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MARRIAGES IN INDIA: WHAT PURPOSE DO THEY SERVE?

INTRODUCTION

Societies have different ways of ordering social relations between individuals. Marriages, formally, refer to the legal unions of two individuals (and in most countries only those of the opposite sex). The legality of the union may be established by civil, religious or other means as recognized by the land of each country (International Institute for Populations Sciences, 2003). In fact however, marriage is a social institution, culturally patterned and integrated into other basic institutions, such as those related to education, the economy and politics. For individual men and women, marriage means the formation of a new family and often the expansion of extended family- and kinship relations(Tsuya, 2001).

In India, marriage has been and still is a social institution of extreme importance. Here a marriage is a contractual agreement, but not always legalized, which formalizes and stabilizes a social relationship that not only encompasses the two persons involved but also two families. In India, the institution of marriage is regarded as the central feature of social ordering and mirrors a vision of what society is (or should be). Therefore, marriage in India is much more than a variety of close personal affiliations uniting two adults. Unlike western concepts of marriage Indian marriages are based upon the following foundations (Cf. Nock, 1998):

1. A marriage is not a free personal choice but is (predominantly) an arranged relation between two families.

2. The maturity of the two individuals is not an essential requirement for marriage.

3. Marriage encompasses a heterosexual relationship.

4. Generally, in Indian marriages the husband is considered the head and principal earner of the family.

5. Sexual fidelity and monogamy of both husband and wife are represented as marital ideals.

6. Marriage typically involves children.

BENEFICIAL EFFECTS OF MARRIAGES

The beneficial effects of marriage in general are said to be that married people live longer, earn more and are said to have better mental and physical health compared to their unmarried counterparts. Moreover, married couples present:

- Lower suicidal rates (Verbrugge, 1979).

- Lower number of fatal accidents (Crago, 1972).

- Lower number of acute and chronic illnesses (Ernster et al, 1979).

- Lower percentages of alcohol dependence (Crum et al, 1993; Layne & Whitehead, 1985).

- Lower frequencies of depression (Pearlin & Johnson, 1977).

Generally therefore, though country-wise discrepancies exist, the institution of marriage seems beneficial to individuals. Yet, men benefit more from marriage as their social status as a married man considerably rises and therefore the quality of life among these married men improves. Research demonstrates however, that women experience more personal satisfaction in marital relationships (Nock, 1998).

DRAWBACKS OF MARRIAGE IN INDIA

However, as mentioned above, there is considerable national variety and all is not well in marital lives of men and women. In India for instance:

- There is great social pressure on both sexes to marry, which deprives an individual of the free choice to remain single.

- Female economic dependency on males makes divorce virtually impossible for many Indian women.

- Love marriages prove to be less long lasting as they lack social sanction and therefore provide less social security.

- Though still an under-researched area, it seems that in India the personal space of couples is less in so-called love marriages than in arranged marriages.

Trends in age at marriage in India

Another worrying factor comes up when we review trends in the age at marriage in India. The average age at marriage among females in India is 18.3 years while for males it is 22.6 years. The age gap between males and females at marriage is 4.3 years (2001 Census). There are huge local variations, however. For instance, although Punjab is one of India's wealthier states, the proportion of girls getting married before the legal age of 18 years has dramatically increased over the past seven years from 12 per cent in 1998-1999 to 19 per cent in 2005-2006. This could be related to Punjab's rapidly declining girl to boy child ratio (2001 Census). In Rajasthan, 41 per cent of adolescent girls aged between 15 and 19 years are married (2001 Census). Though the Government of India has proposed the introduction of new legislation on child marriage that would include provisions for compulsory registration of adult marriages, the recording of child marriages and appointment of 'Child marriage prevention officers', the reality in India still is that one in four adolescent girls between 15 and 19 years of age is married (2001 Census). Moreover, though the average age at marriage in India has been rising slowly over the past twenty years, the practice of child marriage is still widespread. Comparing India with other countries we have the following data regarding the singulate mean age at marriage for females during 1996 to 2001(UNSTATS 2001 Census):

26 years in USA,

23 years in Indonesia, China, Brazil,

21 years in Nigeria, Pakistan,

20 years in India,

19 years in Bangladesh,

Concluding, we can therefore state that the institution of marriage in India certainly serves important social functions. Besides, it provides great individual satisfaction and security to many. Yet, this does not allow us to close our eyes for the less beneficial and more oppressive functions that the institution of marriage also fulfills.

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Review Articles...

