategy. Clinicians should judge for themselves whether the measurement of outcome and need is a reasonable use of their finite time and resources when the true value of this approach has yet to be demonstrated. For people with schizophrenia, invitations and edicts to complete and collect complex outcomes measures, questionnaires and needs assessment tools have not yet been shown to improve the quality of the care that those with schizophrenia and related disorders will receive. For policy makers, attempts to use the results of outcome measures in planning the care of populations with severe mental illnesses are likely to be frustrated or of limited value, when so few clinicians collect and use these data in the care of their individual patients. Policy edicts to collect and use these data may not represent the best use of clinicians' and patients' time and finite healthcare resources.

We propose that measurement of schizophrenia outcome needs to be necessarily done on three dimensions: 1. Persistent symptoms & side effects, 2. Social functioning & Social burden, 3. Independent living and productivity. This may possibly reflect correct outcome and will also be helpful in research and designing service delivery.

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## AGGRESSIVE DRIVING AND ROAD RAGE: AN OVERVIEW

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### ABSTRACT

Last one and half decades have witnessed a significant rise of lay interest in issues pertaining to aggressive driving behaviors as well as a growing volume of research studies on related themes. The paper presents an overview of the empirical literature in this field. Plethora of terms used by researchers and their definitional ambiguities are highlighted. Apart from studies on prevalence of aggressive driving and road rage phenomena across the globe, the paper summarizes studies on factors associated with the same. The review suggests that both socio-demographic and personality factors have been extensively researched although interactions among variables have been less frequently examined.

**Key words:** Aggressive driving, road-rage, driving behaviors

### INTRODUCTION

Anger and aggression on the roads, road rage and issues related to aggressive driving behaviours have gained tremendous popularity in lay as well as scientific literature and social discourse (Asbridge et al, 2006; Burns & Katovich, 2003). Keying in the phrase "aggressive driving" and "road rage" on a common search engine at the beginning of the year 2008 yielded 2,39,000 and 39,60,000 entries respectively. This signifies the extent of interest in these phenomena in the public at large. Using the same phrases for search in an electronic database of scientific psychology journals brought up 296 and 435 articles on the topic of aggressive driving and road rage respectively. There is a possibility that research on these issues is disseminated amongst scientists through publications not comprehensively covered currently under journals in behavioural sciences. However, it is interesting to note that scientific attention to human factors in road traffic accidents can be traced back to several decades. Way back in 1940, Ross systematically reviewed 58,550 accident reports in Michigan states and concluded that only 10% of motor vehicle accidents could be attributed to mechanical problems and road conditions whereas human factors including drivers' attitudes and behaviours accounted for the rest. Ross (1940) went on to emphasize the role of socio-psychological interventions over and above mechanical improvements in road traffic accident prevention. Aggressive driving behaviours including engagement in traffic violations increase the risk of accidents apart from causing stress in fellow drivers that can manifest as /escalate into confrontations and injuries on the road. Galovski and Blanchard (2004) reviewed studies that suggest that environmental factors including background stress interact with driving- stress resulting in negative consequences on the road (driver aggression and accidents)

as well as on interpersonal and occupational functioning and health. Mann and colleagues (2007) based on an interview study found that perpetrators and victims of any kind of road rage as well as "serious" road rage have a significantly higher risk of collision involvement than those who did not report road rage experience.

### Definitional issues

Despite the extent of interest in the issues related to road rage and aggressive driving, a clear consensus among researchers on the definitions of related constructs is yet to emerge (Dula & Geller, 2003). Researchers have attempted to differentiate driver- aggression from assertive driving. Assertive driving has been defined as "time-urgent and self-oriented actions focused on personal progress in traffic including speeding and weaving, that can place other drivers in danger but are not intended to harm others (Hennessy & Wiesenthal, 2001). On the other hand, driver- aggression is described as any action that is intended to physically, psychologically or emotionally harm others in the traffic environment (Hennessy & Wiesenthal, 2001; Li et al, 2004). Though this conceptualization attempts to differentiate aggressive driving from assertive driving on the basis of absence of an intention to harm, yet, the above definition of assertive driving appears to lack the component of "being considerate of others" rights and safety" on the road.

Stradling and Parker (1997) differentiate problematic driving behaviours into "lapses" (e.g. relatively harmless though irritating behaviours like switching on one control when trying to turn on another), "errors" (e.g. potentially dangerous mistakes like misjudging a distance) and "violations" that are intentional behaviours committed with awareness



that one is engaging in a potentially dangerous behaviour (e.g., disregarding speed limit, jumping a traffic signal). Their examination of the available data suggested that those engaging in violations are at the highest risk of crashes and the outcomes of errors might be amplified in the presence of violations.

Very broad and over-inclusive definitions of aggressive driving focus on driving that endangers or is likely to endanger people or property and includes behaviours such as risky driving as well as violence. In some instances, the behaviours included in the definition of aggressive driving have been labeled as risky driving by others without a mention of driver aggression. James (1997) defined aggressive driving as driving under the influence of impaired emotional states that impose one's own preference level of risk on others. This is an example of a broad definition of aggressive driving. On the other hand, Rathbone and Huckabee (1999) argued for treating aggressive driving and road rage as different. They stated that aggressive driving included tailgating, abrupt lane changes and speeding whereas road rage referred to "an incident where an angry or impatient motorist / passenger intentionally injures or kills another motorist/passenger/pedestrian or attempts or threatens to injure/kill another motorist, passenger/pedestrian". Although the use of the term road rage has been popular in media especially in mid 1990's, researchers have tended to prefer restricting the use of the term to extreme behaviours within the rubric of aggressive driving. A scan in the literature makes it evident that road rage is difficult to define. It is not clear as to exactly when or by performance of what kinds of acts (e.g. acts causing physical injury or death) aggressive driving slips into an act of road rage. The initial, conservative use of the term road rage referred to perpetration of an act of criminal violence by a motorist. Unfortunately, the term has been used rather loosely in the media and law enforcing agencies referring to all kinds of aggressive driving behaviours (Davis & Smith, 1998). Fumento (1998) used media amplification theory (Cohen, 1972) to argue that road rage was a media invention rather than a reality.

In an attempt to bring more clarity to the use of the term road rage, Goehring (2000) regarded aggressive driving as a traffic offense and road rage as a criminal offense; defining the latter as "an assault with a motor vehicle or other dangerous weapon by the operator/passenger of one motor vehicle on the operator/passenger of another motor vehicle or vehicles precipitated by an incident which occurred on the roadway". Sarkar et al (2000) utilized a categorical system to describe various driving behaviours: speeding alone, aggressive driving-1 (speeding and any other type of unsafe driving behaviour), aggressive driving-2 (weaving and cutting through traffic without speeding), aggressive driving-3 (tailgating). The last category included road rage which included: verbal harassment, threats, obscene gesturing, flashing high beams, horn honking, malicious braking, firing gun shots, hitting vehicles, chasing a vehicle and trying to run it off

the road. Dula and Geller (2003) reviewed numerous definitions and inconsistent usages of the terms road rage and aggressive driving and suggested elimination of the term road rage in scientific literature. They opined that due to its multiple connotations and usages, it is unlikely to be applied in a consistent fashion. They advocated the use of the phrase "dangerous driving" to encompass the entire behavioural spectrum in question and defined it as any behaviour that endangers or has the potential to endanger others. They pointed out that three classes of dangerous driving have been labeled aggressive driving in the literature: 1. Intentional acts (physical, verbal, gestural) of bodily and/or psychological aggression towards other drivers, passengers or pedestrians. 2. Negative emotions experienced during driving (frustration, anger, rage, dejection, jealousy etc.) 3. Risk taking behaviours (undertaken without the intention to harm self/others). Risky behaviours may occur without the presence of intention to harm or experience of negative emotions. Negative behaviours experienced while driving may affect vigilance while driving and result in unsafe situations. Though frustration and anger often precede aggression, one could experience these emotions without behaving in an aggressive manner. Considering the above elaborations, they proposed to define aggressive driving as "any behaviour that is emitted by a driver while driving that is intended to cause physical and/or psychological harm to any sentient being".

Tasca (2000) reasoned that road rage involved hostile behaviour intended to cause physical harm and should be excluded from the definition of aggressive driving so that the focus remains on behaviours that are more frequent and are amenable to traffic safety interventions. It was also proposed that the definition of aggressive driving should include willful, deliberate behaviours (not unintended result of medical condition, mental lapse or error). In line with the above reasoning, the following definition was offered "a driving behaviour is aggressive if it is deliberate, likely to increase the risk of collision and is motivated by impatience, annoyance, hostility and/or an attempt to save time".

### Prevalence Estimates

It has been estimated that in USA, there may be about 400 billion hostile exchanges between motorists in a period of one year alone (James & Nahl, 2000). A report by American Automobile Association Foundation for Traffic Safety (1997) estimated that incidents of aggression on the roads were rising and that there was more than 50% increase between 1990 and 1996. Jouzaitis (1998) reported that 90% of motorists indicated that they had encountered road rage in 1996 but only 6% admitted to engaging in such behaviours. Scientific literature on road rage /aggressive driving has been emerging from various countries other than USA, such as Canada (Asbridge et al, 2003), Australia (Harding and colleagues, 1998), New Zealand (Brewer, 2000) and the UK (Joint, 1995). A study in Ontario (Smart et al, 2003) indicated that in the one year duration before the study,



nearly 50% of the drivers were cursed at, shouted at or had rude gestures made at them and 7.2% were threatened with damage to their vehicle or personal injury. In the same sample, only about one third of the respondents admitted to shouting, cursing at someone and about 2% reported having threatened to hurt someone or damage their vehicle. On the other hand, another survey report from Ontario (Smart et al, 2005) suggested that proportion of adults experiencing any road rage victimization decreased from 2001 to 2003 (47.5 % to 40.6 %) but the proportion reporting any road rage perpetration remained stable at about one third, during the same period. Based on the pattern of findings the authors hypothesized that reports of victimization may in part reflect media attention to aggression on the roads whereas the stable reports of perpetration may be more reflective of driving congestion and stress. Most episodes of driver aggression are likely to be mild and tend to be used to communicate to other road users that they are angry (Ward et al, 1998). Although road rage/extreme forms of aggression on road appear to be infrequent, milder forms of aggression are very commonly reported. Parker et al (1998) reported that only 11% of their sample participants claimed that they had never engaged in: chasing another driver, sounding horn to convey annoyance or indicated hostility in some way to another driver. In a diary study by Underwood et al (1999), 85% of the drivers reported having experienced anger while driving during a 2-week-study period. There is some evidence to indicate that perpetrations and victimizations frequently co-occur in individuals. Road rage perpetrators, in the study by Asbridge et al (2003), were five times more likely to report victimizations in comparison to non-perpetrators. Published research studies on commercial vehicles are very few. One survey from Pakistan (Shah et al, 2008) reported a very high prevalence of road rage victimization and perpetration among bus and wagon drivers.

As far as the Indian scenario is concerned, a recent review of relevant research output revealed that only 0.8% of the health research from India in the PubMed database was on injuries; road traffic injuries being 0.01 %. This is notwithstanding the fact that injuries are estimated to be responsible for 17% of the health burden in India (Dandona et al, 2004). Gururaj (2005) extensively reviewed the available literature on injuries and related burden in India and observed that pedestrians, riders and pillion riders of motorized two-wheelers and bicyclists are the most vulnerable groups as far as road traffic accidents are concerned. Nearly 75% of deaths and injuries occur among them. Thirty to forty per cent of total deaths and injuries occur among motorized two-wheeler riders and pillion riders due to absence and poor enforcement of laws related to helmet use. The report also indicated that high speeds, alcohol consumption by road users and the absence of traffic coordination are some of the key factors. The number of deaths from road traffic accidents was the second highest in South East Asia region of the WHO study in 2002 and these were mainly accounted for by India (Peden et al, 2004). In this background,

it needs to be noted that there are less than a handful of studies on psychosocial perspectives on aggressive driving and road rage from India. According to a recent survey by LeasePlan, a global vehicle leasing and fleet management company (excerpts of which appeared in Financial Express newspaper report by Doval (2007), 76% of the drivers surveyed across 16 countries (e.g. Germany, Spain, Denmark, the Netherlands, Sweden, Australia, India) felt that traffic congestion levels were serious. India was second on the list of reported congestion on the roads. In India, drivers driving in the wrong direction (64%), those jumping the queues (61%), too much honking (57%) and aggressive driving (51%) were described as the main causes of road rage.

It is important to note that motorized two and three-wheeler vehicles are likely to have the highest growth rate in Asian countries. Two wheelers account for eighty percent of all the non-transport motor vehicles in India (Government of India, 2004) and pedestrians and two wheeler riders are the two most vulnerable groups for road traffic injuries in India as compared to car drivers (Dandona & Mishra, 2004). However, there is a very significant dearth of research attention on aggressive driving and road rage phenomena in two and three wheeler riders. A recent survey of more than 4000 motorized two wheeler riders in a metropolitan city in South India reported on risky behaviours of drivers (Dandona et al, 2006). Eleven percent had not obtained a driving license and twenty one percent had obtained one without taking the mandatory driving test. Roughly 60% reported committing a traffic law violation (e.g. violating red light, no - turn, no entry zone and traffic direction) at least once within the last three months.

#### Factors associated with aggressive driving and road rage

**Traffic congestion:** In the Leaseplan company survey report mentioned earlier that was released in Indian newspapers in 2007 (Doval, 2007), 71% of the drivers across 16 countries reported that congestion level in their countries was serious and 41% reported that it was very serious or critical as compared to 39% reporting the same in the 2002 survey. India was second to Greece in terms of reported level of congestion, 72% rating congestion to be very serious/critical. There are somewhat inconsistent reports about the relationship between traffic congestion and driver anger and aggression. In view of these inconsistencies, Sharkin (2004) hypothesized that there may be interaction effects in as much as that some individuals may be more predisposed to respond with anger under condition of congestion and impedance. Also, aggressive responses may depend upon whether one perceives impedance to be a result of another driver versus other situational conditions.

**Driving and vehicle related variables:** Smart et al (2004) studied the demographic variables in relation to driving exposure and vehicle factors in a population survey of 1,631 regular drivers in Ontario,



Canada. Regression analyses revealed that number of times drivers reported experiencing road rage in the previous 12 months was significantly greater for males and younger respondents. Also, victimization was significantly greater for drivers on busy roads and increased with number of kilometers driven on a typical week. The type of vehicle was not related to victimization. Road rage perpetration increased significantly with number of weekly kilometers driven and was significantly greater for drivers who were always on busy roads and lower for those who never drove on busy roads, and higher for high-performance vehicle drivers. The researchers speculated that drivers of high performance vehicles might experience more frustration when they were prevented from using the full performance capacities of their vehicles on crowded urban roads.

In a questionnaire study of British drivers, Lajunen et al (1999) reported that younger drivers and those with low driving exposure experienced high anger in three kinds of situations: progress being impeded, reckless driving by another person, and direct hostility of another person. Parker et al (2002) reported data from three European countries that suggest that impatient driving was most likely to elicit a reaction and the single behaviour of another person most likely to provoke anger was another driver taking the parking spot one has been waiting for. Parker (2004) presented data that 65% of the drivers reported that they would express anger in some way with horn honking, flashing lights, gesturing or swearing if someone cut and took the parking spot they were waiting for. Twenty percent of the respondents reported that they would be prepared to get out and argue or engage in physically with the other driver in such a situation.

**Individual differences in aggressive driving:** Although situational and environmental factors such as traffic congestion, poor conditions of the roads, amount of time spent in commuting, aggressive stimuli on the road, etc. have been discussed as some of the key risk factors for stress, anger and aggression on the roads; individual variables such as socio-demographic profiles and personality variables of drivers have attracted a lot of attention from researchers.

**Socio-demographic factors:** Two socio-demographic variables, age and gender, have been examined the most. The Department of Environment, Transport and Regions (DETR, 2000) findings revealed that males in the age range 30-59 years were the maximum users of road and this age group had the highest number of victims of road rage. Wright et al (1997) found that men were more likely to perpetrate acts of aggression on road and the bulk of offenders (92%) were adult males. The available research indicates that young adults as compared to older adults display more violation of safe driving norms, slower perception of risk, more dangerous errors and violations (Retting & Williams, 1996). Young drivers have also been reported to experience more irritation and annoyance and aggressive behaviours when faced with traffic congestions (Shinar, 1998). Sharkin (2004)

reviewed several studies that indicate that men commit more dangerous traffic violations, react more aggressively to congestion and to reckless, inconsiderate and impatient driving of others. However, this review also indicated that there are studies that do not show gender differences. Lonczak et al (2007) attempted to examine risky driving outcomes as a function of prioritized risk factors and the role of gender as a moderator. Moderation analysis indicated that positive association between drinking frequency and driving anger was stronger for women.

**Personality variables:** The following section provides a brief description of personality variables that have emerged as important in increasing the propensity for aggressive driving.

**Driver anger and general trait anger:** Deffenbacher et al (2005) applied the state-trait anger theory to driving situations. They proposed that trait driving anger referred to a person's general propensity to become angry when encountering provocation and frustration on the road. State driving anger would refer to one's physiological and emotional arousal when encountering a specific event or series of events on the road. They found that drivers (college students) high in trait driving anger were more frequently angered in day to day driving, reported more intense anger in visualizing provocative scenes and in day to day driving and engaged in more aggressive behaviours than low anger drivers as revealed through driving diaries and surveys. Also, high trait anger drivers reported handling of anger less well when visualizing provocative events and experiences more violations, close calls and loss of concentration though not more of minor/major accidents. These differences between high and low anger drivers did not appear to be explained by amount or frequency of driving (Deffenbacher et al, 2003b). The study results also indicated that those high on trait anger had elevated general trait anger, impulsiveness as well as problematic general anger expression styles. Other studies suggest that high anger drivers are also generally more anxious (Deffenbacher et al, 2003b). Comparisons of reports of anger everyday and in driving situations were the focus of attention in yet another study by Lawton and Nutter (2002). The findings of this Internet based survey indicated that by and large people were equally likely to report anger in driving and non-driving situations. Only 11 % of the sample reported higher anger in driving than in non-driving situations while 14 % reported high anger in non-driving than driving situations. Deffenbacher et al (2003b) differentiated high-anger-drivers who perceived driving-anger to be a problem ("high-anger/problem drivers") from those with a) high-anger-drivers who did not perceive/acknowledge it to be a problem ("high anger/no-problem drivers") and b) low-anger drivers. "High anger/problem drivers" did not differ from "high anger/no-problem drivers" on reports of aggression in a 3-month survey or in response to visualized provocations. However, "high anger/problem drivers" reported more violations than the other two groups and more minor accidents than



low-anger drivers. They also reported more general trait anger, more anger-out and less anger-control than high anger/no problem drivers. This pattern of findings suggested that more extreme aggression may be associated with natural real-life consequences of aggression (e.g. aggressive incidents, close calls etc.) leading to heightened perception of lack of control and motivation to take help of a counseling opportunity.

**Other personality attributes:** Way back in 1956, McGuire compared accident and violation free drivers with accident and violation-incurring drivers using MMPI and Picture Frustration study. The unsafe drivers had significantly higher scores on psychopathic deviate and schizophrenic scales of MMPI. Also, the unsafe drivers group had higher scores on Ego-defensive and need-persistent scales of the Picture Frustration Study. However, neither group produced responses in the clinical range.

