

DEPRESSION AND CARDIOVASCULAR DISEASES

According to Global Burden of Disease survey, by the year 2020, ischemic heart disease (IHD) and major depressive disorders will be two leading causes of disability. The Study ranked unipolar depression as the fourth leading cause of early death and disability worldwide. In developed countries, only IHD confers a higher disease burden than depression (Holden 2000). There exists a complex two-way interaction between depression and cardiovascular diseases though this potential association received little attention for more than 300 years, until Frasure-Smith and colleagues published a study demonstrating that patients who are depressed at the time of an acute myocardial infarction (MI) have markedly elevated mortality as compared with patients who are not depressed (Frasure-Smith et al, 1993). Since then, more than 100 studies have investigated this relationship, providing evidence that depression is prevalent (20% to 35%) in populations with cardiovascular disease, and is predictive of developing cardiovascular disease, and predictive of adverse outcomes among patients with existing cardiac disease. Modern paradigms for coronary heart disease have recently been extended beyond purely biochemical concepts broadening the horizon to incorporate broader dimensions of psychosocial factors which are also pertinent in the field of cardiology. Research interest has been growing substantially in this area exponentially over last two decades.

Epidemiological studies in India revealed that depressive disorder is highly prevalent with a general prevalence of 31.2 to 34 per 1000 population (Ganguly 2000; Madhav 2001). Similarly prevalence of Coronary Artery Disease (CAD) ranges from 33 per 1000 population in rural areas to 90 per 1000 population in urban areas predominantly showing a strong referral bias (Singh et al, 1997). It has been consistently proven in various epidemiological surveys that patients with depression have an increased risk of sudden cardiovascular death when compared with general population. Similarly the risk of depression is highest in the presence of concomitant cardiovascular disease. About 20% of patients with angiographic evidence of CAD have concomitant major depression and similar percentage of acute myocardial infarction (AMI) survivors meet the diagnostic criteria for depression. It has also been found that presence of depression in AMI survivors significantly increases the morbidity and mortality as compared with non-depressed survivors. 6 month post-AMI studies reveal that all categories

were associated with higher rehospitalizations, frequent anginal pains, higher mortality, physical limitations and poor quality of life (Frasure-Smith et al, 1993).

There is significant amount of literature suggesting strong association of depression with Coronary Heart Disease (CHD). Studies have found that the relative risk of depression for CHD related death ranges from 1.5 to 4.5 (Rugulies, 2002), however the biggest flaw is that the studies published in cardiology journals have taken varied criteria for assessment of depression e.g., few studies stuck to nosology though have not taken severity into account. Therefore it would not be prudent to generalize the findings. Literature has consistently demonstrated a gradient between the magnitude of depressive symptoms and the likelihood of adverse cardiovascular events however many studies have failed to find a consistent threshold (Lauzon et al, 2003). The mechanisms for occurrence of comorbidity of depression and cardiovascular disease are poorly understood but there is sufficient data to suggest that it does not occur by chance. Platelet abnormalities, autonomic tone, and health behaviours have all been implicated. There exists also the possibility that depression and vascular disease share certain vulnerability genes (McCaffery et al, 2006).

There is a strong association between clinical manifestations of CHD with the negative psychological state created due to depression. Literature suggests that negative states of hopelessness, pessimism, ruminations, anxiety and hostility have adverse effects on cardiovascular health. Type A behaviour characterized by chronic sense of urgency, impatience, competitiveness, high need for control and competency and anger has been conceptualized as a forerunner of adverse cardiovascular health although subsequently it has not been replicated with recent research methods. Frasure-Smith and Lesprenace (2005) identified all published studies from 2001 to 2003 using a prospective design found that despite various methodological limitations, depression remained a significant risk factor for both development and worsening of CHD. Similarly a recent meta-analysis measuring depression with followup for fatal CHD/incident myocardial infarction or all-cause mortality found that relative risk of future CHD associated with depression was 1.81. Interestingly, studies reporting results adjusted for left ventricular function attenuation reported a relative risk of 2.18

to 1.53. Both etiological and prognostic studies had lower unadjusted effect sizes than studies from which adjusted results were included (Nicholson et al, 2006).

It becomes important at the level of primary care level of health care delivery to identify and screen patients coming with cardiological ailments for concomitant depression. Some instruments like Mini International Neuropsychiatric Interview (MINI) and Beck Depression Inventory can be easily used by primary care providers. Pharmacological management includes use of tricyclic antidepressants though they are notorious to cause tachycardia or in some cases bradycardia with prolongation of QT interval (Roose & Miyazaki, 2005). Selective Serotonin Reuptake Inhibitors (SSRI) is considered as drug of choice as found in the Sertraline Antidepressant Heart Attack Randomized Trial (SADHART) which is the largest study of antidepressant treatment in patients with CHD till date. This study found no difference between Sertraline as compared with placebo on any of the cardiovascular parameters. The post hoc analysis of the SADHART data suggested that as Sertraline is associated with decreased platelet and endothelial activation markers, it might confer a morbidity and mortality advantage. Small sample size was a major limitation of the study (Sorenson et al, 2003). Need for psychosocial intervention in such patients could not be undermined and a study Enhancing Recovery in Coronary Heart Disease Patients Randomized Trial (ENRICH) study done to investigate the impact of adding Cognitive Behavior Therapy to usual care in reducing post MI mortality found that it was an effective way of treating depression in these cases though did not had any impact on cardiovascular mortality and morbidity (Mendes et al, 2006). Also supportive psychotherapy, group therapy and stress management strategies are found to be effective.

To summarize, role of depression as an independent risk factor for coronary disease is moderate though not conclusive so there is a dire need to plan for prospective, observational studies that specifically address linking biological mechanisms that share a common ground in causation of depression and CHD. Such trials should also include people at risk of development of depression in search for preventive measures to avoid this morbidity. Evidence is still lacking regarding the favourable impact of treating depression in patients with CHD. Also this comorbidity should be detected efficiently at primary care level to prevent the wrath of both the illnesses on each other. Longitudinal research is also required for assessing the effectiveness of psychosocial approaches in depressed CHD patients.

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MEDICATION ADHERENCE IN SCHIZOPHRENIA**Mohd Aleem Siddiqui¹, C.R.J. Khess²****ABSTRACT**

Schizophrenia is a common and devastating mental illness associated with significant economic and social effects, often requiring lifelong medication. Over the past 50 years, antipsychotic medications have emerged as the cornerstone in the management of schizophrenia. However, the failure of many patients with schizophrenia to follow their prescribed medication regimen has significantly undermined the promise of antipsychotic medications. Rates of medication non-adherence among outpatients with schizophrenia have been found to approach 50%. Adherence to medications is a complex health behaviour. The term adherence is intended to be nonjudgmental, a statement of fact rather than of blame of the prescriber, patient, or treatment. More recently, clinicians have focused on the need for a collaborative partnership with patients to attain medication adherence. Examining adherence to medications is important for maximizing treatment outcomes with antipsychotics. Improved medication adherence results in improved humanistic, clinical, and economic outcomes and enhances the ability to enjoy a satisfactory quality of life and function.

Key words: *Medication adherence, schizophrenia*

INTRODUCTION

Many individuals with psychiatric disorders remain untreated although effective treatments exist. The treatment gap (the percentage of individuals who require mental health care, but do not receive it) is high for most mental disorders. As per World Health Organization estimate the median treatment gap for schizophrenia, including other non-affective psychosis, was 32.2%. It varies across regions and is likely to be an underestimate due to the unavailability of community-based data from developing countries where services are scarce (Kohn et al, 2004).

Of those who reach the health care system, non-adherence is another hurdle to well being. Adherence to any regimen reflects behaviour of one type or another such as, seeking medical attention, filling prescriptions, taking medications appropriately, immunizations, attending follow-up appointments and executing behavioural modifications, are all examples of therapeutic behaviours. Although reluctance to comply with prescriptions seems to be a human trait and non-adherence is a ubiquitous problem in medicine (Powsner & Spitzer, 2003), some aspects of schizophrenia

might make it especially difficult for patients to adhere to treatment as it is an illness in which insight is more likely to be impaired than is the case with other illnesses. The disorganization and cognitive disturbances are additional symptoms of schizophrenia that interfere with regular intake of medication (Marder et al, 1983). In addition, schizophrenia's chronic course often requires lifelong medication. As a general rule, the longer the medication treatment period, the lower the rates of adherence. Also, schizophrenia and antipsychotics are subject to stigma. The use of antipsychotics is hampered by side effects that make patients more reluctant to follow prescriptions, a reality that apparently has not improved substantially with the advent of atypical antipsychotics (Dolder et al, 2002; Patel et al, 2002). Some patients may think that an easy way to alleviate stigma is to stop treatment. Admissions due to non-adherence are avoidable, at least from a theoretical point of view, and represent a great opportunity for savings. It is necessary to tackle the issue of non-adherence during the inpatient stay for the sake of success of further treatment.

Poor adherence with antipsychotic medications increases the risk of relapse. Non-adherent patients have an average

risk of relapse that is 3.7 times greater than that of adherent patients (Fenton et al, 1997). Relapse due to non-adherence may also be more severe and dangerous. One of the more disturbing consequences of medication non-adherence is an increased potential for assault and dangerous behaviours, especially during periods of psychosis. A coherent approach for reducing non-adherence would benefit substantially from a theoretical model that organizes existing research findings and provides guidance to points of leverage for improving adherence.

The traditional models dominant in the study of patient adherence, such as the Health Belief Model (Rosenstock, 1974; Becker, 1974, Maiman & Becker, 1974), are typically based on a rough cost-benefit calculation in which the patient considers the advantages and burdens of taking medications by weighing the probabilities of risks and benefits. While these models have been useful as organizing frames, they have had limited predictive value and are not helpful in understanding and predicting adherence in schizophrenia. It has long been recognized that external influences independent of patient decision making also affect adherence. Other models focus specifically on the treatment and communication process and the extent to which patients understand and implement the treatment regimen. Still other models focus on parallel processing on the cognitive level through disease and treatment schemas and on the motivational level through emotional response. These models illustrate the importance of specific coping plans to implement intent. Although not fully formulated, patient schemas and coping plans may offer more potential for improving adherence in schizophrenia. It is essential to go beyond the usual individual psychological focus of these models and give attention to contextual cues and reinforcements that are more amenable to intervention within treatment programs.

Non-adherence has been reported to be 10% to 60% in literature (upto 80% in psychoses) and in most of the cases it would result in relapse. Learning how to foster and ensure medication adherence is, therefore, primary therapeutic task in the treatment of schizophrenic patients. Knowledge of how

to improve adherence could contribute as much to treatment as introduction of neuroleptics itself did (Kissling, 1994).

In addition to their positive impact on health status of patient with chronic illnesses, higher rates of adherence confer economic benefits, such as direct savings generated by reduced use of sophisticated and expensive health services needed in cases of disease exacerbation, crisis or relapse. Indirect savings may be attributable to enhancement of, or preservation of quality of life and the social and vocational role of patients.

Five dimensions of adherence have been discussed (WHO, 2003)-

- Socio-economic factors
- Illness related factors
- Therapy related factors
- Patient related factors
- Health care team and system related factors

Definitions of Compliance

Problems with compliance are common in all areas of medicine (Blackwell, 1976). Compliance has been defined as the extent to which a person's behaviour is in line with the medical advice given. It is a complex phenomenon representing a patient's contribution to the management of illness (Babiker, 1986). It comprehends a wide variety of behaviors: failure to enter a treatment program, premature termination of therapy, and incomplete implementation of instructions, like drug prescriptions. Factors associated with non-compliance can be identified in the patient, his network, the illness, the physician, the treatment setting and the medication itself (Blackwell, 1976). Non-compliance is closely related to treatment outcome (Drake et al, 1991). The adherence project of WHO (2003) has adopted the following definition of adherence to long-term therapy "The extent to which a person's behaviour - taking medication, following a diet and/or executing life style changes corresponds with agreed recommendation from a health care provider".

From compliance to adherence

There has been a trend in the literature over the past decade to re-conceptualize adherence. Until recently, adherence to an individual's self-care regimen was termed "compliance." The terminology of compliance, however, has implied an authoritarian relationship between the physician and patient (Jenkins, 1995). Compliance has also been considered to imply that patients must yield to or obey the recommendations of physicians, requiring strict reliance upon medically derived goals. The term "adherence," on the other hand, has been defined as the extent to which a person's behaviour coincides with medical or health advice. Adherence may be more preferable in a medical setting because it allows for a continuum of adherence, and recognizes that self-care behaviours are essentially decisions made by the individual based upon the information provided by the health care professionals. Adherence must involve multiple indicators of self-care, not judged solely upon one specific or problematic behaviour.

Patients with more complex regimens that may include multiple medication administrations, a complex diet, and frequent blood level monitoring events are less likely to have higher rates of adherence. Therefore, it is necessary to conceptualize the individual within the continuum of adherence across all behaviours. Adherence requires comparing an individual's behaviours against those of a standard or recommended practice, as opposed to judging one's behaviour against a provider's recommendation.

Non-adherence in psychotic disorders

Medication adherence should not be seen only as a trait of the patient, or related to motivation or resistance, rather than as collaboration between the patient and a doctor. Models of adherence based on physical medicine (Sackett & Haynes, 1976) do not fit properly in the treatment of psychiatric illnesses, where the insight and perception of illness may also be distorted (Kane, 1985).

Studies evaluating compliance or adherence issues in

psychiatry have focused on medications, dropout from outpatient and rehabilitation programmes, and self discharge from hospital against medical advice. Rates of non-compliance in psychotic disorders have been reported to vary from 11 to 80% (Johnson, 1984; Kane, 1985; Ayuso-Gutierrez & del Rio Vega, 1997).

Socio-demographic factors

In most studies, gender has not been associated with compliance (Fenton et al, 1997). Living alone (Seltzer et al, 1980) and poor housing (Drake et al, 1991) increase the risk of medication non-compliance. Supportive family environment has been reported to have a positive effect on compliance. The family members' awareness of the patient's illness is also connected to better compliance (Smith et al, 1997). Social activity has been related to more positive attitudes towards medication in outpatient care (Draine & Solomon, 1994). Increasing cost and difficult affordability of medication may also become a factor affecting adherence.

Patient and illness related factors

1. Presentation / Symptoms of illness

The symptoms and course of a psychotic illness may affect compliance. Patients harboring paranoid delusions may interpret side-effects as particularly threatening or invasive. Grandiose delusions have been associated with high rate of non-compliance (Van Putten et al, 1976). Presence of depression in psychosis may also result in poor compliance (Pan & Tantam, 1989). Non-compliance may result in a longer duration of treatment (Razali & Yahya, 1995).

Substance abuse in patients of schizophrenia is associated with increasing non-adherence and re-hospitalization. It appears to be a strong predictor of poor adherence in psychosis, especially in men (Miner et al, 1997). More specifically, non-compliance has correlated more clearly with heavy than with slight alcohol use (Drake et al, 1989), and with the use of cannabis (Smith et al, 1997).

2. Loss of Insight

Insight is awareness or recognition of illness, and perception of the progress or origin of symptoms (Amador et al, 1993). David et al (1992) conceptualize insight into three dimensions:

- a. The patient's recognition or awareness of the illness and the realization that the illness is mental;
- b. The ability to re-label the experience of certain mental events as pathological, e.g. realizing that hearing voices could be an auditory hallucination;
- c. Treatment compliance.

Lack of insight often leads to problems in collaboration between patient and doctor and results in poor outcomes. There has been research interest in investigating both the manifestation and negative consequences of lack of insight in psychoses.

3. Cognitive disturbances and memory dysfunctions

Chronic psychotic symptoms result in a significant decline in intellectual abilities. The cognitive deficits may emerge in the domains of attention, memory, executive function, language, oculomotor speed and visuospatial perception. The linkage between cognitive disturbances and compliance in schizophrenia is still somewhat obscure. In addition to the lack of insight, the possible mechanisms between cognitive disturbance and noncompliance include selective encoding of threat-related stimuli in delusional states (Blackwood et al, 2001), misattribution of one's own actions (Franck et al, 2001), or energetic or motivational deficits (Schmand et al, 1994).

Medication-related factors

Medication adherence is reduced by complex treatment regimens and by neuroleptic side-effects (Blackwell, 1976; Kemp et al, 1996), most notably akathisia and akinesia. Patients recently discharged from hospital may be careful with compliance, but this is likely to decline over time with the symptom relief (Kane, 1985). Adherence issues related to medications include errors of omission, purpose, dosage

and timing (Blackwell, 1976).

A negative mood state due to medications has been associated with negative attitudes and impaired compliance (Awad, 1993). Negative attitudes towards antipsychotic medication predict non-compliance (Fenton et al, 1997). The label, package or form of the medication or the type of drug may also alter medication compliance (Blackwell, 1976). Atypical antipsychotic agents, such as olanzapine, risperidone, clozapine, or quetiapine have shown superiority over conventional antipsychotic drugs by producing less extrapyramidal side-effects (Leucht et al, 1999; Geddes et al, 2000) and enhancing cognitive functioning (Keefe et al, 1999; Meyer et al, 2002) however the evidence, so far, regarding atypical antipsychotics and better compliance in schizophrenia has been inconclusive (Allison & Casey, 2001; Chakos et al, 2001).

Health care system related factors

In psychiatry, as in any treatment, it is essential to collaborate with, and prepare and inform the patient about the forthcoming treatment modalities. The effect of patient education as improved outpatient attendance was noted in psychiatry clinics and published in the early and mid 1970's (Goldstein, 1992). Comprehensive psycho-educational and behaviour-oriented treatment models were described ten years later.

The psycho-educational treatment programmes are based on the vulnerability-stress model, or the stress-diathesis hypothesis. As per this module, schizophrenia is dynamically a product of interacting forces, some genetic or biological and some psychological, some innate or constitutional and some learned through experience (Nuechterlein et al, 1994). In follow-up studies, the psycho-educational programmes have resulted in improved outpatient compliance and lower re-hospitalization rates (Wallace et al, 1992). The compliance improving methods used in these programmes are:

1. informing the patient and the family about the purpose and side-effects of medication,

2. cognitive reformulation of family attitudes towards psychiatric illness,
3. home-based outpatient appointments, and
4. flexible dosage in maintenance treatment to avoid neuroleptic side-effects.

Nevertheless, psycho-educational interventions without cognitive reformulation and focusing on patients' attitudes to medication have not been much successful in improving patient adherence (Zygmunt et al, 2002).

Individual, cognitive-behavioural interventions have also resulted in improved compliance. Frank and Gunderson (1990) found an association between a good alliance in individual therapy and medication compliance during 6-month follow-up. A combination of psycho-education, counseling and cognitive therapy resulted in more positive attitudes, but not compliance in schizophrenia patients in a controlled multi-centre study (Buchkremer et al, 1997). In refractory schizophrenia, the use of assertive community treatment programmes resulted in fewer relapses and hospitalization and improved patient satisfaction.

Recent conceptualizations of adherence

In recent times there has been reconceptualization of adherence. Early models of adherence often focused upon the personality or characterological features of the patient, attributing low adherence to a maladaptive personality style. More recent formulations have investigated procedural delivery of medical treatment as well as the individual's beliefs and commitment to engaging in the health behavior. Adherence has been thought of a multidimensional construct, reflecting the dynamic nature of individual patients as well as factors specific to the given treatment or disease. Under this conceptualization, determinants to adherence are often the relative contribution of individual characteristics and beliefs (i.e., motivation, health beliefs, self-efficacy), factors of health care delivery (i.e., physician recommendations), and factors in the individual's environment that may facilitate (e.g., social support) or interfere with treatment adherence. Along this line,

there has been an increased interest in the social, environmental, and psychological factors that may interfere with treatment, commonly referred to as barriers to treatment.

Among the extensive theoretical conceptualizations of adherence, two widely accepted theories of adherence that directly address barriers to treatment are:

- The Health Beliefs Model
- The Transtheoretical Model of Behaviour Change.

The Health Beliefs Model (HBM): The Health Beliefs Model (Rosenstock, 1974; Becker, 1974, Maiman & Becker, 1974) conceptualizes an individual's motivation based upon the expectancy of goal attainment which is a particular health behaviour. According to this model, two facets influence health behaviour, the desire to avoid illness and the belief that a specific health action will prevent (or ameliorate) illness. There are several distinct components of the HBM, including the following: the perceived susceptibility to contracting a condition; the perceived severity of contracting the illness or severity of the illness in itself; the perceived benefits or effectiveness of actions or treatments to reduce the disease threat; perceived barriers or negative aspects of a particular health action that may impede the behaviour; and the cues to action or the stimuli to trigger the decision making process. According to the HBM, the likelihood of attaining the goal of the health behaviour or the expectancy of success of the health action is an output of the impact of the perceived barriers or costs of that action (Clark & Becker, 1998). Hypothetically, if the benefits of the health action outweigh the costs of the action or the barriers to performing the action, then the likelihood of engaging in the health action is higher. However, the likelihood of performing the health action is significantly reduced if the number of barriers to engaging in the behaviour outweighs the benefits of the health behaviour. More importantly, if the perceived severity of the illness is low and an increased number of barriers are present, the model asserts that there will be a low expectancy of engaging in the health prevention behaviour. In fact, the relative contribution of an individual component of the model may exert a stronger influence in predicting the health behaviour, particularly the

presence of barriers to treatment.

The Transtheoretical Model (TTM) of Behaviour Change: The Transtheoretical Model of Behaviour Change was initially developed to conceptualize the process of change that individuals move through in the course of altering an addictive behaviour, namely smoking (Prochaska & DiClemente, 1986; Prochaska et al, 1992). According to the theory, individuals progress through a series of stages, termed stages of change, depending upon their readiness to modify the given behavior. Individuals progress through precontemplation, defined as the stage in which the individual has no intention of changing the given behaviour in the near future (6 months); contemplation, defined as the stage in which the individual may be aware of the problem and may be willing to make a necessary change, but has not yet made a commitment for change; preparation, defined as the stage in which the individual is preparing to make a specific change, as evidenced by experimenting with small changes in health behaviours (e.g., low-fat cooking); action, defined as the stage in which actual modifications are made in behavior, environment, and experiences in order to overcome the given problem; and maintenance, defined as the stage in which individuals attempt to prevent relapse or regression through the stages (Prochaska et al, 1992). The underlying premise of the TTM is that different individuals progress through stages at different times, rates, and readiness to change. Further, interventions failing to match appropriate stage mechanisms and the individual's stage of change are destined for failure, resulting in further frustration for the individual (Prochaska, 1994). In addition to the distinctive stages of change, other change variables, including self-efficacy and decisional balance have been integrated into the model to account for the cognitive processes associated with the behavior change. Self-efficacy refers to the belief that one's own efforts play a critical role in succeeding in difficult situations, or for purposes of the present model succeeding in a given health behaviour (Bandura, 1977; Prochaska & DiClemente, 1986). Decisional balance involves the pros and cons of changing and/or maintaining a current lifestyle. According to the balance of

pros and cons, the decision is hypothetically made in the direction of the balance. Each of these cognitive processes impacts the individual's movement through the stages of change. Decisional balance conceptualizes the role of social and environmental barriers, incorporating barriers into the TTM. As part of decisional balance, the individual is often requested to identify the risks and benefits of their current behaviour, and to evaluate the benefits of and barriers to the given health action or treatment. The self-generated list of barriers to the given treatment, then, may serve as a con to actually engaging in the treatment. If the cons are greater in frequency or the patient weights the cons more than the pros, then according to the construct, the patient will be less likely to engage in the given behaviour.