MAGIC IN HUMAN BEHAVIOUR

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ABSTRACT

Magic is the art of controlling or forecasting natural events, effects or forces and has influenced and coloured every walk of human life and behaviour since time immemorial. It is a spurious system of natural laws which is governed by various principles like the law of similarity (as in Homeopathic/ Imitative magic) or law of contagion (Contagious magic). Impact of witchcraft on society and religion is well evidenced in medieval literature and modern psychoanalytical thinking is coloured by magic as well. Magical beliefs constitute a culturally sanctioned defence mechanism which resolves psychological distress arising from unconscious conflicts or social stresses by displacing or projecting the distress onto inhabitants of the supernatural world. Mysterious anxiety-evoking situations like childbirth, illness and death which evoke awe, uncertainty, inevitability, fear and helplessness in human minds have plenty of magical myths and rituals associated with them across various cultures. The immense psychological as well as supernatural power of magic has been widely utilised in prevention of illness as well as healing of disease and distress. Magic is in vogue among ethnic groups for attaining political power and conducting forensic practices as well as among advanced modern societies as a source of entertainment by performing feats of magicians. Mystery of magic lies in nothing but certain principles of human cognition and perception. Thus magic, an art of witty tricks and healing, and a science of understanding the supernatural and technology of bringing out miracles is the mentor of man in his struggle to conquer destiny.

Key Words: *Magic, human behaviour, magical healing*

INTRODUCTION

Magic has influenced various aspects of human behaviour throughout the ages in various forms; whether in its classical form among indigenous tribes and cultures, or in the behaviour of physicians, artists, politicians and other public figures in subtle forms or in the superstitious beliefs that influence our day to day living-magic remains ubiquitous. Even the nature of magic has transformed itself over the ages-from the sympathetic magic of the sorcerers to the secular magic of the commercial houses. Irrespective of our conscious awareness, magic has crept into all walks of life and all forms of culture.

WHAT MAGIC REALLY MEANS?

Magic is the art that purports to control or forecast natural events, effects, or forces by invoking the supernatural. The practice of using charms, spells, or rituals to attempt to produce supernatural effects or control events in nature is the basis of magic (The American Heritage Dictionary of English Language, 2009). It is the art of apparently influencing events by using mysterious or supernatural forces (Merriam-Webster Online Dictionary, 2009).

Magic may be of various types- conjure, black magic, witchcraft, sorcery, 'bhanmati', and so on. Conjuring tricks are well known feats of art that keep the spectator spellbound and a mode of entertainment since ancient times. Black magic is practised for evil purposes or in league with supposed evil spirits (Merriam-Webster Online Dictionary, 2009).

Witchcraft is said to represent inherent mysterious powers in some unusual individuals who effect harm through an obscure compulsion (Keshavan et al, 1989).

Sorcery refers to the deliberate alteration of events through magic and rituals for good or evil purposes guided by free will

and is often attributed with causation of disease or death (Marwick, 1970).

Bhanmati is a form of sorcery prevalent in southern India over centuries, well known for its healing power, practising exorcism treatment of illnesses (Carstairs & Kapur 1976).

PRINCIPLES OF MAGIC

Magic is a spurious system of natural laws as well as a fallacious guide of conduct. It is a false science as well as an abortive art. Regarded as a system of natural laws that is a statement of the rules which determine the sequence of events throughout the world, it may be called Theoretical Magic. Regarded as a set of precepts which human being observes in order to encompass their ends, it may be called Practical Magic.

As conceptualized by Frazer (1957), magic is of two distinct types based on its underlying laws.

1   Homeopathic or Imitative Magic- based on Law of Similarity which suggests- effect resembles cause. The most familiar application of the principle that like produces like is the attempt which has been made by many people in many ages to injure or destroy an enemy by injuring or destroying an image of him, in the belief that, just as the image suffers, so does the man, and that when it perishes, he must die.

2   Contagious Magic based on Law of Contact or Contagion which states that things which have been in contact with each other continue to act on each other even at a distance. Practices based on this form of magic prevail in various parts of Europe. Thus, in Mecklenburg, it is thought that if one drives a nail into a man's footprint he will fall lame; sometimes it is required that the nail should be taken from a coffin.

MAGIC IN LITERATURE

Literature boasts of several works on witchcraft and magic.

Malleus Maleficarum (The Hammer of Witches): (Kramer &

Sprenger, 1487) is one important piece of work. It is one of the most famous medieval treatises on witches. It challenges arguments against existence of witchcraft and instructs magistrates on how to identify, interrogate and convict witches. According to some schools, Pope Paul IV put a ban on this book in 1490 though it subsequently got clearance in 1559 by the church.