Matthews et al (1991) examined the association between personality dimensions and driver stress across four studies. Neuroticism was found to have a significant correlation with driver stress and aggression. It was suggested that ineffective coping strategies might mediate the relationship between neuroticism and driver stress.

Tsuang et al (1985) reviewed the literature on personality and incidence of psychopathology in traffic accidents. They concluded that there were noticeable trends for association between traffic accidents and certain personality variables including less control over anger and hostility, low tolerance of tension, low maturity, conformity, tendency to take risks and difficulty with authority. The role of psychopathology was found to be rather unclear though there seemed to be a general agreement regarding higher incidents of traffic accidents in people diagnosed with personality disorders and paranoid ideations. Beirness (1993) noted, based on a review of literature, that thrill-seeking, impulsivity and hostility/aggression has been consistently related to involvement in traffic accidents, violations, speeding and drinking and driving.

Parkinson (2001) used retrospective recall of recent experiences of anger on and off the road to examine situational and individual-difference variables in experience of driving anger. It was found that ambivalence over emotional expression was positively associated with driver aggression. The authors surmised that people who want to express anger but are sensitive to social costs involved may be more likely to exhibit aggressive tendencies while driving rather than in face to face interpersonal situations as the costs are likely to be more in the latter situations. Empathic concern as an individual difference variable was found in this study to be related positively to driving anger but negatively to driving aggression. The authors tentatively put forward the interpretation that high empathy may make people more prone to anger when they perceive others to be endangered by a motorist's behaviour

though being sensitive to others, well being, they may show less aggressive responding in the face of anger.

Britt & Garrity (2006) reported that agreeableness was negatively correlated to aggressive behaviour in three driving situations namely, being tailgated, being cut off and inability to pass because of a slow driver. Conscientiousness was negatively related to aggressive behaviours in two of the three driving situations. Both narcissism and extraversion were related to aggressive behaviours in encounters with a slow driver scenario.

In a study in an Indian metropolis, a group of drivers who were legally identified as offending drivers and had to undergo a refresher-training course were compared to a matched group of drivers with safe records. It was observed that offending drivers as compared to the other group, had significant problems in discriminating between controllable and uncontrollable outcomes of situations, were more likely to perceive demands as threatening rather than challenging, were lower in use of positive strategies for emotional regulation and were also higher on a measure of predisposition to aggression (Sanyal & Dasgupta, 2006).

A few researchers have attempted to identify subgroups of drivers based on combinations of several personality attributes. Ulleberg (2002) identified six subtypes of young drivers in a sample from Norwegian countries. These subtypes were noted to be different on risky driving behaviours (self reported), attitudes towards traffic safety, risk perception, self-estimation of driving skills and involvement in accidents. Sensation seeking, normlessness, driving anger, altruism, anxiety and aggression were the personality variables used for arriving at the different clusters in this study. Importantly, it was reported that the two high-risk groups identified differed on their evaluation of and response to a traffic safety campaign.

Matthews et al (1991) extensively reviewed the multiple pathways connecting personality and driving behaviours. These pathways / mediators include differences in cognitive appraisals, arousal levels, preferred level of stimulation, and sensitivity to threat or reward cues etc.

**Driver stress and moods:** Several factors such as immobility of body, constriction, lack of control, territoriality, multi-tasking, ambiguity of communications with commuters from diverse backgrounds etc have been cited as potential stressors while driving. Hennessy and Wiesenthal (2001) reported that drivers who have a predisposition to view driving as generally stressful tend to report more driving aggression as compared to other drivers. It has been proposed that driving stress may impact on appraisals of driving situations and interact with other factors to result in aggressive driving (Hennessy & Wiesenthal, 1999). Garrity and Demick (2001) reported that



temporary mood states such as depression-dejection, anger-hostility, tension-anxiety and fatigue-inertia were negatively related to cautiousness while driving in a driving task situation.

**Attributional processing:** Britt and Garrity (2006) observed that there was dearth of studies in the road rage literature on the role of attributions although attributions are heavily emphasized in general literature on aggression. Attributions regarding one's own behaviours and that of other motorists can influence aggressive behaviours on the roads. Baxter et al (1990) noted that while committing traffic violations, drivers tend to attribute their own behaviours to situational factors but are more likely to attribute a violation committed by other drivers to dispositional factors. Such an attribution bias is likely to become a potential source of aggression as people underestimate the role of their aggressive driving in angering others. In the study conducted by Britt and Garrity (2006), attributing causality for the anger-arousing event to a stable factor in the offending driver was found to be a unique predictor of anger and aggressive behaviours across different driving scenarios.

Matthews and Norris (2002) found that individuals high in trait aggression attributed greater hostility to other drivers in driving scenarios that were presented in an ambiguous fashion without clarity about other drivers' intent. The authors also reported that attributions and personality variables uniquely/independently predicted outcomes.

**Self-presentation style:** Self-presentation, also known as impression management, has been defined as "actor's shaping of his/her responses to create in specific others an impression that is for one reason or another desired by the actor" (Jones & Pittman, 1982). It has also been theorized that there are likely to be individual differences in terms of strengths of different kinds of self-presentation strategies. Bassett et al (2002) applied the self-presentation framework to understanding behaviours while meeting a stranger and while driving. It was found that aggressive driving behaviour positively correlated with "intimidation" and negatively with "ingratiation" and "exemplification" as self-presentation styles. Thus, it appears that those who want to be seen as tough and dominant may report more aggressive driving whereas those who want to be seen as friendly or with high moral standards may report less aggressive behaviours while driving. Martin and Leary (2000) reported that among college goers, risky behaviours including dangerous driving were motivated by self-presentational concerns. Dangerous driving was associated with wanting to be seen as brave and being a risk taker and was employed as a self-presentation tactic in about a quarter of the participants in their sample. Further studies are needed to clarify as to whether self-presentation styles influence actual driving behaviours or mainly self-report of driving behaviours.

**Psychiatric and Substance use related factors:** Butters et al (2006) observed that psychiatric distress on the GHQ significantly increased the odds of both road rage victimization and serious road rage involvement. A review by Gaiovski and Blanchard (2004) indicated that rates of Axis-I and Axis-II psychopathology (intermittent explosive disorder, substance abuse, antisocial and borderline personality disorders) may be higher in aggressive as compared to non-aggressive drivers. Several studies have linked road rage behaviour and impulse control disorders. Jerome et al (2006) presented a meta-analysis and a critique of Attention deficit hyperactivity disorder (ADHD) and driving risk. They reported that there was a correlation evidence of a potential relationship between ADHD symptoms and driver anger and aggression in college students. Individuals with ADHD reported more driving anger and aggressive expression through vehicles than their non-ADHD counterparts (Richards et al, 2006). Mann et al (2004) found that both victims and perpetrators were more likely to report alcohol related problems. Yu et al (2004) examined a sample of individuals undergoing treatment for alcoholism in the context of a drinking-driving related reason. They reported that it was "driving while experiencing ability-impairment" rather than frequency of alcohol use that was the crucial correlate of aggressive driving. Fong et al (2001) provided data from a cross sectional study of individuals attending general practice clinics in UK. Perpetrators as well as victims showed increased psychiatric morbidity as compared to controls. Aggression scores were elevated among perpetrators and perpetration was associated with male gender, illicit drug use and less driving experience.

Police psychologists in New Zealand (Wright et al, 1997) reported that four categories of factors operate together to influence road rage behaviours. These include precipitating factors, offender factors, victim factors and environmental factors. The interactions between person and situational variables were well illustrated in the study by Deffenbacher et al (2003a). In low impedance situations, high trait anger and low trait anger drivers did not differ on state anger or aggression though the former drove at higher speeds. In high impedance situations, the high anger drivers showed greater state anger, verbal and physical aggression as well as higher crash risk.

**Values:** Crimmins and Callahan (2003) poignantly described the role of values as one of the potential determinants of road rage. They stated, "The tendency towards road rage arises not only from what we endure in life, but also from what we want out of life". They reported that after controlling for age, gender and education, drivers who endorsed statements such as "would try anything once" and "like the feeling of speed" showed 38 % higher frequency of exhibiting a crude display of anger namely "giving a finger". Lupton (1999) explored the socio-cultural and psychodynamic meanings of cars as objects and of driving as a practice. They pointed out that advertisements as well as owners anthropomorphize cars and the dominant socio-cultural images of a car involve freedom, power and



eroticism that arouse desire and invoke certain emotional states. Such meanings lay the ground for frustration and anger on the road when others seem to intrude into the personal space of one's "hybrid machine-body".

## EVALUATION AND CONCLUSIONS

On the whole, it appears that road rage is a term that has been more popular in the lay literature and media than in the scientific literature though it is recognized at least by a section of researchers, to be a useful term to describe incidents of extreme aggression by motorists. Aggressive driving has been defined in different ways by different researchers. However, there is one common feature that seems to underlie most definitions of aggressive driving and differentiate it from other kinds of risky/unsafe driving behaviours: "verbally, non-verbally and/or physically aggressive behaviours carried out with an intention to cause psychological and/or physical harm to the fellow motorists and/or pedestrians and often involving an experience of anger. The problematic aspect of applying these definitions is that it is not easy to assess "intention to harm". Assessment of "intention" has to be either through reliance on subjective reports or through an inference based on observations of aggressive behaviours. Self-reports in these contexts can be biased due to operation of socially desirable responding and indirectly inferring intent through behavioural observations can have its own pitfalls as it assumes a clear motive to harm in all instances of occurrences of specified behaviours. Another difficulty posed in such definitions is that the term "intention" may be assumed to indicate a deliberate response. However, in experiences of anger, aggressive behaviours may be learned reactions that are seen as automatic over which individual experiences little control or a sense of choice rather than as reasoned/ effortful responses enacted with a full sense of control. An inclusion of the element of "potential emotional dysregulation/ loss of control over anger" in the definition of aggressive driving seems to offer two advantages: It covers the entire range of possibility i.e., an aggressive behaviour carried out with full awareness and a sense of control as well as one emitted as result of losing control over the emotional response. Secondly, such a definition is likely to be more acceptable and enhance readiness for interventions among motorists who are able to construe their aggression on the road as stemming from a problem with managing anger. Another issue on which more consensus is needed is whether the definition of aggressive driving should incorporate a range of negative emotions and not merely anger.

There are conflicting reports regarding prevalence of aggressive driving and road rage, mostly due to lack of uniformity in defining, sampling and assessing these phenomena. There has been a definite rise in media attention on aggression on the roads from the nineties onwards. However, it is unclear whether this is reflective of actual increases in instances of "road rage" or increases in reporting. The

prevalence of aggressive driving has probably risen compared to the early nineties with rise in traffic congestion in various countries; however, whether the rates are consistently increasing /have remained stable from year to year is a question that is yet to be clearly answered. Indian research on aggressive driving from a psychosocial perspective is extremely limited though there are studies on road traffic accidents and unsafe driving. Published research studies on two-wheeler and three wheeler riders, buses and multi-utility vehicles are conspicuous by their rarity in global as well as Indian literature although perspectives and accident databases in India indicate the need to focus on these groups.

Although it is well accepted that aggressive driving behaviours are a product of multiple factors, interaction effects among variables have been infrequently addressed in research. A scan of the literature suggests that the research has focused on anger mostly in the context of aggressive behaviours on the roads at the cost of relative exclusion of examining anger on the road that does not manifest itself in the form of aggressive driving and the methods adopted to manage anger in such instances. Similarly, McDonald (2006) based on an extensive review, recommended the need for scientific enquiry on the construct of "respect on the road". Such a strength perspective in research is likely to complement the currently popular approaches in providing leads for intervention planning.

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## NATIONAL MENTAL HEALTH PROGRAMME IN INDIA: AN UPDATE

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### ABSTRACT

Nearly 10% of the Indian population suffers from psychiatric disorders that require some form of help. Given the fact that India constitutes 1/6th of the world population, this 10% figure translates into mammoth numbers, necessitating the need for a comprehensive mental health care delivery programme. With this objective in mind, the Ministry of Health and Family welfare launched the National Mental Health Programme (NMHP) in 1982 to ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future. The programme failed to gain the desired momentum in the initial years and the progress was tardy. Following the success of the Bellary model of mental health care delivery carried out by National Institute of Mental Health and Neurosciences (NIMHANS) in 1984, the District Mental Health Programme with a community based approach was launched in 1996 under the NMHP. Though the DMHP appeared very pragmatic, it failed to bring the desired momentum to the NMHP. Later, legal injunctions from the Supreme Court of India and the interventions by the National Human Rights Commission about the plight of the mentally ill brought some life to the programme in the form of proper budgetary allocations and expansion of the District Mental Health Programme. Though significant work has been done in the past two and a half decades in terms of development of infrastructure and dissemination of information, a lot remains to be done to "ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future".

**Key words:** *National mental health programme, district mental health programme, national human rights commission report, national survey of mental health resources, national mental health policy, Erwerdi fire.*

### INTRODUCTION

The past century witnessed significant achievements in the treatment and prevention of communicable diseases worldwide. This development has made it possible to focus on non-communicable diseases which now constitute the major health problem across the globe, more so in the developed world. Among the non-communicable diseases, mental and behavioral disorders have profound implications on the health and well-being not only of individuals but also of families and entire communities. Globally, the prevalence of mental and behavioral disorders was about 10% accounting for 12% of the total disability adjusted life years (DALYs) lost to all diseases and injuries in 2000 and the burden is projected to reach 15% by 2020 (WHO, 2001). The epidemiological studies from India present a similar picture with nearly 1% of the population suffering from serious mental disorders and 5-10% from moderate disorders, requiring psychiatric help (Gururaj & Isaac, 2004). To cater to this increasing number of mentally ill people, the national mental health programme was launched in 1982 to develop infrastructure and manpower for delivery of mental health care services. This paper aims to review the progress of the national mental health programme in the past two and a half decades.

### NATIONAL MENTAL HEALTH PROGRAMME (NMHP) IN INDIA: THE BEGINNING

#### The Evolution of the Programme

The epidemiological studies carried out in the post independence period in India, contrary to the commonly held beliefs of low psychiatric morbidity in this tranquil community, revealed an alarming magnitude of psychiatric disorders. This humbling reality, together with developments in various fields including the Alma Ata declaration on primary health care, the commitment of the country to provide health services to all and the availability of a large infrastructure for general health services, led to the realization of the need of a comprehensive policy regarding mental health. In order to devise a comprehensive mental health care programme, an expert group was formed in 1980, who after a year of deliberations prepared the first draft of the NMHP in February, 1981 at Lucknow. This draft was later discussed in detail by people from different walks of life at two workshops held in Delhi on 20-21 July, 1981 and 2nd of August, 1982 leading to the development of the final draft which was submitted to the Central Council of Health on 18-20 August 1982, for its adoption as the NMHP for India. A resolution was adopted that:



"Mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of health, education and social welfare. Realizing the importance of mental health in the course curricula for various levels of health professionals, suitable action should be taken in consultation with the appropriate authorities to strengthen the mental health education components. While appreciating the efforts of the central government in pursuing legislative action on Mental Health Bill, the joint conference expressed its earnestness to see that the bill takes a legal shape at the earliest" (Murthy, 2004).

### The Programme

The NMHP provided comprehensive details about its objectives, approaches and set targets to be achieved in a stipulated time. The objectives outlined were:

- To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population,
- To encourage the application of mental health knowledge in general healthcare and in social development, and
- To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The approaches to the statement of programme objectives outlined in the NMHP were:

- Diffusion of mental health skills to the periphery of the health service system,
- Appropriate appointment of tasks in mental healthcare,
- Equitable and balanced territorial distribution of resources,
- Integration of basic mental healthcare into general health care services,
- Linkage to community development,
- Mental healthcare,
- Mental health training, and
- Mental retardation and drug dependence.

The plan of action aimed at achieving the above objectives consisted of a set of targets (goals), and of detailed activities that included:

- Within one year, each state will have adopted the present plan of action in the field of mental health.
- Within one year, a task force will have worked out the outlines of a curriculum of mental health workers identified in the different states as the most suitable to apply basic mental health skills, and for medical officers working at Primary Health

Centre (PHC) level.

- Within five years, at least 5,000 of the target non-medical professionals will have undergone a two-week training programme on mental healthcare.
- Within five years, at least 20% of all physicians working in PHC will have undergone a two-week training programme in mental health.
- The creation of the post of a psychiatrist in at least 50% of the districts within five years.
- On the recommendation of a task force, appropriate psychotropic drugs to be used at the PHC level will be included in the list of essential drugs in India.
- Psychiatric units with in-patient beds will be provided at all medical college hospitals in the country within five years (Directorate General of Health Services, 1982).

As the coming years proved, the NMHP was a very ambitious programme with little consideration of the ground realities.

### PROGRESS DURING THE SEVENTH FIVE YEAR PLAN (1985-90)

The first opportunity to develop a plan of action following the formulation of NMHP came with the 7th five year plan wherein the NMHP was adopted as the basic document for mental health care. The National Advisory Group on Mental Health (NAGMH) was formed in August 1988 as recommended in the NMHP. Though the seventh five year plan endorsed the NMHP, the budget allocation for mental health sector was small enough (only Rs 1 crore) to render it impossible to achieve the set goals. The major work carried out during the seventh five year plan was creating awareness about mental health through workshops for planners, mental health professionals and key administrators and paramedical personnel in different parts of the country and development of support material for NMHP at Central Institute of Psychiatry (CIP), Ranchi, National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, and Postgraduate Institute of Medical Education and Research (PGI), Chandigarh. The initial years of experience with the NMHP led to the development of more pragmatic approaches in the form of District Mental Health programme (Planning Commission, 1985; Nizami et al, 1992).

### DISTRICT MENTAL HEALTH PROGRAMME (DMHP): A PRAGMATIC STEP

In 1984, NIMHANS launched a pilot model programme in the Bellary district to implement the NMHP at a district level in collaboration with the district administration and the Director of Health Services, Karnataka. Compared to the ambitious NMHP, it appeared more prudent to see the practicality of the involvement of primary health care providers for the delivery of mental health care services in just one

district. The health workers at the Primary Health Centers (PHCs) in the district were trained to recognize and manage mentally ill patients. At the district level, a specially trained programme officer was appointed to conduct regular mental health clinics and to monitor the progress of PHCs all over the district. The model was successful in providing mental health care services to around 2 million people and showed the possibility of delivering mental health care services through the peripheral health service system. Following this model and its recommendation by the Central Council of Health and Family Welfare in October, 1995 and as resolved in the workshop of Health Administrators held in February, 1996, the District Mental Health Programme with a community based approach was launched in four districts, one each in the states of Andhra Pradesh, Assam, Rajasthan and Tamil Nadu in 1996-97 on a pilot basis under the NMHP (Issac, 1987; Kapur, 2004). The components of DMHP include:

- Training programmes for all workers in the mental health team at the identified nodal institute in the State.
- Public education in the mental health to increase awareness and reduce stigma.
- Provision of the OPD and indoor services for early detection and treatment.
- Providing valuable data and experience at the level of community to the state and centre for future planning, improvement in service and research.

The funds were to be provided by the Govt. of India to the state governments and the nodal institutes to meet the expenditure on staff, equipments, vehicles, medicine, stationary, contingencies, training, etc., for initial 5 years and thereafter the states had to manage it themselves. Financial help was also sought from agencies like World Bank and World Health Organization (WHO) to support various components of the programme. As had been envisaged, the DMHP started gaining momentum in the coming years.