The TTM has gained extensive support and validation across addictive behaviours, adoption of positive health behaviors, and cessation of maladaptive health behaviours (Prochaska, 1994).

Evaluation of medication adherence

A wide variety of methods have been used in the literature to assess medication adherence. Unfortunately, a "gold standard" measurement technique has yet to be determined, as each technique has limitations and advantages unique to the research question. Measurement alternatives include patient self-reported adherence, pill counts, indirect physiological parameters, electronic monitoring systems, and pharmacy refill data.

Self-report measures: Patient self-report of adherence to a medication regimen involves the patient's retrospective account of the percentage of time that the medication was taken as prescribed over a given time period. Adherence can be assessed through interviews, questionnaires, and diaries. Self-report assessment is relatively inexpensive, convenient, simple, and applicable to a variety of behaviours of interest. Unfortunately, self-report assessments are subjective to error and sampling bias that can impair their utility in clinical and research settings (Hays et al, 1994).

Individuals asked to self-report adherence tend to over-report adherence. They may be responsive to social desirability, and appear susceptible to recency or primacy effects influencing the recall of their behaviour over time. Still the patients self-report remains a convenient, inexpensive measure of adherence.

Biochemical and physiological measures: Bioassays or biochemical analyses have been widely used in clinical trials to objectively verify the presence of a drug or its derivatives in an individual's blood. Of all adherence-based measures, biochemical analysis is the only measurement technique that confirms whether or not the patient has taken the prescribed medication. However, these assays are available only for certain medications with appropriate derivatives or markers (Hays et al, 1994). Biochemical analyses are most accurate with repeated measures, which may be costly, unpleasant, or inconvenient for the patient, and impractical to the provider and researcher. Physiological parameters indirectly reflect adherence because they are subject to influences from numerous contributing factors such as the nature of the disease itself and the quality of patient care (Hays et al, 1994).

Pill counts: Pill counts of the prescribed medication regimen have been widely used in medication adherence research. During a patient encounter, the researcher/clinician counts or weighs the prescribed medication, subtracting it from the original supply, to determine whether the patient maintained the therapeutic regimen (Greenberg, 1984). Pill counts are relatively low cost, provided they are an established component of patient care. Unfortunately, pill counts for a large scale study can be expensive, should the addition of personnel or procedures be necessary.

Patients must also bring their unused medication back in order to obtain a refill, a practice that may hypothetically signal patients that their medication practices are being monitored (i.e., reactivity). Finally, analyses of pill counts are limited by several factors, such as the dose schedule the individual followed, amount per dosage, number of missed dosages, and whether the individual ingested the medication at all.

Electronic medication monitoring: The use of electronic medication monitoring may be considered the closest to a gold standard for medication adherence monitoring (Claxton et al, 2001). Devices housed within the pill bottle cap or designed as a blister pack include microprocessors that electronically record the time and date that the bottle or pack is opened. These data can be downloaded for assimilation and statistical analyses. Unfortunately, these monitors and the accompanying software are expensive. As with other adherence measures, these devices cannot determine whether the medication was taken, only the time and date that the pill cap or blister pack was opened. And the cost of implementing electronic medication monitors may only be feasible for experimental clinical trials.

Pharmacy refill data: Pharmacy refill data provide a viable adherence measure for the assessment of medication adherence. Pharmacy refill data can provide researchers with information regarding the refill practices of the patient, the timing of the refills or medication pickups (particularly in determining the time of the month the refill is exercised), and the amount of medication dispensed. Although pharmacy data are not a direct measure of adherence, it offers distinct advantages in examining medication adherence data in a naturalistic and longitudinal investigation.

Impact of non-adherence

Non-adherence with medication regimens is among the most common causes of psychotic relapse and the need for re-hospitalization. The cost of partial compliance in schizophrenia is also substantial. Weiden and Olfson (1995) found that non-adherence in schizophrenia accounted for about 40% of the annual costs of re-hospitalization. Haywood and colleagues (1995) also found that non-compliance with medications, along with alcohol and substance abuse was the most important factor related to a need for re-hospitalization, or the "revolving door" phenomenon.

Other studies indicated that patients who relapsed when they were not taking their medications tended to have more severe

relapses than those who relapsed while they were taking medication (Kemp et al, 1996). Those who relapsed when not taking medications were more likely to require involuntary hospitalization and were more likely to have attempted suicide or to have committed a violent act. The combination of non-compliance with medication and substance abuse was related to the risk for violence in the community.

Johnson et al (1983) also found that patients with schizophrenia who experienced a relapse did not return to their pre-relapse level of social adjustment 1 year after recovery. This finding is important because it emphasizes that the cost of relapse is much greater than just the cost of re-hospitalization. The cost of relapse may be particularly severe for patients with jobs and family responsibilities since they have the most to lose.

Interventions for improving adherence

The strategies for improving adherence have been described in these broad categories: adherence counseling for patients, patient education, family therapy, or a combination of two or more of these. The most complex of the interventions involved combining patient education and counseling demonstrated significant improvements in adherence and depressive symptoms compared with patients receiving usual care (McDonald et al, 2002). Evaluation of the effectiveness of a compliance counseling program in patients with psychotic disorders suggested patients receiving compliance therapy had higher adherence ratings and better social functioning than patients receiving nonspecific counseling. Also, patients receiving compliance therapy had significantly greater insight than those receiving nonspecific counseling (Kemp et al, 1998). Strang et al (1981) found that clinical staff working closely with families of schizophrenic patients resulted in significant improvements in adherence and clinical outcomes compared with individual supportive therapy. Zhang et al (1994) demonstrated that, despite a lack of improvement in adherence, there was a significant effect of family therapy on

preventing relapses among patients with schizophrenia.

However some other studies found that there was no significant difference in relapse rate or medication adherence in schizophrenic patients receiving individual, semi-structured educational sessions compared with patients receiving usual care (Chaplin & Kent, 1998). Interventions consisting of family psychoeducation in patients with schizophrenia had no effect on improving adherence or on major clinical outcomes such as psychopathology or psychosocial functioning.

Overall, combination interventions and compliance counseling for patients appeared to be effective for improving clinical and adherence outcomes (Katon et al, 2001), followed closely by family-oriented therapies, which were successful for both adherence and clinical outcomes in some cases (Strang et al, 1981) and less successful in other studies (Zhang et al, 1994). The education-oriented interventions were generally unsuccessful (Chaplin & Kent, 1998).

CONCLUSION

Being clinically common and crucial in relation to outcome, problems with adherence arise from multiple reasons. In psychotic disorders compliance involves specific factors, such as side-effects of antipsychotic medication, attitudes towards treatment, insight regarding symptoms, or disturbances in cognitive functioning. Most of the previous studies have focused on the weight of medication effects and side-effects. Similarly, attitudes towards medication, and the roles of psychopathology, insight and substance abuse have been described as factors contributing to non-compliance. There is evidence of better compliance using specific psychosocial treatment methods, such as cognitive-behavioural interventions and assertive community treatment. The results with some sociodemographic factors, especially living circumstances, are not very clear. Cognitive functioning has shown some connection with insight, but its role in compliance is still unclear.

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DISTRICT MENTAL HEALTH PROGRAMME: A CRITICAL APPRAISAL

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ABSTRACT

The District Mental Health Programme (DMHP), launched in India as part of the National Mental Health Programme (NMHP), is currently being implemented in 92 districts. This article describes DMHP and present status of mental health services in India. It reviews on the success and failure of the NMHP and the factors associated with it as well as provides for the plan of action to meet the high burden of mental illness through limited resources.

Key Words: *Mental health services, district, community health*

INTRODUCTION

Mental health problems currently are said to constitute about 8 % of the global burden of disease and more than 15 % of adults in developing societies are estimated to suffer from mental illness. According to the new concept of measuring disability called Disability Adjusted Life Years (DALY)(WHO, 2001), mental disorders constitute a significant part of total DALY i.e. 8.1% (Desjarlais et al, 1995). The seriousness of the problem in India is indicated by the fact that the estimated overall prevalence rates of mental illness vary from 9.5/1000 to 102.5/1000 (World Development Report, 1993). It is further estimated that every year, nearly thirty million suffer from mental illnesses and there are 175,000 new cases. In spite of the disease burden being so high, mental health has remained a neglected area amongst the health priorities (Prabhu & Raghuram, 1987).

In earlier times, some notable efforts had been made to bring changes in custodial care of the mentally ill. The Bhole Committee, set up in 1946, recommended improvement in the existing 17 mental hospitals and an increase in the number of mental institutions. Thus, there was emergence of seven major psychiatric hospitals in the states of Gujarat, Punjab, Jammu & Kashmir, West Bengal and Delhi as well

as improvement in the existing institutions with due efforts of Sir Moore Taylor. District mental Health Programme (DMHP) implemented today is a result of his efforts. However, major changes in mental health scenario in India began with the asylum fire tragedy at Erwadi in Tamilnadu which opened the eyes of policy makers to the needs of mentally ill people.

In India Community mental health began in 1950s and Dr. Vidya Sagar of Amritsar Mental Hospital was one of the pioneers who involved family members in the treatment of mentally ill persons. Then in 1960s, General Hospital Psychiatric Units (GHPUs) had been set up in various parts of India. Under National Institute of Mental Health and Neurosciences (NIMHANS) Crash Programme (1975), a community psychiatry unit started functioning in October 1975 along with primary health center (PHC) based rural mental health programme, general practitioner based urban mental health programme, school mental health programme, home based follow up psychiatric patients and psychiatric camps. Chandigarh rural mental health programme (Wig et al, 1981) began in Post Graduate Institute of Medical Education and Research, Chandigarh (PGIMER) with the help of World Health Organisation (WHO). They also developed training manuals for the PHC personnel. Indian Council of Medical Research, Department of Science and Technology (ICMR

DST) in 1980s conducted a study to examine the ability of doctors and health workers to recognize and manage psychotics and epileptics at the PHC level. The study was carried out at 4 centers - Bangalore, Vadodra, Patiala, and Kolkata. It was found that there was lack of motivation and leadership in them and the influence of PHC personnel in the community was extremely poor, though intensive training was provided to them (Agarwal et al, 2004).

NATIONAL MENTAL HEALTH PROGRAMME: AN OVERVIEW

Without taking into account results of ICMR DST study, the National Mental Health Programme (NMHP) was launched in seventh five year plan and what happened in the subsequent five years is a sad story. The Government of India launched this programme in 1982 after Alma Ata declaration of Health for All by the Year 2000 in 1978. NMHP aimed at the prevention and treatment of mental and neurological disorders and associated disabilities and the use of mental health technology to improve general health services by providing community based mental health care using the existing public health infrastructure.

It sets various goals which was more of a wish list describing adoption of the present plan of action in the field of mental health in each state, appointment of a focal point within the Ministry of Health, specifically for mental health action, formation of National Coordinating Group comprising representatives of all states, senior health administrators and professionals from psychiatry, education, social welfare and other related professionals and creation of a task force to identify mental health workers in the different states to apply basic mental health skills at Primary Health Centres (PHCs) within one year. It also promised that within five years, at least 5,000 of the target non-medical professionals and at least 20% of all physicians working in PHC would undergo a two-week training programme in mental health along with the creation of post of a psychiatrist in at least 50% of the districts. The District Programmes would be fully operational in at least one district in every state and Union Territory (UT), and in at least half of all districts in some states (Devi, 2002). A

programme officer would be appointed, responsible for the organisation and supervision of the mental health programme and each state would provide additional support for incorporating community mental health components in the curricula of teaching institutions within five years. Appropriate psychotropic drugs to be used at the PHC level would be included in the list of essential drugs in India. Psychiatric units with in-patient beds would be provided at all medical college hospitals in the country within five years.

There were progresses after enactment of NMHP between 1982 and 2002. The models for integration of mental health in PHCs were developed as Raipur Rani in Haryana, supported by WHO in 1970 and the community mental health and training centre in Sakalwada, Karnataka initiated by NIMHANS, Bangalore in 1984. These models were replicated in 25 districts of 20 states between 1995 and 2000. Also community care alternatives and Non-Government Organization (NGO) initiatives which included day care centers, half-way homes, long-stay homes, suicide prevention and school mental health programmes. The human resource in terms of mental health professional increased and public awareness improved due to community-based mental health care and growth of mass media. The ICMR, New Delhi, gave a thrust to mental health research.

Various legislations related to mental health were enacted like Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 (GOI, 1985), Mental Health Act, 1987 (GOI, 1987), Persons with Disability Act, 1995 (GOI, 1995) which included mental illness as one of the disabilities. National Human Rights Commission (NHRC) declared Human rights of mentally ill persons in 1999 and National Health Policy (GOI, 2002) clearly recognized mental health as a part of general health.

The initiation of NMHP was a milestone in the history of mental health care in India. After its formulation, Indian health plans as well as the five-year plans started allotting money for mental health programmes. A budgetary allocation of Rs.28 crore was made during the ninth five-year plan and of Rs. 190 crore

(later reduced to Rs. 139 crore) during the Tenth Five-Year Plan period for the programme. NMHP also proposed strengthening of department of psychiatry in medical colleges, modernisation of mental hospitals, focusing on Information Education and Communication (IEC), public education, research and training.

Notwithstanding the result of the ICMR-DST study, NIMHANS launched a pilot model programme in the Bellary district in the 1980s to implement District Mental Health Programme (DMHP) as a part of NMHP. The personnel of the PHCs in the district were trained to recognise and manage mental patients in the community. Good results were obtained and as a result of this, manuals of mental health for different categories of health personnel, recording systems, training videos, assessment forms and public education materials were developed. Over time, DMHP was implemented in more districts. But on close scrutiny of this experiment, the picture did not appear to be as rosy as claimed. The difficulties which are encountered are as follows:

1. Concluding correct diagnosis
2. The choice of appropriate medication, as well as dosage
3. Difficulty in handling side effects of medicines
4. Administrative problems like the transfer of personnel who became acquainted with the programme
5. Poor motivation on the part of the personnel, and
6. The erratic supply of drugs.

However, there are some distinct advantages in planning mental health care at the district level rather than at the PHC level. It allows the utilization of all available resources and not only those available in the health sector thereby facilitates inter-sectorial collaboration. Since a district is an independent administrative unit, the district health organization has the authority to plan activities, thus ensuring decentralization of planning.

Various major developmental milestones of DMHP were launching of DMHP in 4 more districts with a grant assistance

of Rs. 22.5 lakhs in 1996-1997 with a budgetary allocation of Rs. 28 crores for NMHP during the 9th five-year plan. During 1997-2001, DMHP was extended in 40 more districts in 20 states and planned to cover 400 districts with a grant allocation of Rs. 100 to 200 crores at the dawn of 12th Five Year Plan (Agarwal et al, 2004).

PRESENT STATUS AND INFRASTRUCTURES AVAILABLE FOR MENTAL HEALTH CARE IN INDIA

The mental health services in India consist of specialized mental hospitals, psychiatric units in general and teaching hospitals, private mental health clinics and nursing homes, voluntary sector services and traditional services ranging from homeopathy and ayurveda to magico-spiritualism. The conditions in the state mental hospitals have been pointed out to be dismal in terms of treatment, care, accommodation and nutrition (Mondal, 1995). The average expenditure per patient per day is between Rs.20 and Rs.30, which is grossly inadequate. Despite an increase in the number of mental hospitals from 30 in 1951 to 45 in 1991, there is an acute shortage of beds. Moreover, most of the beds are in urban areas, thus excluding the vast majority of the rural population from easy access to mental health facilities (Sharma, 1990). The dominant modes of treatment are pharmacotherapy and electro-convulsive therapy; the availability of other modes such as child guidance clinics, occupational therapy units, detoxification centres and follow-up clinics, is secondary and varies considerably across institutions. Common psychiatric medicines such as amitriptyline, lithium, chlorpromazine (CPZ), phenobarbital, phenytoin, haloperidol, carbamazepine, imipramine and resperidone are available in few district hospitals. District hospitals lack adequate laboratories. Another serious lacuna of the mental health programme in India has been the shortage of medically trained psychiatrists with adequate para-medical professionals such as psychotherapists, counselors and psychiatric social workers. There are only two psychiatrists per 10 lakh population as against 150 per 10 lakh population in USA (Thukral, 1990).

The services of the private clinics and nursing homes and

those in the voluntary sector are limited in scope and confined to small sections of the urban population. The traditional services, for their part, are not able to provide a clear alternative facility to people. Furthermore, despite the large number of native healers, exorcists, shamans and charlatans of mental healing, it is not clear at what level people use these services (Weiss et al, 1983).

BARRIERS TO REACH NMHP GOALS - REASONS FOR FAILURE OF NMHP

The goals set out in the 1982 document were too ambitious to begin with and not enough attention was paid to all aspects of its implementation. Though the NMHP came into being in 1982, the subsequent three Five Year Plans did not make adequate allocation of funds. Further, the funds allotted were not fully utilised. There was limited undergraduate training in psychiatry and inadequate human resources in mental health. The community care models developed had not been adequately evaluated. The implementation of DMHP between 1995 and 2000 continued to be one of the extension services by professionals rather than true integration of mental health with primary healthcare.

Along with these barriers there are lacunae in planning strategies which lead to poor progress. The NMHP, in tune with the Alma Ata Declaration, promised 'availability and accessibility of mental health care for all', but prioritised epilepsy, mental retardation and psychoses, thus limiting itself to only a very small target population. The programme was such designed as to make do with existing infrastructure and personnel without incurring any extra expenditure. Divorced from ground realities, the programme followed top down approach. The agenda of the NMHP was to humanize mental health practice by incorporating the principles of community care. However, the NMHP was at best ineffective, and at worst, it promoted the dehumanised models of cure that it explicitly rejected.

THE PLAN OF ACTION FOR MENTAL HEALTH

For a nation like India where the resources are inadequate

and burden is high, the following plan of action can be proposed for better results and proper care (World Health Report, 2001):

1. Organising services - Currently, most districts do not have trained professionals or the mental health infrastructure to provide essential mental healthcare. It is recommended to provide mental health in primary care and to make psychotropic drugs available.

2. Community mental healthcare facilities - Shifting patients from mental hospitals for care in the community is also cost-effective, respects human rights and also reduces the stigma of taking treatment. This shift towards community care requires health workers and rehabilitation services to be available at the community level, along with the provision of crisis support, protected housing, and sheltered employment. The different facilities required are day care centres, half-way homes, long-stay homes, sheltered workshops, de-addiction centres and suicide prevention centres.

3. Support to families - Families are primary care providers. They need support from the government and the society in a number of ways, including financial support. They also need an understanding of the illness in question, and the skills to care for the ill. In addition, they must ensure medication compliance, be able to recognise early signs of relapse, handle swift resolution of crisis, and reduce social and personal disability. The government should plan to provide these services to family.

4. Human resource development - There is both a gross deficiency in the available personnel as well as unequal distribution of available specialists. The measures outlined for meeting this need, are undergraduate training in psychiatry for medical students, appointing psychiatrists to staff the departments of psychiatry at the medical colleges, the district/taluka hospitals and to support voluntary organisations providing community care; to take general psychologists, social workers and nurses and train them for a period of 3-6 months at postgraduate mental health training centres and

post them to work in different settings and identifying rehabilitation professionals. Suitably experienced senior medical officers can be selected to become programme officers and trained at postgraduate training centres, for a period of three months.

5. Public mental health education - There is a need for public education and awareness campaigns on mental health. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders.

6. Private sector mental healthcare - The private sector could play a major service role. Private psychiatrists can support the programme in a number of ways such as systematically recording their work to provide an understanding of the magnitude of mental health needs, clarifying the treatment utilisation and related issues, working in the medical colleges and regional hospitals as honorary consultants, training of PHC personnel, supporting the NGOs in their mental health initiatives, initiating special mental health programmes and encouraging public mental health education.

7. Support to voluntary organizations - NGOs are often more sensitive to the local realities than centrally driven programmes and are usually strongly committed to innovation and change. They often play an extremely important role in filling the gap between community needs and available community services.

8. Promotion and preventive activities - The life skills education programmes for school children can be an initial effort to develop suitable preventive measure at basic level. Similarly, psycho-social care of survivors of disasters should be part of all relief, rehabilitation, reconstruction and reconciliation programmes, following man-made and natural disasters.

9. Administrative support - In view of the importance of the mental health programme and the magnitude of the initiatives to be undertaken, a full-time Joint Director (Mental Health)

should be appointed at the Directorate of Health Services. At the district there should be two mental health teams, one each in the district medical office and the other at the district hospital. Such teams will result in both clinical care and the integration of mental health at the peripheral institutions.

NMHP IN 10th FIVE YEAR PLAN (2002)

The National Health Policy (Govt. of India, 2002) also envisaged a network of decentralized mental health services for ameliorating the more common categories of neuro-psychiatric disorders. The budgetary support for the NMHP was increased nearly 7-fold, to Rs 190 crores in the 10th Five Year Plan, up from Rs 28 crores when the project was initiated on a pilot basis during the 9th Plan. The main thrust of the NMHP was to provide community based mental health care, integrated with the existing general health care system, in 100 districts across the country in the first phase and 100 more in the second phase during the 10th Five Year Plan. Moreover, it was proposed to integrate the treatment for epilepsy and dementia with the DMHP. Though the set targets were not achieved, yet, progress was achieved in the form of implementation of DMHP in about 100 districts.

MENTAL HEALTH IN 11th FIVE YEAR PLAN (2007-2012)

It would be tempting to extend the current programme in 11th Five Year Plan to cover the whole country hoping that an extension carries danger of failure. The team of professionals at the central, state and regional levels would be created to continuously develop the interventions, evaluate the quality of care and make mid-course corrections. There would be national level initiative for human resource development for mental health care. This would include improving the psychiatric training in the undergraduate medical education, increasing the training for non-medical mental health professionals, utilizing them to a larger extent and bringing clear guidelines for the different paraprofessionals like counselors, volunteers, family level carers, etc. to be part of the mental health care programmes. The different models of care by systematic evaluation, specifically the DMHP, the

school-based interventions, the suicide prevention programme, substance abuse programmes, family support initiatives and rehabilitation needs of the chronic patients to cover a large population would be consolidated.