Till date, it is considered as one of the earliest and most valuable documents about concept of mental illness and witchcraft and has become infamous for the tremendous aftermath it created in name of 'witch hunting' in the 15th and 16th century Europe. Once witchcraft was officially recognized, great effort was taken to interrogate and find 'witches' amidst the women, the socially disenfranchised and the mentally ill. It has been theorized that English Government's systematic efforts for dealing with witchcraft served as a form of repressive deviance management. Another benefit to church and state of the witch-hunting hysteria was that it effectively shifted public attention away from growing demands for more equitable distribution of wealth (Currie, 1968, cited in Knoll, 2008).

Totem and Taboo: Another important doctrine on magic and psychology was that by the great psycho-analyst Sigmund Freud published in German in 1913 under the title Totem and Taboo: Resemblances between the Mental Lives of Savages and Neurotics. It is a collection of four essays which are-

1)   The Horror of Incest- The first and shortest of the four essays concerns incest taboos adopted by societies believing in Totemism using examples mostly from the Australian Aborigines gathered and discussed by anthropologist James George Frazer (1957).

2)   Taboo and Emotional Ambivalence- Freud considers the relationship of taboos to totemism on concepts 'projection' and 'ambivalence' he developed during his work with neurotic patients in Vienna to discuss the relationship between taboo and totemism. Like neurotics, 'primitive' people feel ambivalent about most people in their lives, but will not admit this consciously to them.

3) Animism, Magic and Omnipotence of Thoughts- Freud examines the animism and narcissistic phase associated with a primitive understanding of the universe and early libidinal development. A belief in magic and sorcery derives from an overvaluation of psychical acts whereby the structural conditions of mind are transposed onto the world: this overvaluation survives in both primitive men and neurotics.

4) The Return of Totemism in Childhood-Here Freud argues that combining one of Charles Darwin's more speculative theories about the arrangements of early human societies (a single alpha-male surrounded by a harem of females, similar to the arrangement of gorilla groupings) with the theory of the sacrifice ritual taken from William Robertson Smith, located the origins of totemism in a singular event, whereby a band of prehistoric brothers expelled from the alpha-male group returned to kill their father, whom they both feared and respected. In this respect, Freud located the beginnings of the Oedipus complex at the origins of human society, and postulated that all religion was in effect an extended and collective form of guilt and ambivalence to cope with the killing of the father figure (which he saw as the true original sin).

The Golden Bough: A Study in Magic and Religion: It is a wide-ranging comparative study of mythology and religion, written by Scottish anthropologist Sir James George Frazer (1854-1941).The Golden Bough attempts to define the shared elements of religious belief, ranging from ancient belief systems to relatively modern religions such as Christianity. Its thesis is that old religions were fertility cults that revolved around the worship of, and periodic sacrifice of, a sacred king. This king was the incarnation of a dying and reviving god, a solar deity who underwent a mystic marriage to a goddess of the earth, who died at the harvest, and was reincarnated in the spring. The book's influence on the emerging discipline of anthropology was pervasive and undeniable.

MAGIC-THE OTHER NAME FOR UNKNOWN

Luminal or marginal situations are always considered dangerous and anxiety provoking simply because transition is neither one state nor another, it is indefinable - and this nature arouses awe in human mind (Gennep, 1909).

CHILDBIRTH, PLACENTA AND MYTHS

The sense of mystery and wonder at birth and pregnancy, with nine months of anxiety and uncertainty built up - make the event special, important and dangerous and this impending danger and anxiety is relieved by performance of elaborate Placenta Rituals.

In ancient Egypt, extensive precautions were taken to protect Pharaoh's placenta which was wrapped in special bundle (Murray, 1930, cited in Davidson, 1985) known as Bundle of Life. This represented the Pharaoh in state and religious ceremonies. Otuzco women, the Quolla in South America, people in Columbia, India (Davidson, 1985), and the Talmud (Jewish code of law) acknowledge the magical powers of placenta.

DEATH, HEXING AND PERSUATION

Similar to birth of a child, death creates an aura in human mind due to its sudden, unpredictable, inevitable character. Here the role of black magic also comes into play. Hex death is one that follows a ritualized pronouncement of death by someone of immense power and authority, some elemental requirements of hexing being:

1) The victim, all acquaintances and family members must accept the ability and power of witch doctor to induce death by hexing. There must be no exception to this jointly held belief.

2) All known previous victims of hexing must have died; no one should have been known to survive a hexing.

3) Everyone known to the victim of hexing must believe and begin to act as though the victim were already dead.

There are evidences in form of case reports where 'medical magic' had to be performed to counter 'voodoo hex' or an anticipated death took place on time, well in keeping with the patient's expectation but leaving the doctors baffled because of the lack of adequate pathological evidence for death (Meador, 1992).