#### PROGRESS DURING THE EIGHTH FIVE YEAR PLAN (1992-97)

During the eighth five year plan mental health services were given priority. Though it was proposed to start a psychiatric centre in each district and also to encourage every medical college to start a separate department of psychiatry so that the required manpower, both medical and para-medical, can be trained; this ambitious proposal could not fructify. Nevertheless, DMHP with a community based approach was launched in four districts, one each in the States of Andhra Pradesh, Assam, Rajasthan and Tamil Nadu on a pilot basis under the National Mental Health Programme (Planning Commission, 1992).

#### PROGRESS DURING THE NINTH FIVE YEAR PLAN (1997-2002)

By the end of the 9th five year plan there were around 20,000 beds in mental hospitals and 2,000 to 3,000 psychiatric beds in general and teaching hospitals with fifty per cent of the psychiatric beds being occupied by patients undergoing long term treatment. Even then less than 10% of the mentally ill persons had access to appropriate care. During this plan district mental health programme was implemented in 27 districts. And though advocates of mental health were demanding more money for the implementation of NMHP, the modest outlay of Rs 28 crores could not be utilized during the plan period (Planning Commission, 1997).

The efforts of the NMHP had started bearing fruit. As people became aware of the mental health related issues, their concern about the dismal state of mental hospitals across the country increased leading to some landmark Supreme Court injunctions.

#### THE NATIONAL HUMAN RIGHTS COMMISSION REPORT (1999): A LANDMARK

Following several public interest litigations in the 1980s about the plight of patients in mental hospitals, the Supreme Court of India ordered a detailed enquiry into the conditions of mental hospitals. The National Human Rights Commission (NHRC) was entrusted by the Supreme Court with the responsibility of monitoring the status of these mental hospitals. Evidence of violation of the fundamental rights enshrined in Article 21 of the mentally ill led the NHRC to examine the problem and recommend appropriate remedial measures. The NHRC took up the issue of quality assurance in mental health and assigned NIMHANS to carry out the project. The main objectives of the project were:

- To analyze the conditions prevailing in government and private mental hospitals in various parts of India, and
- To generate possible solutions for improving standards of care.

#### Findings of the NHRC Project

The project team personally visited 59 facilities, including government-run mental hospitals (32), general hospital psychiatry units (16) and private psychiatric treatment centers (10). In a majority of the hospitals the team observed:

- An archaic structure of the buildings and practices with existence of cells without any sanitary facilities, giving a prison like ambience.
- Poor living environments with overcrowding (bed: patient, 1:1.4), poor sanitary conditions, poor quality of food.
- Poor or nonexistent lab facilities.



- Lack of staff-with a psychiatrist patient ratio in some hospitals of 1:200 (two hospitals had no psychiatrist) and even poorer presence of psychologists and social workers;
- Lack of rehabilitation facilities; and
- Poor documentation of patient information.

The NHRC project findings led to changes, both direct and indirect. In many states, sensitization of the administration led to efforts at improving basic amenities and evolving minimal standards of care in mental hospitals in consultation with medical superintendents. Also, financial support to many of the hospitals for structural improvement was sanctioned (NHRC, 1999; NIMHANS, 2000; Dhanda, 2000).

In keeping with the culture norms in India, a large number of mentally ill patients land with the faith healers, quacks, etc., in different settings. Though the NHRC addressed the issues of the mentally ill in government and private psychiatric facilities, it failed to see the larger picture. It took a fire to light this darkness.

#### THE ERWADI FIRE: AN EYE OPENER

In the early hours of August 6, 2001, fire engulfed the thatched roof of the Moideen Badusha Mental Home at Erwadi, a village 27 km south of Ramanathapuram town in southern Tamil Nadu, killing 28 of the 43 inmates, leaving 9 with burns and 6 missing. The incident evoked response at the state as well as the national level. The N. Ramadas commission, set up to inquire into the incident concluded that of the 43 patients in the asylum, 15 who had not been chained had escaped the fire (though three women among them died later of severe burns) while the rest were chained and devoured by the flames. Following the commission's recommendations the other 17 homes functioning in Erwadi were closed down and the patients from these transferred to proper psychiatric facilities mainly the Institute of Mental Health (IMH), Chennai. The commission recommended setting up of mental hospitals in Thanjavur, Tiruchi, Madurai and Ramanathapuram, and one of them exclusively for women. The implementation of district mental health programme in Ramanathapuram and Madurai districts was to begin with immediate effect (The Hindu, August 07, 2001; Frontline, August 18 - 31, 2001; September 01 - 14, 2001; July 20 - August 02, 2002).

The Supreme Court of India in response to the civil writ petition 334 of 2001 about the Erwadi incident ordered certain measures that have a significant bearing on the delivery of mental health services. These include:

- Every State and Union Territory (UT) shall undertake a comprehensive need assessment survey and file the report on the availability of mental health resource personnel in the state, the type of mental health delivery system available in the state, and an estimate of the mental health services that

would be required having regard to the population of the state and the incidence of mental illness.

- The chief secretary of each state and administrator/ commissioner of every union territory (UT) shall file an affidavit stating clearly whether minimum standards have been prescribed for.
- Licensing of mental health institutions in the state/UT and whether any mentally challenged person has been found to be chained in any part of the state/UT.
- Directed Union of India to constitute a committee to give recommendations on the issue of care of mentally challenged persons who have no immediate relatives or who have been abandoned by relatives.
- To frame norms for non-government organizations working in the field of mental health and to ensure that the services rendered by them are supervised by qualified/ trained persons.
- Two members of the legal aid board of each state be appointed to make monthly visit to such institutions, so as to assist the patients and their relatives in applying for discharge from the institutions if they have fully recovered, and do not require institutional assistance any longer or to find out whether as a matter of fact they require any such treatment as indoor patients.
- All patients ready to be discharged, but are not being discharged due to family not taking them back, or lack of support in the community, should be placed in a home-like accommodation created on the hospital campus itself. This accommodation could be an existing ward converted to have a home-like environment, with patients being taught house keeping skills, cooking, shopping and also encouraged to take up responsibilities in the hospital for which they should be paid for and then gradually encouraged to go to the community for work (Supreme Court of India, 2002).

Besides the legal injunctions, the Erwadi fire lead to a land mark survey of the existing mental health resources in the country.

#### WHERE INDIA STANDS: NUMBERS SPEAK

##### The Existing Infrastructure: National Survey of Mental Health Resources

In May 2001, several months before the tragedy at Erwadi, a small group was constituted in the Directorate General of Health Services to analyze the causes of the underperformance in mental health sector and to suggest corrective measures. In order to generate baseline data in respect of mental health laws and services, detailed

questionnaires were sent to all state governments, but the response was poor. Later, consequent upon the directions issued by the Hon'ble Supreme Court in the civil writ petition 334 of 2001, the same format was used to collect the required information. The first questionnaire dealt with issues related to the implementation of the Mental Health Act, 1987 and the rules framed thereunder, as well as functional issues concerning the State Mental Health Authorities and the state of the mental health services in various States. The second questionnaire was designed to evaluate the current status of the 37 government-run mental hospitals with regard to their infrastructure, staff, clinical services, availability of drugs and other treatment modalities, quality of food/kitchen facilities, availability of linen/patient clothing, recreational facilities, and vocational/rehabilitation facilities. The survey revealed that:

- Though the Mental Health Act, 1987 has been implemented in most of the states concerned, the rules thereunder have not been framed by all the states.
- Mental Health Cells have not been established in most of the states, though State Mental Health Authorities have been constituted in a majority.
- The situation in respect to licensing authorities and appointment of visitors/inspections required to be carried out by them was also found to be unsatisfactory.
- The buildings of most of the hospitals are old, dilapidated and beyond economic repair, though significant progress has been made in several areas following the NHRC report.
- Significant deficiencies or complete absence of psychiatric nurses, psychiatric social workers, clinical psychologist, occupational therapist and laboratory technicians were found in a majority of the mental hospitals surveyed, though some improvement has taken place since the NHRC report.
- Clinical services and the availability of investigative facilities including modern investigations like CT scan, ultrasound, etc., are largely inadequate mainly due to the lack of proper staff and equipment.
- Availability of drugs is generally adequate but typical antipsychotic drugs are still widely used.
- The quality/quantity of food for the patients has improved but offers scope for improvement, especially with regard to variety and the way it is served.
- Linen is usually inadequate or even non-existent in some hospitals. Many patients lie on the floors, often without mattresses.
- The recreational facilities are missing in most of the mental hospitals.
- Vocational and rehabilitation facilities are still rudimentary and mostly obsolete, patterned for the old custodial mode of mental hospitals.

- The lingering custodial atmosphere in mental hospitals can be traced to one common malady-the high proportion (up to 50% or even more) of long-stay patients (Directorate General of Health Services, 2002).

### The Burden of Mental Illnesses

The epidemiological studies from India indicate that nearly 1% of the population suffers from serious mental disorders and 5-10% from moderate disorders (Gururaj & Isaac, 2004). Taking the rate of major mental disorders at 1% and minor mental disorders at 5%, the disease burden comes out to be 10,270,165 for major mental disorders and 51,251,625 for minor mental disorders as per the population data of census 2001. The existing mental health services to cater to this mammoth diseased population include a total of 25,989 available psychiatric beds, 2,219 psychiatrist (9,696 ideally required taking psychiatrist patient ratio of 1: 10000), 843 clinical psychologists (13,259 ideally required taking the psychologist patient ratio of 1.5:10000), and 290 psychiatric social workers (PSW) (19,064 ideally required taking the PSW : patient ratio of 2:10000). Ironically, the survey shows the number of psychiatric nurses to be more than required. Though, these figures represent rough estimates, they give an idea of the ground we have to cover before the objective of "the greatest good to the largest number" can be met (Directorate General of Health Services, 2002).

### RESTRUCTURING THE MENTAL HEALTH CARE DELIVERY: SECURING FUTURE

#### National Mental Health Policy (2001)

Considering the present status of mental health the need of a comprehensive policy that guides our future investments in mental health seems pertinent. In this connection, a comprehensive National Mental Health Policy (NMHP) was drafted in 2001. The national mental health policy emphasizes that the mental health services should ensure:

- Accessibility of at least basic psychiatric facilities within the community to as large a section of the population as possible in all parts of the country.
- Affordability of the services with regard to the initial capital cost as well as recurring expenditure to accord with our limited resources and low-income levels of the consumer population.
- Adaptability to the widely varying geographical, socio-cultural and economic mosaic of our vast country.
- Acceptability of mental healthcare by the target population in



the context of low levels of literacy, ignorance, superstition, economic backwardness and lack of empowerment of women, adolescents and children.

- Assessment of performance at the ground level through continuous monitoring, online audit by an independent agency and periodic review at the national level in order to identify areas of non-performance/reasons for the same at an early stage and introduce necessary corrective measures as well as relevant feedback for future planning.

The NMHP, 2001 emphasized five thrust areas to be worked on keeping the National Mental Health Programme as the tactical vehicle. The thrust areas are:

- The DMHP to be redesigned around a nodal institution which in most instances will be the zonal medical college. School mental health programmes and dementia care services may be gradually integrated with the DMHP.
- Strengthening the medical college psychiatry departments with a view to develop psychiatric manpower, improve psychiatric treatment facilities at the secondary level and to promote the development of general hospital psychiatry in order to reduce and eventually to eliminate to a large extent the need for big mental hospitals with all their attendant infirmities.
- Streamlining and modernization of mental hospitals to transform them from the present mainly custodial mode to tertiary care centers of excellence.
- Strengthening of Central and State Mental Health Authorities in order that they may effectively fulfill their role of monitoring ongoing mental health programmes.
- Research and training aimed at building up an extensive database of epidemiological information relating to mental disorders and their course/outcome, therapeutic needs of the community, development of better and more cost-effective intervention models, promotion of intersectoral research and providing the necessary inputs/conceptual framework for health and policy planning.

The NMHP, 2001 also proposed a time frame for the attainment of the policy objectives subjected to availability of resources in future five year plans. The policy also focused on psychiatric problems specific to certain vulnerable sections of the population like senior citizens, women, children and disaster victims (Goel et al, 2004).

#### Restrategized NMHP

The NMHP started in 1982 with high hopes, but it failed to gain the desired momentum. After an in-depth analysis to identify the causes

of poor performance and to formulate remedial measures by the Directorate General of Health Services in early 2001, the NMHP underwent radical restructuring. The restrategized NMHP incorporated the five basic components of the National Mental Health Policy (2001). After approval by the Ministry of Health and Family Welfare, the Planning Commission, the Ministry of Finance and, finally, the Cabinet Committee on Economic Affairs (CCEA), the restrategized NMHP was formally launched by the health secretary at a national workshop held at Vigyan Bhawan, New Delhi on 22 October, 2003. The restrategized NMHP touched ground with the implementation of the tenth five year plan (Agarwal et al, 2004).

#### PROGRESS DURING THE TENTH FIVE YEAR PLAN (2002-07)

The approved outlay of Rs 190 crores for mental health during 10th five year plan was subsequently reduced to Rs 139 crores, due to non-utilization of funds. Three main resource centers for providing technical inputs and training under NMHP identified were: CIP (Ranchi), NIMHANS (Bangalore) and Institute of Human Behavior and Allied Sciences (IHBAS, Delhi). The DMHP was expanded to 94 districts and 24 general hospital psychiatric units were upgraded, besides strengthening of 19 psychiatric hospitals. An amount of 11 lakhs was spent on information, education and communication (IEC) activities while research focused on operational aspects of mental health programme was carried out with a budget of 45.91 lakhs (Planning Commission, 2002).

#### PROPOSAL FOR THE ELEVENTH FIVE YEAR PLAN (2007-2012)

The recommendations of the 2003 review of the NMHP form the guiding principles of the 11th five year plan proposal. The strategies proposed by the working group on communicable and non-communicable diseases for the 11th five year plan are:

- Integrating mental health with primary care through NMHP.
- Providing tertiary care institutions for the treatment of mental disorders.
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like Central and State Mental Health Authorities.

Based on these strategies the following components of the revised NMHP are proposed:

- Expansion of the DMHP to 500 districts all over the country with some modifications. The cost of DMHP may be increased to 1.60 crores per district.
- Improvement in health manpower status by increasing the number of postgraduate trainees in psychiatry as well as imparting short-term training courses to general practitioners.

It is proposed to facilitate 50 MD seats, 25 DPM seats in the teaching colleges and to train 5000 taluk level medical doctors for a period of 6 months to 1 year as a part of a certificate course.

- The research areas to be focused may include biology of mental disorders, early intervention for mental disorders, improving the long term outcomes in drug and alcohol related disorders, social factors/support systems to lower disability in chronic psychosis and health behavior research. A grant of 20 crores in the 11th five year plan has been sought for this purpose.
- IEC activities involving the development of public awareness material such as video clippings, posters, radio wordings. Training material for under graduate/postgraduate training in the form of video, interactive CDs, use of the internet have to be developed. A budget of Rs.25 crores has been proposed for this area.
- Support money for implementing of Mental Health Act and running the Mental Health Authorities is proposed at Rs.10 crores.
- School Mental Health Programme to be implemented by imparting life skills education using teachers as trained resource staff. It is planned that the scheme is implemented at a rate of 100 districts each year making a total of 500 districts to be covered in 11th plan.
- Non-governmental Agencies have an important role to play. A sum of Rs 20 lakhs may be given for them to organize camps, educate public, etc.

### Revised methodology of the DMHP

A revised methodology of the DMHP will be followed during the eleventh five year plan. The emphasis will be on reaching the unreached-severe mental disorders on a priority in the first year of the DMHP. The essential approach involves training of physician in psychiatry. The monitoring of the DMHP will follow the following hierarchy:



State Monitory Agency  
(Joint director- Mental Health,  
Secretary of the State Mental Health authority,  
Project coordinator with a medical background)

↓

District Level  
(District Programme Officer)

The functional aspects of the monitoring would include:

Central Monitoring Agency for DMHP  
(In touch with state monitoring agency and each DMHP  
by a dedicated fax line and Email,  
meet with state monitoring agency and programme  
officers of DMHP every 6-12 months,  
visit each DMHP with state monitoring agency  
personnel once in a year)

↑

State Monitoring Agency  
(meets each DMHP programme officer once in 3 months,  
visits each DMHP and meets medical officers in 6 months)

↑

District Programme officer  
(meets medical officer in each taluk monthly,  
visits each taluk monthly)  
(Directorate General of Health services, 2006)

### COMMUNITY PSYCHIATRY AND NMHP

The involvement of family members in the treatment of the mentally ill by Vidya Sagar at the Amritsar Mental Hospital in 1950s may be said to have heralded the beginning of community psychiatry in India. Though the step was taken due to shortage of staff in the hospital, the participation of the family members in the treatment process showed encouraging results (Kapur, 2004). Later on, the development of the community psychiatry took place mainly in two directions-the setting up of community based mental health services and the establishment of psychiatric units in general hospitals. The first community based mental health care initiative was started by CIP in the form of rural mental health centre at Mandar in 1967 (Nizamie et al, 2008). Subsequently, a community psychiatry unit was established by NIMHANS in 1975 and a rural mental health programme was started by PGI with the help of WHO. Though the first general hospital psychiatric unit (GHPU) was established at R. G Kar Medical College at Kolkata in 1933, others followed much later in the 1960s. NMHP started with the aim of developing community based psychiatric care



and steered the later development of GHPUs and community based mental health services through DMHP. Currently there are more than 200 GHPUs functioning in the country and DMHP has been implemented in 94 districts (Kapur, 2004). Besides expanding these services, there is a need to assess and improve their functioning.

## CONCLUSION

The national mental health programme is more than two and a half decades old and it hasn't even achieved what it had planned to achieve in the first five years. Though money was one of the limiting factors in the initial years but later a significant proportion of the allotted budget had to be returned back as there were no takers. It seems pertinent at this point in time to answer a few questions- Do we have enough research based evidence to show the practicability of the programme? Are there better research based models of health care delivery? Unfortunately, the answer to both the above questions is in negative. The need of the hour is to take stock of the situation and to develop research based models of health care delivery suitable to our needs.

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## METAPHOR, NARRATIVES, AND THE UNCONSCIOUS: AN INTEGRATED PSYCHOTHERAPY CASE STUDY

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### ABSTRACT

**Background:** Integration of theoretical concepts in psychotherapy practice is perhaps one of the most difficult challenges for young therapists as well as supervisors. **Aim:** The authors present an integrated psychotherapy case study illustrating the use of metaphors and narrative techniques in individual psychotherapy for a young woman with obsessive compulsive disorder as well as marital conflict. The client-initiated integration described in this article shows how metaphors and narrative techniques were used to reach the unconscious conflicts. **Results:** Psychodynamic and narrative therapy language in the supervision discussion facilitated revised formulation and transformed the overall style of therapy. **Conclusion:** The article describes the nature of emotional resolutions achieved for the client's fear of breast cancer, disturbing dreams and sexual anxiety.

**Key words:** *Integration, unconscious, narrative, metaphor, woman*

### INTRODUCTION

The psychotherapy integration movement over the last few decades has accepted many different routes for integration like - theoretical/assimilative integration, eclecticism through the course of therapy, and emphasis on common factors rather than techniques (Lampropoulos, 2006). This movement has made psychotherapy training and supervision less rigid and more challenging. An integrationist supervision environment allows the therapist to utilize whatever procedures appear to best meet the needs of a particular client and not remain confined within one theory/technique (Garfield, 1991). It is driven by the practitioners' growing sense of discontent with single school approaches, their desire to look beyond single school boundaries, and sensing the relevance of multiple perspectives for mastery over clinical phenomena. Integrating the best constructs, clinical strategies and techniques from various psychotherapeutic orientations can advance the comprehensiveness of treatment (Wolfe, 1994; Wolfe & Goldfried, 1988). Integration of approaches can not only facilitate short-term symptom relief but also promote long-term resolution of conflicts (Cox & Theilgaard, 1987). This article shows the importance of using an integrated approach for intrapsychic conflicts that were unresolved by other forms of therapies.