Mental health components would be incorporated in national level programmes like the Integrated Child Development Schemes (ICDS), education system, and use of traditional systems like yoga, meditation, so that the mental health promotive activities become part of the programme. The areas not included in the earlier plan periods like support for families of the mentally ill persons, prevention of suicide, life skills education, disaster mental health care and care of the elderly would be taken up to develop models during the 11th Plan, so that suitable expansion in the next Plan period can occur. The overall effort would be to create structures that would meet the long-term mental health programme development in the country, as against the focus on only rapid expansion of the current models of care.

TWELFTH FIVE YEAR PLAN AND VISION 2020

The DMHP would be extended to all the remaining districts and the gains made in the previous plans would be consolidated, further upgradation of the medical college psychiatry departments would be undertaken and mental hospitals would be taken up for disinvestment/ reconstruction. Non-viable mental hospitals would be closed down or merged with general hospitals to create GHPUs. Central and State Mental Health Authorities would be further reinforced and technologically more sophisticated long-term research projects would be initiated in selected institutions while continuing support to community-based research. IEC activities would be augmented to cover all sections of the population across the whole country. A comprehensive, holistic assessment and review of programme performance in the preceding two decades would be undertaken at the national and state levels by an independent agency to identify achievements, areas of non- or poor-performance, remedial measures, current needs and future requirements.

CONCLUSION

It is sobering to realize that more than half a century after the Bhore Committee had focused attention on the need to revitalise mental health services in the country and over two decades into the NMHP, its basic component, the DMHP covers only 92 out of 593 districts across India. Also it is estimated that one in four families, at least one member is currently suffering from a mental or behavioural disorder. These families are required not only to provide physical and emotional support, but also to bear the negative impact of stigma and discrimination present. It has been shown that quality of life continues to be poor even after recovery from mental disorders as a result of social factors that include stigma and discrimination. It is a fact that even in the twenty first century, mentally ill patients are taken for treatment to traditional healers, exclusively or alongside visits to modern doctors. Professionals should make contact with religious and spiritual centres which provide help to the mentally distressed. There is great scope for both groups to learn from each other in providing care for the needy.

There are limited facilities available for mental health training. The irony is that all these centers have become hubs to export trained people abroad. Many mental health professionals are migrating to developed countries, which offer more lucrative jobs. For instance, in the year 2003, more than 82 psychiatrists sought short term and long term employment in the United Kingdom in response to the latter's international recruitment drive (Agarwal et al, 2004).

This dismal scenario calls for an urgent, time-bound remedial action plan which would ensure:

- (a) Accessibility of at least basic psychiatric facilities within the community
- (b) Affordability of the services in accordance with our limited resources and low-income levels of the consumer population.
- (c) Adaptability to the widely varying geographical, socio-cultural and economic mosaic of our vast country.

- (d) 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.
- (e) Assessment of performance at the ground level

There are many ways to improve the lives of people with mental disorders. One important way is through policies, plans and programmes based on realistic and attainable goals which can lead to better services. Even when resources are constrained means can be found to secure more resources for mental health, improve rights and mental health standards and conditions in the country. It is submitted that the major hurdle in the path of providing mental healthcare to the community lies not in the purse but in our minds. If we can rid ourselves of the obsolete notions of the inevitability of institutionalised psychiatric treatment and think innovatively, it is possible to create an effective community-based mental healthcare delivery system with our existing resources.

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JOB STRESS, ITS CONSEQUENCES AND MANAGEMENT: A REVIEW

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ABSTRACT

Job stress is a widely experienced problem that results in substantial cost to individual employees and organization at large around the world. Anderson et al. (2002) envisioned that the changing nature of work has placed unprecedented demands on employees and fuelled concerns about the effect this change is having on well being and psychological health of employees and on the development and growth of the organization as such. Perpetual, negative work related psychological state may reflect in the form of exhaustion, distress, reduced efficiency and dysfunctional attitude at the work place, which in turn impairs the affective, cognitive, behavioural and motivational components of the individual. In the process of managing such problems, intervention strategies are focused at the organizational level, the individual organizational interface level and at the individuals' level. Changing work situations, interpersonal skill training, time management, preparing peer support system, SWOT analysis, systematic desensitization and relaxation are the techniques used by the researchers and practitioners to reduce and overcome the job stress.

Key words: *Job stress, motivation, management-intervention.*

INTRODUCTION

Job stress is a matter of concern for the employees working in the industries, organization and society as a whole. There are ample evidences suggesting high prevalence of job stress. Paoli (1997), in a survey among European workers, observed that 29 per cent employees have got their health affected due to their work activity. Most frequently work related health problems experienced were: back pain, stress and overall fatigue. Anderson et al, (2002) have observed that changing nature of work has affected employees well being, psychological health as well as organisation's growth.

An immense growth of stress related absenteeism was observed in Britain. Increased absenteeism due to nervousness debility and headache has been demonstrated by Hingley and Cooper (1986). Houtman (1997) has concluded that mental disorders accounted for 11 per cent of workers' disability claims at one point of time in the Netherlands. This rate continued to increase steadily, so that 30 per cent were assessed till 2001 as work disability on mental grounds the largest single diagnostic group, followed by musculo skeletal disorders (28 percent) and

cardiovascular disease (8 percent). Developing country like India also is not untouched from such facts.

Consequences of Job Stress

Job stress can be referred by physical force or external pressure that is exerted on person, which in turn results in tension or strain (Kahn & Byosiere, 1992). Within certain limits, people are able to deal with such pressure and adapt to the situation, to recover when the stressful period is over. This seems synonym to the psychological bending and springing back of an internal backup. However, when the pressure is too large individuals are unable to cope up with the stressors because individuals' adaptability is determined by psychophysical characteristics, his or her stress tolerance, availability of social support and by the demand of environmental needs.

Chmiel (2000), has expressed and visualized the consequences of job stress in different ways and classified into five different clusters which affect individuals, their interpersonal relationship and organization to which individuals are associated. Stress displays itself not only in

the form of individual symptoms, but also in the form of symptoms at the interpersonal and organizational level. Major consequences of job stress are discussed as under :

1. Affective Impairment

Impact of the job stress may be witnessed in the form of affective impairment and individual may suffer with the symptoms of anxiety, tension, anger, depressed mood and apathy. Sinha (2005) has concluded that strenuous working conditions leads to anxiety, depression, somatic complaints and maladjustment. These symptomatology result in irritability and being over sensitive while dealing with interpersonal relationship. At organizational level job dissatisfaction becomes quite obvious and surfaces while performing the job.

2. Cognitive Impairment

Cognitions of the individual are directly related to the individual's performance, their social functioning and occupational functioning. The effects of cognitive impairment have been noticed in the individuals as helplessness, powerlessness, difficulty in quickness and correctness in decision making. Logical reasoning, one of the basic aspects of cognition also gets affected and individual may express hostility, suspiciousness and projection towards others at the work place. Cognitive impairment put its effect at organizational level and individual may reflect cynicism about work role, not feeling appreciated, distrust in peers, supervisors and management (Chmiel, 2000) .

3. Physical Condition

Mind and body, are reciprocally dependent on each other. Stress at work place may cause health problems (Jamison et al, 2004; Leitner & Resch, 2005), physical distress in the form of headache, nausea, psychosomatic disorders (gastro intestinal disorders, coronary disease etc.). Psychological stress at work place may lead towards impairment of immune system and hormonal disturbances in the individuals. Such physical conditions of the individuals affect the social and occupational performance at work place.

4. Behavioural Functioning

It has been concluded by several researchers (Chmiel,2000;

Shina,2005) that Job stress is most likely to be seen in the form of behavioural expression. The individuals who are faced with stress at work place may reflect hyperactivity, impulsivity, increased consumption of stimulants (caffeine, tobacco, etc.). Such behavioural problems may put their impact on interpersonal relationship and individuals show violent outburst, aggressive behaviour, interpersonal conflict, social isolation and withdrawal. Organizations at large are not untouched by behavioural problems of the employees. Behavioural problems of employees of any organization results in poor work performance, declined productivity, tardiness turnover, increased sick leave and poor time management and ultimately decline overall growth and development of the organization.

5. Motivational Level

Job stress affects the motivational level of the individuals. Higher the stress, lower is the motivational level. Possible stress symptoms at the individual level may be seen in the form of loss of zeal, loss of enthusiasm, disillusionment, disappointment, boredom and demoralization. Such symptomatology would affect the interpersonal interaction among the co workers, seniors and subordinates. Loss of interest in others, discouragement and indifference are quite common. Loss of work motivation, resistance to go to work, dampening of work initiative and low morale so on so forth have been envisioned by the researchers in the field of stress and its effect on organizational level.

Stress reaction can differ in their intensity. In the case of prolonged exposure of stressful situations, the individual may not be able to reduce his or her physiological state of stress, and high activation levels are sustained (Ursin, 1986). This can in turn give rise to chronic physical i.e. coronary heart disease (Siegrist, 1996; Kjeldsen et al, 2006) and/or psychological stress complaints, i.e., burnout (Maslach & Jackson, 1986; Schafeli & Enzmann, 1998; Fenga et al, 2007; Spear et al, 2004; Nyssen et al, 2003; Greenglass & Burke, 2001; De Bacquer et al, 2005).

Management of Job Stress

Since job stress is an experienced incongruence between environmental demands and individual situational resources available which is accompanied by psychological, physical

or behavioural symptoms. Its effect is percolated from individuals to their social group and ultimately to the organizational level. To prevent or reduce the job stress, as appeared in the book "Introduction to work and organizational psychology: A European Perspective" edited by Chmiel (2000), job stress interventions may focus at three pronged strategic parameters.

1. Strategies focused at Organizational Level

At this level of management strategy, the source of the problem is tackled by changing the work situation through organization based interventions to reduce the negative reaction of the employees. Job stress management at organizational level may serve the purposes of early identification of the factors responsible for rise of job stress and also serve the purpose of knowing the reactions of the employees emerged due to stress available at work place. Once the identification of job stressors and stress reactions through job stress audits are confirmed, the steps are taken by top and middle level of managers in terms of organization based interventions programmes. These programmes are designed to remove or reduce the stressors through improvement of job content and the work environment, better time management, free communication (top to down and down to top), participation of employees in decision making, solution pertaining to conflict management and organizational development. Corporate fitness is taken into consideration. Intervention and management programmes at organizational level help in career management, anticipatory social interaction, institutionalization of procedures and services, employees wellness programmes, occupational health and safety services necessary for the growth and development of the organization and employees as well which ultimately helps in reduction of stressors at work place (Chmiel,2000).

2. Strategy Focused at Organization as well as Individual

As we know there is an organization and there are individual employees. When employees' threshold to specific stressors is low, there will be decreased resistance to the stressors and vulnerability would also increase. Thus, the interface of organization individual shows prime significance. To get rid of stressors vulnerability, the management strategy at this level may seek personal screening for the purpose of increasing awareness and assessment of employees level

of job stress in relation to others in the organization. After identification of the stressors at work place, improvement of employees coping skills become important. Through time management technique employees are trained and taught to make use of time effectively and productively. Proper time scheduling, planning, prioritizing and delegating the duties help in time management training (Higgins, 1998). Interpersonal skill training paves the way to deal effectively with co workers, superiors, subordinates and customers. Assertiveness is very popular technique included in management strategy. Promoting a realistic image of job helps in escaping from initial reality shock that might lead early career burnout (Cherniss, 1995). Management programmes work as bridging mechanism for balancing between occupational and personal life.

Preparing peer support group, providing coaching and career planning are included into management capsule. Peer group provides basis to exchange of information, support the employees emotionally and try to solve problems of work place. Coaching arranged by the organization designates the process that includes series of events to overcome potential work problems. Strength, Weakness, Opportunity and Threats (SWOT) analysis regarding employees organization interface help to reduce the job stress, which is conducted by highly specialized professionals who deal with the dynamics of behaviour.

3. Strategy Focused at the Individual

Referring the individual employee and individual differences, while discussing the job stress seems to be worthwhile. Individual's psychic frame, his/her perception and apperception increases and/or decreases the work performance in resultant of job stress. In therapeutic intervention programme individuals are targeted to keep a stress diary, personal record and log of events provoking stress through powerful self monitoring technique. Didactic stress management provides increased awareness and improving self care with reference to job stress. McDonald and Hodgdon (1991) have demonstrated the positive effect of physical exercise as most powerful antidote to stress.

Systematic desensitization technique is used by several researchers to increase the threshold level of the individuals towards stress provoking situations at work. Cognitive

behavioural techniques pave the way in order to change emotions or specific reactions to the stressful situations (Kim, 2007). Relaxation has been proved to be commonly used and effective technique in relieving the job stress (Kim, 2007). Positive and alternate output of behaviour is envisioned while relaxation therapy. All the therapeutic and management strategies discussed above are significant enough to reduce and overcome the job stress but these techniques work best when combined together as per demand of hours and situations.

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QUALITY OF LIFE ISSUES IN MENTAL DISORDERS: EMERGENCE OF A NEW PARADIGM FOR MEASURING OUTCOME OF DISORDERS

Dipanjan Bhattacharjee¹, Narendra Kumar Singh², Basudeb Das³

ABSTRACT

The concept of quality of life came in the field of mental health in the decade of 1980s. After the emergence it has become an important construct to talk about the outcome of mental disorders. The World Health Organization defines quality of life as: "individuals' perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". Quality of life may be defined as a person's sense of wellbeing and satisfaction with his/her life circumstances, as well as a person's health status and access to resources and opportunities. The QOL construct has got both subjective and objective facets. Generally QOL encompasses things like 'sense of well-being', 'access to resources and opportunities', 'optimum level of functioning', 'self-esteem', etc. In mental health mere alleviation of psychopathologies is not the objective of the treatment but helping the patients to regain his abilities in all domains of his social and personal functioning is the target.

Key words: *Quality of Life, well-being, mental health.*

INTRODUCTION

Today mental health needs of severely mentally ill people are not mere alleviation of psychopathology but include broad domains of health and social functioning, which are extremely essential for surviving and getting accustomed in the community life. Those needs can be myriad in nature such as: "needs of the patients" and "needs of their caregivers" (Phelan et al, 1995). A general consensus has been emerging across the Western World that mental healthcare should be provided on the basis of need, with an intended goal of improving subjective quality of life (Mental Health Branch, 1997; Lasalvia et al, 2000).

In recent years there has been increasing interest in the inclusion of both subjective and objective quality of life (QOL) of the people with mental disorders in order to measure the efficacy of the treatment and outcome of mental disorders. QOL measures are now included almost routinely in most clinical or intervention work in mental disorders, be it severe and debilitating illness like schizophrenia or a neurotic

disorder like Obsessive Compulsive Disorder or Panic disorder.

DEFINITION OF QOL

There is no uniformly accepted definition of QOL. The World Health Organization defined QOL as 'individuals' perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns' (Saxena & Orley, 1997). There is general consensus that QOL encompasses factors like "access to resources and opportunities", "fulfillment of life's roles", "level of functioning and a sense of well being or life satisfaction" (Atkinson et al, 1997). Lehman (1983) defined QOL as: "the sense of wellbeing and satisfaction experienced by people under their current life circumstances".

Angermeyer and Kilian (2006) have propounded models of QOL as:

- i. The "subjective satisfaction model" (the level of QOL experienced by an individual depends on whether or

- not his/her actual living conditions are in a position to meet his/her needs, wants, and wishes);
- ii. The "combined subjective satisfaction/importance model" (which gives different emphasis to different life domains or functionality areas);
 - iii. The "role functioning model" (the individual enjoys a good quality of life if he/she performs adequately as well as appropriately in his/her given social roles and his/her needs are satisfied appropriately);
 - iv. The "dynamic process model of QOL" depicts the interrelatedness of the components of the environment, the person and cognitive adaptation processes.

According to Albrecht and Fitzpatrick (1994), the quality of life construct may have following four uses:

- a) As an outcome measure or yardstick in clinical trials and health services research
- b) For assessing the health needs of a given population
- c) For the planning of clinical care of individual patients
- d) For resource allocation

INFLUENTIAL FACTORS OF QUALITY OF LIFE IN MENTAL DISORDERS

There can be several factors which can either promote or thwart quality of life of the patients with mental disorders. These are:

- i. severity of symptoms (Hofer et al, 2004);
- ii. age of the patients (Norman et al, 2000);
- iii. medication side effects (Hofer et al, 2004);
- iv. patients' subjective response to medication (Voruganti et al, 1998).

Some researchers suggested that psychopathologies like

'depressed mood and anxiety symptoms' are associated with worse QOL, whereas the association between 'positive or negative psychotic symptoms' and 'subjective quality of life' is more uncertain. Older patients seem to be more satisfied with their lives than younger patients (Meltzer et al, 1990; Corrigan & Buican, 1995; Browne et al, 1996; Tollefson & Anderson, 1999; Lehman et al, 1982). Factors like 'neuroleptic induced side effects like akathisia and dysphoria' are associated with poor subjective well-being lowering the quality of life of the patients with severe mental disorders.

Unlike disease-specific measures, quality of life measures assess well-being either overall or across several domains. This is important because disease-specific measures of severity of illness may not be sensitive to various relevant domains of life. For example, a depressed patient may have a reduction in the severity of the depression yet may not be ready and/or able to return to work, or a patient's mood may improve on medication but at the cost of untoward side effects that reduce quality of life (Zhang et al, 2006). Studies focusing QOL for individuals with severe mental illnesses have identified a number of important influential factors, such as social support (Ritsner, 2003), unmet need (Becker et al, 2005), and medication side effects (Awad et al, 1997).

QUALITY OF LIFE RESEARCHES IN MENTAL DISORDERS

Schizophrenia

Severe mental disorder like schizophrenia affects all areas of life functioning. Presently the consensus among clinicians that reduction of symptoms and syndromal recovery are not the aims of schizophrenia treatment but ensuring better quality of life and level of functioning have become the ultimate goals (Malla et al, 2006).

Though it is worthy to mention that schizophrenia is a disorder with myriad psychopathology and affects all domains of one's life repertoire, due to this problem and wide variations in measurement strategies and definitions of QOL, it has been difficult to identify which psychiatric symptom is most strongly

associated with poor QOL in individuals with schizophrenia. Furthermore, the strength of these associations has also been difficult to discern. Some studies showed small to moderate relationships between psychiatric symptoms and QOL and others' findings suggest that certain aspects of these concepts may be either indistinguishable or not so definitive (Eack & Newhill, 2007). The cause of variability in relationship between psychiatric symptoms and QOL in different studies may also be due to the sample differences. Studies measuring QOL of schizophrenia patients in inpatient set-ups show that patients are less concerned to their ability due to florid psychopathology and less disruptive to secure their needs (Eack & Newhill, 2007). Studies on QOL of in-patients with schizophrenia also showed that besides symptoms, factors like 'social support' and 'self-esteem' may also influence QOL of schizophrenia patients (Ritsner et al, 2000; Ritsner, 2003). Some studies mention that course of the illness is also a differentiating factor in QOL. Patients who have developed the illness recently have marked difference in QOL than chronic patients. Here differentiating factors are 'negative symptoms' and 'general psychopathology'. At the early course of illness presence of those factors become mostly influential on the QOL than the chronic phases (Browne et al, 2000; Priebe et al, 2000).

Affective Disorders

Affective disorders like mania and depression have been on the rise and with the advent of newer, specific and evidence based treatment both in the form of pharmacotherapy and psychotherapy 'health related quality of life' comes in the picture very frequently to judge the efficacy of these treatment (Keller et al, 1986). Several studies have demonstrated that social and occupational deficits in patients with bipolar disorder are as equal as other severe mental illness like schizophrenia (Coryell et al, 1989; O'Connell et al, 1991). Votja et al (2001) opined that mania and hypomania are the syndromes characterized by reduced sense of well-being not popularly known as increased sense of well-being. Moreover these authors mentioned that 'depressive symptoms' are primary determinants of QOL in bipolar disorder. Many factors may affect the perceived quality of life of the patients with

bipolar disorder. Those factors can be 'higher rate of lifetime prevalence of psychiatric co-morbidities, e.g., anxiety disorders and substance use disorders (Suppes et al, 2000; Creed et al, 2002), socio-demographic profile, personality characteristics, stressful life events (Hammen & Gitlin, 1997; McPherson et al, 1993), social maladjustment (Perugi et al, 1988), disruption in family, social and occupational functioning, severe family burden (Chakrabarty et al, 1992), social support system and its functionality (Cohen & Syme, 1985), etc.

Anxiety and Neurotic Disorders

In case of anxiety and neurotic disorders significant impairment in both subjective and objective QOL may occur and its magnitude can be as equal as other psychiatric disorders. Massion et al (1993) pointed that there were very severe impact of panic disorder and/or generalized anxiety disorder on quality of life of the patients with those disorders. There were evidences that anxiety disorders like 'obsessive-compulsive disorder' (Wittchen et al, 1992), 'panic disorder' (Hollifield et al, 1997; Rubin et al, 2000) and 'social anxiety disorder' (Wittchen & Beloch, 1996) can lead to substantial impairment in life functioning areas as well as lowering of quality of life and subjective well-being. In many cases, the quality-of-life impairments associated with these anxiety disorders are equal to or even greater than some chronic medical disorders (Spitzer et al, 1995; Sherbourne et al, 1996).

Other Disorders

Accordingly in case of substance use disorder, dementia and other organic disorders, the construct of QOL have been applied by various researchers time to time to measure the QOL and sense of well-being of the patients. Psychiatric and physical co-morbidity are quite common among the patients with chronic substance use. QOL of the patients largely depends on the fact that how quickly the associated psychiatric symptoms get dissolved (Schaar & Öjehagen, 2003). Additionally factors which have the potentiality to enhance QOL of the addicted individuals: 'abstinence', 'controlled or minimal intake of substance', etc (Schaar & Öjehagen, 2003). Factors which can hamper the QOL are: 'psychiatric comorbidity',

'inadequate social support', 'sleep disturbances', 'presence of physical comorbidity', 'poor social functioning', 'poor social integration', etc (Schaar & Öjehagen, 2003; Foster et al, 1999). Singh et al (2005) stated that patients with concomitant bipolar disorder and alcohol addiction have poorer QOL than patients with any single diagnosis either bipolar disorder only or alcohol addiction.