SPELL OF CULTURE ON HUMAN BEHAVIOUR

As magic casts a spell on human cognition, perception and response to natural happenings from birth till death, culture too showers its special effects to colour the themes underlying human thinking and behaviour. To understand human behaviour, the understanding of his culture and practices, beliefs and disbeliefs becomes markedly important.

UNDERSTANDING MENTAL ILLNESS IN CULTURAL CONTEXT

Culture has profound effect on expression of ideas of distress and health seeking behaviour. Some cultures tend to mask latent delusional thinking because of their overall magical configuration (Benedict & Jacks, 1954). In American society, which emphasizes rationality and scientific objectivity rather than supernaturalism, a psychotic person would find more difficulty to adjust and his or her symptoms would more likely be identified earlier than in Indian society where magic and supernaturalism is a part of the culture.

Non-Christian belief system

On interviewing health care providers in Harare, it was found astonishingly that there was no term to include broad heading of mental illness, the closest one being 'kupange' which dealt with several mental disorders (Patel et al, 1995).

Although mind is sited in head region, heart also plays an important role in emotional mediation and behaviour, suggesting that if patient believes that he has distress in heart, he may be suffering from mental illness.

Mental illness is intimately related to beliefs about spiritual causation-ancestral spirits guarded society, and if this was broken, they showed displeasure by inflicting illness. Evil spirits could be used by jealous persons to inflict illness and witchcraft is often used as evidence to explain misfortune.

Christian belief system

The basis of Christian views on causation of psychological and somatic disorders as demon induced are reported in New Testament which describes 2 types of conditions:

1. Bizarre or dangerous behaviour of convulsion and of demons speaking through the afflicted - classical case of 'possession' comparable to modern descriptions of dissociative illness (Prins, 1992).

2. Physical ailments healed by rebuking spirits through exorcism, sometimes dramatically, more often calmly commanding spirits to leave the afflicted (Hankoff, 1992).

PATTERN OF DISORDERS ATTRIBUTED TO SORCERY IN THE INDIAN SUBCONTINENT

Narasimhaiah (1982) described several simultaneous outbreaks of illnesses attributed to sorcery in some districts of north Karnataka which were possibly related to several social and political factors (e.g., recent famines, increasing unemployment, inadequate health services and conflicts between rival religious communities). Keshavan et al (1989) described the patterns of illnesses attributed to "Bhanmati" sorcery in one of the villages where an outbreak of epidemic hysteria occurred. Conversion and somatization disorders were the commonest diagnostic categories and occurred most often among women. A similar pattern was found in other parts of south India in earlier studies among urban Muslim women (Janakiramaiah & Subbukrishna, 1980), psychiatric out-patient populations (Gautam & Kapur, 1978), and rural populations (Carstairs & Kapur, 1976).An almost identical pattern has also been described in West Bengal (Bhattacharya, 1986) and Bangladesh (Marks & Groves, 1989). Most of these patients do not consult medical doctors. Instead, they place their hopes on their own indigenous health-system

comprising of local healers which is commensurate with their belief-system. Confrontation of these deep-rooted beliefs should be carefully avoided in order to gain their confidence. Finally, the most important step would be to develop more innovative culturally compatible psychotherapeutic models (Neki et al, 1986).

MAGIC BEHIND SEXUALITY, POWER AND POLITICS

Anthropology has long recognized the inadvertent polluting power of male and female genitals. 'Yoruba' have a concept that power or vital force is present in all living things and some inanimate things too, and is communicable as positive or negative influence (Douglas, 1966). Negative form, such as contagion can result in pollution, e.g., cultural accommodation for the polluting power of menstrual blood is ancient and widely recognized, explicit in the biblical book of Leviticus and widely described in anthropology (Buckley & Gottlieb, 1988). Personal power is believed to be concentrated in and may be projected through certain parts specifically, eye, mouth and genitals. Power associated with sexuality and reproduction is especially strong and potentially dangerous. People speak of privacy and decorum as reasons for dressing, especially for covering genitals but anthropologists have widely recognized containment of genital power as a principle factor in universal cultural practice (Stevens, 2006). In Yoruba, concept of personal power is termed 'ashe' which is explicitly associated with menstrual blood and intensifies with maturity through child birth and beyond. In some people 'ashe' may become corrupted and they become witches (aje), capable of flight and transformation and of doing all evils including cannibalism and vampirism and also witches interfere with people's sexuality and fertility (Stevens, 2005).