Integration of behavioural/cognitive psychotherapies with other schools of psychotherapy is one of the commonest models used in clinical practice. Most therapists in training feel quite competent in using such combined formulations. Moreover, psychotherapy literature has extensive material on integration of Cognitive Behaviour Therapy (CBT) with other

approaches (Goldfried, 1995; Stricker & Gold, 1993), although there is less literature on integration within other theoretical approaches (Holmes & Bateman, 2002). Besides, published psychotherapy case studies also emphasise techniques-based integration rather than conceptual integration.

This psychotherapy case study highlights integration of two theoretical constructs that are rarely discussed in psychotherapy literature: metaphor from the psychodynamic school, and narrative from the post-modern school of narrative therapy. Integration was prompted by the client rather than driven by training or supervision.

### BACKGROUND DETAILS: THERAPIST

At the time when this therapy was carried out, the therapist (first author) had finished five years of university based psychology-degree courses, and had completed six months' training in clinical psychology (as part of her 2 year MPhil program in clinical psychology offered by a large mental health training institute). The model of psychotherapy training in the course is client-centred (Rao, 2001). The training facilitates therapies that bring out the best fit between a client's needs and a therapist's competencies. The therapist for the case reported here had gained some degree of mastery over supportive, cognitive and systemic orientations at the time of providing the therapy. The supervisor (second author, with 7 years of supervisory experience post PhD and 15 years of clinical experience at the time of this case supervision) uses psychodynamic, client-centred, narrative feminist, systemic, and cognitive approaches in her practice as well as



supervision. The therapist and the supervisor are woman professionals.

## BACKGROUND DETAILS: PSYCHOTHERAPY CLIENT

### *Summary of Client's History*

Mrs. AM was a 30 year old, married Muslim lady with a two year old boy. She belonged to the middle socioeconomic status and lived in a joint family in Bangalore, India. She was the youngest of four siblings and had discontinued education after completing 12 years of schooling. She remembers being a pampered child and being admired for her good looks in her family during childhood. Later, she held a romantic vision of the world. She dreamt about a beautiful future and about all the fine things that would come her way once married. When she was 19 years old, her parents arranged for her marriage to a first cousin (eight years older to her).

At the time of Mrs. AM's first consultation six years ago, her husband had brought her for psychiatric treatment due to certain symptoms of two years' duration. Her problems were persistent doubts and ruminations regarding the fidelity of her husband, self injurious behaviour in the form of banging her head against a wall, biting herself, pulling her hair, decreased sleep, decline in household chores, crying spells, feelings of sadness, washing her hands repeatedly, checking locks, switches, gas connections used for kitchen stove and fits, when she became unconscious and had occasional incontinence. Her initial diagnosis was obsessive compulsive disorder with secondary depression and generalized seizures.

### *Treatment History*

Mrs. AM had been under treatment for over six years prior to the therapy reported here. During her hospital stay for 2 months, initially she showed regressed behaviour in the ward, and ventilated about interpersonal problems with mother-in-law and husband. Subsequently, all of them participated in family therapy and made structural and communication changes to improve relationship satisfaction. They continued marital therapy for another six months after discharge. Since then, the client was on regular medication for the following two years and her seizures and OCD symptoms remitted. Pharmacotherapy was stopped as she was pregnant. She had fear of childbirth but otherwise remained symptom free for the next two years and had no contact with her treating team during that period.

### *Relevant Themes from Previous Therapies*

Mrs. AM's doubts about her husband's fidelity had started after a female relative indicated to her that the client's husband had actually been in love with her (female relative), and that he had married the client only because his mother had insisted upon it. Subsequently,

whenever he was away at work, the client wondered whether he had gone to visit the other woman.

Marital therapy sessions also showed that: 1) the husband was reluctant to get married and had done so under pressure, 2) the client's notions about marriage were more romantic than those of her husband, and she was disappointed that her husband was not very expressive, 3) her regressed behaviour was a means for getting husband's attention, 4) the husband had also been physically violent with her, 5) conjoint discussions over her suspicions regarding the husband's fidelity clarified that he had no romantic interest in anyone else before marriage, and 6) therapy increased shared activities and direct communication in their relationship. Physical abuse had also stopped with therapy and her impulsive and childish tantrums had decreased.

### *Presenting Problem for Current Therapy*

When Mrs. AM's child was two years old, she sought help for re-emergence of doubts about the husband's fidelity, and difficulty in controlling her anger. She would lose control completely when she was angry and would be physically and verbally abusive towards her child. Systemic contributions had weakened in these presenting problems. Thus, individual psychotherapy was suggested to explore her difficulties.

### *Therapy Structure for Current Therapy*

Initially, Mrs. AM was quite irregular in her hospital visits and therapy appointments. Overall, the present therapy lasted for seven months and 25 sessions (mostly weekly, becoming fortnightly during termination phase). However, sessions 14 to 19 were held over approximately a two-week period with intense therapeutic engagement shown by the client. The following sections condense the therapeutic material and approaches used from an integrated platform.

## FROM CONTENT TO FORMULATION

### *Initial Interviews*

During the early exploratory sessions, Mrs. AM conveyed that her anger was the most distressing issue for her. She lost her temper on small matters and did rash things like hitting or verbally abusing her husband. In his absence she would hit their son. Her doubt that the husband was having an affair with someone was persisting. When in distress, she would often break something in the house, or go out and spend money. Later, she would regret her actions, cry, feel depressed, and beg forgiveness from her husband/son. She feared that everyone (in laws, neighbours, nephews and nieces) thought negatively about her. Furthermore, she had internalised this and



believed that she was a bad person. She had also noticed that if she was the only person standing in the room she would not be offered a chair by others. Since on most occasions no one noticed her presence or absence, she concluded that everyone (including all children in the household) hated her. These issues distressed her extremely.

### *Initial Formulation*

Using the client's history at first contact as well as her therapy history, we created a cognitive behavioural model of intervention for her anger. She had a long-standing history of obsessive symptoms that had been brought under control using cognitive techniques like distraction and verbal challenge. So, the same model was extended to the presenting problems. It seemed that a good fit is possible between the selected model and the client's experiences. She held a negative view of herself and the world and focused only on all that was wrong in life. Several cognitive distortions such as "I am bad", "No body loves me because I am unlovable" needed to be modified. She also lacked good problem solving skills and was often impulsive. Her interpersonal difficulties, anger and cognitive distortions seemed related. This suggested that interpersonal skills training and cognitive restructuring, with a focus on anger management, would help her deal with difficult situations in a more effective manner.

### *Initial Therapy Plan*

The aim for the next few sessions was to obtain details regarding: 1) various crisis moments; 2) her feelings during those moments; 3) the triggering events; and 4) her cognitions. The therapist motivated the client by emphasizing that their discussions will help her find new ways that would not make her feel remorseful at the end of the difficult situation.

### *From New themes to Revised Formulation*

The therapist noticed that Mrs. AM described some events/themes which failed to fit with themes from earlier sessions. These vividly and unexpectedly presented themes created images of repressed material for the therapist. The first theme came up in a sudden moment of disclosures in one of the sessions when the client recounted an affair that she had before her marriage. She was in love with a young man for 4 years and wanted to marry him. Her parents, however, had decided to get her married to her aunt's son. She could not reveal her secrets to her parents as she feared opposition and disgrace in the family. Moreover, she was unable to inform her boyfriend about her forthcoming marriage as she feared that he may create a scene. So, without a word to him, she went ahead with the marriage. Her husband's sisters, who were also her cousins and confidantes knew about her earlier relationship. Since then, she continued to dread that

they may disclose her secrets to her husband. The second theme was about a holiday that the entire joint family had taken together. She recollected that when she wore a dress that her husband had bought for her, he dragged her to the beach and played in the waves with her in spite of the elders' presence. The episode implied tension between them and left many incomplete images with the therapist. The third event was about one night when her husband was late in returning home. She feared that he had had an accident. This made her run out of the house, crying and barefoot, onto the road where she found him returning home. The fourth theme was the fear of dying of breast cancer. She felt that she probably deserved it since she has sinned against her boyfriend. She had also been visiting a faith healer, a "hazrat" who had told her that a "shaitaan" (evil spirit) sat on her breast. The "hazrat" had also attempted to exorcise this "shaitaan". Yet, she lived in perpetual dread of this spirit. She was afraid to go out or go to the bathroom alone, and feared that this "shaitaan" would drink her blood if he attacked her.

Her narrative showed that a "here and now" approach based on cognitive theory could not explain her problems. In her experiences, feelings of fear and shame were as prominent as those of anger. These fears could not be explained through linear traces of behaviours and thoughts. Richert (2003) describes these as therapeutic opportunities for narrative work. These are moments when a client gives a story that does not form a part of earlier stories.

However, in the initial supervision sessions, the therapist continued to scrutinize the client's themes from a cognitive perspective. Her quest was to search for what 'exactly' happened, what was irrational, and what needed correction through therapy. Slowly, cognitive psychology language was abandoned. The unconscious forces were recognised through terms like 'conflicts', 'fears', ambivalence in feelings, even though these defied complete formulations. Themes were not preserved discretely. Instead, they were allowed to merge with one another. This was similar to the way the client merged these themes in her sessions. In addition, therapeutic relationship style was also redefined to emphasise on the therapist's qualities that facilitated the narratives. Supervision sessions raised these reflections and the therapist resumed therapy with a different strategy. To continue the therapy sessions, she tried to imagine what lay below the tip of the iceberg.

Consequently, the assumption of anger from conscious conflicts was replaced with the notion that it emerged from unresolved conflict(s). These were associated with the avoidance and denial of earlier relationship, repression of affectional and intimacy needs, and sense of 'shameful self', creating free-floating anxiety. Fears of abandonment were projections of her having abandoned a loved person. 'Shaitaan' was a metaphor for her boyfriend, and 'breast cancer' suggested



life-threatening secrets in her heart. Moreover, various signs of fear were visible in her themes. This new formulation reflected the power of her narrative in therapy.

The therapist found that she could not work with the client's material as an expert. Therefore, sessions were approached with openness. Her selective recall of certain events (Richert, 2006) was viewed with a 'not knowing' stance. Yet, the therapist's activity level remained high through encouragement, restatements, reflections, and clarifications. Open-ended questions and empathic statements were also very useful. Nevertheless, therapist had to give up control on the client's story and this was quite anxiety-provoking for the therapist. The transition from a more structured orientation to handling this kind of symbolic material was a difficult one. What's more, therapist was puzzled by what the client was trying to communicate. Some of her stories were so fantastic that the therapist found herself internally challenging their truth. Nothing in the client's history or prior therapy had prepared her for this kind of material.

In sessions, Mrs AM was no longer required to express her cognitions, behaviours, and emotions coherently or completely. Instead, she was allowed to wander into all her experiences with the assumption that what she chooses to tell will have psychological significance. The therapy process was somewhat like what Gold (2006) describes as "...unique and ironic role reversal in the therapeutic relationship." Therapist prepared herself for not having a specific insight into her unconscious in the beginning, rather to let it emerge through her stories.

Nevertheless, Mrs. AM had a story to tell. For her, each of the themes narrated was meaningful. What appeared as 'hints' about her conflict were for her very vivid experiences with intense emotions. The themes listed earlier showed merely the tip of the iceberg. The incidents narrated were more than descriptions of real events. With this, she was testing the therapist and the therapeutic relationship. Sometimes, such themes seem innocuous, irrelevant or too oblique to the presenting problem. At other times, they do not suit the therapist's skills. This may inhibit some therapists from responding to client-initiated integration, especially when client may not have specific information to find suitable therapy for themselves (Gold, 2006).

### *On Metaphors in Therapy*

Campbell and Enckell (2005) emphasise that metaphors are not just ornamental but are instruments that help therapist see dimensions of reality that are not describable in any other way. They have relevance not only in psychodynamic theory but also in literary theory, cognitive research, gender studies, epistemology, and theory of science.

Two metaphors obvious in Mrs. AM's content were: 'shaitaan' and 'breast cancer'. Many authors have noticed that using metaphors allows for much freer communication between client and therapist. Cox and Theilgaard (1987) believe it helps to build insight as it exerts a synthesizing effect by building a bridge between the iconic mode of the right and the linguistic mode of the left hemisphere, and helps the client access unconscious material.

Once the therapist accepted the client's metaphors, they formed central themes for sessions. A metaphor can often be allowed to dominate therapeutic dialogues. Fox (2001) lists the benefits of working with a metaphor as follows:

- Non threatening nature
- Operates on many, even contradictory levels
- Evokes more than intellectual responses
- Appeals to the unconscious
- Is indirectly revealing
- Helps bypass resistant postures
- Promotes multiple responses
- Highlights the moment
- Makes the interaction memorable
- It is lively, gripping and engaging
- Supplies infinite variety and uniqueness
- Provides process fluidity

The therapist hoped to generate a new understanding of conflicts through the metaphors. Situations that seemed complex and uncertain at first needed clarity, and the diagnosis of the problem and the solutions needed to become more obvious. Berlin et al (1991) maintain that one needs to put aside the question of the truth of metaphors. They are best viewed as being appropriate or inappropriate to the situation, more or less useful and more or less revealing rather than as true or false.

### **NARRATIVES, METAPHORS AND RESOLUTION OF THE UNCONSCIOUS CONFLICTS**

Mrs. AM's narrations challenged the therapist's 'capacity to believe'. Winnicott has referred to this in 'Through Paediatrics to Psychoanalysis', published in 1935. He cautions against locating experiences in external reality versus fantasy. Instead, he suggests comparing external reality not so much with fantasy as with inner reality. Viewing client's experiences as internal realities rather than fantasies helped the therapist 'believe' the client.

Therapy moved forward only when the therapist could accept the client's story as being an internal reality. Therapist accepted that the events narrated may have actually happened or may have been imaginary. Accepting this ambiguity is an essential part of narrative



knowing (McLeod, 1997), and helps therapists accept implicit meanings in stories. Moreover, the therapist's role as a good audience also influences the narrative. Emotional support, approval, reassurance and open-ended questions completed and validated the story in this case. Paraphrasing created focus on specific aspects of the story and helped communicate to the client that the therapist had 'heard' the story.

Three themes from the sessions illustrate how narratives and metaphors were used to resolve Mrs. AM's unconscious conflicts.

### I. Fears of 'shaitaan' and breast cancer

The client had expressed the fear of a 'shaitaan' on her breast (who sat on her chest) as well as fear of breast cancer. Though she tried to relieve herself of this fear by visiting a 'hazrat' (a faith healer), the fear had continued. As a result, she was afraid of going out or of going to bathe alone lest he attack her and drink her blood. Further, whenever the doorbell rang she was afraid of being attacked by this creature.

The therapist used this metaphor to create a new version of her story, and attempted to bring the stories together. Her disclosure of her previous relationship was like a "load off her chest". All these years she had lived with a "heavy heart" and it weighed on her to think that she had left her boyfriend without any warning. Here, the therapist weaved a psychic cohesion out of the preformed metaphor of 'shaitaan', similar to what Campbell and Enckell (2005) describe in their work. These connections created a stable psychic fabric that bound the psychological tension around the unresolved conflict. The 'shaitaan' and the boyfriend were linked into a new concrete metaphor - from 'as if the boyfriend was a 'shaitaan' to...the boyfriend is a 'shaitaan'.

These phrases were presented to her in a somewhat discontinuous fashion and with pauses and blanks to stimulate further narrative. Consequently, the structuring of the content was left to her. Interpretative statements were avoided. Gradually, her wish became visible in the linguistic sphere. She also expressed her feelings freely. Often, she thought of her boyfriend and of his love and care for her. She wished her husband had been more like him, more tender, communicative, and appreciative of her. She also remembered that on several occasions she had called her husband by her boyfriend's name. Though she was grateful that he had not realized it, she lived with the constant fear that the husband's sisters may let out her secrets. Eventually, she linked her fear of going out, and her belief that no one loved her, to her conviction that everyone knew about the affair. She was also afraid that she may meet her boyfriend either on the street or at her doorstep. She lived with the conflicts between

wanting to be with him and wanting her husband to be more like him. Yet, she suppressed these desires even from her awareness. She wanted to exorcise these out of her system. The struggle sapped her strength, it 'drank her blood', 'weighed her heart down with cancer'. She was afraid that in a moment of weakness when alone these suppressed wishes (her 'dark' secrets) may leap out at her and destroy her and her world.

As her story evolved, she expanded more on her previous relationship and her disappointments. She expressed guilt over the conflict in her mind, and this was discussed in many sessions. Her story altered as she became more involved in developing it. She felt guilty about deceiving her husband and about deserting her boy friend. She was then encouraged to see how this was affecting her relationship with her husband. She noticed that she often found herself comparing him with the boyfriend. She also examined why she had chosen not to say anything about her marriage to her boyfriend. Thus, she attended tentatively all the alternative stories that could have unfolded in her life.

Zimmerman and Dickerson (1994) mention that people use a narrative metaphor to organize experiences as stories. Interventions must focus on eliciting those experiences that are excluded because they do not fit with the dominant narrative.

A therapist must help client co-author a new story, a more liveable story, with self as the narrator at the centre. The therapist must also add the cultural and political realities into the room, and open space for marginalized perspectives. In this case, these were about the realities of belonging to a culture that encourages restraint in affection, discourages individual choices for life partners and is very other-oriented. Personal narratives are not neutral, they are told from the position of self as the narrator with the self as a protagonist. In co-authoring the story, the client's guilt, anger, and fear came closer. She felt angry at herself for being helpless in the face of her family's choice of groom for her. The therapist consolidated that her present anger was possibly a residue of unresolved past issues. This is how her narrative about the previous relationship reached a closure.

### II. A dream

Mrs. AM dreamt that four men came into the house late in the night when everyone was asleep. They tied up her husband and took him away and she was left behind crying and screaming. She then woke up and believed that the dream was true. This made her run, barefoot and in her nightdress, to her brother in laws house nearby. The brother-in-law then telephoned her home and found the husband safe at home. She cried for a whole day after this event as she could not understand it. It had seemed so real to her that she was ready to



swear that it had actually happened.

The dream suggested that her terror of having lost her husband was a part of her unconscious wish to make him disappear. She had not "seen" her husband even when she woke up. He was right there in the house, but she failed to see him. Instead she ran to her brother in law for protection. According to Freud, dreams are formed from unconscious wishes aroused during the previous day. A simple way of escaping from a disturbing wish is to have it fulfilled, i.e., to perceive the wish as fulfilled. The preconscious is used to actualise the wish-fulfilment and to put the wish perceptually on a stage. Dreams are the 'royal roads' to the unconscious and have manifest content as well as latent meanings (derived from dream symbols) (Corey, 2001). Manifest content of the dream reported was used here to understand her unconscious wish. In her dream, she wishes unconsciously to harm her husband who had hurt her in many ways over the years. When she is awake, she does not see him as her protector and must run to someone else for help.

She mentioned another dream which was equally lifelike. She dreamt that she had beaten her nephew for troubling her. Subsequently, despite everyone reassuring her about it being a dream and not a reality, she felt guilty and gave her nephew sweets and chocolates to makeup for her dream.