Measurement of QOL in dementia is a complex task. Dementia is characterized by the development of difficulties in keeping pace with everyday tasks of daily living, personality changes, marked neurocognitive deficits and a loss of capacity to act independently (Moyle et al, 2007). Nearly half the people with dementia live in the community and with their close family members, the insidious and progressive nature of the illness condition, which leads to gross impairment in the domains like cognitive function, memory and sense of self, may ensure family stress and generation of low self esteem to the patients and their family members. Good alliance between family and tertiary treatment centre can influence and even reduce the QOL of family caregivers (Moyle et al, 2007).

In dementia and Alzheimer's disease factors like 'agitation', 'depression', 'apathy' and 'irritability', 'caregivers' distress' are significant predictors of quality of life (Samus et al, 2005; Fuh & Wang, 2006), as well as other factors like 'psychosis syndrome (delusion, hallucination, disinhibition, irritability, aberrant motor activity)' (Matsui et al, 2006). Severity in neuropsychiatric symptoms in patients can impair the QOL of the patients with dementia (Samus et al, 2005; Shin et al, 2005). In dementia and Alzheimer's diseases QOL of both the patients and their caregivers can be increased by applying few strategies like 'training of the patients to compensate their cognitive decline', 'deputing specially trained and motivated workers in dementia care' 'formulation of well-planned activity scheduling of the patients', 'ensuring better patients-staff communication', 'favourable involvement of staffs in in-patient set ups', 'proper identification and resorting appropriate treatment of neuropsychiatric complications', etc (Zimmerman et al, 2005; Shin et al, 2005).

CONCLUSION

Quality of life and well-being these have replace the previously adored yardstick, i.e. amelioration of a person's mental state. Now in addition to alleviation of psychopathology of the illness outcome of the illness is judged by the factors like 'how the patient feels about his or her own life'? Over the years a movement namely 'consumer right protection' gained momentum in Western countries and slowly it is inflicting Indian society too. It has some good aspects, such as persons who are the recipients of the clinical services should have the right to say 'how good or effective is the treatment what they received?' This subjective sense of well-being and quality of life can be emerged as the yardstick to judge the efficacy of treatment. Besides this the concept of QOL can ensure better functioning of existing mental health services and look on the holistic improvement of the person with mental and behavioural disorders.

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MARITAL PROBLEMS AND PSYCHOLOGICAL DISTRESS AMONG WOMEN ATTENDING FAMILY COUNSELLING CENTRE

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ABSTRACT

A sample of fifty eight women with marital problems registered at the Family Counselling Centre was interviewed for the extent of psychological distress. The scores on the 28 - item version of General Health Questionnaire (GHQ-28) indicated a high level of distress among the sample. The distress was more pronounced in the dimension of depression. The distress was mostly experienced by the less educated women as well as those who were currently employed. Further, the distress was also found to have significant positive correlation with the age of the women, duration of their marriage and size of their children. Moreover, the distress was mostly found among the women whose husbands were dependent on alcohol or had extramarital relationship. The distress was not associated with the dowry related problems of the women. The implications of these findings were discussed in the context of role of the Family Counseling Centres in the preventive mental health care of women in India.

Key words: *Psychological distress, counselling, marital problems, women*

INTRODUCTION

The family, as a primary social group is expected to facilitate healthy relationships among its members for its growth and development. During the difficult times, a healthy family functions as a valuable resource to its members. In contrast, a family with broken relationships could create further problems to family members.

In the west, marriages end in failure due to infidelity, emotional problems, spouse abuse, sexual problems, alcoholism, communication problems and financial problems (US Bureau of the Census, 1991). The Indian scenario of marriage and family breakdown was attributed to personal factors, interpersonal factors, family factors and crisis situation (Desai, 1991).

Many of the stress related disorders particularly among the women are known to be linked with their problems in daily life situations. Studies conducted in mental health setting have linked the current marital difficulties or discord associated

with severe mental illnesses and psychological distress such as depression, anxiety, nervousness, sleeplessness, moodiness and somatoform disorders among the married women (Brown & Harris, 1978; Huddleston & Hawkings, 1991; Aseltine & Kessler, 1993). Several lines of evidence have also linked marital turmoil to clinically significant depression. Paykel et al, (1969) have reported that marital difficulties are the most likely events occurred among depressed women prior to the onset of depression. Morrice (1974) reported that 30 percent of 266 cases admitted to day hospital were found to have associated interpersonal problems with spouse prior to the onset of mental illness.

The marital difficulties associated with depression include pathogenic nature of marital interaction, interpersonal and intra personal difficulties, lower problem-solving ability, physical aggression by husband, poor marital quality, and extra marital relationship of husband (Krietman et al., 1971; Corney, 1987; O'Leary et al, 1994; Charney & Prannass, 1995, Krudek, 1998; Hope, et al, 1999). In a multiple regression

analysis, the prediction of wife's depression was found to enhance by measures of overt marital disharmony, attribution of causality for relationship difficulties to their own behavior, and failure to attribute difficulties to their husband's behavior (Helim & Snyder, 1991). In a study of 50 white women with the unipolar affective disorder or dysthymia, who were maritally discordant, it was found that marital attribution of blame was most consequential for marital discord, while depressogenic cognition was most consequential for depression (Townesley et al, 1991).

The existing literature on the marital problems and psychological distress among the married women has exclusively been derived from clinical population. There are several non-mental health settings such as Family Counselling Centres (FCC) in India which also provide services to the women having marital problems. There is a lack of research in understanding nature of marital problems and psychological distress of the women in non-mental health setting like Family Counselling Center (FCC) in India. Against this background the present study was conducted with the aim of exploring the nature and extent of problems presented by women in Family Counselling Centre (FCC). The preliminary data on nature of services and the type of problems of the women attending FCC were reported elsewhere (Vranda & Charndarsekhar-Rao, 2006). The present paper highlights the results on the relationship between marital problems and psychological distress among a sample of women from the same setting.

METHODS AND MATERIALS

The sample comprised of 58 women with marital problems who sought help for the first time at Family Counseling Centre, Bangalore during the three months study period. The background information about the sample was obtained using socio-demographic data sheet and sets of open ended questions for assessing the nature and duration of marital problems. The psychological distress was assessed through the administration of the 28-item version of General Health Questionnaire (GHQ-28) of Goldberg and Hiller (1979). The

GHQ-28 was derived by factor analysis of the original 60-items of the scale. The items in the scale were equally divided into four dimensions namely: Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction and Severe Depression. The existence of four subscales permits analysis within subscales (Bowling, 1992). A 4-point scale was adopted for the purpose. The score of the scale ranged from 0 indicating less distress and 3 for high distress, thus higher the scores indicate greater distress. This scale is often used as measure of psychological wellbeing and psychological distress (Goldberg & Williams, 1988; Zimmermann-Tansella, et al, 1991).

RESULTS

Table1: Socio-Demographic Characteristics of Respondents

Sl.No	Socio-Demographic Characteristics	Respondents (N=58)	
		Number	%
1	Age(in yrs)		
	15-20	20	34.5
	21-26	29	50.0
	27 & above	9	15.4
2	Religion		
	Hindu	42	72.4
	Non Hindu	16	27.6
3	Education		
	Less Educated (Illiterate/primary/high school)	35	60.3
	More Educated	23	39.7
4	Occupation		
	Non Working	45	77.6
	Working	13	22.4
5	Marital Status		
	Married	38	65.5
	Deserted	16	27.6
	Separated	4	6.9
6	Type of family		
	Joint family	43	75.0
	Nuclear family	15	25.0
7	Duration of Marriage		
	Below 12	22	37.9
	12 to < 24	9	15.5
	24 to< 48	8	13.8
	48 and above	19	32.8
8	No. of Children		
	0	29	50.0
	1	18	31.0
	2	2	3.5
	More than 2 Children	9	15.5
9	Duration of Problems (in months)		
	Less than 10	20	34.5
	11 to 30	13	22.4
	31 to 50	14	24.1
	51 and above	11	19.0
11	Types of Marital Problem*		
	Dowry related martial problems	35	60.3
	Alcoholism in husband	19	32.8
	Husband's extramarital affairs	6	10.3
	Others (Bigamy, Impotency in husband)	5	8.6

* Items are not mutually exclusive. Hence total is more than 58

The socio-demographic characteristics of women (Table-1) show that majority (84.5 %) of women were in the age group of 15-26 years. About 79.3% women were from urban background, 72.4 % were Hindus and 60.3% of women had less education. Majority (77.6%) were non-working women. 65.5% of women were married. Most of the women (53.4%) had been married for less than 24 months, although 32.8% had 4 or more years of marital life. Half of the sample had no children.

Majority of the women (34.5%) presented marital problems with duration of less than 10 months. 60.3 percent of the women reported dowry related problems, while 32.8 % of women reported problems due to alcohol consumption by their husbands. A relatively small proportion of women (10.3%) also reported problems related to husband's extra- marital relationship.

Extent of Psychological Distress among Women at Family Counseling Centre:

Table2: Extent of Psychological Distress among Women at FCC

Sl. No.	Domains of Psychological Distress (GHQ Scores)	Distress in Women (N=58)		
		Mean Score	SD	Range (Min-Max)
1	Somatic Symptoms	11.16	6.92	0-21
2	Anxiety and Insomnia	11.16	7.22	0-21
3	Social Dysfunction	10.81	5.65	1-21
4	Severe Depression	15.43	7.41	0-21
5	Overall Distress	48.63	23.45	3-84

The mean psychological distress (table-2) among the women presented with problems at FCC was found to be 48.63 (SD=23.45). The manifestations of distress were highest (Mean=15.43; SD=7.41) in the area of severe depression and lowest (Mean=10.81; SD=5.65) in the area of social dysfunction. The other areas such as anxiety and insomnia and somatic symptoms were in the middle order.

Further analysis shows (table-3) that psychological distress was significantly high among the less educated ($p<0.001$) or unemployed housewives ($p<0.05$) with marital problems. The results (table-4) also indicate that all the domains of

psychological distress were positively correlated ($p<0.01$) with age, number of children and duration of marriage. This inter correlation was predominantly seen in the dimensions of somatic symptoms and social dysfunction.

Table3: Socio-Demographic Variables and Distress (Overall) among Women at FCC

Sl. No.	Socio-Demographic Variables	Psychological Distress (Overall)			't'-Values
		n	Mean	SD	
1	Religious Background				
	Hindu	42	51.38	22.97	1.467
	Non-Hindu	16	41.37	23.88	
2	Education				
	Less Educated (Illiterate/primary/high school)	35	52.29	19.30	3.875***
	More Educated	23	35.43	23.40	
3	Occupation				
	Non-Working	45	52.56	22.37	2.483*
	Working	13	35.00	22.74	
4	Marital Status				
	Married	38	48.26	20.69	-0.615
	Deserted, Divorced & Separated	20	52.10	25.89	

Level of Significance at *** $p<0.001$ * $p<0.05$

Table4: Correlations among the Domains of Psychological Distress and Background Characteristics of Women

GHQ vs. Background Variable	Somatic Symptoms	Anxiety & Isomnia	Social Dysfunc	Severe Depre.	Overall Distress
Age	0.361 **	0.289 *	0.374 **	0.317 *	0.379 **
Duration of Marriage	0.551 **	0.472 **	0.410 **	0.441 **	0.546 **
No. of Children	0.392 **	0.344 **	0.338 **	0.363 **	0.417 **

** Correlation is Significant at the 0.01 level (2-tailed)

* Correlation is Significant at the 0.05 level (2-tailed)

Relationship between Distress and Marital Problems among the Women at Family Counseling Centre

With regard to the relationship between the type of marital problems and extent of psychological distress among the women attending FCC, the results (table-5) revealed that the women with alcohol dependent husbands have experienced significantly ($p < 0.001$) higher level of overall distress than those women whose husbands were not using alcohol. The distress among these women with alcohol dependent husbands was significantly pronounced in all the dimensions of psychological distress, namely, somatic symptoms ($p<0.001$) anxiety and insomnia ($p<0.001$), social dysfunction

Table 5 : Extent of Psychological Distress and Types of Marital Problems among Women at FCC

Types of Marital Problems	Psychological Distress (N=58)										
	Somatic Symptoms			Anxiety & Insomnia		Social Dysfunction		Severe Depression		Overall Distress	
	n	Mean(SD)	't'-Values	Mean(SD)	't'-Values	Mean(SD)	't'-Values	Mean(SD)	't'-Values	Mean(SD)	't'-Values
1. Alcoholism in Husband											
Present	19	16.32(3.89)	4.353***	15.74(4.51)	3.387***	13.37(5.40)	2.933**	19.79(2.20)	3.277***	65.21(13.81)	4.202***
Absent	39	9.28(6.48)		9.46(7.42)		9.44(4.48)		13.79(7.79)		41.97(22.03)	
2. Husband's Extra Marital Affairs											
Present	6	14.83(5.78)	1.275	12.67(7.23)	0.410	13.17(6.74)	1.244	20.17(2.04)	3.756***	60.83(19.87)	1.303
Absent	52	11.21(6.66)		11.38(7.26)		10.44(4.88)		15.27(7.26)		48.29(22.56)	
3. Dowry Related Problems											
Present	35	12.11(6.05)	0.746	12.63(6.65)	1.464	11.06(5.48)	0.610	17.06(4.59)	1.756	52.86(18.5)	1.378
Absent	23	10.78(7.48)		9.83(7.83)		10.22(4.54)		13.78(9.51)		44.61(27.13)	

Level of Significance at ** $p < 0.01$, *** $p < 0.001$

($p < 0.01$), and severe depression ($p < 0.01$). The women whose husbands had extra-marital relationship have reported significantly ($p < 0.001$) high distress in the dimension of severe depression, although the difference was not reflected in the overall distress. Surprisingly, the findings of this study did not show significant difference in the extent of psychological distress experienced by women with or without dowry related problems.

DISCUSSION

The present study aimed at exploring the nature of marital problems and extent of psychological distress among the women who sought help at a Family Counseling Centre (FCC), Bangalore. The findings have clearly demonstrated the presence of considerably high psychological distress mainly in the form of severe depression, anxiety and insomnia somatic symptoms among these women with marital problems at a non-mental health setting.

The findings of current study support the earlier findings that marital problems precede psychological distress especially in the form of depression among women. Many studies have shown that marriage was beneficial to men but not for women (Bernard, 1972; Fox, 1980). Research evidence shows that marital problems or discord was the direct risk factor for depression among the women (Coombs, 1991; Christian, et al., 1994; Davis et al, 1997; Whisman & Bruce, 1999). The Marital Discord Model of Depression developed by Beach et

al, (1990) suggests that marital discord leads to marital stressors and losses in intimacy and spousal support, which in turn contribute to depression. The Self-in-Relation theory also points that women are particularly vulnerable to the depressogenic effects of marital problems, because they are socialized to develop a sense of self that is rooted in their relationships with others (Jordan et al, 1991).

One of the important findings of the current study is that the women with alcohol dependent husbands had significantly higher psychological distress than the women whose husbands did not use alcohol. The distress among these women was mostly found to be in the form of severe depression and somatic symptoms. Similar findings were reported in both Indian and Western studies. Hilberman and Alksne (1962) reported that women living with alcohol dependent husbands had high levels of psycho-physiological symptoms compared to separated women or wives of abstinent alcoholics. Drewery and Rae (1969) found that wives of alcoholics are depressed and unsociable. Similarly, Sathyanarayana Rao and Kuruvilla (1992) reported that avoidance, indulgence and fearful withdrawal were the common coping strategies adopted by the wives of alcoholics.

The present study points that the women whose husbands had extramarital relationship showed significantly higher level of distress in the form of severe depression. Anguish, depression, anger, and humiliation were reported to be the

common emotional experiences among the spouses of unfaithful partners. Cano & O'Leary (2000) found that women who experienced marital stressors that involved humiliation or devaluation or husband's infidelity were six times more likely to be diagnosed with major depression as compared to controls who did not experience such a stressor but reported similar levels of marital discord.

In general, the victims of dowry harassment were reported to have higher psychological symptoms such as depression, somatization, hostility, anxiety, phobia, paranoid ideation, obsession compulsion, sensitivity and psychotism (Aggarwal & Thatte, 1988). But, the findings of the current study did not show that women with dowry related problems have higher mean distress compared to women without dowry related problems. Indeed the extent of distress was found to be relatively less among women with dowry related problems.

The relationship between marriage and psychological distress is a very complicated matter and perhaps be compounded with other variables. In the present study the variables such as age of the women, the duration of marriage and number of children were found to be positively correlated with higher levels of psychological distress among the women seeking help at FCC. Further, the less educated and non-working women were found to have experienced higher level of psychological distress. Earlier, Sethi et al, (1972) have reported that the less educated persons were more prone to psychiatric illness in the presence of other variables such as lower status, unskilled jobs etc. Paul and Mechanic (1983) found that employed married women experienced slightly less distress than housewives. Similarly, Parry and Sharp (1986) reported that the women working outside the home had lesser extent of depression.

CONCLUSION

The current study is unique in its nature of data on the extent of psychological distress and marital problems obtained from the women attending the non-clinical community service setting. The finding showing that the alcoholism or extra marital relationship among the husbands were associated with

psychological distress among the women has long term implications for preventive and curative services at Family Counseling Centre in India. Although, the marital problems for majority of the women in this study was reported to be due to dowry related problems, however, the consequent psychological distress among these women was not found to be different from those who did not have dowry related problems. This particular finding indirectly implies the kind of socio-cultural acceptance and tolerance that exist among the Indian women.

The generalizations of the findings of the study are subject to few methodological corrections and further research. The sample size was very small and represents only one of the Family Counseling Centres in Bangalore. Moreover, the types of marital problems used in the study were not mutually exclusive. Indeed, some women had more than one problem. Nevertheless, these findings of the study emphasize that family counselors must give more attention to their client's psychological distress associated with marital problems or marital stressors. The counselors need to incorporate many interventions based on a sound theoretical knowledge on marital problems and marital counseling. It is important that the family counselors are trained in the areas of psychiatric social work assessments and psychosocial therapeutic modalities such as short term cognitive behavioral marital and family therapy, solution focused therapy etc. An active collaboration between the family counselors and mental health professionals would not only improve the quality of family counseling services but also facilitate mental health research in general population.

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DIAGNOSTIC STABILITY IN PSYCHOSES

Arvind Nongpiur¹, Vinod K Sinha², Pushpal Desarkar³

ABSTRACT

Background: Diagnostic stability in adult psychosis is found to be high in schizophrenia and affective disorders and low for other psychotic disorders. The present study was conducted on in-patients of Central Institute of Psychiatry readmitted for a psychotic illness, to find out the stability of diagnoses across the admissions and to see the nature of change of diagnoses using the ICD10 and DSM IV classification systems. **Method:** Out of 60 patients, 23 were admitted for three times, 9 for four times and 2 for five times and all admissions were rated (and diagnosis was generated according to ICD 10 and DSM- IV) using the OPCRIT computer program. **Results:** Stability of diagnosis was higher for affective disorders 85.90% (ICD 10) and 89.46% (DSM-IV) while schizophrenia had stability of 76.79% (ICD 10) and 79.16 % (DSM-IV). More changes were seen in schizophrenia than affective disorders. Stability was low for all other psychotic disorders. **Conclusion:** Stability of diagnosis in adult psychosis was found to be high for affective disorders and schizophrenia but low for other psychotic disorders.

Key words: *Diagnostic stability, diagnostic shift, adult, affective disorders, schizophrenia.*

INTRODUCTION

Diagnostic stability is the degree to which a diagnosis remains constant at subsequent patient assessments (Fennig et al, 1994). Diagnoses of psychotic illnesses are based on the presence or absence of characteristic symptoms which vary during the course and treatment of these illnesses and raise the question of how stable diagnoses of psychosis remain over time.

Historically, the development of the concepts of psychoses have not been too decisive. Changes of symptomatology from schizophrenia to affective disorders have been described (Ziskind et al, 1971). Much has changed from the 'two entity' concept of Kraepelin with descriptions of what are commonly called 'third psychosis' after accounts of 'cycloid psychosis' by Wernicke-Kleist-Leonhard school of psychiatry and 'reactive psychosis' by McCabe (1975), schizoaffective psychosis by Kasanin (1933) and boufee delirante by Pichot (1982). Diagnostic changes between schizophrenia and affective disorders also interact with ethnicity, increasing the complexity of diagnostic stability (Mukherjee et al, 1983), and hence follow-up studies were required to substantiate the validity and reliability of clinical diagnoses (Robins & Guze, 1970).

Studying the admission patterns and diagnostic stability of patients with functional psychosis in Denmark during a 2 year observation period, Jorgensen & Mortensen (1988) found the stability for schizophrenia to be 74.6% and affective disorder to be 72.9% while Vetter & Koller (1993) found schizophrenia to be very stable with 93% of 46 patients retaining the same diagnosis at follow-up.

Fennig et al (1994) followed up a cohort of patients for six months and found that, schizophrenic disorders had relatively high short term stability of 89%. Chen et al (1996) studied the stability of diagnosis in schizophrenia in a longitudinal study of 7 years duration and found women to have more diagnostic changes than men.

In a study which is similar in methodology, Forrester et al (2001) examined the readmitted patients using OPCRIT (Mc Guffin, 1991) and maximum diagnostic changes were from 1st to 2nd admissions. Schizophrenia was the most stable diagnosis in their study with percentages ranging from 57.6% to 97.9% with considerable shift from other diagnoses towards schizophrenia. Studies by Veen et al (2004) and Whitty et al (2005) also found higher stability for schizophrenia which was 91% and 97% respectively than affective disorders which was 67% and 80% respectively.

In affective disorders, Amin et al (1999) found 91% stability for ICD 10 (WHO, 1992) diagnosis of bipolar disorder whereas only 78% of those diagnosed remained same when DSM-III-R (APA, 1987) criteria was used. Kessing (2005) found the diagnosis of bipolar affective disorder to decrease continuously with treatment and later contacts, which was in contrast to the diagnosis of schizophrenia spectrum disorder, which increased towards later contacts. The most recent study to examine diagnostic stability was done by Addington et al (2006) where schizophrenia had the highest prospective consistency (95%), schizophreniform disorder was less stable (36%) with shifts towards schizophrenia being more common.

Majority of the studies in India are on acute and transient psychotic disorders and these disorders have been found to have good outcome and stability of diagnosis over a short period of time (Chavan & Kulhara, 1988; Susser et al, 1998; Sajith et al, 2002). However, Singh et al (2004) found the stability to be very low in males (14%) but was moderately stable in females (73%). One study from India that examined diagnostic stability in psychosis of child and adolescent population (Srinath et al, 1997) found 100% stability for bipolar affective disorders and stability for other psychoses was 82%.