MAGIC IN FORENSIC PRACTICES

The investigation of death in traditional indigenous communities often involve 'men of high degree' performing rituals and procedures to ascertain whether sorcery was involved in an unnatural death, to identify the perpetrator for

suitable retribution or compensation. In Aboriginal population of Australia, investigation of such cases are held at 'sorry camps' which consists of temporary meeting camps distant from facilities and amenities with the purpose of ensuring the safe passage of the spirit of the deceased to the land of dead assisted by traditional song and dance. In Papua New Guinea, after some unusual death, the elders of the society take the corpse to some nearby groove of trees, cover the body with some leaves while villagers walk by the corpse. Any movement of leaves or insects, or any unusual events occurring during this process may indicate to them a likely perpetrator, and compensation may be claimed with a 'pay back' killing (Byard & Chivell, 2005).

Traditional 'clever men' may also assume the role of coroner and point out the responsible by examining the ground around burial, inspecting bones, fluid or hair from the deceased person in an attempt to be guided by the spirit of the dead or see the spirit of the dead person moving around the perpetrator. Sometimes, a ritual fire would be lit and the man of high degree would gaze through the smoke to visualize the sorcerer (Elkin, 1977).

MAGICAL IDEATION AS DEFENSE MECHANISM

Exotic beliefs and practices have traditionally been a major concern in anthropology, the interest in beliefs in sorcery being one of them. In addition to documenting the range of beliefs across cultures and speculating about their origins, anthropologists have suggested several hypotheses to account for their persistence.

Evans-Pritchard (1937) argued that sorcery and witchcraft provide the Azande with explanations for misfortune in an unpredictable world. Malinowski (1954) thought that Trobrianders resort to magical intervention when practical knowledge is lacking and took to magic and rituals in circumstances which were life-threatening and dangerous (Dressler, 1985). These personalistic beliefs of misfortune, resulting from the active and purposeful intervention of supernatural being have also been found to be related to a

variety of social and psychological factors (Foster, 1976). Several ethnographers have found personalistic beliefs to be related to social stressors experienced by individuals (Marwick, 1970; Nadel, 1952). Finally, it has been suggested that, these belief systems represent a 'culturally constituted defense mechanism' because they enable the individual to resolve psychological distress, either arising from unconscious conflicts or social stressors, by displaying or projecting that distress onto beings inhabiting the supernatural world (Le Vine, 1973).

Most modern operationalizations of magical ideation derive from Meehl's definition - belief, quasi-belief or semi serious entertainment of possibility that events which, according to the usual concepts of this culture, cannot have a relation with each other, might somehow, nevertheless do so. The characteristic example is that of a child trying to hide himself from others by covering the eyes with his hands (te Wildt et al, 2004).

Magical ideation can be viewed as an early expression of human thought in terms of both ontology and genetic psychology.

MAGIC IN HEALING OF ILLNESS

In the Christian community of West Indies, a ceremony called 'mourning' is predominant involving prayer, fasting and experiencing of dreams and visions while in isolation. Mourners experienced several benefits to the practice e.g., relief of depressed mood, ability to foresee and avoid danger, improvement in decision making ability, heightened facility to communicate with God among others. Thus, ability of churches to provide psychological help and decrease high cost of mental health care in black, under developed communities gets substantiated (Griffith & Mahy, 1984).

In Africa, land of high mortality and many endemic diseases and long emphasis on supernatural interpretation of health problems (Evans-Pritchard, 1937), a ritual named 'kannaalen' (feminine, collective ritual) is performed in circumstances when two of a woman's children die early; two miscarriages occur or in cases of primary or secondary infertility. It is an extended period (3-5 years) of exile in an adoptive village. Its first step is official attribution of etiological agent by a diviner (ajuuberew), cause being: Ghost of an ancestor (akaalena); a soul devouring witch (agalaw) or malignant spirit (satanee). For infertility, witches and spirits are responsible corresponding to sorcerer (brok) and he/she is a very close relative even the woman herself (certain if problem continues even after ritual is completed). Kanaalen is supposed to ward off evil in 3 ways: i) humiliated (eating with dogs, bearing obscene name for life and becoming a buffoonery), the woman can not be envied by anyone, thus decreasing jealousy and rivalry which are the main causes of inducing evil ii) under new name and clothes, woman loses her superficial attributes and changes to another person, avoiding the evil and iii) pretending to kill ill child (symbolically by village women) is also an exorcism and prevents real death, being touched by evil doers (Fassin & Badji, 1986).

Another well known mode is the animal assisted therapy. Boris Levinson, a psychiatrist from New York first specifically highlighted the issues of animal assisted psychotherapy, especially in disabled persons. Researchers found evidence that animal contact has significant health benefits which positively influence transient physiological states, morale and feelings of low self worth (Odendaal, 2000).