In both cases, her dream conveyed her desire to harm. She felt guilty about it and would repair it in the nephews case by giving him sweets, and to the husband by apologizing.

Manifestation of guilt could explain her earlier OCD symptoms as well. Compulsions often keep the guilt laden secret desires from being exposed. She had dangerous wishes and secrets that made her guilty and that had to be kept hidden. This was symbolically represented in her desire to keep her unborn baby inside her during her pregnancy, and helps explain her fear of childbirth.

Sessions generated new narratives from guilt concerning dreams. Contemporary feelings about her husband as well as sources of ambivalences towards him were connected. She became less perplexed by her dreams, and got involved in trying to know her feelings better. Eventually, in her comparisons between husband and boyfriend she became more favourable to her husband and more reasonable as well.

### III. Sexual themes

Some of Mrs. AM's anger towards her husband was associated with their sexual relationship. She brought up this theme as tentatively into sessions as the earlier themes. In fact, it was only after many hints from her, and active encouragement from supervision that the therapist

addressed sexual themes in sessions. Sexual anxiety was evident in: 1) the event where her husband buys her a dress and drags her into the sea in spite of the whole family being present; 2) her complaints about all children (from the joint family household) being perpetually present in their room, and her wish that her husband should put a "red light" as a signal outside their room so that others stay away from their space, and 3) the fact that she had never allowed doctors to do a PV examination and had delivered her child by caesarean section.

The therapist referred to sexuality conflicts by suggesting that many disturbing things seemed to have happened to the client's body and that these were of concern to the therapist. Her vulnerabilities as a woman, her comparisons with other women, 'body talk' in all her stories were presented back to her. The use of 'I' statements by the therapist kept the client engaged in the content and kept the anxiety with the therapist. She was then asked to consider if these discrete events had any connections. Her responses slowly became a complete story.

The client described that she had no idea about the act of sex till four days before her marriage. She and her boyfriend would kiss and hold hands and she would feel loved and wanted by him. She was shocked to learn details about the sexual intercourse from her aunt. On her wedding night, her husband had beaten her because she refused to have sex with him. This pattern had continued for several months and they had intercourse only 4-5 months later. She felt that her husband had treated her no better than a prostitute in a 'red light' area, that she had been used only for her body, and that what happened to her was like being raped.

Although her husband had stopped hitting her after marital therapy, she continued to feel used by him. It was only during moments of sexual intimacy that he displayed any interest towards her. She longed to have a genuine relationship with him and have him acknowledge her. She had never felt any sexual pleasure with him but felt that she could if he was more kind. Due to these experiences, she did not like gynaecological examinations. Moreover, she could not share her difficulties with anyone. She had attempted to tell her mother, but her mother fell ill after hearing only half of it.

Many sessions were devoted to the above themes. One of the consequences of the storying process is the meaning making about the others involved. Clients often experience ones own intentions as good and others' actions and intentions as problems (Zimmerman & Dickerson, 1994). When her narratives appeared less fragmented, rewritten, they were less other-focused, and showed her preferred outcomes. A 'here and now' perspective could also be initiated at this stage. The client was able to move from symbolic communication to



direct sharing in therapy. She was able to see how her feelings of anger and frustration with her marriage and the initial sexual trauma from 10 years ago were linked to what was happening now. In one of the sessions (at around the fourth month in this therapy), she expressed a wish to have another child and desire to do it right this time.

### Termination

In the last few sessions, Mrs. AM wanted to improve her marital relationship and was also willing to focus on herself with reference to her marriage. Sessions concentrated on the meaning she was making of her experiences. The therapist helped her understand that she can lead the way in making new meaning. She learned better anger management techniques and problem solving abilities. She spoke of a 'weight being lifted off her chest' and no longer felt afraid of going out.

Her OCD symptoms were under control and she had stopped visiting the faith healer.

### DISCUSSION

Metaphors are often useful sources that reveal the exchange between the conscious and the unconscious, between the concrete and the abstract. Metaphors have mutative capacity as well. Cox and Theilgaard (1987) explain how these are ways of putting us in touch with what is too far or too close for us to see. This client's verbalizations showed how crucial the metaphor of 'shaitaan' was for her to reveal her fears to the therapist. A metaphor is often the source of an internalized locus of conflict (Schoeneman et al, 2004). The therapist's willingness to work with this metaphor was equally important. The client's ordering of discrete events as well as the reality that she lived in was accepted by the therapist. The therapist also appreciated how her narrative disempowered her as it was so fragmented and incomplete. Subsequently, the therapist empowered her through a narrative stance and helped her move towards a different narrative and her preferred outcome. This shows the usefulness of metaphors is not only for understanding the unconscious material but also for promoting resolution of conflicts.

This case report also shows how psychodynamic work is possible without using transference interpretation. In psychodynamic literature, metaphor and transference are seen as having identical meaning. Both mean to 'carry across' in Greek and Latin. The therapist's use of metaphors (concrete metaphors and psychic cohesion used to approach psychologically distant material across sessions) replaced the need for direct interpretation and helped bypass transference material.

The narrative-metaphor method has undoubtedly functioned as a technique for carrying, mobilizing, expressing, and integrating affect and cognition in the therapeutic process. It has helped to free the therapist from having to use interpretation of resistance for resolution of ambivalences. From an integrated perspective, ambivalence is seen as a sign of inherent limitations in problem-saturated stories that forms the core-ordering process (Richert, 2003). Over and above these purposeful processes initiated by the therapist, her unfailingly respectful, supportive and collaborative relationship facilitated this therapy. However, micro processes in sessions did appear chaotic at times. In some sessions, coherence was missing in the client's as well as the therapist's immediate experiences. Emotional resolution was not associated with a discrete moment in session or specific spontaneous insight. Rather, it occurred very subtly, with signs of what she had presumed to be intolerable previously appearing to be acceptable. In the last few sessions, the client's endurance increased, and she took on more and more to tolerate as she shifted from fantasy/discrete events-based anxieties to more reality-based anxieties.

The therapist used a narrative-psychodynamic approach in this case. Use of pure narrative approach would perhaps leave the perceptual aspects of the metaphor impossible to reach. Cox and Theilgaard (1987) have pointed out the dangers of metaphors as well. Therapists may remain trapped in metaphors or clients may use it as a hiding place. In this case, however, narrative technique was useful to recognize and transform metaphors. This helped resolve unconscious conflicts in an anxiety-provoking therapy context.

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## ATTRIBUTIONAL STYLE, MARITAL QUALITY, AND FAMILY INTERACTION PATTERN OF PARENTS OF CHILDREN HAVING EPILEPSY

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### ABSTRACT

**Background:** The presence of a child with a chronic illness may place the family at the risk of their physical and emotional well-being. During such stressful times for the family, parents might develop different attributional styles that would affect the marital life and the family functioning. Therefore, it seems significant to find the different patterns of attributional styles used by the spouses in marital satisfaction and family functioning. **Aim:** The present study investigated if any differences exist in attributional style, marital quality, and family interaction pattern of parents of children having epilepsy and parents of normal controls. **Results:** Parents with children having epilepsy had a more stable, internal, and global attributional style but poor marital quality as compared to parents of normal controls. In family interaction pattern, parents of children with epilepsy were significantly better as compared with parents of normal controls. **Conclusion:** Different attributional styles used by both the groups helped to understand how it affected the marital quality and family interaction pattern.

**Key words:** Attributional style, marital quality, family interaction, epilepsy, parents

### INTRODUCTION

Childhood epilepsies are a common cause of disability and morbidity. Worldwide incidence indicates 3.5 million people develop epilepsy annually and about 40 per cent are under the age of 15 years (Brorson & Wranne, 1987; Sidenvall et al, 1993). The prevalence rates of studies from Europe and North America report 4-5/1,000 (Beilmann et al, 1999; Eriksson & Koivikko, 1997). In India, the highest age-specific prevalence rate of 6.5/1,000 is reported in 10 to 19 year-old age group (Radhakrishnan et al, 2000).

Parents face significant stresses and problems when their child suffers with a disabling condition (Adesida & Foreman, 1999). The diagnosis of any disorder may represent the loss of a perfect child (Taylor, 1989). Various studies suggest that the family members of epileptic individuals have high levels of anxiety, depression and disturbed intimate relationships (Thompson & Upton, 1992), restriction in social activities and increased responsibilities (Ferrari et al, 1983), stigmatization, stress, psychological morbidities, marital problems, poor self-esteem, and restriction of social activities (Ellis et al, 2000).

#### Attributional styles and Attributions in family

"Attributional" research concerns the consequences of attributions. If the uncontrollable events are caused by something about the person (internal attributions), non-transient factors (stable attributions), and present in a number of situations (global attributions), the attribution

leads to loss of self-esteem, long lasting, and pervasive. Thus, attributing uncontrollable bad events to internal, stable, and global factors leads to depression.

Reviews of the parent attribution literature (Bugental & Happaney, 2002) have identified situational, child and parent factors that influence the kind of attributions that parents make. White and Barrowclough (1998) found depressed mothers made more spontaneous causal attributions and had more internal and stable attributions about themselves as the cause of their child's problem behaviour. Austin and McDermott (1988) found that positive parental attitudes towards their child's epilepsy correlated with positive parental coping patterns.

#### Attributions and marital quality

Attributions serve a number of functions for members of intimate relationships. In studies of marital attributions, the most consistent findings have been that distressed spouses see the causes of their partners' negative behaviours as more global and stable than nondistressed spouses. Lauvee (2005) found that couples whose children were diagnosed with cancer with factors associated with positive and negative change in marital relationships, a positive change in marital relationship was associated with both the mothers' and fathers' resources and perceptions. Fincham et al (1989) found that distressed wives made dysfunctional attributions for partner's behaviour.



## The impact of childhood epilepsy on the family

Lane et al (1998) investigated the incidence of perceived caregiver burden following surgical treatment for epilepsy, usually temporal lobectomy. Analysis suggested that depression and patient functioning, separate from seizure control, predicted caregiver burden. Hoare and Russell (1995) found that poorly controlled epilepsy differed significantly in higher levels of moodiness, alertness, teasing, marriage, restrictions for siblings, lack of family activities, quantity of arguments at home, and lack of entertainments.

Since majority of existing studies have focused on childhood epilepsy, most investigations of the family have been directed toward parenting styles and the potential impact on the child. Less concern has been directed toward the possible effect the child may have on the parents. It was hypothesized that there will be no significant difference in attributional style, marital quality, and family interaction pattern between parents of children having epilepsy and parents of normal controls.

## METHODOLOGY

### Participants

The present work was a cross-sectional, hospital based study conducted at Central Institute of Psychiatry (CIP), Ranchi. Data was collected from Epilepsy Clinic. In this study, 30 parents (15 couples) of children having epilepsy according to International League Against Epilepsy (ILAE) classification of seizure type and 30 parents (15 couples) of normal controls were taken. The inclusion criteria included both parents living with the child since birth, biological parents and duration of marriage should be at least one year. The age range of the child was 2 to 17 years. Data was collected from the same parents of the child. Informed consent was taken. Exclusion criteria included history of any major psychiatric illness in the parents, any neurological or major medical condition. Single parents were not taken for the study. The protocol of the research was passed by the ethical committee at the institute.

### Tools used

#### 1. Socio Demographic and Clinical Data Sheet

The data sheet was divided into two parts. The first covers the child's registration number, age, sex, education, diagnosis, age of onset, and duration of illness. The second part covers the parents' age, sex, education, occupation, time spent with the child, family income, and type of family.

#### 2. General Health Questionnaire-12 (GHQ-12; Goldberg, 1978)

It is a self administered screening test used to rule out any

psychiatric illness and it has been proved to be reliable and valid tool in several research studies.

#### 3. Attributional Style Questionnaire (ASQ; Peterson et al, 1982)

This questionnaire consists of 12 hypothetical situations involving 6 good and 6 bad outcomes and 48 questions regarding the same. The three attributional dimensions measured are internality, stability, and globality. It gives 11 subscales based on three items each.

#### 4. Marital Quality Scale (MQS; Shah, 1995)

It is a self-report scale to assess quality of marital life and standardized on normal population in India. The scale comprises of 50 items with a 4 point scale (1-4). The male and female forms are provided to be administered according to gender. The scale has 28 positively worded items and 22 negatively worded items. The scale provides two types of scores: total score and scores on 12 factors of the scale. The range for the total score is 50-200. Higher score indicates lower quality of marital life.

#### 5. Family Interaction Pattern Scale (FIPS; Bhatti et al, 1986)

FIPS is a self-report to assess family functioning and has been standardized on normal and patient population in India. FIPS consists of 106 items with a 4 point scale (1-4). It measures 6 areas of family functioning.

### Procedure

At the outset, informed consent was taken from all the participants. Socio-demographic data was filled after gathering the required information from the participants. GHQ-12 was administered to rule out any mental health problem during assessment.

### Statistical Analysis

Descriptive statistics (means, standard deviations, and percentages), Chi-square, and Multiple Analysis of Variance (MANOVA) were used for quantitative analysis. SPSS 11 (Statistical Package for Social Sciences, Inc., Chicago) was used to analyze the data.

## RESULTS

Total sample consisted of 60 parents; 30 parents (15 couples) of children having epilepsy and 30 parents (15 couples) of normal controls. Age and sex of control and normal children were matched.

Socio-demographic characteristics of experimental and normal controls showed significant difference in terms of number of siblings, father's time with the child, and mother's time with the child (Table 1).

**Table 1: Comparison of socio-demographic profile of experimental and normal controls**

Variables	Experimental	Control	t	p
Child's education	4.73 ± 3.63	5.86 ± 3.52	- .867	.393
Number of Siblings	3.06 ± 1.75	1.86 ± .91	2.352	.026*
Father's age	38.60 ± 6.76	36.73 ± 4.87	.867	.394
Father's education	12.00 ± 4.82	12.86 ± 3.04	- .588	.561
Father's time with child	7.46 ± 3.66	11.46 ± 4.73	-2.589	.015*
Mother's age	32.66 ± 5.19	33.20 ± 6.30	-.253	.802
Mother's education	9.60 ± 5.30	9.60 ± 3.58	.000	1.000
Mother's time with child	24.00 ± .00	19.40 ± 5.97	2.982	.006**

\*p < .05

\*\*p < .01

In attributional style, stability positive (SP) was higher in normal controls (4.84 ± 0.52; 4.68 ± 0.87). Parents with epileptic children scored

higher in globality positive (GP) (5.06 ± 1.35; 4.51 ± 0.96), internality negative (IN) (4.47 ± 1.10; 4.66 ± 1.61), stability negative (SN) (3.81 ± 1.44; 4.39 ± 0.84), globality negative (GN) (4.23 ± 1.55; 4.20 ± 1.30), composite negative (CON) (4.21 ± 0.97; 4.41 ± 0.86), and globality (GLOB) (4.68 ± 1.15; 4.42 ± 0.91) (Table 2).

In marital quality, parents with epileptic children scored significantly higher (higher the score poorer the marital quality) in understanding (11.26 ± 4.90; 11.26 ± 3.17), rejection (22.93 ± 5.76; 22.26 ± 5.22), satisfaction (6.53 ± 2.55; 6.60 ± 2.29), affection (10.06 ± 3.78; 10.93 ± 4.14), decision making (9.26 ± 2.86; 10.06 ± 2.76), discontent (4.26 ± 1.53; 4.53 ± 1.88), dissolution potential (1.13 ± 0.35; 1.53 ± 0.83), dominance (4.46 ± 2.16; 6.20 ± 2.04), self disclosure (4.46 ± 1.92; 6.60 ± 2.92), and the overall marital quality (87.20 ± 20.01; 91.86 ± 17.86) (Table 3).

In family interaction pattern the scores of parents with epileptic children were found to be higher in social support (21.73 ± 6.16; 23.66 ± 4.30), role structure (53.13 ± 9.97; 56.53 ± 6.33), communication (54.00 ± 12.51; 56.06 ± 7.58), and cohesiveness (28.33 ± 6.91; 30.93 ± 8.17) (Table 4).

**Table 2: Comparison of attributional style between parents of children having epilepsy and normal controls**

Variables	*Exp. Father Mean ± SD (N=15)	*Exp. Mother Mean ± SD (N=15)	*Con. Father Mean ± SD (N=15)	*Con. Mother Mean ± SD (N=15)	F	p	Post hoc
IP	4.27 ± 1.33	3.84 ± 1.12	4.65 ± 0.59	4.33 ± 1.00	2.12	0.107	b < a < d < c
SP	4.25 ± 0.93	3.94 ± 0.91	4.84 ± 0.52	4.68 ± 0.87	3.64	0.018*	b < a < d < c
GP	5.06 ± 1.35	4.51 ± 0.96	4.16 ± 0.49	4.34 ± 0.51	2.78	0.049*	a > b > c > d
IN	4.47 ± 1.10	4.66 ± 1.61	3.57 ± 0.65	3.98 ± 0.79	2.97	0.039*	b > a > d > c
SN	3.81 ± 1.44	4.39 ± 0.84	3.37 ± 0.95	3.69 ± 0.46	2.79	0.048*	b > a > d > c
GN	4.23 ± 1.55	4.20 ± 1.30	3.18 ± 0.73	3.40 ± 0.82	3.28	0.027*	a > b > d > c
COP	4.52 ± 0.93	4.09 ± 0.77	4.49 ± 0.35	4.53 ± 0.52	1.41	0.248	b < c < a < d
CON	4.21 ± 0.97	4.41 ± 0.86	3.37 ± 0.41	3.72 ± 0.54	6.06	0.001**	b > a > d > c
IN	4.37 ± 0.73	4.24 ± 0.97	4.04 ± 0.26	4.28 ± 0.41	0.65	0.585	a > d > b > c
STAB	4.05 ± 0.91	4.28 ± 0.69	4.10 ± 0.42	4.24 ± 0.49	0.39	0.759	b > d > c > a
GLOB	4.68 ± 1.15	4.42 ± 0.91	3.67 ± 0.48	3.89 ± 0.62	4.59	0.006**	a > b > d > c

\*p < .05

\*\*p < .01

IP = Internality positive

COP = Composite positive

IN = Internality negative

STAB = Stability

SN = Stability negative

GLOB = Globality

GN = Globality negative

SP = Stability positive

CON = Composite negative

GP = Globality positive

IN = Internality

a = experimental father, b = experimental mother, c = control father, d = control mother



Table 3: Comparison of marital quality between parents of children having epilepsy and normal controls

Variables	*Exp. Father Mean $\pm$ SD (N=15)	*Exp. Mother Mean $\pm$ SD (N=15)	*Con. Father Mean $\pm$ SD (N=15)	*Con. Mother Mean $\pm$ SD (N=15)	F	p	Post hoc
Understanding	11.26 $\pm$ 4.90	11.26 $\pm$ 3.17	7.33 $\pm$ 0.89	7.53 $\pm$ 0.91	8.22	0.000**	ab>cd
Rejection	22.93 $\pm$ 5.76	22.26 $\pm$ 5.22	12.93 $\pm$ 2.37	18.53 $\pm$ 3.04	16.71	0.000**	a>b>d>c
Satisfaction	6.53 $\pm$ 2.55	6.60 $\pm$ 2.29	5.13 $\pm$ 0.51	5.13 $\pm$ 0.51	3.33	0.026*	b>a>cd
Affection	10.06 $\pm$ 3.78	10.93 $\pm$ 4.14	6.26 $\pm$ 0.79	6.40 $\pm$ 1.63	10.17	0.000**	b>a>d>c
Despair	4.26 $\pm$ 1.79	4.33 $\pm$ 1.67	3.06 $\pm$ 0.79	4.00 $\pm$ 1.73	2.12	0.107	b>a>d>c
Decision making	9.26 $\pm$ 2.86	10.06 $\pm$ 2.76	6.40 $\pm$ 0.73	7.26 $\pm$ 0.96	10.07	0.000**	b>a>d>c
Discontent	4.26 $\pm$ 1.53	4.53 $\pm$ 1.88	2.33 $\pm$ 0.72	2.66 $\pm$ 1.67	8.01	0.000**	b>a>d>c
Dissolution potential	1.13 $\pm$ 0.35	1.53 $\pm$ 0.83	1.13 $\pm$ 0.51	1.00 $\pm$ 0.00	2.94	0.041*	b>ac>d
Dominance	4.46 $\pm$ 2.16	6.20 $\pm$ 2.04	3.55 $\pm$ 1.30	5.66 $\pm$ 1.39	6.89	0.000**	b>d>a>c
Self disclosure	4.46 $\pm$ 1.92	6.60 $\pm$ 2.92	3.06 $\pm$ 0.25	3.86 $\pm$ 1.18	10.01	0.000**	b>a>d>c
Trust	1.33 $\pm$ 0.72	1.33 $\pm$ 0.35	1.53 $\pm$ 2.06	1.00 $\pm$ 0.00	0.66	0.577	c>ab>d
Role functioning	7.20 $\pm$ 1.65	7.00 $\pm$ 2.23	6.93 $\pm$ 2.15	6.80 $\pm$ 0.77	0.12	0.943	a>b>c>d
Marital quality total score	87.20 $\pm$ 20.01	91.86 $\pm$ 17.86	58.13 $\pm$ 5.93	69.33 $\pm$ 6.33	18.59	0.000**	b>a>d>c

\*p &lt; .05 \*\*p &lt; .01

a = experimental father, b = experimental mother, c = control father, d = control mother.