Earlier studies (Forrester et al, 2001; Veen et al, 2004; Whitty et al, 2005) have addressed stability of diagnosis in different cohort of patients. Some studies (Schwartz et al, 2000; Whitty et al, 2005) have addressed issues of predictors of shift in diagnosis and comparison between diagnostic systems mainly DSM-III-R (APA, 1987) and ICD 10 (WHO, 1992) on schizophrenia and affective disorders. This study was conducted with an aim to make a comparison between ICD 10 (WHO, 1992) and DSM IV (APA, 1994) and also to see the change to and from a disorder apart from schizophrenia and affective disorders.

MATERIALS AND METHODS

The present study was a hospital based, retrospective study, based on case records and patient interview with a time-bound sample of patients who were readmitted between 1st October and 1st December 2005. This study was conducted

at the Central Institute of Psychiatry (CIP), Ranchi, and the study protocol was approved by the institute's ethical committee.

All patients who were re-admitted at the hospital between 1st October 2005 and 1st December 2005 for a psychotic illness and those who gave informed consent were taken up for the study. Patients diagnosed with organic psychosis, psychosis due to use of substances except caffeine and nicotine dependence or any other co-morbid psychiatric illness were excluded from the study.

The operational criteria (OPCRIT) computer programme (Mc Guffin et al, 1991) windows version 4.0, which was released in 2004, was used in this study. The OPCRIT checklist for psychotic and affective illness has been designed to facilitate a polydiagnostic approach to mental illness. The package is specifically designed for the needs of the researcher and is intended to be used by trained clinicians or investigators trained in clinical research. OPCRIT checklist ratings can be based on hospital case notes, prepared abstracts or on written material supplemented by personal interview.

Procedure

The information for each admission was collected and entered into a data sheet by a single rater, which contains the '90 item checklist' of the OPCRIT computer programme. The information of past admissions was collected from the case record file of the patient and the rating for the current admission was supplemented by a personal interview. After collection, the data of each admission was entered into the computer programme by the same rater and an output (diagnoses) was generated by the computer programme. The diagnosis according to ICD 10 (WHO, 1992) and DSM IV (APA, 1994) was then recorded in the same data sheet which was separate for each patient.

Statistical analysis

A qualitative analysis was done in the following steps:-

1. Those who did not have any change of diagnosis at all in

any of the admissions from among the total number of patients were separated and the diagnosis was computed and entered accordingly as Affective Disorders (hypomania, mania, depressive disorder and bipolar affective disorder), Schizophrenia, Delusional Disorder and 'Others' (Schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis, psychosis not otherwise specified and no diagnosis).

2. Data of those whose diagnosis had changed in any of the admission, were further analyzed 'pair-wise' i.e. between 1st and 2nd admission, 2nd and 3rd admission and so on, and the diagnoses were examined and computed 'pair wise'.

3. The diagnostic stability i.e. the proportion of individuals who retained the same diagnosis between the pairs of admission was then calculated and tabulated by examining the number of patients who retained their diagnosis.

4. A further analysis of the nature of change of diagnosis was done by qualitative analysis.

RESULTS

One hundred and eighteen patients were admitted at least twice during the study period that included 103 males and 15 females out of which 60 patients (M= 51; F= 9) fulfilled the inclusion and exclusion criteria and were taken up for the study. Out of the total, 23 patients were admitted for the third

time, 9 patients were admitted four times and only 2 patients were admitted for the 5th time.

Table 1 shows the mean age of onset of 25 years with a standard deviation of 9.25. Out of them 83.3% (n=50) were employed or were doing some productive work and only 3.3% (n=2) had poor pre-morbid work adjustment. 11.7% (n=7) of them had a family history of schizophrenia and 23.3% (n=14) had a family history of another psychiatric disorder. Only 6.7% (n=4) had a definite psychosocial stressor prior to onset and only 1.7% (n=1) had pre-morbid personality disorder.

Table 1: Socio Demographic profile

Mean age of onset (in years)		25.45 ± 9.25	
(Mean ± SD)			
Gender	Male	51	(85%)
	Female	9	(15%)
Marital status	Married	42	(70%)
	Unmarried	18	(30%)
Employment	Employed	50	(83.3%)
	Unemployed	10	(16.7%)
Poor premorbid work adjustment	No	58	(96.7%)
	Yes	2	(3.3%)
Premorbid personality disorder	No	59	(98.3%)
	Yes	1	(1.7%)
Family history of schizophrenia	No	53	(88.3%)
	Yes	7	(11.7%)
Family history of other psychiatric disorder	No	46	(76.7%)
	Yes	14	(23.3%)
Definite psychosocial stressor prior to onset	No	56	(93.3%)
	Yes	4	(6.7%)

Table 2: Frequency of diagnostic assignment (percentages), for pair-wise admissions

Diagnosis according to		ADMISSIONS N=60				ADMISSIONS N=23				ADMISSIONS N=9				ADMISSIONS N=2			
		First		Second		Third		Third		Fourth		Fourth		Fifth		Fifth	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Affective Disorder *	ICD 10	38	(63.33)	37	(61.67)	17	(73.91)	15	(65.21)	5	(55.56)	4	(44.44)	1	(50.00)	1	(50.00)
	DSM IV	35	(58.33)	37	(61.67)	17	(73.91)	17	(73.91)	5	(55.56)	4	(44.44)	1	(50.00)	1	(50.00)
Schizophrenia	ICD 10	14	(23.33)	15	(25.00)	4	(17.39)	4	(17.39)	2	(22.22)	3	(33.33)	0	0	0	0
	DSM IV	12	(20.00)	14	(23.33)	4	(17.39)	3	(13.04)	1	(11.11)	3	(33.33)	0	0	0	0
Delusional Disorders	ICD 10	1	(1.67)	3	(5.00)	0	0	1	(4.34)	1	(11.11)	0	0	0	0	0	0
	DSM IV	3	(5.00)	0	0	0	0	1	(4.34)	1	(11.11)	0	0	0	0	0	0
Others **	ICD 10	7	(11.67)	5	(8.33)	2	(8.69)	3	(13.04)	1	(11.11)	2	(22.22)	1	(50.00)	1	(50.00)
	DSM IV	10	(16.67)	9	(15.00)	2	(8.69)	2	(8.69)	2	(22.22)	2	(22.22)	1	(50.00)	1	(50.00)

* includes hypomania, mania, depressive disorders and bipolar affective disorder, ** includes Schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis, psychosis not otherwise specified and no diagnosis.

Table 3: Diagnostic stability across different admissions (percentages)

Diagnosis according to		N=60			N=23			N=9			N=2		
		ADMISSIONS			ADMISSIONS			ADMISSIONS			ADMISSIONS		
		1st	2nd	Stability	2nd	3rd	Stability	3rd	4th	Stability	4th	5th	Stability
Affective Disorder *	ICD 10	38	34	89.47%	17	15	88.24%	5	4	80%	1	1	N/a#
	DSM IV	35	33	94.28%	17	16	94.12%	5	4	80%	1	1	N/a#
Schizophrenia	ICD 10	14	11	78.57%	4	3	75%	2	2	N/a#	-	-	-
	DSM IV	12	10	83.33%	4	3	75%	1	1	N/a#	-	-	-
Delusional Disorders	ICD 10	1	1	N/a#	-	-	-	1	-	-	-	-	-
	DSM IV	3	-	-	-	-	-	1	-	-	-	-	-
Others **	ICD 10	7	3	42.86%	2	2	N/a#	1	1	N/a#	1	1	N/a#
	DSM IV	10	5	50%	2	1	N/a#	2	1	N/a#	1	1	N/a#

* includes hypomania, mania, depressive disorders and bipolar affective disorder,

** includes Schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis, psychosis not otherwise specified and no diagnosis,

diagnostic stability was not calculated if n<4 in the initial diagnosis.

As shown in table 2, the percentage of patients admitted with affective disorders remains comparable throughout the five admissions, being in the range of 63.33% to 50.00% through admissions 1 to 5 for ICD 10 and 58.33% and 50.00% for DSM IV. The percentage for schizophrenia showed an increasing trend from 23.33% in the 1st admission, 25% in the 2nd, 17.39% in the third and 33.33% in the fourth admission as per ICD 10 and an increases from 20% in the 1st admission, 23.33% in the 2nd, 13.04% in the third and finally to 33.33% in the fourth admission for DSM-IV.

The percentage of patients diagnosed with delusional disorders was very low i.e. 1.67% for ICD 10 in the first admission and 4.34% in the third admission and for DSM IV the figures were 5.00% in the 1st admission and 4.34% in the 3rd admission.

Even when lumped together, the 'others' category was diagnosed infrequently with n=6 (10.00%) according to ICD X and n=10 (16.67%) according to DSM IV in the first admission but even so, their presence, albeit in small numbers was seen through all admissions.

When diagnostic stability was assessed (table 3), it was seen that 38 patients were diagnosed as having an affective disorder according to ICD 10 in the 1st admission and out of these, 34 retained the diagnosis at the 2nd admission giving a diagnostic stability of 89.47%. In 2nd and 3rd admissions the percentage was 88.24% and 80% between the 3rd and

4th admissions.

In DSM IV affective disorders, 33 out of 35 patients retained the diagnosis at second admission with the stability being 94.28%. In those with more than two admissions, there was stability of 94.12% by 3rd admission and 80% at 4th admission.

The number of patients admitted with diagnosis of schizophrenia was comparatively lower, 23.33% according to ICD 10, 20% according to DSM IV at first admission. Fourteen out of 11 patients retained the diagnosis at the 2nd admission giving a diagnostic stability of 78.57%, 75% between the 2nd and 3rd admissions. According to DSM IV, 10 out of 12 patients retained the diagnosis at the 2nd admission giving a diagnostic stability of 83.33% and 3 out of 4 retained the diagnosis at the 3rd admission giving a stability of 75%. The stability for the 'others' category was only 42.86 for ICD 10 and 50% for DSM IV.

Table 4: Overall stability of diagnosis combining all admissions (percentages)

DIAGNOSIS	ICD 10 (%)	DSM IV (%)
Affective disorders*	85.90	89.46
Schizophrenia	76.79	79.16
Others**	42.86	50

* includes hypomania, mania, depressive disorders and bipolar affective disorder

** includes Schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis, psychosis not otherwise specified and no diagnosis.

Of all the diagnoses, affective disorders had the highest stability of 85.90% (ICD 10) and 89.46% (DSM IV) and stability of schizophrenia was 76.79% (ICD 10) and 79.16% (DSM IV) while the 'others' category had stability of 42.86% (ICD 10) and 50% (DSM IV) (Table 4).

Table 5: Nature of change of diagnosis from first to second admission.

Diagnostic Changes		1ST -2ND		Admission	
From	To	ICD 10		DSM IV	
Affective Disorders*	Schizophrenia	2.63	0		
	Delusional Disorders	5.26	10.52	0	5.71
	Others	2.63			5.71
Schizophrenia	Affective Disorders	14.28		8.33	
	Delusional Disorders	0	21.42	0	16.6
	Others	7.14		8.33	
Delusional Disorders	Affective Disorders	0		33.33	100
	Schizophrenia	0		33.33	
	Others	0		33.33	
Others**	Affective Disorders	14.29		30.00	
	Disorders	42.86	57.15	20.00	50
	Schizophrenia	0		0	

(all figures are in percentages)

* includes hypomania, mania, depressive disorders and bipolar affective disorder

** includes Schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis, psychosis not otherwise specified and no diagnosis

The maximum number of change of diagnosis was seen from the 1st to 2nd admissions (11 according to ICD 10 and 12 for DSM IV). As shown in table 5, there was 10.52% (ICD 10) and 5.71% (DSM IV) change from affective disorders to other disorders whereas the figures for schizophrenia were 21.42% (ICD 10) and 16.6% (DSM IV). The percentages were highest for the 'others' category where there was 57.15% (ICD 10) and 50% (DSM IV) change of diagnosis to other disorders.

DISCUSSION

Nature of diagnoses across admissions

In our study, affective disorders and schizophrenia were the main diagnoses seen across admissions. While affective disorders were found to be stable throughout the five re-admissions in both the diagnostic systems examined i.e. in ICD 10 (63.33% in the first and , 50% in the 5th admission)

and DSM IV (58.33% in 1st and 50.00% in 5th admission), schizophrenia on the other hand had an increasing trend from 23.33% (ICD 10) and 20.00% (DSM IV) in the 1st admission to 33.33% (ICD 10) and 44.44% (DSM IV) in the 4th admission which was similar to the findings of Forrester et al (2001) and Jorgensen & Mortensen (1988). One reason could be that, both affective disorders and schizophrenia were more likely to be readmitted and the increase in the percentages from first to last admission in schizophrenia, suggests that a change of diagnosis to schizophrenia had occurred sometime during the course of illness. Kessing (2005) however, found that a substantial proportion of patients who initially presented with prodromal syndromes such as transient psychosis, reaction to stress/adjustment disorder or mental and behavioural disorder due to psychoactive substance use eventually got a diagnosis of bipolar disorder later on leading to an increase of ICD 10 affective disorder diagnosis towards later contacts.

The delusional disorders and 'other' psychotic disorders that consist of schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis and psychosis not otherwise specified were very few in number in the first admission itself and remained so in all admissions which was in agreement with previous studies (Jorgensen & Mortensen, 1988; Forrester et al, 2001; Whitty et al, 2005).

Another observation was the occurrence of few patients who does not fall in any of the diagnostic category when OPCRIT (Mc Guffin et al, 1991) diagnosis was considered (n=2) in admission 4 and in admission 5 (n=1) and 'no diagnosis' was generated by OPCRIT. This could be due to the fact that the OPCRIT (Mc Guffin et al, 1991) computer program follows a rigid algorithm and symptoms had to be present for it to generate a diagnosis. Fennig et al (1994) had reported the existence of a residual group of patients whose clinical conditions did not fall into any of the specific diagnostic categories of DSM-III-R (APA, 1987) despite the intensive longitudinal diagnostic process used in their study, and there were also a few who had initially been given a specific diagnosis but who received a nonspecific diagnosis at 6 months. This group, representing about 9% of their total

sample, according to them, deserves more intensive scrutiny both phenomenologically and longitudinally.

Stability of diagnoses across admissions

Affective disorder was found to be the most stable of all diagnoses with stability of 85.90% according to ICD 10 (WHO, 1992) and 89.46% according to DSM IV (APA, 1994). Our findings were consistent with studies by Fennig et al (1994) who reported stability coefficients of 86.5% to 89.9%, and Amin et al (1999) where it was 78% according to DSM-III-R (APA, 1987) and 91% according to ICD 10 (WHO, 1992). However, other studies reported lower stability for affective disorders with figures of 72.9% (Jorgensen & Mortensen, 1988), 67% (Veen et al, 2004) and 80% (Whitty et al, 2005). Another study by Srinath et al (1997) in psychosis of childhood and adolescent onset reported 100% stability for bipolar affective disorder which was similar to the findings in this study.

Schizophrenia was also found to be a stable diagnosis with overall stability of 76.79% according to ICD 10 (WHO, 1992) and 79.16% according to DSM IV (APA, 1994). Our finding was similar with studies that had used DSM III R (APA, 1987), where Jorgensen & Mortensen (1988) had found the stability of schizophrenia to be 74.6%. Various studies have found stability of schizophrenia ranging from 75 to 83.7% across admissions (Stanton & Joyce 1993; Fennig et al, 1994; Amin et al, 1999; Forrester et al, 2001). Our finding was also similar to another study done in India by Srinath et al (1997) where they found 67% stability for the diagnosis of schizophrenia.

However, the stability coefficient for schizophrenia in our study was lower than the studies that had used DSM IV (APA, 1994) e.g. 92% by Schwartz et al (2000), 91% by Veen et al (2004), 97% by Whitty et al (2005) and 95% by Addington et al (2006). One explanation for the lower stability of schizophrenia diagnosis in this study could be due to lesser number of patients with schizophrenia representing the sample. Another reason could be that symptom variance in schizophrenia may be different in this part of the world and some patients could have fulfilled symptoms of other disorders leading to the lower stability percentage.

The stability of other conditions like schizoaffective disorder, acute and transient psychotic disorder, schizophreniform disorder, unspecified non-organic psychosis and psychosis

not otherwise specified was 50% and most diagnoses had changed at the second admission itself in both the ICD 10 (WHO, 1992) and DSM IV (APA, 1994) systems. This finding was consistent with all previous studies and especially with a recent study from India by Singh et al (2004) where after 3 years follow-up half of their patients had their diagnoses changed to another disorder.

Change of diagnoses across admissions

Forrester et al (2001) found maximum diagnostic changes between the 1st and 2nd admissions and in our study also, the maximum change of diagnosis was from 1st to 2nd admissions. Chen et al (1996) found that 15% of men and 34.9% of women who were initially diagnosed with schizophrenia, had their diagnoses changed, most commonly to affective disorders (50%) which was similar to what we see in our findings i.e. 14.28% with ICD 10 (WHO, 1992) and 8.33% with DSM IV (APA, 1994). Our findings of 21.42% (ICD 10) (WHO, 1992) and 16.6% (DSM IV) (APA, 1994) change from schizophrenia to other disorders were higher than those of Veen et al (2004), Whitty et al (2005) and Addington et al (2006) where they had used DSM IV (APA, 1994) diagnosis.

Only 10.52% of ICD X (WHO, 1992) affective disorder had their diagnoses changed in the 2nd admission which is lower than 30% change of diagnosis in affective disorders as reported by Kessing (2005). While comparing with studies that had used DSM IV, our finding of 5.71% (DSM IV) (APA, 1994) was lower than those of Veen et al (2004), Whitty et al (2005) and Addington et al (2006) but similar to the finding of Srinath et al (1997). The reason for the lower change of bipolar disorders could be due to lesser symptom variance of bipolar disorder in this part of the world.

Most studies (Forrester et al, 2001; Veen et al, 2004; Whitty et al, 2005; Addington et al, 2006) had reported low stability for schizoaffective disorders, acute and transient psychoses, schizophreniform disorders and unspecified psychoses and our findings of 42.86% for ICD 10 and 50% for DSM IV were in agreement with them. The nature of change of diagnoses from the 'others' category in our study was 42.86% (ICD 10) and 20% (DSM IV) to schizophrenia and 14.29% (ICD 10) and 30% (DSM IV) to affective disorders respectively, which again were consistent with the findings by Singh et al (2004).

CONCLUSION

Stability of diagnosis in adult psychosis was found to be high for affective disorders and schizophrenia but low for other disorders. The finding of a higher stability of affective disorders when compared to schizophrenia was consistent with another study done in India. This study has its limitations by being retrospective in design. The sample size was also less and female population was under represented. Moreover it does not address the factors leading to the change in diagnosis. Future studies should focus on the symptom variance of affective disorders in this part of the world and should see if it is different from the rest of the world. The predictors for change in diagnosis can be another focus for research.

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APPRAISAL OF SPOUSE'S EGO-SYNTONIC PERSONALITY CHARACTERISTICS AND QUALITY OF MARITAL LIFE: A PRELIMINARY REPORT

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ABSTRACT

Background: Among the various complex relationships prevailing in the society, marriage is the most intimate of all human interactions. A key component of maintenance of an intimate relationship could be one's attribution style, where negative attribution elevates the chances of conflict in marital relationship. **Aim & Method:** The relationship of the attribution of spouse's personality predisposition in the domains of personality disorder of DSM-IV (APA, 1994) and perceived marital quality has been investigated. In the present study, 35 married Bengali, Hindu couples of Kolkata metropolis, who were within 3 to 10 years of their marriages, have been investigated. The Marital Quality Scale (Shah, 1995) and an analogue framed for the items on Personality Disorder of DSM IV (APA, 1994) have been used to assess their quality of marital life and to understand the perceived traits of personality (on dimension of personality disorders of DSM- IV, APA, 1994) in their spouse. **Results:** Results suggest that the males' marital quality is maximally correlated to their attribution of features of "Not otherwise specified" category of personality of DSM-IV in their spouses, whereas, the attribution of the characteristics of cluster B personality of DSM-IV in the male spouses was found to be correlated with marital quality of the females. **Conclusion:** It is concluded that there exists a relationship between the marital quality and the perception of spouse's personality characteristics. Study also indicates that males put more importance on care giving and interpersonal communication and females emphasize on commitment in male spouse, to maintain a healthy marital relationship.

Key Words: *Attribution, marital quality, personality disorder*

INTRODUCTION

Marital relationship is generally conceptualized as the kind of relationship, which rests on the passionate desire for affectionate interaction between the couples, the initiation of which occurs through mutual attraction (Moghaddam et al, 1993). Personalities of the spouses could play a crucial role towards understanding each other. Few studies (Bradbury & Fincham, 1992; Cobb et al, 2001) have examined one's personality as perceived by the spouse in relation to marital quality. Previous studies indicate that self and partner-perception predicts quality of relationship in married couples (Cobb et al, 2001) and maladaptive attributions contribute to conflict that results in dysfunctional relationship (Bradbury & Fincham, 1992). It is also feasible that satisfaction could lead to more positive partner-perceptions and self-perceptions. It is obvious that characteristics, which are pronounced in

individuals with personality disorder, are also normally distributed in the population, though not in a pathological form. Thus, variation in the profile of these characteristics, within a range, may be presumed to have an impact on marital relationship and could act as the determining factor of marital quality. Thus the study aims to find out the relationship between those characteristics and marital quality of spouses.

METHOD

Sample

The sample comprised of 35 Hindu, Bengali married couples of Kolkata, married for 3 to 10 years. Subjects with diagnosis of any psychiatric disorder, or having any chronic physical illness, remarriage, separation, divorce, living with more than one spouse, inter religion marriage, inter-cast marriage,

having low socio-economic status were excluded from the study. Females aged below 21 years and males below 23 years were excluded. Individual more than 40 years of age, education below 12 years, non-residents of Kolkata were not included in the study.

The following tools were used in the present study

1. **Information Schedule:** The information Schedule, constructed by the researchers themselves, aimed at eliciting demographic information like age, sex, mother tongue, education, occupation, family income, number of family members, number of children, duration of marital life, age when married, any incidence of sexual problem, abortion, miscarriage or infertility etc., pattern of interpersonal relationship in home, work place and neighbourhood, and the like.

2. **Marital Quality Scale:** A multidimensional scale in English, developed by Shah (1995) which has a four point rating scale, consisting of 50 items, 28 of which are positively worded items and rest are negatively worded. Four types of answers are provided against each statement, that is U' (usually), S (some times), R (rarely), N (never). It measures twelve factors e.g. understanding, rejection, satisfaction, affection, despair, decision making, discontent, dissolution potentials, dominance, self disclosure, trust, role functioning. The scale provides two types of scores:

a. Total scale score,

b. Scores on twelve factors of the scale.

It has male and female forms. This scale has high internal consistency (coefficient alpha = 0.91) and high test retest reliability ($r = 0.83$; over a 6 week interval). It has well established content and construct validity.