The Asian countries have been dealing with magical cures since time immemorial. In South Eastern Asian Muslim population, a wide variety of physical and emotional disorders are thought to be caused by 'sorcery' which can be of 2 types:

1. Kunni- when someone who envies the victim casts a spell,

2. Urfi- when a chance circumstance caused by someone leaving the house causes possession.

For healing, clients consult a religious healer, 'Mullah', who uses hair or leaves to create an alternative spell to counteract the initial 'kunni' or 'urfi'. He may also treat the patient with an

amulet or 'tabiz' containing verses from the Koran to be worn around neck or arm (Bhattacharya, 1986). Other modes of healing include giving holy water or holy mustard oil over which Koranic verses may have been read or into which paper with koranic verses written on may have been dipped.

Kodi rituals of curing use anthropomorphized objects - the drum and the spear - as intermediaries to communicate with the spirits causing the affliction. It is practised in eastern Indonesia. The spear is believed to cut through the cause of the illness at the divination by guiding the voice of the human diviner. The drum beaten during an all night ceremony has important meaning. A myth at the opening of the ceremony tells the drum's personal story or biography which is identified with the suffering patient. The myth of the drum's origin provides a narrative structure for the whole ritual and defines the basis for its efficacy. The percussive sounds of the drum and gongs are said to make the patient feel better (Hoskins, 1988).

In the context of magic, hypnosis and reiki deserve mention. Hypnosis is basically a technique for focusing awareness and at the same time broadening perception to appreciate full spectrum of events and see beyond the merely superficial. Practice results in focusing and fine tuning the mind so that all mental, bodily and spiritual levels function in harmony. These phenomena were first formally described as therapeutic instruments in the 18th century with Mesmer's controversial theory that magnetic energy or an invisible fluid could be channeled from a therapist or an object to correct imbalances and to restore health to an individual with illness (Spiegel et al, 2005). Despite gaining recognition as a potential mode of therapy, hypnosis can also be considered to be belonging to the realm of magical cures only.

Reiki is a spiritual practice developed in 1922 by Mikao Usui. After three weeks of fasting and meditating on Mount Kurama, in Japan, Usui claimed to have received the ability of "healing without energy depletion". An aspect of the practice, tenohira or palm healing, is used as a form of complementary and alternative medicine (CAM). Tenohira is a technique whereby practitioners believe they are moving "healing energy" (a form of ki) through the palms (Lee et al, 2008). It is reported that the recipient often feels warmth or tingling in the area being treated, even when a non-touching approach is being used. A state of deep relaxation, combined with a general feeling of well-being, is usually the most noticeable immediate effect of the treatment, although emotional releases can also occur. Localized Reiki treatments involve the practitioner's hands being held on or near a specific part of the body. Recent injuries are usually treated in this way, with the site of injury being targeted.

MAGIC BEHIND MAGICAL FEATS

Let's turn our attention to magicians. 'Magic' to a common man is all what is shown by the magicians. Now where lies the magic? Is it the magician who performs it? Or it lies in us who are 'fooled' by his tricks? Or it is just another mystery of nature? It may be so that the magic lies in the behaviour of the magicians.

The magicians have learned how to perform acts that are perceived as defying the laws of physics and logic. These not only leave an audience baffled and amazed, but effects by magicians can also provide us with valuable tools to investigate human perception and cognition. There are certain principles a magician uses during his performance:

1) Misdirection-or diversion of attention away from method. Recent findings in vision science tells that only a small part of the information that enters our eyes- the part that is attended- enters our conscious awareness and this has been used by magicians over centuries.

2) Illusion-magicians use optical (physical factors) and cognitive (psychological factors) illusions to baffle the audience. Vision science has recently shown much of vision is a form of intelligent hallucination- to perceive depth, vision system must recover the 3rd dimension from 2D image available on retina. As multiple solutions are generally possible for a given image,

the result must be obtained by applying assumptions of some kind. This approach leads to illusion.

3) Forcing-the process by which one's choice can be systematically controlled without making the person aware is forcing. Magicians have long used this process to construct a context that favours reflexive behaviour e.g., putting spectator under considerable stress to act quickly. Later the person has only memory that the choice had been his own (Kuhn et al, 2008).

These methods are not only used by magicians alone but also have a wider use. Techniques of physical misdirection forms the basis of 'coercive graphics', while concept of forcing is at heart of advertising industry and political propaganda.

Thus, interestingly, newer researches point to the fact that both magic and psychology can learn from each other. With development of 'science of magic', newer techniques will develop for modifying perception and cognition and it will also help in investigating mind without destroying the necessary mysteries and secrets that give us so much joy.

CONCLUSION

Magic is an art of witty tricks, feats and healing; a science of understanding the laws of supernatural or incomprehensible natural events, the technology of primitive undeveloped side of human mind which explains oddities and brings about the miracle. One can not live without magic. It is overtly or covertly manifested in our behaviour, thinking and perception of the alien world. In our constant struggle to conquer destiny it is magic which protects us from the helplessness arising out of meeting the unknown by making it astonishing rather than intimidating.