Table 4: Comparison of family interaction pattern between parents of children having epilepsy and normal controls

Variables	*Exp. Father Mean $\pm$ SD (N=15)	*Exp. Mother Mean $\pm$ SD (N=15)	*Con. Father Mean $\pm$ SD (N=15)	*Con. Mother Mean $\pm$ SD (N=15)	F	p	Post hoc
Reinforcement	19.40 $\pm$ 4.89	20.13 $\pm$ 5.64	17.86 $\pm$ 2.16	17.20 $\pm$ 2.17	1.67	0.182	b>a>c>d
Social support	21.73 $\pm$ 6.16	23.66 $\pm$ 4.30	18.46 $\pm$ 3.79	16.86 $\pm$ 2.50	7.37	0.000**	b>a>c>d
Role structure	53.13 $\pm$ 9.97	56.53 $\pm$ 6.33	44.13 $\pm$ 4.93	44.93 $\pm$ 7.62	10.10	0.000**	b>a>d>c
Communication	54.00 $\pm$ 12.51	56.06 $\pm$ 7.58	47.73 $\pm$ 3.26	49.66 $\pm$ 5.52	3.45	0.022*	b>a>d>c
Cohesiveness	28.33 $\pm$ 6.91	30.93 $\pm$ 8.17	23.00 $\pm$ 4.35	23.93 $\pm$ 6.58	4.73	0.005**	b>a>d>c
Leadership	39.00 $\pm$ 8.93	38.80 $\pm$ 5.87	33.46 $\pm$ 5.31	35.00 $\pm$ 5.63	2.63	0.059	a>b>d>c

\*p &lt; .05 \*\*p &lt; .01

a = experimental father, b = experimental mother, c = control father, d = control mother.

## DISCUSSION

The present study was designed keeping in view certain limitations in the previous research done on this area as most of them studied the impact of child's illness on maternal health but this study also included paternal domain. In our study a control group was added and data was analysed using multivariate statistics which made comparisons more methodologically viable.

Socio-demographic characteristics of experimental and normal controls showed significant difference in terms of number of siblings, where the number of siblings were more in the experimental group (3.06  $\pm$  1.75) vs controls (1.86  $\pm$  .91); father's time with child, where normal father's spend more time with the child (11.46  $\pm$  4.73) vs fathers of children having epilepsy (7.46  $\pm$  3.66); and mother's time with child, where mothers in the experimental group spend more time with the

child (24.00  $\pm$  .00) vs (19.40  $\pm$  5.97). This has been cited by other workers (Datta et al, 2006).

In attributional style (Table 2), there was significant difference in stability positive (SP), where parents with normal children had more positive attributional style in their day-to-day situation since they did not experience any stress because of the absence of any child in the family with an illness.

In stability negative (SN) domain, parents with epileptic children scored higher than normal parents due to presence of an epileptic child in the family which had a long lasting negative impact (Lotham et al, 1990).

Parents with epileptic children scored higher in globality positive (GP), globality negative (GN) and total globality (GLOB) domains revealing that the attributional style used was pervasive across all situations

which they attributed to the presence of a child with epilepsy in the family which was affecting all spheres in their life. In internality negative (IN) domain parents with epileptic children revealed more internalization, that they are responsible for the child's condition. This internal attribution may involve loss of self-esteem in parents with children having epilepsy which was also found in a study with similar methodology although they had not used control population (Abramson et al, 1982).

Parents with children having epilepsy revealed more pessimistic attributional style with higher scores on composite negative (CON) domain and expressed negative events in terms of self, events which are likely to occur, and events that are likely to be pervasive and widespread in all situations leading to high levels of anxiety, stress and lifestyle changes which has also been reported before (Thomas & Upton, 1992).

#### Comparison of marital quality between parents of children having epilepsy and normal controls

Parents of epileptic children scored higher in understanding, rejection, satisfaction, affection, decision making, discontent, dissolution potential, dominance, self disclosure, and total marital quality score (Table 3). This is in validation to the findings of Bradbury and Fincham (1992) who found that maladaptive attributions can contribute to conflicting behaviour and relationship dissatisfaction.

Parents with epileptic children scored higher in dissolution potential which is in contradiction to the findings by Shah (1995) where in the Indian context lesser prevalence of divorce was found in the Indian society.

Dominance was found to be higher in parents of epileptic children. The reason could be that one of the spouses in the relationship is more distressed than the other. Discussion of long term plans, admitting each other's mistake and trusting each other was found to be less among parents with epileptic children.

The overall marital quality found that parents with epileptic children had marital conflict leading to psychological and physical dysfunction, decreased interpersonal trust and failed to generate changes in subsequent marital interactions. Lauvee (2005) in a similar study compared couples who reported a strengthened relationship with those who experienced a deteriorated relationship and found that the relationship change could be more strongly predicted by the child's illness duration, the father's sense of coherence, and the mother's social support.

#### Comparison of family interaction pattern between parents of children having epilepsy and normal controls

In family interaction pattern (Table 4) social support, role structure, communication, and cohesiveness were higher in experimental parents as compared to normal controls. Though there was poor marital quality, family interaction was better probably because of the extended social support they received outside from the marital relationship. Mothers of the patients with epilepsy perceived less social support although they were found to be the nominal head of the family as seen by Suman and Nagalakshmi (1995).

In role structure, there was adequate role allocation, role prescription, and role strain (Bhatti et al, 1986) present in the parents with epileptic children.

Adequate communication and cohesiveness were also present in the family of parents with epileptic children. However, on multiple comparisons, it was found that mothers with a child suffering from epilepsy had the most difficulty in communication. This has been consistent with the findings of Gantman (1978).

#### CONCLUSION

Significant difference was found in seven of the attributional styles, ten of marital quality variables and four in family interaction pattern in parents with epileptic children as compared with the normal controls. Thus, the result shows that the presence of a child with epilepsy in the family leads to more internal, stable, and global attributional style, and poor marital quality. But presence of an epileptic child did not disturb the family interaction. Future research direction includes assessing children from neonatal period, a long-term follow up, greater sample size, assess rural and urban population, probing the relation of various psychosocial and biomedical variables on outcome.

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## CURRENT SOCIAL FUNCTIONING IN ADULT ONSET SCHIZOPHRENIA AND ITS RELATION WITH NEGATIVE SYMPTOMS

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### ABSTRACT

**Background:** In schizophrenia, relation exists between psychopathology and social functioning. **Aim:** Determining relationship of negative symptoms with current social functioning in adult onset (> 19 years) schizophrenia. **Methodology:** Eighty schizophrenia patients [ICD-10-DCR], of both sexes (18-60 years), on follow-up for >6 months, with no change of diagnosis and without comorbidities, having onset of illness > 19 years of age, accompanied by informants having contact with the patient for a period of >12 months prior to the first psychiatric contact or symptom onset were assessed with various tools. **Results:** Self-concern and other social roles had negative correlation with all negative symptoms. Occupational role had negative correlation with affective flattening, avolition-apathy and anhedonia-asociality. Family role had negative correlation with avolition-apathy and inattention. **Conclusion:** Current social functioning had significant negative correlation with concurrent negative symptoms.

**Key Words:** Psychopathology, social functioning, negative symptoms, schizophrenia

### INTRODUCTION

Social functioning or social adjustment are general terms used to refer to the ability of individuals to meet defined societal roles such as homemaker, worker, student spouse, family member, or friend (Mueser & Tarrier, 1998). Goldman et al (1988) have defined social functioning as "one's capacity to interact appropriately and communicate effectively with other individuals both at work and in one's personal life".

Clinicians and researchers in schizophrenia have posited that symptoms and social functioning are intertwined (Glynn, 1998). Assessing social functioning is of critical importance in schizophrenia as it is a primary target for various rehabilitation programs. The discovery of neuroleptic medications rendered many patients amenable to psychosocial treatments who previously were unable to participate in such interventions. Despite the beneficial effects of neuroleptics on symptom severity and forestalling relapses, these medications have limited effects on social adjustments, indicating a need for interventions that target these areas of functioning. The prognostic significance of social functioning in schizophrenia suggests that interventions that are successful in improving social adjustments may have positive effects on the long-term outcome of the disorder (Mueser & Tarrier, 1998). Rise of deinstitutionalization movements in treatment of serious psychiatric disorders have highlighted social functioning as an important rehabilitation variable. Current level of symptomatology is important, as that is a potent

predictor of outcome. Thus, it will have a role in further understanding and management of schizophrenia.

Social functioning reflects patients' clinical condition; it has been found to be inversely associated with nearly all indices of illness severity, deteriorates when symptoms intensify, improves with betterment of clinical situation and is linked with poor prognoses and high risks for symptom relapse (Johnstone et al, 1990; Perlick et al, 1992).

Because of its complexity, social functioning is a difficult concept to measure validly. Social functioning in schizophrenia tends to vary among patients and within patients at different points in time (as well as in different stages of illness). The social withdrawal and inability to perform social roles persist even after acute symptoms abate (Bellack et al, 1990; Bailer et al, 1996). Follow up studies of patients with persistent schizophrenia who have moved from institutional to community settings show little change in patients' social functioning between the initial and follow up assessments (Okin et al, 1995).

For assessment of current social functioning, researchers mostly have used two approaches. Researchers (Glynn, 1998; Addington & Addington, 1999) have assessed psychopathology and concurrent social functioning and have correlated them. A second less prevalent strategy was more thorough assessment of relation of overall psychopathology to a single area of social functioning. Some studies attempt to test more expanded models of predictors of social functioning by including variables such as premorbid functioning



(Glynn, 1998). Published research in this area state that there is statistically significant relation between some measures of psychopathology and concurrent social functioning; and when separate constellation of symptoms are evaluated, negative symptoms have very strong relation with social functioning (Bellack et al, 1990; Addington & Addington, 1999).

Negative symptoms are fairly specific to schizophrenia (Cuesta & Peralta, 1995), occur only infrequently in other psychiatric disorders (Pogue Geile & Harrow, 1984) and even if they occur in other illnesses, they do not appear to endure except in schizophrenia (Husted et al, 1995). Also negative symptoms are more stable than positive symptoms, implying that they are core feature of schizophrenia (Eaton et al, 1995; Mueser et al, 1991).

About individual negative symptoms, it has been found out that symptoms like avoidance and withdrawal show strong negative association with social functioning (Hoffman & Kupper, 1997). Similarly, psychomotor retardation (Harvey et al, 1996), social withdrawal (Coryell & Tsuang, 1986), and poverty of speech (Pogue-Geile & Harrow, 1984) are all associated with poorer occupational outcome. Anergia has been seen to impair nonverbal social abilities more than the verbal ones (Mueser et al, 1996). Anhedonia appears to mediate the relationship between risk for schizophrenia and later social dysfunction (Freedman et al, 1998).

Schizophrenia with onset during various ages of life are distinctly different from each other (McClellan, 2005). This study attempted to determine relationship of negative symptoms with current social functioning in adult onset (> 19 years) schizophrenia.

## PROCEDURE

### Sample characteristics

Consenting male and female subjects from 18 to 60 years of age, diagnosed with schizophrenia (ICD-10-DCR criteria), with age of onset of illness at > 19 years and not having comorbid serious medical illnesses, mental retardation and other psychiatric diagnosis including substance dependence (except nicotine and caffeine) and personality disorders were taken up for the study. Patients were accompanied by guardians with > 5 years of formal education and who had been in contact with the patient for more than 12 months before the first psychiatric hospital admission or contact with a psychiatrist or before evidence of characteristic florid psychotic symptomatology. Patients were on a regular follow up for > 6 months with no subsequent change in diagnosis or addition of any comorbid psychiatric diagnosis.

### Description of the tools

**Sociodemographic and Clinical Data Sheet:** To record relevant details of each case.

**Social Functioning Index of Schizophrenia Research Foundation (SCARF)- India** (Padmavathi et al, 1995): Measures social functioning over four domains having 4/5 subcomponents; they are: self-concern, occupational role, role in the family and other social roles. Information is obtained from subject and / or informant and a global assessment of social functioning is made on a three-point scale with Mild impairment: >60; Moderate impairment: 30-60; Severe impairment: <30.

**Scale for Assessment of Negative Symptoms (SANS)-** (Andreasen, 1983): Designed to assess five domains of the negative symptoms complex e.g., alogia, affective flattening, avolition-apathy and attention.

**Structured Interview Guide For The Hamilton Depression Rating Scale (SIGH-D)-** (Williams, 1988): An observer-rated scale consisting of 21 items uses the standard version of HDRS with few minor changes in anchor-point cues.

**Simpson-Angus Extrapyramidal Side-effect Rating Scale-** (Simpson & Angus, 1970): A 10 item instrument used to measure the symptoms of parkinsonism or parkinsonian side effects related to the use of antipsychotic medications.

Consenting adult male and female patients meeting the inclusion and exclusion criteria were taken up by purposive sampling. A detailed interview to fill the sociodemographic and clinical datasheet was initially undertaken with each patient and the accompanying guardian. His / Her current social functioning was rated on SCARF- India's social functioning index, and negative symptoms were rated using Scale for Assessment of Negative Symptoms (SANS). For estimation of drug induced extrapyramidal side effects, which may mimic negative symptoms, Simpson-Angus extrapyramidal rating scale was applied and for exclusion of depressive symptoms, Structured Interview Guide for the Hamilton Depression Rating Scale (SIGH-D) was used.

## RESULTS

The data collected were numerically coded and put into Statistical Package for Social Sciences (SPSS) 10.1 for Windows 98 and analyzed. Frequency analysis was done as part of descriptive statistics, to describe the sample in terms of socio-demographic and clinical characteristics. Analysis was done correlating scores of various domains of SANS and SCARF-SFI. Correlation was also done between SCARF-SFI sub scores and SANS sub scores. Bivariate correlational statistical analysis using Pearson's *r* was carried out for that purpose.

To control for the effects of secondary negative symptoms over different variables partial correlation was carried out controlling for

the effects of scores of SIGH-D and Simpson -Angus scales.

**Table 1: Socio-demographic and clinical characteristics of the sample (N = 80)**

	Minimum	Maximum	Mean	S.D.
Age (yrs)	22.00	60.00	34.025	7.783
Total education (in yrs)	00.00	21.00	12.262	4.450
Age of onset of schizophrenia	18.00	50.00	26.087	6.525
Duration of illness (in years)	18.00	23.00	7.952	5.449
Duration of untreated psychosis (in months)	00.00	120.00	11.712	18.394
Total number of hospitalization	00.00	9.00	1.212	1.643
Total stay in hospital (in months)	00.00	20.00	1.925	3.1088
Current antipsychotic treatment (CPZ equivalent)	50.00	875.00	311.950	183.510
	Min.	Max.	Median	
Duration of current drug regime (in months)	1.00	180.00	6.000	
Sex		N	%	
	Male	62	77.5	
	Female	18	22.5	
Residence				
	Urban	44	55.0	
	Rural	36	45.0	
Marital status				
	Single	36	45.0	
	Married	44	55.0	
Religion				
	Hindu	68	85.0	
	Christian	06	07.5	
	Muslim	03	03.8	
	Others	03	03.8	
Occupation of the patient				
	Employed	37	46.3	
	Unemployed	24	30.0	
	Others	12	15.0	
	Student	07	08.8	
Total family income per month (Rupees per month)				
	0-5000	37	46.3	
	5000-10000	22	27.5	
	> 10000	21	26.3	
Family composition				
	Nuclear	58	72.5	
	Non nuclear	22	27.5	
Type of schizophrenia				
	Paranoid	54	67.5	
	Undifferentiated	18	22.5	
	Others	08	10.0	
Family history of mental illness				
	Absent	47	58.8	
	Present	33	41.2	
Categories of mental illness amongst those with positive family history (n=33)				
	Non affective	20	60.6	
	Others	09	27.3	
	Affective	04	12.1	
Relationship with the patient of those relatives having mental illness				
	1st degree relative	18	54.5	
	2nd degree relative	11	33.3	
	Others	4	12.1	
Categories of current anti-psychotic regime received by the patient				
	Atypical only	60	75.0	
	Others	14	17.5	
	Typical only	06	07.5	
Categories of antipsychotic received by patient according to clozapine profile				
	Non clozapine	69	86.3	
	Clozapine only	06	07.5	
	Clozapine+ additional	05	06.3	
Compliance				
	Good	76	95.0	
	Satisfactory	03	3.8	
	Poor	01	1.2	
Mode of onset				
	Insidious	67	83.8	
	Acute	13	16.2	
Course of illness				
	Improving	76	95.0	
	Static	04	05.0	
	Deteriorating	00	00.0	

Table 1 shows the sociodemographic and clinical characteristics of the sample (N = 80)

**Table2: Correlation (Pearson's r) of SCARF-SFI total score with SANS, SIGH-D and Simpson-Angus total scores in adult onset (>19 years) schizophrenia (N = 80)**

	SCARF-SFI total
SANS total	-0.642**
SIGH-D total	-0.480**
Simpson-Angus total	-0.293**

\*\* Correlation is significant at 0.01 level (two- tailed)

Abbreviations: Simpson-Angus: Simpson-Angus Extra pyramidal Side-effect rating Scale, SANS: Scale for Assessment of Negative Symptoms, SCARF-SFI: Schizophrenia Research Foundation-Social Functioning Index, SIGH-D: Structured Interview Guide for the Hamilton Depression Rating Scale

Table 2 shows significant negative ( $p < 0.01$ ) correlation of SCARF-SFI total score with total scores of SANS, SIGH-D and Simpson Angus Scales in adult onset (>19 years) schizophrenia .