3. **DSM IV Analog:** DSM-IV Analogue is a self report inventory, made up of criteria of personality disorders, given by DSM IV (APA, 1994). This analogue helps to understand the traits of

personality present in normal population. It measures 12 personality types, e.g. Paranoid, Schizoid, Schizotypal, Histrionic, Narcissistic, Anti-Social, Borderline, Avoidant, Dependent, Obsessive compulsive, Depressive, Passive aggressive. The rating scale has 93 items in statement form, with a four point rating scale, and for each statement four types of answer are provided; 1= 'disagree'; 2= 'agree to some extent'; 3= 'agree to considerable extent'; 4= 'strongly agree'. Individuals have to rank the characteristics, as they perceive the intensity of their presence.

Procedure

Couples were selected, following the inclusion and exclusion criteria. Rapport was established and initial consent was taken from them. Information Schedule was filled in by them. Husbands and wives were interviewed separately using Marital Quality Scale and DSM IV Analog scale. Male version of Marital Quality Scale was presented to the husbands to assess their quality of marital life and their perception about their wives on the domain of personality disorders on DSM IV Analog scale. In case of females, female version of Marital Quality Scale was presented to them; to assess their quality of marital life and DSM IV Analog scale was administered to assess their perception about their husbands on the domain of personality disorders. For the purpose of the study, only total scale score of Marital Quality Scale were computed following scoring procedure and for DSM IV Analog Scale scores of 12 personality types were computed separately, then summation of scores of Paranoid, Schizoid, Schizotypal personalities were computed to get score of Cluster A (CA) personality; summation of scores of Histrionic, Narcissistic, Anti-Social, Borderline personalities were computed to get score of Cluster B (CB) personality. To get score of Cluster C (CC) personality, summation of scores of Avoidant, Dependent, Obsessive compulsive personalities were computed and summation of scores of Depressive, Passive aggressive personalities were computed to get score of Not Otherwise Specified (NOS) personality.

Statistical Analysis

Means and standard deviations (SD) were computed for each of the test variables investigated in the study. The Pearson's product moment correlations (r) were employed to find out the relation between variables. Partial correlations were computed to obtain the relationship between variables when the effect of other variables was excluded. Regression analyses (R) were computed to find out the predictor (personality of spouse) of quality of marital life. P value less than 0.05 was used to determine the level of statistical significance.

RESULTS

The mean and standard deviations (SD) of the perception of the wives' characteristics on all the clusters of personality (A,B,C, NOS) by their husbands and the appraisal of the husbands' characteristics by the wives have been depicted in the table- 1.

Table1: Mean and SD of Cluster total scores of self perception and perception of spouse, of both male and female

Clusters of personality	Male		Female	
	Self Mean	Spouse SD	Self Mean	Spouse SD
Cluster A	34.88	8.65	34.85	10.38
Cluster B	49.80	10.75	50.45	11.00
Cluster C	38.41	8.48	39.68	8.38
NOS personality	20.91	6.84	21.57	5.68

Table 2: Partial correlations between marital quality and appraisal of spouse's personality

Perception of Spouse personality	Partialled out the effect	Correlation with Marital quality of male	Correlation with Marital quality of female
Cluster A (CA)	CB, CC, NOS	0.0150	0.0752
Cluster B (CB)	CA, CC, NOS	0.0748	0.3643*
Cluster C (CC)	CA, CB, NOS	- 0.2093	-0.2525
Not other wise specified personality (NOS)	CA, CB, CC	0.3528*	-0.2406

* Indicating significant at 0.05 level of significance

It is evident from the results that marital quality of males has direct correlations with their perception of wives' characteristics on cluster-A ($r=0.439$, $p<0.01$), B ($r=0.407$, $p<0.05$) and not

other wise specified categories (NOS) ($r=0.523$, $p<0.01$) of personality, while females' perception of their husbands on the clusters of A, B, C and NOS categories did not show any significant correlation with their marital quality.

Results of partial correlation between marital quality and appraisal of spouse's personality(table-2) further indicates that when the effects of the characteristics of the cluster A, B and C in female are partialled out, the category of not otherwise specified (NOS) personality is found to have direct correlation($r=0.3528$, $p<0.05$) with the marital quality of male. But characteristics of cluster- B personality of husband have direct significant correlation($r=0.3643$, $p<0.05$) with marital quality of female.

Thus poor quality of marriage of male is highly correlated with the characteristics of the category of NOS personality in their female counterpart. On the other hand, when the effects of CA, CC and NOS personalities are excluded, then CB personality of their male counterpart causes low quality of marital life for females.

A significantly positive correlation between marital quality of males and the depressive personality (table 3) in their spouses suggests greater impact of depressive personality on marital quality of males than the characteristics of other categories.

Table3: Partial correlation between personality types included in Not other wise specified (NOS) personality of spouse, as perceived by male and their own marital quality

Males' perception of Spouse personality predisposition, as -	Partiallying out the effect of-	Correlation with Marital quality
Depressive personality	Passive aggressive	0.4788**
Passive aggressive personality	Depressive	0.0186

**Indicating significant at 0.01 level of significance

The results of stepwise regression analysis reveals that only characteristics of not otherwise category (NOS) of specified personality disorder of female ($R=0.523$, $p<0.001$) and more specifically, the depressive personality characteristics of female($R=0.588$, $p<0.0001$) predict males' quality of marital life.

DISCUSSION

The results of correlation between the marital quality of male and their appraisal of the ego-syntonic characteristics of cluster-A (CA) and cluster-B (CB) categories of personality in their wives suggest that the perception of these characteristics in spouse reduces the marital quality of male. Withdrawal tendency, mistrust, oddity and "indifferent attitude" of the person with the characteristics of CA would create negative condition which is not conducive to maintain a satisfactory relationship, and would not only fail to maintain an intimate relationship with their partner (due to their deficiency in reciprocation) but could also reinforce the ending of the relationship. Moreover, when they perceive the CA characteristic in their wives coupled with the personality characteristics of CB like impulsivity, unpredictability and lack of support, love, affection and commitment, it perhaps intensify their negative marital quality.

Moreover, withdrawal tendencies and impulsivity both indicate inadequate role functioning, which could explain the poor marital quality in males due to their perception of discrepancies between role expectation and role performance in their wives. This observation is in agreement with the concept of Role theory (Tharp, 1963), that explains the discrepancy between role expectancy and role performance of spouse to be a determinant of marital relationship. The finding is also in conformity with the report of the study of Bond & Cheung (1983) and Sheweder & Bourne (1982) that indicates that people portray others in terms of their social role and interpersonal interaction.

However, the observation of no relationship between cluster CA and CB with quality of marital life of male when effects of other clusters are partialled out requires an explanation.

The distribution of the scores of CA and CB in the present study is found to be positively skewed (figure 1), the scores being massed on the lower side of the normal probability curve, indicating the presence of the characteristics of that specific cluster of personality is least pronounced in female as perceived by male. Distribution of scores of personality incorporated in CA (Paranoid, Schizoid, Schizotypal) (figure 2) and CB (Histrionic, Narcissistic, Borderline, Anti social) (figure

3 & figure 4) also indicates similar nature of distribution in Normal Probability Curve(NPC). Especially in case of anti-social personality, the scores are not only massed at the lower end but scores also indicate the absence of a few of the characteristics, as expected. Thus, perhaps, presence of characteristics in lower end of the NPC fails to have the potency to create any problem for maintaining marital quality when they are considered individually. However, their significant detrimental effect on conjugal life, when coupled with other clusters, may be attributable to the combined impact of the negative characteristics of all the dimensions on the marital quality of male.

Figure 1:-Distribution of presence of characteristics of CA & CB personality of wife, as attributed by husband

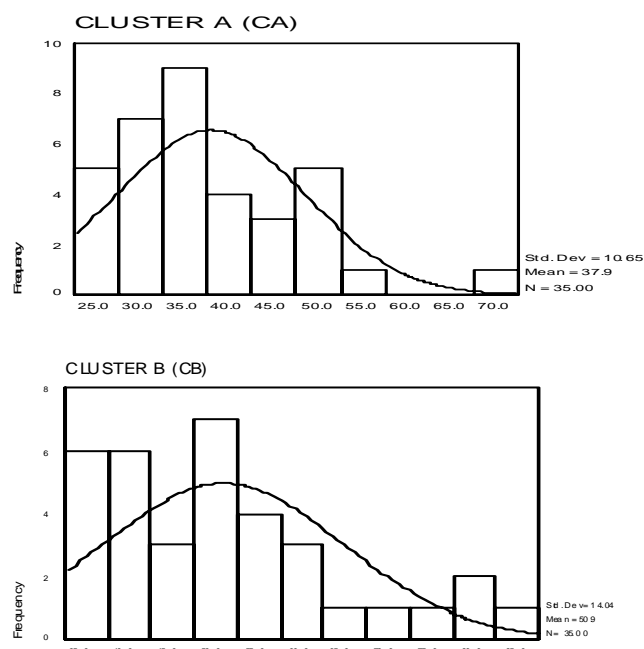
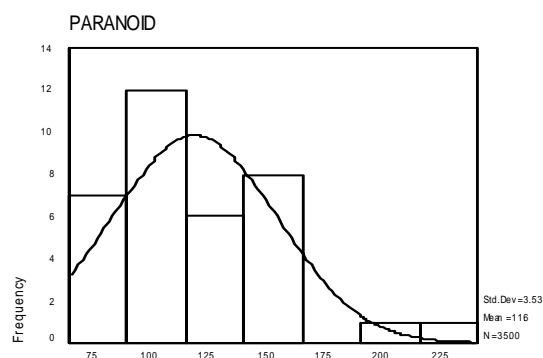


Figure 2: Distribution of presence of characteristics of Paranoid, Schizoid, Schizotypal personality of wife, as attributed by husband



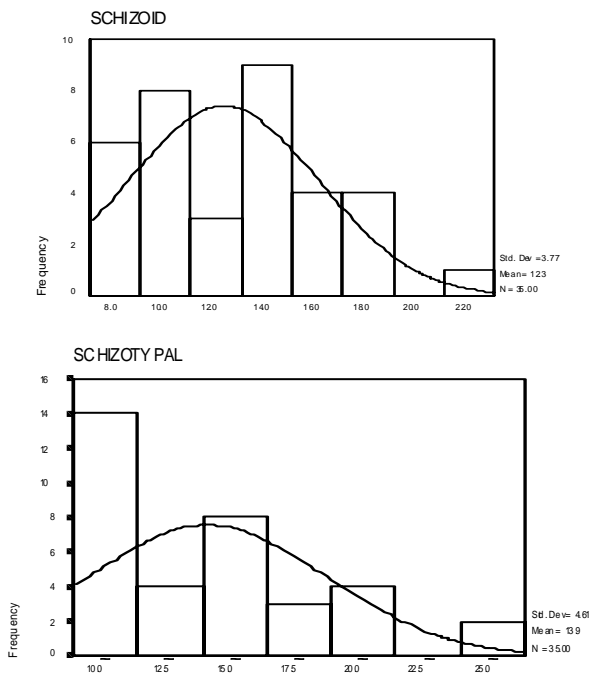


Figure 3: Distribution of presence of characteristics of Histrionic, Narcissistic, Anti-social, Borderline personality of wife, as attributed by husband

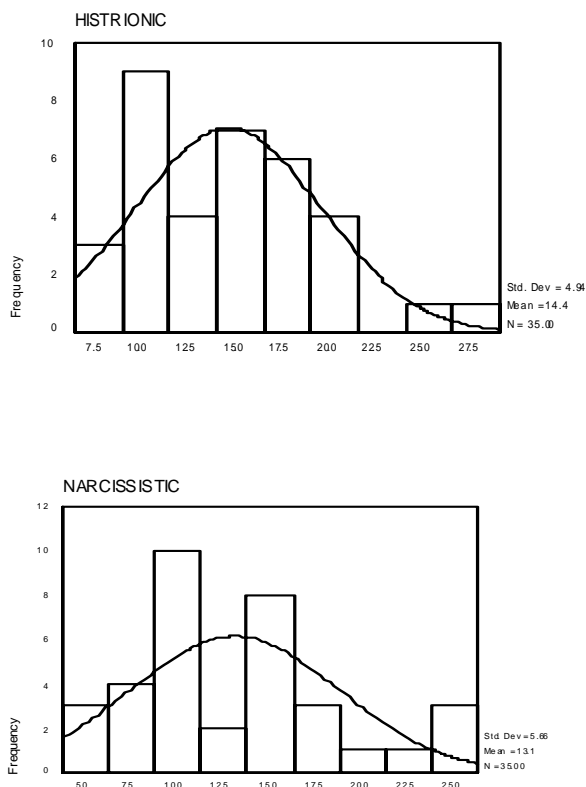
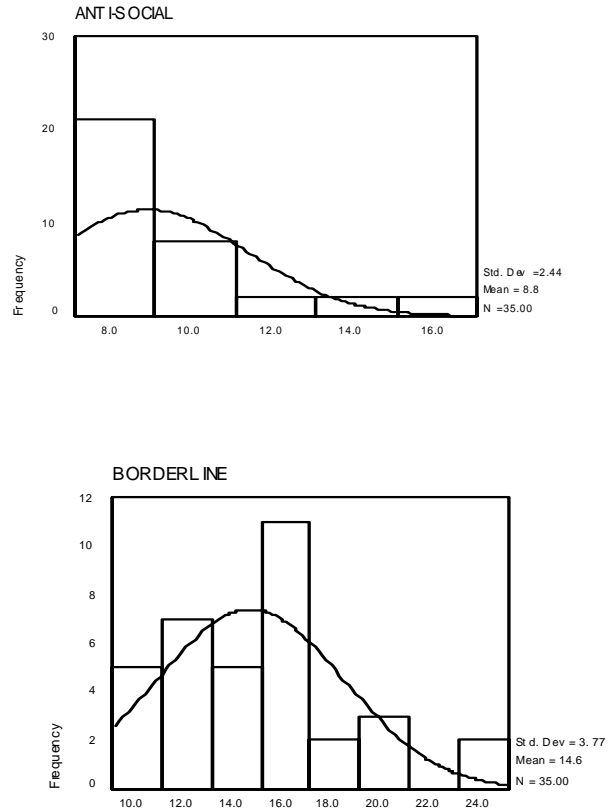


Figure 4: Distribution of presence of characteristics of Anti-social, Borderline personality of wife, as attributed by husband



It is noteworthy that the findings of direct correlation between the not otherwise specified ($r=0.588$, $p<0.0001$) category of personality (NOS) of wives and marital quality of husbands, excluding the effects of other clusters, signify the independent and the most potent impact of wives' status on NOS on the marital quality of the husband.

Individuals with characteristics of NOS, owing to the characteristic of passive resistance that incapacitate them to resolve any problem (Davison & Neale, 2001), can not provide others with emotional well-being, self confidence, and security, which have been ascribed as indices of quality of interpersonal relationship (Blood & Wolfe, 1960).

It is widely known that depressive and passive-aggressive category (NOS), are characterized by preoccupation with

negative events (depressive personality), faultfinding tendencies, and passive resistance to routine social role (passive aggressive personality). The finding of significant impact of passive-aggressive category (NOS) on marital quality of the male spouse is substantiated from the previous research report (Shah, 1995) which showed that pessimism, hard to please and fault finding attitude, humiliating and depreciating interactions are expressions of hostility and have immense potential to lead to marital disharmony. An intimate relationship of the individuals, belonging to this cluster, is rarely characterized by tranquillity or happiness (Kaplan & Sadock, 1998). Since the perceived passive aggressive quality in wives are appraised as bound to their ill feeling and are hard to please, their male counterparts perhaps remain hungry for love, affection, good interpersonal interaction and marital satisfaction. The passive resistance against performing their socially prescribed role may be another major reason to make their spouse perceive the marriage as of poor quality, and to feel disturbed in maintaining the relationship. It is further supported by the result of regression analysis, which indicates that perception of characteristics of NOS in wives by males significantly predict males' quality of marital life.

The findings of a positive correlation between marital quality of male and the depressive personality of the spouse (which is incorporated in NOS), excluding the effect of characteristics of passive aggressive personality of NOS suggest that perceived depressive characteristics in female has a significant impact on marital quality of male. Presumably, individuals with this type of personality though are serious, disciplined, conscientious, and responsible (Kaplan & Sadock, 1998), marital relation is possibly thwarted owing to their hesitation, indecision, feeling of inadequacy and hopelessness. Their pessimistic nature, feeling of guilt and tendency to get discouraged easily under new condition, minimize the reinforcement for maintaining an intimate relationship. Consequently, the quality of marriage deteriorates. This is further supported by the result of regression of perceived depressive personality of female on male's perception of marital quality.

Considering the female's perception of the male spouse, no such significant impact of personality cluster on female's quality of marital life requires an explanation.

Results of female's perception of husbands personality as CA, CB, CC and NOS not being correlated with their marital quality delineates their perception of husbands' personality to have a negligible effect on their marital quality. Presumably, the feminine style of social mixing (Cutrona, 1996), helps them to share their feelings with others, thereby, feeling of getting social support from others, owing to its rewarding consequence, perhaps help them to maintain their emotional health (Wills, 1991), and compensate for emotional loneliness induced by lack of intimate relationship with husband.

Appraisal of CB personality characteristics in husband being independent of other cluster effect (table 3) is found to be directly correlated with marital quality of females, which delineates that egocentricity, unpredictability, non committing characteristics of CB in husbands are more disturbing for women than withdrawal or avoiding characteristics of the spouse. These characteristics of cluster B fail to provide the wife with security, sincerity and faithfulness, thus they perhaps loose the meaning of intimate relationship, which reduces the female's quality of marital life. This suggests that females give more importance for commitment of spouse to maintain a harmonious conjugal life, the characteristic which is least observed in CB personality.

CONCLUSION

Present study shows that there exists a relationship between the perception of spouse's ego-syntonic personality and one's marital quality. This study also indicates that males put more importance onto caregiving and interpersonal communication and females prioritize presence of commitment in male spouse, to maintain a healthy marital relationship. The study may be a useful piece of information in marital counselling, particularly, in our cultural context.

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SCHOOL BASED MENTAL HEALTH PROGRAMME: FEW CASE VIGNETTES

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ABSTRACT

Background: School mental health has been recognized and initiated in many parts of the country though mainly by the non-government organizations or teaching hospitals, particularly the psychiatry institutes. **Objectives:** a) to identify commonest factors associated with scholastic problems, and b) to develop case studies and c) to study the utility of multidisciplinary approach in managing the academic and mental health problems in the school context. **Methods:** A multidisciplinary team under the supervision of a consultant in psychiatry delivered the intervention utilizing mainly the principles of applied behavioural analysis. **Results:** Faulty learning strategies (51%), peer related adjustment problems (13%), uncongenial family environment (12%), core psychiatric disorders (10%), borderline intelligence or mental retardation (8%) and poor teaching strategies or class room environment (6%) were the major contributors of academic problems. **Conclusion:** Most of the problems leading to scholastic and behavioural problems can be managed through multidisciplinary approach. Case vignettes will help teachers and parents deal with the children's problems effectively.

Key words: *School mental health, multidisciplinary approach.*

INTRODUCTION

There are unequivocal evidences that school going children suffer from various emotional and psychiatric problems (Last & Strauss, 1990; Berg, 1996; Hirisave & Shanti, 2002; Shenoy et al, 1998), which will affect the academic performance and self-esteem (Mukerjee et al, 1995). However, all academic problems need not be due to psychiatric disorders alone but still they need intervention (Berg et al, 1993; Bools et al, 1990).

School based mental health programmes essentially focus on the issues related to scholastic performance and overall well being of the school going children. In the West, such programmes are an integral part of educational system (Rappaport, 2001). Western models demanding excellent infrastructure facilities and greater intersectoral co-operation would be difficult and unaffordable in developing countries like India (Sinha et al, 2003). In this respect, indigenous models should be planned and implemented as per the needs. Or, even if the Western models are adopted, it is important to understand which elements of the programmes are not

culturally limited and can remain unchanged, and which portions must be changed to make them culturally relevant (Jandhyala et al, 1991).

In India, the school mental health programmes were initiated primarily by non-government organizations, with technical support from premier postgraduate training institutes (Kapur, 1997). Sensitive to the needs of the school going children, the Central Institute of Psychiatry (CIP), Ranchi has been successfully carrying out the school based mental health programmes for about eight years. The model was found to be successful as it has least effect on a student's school attendance rate due to monthly consultations at the school itself, and effective implementation of the selected intervention because of teachers' and parents' participation (Kishore & Sinha, 2002; Sinha et al, 2003). In this background, the objectives were: a) to identify commonest factors associated with such problems, and b) to develop case studies and c) to study the utility of multidisciplinary approach in managing the mental health problems in the school context.

METHOD

A team consisting of Postgraduate Trainees (PGTs) in clinical psychology and psychiatric social work visited the community based school on a fixed day every month under the supervision of a consultant in psychiatry. By the time the team reaches the school, the principal would ensure that teachers identify specific problems in their students and call the respective parents to attend the counselling session with the professionals. The PGTs in clinical psychology and psychiatric social work would gather the information by interviewing the parents, teachers and children separately and compile the information to make appropriate programme based predominantly on applied behavioural analysis under the supervision of the senior author (VKS). In some cases, even the peer group would be interviewed. For interviewing, the case-record file developed for the child psychiatry unit of CIP was used. After the assessment, the children were broadly divided into those needing a). Psychiatric intervention, b). School support, c). Family support and d). combination of support. If a particular child needed psychiatric help he or she would be referred to the community based extension clinic run by the team of psychiatrists from CIP. If the children required school support, the teachers and peers were counseled on the nature and level of support required within their capacity. If the children required family support the same was conveyed to the parents. In all these approaches, the child was given psychoeducation about the nature of the problem, course, prognosis and management plan.

RESULTS

As part of the programmes, various private and government schools in Ranchi and neighborhood districts were covered. The success rate was encouraging. From 2000-2006, over 1000 children were referred for various problems. Analysis of the academic problems revealed that they could be mostly accountable to faulty learning strategies (51%), peer related adjustment problems (13%), uncongenial family environment (12%), core psychiatric disorders (10%), low intelligence and sensory motor impairments (8%) and poor teaching strategies

or classroom environment (6%). It should be a matter of respite to note that majority of these factors could be modified. The case vignettes as given below will highlight various strategies used by the team.