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COUPLES THERAPY AND EXTRA-MARITAL INVOLVEMENT: PRINCIPLES AND PRACTICES

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ABSTRACT

Marital relationships often go through difficult times, but emotional upheavals experienced after the discovery of an extra marital involvement create an extremely challenging context for therapy. Research on this domain is limited and quite often the knowledge is stored in places mostly inaccessible to clinical settings. Yet, these relationship anxieties are frequently a part of the presenting complaints for a large number of clients with psychiatric disorders as well as with marital discord. Extra-marital involvement becomes traumatic when it shatters the basic assumptions about the relationship, changes one's view about self and the partner and makes people feel completely, existentially vulnerable. When there is intense pain and crisis, growth fostering significant changes are also possible and a skilled therapist can help the clients in making right decisions and moving forward. This article provides a few facts, perspectives and strategies that can be useful while working with 'extra-marital involvement'. It focuses on EMI issues in clinical setting and is in two parts: Part one, provides information to help clinicians differentiate and document extra-marital involvement issues more accurately, and Part two covers guidelines for therapy with couples affected by these concerns.

Key words: *Extra-marital involvement, infidelity, couples therapy, India*

INTRODUCTION

Marital relationships are often troubled with the issues of suspiciousness, jealousy, adulterous behaviour and secrecy. Yet, when faced with it most clinicians and therapists reach a therapeutic impasse. Some chose to merely witness it in a client's disclosures, some use the index of 'bizarreness', label it as a delusion and treat it with pharmacotherapy, some who feel more brave might venture to verify it with the family members, but may continue to be helpless about it. While different terms like infidelity, affair, extra-marital sex, extra-dyadic or extra-marital involvement are used in literature with similar connotations, in this article we will be using the term 'extra-marital involvement' (EMI).

EMI has been defined as a sexual and/or emotional act engaged in by one person within a committed relationship, where such an act occurs outside of the primary relationship and constitutes a breach of trust and/or violation of agreed upon norms (overt and covert) by one or both individuals in that relationship, in relation to romantic/emotional or sexual exclusivity (Blow & Hartnett, 2005). It can be distinguished

from 'jealousy' i.e., concern about loss of a partner's affection, attention, and love to a rival. Literature refers to not only explicit behaviours like having sex and kissing but also to ambiguous and secretive behaviours like fantasizing and lying, as part of EMI. O'Leary (1998) defined EMI as a 'sexual behavior that violates the explicit or implicit expectations of the relationship, or non-sexual behaviour that involves sharing intimate feelings and thoughts with an extramarital partner, and secrecy that violates the explicit or implicit expectations of the relationship'. Associated with EMI is a sense of 'betrayal' as if something important and exclusive has been shared thereby diminishing the relationship. Destructive strategies may get activated like comparisons with the affair partner or inducing threat or guilt. It has also been associated with increased risk of sexually transmitted diseases in the unsuspecting partner (Tolley et al, 2006), domestic violence (CWSD, 2005) marital breakdown (Rao & Sekhar, 2002) and suicide (Srivastava & Arora 2007).

While various international studies have reported different prevalence rates, in India, Kamasutra Annual Sex Survey (2004) found 13% people reporting extra-marital sex, of which 68% have one and 32% have more than one partner. In another

survey of 8 selected medical institutions in Bangalore, out of 286 people suffering from sexually transmitted disease, 79.4% were having extra marital sex (Kanbargi & Kanbargi, 1996). In 1995, according to Doshi (2005) in a Bandra court Mumbai, out of the 2,055 divorce cases filed 308 were due to adultery.

Psychological Formulations for Extra-Marital Involvement

Typology: EMI can be categorized on the basis of time-span of involvement or as per being primarily sexual, emotional or combined type. Brown (2007) categorizes affairs as intimacy avoidance, conflict avoidance, sexual addiction, split self, and exit affairs, using a more dynamic interpretation of affairs. EMI can have varied motivations or a combination of factors ranging from intra-psychic, interpersonal to social. Sexual addiction, pursuit of excitement or fantasy, wish to punish self or spouse or need to get out of one's marriage might be present. It may also be associated with attachment style, felt loneliness, affection needs, yearning for an emotional connection or and attempt towards individuation and self-discovery. It might be encouraged by socio-cultural gender based norms, or may be justified on the basis of circumstances (a traveling job). Researches have found that high EMI is associated with women having anxious-attachment style; men having dismissive attachment style or their partners having enmeshed-preoccupied or avoidant-fearful attachment style. Deficits in the primary relationship, low commitment, or high quality alternative partners could also create EMIs.