**Table 3: Correlation (Pearson's r) of SANS total score with SIGH-D and Simpson-Angus total scores amongst adult onset (>19 years) schizophrenia (N=80).**

	SIGH-D total	Simpson-Angus total
SANS total	0.400**	0.158

\*\* Correlation is significant at 0.01 level (two- tailed)

Abbreviations: Simpson-Angus: Simpson-Angus Extra pyramidal Side-effect rating Scale, SANS: Scale for Assessment of Negative Symptoms, SIGH-D : Structured Interview Guide for the Hamilton Depression Rating Scale

Table 3 shows SANS total score and SIGH-D total scores were significantly negatively correlated ( $p < 0.01$ ) in adult onset (>19 years) schizophrenia.

**Table 4: Correlation (Pearson's r) between SIGH-D and Simpson-Angus total amongst adult onset (>19 years) schizophrenia population (N=80)**

	Simpson-Angus total
SIGH-D total	0.301**

\*\* Correlation is significant at 0.01 level (two- tailed)

Abbreviations: SIGH-D: Structured Interview Guide for the Hamilton Depression Rating Scale, Simpson-Angus: Simpson-Angus Extra pyramidal Side-effect rating Scale.

Table 4 shows significant correlation between total scores of SIGH-D and Simpson-Angus amongst adult onset (>19 years) schizophrenia ( $p < 0.01$ ).



**Table 5: Partial correlation between total scores of SCARF-SFI and total score of SANS controlling for the effects of total scores of SIGH-D and Simpson-Angus in adult onset (age>19 years) schizophrenia (N=80).**

	SANS total score	p
SCARF-SFI total score	-0.549***	0.000

\*\*\* Correlation is significant at <0.001 level (two-tailed)

Table 5 shows total scores of SCARF-SFI and SANS are significantly negatively correlated ( $p < 0.001$ ) even when controlled for the effects of total scores of SIGH-D and Simpson-Angus Scales in adult onset (> years) schizophrenia.

**Table 6: Correlation between components of SCARF-SFI and SANS in adult onset (>19 years) schizophrenia (N=80)**

	SCARF-SFI domains			
	Self concern	Occupational role	Family role	Other soc. role
Affective flattening	-0.414**	-0.324**	-0.208	-0.425**
Alogia	-0.436**	-0.157	-0.216	-0.313**
Avolition apathy	-0.561**	-0.653**	-0.335**	-0.540**
Anhedonia asociality	-0.562**	-0.434**	-0.216	-0.551**
Attention	-0.413**	-0.179	-0.346**	-0.268*

\* Correlation is significant at 0.05 level (two-tailed)

\*\* Correlation is significant at 0.01 level (two-tailed)

Table 6 shows Self-concern domain of SCARF-SFI which is negatively correlated ( $p < 0.01$ ) with all the domains of SANS. The occupational role domain of SCARF-SFI has negative correlation ( $p < 0.01$ ) with affective flattening, avolition apathy and anhedonia-asociality domain of SANS. The family role domain has negative correlation ( $p < 0.01$ ) with avolition-apathy and attention. The other social role domain of SCARF-SFI is negatively correlated with all the domains of SANS (for domain of attention  $p < 0.05$  and for other domains  $p < 0.01$ ).

## DISCUSSION

This study attempts to improve the methodological shortcoming of the previous studies conducted in this area by following means:

Patients, who after being diagnosed as having schizophrenia according to ICD-10-DCR, must be on a regular follow up for > 6 months with no subsequent change or inclusion of any comorbid diagnosis. This stringent criterion implies diagnostic stability and lesser chance of contamination by other diagnostic groups, which was a pitfall of many earlier studies. Guardians having at least 5 years of formal education provided better information. Earlier studies in India have used scales like World Health Organization- Disability Assessment Schedule (WHO-DAS) etc. to assess social functioning.

SCARF-SFI is a distinct improvement upon those scales as it is standardized and tested for the Indian population.

Tandon et al (2000) had defined two categories of negative symptoms. One was the phasic negative symptom, which subside following four weeks of antipsychotic treatment and another was the enduring or primary negative symptom, which persists even following four weeks of treatment. In this study, patients were included only after they were on regular follow up/treatment, for a period of minimum six months after being diagnosed as having schizophrenia. Therefore, the primary enduring variety of negative symptoms could be assessed effectively.

Depression, extra pyramidal side effects due to antipsychotics and chronic institutionalization mimics negative symptoms in schizophrenia. In this study, no chronic institutionalized patient was taken. Sample was collected from outpatient department, fresh admissions in indoor or from follow-up cases of chronic schizophrenia clinic run by the center of study. To find out the effects of depression and extra pyramidal side effects over negative symptom, Structured Interview Guide for Hamilton Depression Rating Scale (SIGH-D) and Simpson-Angus Extra pyramidal Side-effect Rating Scale were used. Effects of those on negative symptoms of the study subjects were controlled during statistical analysis on partial correlation model. This is a distinct methodological improvement from earlier studies.

In adult onset (>19 years) schizophrenia subgroup (N=80), a significant negative correlation ( $p < 0.01$ ) of SCARF-SFI total score with total scores of SANS was found. Also, significant negative correlation was found with total score of SCARF-SFI and total scores of SIGH-D and Simpson-Angus respectively. The relationship between SANS total score and SCARF-SFI total score was subjected to scrutiny in partial correlation model of statistics, controlling for the confounding factors of SIGH-D score and Simpson-Angus score, for depression and extra pyramidal side effects respectively, which may mimic as secondary negative symptoms. On that partial correlation model too negative correlation of SANS total was found with the total score of SCARF-SFI ( $p < 0.001$ ).

It was found that the self-concern domain was significantly negatively correlated with all the domains of SANS ( $p < 0.01$  level). The occupational role domain had negative correlation ( $p < 0.01$ ) with affective flattening, avolition-apathy and anhedonia-asociality; but the correlation was not significant with alogia and attentional impairment. The family role domain was found to be negatively correlated ( $p < 0.01$ ) with avolition-apathy and attentional impairment but not with other domains of SANS. The other social role sector which primarily incorporates social interactions with friends, neighbours, distant relatives, colleagues and mingling with social activity groups was found to be having negative correlation upto a



variable degree ( $p$  value ranging from  $<0.05$  to  $<0.01$ ) with SANS domains. This finding was fully corroborative with the study by Breier et al (1991) and Bellack et al (1990).

Analyzing the results in a holistic way, it could be observed that in the adult onset ( $>19$  years) subgroup, negative symptoms had significant impact on current social functioning. Available literature has numerous studies with almost similar findings. Negative symptoms have been related to reduced social competence (Bellack et al, 1990; Lysaker & Bell, 1995) and to impairments in both vocational and avocational pursuits and in social problem solving (Davidson & McGlashan, 1997; Hoffman & Kupper, 1997). Psychomotor retardation (Harvey et al, 1996), social withdrawal (Coryell & Tsuang, 1986) and poverty of speech (Pogue-Geile & Harrow, 1984) are all associated with poorer occupational outcome.

A number of factors can be expected to influence social behaviour in schizophrenia (Bellack & Mueser, 1993). They are:

#### **Social skills**

The term "skill" is used to emphasize the social competence is based on a set of learned performance abilities, rather than traits, needs, or other "interpsychic" processes. Poor social behaviour is often the result of social skills deficits. Social dysfunction results from three circumstances: when the individual does not know how to perform appropriately, when he or she does not use skills in his or her repertoire when they are called for, or when appropriate behaviour is undermined by socially inappropriate behaviour. Individuals with schizophrenia fail to learn appropriate social behaviours for three reasons. First, children who otherwise seem normal but who later develop schizophrenia in adulthood seem to have subtle attention deficits in childhood. These deficits interfere with the development of appropriate social relationships and the acquisition of social skills. Second, schizophrenia often strikes first in late adolescence or young adulthood, a critical period for mastery of adult social roles and skills, such as dating and sexual behaviours, work related skills, and the ability to form and maintain adult relationships. Many individuals with schizophrenia gradually develop isolated lives, punctuated by lengthy periods in psychiatric hospitals or in community residences. Such events remove clients from their "normal" peer group, provide few opportunities to engage in age-appropriate social roles, and limit social contacts to mental health staff and other severely ill clients. Moreover, skills mastered earlier in life may be lost because of disuse or lack of reinforcement by the environment (Bellack et al, 1997).

#### **Psychotic symptoms**

Patients can be expected to have difficulty fulfilling social roles and behaving in a socially inappropriate manner at the height of acute

exacerbations (Bellack et al, 1997).

#### **Motivational factors**

Most chronic clients have a history of social failure, rejection, and criticism. As a result, they learn that it may be safer to minimize social interactions than to risk further failure or censure (Bellack et al, 1997).

#### **Affective states**

Social interaction often is very anxiety provoking to individuals with schizophrenia and leads to avoidance. Clients are particularly sensitive to conflict and criticism and will withdraw from potential conflict situations even when they are being taken advantage of or unjustly accused of things they have not done (Bellack et al, 1992).

#### **Environmental factors**

Schizophrenia patients' skills tend to be limited and their performance often is odd or imperfect in some way. Unfortunately, many people are not tolerant of idiosyncrasies or social errors and tend to be unsympathetic, impatient, or overtly critical. Many patients do not have the resources to participate in social-recreational activities that they might otherwise be able to succeed in and enjoy. Also, many patients are isolated and do not have good social networks. The illness is stigmatizing, leading others to avoid them. Repeated exacerbations and periods in the hospital disrupt relationships and gradually remove clients from the social environment (Bellack et al, 1997).

#### **Neurobiological factors**

The illness is characterized by significant deficits in information processing (Seidman et al, 1992), attention and memory, especially with short-term verbal memory (Mueser et al, 1991). Patients have difficulty drawing abstractions or deducing relationships between events e.g., between current and past experience. These symptoms along with negative symptoms deprive the patient of the motivation and energy to participate in social activity or to enjoy interactions with others.

Practical implications of these findings of the current study are manifold. Schizophrenia is a leading worldwide public health problem that exacts enormous personal and economic costs. Negative symptoms have been detected to be the major contributor of socio-occupational dysfunction in this schizophrenic subgroup. Adequate recognition of this subgroup and implementations of appropriate interventions may help in amelioration of one of the biggest disabilities of world. The negative symptoms could be managed with pharmacological and/or psychosocial interventions like token economy, social skills training and cognitive behavioural therapy, to help this patients lead a more fruitful life.



The above study has the following limitations, which should be taken care of in future studies:

1. The study was conducted in a tertiary care hospital where mainly assessment of severely ill patients is done. Replication is required in a population-based larger sample, drawn in a randomized fashion.
2. Current study has a male: female ratio of about 4:1, thereby limiting statistical power of tests in case of females. Future study should incorporate more number of female cases.
3. The cross-sectional study design fails to point out any changes on the level of negative symptoms over the course of time. No association between dosage and kind of antipsychotics and positive and negative symptoms have been looked for. Future studies should incorporate those aspects.
4. Biological correlates of current social functioning or concurrent schizophrenic symptoms have not been looked for. Future studies should include advanced neuroimaging techniques, neurophysiological investigations or evaluate biochemical parameters in blood or CSF in individuals with schizophrenia.
5. Present study lacked measures like information processing deficit, self-stigma, work and residential environments. Further endeavor should incorporate these domains of social network indicators and measures of work and residential environment.

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## Brief Communication...

## RELATIONSHIP BETWEEN ACADEMIC ACHIEVEMENT, SELF-ESTEEM AND INTERPERSONAL COMPETENCE AMONG SCHOOL GOING ADOLESCENTS

Ranjeet Kumar<sup>1</sup>, M. Thomas Kishore<sup>2</sup>

## ABSTRACT

**Background:** Academic achievement has considerable effect on the self-esteem of the children and it also influences the interpersonal competence. **Aim and Objectives:** Since the children spend a considerable part of their time in the schools, it is necessary to study its effect on self-esteem and interpersonal competence as they shape the personality. **Methodology:** Boys and girls (N=50) aged 12 to 15 years, from class VIII to X were included in the study through random sampling method. Based on the teachers' ratings they were classified into three groups below average, average, and above average. All the participants were administered interpersonal competence scale and self-esteem scale. **Results:** Results indicated that the three groups did not differ in their self-esteem. However, they significantly differed in their interpersonal competence. There were no significant differences between the boys and girls in academic achievement.

**Key Words:** Academic achievement, self-esteem, interpersonal competence and adolescents

## INTRODUCTION

School is the strongest institution in the child's life and there are unprecedented opportunities to improve the lives of children as a typical day is organized around attendance at school (Hendren et al, 1994; Kaplan, 2000). It is the place where children develop, to a considerable extent, self-esteem and social competence. Erik Erikson (1963) postulated that adolescents put in hard work to attain a sense of achievement during the school going period. If they succeed in their goals they develop feelings of self-confidence and pride concerning one's achievements. Conversely, one's own beliefs that work and achievements are below the mark produces inferiority. Given that 20-50% of school children suffer from scholastic backwardness, understanding the factors associated with this should be a major issue while dealing with school children (Kapur, 1985; Shenoy & Kapur, 1996).

Academic achievement has been related to various factors such as social competence, intelligence and economic status (Kakar, 1970; Wig & Nagpal, 1972; Bapna & Ramanujam, 1976). But many studies did not address the issue of what causes these problems (Kapur, 1995). For example, though there is a correlation between academic achievement and economic status, its influence accounts for 5% only. Or, even if the relationship existed it was found to be low (Kohn, 1994). These aspects point that there are other factors associated with academic achievement.

Consistent with Erikson's postulations (1963), several studies from the West revealed that academic motivation declines in the

adolescence. Senses of anonymity and poor peer relationships were found to be responsible for this (Thornburg & Glider, 1984; Paulson, 1994).

From the available literature, it appears that self-esteem is poorly correlated with academic achievement but has a strong relationship with social or interpersonal competence. The present study was designed to understand the cumulative relationship of self-esteem and peer relations (i.e., social competence) with academic achievement.

## MATERIALS AND METHODS

The study was conducted at a private English medium school in Ranchi. Boys and girls of class VIII through IX were included in the study through random sampling, after an informed consent of the school principal and children themselves.

## Tools

1. **Culture Free Self-Esteem Scale (Battle, 1981):** It consists of 60 items of yes- or no- type choice. High score indicates high self-esteem.
2. **Interpersonal Competence Scale (Cairns et al, 1995):** It contains 18 items rated on bipolar continuum of a 7-point scale. It is meant for children from grade III through XII. Teachers, school counselors and administrators should administer it. It yields six factors of social competence: aggression, academic achievement, popularity, affiliation, Olympian qualities and internalizing problems.

## Procedure

The children were administered Culture Free Self-Esteem Scale (Battle, 1981) in a group setting. Class teachers' ratings were obtained on Interpersonal Competence Scale (Cairns et al, 1995) and academic achievement. Based on the teachers' ratings, children were divided into three groups for their academic achievement- low achievers (<35%), average (36 to 74%) and high achievers (>75%). The grouping is similar to that of Shenoy & Kapur (1996).

The data was analyzed with SPSS for Windows (Version 11.0). Percentages, Chi-square, One way-ANOVA, Post-hoc Analysis, and regression analysis were done.

## RESULTS

The mean age of the group was 13.6 (.76) years. And, the sample consisted of 28 boys and 22 girls. There were no significant differences among the low, average and high achievers in their age, education, sex and socio-economic status (Table 1). With respect to the academic achievement, no significant group differences were found in the self-esteem. However, the groups differed significantly in all the areas of social competence except aggression (table 2). Academic achievement could be predicted by the social competence ( $t = 2.95$ ;  $p = .005$ ) (Table 3).

**Table 1: Group differences in the socio-demographic variables**

Variables	Academic achievement			F/x <sup>2</sup> df=2
	Low n= 16	Average n= 25	High n= 9	
Age	13.38±.89	13.72±.61	13.67±.87	1.06
Education	8.38±.50	8.44±.51	8.56±.53	0.36
Sex				
Male [n (%)]	10(62.5%)	15(60%)	3(33.3%)	2.31
Female [n (%)]	6(37.5%)	10(40%)	6(66.7%)	
Socio- Economic Status				
< 5000 Rs/M [n (%)]	15(93.8%)	17(68%)	8(88.9%)	4.59
>5000 Rs./M [n (%)]	1(6.3%)	8(32%)	1(11.1%)	

**Table 2: Group differences in self-esteem and social competence**

		Academic achievement				F/x <sup>2</sup>	Post-hoc*
		Low (L) N= 16	Average (A) N= 25	High (H) N= 9			
Self-esteem		29.38 8.03	30.00 6.04	33.67 4.58	1.36		NS
Social competence	Aggression	5.39 1.39	4.85 1.27	4.81 1.98	.79		NS
	Popularity	4.15 1.76	4.81 1.14	5.37 1.07	2.35		L<H
	Academic achievement	1.56 .88	2.33 1.08	3.71 1.24	11.93		L<A L<H A<H
	Affiliation	4.31 1.39	4.52 1.27	5.50 1.09	2.66		L<H
	Olympian	3.02 1.49	3.43 1.49	4.26 .83	2.26		L<H
	Internalizing problems	4.00 1.04	4.24 .91	3.15 .73	4.61		L>H A>H
	Total Scores	22.44 3.41	23.99 3.05	26.79 3.71	5.06		L<A L<H A<H

NS = not significant

\* The mean difference is significant at .05

**Table 3: Regression analysis**

	Unst*	Standard Error	Stan**	t	p-value
Self-esteem	1.20	.01	.11	.83	.41
Economic status	.19	.23	.11	.85	.39
Social competence	7.87	.03	.39	2.95	.005

\*Unstandardized \*\*Standardized

## DISCUSSION

Consistent with earlier studies, the present findings reveal that there were no gender differences in academic achievement (Kaplan, 2000). Contrary to earlier studies (Francis, 1997; Gurney, 1987), in the present study, self-esteem did not differ with respect to the academic achievement. The reason could be that self-esteem is a very broad concept in which various aspects of self and the achievement may be one component (Frey & Carlock, 1989; Kohn, 1994). However, social competence seems to be associated with academic achievement, which may imply that peer relations and social competence affect the academic achievement or vice versa (Paulson, 1994).

The low-achievers were less popular, lacked affiliations and sporting prowess. Interestingly, there were no significant differences between the average and high achievers in popularity. It means that children with extreme performances only will be detected for their popularity. The low achievers had more internalizing problems. At this point it is not clear whether educational failures cause emotional disturbances (McGee et al, 1986) or whether there is a common etiology for both (Shenoy & Kapur, 1996). In the present study, the socio-economic status had no effect on any of the study variables. Probably, it could be due to the fact that the study was done in a private English medium school where all the children were from middle and high socio-economic status.



From the above findings, it can be concluded that academic achievement is more associated with social competence when compared to self-esteem and economic status. The school-based interventions can focus on improving the social competence, which might help improving the academic achievement and reduce the internalizing problems in children.

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## Book Review...



Title : THE WHITE CASTLE

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Publisher : CARCANET PRESS LTD, BY FABER AND FABER  
LIMITED, LONDON

Price in India: £ 2.75 (INR 237 approx)

ISBN: 978-0-571-16466-0

ISBN: 0-571-16466-8

### Orhan Pamuk

Orhan Pamuk was born in Istanbul in 1952 in the wealthy westernized district of Nisantasi. Till his college life he had a great passion for paintings and dreamt of being an artist. After graduating from the secular American Robert College in Istanbul, Orhan Pamuk studied architecture at Istanbul Technical University for three years, but abandoned the course when he gave up his ambition to become an architect and artist. He went to study journalism. It was then that he decided to devote his life to writing and from the age of 23, he started the journey to become the one we know him today. He never worked as a journalist and soon became a full-time novelist.