Case 1: Master AK was a 14 year old boy referred with the complaints of telling lies, smoking in the class, and bullying others. Apparently, parents were only aware of the academic problems and they refused to believe when the school authorities brought the other problems to their notice, until he failed in class VIII. On detailed interview, he was found to have adjustment disorder, and he also confided that the complaints were correct. A detailed behavioural analysis revealed that these problems typically started around 13 years of age and were largely related to peer-acceptance. While the scholastic backwardness was due to lack of structured study schedule and misconceptions that he did not have to put in efforts as all his siblings were studying in prestigious colleges, other problem behaviours were related to gain peer acceptance. He was first counseled about the misconceptions regarding generalizing his siblings' success to his success. He was also asked to note the benefits and losses associated with continuing certain behaviours for peer-acceptance, and to find out alternate ways of obtaining peer acceptance. Then he was encouraged to plan a structured study schedule, for which he had to maintain a diary. The parents and teachers would monitor the program. Whenever he completed the task mentioned in the schedule, the parents and teachers in the respective settings appreciated him, and he would be allowed to choose rewards that were mutually agreed upon. Once the target behaviours were met, new targets were included. For the academics, his performance was compared with his previous achievements. Therefore, it was essentially a criterion-referenced approach. At the end of four months follow-up the parents and teachers reported a consistent progress in the academics as well as social conduct. He passed class IX with average marks.

Case2: Master AD, a 13 year old male studying in class IX was referred with scholastic backwardness. He complained

of memory problems. Detailed interview and an intellectual assessment ruled out psychiatric disorders, intellectual deficits and family problems. The memory problems were restricted to academics only, though not specific to any subject. Therefore, assessment was focused on study habits, which revealed that the problems were primarily due to lack of structured study routine, faulty learning habits, attention span and motivation. With the help of the child himself, a structured routine was prepared in such a way that he would begin and end the study hours with subjects of his interest, and the study hours would be followed by the activities of the child's interest. The academic tasks were given to fit into the attention span of the child. The behavioural contract was made the he would be entitled for activity rewards (e.g. play/TV/ monitor the class) as early as he would complete a given academic task. After learning a new concept he was advised to write down the main points of the concepts in a diary. He was also asked to revise the topics once a week by looking at the short notes maintained in the diary. It helped the parents and teachers to monitor the progress than simply emphasizing on the time spent by the child on a given task. Gradually, the time spending on each task was increased. Reports of the parents and teachers revealed a considerable progress in his class tests as well as participation in the academic activities.

Case 3: Master BS, a 7 year old boy from class II was referred with the complaints of restlessness and inattention. The psychological assessment and the parental interview ruled out developmental delay, sensory-motor deficits and hyperkinetic disorder. He would need constant reminders every three to four minutes. Separate strategies were prepared for school and home setting. The teachers were advised to keep the child in the first three rows as much as possible, and to call him by name before giving any task. Since it was not possible for the teacher to monitor him all the time, peer tutoring/monitoring was employed wherever possible. At home, structured schedule was made, which also incorporated play activities to improve attention. They were mainly- sorting out large objects (e.g. clothes, vegetables, utensils etc.) in the beginning to finer things (e.g. separating

various pulses) at the end; using newspaper cuttings to find out as many target letters as possible. Gradually, academic activities were introduced to fit with his attention span, which was increased once the target level was achieved i.e. when the baseline assessment showed that he could do only two sums of two digit additions in five minutes, he was given only two till achieved accuracy, and later the number of sums were gradually increased. At the end of three months of intervention, it was observed that he was able to concentrate on academic and domestic tasks till completion.

Case 4: Master JH, a 12 year old boy studying in class VI was referred for lack of participation in the class room activities, and parental complaints of frequent fights with his younger brother, lack of attention and concentration and irritability. History and a mental status examination revealed that the boy was suffering from mild depression. There were some significant psychosocial factors responsible for this. They were- lack of empathy from the parents, pressure for academics, lack of recreational activity, and transfer from a school where he studied in a residential setting for five years, and teachers' critical comments. Especially, constant pressure from the parents to excel in studies and frequent comparisons with younger brother had potentially mediated with his negative self-evaluations. Thus, for the fear of failure he would rarely participate in group situations. As a first step in intervention he was counseled about the need for medication. Then, parents and teachers were counseled separately to understand the individual differences, and to identify the strengths in him, and encourage him to pursue activities accordingly. They were also counseled about the impact of constant criticism, and the differential reinforcement. To improve his social skills, he was made monitor during the art classes, as he was good in art and sports. Similarly, he was given home-tasks, which he had to perform with his brother (e.g. cleaning the house, buying snacks for home etc.). During a period of three months, there was gradual improvement in level of depression, sibling relations, peer adjustment, and participation in the academics.

DISCUSSION

Descriptive analysis of the data reveals that mostly environmental factors were associated with the scholastic problems, which could be easily intervened. The above case vignettes also illustrate the importance of school based mental health services delivered by multidisciplinary team and the collaborative efforts by the teachers and parents. It was also observed that many of the goals in school mental health could be achieved only by maximum participation from the teachers and parents. Especially, such participation will help monitoring the impact of therapy in more than one environment. This is also important for decisions regarding termination of the therapy because certain problem behaviours might perish in one environment but continue to occur in another. For example, a child referred for conduct problems starts showing positive changes only in school but not in the home environment, points that the maintaining factors are existent in the home situation, which in turn will give an idea about further plan. Clinical experience also showed that teachers and parents often employ indigenous techniques to address these issues by virtue of their expertise and experience. Therefore, future studies may focus the strategies employed by teachers and parents and compare them with clinician-assisted strategies.

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INFLUENCE OF THE LEVEL OF EDUCATION ON PROSPECTIVE MEMORY

Devvarta Kumar¹

ABSTRACT

Present study is a preliminary research investigating the influence of the level of education on prospective memory. In a single experiment, the tasks for prospective memory were administered on three groups of people having low, medium and high levels of education. The low education group had poor performance on the tasks as compared to the medium and high education groups; however, the medium and high education groups did not differ with each other. Findings have been discussed in the light of education being, possibly, an important intervening variable in determining performance on prospective memory tasks.

Key words: *Education, prospective memory*

INTRODUCTION

Education, an important aspect of human life, requires active utilization of simple and complex cognitive abilities for the acquisition of knowledge and skills. From neuropsychological perspective, the operations involved in education results in improved cognitive functions and, in turn, a higher 'cognitive reserve' (Katzman, 1993; Stern et al, 1994, 1999; LeCarret et al, 2003a; Kesler et al, 2003; Bennett et al, 2003).

The relationship of the level of education and cognitive abilities has been replicated frequently (Plassman et al, 1995; Elwan et al, 2003; Stern et al, 1999; Bennett et al, 2003). For example, of the different factors considered to be affecting performance on any psychological test in general and, particularly, on the neuropsychological tests, 'level of education' has an important place. Tests that assess cognitive functions have, usually, education based norms and these norms clearly implicate that people differ in their performance according to their level of education (Crum et al, 1993; Ainslie & Murden, 1993).

Various reasons for the relationship between education and cognitive functions have been proposed. Education's positive impact on conceptual ability, encoding of material, neuronal activation and so forth are a few important factors that may mediate in the relationship between education and cognitive

functions. For example, it is hypothesized that highly educated older adults with age-related decline in cognitive abilities differ in using strategies and neural circuits with their low education counterparts, which help them in coping with the decline (Stern et al, 1999). Similarly, animal studies have shown that enriched environment that lead to better stimulation of the brain has positive effect in terms of neurogenesis and synaptogenesis (Gould et al, 1999; Kempermann et al, 2002). Undoubtedly, in human beings education is an important factor that persistently stimulates the brain.

Studies have unequivocally replicated the effect of education on the performance of tasks assessing various cognitive functions such as episodic memory, working memory, visual retention, visual naming, verbal intelligence, executive functions, visuoperceptual and visuocstructional abilities (Gambini et al, 1992; Wiederholt et al, 1993; Reis et al, 1994; Bherer et al, 2001; LeCarret et al, 2003b; Rosselli & Ardila, 2003; Tombaugh, 2004; Springer et al, 2005). However, researches investigating the relationship between educational level and prospective memory (ProM) are sparse.

ProM, a pervasive cognitive function of our day-to-day life, requires an individual to execute an intended action at some designated point in future (McDaniel & Einstein, 2000). For example, forming an intention to buy grocery while returning back from office and executing this intention at the appropriate

uncture, is an example of ProM. It is obvious that many a times we face difficulty at our work place or at home due to the failure of this memory system.

Available literature indicates that ProM is affected by various factors such as intelligence, working memory, motivation, retention interval and executive functions (Loftus, 1971; Cockburn & Smith, 1991; Einstein & McDaniel, 1996; Mantyla, 1996; Burgess & Shallice, 1997; McDaniel & Einstein, 2000). As far as the role of education in ProM is concerned, equivocal findings have been reported in a few studies in which the relationship between ability level and ProM was explored and education was kept as one of the determinants of the ability level. For example, Cockburn and Smith (1991) did not find any effect of education on ProM. However, in this study only older adults were recruited as participants; hence, it is tough to ascertain that the findings hold true for all age groups or only for old age people.

In another study (Cherry & LeCompte, 1999), ability level was found to be contributing to ProM. In this study, ability level was determined by the combination of education and verbal intelligence. However, when treated separately, education was found to be a more important determinant of ProM than verbal intelligence.

Keeping in view the role of education in cognitive functions and non-conclusive findings regarding the influence of education on ProM, present study was carried out to see if a relationship exists between the level of education and ProM. It was hypothesized that subjects with different levels of education will differ in their performance on ProM tasks.

METHOD

Participants

Three groups, divided on the basis of the level of education (low education group [N = 12], medium education group [N = 20] and high education group [N = 18]), of healthy right handed male community dwellers, served as participants for the present study. Low education group had 10 or less (M = 9.33,

SD = .58), medium education group had 11-14 (M = 12.35, SD = .93) and high education group had 15 or more (M = 16.05, SD = 1.25) years of education.

Presences of any psychiatric (including substance or alcohol abuse) or neurologic disorder were exclusion criteria for the participants. Healthiness in the participants was ascertained with the help of the General Health Questionnaire - 5 (Shamsunder et al, 1986).

Each participant was explained the details of the experimentation in the beginning. However, the real intent of assessment of ProM was debriefed only at the end of experiment, as it could have affected their performance. Furthermore, they were also informed that the results would be kept confidential and would not be used for any commercial purposes. None of the participants were paid for participation.

Procedure

Participants were tested individually. The testing was done in a sound proof room where extraneous disturbances were minimal. For the assessment of ProM, following the Einstein and McDaniel paradigm (Einstein & McDaniel, 1990), two separate lists of 75 general knowledge items were prepared with each list having 5 items with embedded ProM targets (in one list, general knowledge items with the term 'Prime minister' and in other 'State' as ProM targets). Both the lists were in 'Hindi' (Hindi terms for 'Prime minister' and 'State' are 'Pradhanmantry' and 'Rajya' respectively). For each item, the subjects had to choose one answer from four possible answers. ProM targets were embedded in every 15th item. However, in order to prevent the subjects' inferring the sequence of ProM target presentation (i.e., he has to execute the intended ProM activity on every 15th item), the items were not numbered. To reduce their anxiety, subjects were told that general knowledge items were not meant for assessment of their intelligence and that the experimenter was interested in just knowing their level of general awareness. Moreover, the complexity level of the intervening tasks was kept minimal to keep it even for all the groups (e.g., 'who was the first Prime

Minister of India?). In order to reduce the complexity level of the intervening task, general knowledge items were taken from the 4th to 8th grade curriculum books. The items were presented on a computer monitor; however, they were 'self-paced' as the subjects had to choose one answer from four possible alternatives and there was no time limit.

Subjects were told that while working on the general knowledge items, from time to time they would see questions that would have the words 'Prime minister' (in the first set) or 'State' (in the second set) and at that time, apart from answering the question, they had to tap the table too. None of the target words had any additional identifier (e.g., words in bold, italics or underlined) to facilitate the identification. Each correct response on ProM target was given a score of one.

Participants were given the two sets of general knowledge items (with embedded ProM targets) at the gap of 2-3 days. The reason for giving two sets was, simply, to see consistency in performance.

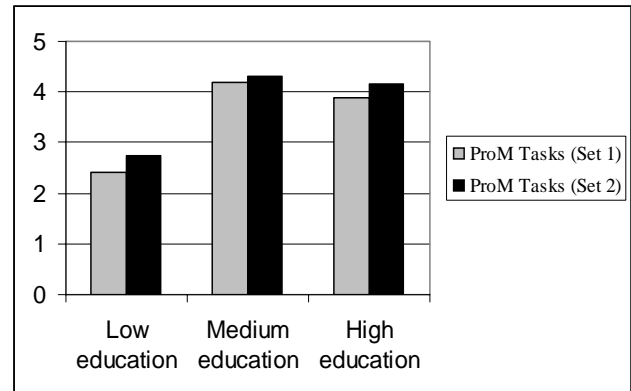
Statistical analysis

One way ANOVA was used to compare the average age of three groups. Repeated measures ANOVA with ProM list 1 and list 2 as within subjects variables and group as between subjects variable was calculated.

RESULTS

The average performance of the three groups on ProM tasks has been shown in the figure 1. Effect of task (i.e., ProM task) (Wilks' Lambda = .95; $F = 2.02$; $DF = 47, 1$; $p > .05$) and task x group interaction (Wilks' Lambda = .99; $F = .19$; $DF = 47, 2$; $p > .05$) were non-significant. However, group effect was significant ($F = 5.56$, $DF = 2$, $p < .01$). Post-hoc comparisons (Bonferroni) showed that the low education group differed, in terms of ProM task performance, with both medium and high education groups ($p < .01$ and $p < .05$ respectively), but the medium and high education groups did not differ ($p > .05$).

Figure 1. Performance of low-, medium- and high-education groups on ProM tasks (sets 1 and 2)



DISCUSSION

In the present study, low education group's poor performance on ProM tasks as compared to the medium and high education groups implicate that, to a certain extent, level of education can have effect on the performance of ProM tasks. However, lack of any difference between medium and high education groups implicates that the level of education and ProM ability does not have a perfectly linear relationship and, in turn, indicates that a modest level of education is enough to conceptualize and execute a ProM task.

Level of education is known to improve the utilization of cognitive abilities (LeCarret et al, 2003a,b). It is likely that individuals with higher level of education involve the cognitive processes, responsible for successful execution of ProM tasks, more effectively than individuals with low educational levels. For example, it is possible that people with high educational level form better strategies for execution of intentions at the right juncture which, in turn, enhances their performance on the ProM tasks. This explanation gets strengthened by the fact that ProM is a conceptually driven instead of a perceptually driven process (McDaniel et al, 1998) and; hence, for successful execution of intention, better conceptualization of the task in hand is required.

Yet, the question remains that why medium and high education groups did not differ? It is possible that the ProM tasks and the intervening tasks were quite simple and hence, strategy formation for execution of the task did not need much complexity. Thus, people with modest level of education could execute the tasks.

Findings of this study highlights that while assessing one's ProM ability his/her level of education should be taken into account.

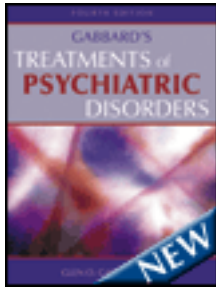
Very small sample size in all three groups limits the generalization of the findings of this study. Further studies, with larger sample, are needed to understand the underlying factors that determine the effect of education on ProM. Studies incorporating subjects of varying education as well as ProM tasks with varying complexities would be ideal in this direction.

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Title : GABBARD'S TREATMENTS OF PSYCHIATRIC DISORDERS
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Author : Glen O. Gabbard

INTRODUCTION

The knowledge base of Medicine is said to double every five years, and Psychiatry is one of the most rapidly growing medical specialties. There are rapid advances in the theoretical understandings on mental disorders, new psychopharmacological agents and psychotherapeutic approaches are being introduced every year, and effectiveness research of more and more vigorous methodologies are being reported every month. It has become extremely difficult for practicing mental health professionals to keep themselves abreast of the latest advances in the specialty which are of direct relevance to their day-to-day clinical practice. A reference book dedicated to the management of psychiatric disorders, coordinated by someone who is proficient in both psychopharmacologic and psychotherapeutic modalities, which incorporates both empirically validated interventions and accumulated clinical wisdom, is the need of the hour, and *Treatments of Psychiatric Disorders* edited by Glen O Gabbard wonderfully accomplishes this role.

The first edition of this book was published in 1989 as the Taskforce Report of the American Psychiatric Association. Keeping the busy practitioner in mind, the fourth edition is published as a handy hard-bound single volume. The book is divided into twelve parts following the DSM-IV classification, and each part is edited by experts in the field (e.g.: Neuropsychiatry by Stuart C. Yudofsky and Robert E. Hales, Mood Disorders by John Rush). The parts are further divided

into a total of 57 chapters spanning nearly 900 pages.

How the book is different

Covers management of very specific problems: The book addresses many clinical issues which are usually overlooked by textbooks, like -

- " Treatment of suicidal behavior in children and adolescents,
- " Psychotherapy for psychiatric disorders in persons with intellectual disability,
- " Management of weight gain which accompanies smoking cessation, and
- " Combining CBT and medications for effective management of panic disorder.

Highlights limitations of certain existing practices: The book challenges some of the prevalent clinical practices with support of empirical data. For e.g., the book summarizes that controlled studies do not support the use of the higher doses of SSRIs in OCD, that "it remains to be seen whether the new antipsychotics will offer side-effect advantages over haloperidol to increase compliance and reduce relapse sufficiently to balance their increased cost", and that evidence for the efficacy of oxcarbazepine in mania is absent. It quotes a study in which the placebo was found to have significantly greater antimanic property than gabapentin.

Though many CBT protocols advocate use of breathing retraining (BR) to manage the physical symptoms of panic disorder, according to the book this use runs counter to the core message of CBT that physical sensations associated with anxiety are harmless and do not need to be avoided. Also, BR may become a safety behavior that patients rely on to get through anxiety-provoking situations and it may maintain their fear of physical symptoms in the long term. Hence, the book recommends that BR should be de-emphasized in favor of other CBT skills in management of panic disorder.

Provides interesting clinical tips: The book illustrates a few novel methods to administer some commonly used treatments. For e.g., patients who are prescribed propranolol for performance anxiety may be encouraged to first take a test dose at home to allay any fears about tolerability and to test whether dosage is adequate to block an exercise-induced increase in heart rate. Intravenous clomipramine sometimes initiates improvement in OCD patients who are unresponsive to or intolerant of oral clomipramine due to less first pass metabolism, and the book quotes a research findings that inhibiting the metabolism of clomipramine with fluvoxamine may be a convenient method for producing "oral-intravenous clomipramine." The book advocates use of a twice-a-day or thrice-a-day dosing for clonazepam in management of social anxiety disorder despite its long half life, though it provides no research support for this recommendation.

Introduces new interventions: The book discusses many new additions to the mental health practitioner's armamentaria. Nicotine lozenge, nicotine inhaler and varenicline are new tools for management of nicotine dependence. Nicotine lozenge is absorbed through the oral mucosa, like the nicotine gum. The nicotine inhaler delivers nicotine buccally to the mouth and throat, but not to the lungs, and addresses both the physical dependence and the behavioral and sensory aspects of smoking. Varenicline, the first medication designed specifically to aid in smoking cessation, is a nicotinic receptor partial agonist, which simultaneously stimulate dopamine release and block nicotine receptors.

Flexible psychotherapy for schizophrenia integrates clinical perspectives and available evidence into a coherent treatment strategy. It is based on the assumptions that a stress-diathesis model represents the best available integration of data pertinent to the etiology, course, and outcome of schizophrenia; schizophrenia and individuals affected with it are heterogeneous; schizophrenia has a phasic course; and that outcome of schizophrenia is variable.

The part on depression treatment extensively discusses many new modalities like vagus nerve stimulation, transcranial magnetic stimulation, magnetic seizure therapy, deep brain stimulation and transcranial direct current stimulation, and an entire chapter is devoted to light therapy.

The book covers the findings many recent clinical trials of methodological vigor like Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) and Measurement and Treatment Research in Cognition in Schizophrenia (MATRICS). The book also hints at some promising treatments in development, like N-desmethyl clozapine (NDMC). Though pharmacological properties of NDMC are similar to those of its prodrug clozapine, it is an M1/M5 agonist while clozapine is M1/M5 antagonist. Hence, NDMC may turn out to be an antipsychotic as efficacious as clozapine with superior efficacy in cognitive dysfunction.

Reveals avenues for future research: A closer look at the book discloses areas in which research is currently limited. Future researcher can investigate the efficacy of -

- " A combination of augmenting agents in refractory depression
- " A combination of antidepressants from different classes in refractory depression
- " A combination of two potent SSRIs in refractory OCD
- " Imaginal exposure in social anxiety disorder

Overview of selected parts/chapters

Schizophrenia: The chapter is titled "Clinical

psychopharmacology and cognitive remediation", in the light of emerging literature on the cognitive deficits which persist in many patients despite improvement in positive and negative symptoms. There are sections devoted to cognition-enhancing pharmacology, cognitive remediation, and computer-assisted cognitive rehabilitation. The authors note that the monotherapy approach should be replaced by use of different treatments for groups of symptoms that can be demonstrated to cluster together by disease course, mechanism and treatment response. For e.g., as augmentation of D1 signaling can improve cognition, especially working memory, cognitive dysfunction may be treated with an augmenter of D1 signaling while psychosis is treated with antipsychotics.

Personality disorders (PDs): The part is about a hundred pages long and is one of the most elaborate and state-of-the-art reviews available on the topic. The chapters have been updated against the backdrop of three significant advances in the understanding about PDs - the findings from longitudinal research that PDs undergo substantial improvements, the reports on significant genetic determination of PDs, and the manualization of psychoanalytic psychotherapy which permits testing and replication. Authors conceptualize PDs as a hybrid that includes responsive/reactive components (e.g. deliberate self-harm) and other components that prove to be more trait-like (e.g., shyness), opening possibilities that shorter-term or more narrowly focused interventions which address different components of a personality disorder can have a significant role.

Somatization disorder: Though the chapter begins "somatization disorder is among the best-validated disorders in psychiatry, but no specific treatment is known for it", it is one of the best available collection of practical advice on management of the disorder. The authors note that telling patients that there is nothing wrong with them physically and that their symptoms are produced "in their heads" would invariably lead them to go "doctor shopping". Instead, after ruling out other medical problems, a simple dialogue of "I have good news and bad news" is a good alternative: The "good news" is that the patient does not have an acute, fatal, or degenerative illness; the "bad news" is that the physician does not know for certain what is causing the symptoms.

Only later in the therapy are the patients told that they have somatization disorder and the diagnosis is discussed in detail.