His first novel *Cevdet Bey and His Sons* was published in 1982 which won him the Orhan Kemal and Milliyet literary prizes. For his second novel *Sessiz Ev* (The Silent House), he was awarded Madar Ali Novel Prize and also the 1991 Prix de la Découverte Européenne for the French translation of this novel. Then followed a series of novels which got appreciation from many quarters of the Turkish as well as greater European society. More creations came up in the form of *The White Castle*, *The Black Book*, *The Secret Face*, *The Other Colours*, *My Name is Red* and many more. The list of awards and prizes became longer and in 2006, he received the most prestigious award in the world: the Nobel Prize in literature for his famous novel *Istanbul: Memoirs of the City*.

### The White Castle: Storyline

It can be said that *The White Castle* made Pamuk an internationally famous novelist after it won him the Independent Award for Foreign

Fiction in 1990. It was the first of his novels to be translated into English and readers across the world were moved by its impact which was aptly reflected by The New York Times review saying "A new star has risen in the east—Orhan Pamuk."

The story is about an ambitious and enthusiastic Italian scholar, the unnamed narrator of the novel, who was sailing from Venice to Naples. His life met a dramatic change as he was taken prisoner by the Ottoman Empire forces. He shares: Many men believe that no life is determined in advance, that all stories are essentially a chain of coincidences. And yet, even those who believe this come to the conclusion, when they look back, that events they once took for chance were really inevitable. These words reflect a young scholar's conflict. After a long life in Turkey, a country occupied by people of a different religion, culture and views of life, after seeing that his life could not be like what he thought it would be, but was full of experiences he enjoyed every now and again and after a life which has given him unexpected success and recognition through a look-alike of him, he still was not sure which life was better. The one he dreamt of from his childhood days in his own country or the one he actually had lived over the years in the neighbouring country which ironically he had started liking.

After being taken to Turkey he gets a master, a minor Turkish courtier named Hoja. Hoja is another ambitious and zealous person who always believed in the superiority of the Ottoman Empire over the Europeans and the key towards further supremacy, as he believed, lied in gaining mastery over the science the western world was so fascinated about. In a matter of months they became partners and



took up new projects to gain the confidence of the young Sultan. From the display of fireworks in celebrations to building up weapons effective in massive warfare they went on working hard to create a masterpiece which would leave the world in awe.

After the initial phase of resistance, when the narrator found Hoja much less intelligent or creative and more obstinate and crude in his methods, dealings and thinking, the two young people discovered themselves and each other. The creativity, the imagination, the logic, the analytic mind and craving for glory was seen in both of them, albeit with different presentations. Despite the presence of rivalry and an urge to outperform the other, the respect for the qualities in the other person built up from both ends.

The young sultan of the country grew up and became more powerful and confident. Both these young people got recognized and appreciated for their efforts amidst mild protests from the other quarters of the palace and the two people became more and more unified; in their thoughts and actions, also in their dreams and ambitions. In the final phase, Hoja gets the opportunity to put all his, all their imagination and creativity into practice when he was given the charge of building up a weapon which would be used in the Sultan's war against the East Europeans. There they found the white castle, which they dreamt of conquering. The story takes a dramatic turn from there with Hoja fleeing to Italy, impersonating the narrator who stays back in Turkey as Hoja.

#### The White Castle: Review

The novel gives us new perspectives into life. It tells us about an individual who keeps rediscovering himself. He finds and appreciates new talents in him, new figments of imagination which find their ways into new creations. The characters grew older as the story progressed but one would think that they remained young throughout as the enthusiasm never faded, the creativity shone all through and the zeal for success was never wanting. Even at the fag end of life when the story is about to end, the reflections of the narrator does not portray regret, rather they reflect how content he felt through the richness of experiences he had gathered in an unexpectedly eventful life of his.

The narrator did face in the initial phase, what in social psychology is known as pressures towards conformity, through various descriptive and injunctive norms. He did try to resist the pressure as he always felt the need to maintain individuality and had a strong desire to maintain control over the events of his life. He was successful in the attempt upto a point of time after which he himself became the part of the society.

The entire novel also has mirrored the changes and transitions of

various states of mind the narrator went through. He was only 23 when he was held captive; a time when his feeling of what he was, was just as important as his appreciation of what he appeared in other people's eyes: his fiancée, friends, parents and relatives. Forced to face an unexpected change in environment with different people and expectations, he initially distanced himself from the proceedings. The idea of the role he was supposed to play or he wanted to take up, did not crystallize in his mind all that well initially. It came with the passage of time and in the process he became an active partner of his look alike Hoja to form a productive unit.

Pamuk, in his smart way leaves us guessing about who the protagonist character is; the narrator or Hoja. But one really wonders: are these two people indeed different? In fact it seems as if they are the same person living in two countries and fate got them together. Hoja indeed reminds us of the 'Another Orhan', Pamuk describes so elaborately in 'Istanbul'. The differences between them faded in no time and soon they started to think and believe, imagine and create in unison and surprised the people around them. The initial dislike about Hoja the narrator had blended with the admiration and respect for him he developed subsequently. In the end after having exchanged their positions and in the process their lives, the narrator tells how his efforts to forget Hoja went in vain. The conflict remained in his mind. Conflict about which life could be better; the one he was living in Turkey or the one he could have lived in Italy; who was indeed better, himself or Hoja? Pamuk tempts us to think if the two persons who looked alike were the two selves of the same person. As they themselves went on to form an unit the two characters showed the blend of art and science, modernism and convention, and the pleasant blend of east and west. It was as if through union with the other, the dreams were realized, the imaginations were shaped and the ideas became concepts.

The concepts of east and west, the differences in their methods, approaches, arts and science, lifestyles and ideas have been delicately portrayed by Pamuk. The novel is written in the backdrop of Ottoman empire, the golden era of Turkey. The Ottoman forces which came to Bursa in 1288, claimed power in 1299, and seized Constantinople in 1453, ruled Turkey till 1922 when Sultan Mehmed VI stepped down. Over centuries the Ottoman emperors, especially Mehmed II and Suleyman the Magnificent, took Turkey to an unprecedented height of military, cultural and academic excellence. But the novel also gives a hint that it has not depicted a picture of the time of the ultimate excellence, rather than a time of falling glory. It was the time when the European powers were catching up and their advancement in the science and technology was starting to mark its presence everywhere in civilization. A need for reform in administration, military force and social system of Turkey was being felt in many quarters. Sultan Mahmud II attempted to modernize



(criticized as to 'Europeanize') his army which met with resistance from the Janissaries ('new troops'). But a general feeling of need for change was prevalent among the youth; which got reflected in this novel by Hoja's tremendous zeal for innovative creations. Creations that would give Turkey the edge in warfare as well as in science, astronomy; the edge which will reinstall Turkey's supremacy over her neighbours. Hoja's quest of knowledge in science and urge to gain expertise in the field reflects a common Turk's belief that it is the area where the Turks lagged behind the western world. May be it was this dearth in expertise in science which prevented them from gaining superiority in the entire Europe.

The Turkish society had gone through changes over the centuries, percolated down from the high ranked rulers as well as the popular religious leaders involved in decision making; who themselves had gone through the metamorphosis coming out of social, cultural and political needs, as felt from within as well as from outside. In the process, though the gross cohesiveness among people was maintained, conflicts started to surface up. The opposing interests of the political leaders (who tried to 'modernize' the country) and the religious leaders (who tried to practise and maintain conventional rules) often lead to reciprocal faulty attributions and faulty communications, only to worsen the conflict in the larger society. The boundaries between the ethnic (Greeks, Armenians, Turks etc) and religious (Muslim, Christian, Jews etc) groups became more and more rigid, with repeated attempts from the sultans to 'liberalise' the society without transparently explaining the causes behind them. Each group considered themselves to be the poor victims of unfair treatments, with the perception of claimed 'equality' to be the process of 'equalization downward', with dismissal of the better status earned through generations of hard work and discipline. It hurt the majority Turkish sentiment as they had all made Turkey the home for peaceful coexistence of all ethnicities and religion, including the slaves who were given fairer status than any other contemporary country of Europe or Asia. The growing dissent and agitation took their toll on patriotism. The surprising emigration of Hoja to Italy near the end of the narration reflected the sad story. The national pride of the people of Turkey was getting undermined slowly.

One would say, that the view of Turkey 'The White Castle' portrays, is essentially European. This is not hard to understand. Orhan Pamuk is the citizen of a modern, post-Atatürk Turkey. Mustafa Kemal Atatürk, who successfully fought the Turkish National Movement (Turkish War of Independence) against the allied forces, prevented a partition of the country. After that he made reforms in his attempt of modernization; in the field of domestic and international politics, language, law and many other areas. Subsequently Turkey's persistent effort to get enmeshed with the West, over the following decades has drawn criticism from some quarters as attempts to 'westernize'

Turkey, rather than to 'modernize' her. It was viewed as Turkey's surrender to the growing and overpowering western influence in culture, lifestyle and language, ignoring the rich and vivid past. As Bernard Lewis (What Went Wrong: Western Impact and Middle Eastern Response; Phoenix, 2004) pointed out, a westerner in that period of fading glory and many Muslims now might suggest the role of science and the philosophy that sustains it, behind the loss of Muslim empires' supremacy. However, the civilizations had their own philosophy that had retained and perfected the heritage of ancients under the aegis of Islam. They had their own science, handed down by their own scientists of the past. Taqiuddin (also described as Taqi al-Din by some historians), the great Syria/Egypt born astronomer who built an observatory in Istanbul in 16th century, finds a mention in the current novel, but the overwhelming picture is, of a sense of threat among the hearts of the Turkish rulers and bureaucrats of being overtaken by the westerners with the advancement in science and technology. No one knows if this is the way things went actually in history, but Pamuk avoids the controversy about who is better; the east or the west. Rather, through the analytical mind he is gifted with, he shows us the real picture. The differences between east and west are little, on a larger frame they are all too similar. This impressed the narrator of the story who stayed back in Turkey. He missed his motherland but he grew up to love his new country. It was not with resignation that he lived in Turkey in the later years, but with natural spontaneity that he embraced it and imbibed the ways and means of life.

The White Castle remains special not just for its superior analysis of character, meticulous description of a medieval age Turkish lifestyle, complicated politics in the royal palace, the intricate mind-games between two young scholars, but for the fact that it fascinates readers of today about how unpredictable yet interesting life can be. Orhan Pamuk's masterpiece will be remembered for years to come as it gives new perspectives into life and makes one think about the most unknown and least understood person: himself.

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## Movie Review...

**"PERFUME: THE STORY OF A MURDERER"**Sagar Lavania<sup>1</sup>, CRJ Khess<sup>2</sup>, Kainaz N. Dotivala<sup>3</sup>

When one thinks of perfume, one experiences pleasant olfactory sensations. Movies evoke enjoyable audible and visual sensations. It is almost implausible to imagine that these varied sensory experiences, however delightful they maybe, could ever cross paths and that the power of smell can be effectively conveyed through a movie.

The film "PERFUME: The Story of a Murderer," is adapted from an allegedly "unfilmable" book 'Das Parfum' by German novelist Patrick Süskind, initially published in 1985, and is one of the most expensive European films ever made. The film's evocation of 18th century Paris is very real. However, Perfume is visually opulent, sometimes excessively, as even squalor and disease look beautiful, with the costumes, settings and cinematography.

Director Tom Tykwer has effectively tried to influence the audience with the power of smell. He achieves this by pairing a lightly mocking commentary from John Hurt, with lush visual imagery that tracks the olfactory exploration of the protagonist. To do this, he uses jarring macro shots of rotting carcasses and other odorous substances, and then suddenly replaces those images with extreme close-ups of nostrils. Thus the intensity of smelling experience had been depicted by facial expression of those who are smelling, use of music (arranged by Tykwer himself), zoom in shots of objects, and so on. The director has successfully conveyed the spectrum of olfactory sensation with varied passion.

A magical realist period movie, Perfume is a gripping, original thriller. The movie recounts the story of Jean-Baptiste Grenouille (Ben Whishaw) who was born in horrific conditions in 18th century France in the middle of a hot day in the filth of a Parisian fish market. An unwanted child, he is destined by his mother to be swept away with the rotting remains of the day. However, the infant survives, holding on to life that he smells vividly, sending instead his mother to the gallows. Grenouille possesses no scent of his own but is blessed with a nose in a billion, capable of identifying any odour from a distance and any note in a perfume's composition. He is sent to a Dickensian orphanage where he is shunned by the other children, who attempt to smother him, seemingly aware of his strange nature. He spends the initial years of his childhood mute and alone. Sold into a tannery, he becomes a dumb and compliant slave until a trip to the city overwhelms him with sensual delight. In the city he was introduced to thousand and thousands of new smells. Some that would change his life forever.

Intoxicated by the smell of a beautiful young plum seller (Karoline Herfurth), he tracks her through the Paris slums, but inadvertently kills her after a scuffle.

Untroubled by her death, he tries to overcome the womanly scent of her but the intoxicating power of her smell transforms his passion into obsession. He decides to learn to capture that smell. He persuades a wrecked celebrity Italian perfumer, Giuseppe Baldini (Dustin Hoffman) to teach him distillation and the other intricacies of perfume making. In exchange he offers his skills in identifying a perfume's ingredients and concocting ever more fascinating fragrances. Together they rebuild Baldini's business, surpassing his former glory. But Grenouille quickly becomes frustrated at his failure to preserve a perfect scent and goes to the picturesque town of Grasse, the Eden of perfume production.

Upon arrival in the town, he is captivated by the sight of the enchanting young Laura (Rachel Hurd-Wood), the daughter of Antoine Richis (Alan Rickman), one of Grasse's more important citizens. Grenouille resolves to 'capture' Laura's essence as the key note in his masterpiece, triggering an oddly chaste, asexual killing spree that sends him in pursuit of 13 women. Except for one prostitute, his victims are all virgins and destined to die sexually untouched. As the townspeople clamour to protect their daughters, led by the psychologically astute Richis, the film becomes enthralling. As the corpses pile higher without any betrayal of guilt from the killer, the investigation becomes full of drama. He is eventually sniffed out by a pet dog that belonged to one of his victims and is destined for the gallows.

At the culminating point of Grenouille's career, he reveals that he could manipulate people with the power of perfume. His genius is finally revealed to the world. Thus ensues a mass orgy. He experiences a moment of super human triumph and mass adoration while his worshippers experience religious and erotic ecstasy. His destiny however, brings him back to the same horrific fish market in Paris where he was born. He experienced perfect olfaction and power over mankind until his own lack of human smell took over him and inspired the last destructive act on his part. At the end of the movie, people were delighted to eat every part of his body to catch every bit of perfume he sprinkled on himself.

The character of the protagonist is almost unreal. Untamed, awkward,

and amoral to the extent, it will emerge as that of sociopathy. Grenouille is portrayed as an autistic serial killer. Whishaw plays him with a blank, sexless intensity, devoid of inner life, save for a rodent-like bearing and cunning. Born and bred in depravity, he learns to talk only after the age of 5 and is unable to relate to humans at all. He appears peculiar and eccentric, and does not seem to have much interest in the mundane realities of life. However he almost has a supernatural sense of smell. His life appears driven by a purpose: that of preserving smells and creating the ultimate perfume, which takes on an obsessional quality that borders on being delusional. In trying to seek the value and importance of his own existence he ruthlessly vanquishes that of others. The power he seeks through his magical perfume is finally attained and yet once achieved it loses its essence and with it the purpose of his life.

In spite of the theme of the film being uniformly dark, it is peppered with much humour. Although much gore is blatantly depicted in the film, the viewer is left slightly untouched by its horrors. One tends to look very pitifully at the protagonist and often feels dissociated from his actions. The film is filled with an almost bizarre irony, leaving the audience with mixed emotions. *Perfume* is a truly unique unsettling experience.

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## MY LIFE

*The article that follows is part of the Indian Journal of Social Psychiatry's (IJSP) Memoirs series. We hope that mental health professionals will take the opportunity to learn about the issues and difficulties confronted by the patients. In addition we hope that these accounts will give patients and families a better sense of not being alone in confronting problems that can be anticipated by persons with serious emotional problems. We welcome other contributions from patients, ex-patients or family members.*

*Clinicians who see articulate patients should encourage these patients to submit their articles to Editor, IJSP, Memoirs, Central Institute of Psychiatry, Ranchi-834006—The Editors.*

I was born in a remote village of Nawada, Bihar. My father was a 'mining sardar' in Eastern Coalfields Limited working in Raniganj, Bihar. I spent my childhood in a village with my mother and two young sisters. My village was very beautiful and quiet and the people were friendly and helping. I still cherish the memory of my childhood days. I joined village school and soon became a loved one in the entire school. I enjoyed studies and play equally and had many friends. My father used to visit us every month and we were a happy family. I passed my matriculation in 1994 after which I went to Raniganj to stay with my father to pursue higher studies. Though I didn't like the life of a busy town but soon with the increasing study load I gradually got used to the schedule. I joined B.Com and while I was studying that, my father fell ill. He was a heavy smoker and subsequently diagnosed to be suffering from lung cancer. It was a shock for the entire family and my mother simply broke down. Despite treatment from various places he passed away in 2000 during my B.Com final examinations. After graduation, I got a job in my father's office on compensatory grounds as attendance clerk. It was a new life for me, a new responsibility and everything was nice once again though I missed my father always.

In 2003, I first noticed the world around me to change. I assumed that my co-workers were trying to pull me down by conspiring against me and all were trying hard to stop my promotion. I had one more severe difficulty. How would you feel if someone comes to know of your plans and thought beforehand without being told? It was really a

horrible experience for me. I started to avoid people but still they would read my mind out. I thought there was a brain recording machine and it reads my mind and reports against me. Everybody went ahead of me. There was another problem—that I would hear a sound continuously. I would hear people talking about me constantly wherever I went. Some voices I would make out especially those of my co-workers, talking about me, planning to harm me. Sometimes they abused me and called me mad. I could not see anybody around which would make me more worried that what was happening to me! Every time I charged at them; they would laugh at me. I became irregular at work and would not feel like going anywhere, trying to hide myself from others. But I could not.... In the meantime I was married against my wish though my wife soon came to know about my experiences and started calling me a rude, ill-behaved and 'mad' person. She would stay most of the times in her 'maika' and would visit me once in a while. I would feel sad and left out.

With all my problems my mother took me to a doctor in 2006 and I was diagnosed to be suffering from "schizophrenia". I was put on medicines which I took regularly though the fact that people would come to know about my thoughts never stopped. I was admitted in a mental hospital but despite of efforts of many doctors that 'brain machine' continued to work. I felt it was never going to stop, until I die. For two years I continued to suffer in and out of the hospital after which I was finally admitted this time when I was given some different treatment.

This time I feel good as the voices have stooped disturbing me and the machine has not been troubling me any more. Oh! I feel so relieved. I have been told by my doctors that I have a disease of mind which can be cured with the help of medicines. I am so thankful to my doctors and all hospital people who have helped me to get rid of my ailment. I liked the atmosphere of the hospital as it reminded me of my old home in the village. Now I wish to go back home and to join my colliery job, and in future I would like to live with my wife and mother and someday I dream to have a child of my own.

Name withheld on ethical ground

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- Bhugra, D. & Mastrogianni, A. (2004) Globalization and mental disorder: Overview in relation to depression. *British Journal of Psychiatry*, 184, 10-20.
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