Criticisms and suggestions

- " Chapters on conduct disorder, sleep disorders and sexual dysfunctions are very brief, and could have been more exhaustive.
- " As the book sticks to the DSM-IV classification, many disorders which are included only in ICD-10 (like dissociative stupor, trance and possession disorders, etc.) and conditions which are clinically relevant but are not yet incorporated in the classificatory systems (like schizotaxia, minimal cognitive impairment, etc.) are not covered. Also, the management of comorbidities is not sufficiently covered, partly due to this compartmentalization.
- " The techniques of behavioral therapy for ADHD described in the book Attention-deficit Hyperactivity Disorder written by Larry B Silver and published by American Psychiatric Publishing are very easy to use and effective. It would have been useful if the contents of that chapter were included in this book.
- " Illustrations are used only sparingly, and those present look amateurish.
- " Chapter on management of ADHD has various brand names (like Concerta, Ritalin LA, etc.) as subheadings, and this is unfortunate.
- " The second edition of the book published in 1995 had an Indian edition, and its price was about 1/10 of that of the new edition. It will be immensely useful for mental health professionals in India if an Indian edition of the fourth edition is published.
- " Inclusion of the book's contents in a Compact Disc would have made the retrieval of necessary information easier and faster.

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'THE HOUSE OF SAND AND FOG'**Mahesh Hembram¹, Shashi K. Pande²**

The House of Sand and Fog is a film of deep psychological interest. It works at several levels.

Psychoanalytically, looking through the lens of the object relations theory the movie brings to focus the emotional power that a transitional object wields-destructively, in this instance-on the lives of two individuals whose fates get entwisted when, for different psychological reasons, they are smitten by the lure of the same transitional object. Psychopathologically, it depicts with near-clinical acumen the dramatic upheavals that a borderline personality brings about on itself and others. Crossculturally, the movie highlights, like light and shade in a chiaroscuro, the contrast between the Eastern and the Western modes of behavior, each flawed, each exalted in its own way. And finally, philosophically-as its very name suggests-the movie in the end scripts the epitaph on life itself: its only reality is the permanence of transitoriness-a conclusion that India reached millennia ago.

The story revolves around a modest beach house on the California Coast put up for auction because its owner defaulted on a tax debt erroneously owed to the city. The stubborn personalities and mutual misunderstandings of the three main characters create a compelling tragedy of contested houses, broken homes, and shattered dreams. All this results in a human situation where forces build up to a point where there can be no escape from the pain and woes of life. The House of Sand and Fog is a devastating look at the American Dream gone awry.

The movie is based on the novel written by Andre Dubus and is directed by Vadim Perelman. It was released in December 2003. It was nominated for three Academy Awards: Best Original Score (James Horner), Best Actor (Ben Kingsley) and Best Supporting Actress (Shohreh Aghdashloo). It is a

story where hopes-not hatreds-ultimately ravage, dividing two people who are searching for the same thing, their transitional object. No matter what failures have come before, no matter how many triumphs there have been, there is always the chance the latest test might be the one that undoes everything.

Kathy Nicolo

Jennifer Connelly plays Kathy Nicolo, the protagonist of the story. She is a careless youngster filled with boredom, nearly decompensating in a little frumpy house near the San Francisco Bay after being deserted by her husband. She is a wreck, her plight a bit hard to sympathize with. The phone wakes her up, and her mother calls and asks how her husband is and tells her that she is going to come visit her. Kathy hides the truth from her, telling her mother that her husband is asleep next to her, and tries to get out of the visit, but can't. After faking an excuse to end the conversation, she hangs up and gets out of the now vacant bed.

In one of the picture's more unsettling ironies, her lawyer pointedly tells the young woman that this whole mess could easily have been averted had the depressed woman simply opened her mail. Filled with rage, vacillation and disappointment, Kathy is at a loss to explain the wreck she's made of herself. Instead, she falls into a torridly self-destructive relationship with Burdon, a policeman, as an anodyne for her pain. She is clearly emptied of the drive to put her life back together and is numbly surprised when the government comes to seize her house because she supposedly didn't pay back taxes or replied to letters sent in this regard.

James Masterson has described certain patterns of mother-infant interaction that interfere with the separation individuation

process and lead to a borderline psychopathology. In the character of Kathy, as portrayed in the movie, this psychopathology surfaces more clearly when she loses the house. She is coming out of addiction and a failed relationship with her husband but again resorts to smoking and drinking and to entering yet again into another unstable, intense relationship—all this in a frantic effort to avoid abandonment. She is plagued with this chronic emptiness; she has these frequent displays of temper, constant feelings of rage, mood swings and even attempts to end her own life. She evokes sympathy, being described a "broken bird." Since she is evicted on the spot, she doesn't have time to find out how this all happened. But the pile of envelopes under the mail slot shows that she probably had the time to prevent the debacle, even if not the will. With all her worldly possessions in storage and herself booked into a cheap hotel, she meets with a lawyer (Fisher) who tries to solve the problem. There was a mistake. She owed no back taxes and she had sent a notice to the correct officials, but didn't do the follow-up paperwork. And therefore its status mistakenly reverted back to that of a recoverable asset.

Connelly has already played in 'Requiem for a Dream' a woman whose life is shattered by addiction and ill luck; The House of Sand and Fog' evokes that earlier film by painstakingly reenacting its central image of Connelly standing at the end of a pier, looking out to the sea. Her figure is shrouded in a dim blankness—suggesting a helpless vulnerability but also keeping the viewers guessing what she will do next.

Colonel Massoud Amir Behrani

Colonel Behrani (Ben Kingsley), once an elite member of the Shah's inner circle, was forced to flee the Iranian Revolution with his family, abandoning his beloved house—his transitional object— with its view over the Caspian Sea. Andre Dubus wastes no time in capturing the dark side of the immigrant experience in America at the end of the 20th century. The movie opens with a highway crew comprising of several nationalities picking up litter on a hot California summer day. The Colonel's

imagination fires up when in an advertisement he sees the cheap purchase of a recently repossessed house with a similar view over the bay of San Francisco. He considers it as a long-awaited opportunity to begin rebuilding the life which had been wrested from him. He pours his entire life savings into the house. It is an opportunity to return to the days of prosperity and fortune his family once took for granted—the house as the first step in that direction. He's a man with an excess of pride. He hides his financial woes and his jobs, as a highway crewman and a part-time convenience store clerk, from friends and family. He has a residue of arrogance from his once-lofty post. Image is all important to him: He spends half of what remains of his former prosperity on a lavish wedding of his daughter into a respectable (and wealthy) family. He is also a man of honour and valour and high self-esteem; he is fighting for survival in a foreign land but is hounded by a past. He does what a "man" must do for his family.

The colonel is also a prototype of a status-conscious Asian male. This is clearly seen when he says, "In my country, you won't be worthy to raise your eyes to me! You are nothing! NOTHING!" But then, we also see the other side of this man. When confronted with Kathy's situation, he is genuinely sorry for her. But, though he feels guilty, his own desperation outweighs his sense of decency, and he refuses to sell back the house to her.

There are enormous inner forces that a human being can bring to bear on himself to sustain, to accommodate, to understand, and to cope with loss. Human beings are extraordinary animals in their capacity to endure loss after loss after loss. To put it briefly, Behrani is a man who lost his king, and then his country, his son, his wife, his home and, finally, himself." He embraces death having failed to do any good for the family.

After playing a charismatic Indian pacifist in 'Ghandi', a powerless Russian composer in 'Testament', and a psychotic cockney criminal in 'Sexy Beast', Kingsley again confirms that he is the grand master of versatility as he brings a fragile

dignity to the difficult-not always likeable-character of the fallen colonel. None other could have done justice to such a complex characterization.

Deputy Sheriff Lester Burdon

The Deputy Sheriff, who accompanies the repossession team, takes pity on the woman-Kathy-as she sits pathetically on the floor, stunned. He volunteers to help her get moved. Then one day, the kind-but married-Officer Burdon finds Kathy parked in front of the police station in her car. They strike up a strained kind of relationship, working each other for their own personal gain. Kathy places her trust in Burdon; he falls for her-and treads headlong into a maelstrom. Lester's relationship with Kathy sprouts from his impulse to help a woman in distress. She needs help and his heart opens up to her. Perhaps, this has its origin in his instinctive reaction as a policeman to a person in trouble. He sees her as someone who is really vulnerable and on the verge of imploding. But his trying to protect her becomes a catalyst for much of what happens later.

Lester idealizes the situation with Kathy; he thinks he is going to be a knight in shining armour, rushing in to save this poor woman. He has nothing but compassion for her initially. His compassion, however, leads to a kind of mutual dependence, which in turn becomes a blind love that makes him believe he is doing the right thing up to the very end. His police powers embolden him to intimidate Mr. Behrani into working out a deal for Kathy. The narcissism of power is portrayed well and we also get a glimpse of what we can call antisocial elements in him. "It takes a thief to catch a thief," as the saying goes about the police profession. Lester leaves a wife and two children and a home because he feels there is something emotionally missing for him there. In reaching out to Kathy, he's trying to start life anew. Burdon makes us ponder whether we do things what we are destined to do, or is it the personality that leads us to choose what we do. His impulsive behaviour, his disregard for law, which he has taken a vow to uphold, his deceitfulness and a tendency to con others, and his failure to plan and to consider the consequences of his actions, all

point towards antisocial traits. It seems that he joined the police force so that he could do things the way he wants. He cons, threatens, and goes beyond the books.

Contrast of Characters

Kathy and Mr. Behrani are the two ends of the same experience. One is a privileged, pretty young woman for whom her father worked hard to build a sort of fairy tale. The parents bequeathed her and her husband a house so they can live happily ever after. But when she naturally wants the next step to complete the set-children-her husband dumps her. Her lack of experience and of necessary drive to make things happen by her own efforts leave us with the impression that she is spoiled and incompetent. But this is quite probably the kind of girl the father created.

The colonel is a strong, proud, hardworking patriarch of an Eastern family. In his desire to provide them with a life of splendor, he ends up floating a paper boat on top of a sea of chaos and danger. His motivation-utterly controlling and overbearing-to create a protected Eden for his family and to recover his lost status, shocks us with its foreign and frightening fierceness. He fawns over his children as if they were a prince and a princess. He loves his wife, but, as trouble escalates and as he fails to inform her enough to make sense of it, she bursts out at him, overflowing with anxiety and rage that only a helpless, childlike, protected Asian woman knows. And he smacks her across the face for it! At that moment, we think he is a Monster. But this is not so either. The colonel feels for Kathy at last and relinquishes his victory. Towards the end of the movie, Mr. Behrani ultimately sees Kathy's situation with the eyes of a father. He recognizes her as a woman who once had dignity, but now has no wealth, and no father or a husband to protect her. She is just a waif. He, more than most, could at last empathize with her "lost princess" tragedy.

Also, there is a suggestion towards the end that in Kathy began, in parallel, a daughterly attachment to Behrani as he finally understood her plight and even though he had been rough, indeed cruel, to her at first.

The Essence

It is sad enough to see in the movie the difficulties of cultural transition, but to see them broken down in stark human terms is devastating.

What makes *The House of Sand and Fog* such an agonizing experience is that you know that the movie is going to end badly, but you just don't know how badly and for whom the worse will come. What will happen to this tiny little house on a hill with a partial ocean view? The house in this movie is not merely a part of the setting, not just the centerpiece or bone of contention between the lead actors, but a character unto itself—nothing less than an incarnated transition object! Both the people at the center of the story are both good and flawed, and both have a valid stake in the property. The movie is impartial in its representation and doesn't declare who is wrong or right, or who should ultimately get the house. This is a film whose tragic conclusion is forecast mistily from the very beginning, but remains obscure until the fog clears in the final scenes. The movie seizes your emotions, wrenches them, and requires that you prepare yourself for the complex emotions of the two star-crossed individuals entangled in this battle for the humble ocean side cottage. You will think for both the characters and feel for their struggle and want both to have the house, knowing that it is an impossible option. There is intense amount of pain in this film and director Vadim Perelman ensures that you will feel it and that you would leave the theatre in tears, realizing that the American Dream can at times become a cruel reality.

However, despite the seeming pessimism, tragedy has value in demonstrating the depths we can fall to if we allow fate and flaws to determine matters. Each time in the movie those involved failed to do what was right or proper, or acted only for themselves, it made it harder to make things work out. Eventually it leads to ruin for all involved. The truth is that life is full of joy and full of great sorrow, and you can't have one without the other. We believe people do not go to movies only to be entertained or transported to someplace else. They also

go to delve deeper into the human experience.

The Setting

The interesting thing about the area of Pacifica where the screenplay is set is that in the midst of this amazingly beautiful setting there is a series of small, middle-class houses. You look over the telephone poles and the rooftops with electric wires and antennas, and beyond you see this magnificent ocean view. To complete the backdrop, a strand of pine trees has been added by the art department, much like those that play so vividly in Behrani's memories of better days with his family on the shores of the Caspian Sea.

Few Questions

The movie raises a few difficult questions such as who is sicker, whom the house belongs to, who is wrong and who is right?

"The house" becomes meaningless to Kathy in the end when she sees people around her dying. She becomes emotionally distraught and weeps for the death of Behrani and his wife. As the bodies are being taken away by the paramedics, a policeman asks Kathy if the house is hers. After a pause, she replies "no". We thus watch the transitional object becoming in front of our eyes-decathected, such is the reach and depth of this powerful movie.

There is symbolism in the name of the movie. It is a reminder of the transitoriness of things. And of their insubstantiality. The fog does not stay forever; the sand cannot be held for long in the hand.

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 2. **Dr. Shashi K. Pande**, M.D., (Corresponding Author), Former Associate Professor Johns Hopkins University, USA, Former Director and Professor of Central Institute of Psychiatry, Kanke, Ranchi-834006, Jharkhand, Email : shashi_piret@mac.com
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MY IDENTITY , MY LIFE

The article that follows is a 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

As a child I was sexually abused by a male worker in the school where I studied. As a young man, I was, on a couple of occasions, sexually involved with a couple of males. This was during my days as a seminarian in training for the priesthood in the Catholic Church. Then, as time went on, and over a period of very many years, I have been emotionally and physically involved with a few women, thereby bringing much guilt. A couple of these relationships still endure. But now they are at a different level. While the emotional attachments still remain, there is now a level of intimacy which is very satisfying and enriching, and in keeping with my vows as a religious man. This is so at the time of writing.

In 1988, I had gone to the USA for studies. There, in my second year, I suffered a total breakdown leading to psychiatric intervention. In 1990 I returned to India and went to Bangalore for psychological counseling sessions. These sessions only made me worse. I got hooked on the birds and other creatures. I felt they were giving me messages and I was compelled to act on these messages. I was completely trapped and started seeing a psychiatrist in Bangalore. I began medication. Off and on I had relapses.

Over the years I have struggled with homosexuality and pedophilia. Once I called two male students to my living

quarters with the intention of showing them my genitals. But I did not do so. I was admitted to CIP, Ranchi, for a month's treatment. I am currently in Hazaribagh where I meet the CIP doctors regularly. At the time of writing I can see very great improvement in my psychological health. The chirping of the birds does not disturb me any longer. And, most important, there are no messages that I get from the birds. This is a tremendous relief. Now there is more self-control and discipline in my life. I am now more self-directed rather than other-directed. The relationships with my women friends are very positive, and are a big help in my commitment to God as a religious person. I am happy the way I am.

Name withheld on ethical ground

INSTRUCTION FOR AUTHORS

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All contributions should be written in English. All manuscripts apart from "Letters to the Editor", "Book Reviews" and "Film Reviews" are reviewed by two or more assessors.

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Reviews are usually invited by the Editor. However, good quality reviews on pertinent topics can be submitted for publication. The maximum length of reviews (including abstract and references) is 7500 words. Abstract may be an unstructured summary which should not exceed 250 words.

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Under this section data from preliminary studies, studies done with smaller sample size, worthwhile replication studies, or negative studies of important topics are published. Single case reports do not meet the criteria for this section. Brief Communications cannot exceed 2500 words, including an abstract of no more than 150 words, text, and references). No more than one table or one figure can be included.

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Brief letters (maximum of 1000 words, including references; no tables or figures) will be considered if they include the notation "for publication". These limits may be exceeded in *exceptional circumstances*, but authors are advised to confer first with the Editorial Office.

Case reports or any other uncontrolled observations should be submitted as Letters to the Editor. Letters critical of an article published in the *Journal* must be received within six months of the article's

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The Indian Journal of Social Psychiatry also publishes critical reviews written on recently published books or films pertinent to social psychiatry. Usually such reviews are invited by the Editor. However, authors can submit their reviews for publication. The Editor takes the final decision as to which review is suitable for publication. In no circumstances should reviews exceed 2500 words.

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All parts of the manuscript must be double-spaced throughout with a minimum margin of 1 inch on all sides. The manuscript should be arranged in the following order, with each item beginning a new page: a) cover letter, b) title page, c) abstract, d) text, e) references, and f) tables and/or figures. All pages must be numbered.

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This should contain the title of the contribution, and the name(s) and address(es) of the author(s), and position titles at their respective institutions/places of employment. Make titles concise, and as precise and specific as possible for abstracting purposes. The full postal address, telephone and facsimile numbers, and Email address (if available) of the author who will receive correspondence and check the proofs should be included, as well as the present address of any author if different from that where the work was carried out. Addresses for authors other than the correspondence author should contain the department, institution, city and country. Position titles of all authors at their respective institutions/places of employment should be included.

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Method: design, setting, sample, interventions (if appropriate), chief outcome measures.

Results: provide main findings with p values.

Conclusions: only those related to results, both positive and negative, highlighting limitations as appropriate and clinical and research implications.

Key words: three to six key words that will assist indexers in cross-referencing the article should be supplied. Use of the medical subject headings (MeSH) list from Index Medicus would be suitable.

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The text should be written in grammatically correct good English. It should be typed double-spaced throughout with at least 1 inch margins on all sides.

Pejorative Language: Do not use pejorative labels like 'schizophrenics', 'psychotics' and 'neurotics'. Instead refer to 'patients with schizophrenia', etc.

Abbreviations: Abbreviations should in general be avoided. However, phrases may be abbreviated if their shortened form is widely known and they are used repeatedly (e.g. CNS, OCD etc). When first used in the text, they should be spelt out in full followed by the abbreviation in brackets.

e) References:

References should include a list of all articles and books at the end of the paper. Arrange alphabetically by the authors' names and date of publication in parentheses. Authors should follow journal style for reference list using the following examples.

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

Rosenberg, A.A., Solarz, A.L., Bailey, W.A.(1991) Psychology and homelessness: A public policy & advocacy agenda. *American Psychologist*, 46, 1239-1244.

Woodward, D., Drager, N., Beaglehole, R., et al (2001) Globalization and health: a framework for analysis and action. *Bulletin of the World Health Organization*, 79, 875-881.

Marsella, A. (1995) Urbanization, mental health and psychosocial well-being. In: Harpham, T. & Blue, I., (Eds.), *Urbanization and Mental Health in Developing Countries*, pp.17-40, Aldershot: Avebury.

Tables

Tables should be included on a separate page, numbered with Arabic numerals and accompanied by short titles at the top. Each table must be referred to in the text in consecutive order. Data presented should, in general, not be duplicated in the text or figures. Explanatory matter should be placed in footnotes below the tabular matter and not included in the title. All non-standard abbreviations should also be explained in

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Line drawings and graphs should be professionally drawn. All lettering should be done professionally and should be of adequate size to retain clarity after reduction. Figures should be numbered in Arabic.

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The manuscript should be sent to the editor's office:

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Indian Journal of Social Psychiatry

Central Institute of Psychiatry

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OBITUARY

Professor Anil Malhotra (1949-2007)

Professor Anil Malhotra, President of Indian Association for Social Psychiatry, an eminent professional, pioneer in the development of Drug Deaddiction programmes, under whom Addiction Psychiatry achieved a new horizon at Postgraduate Institute of Medical Education & Research (PGIMER), Chandigarh passed away on 21st August 2007 leaving behind a huge void, albeit a legacy which would continue to guide students and colleagues for years to come in the field of social and addiction psychiatry.

Professor Malhotra was born on 25th August 1949 in Delhi. He was an alumnus of Punjab University Chandigarh where he did his M.A. in Psychology. Soon he moved to Bangalore where he joined National Institute of Mental Health and Neurosciences (NIMHANS) and pursued Diploma in Medical & Social Psychology (D. M&SP) and then completed doctoral programme (PhD) in Clinical Psychology. Thereafter he joined as a lecturer at the Department of Clinical Psychology at NIMHANS where he worked briefly after which he decided to go back to his alma-mater, Chandigarh. He started working in the field of Addiction Psychiatry in the year 1974 and soon became a distinguished professional in that field. He was passionate for his work with patients with addiction problems since the time when addiction was understood more as deviance against normal behaviour rather than illness. His sheer optimism and endurance helped him to carve a niche in the field of treatment of drug abuse.

In 1980 Dr. Malhotra joined the Department of Clinical Psychology at PGIMER, Chandigarh which remained his professional domain till his untimely demise. He was one of the pioneers who were involved in the conception, establishment and functioning of Drug Deaddiction and Treatment Centre (DDTC) at PGI. Under his able guidance and supervision, the Centre became an excellent service facility and a nodal centre in the region. He was instrumental in development of Collaborative Partnership Model in Addiction Psychiatry which changed the course and outcome of addiction treatment and was widely recognized internationally. He had been visiting professor to several major Deaddiction centres in Netherlands, Belgium, United

Kingdom and United States. He was a consultant to WHO-Worldwide Prevention Program on Substance Abuse, Geneva and Ministry of Health and Family Welfare, Government of India for the development of community based projects on demand reduction aspects. He was bestowed upon by the honorary post of Professor at the Albert Schweitzer University, Geneva, Switzerland.

Dr. Malhotra was an excellent orator, teacher, researcher and an empathetic professional in his field. He had published more than 120 research papers in various national and international journals and had contributed more than 20 chapters in books related to mental health. He had also authored/edited five books. He was on the editorial and advisory board of six international and national journals. He was also involved in several organizations associated with his areas of work and was instrumental in organizing many national and international conferences. He was the President of Indian Association of Social Psychiatry and Secretary General of the Indian Association of Child and Adolescent mental health. Considering his eminence in the field of addiction and social psychiatry he had been conferred with the honorary fellowship of The ACADEMIA, Medicine and Psychiatria Foundation, New York, USA and ASCONA, Scientific Council Foundation of Psychosomatic and Social Medicine, Ascona, Switzerland. He had been a fellow at 14 national and international associations.

His contributions to the growth and development of addiction and social psychiatry in India are countless and his kind blessings to the Indian Association for Social Psychiatry as its General Secretary and then President would always be nurtured and remembered for many years to come. His sad demise has left all of us with a huge and imperishable void. He has left behind footprints which would continue to guide his colleagues, students and well-wishers for many years to come.

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