Lusterman (2005) believes EMI can be related to past, family of origin, or with difficulties in making transition to married life. It may arise from faulty beliefs about opposite gender, confusion regarding one's sexual orientation, or questions about one's desirability, and sexual adequacy especially in middle age. Sometimes an affair is a temporary distraction, to cope with life's difficulties. Some 'tripod affairs' also help maintain an unsatisfactory relationship, especially in an arranged marriage (Bagarozzi, 2008). Online EMI on the other hand often involve individuals who are high on manipulation,

exhibitionism and low on self-disclosure and dyadic cohesion. They express their sexual fantasies in anonymous interactions, with relative safety and avoid psychological discomfort by rationalizing those behaviours as innocent and harmless (Mileham, 2007; Aviram & Amichai-Hamburger, 2005).

In India, an individual's ideas of romantic love (influenced by movies, mass media) its experiences and expectations may transgress societal norms. In many marriages, this conflict between individual ideas and family/ societal expectations may lead to considerable psychological distress and wish to go beyond societal rules. Further, women are expected to marry up socially, economically or ritually (e.g. caste), resulting in men bringing greater personal resources to the marriage. Thus, men having greater control, authority, and freedom in the relationship, influences a man's decision to pursue an extramarital affair and simultaneously limits the wife's options (Basu, 2006). In order to maintain the marriage or gain some sense of "power", in such situations many wives are either forced to or choose to accept or ignore their husband's EMI.

Further, Asian religions focus on 'purity', but the standards for men and women are quite different. Patriarchy might grant power to men that women might be denied. Culturally, it may be more acceptable for a man to have an affair, which might be treated as a secret and the wife might be advised or encouraged to ignore it or find ways to win him back. However, a married or unmarried woman having an affair would be treated quite differently and consequently might lose home, family, and social support (Madathil & Sandhu, 2008). As per research in Indian context, few relevant factors associated with EMI are: norms of masculinity and need to assert sexual prowess in men (Verma & Mahendra, 2004), husband's and wife's age, wife's perception of domestic violence, husband's education and place of birth, husband's alcohol use, wife's willingness to engage in marital sex, and types of marital sexual acts (Schensul et al, 2006).

Overall, Ables and Brandsma (1977) summarize possible

reasons for an EMI as: intellectual liberalism, romantic charm of intensive EMI, reassurance seeking during unavoidable times of couple conflicts, long-term relationship dissatisfaction and presence of compulsive need.

Clinical Framework

Disclosure of an affair is a major event in a couple's relationship history, a turning point which shakes assumptions about a predictable world and brings upheaval in values, beliefs and behaviour patterns. Jankowiak et al, 2002) found three types of responses in couples to EMI: use of self-help, appeals to higher authority, and appeals to the general public. The self-help techniques are behaviours like resolving the matter between the couple (including use of verbal/ physical violence) and distancing (by leaving partner, emotional withdrawal, and suicide). Genders differ in preferred responses, men prefer physical violence and women prefer distancing themselves. Men also prefer taking the matter to a formal institution, whereas women prefer appeal to the general public, using methods such as gossip.

Some studies show a small percentage of couples improve their relationship after an EMI and there may be specific positive outcomes like increased assertiveness and better communication (Charny & Parnass, 1995; Olson et al, 2002).

Assessment

Assessment of relationship betrayals should be done with respect, sensitivity and attention to non-verbal cues. Whisman & Wagers (2005) recommend therapist should inquire about betrayals routinely (e.g., Has there been any sexual or emotional betrayals or infidelities in the relationship?). No questionnaire has been widely used and clinicians prefer clinical interview to explore more, once there is a disclosure of EMI by the partners. Every EMI can be understood using 7 dimensions. These are: time, degree of emotional involvement, sexual intercourse or abstinence, single/ bilateral, heterosexual/ homosexual and number of EMI partners (Humphrey, 1987). On the other hand, Allen & Atkins

(2005) have given two independent but mutually influencing dimensions- Systemic (4 domains; intra-personal, spouse-related, marriage/primary relationship related and contextual) and temporal (6 stages: predisposing, approach, initial involvement, maintenance, disclosure/discovery and response) for clinical evaluation of EMI.

In general, it is required to assess/ explore level of crisis, trauma of discovery, cognitions and emotions both before and after the affair, current and past relational patterns of the couple and family of origin, the life stage, presence of any stressors and any mental health disorders.

Clinical diagnosis of extra-marital involvement

Generally, the diagnosis of Adjustment Disorder (with mixed anxiety and depressive mood) is coded for the non-involved partner, who has discovered the EMI, as per DSM IV (APA, 1994). But often reactions of non-involved partner are similar to post traumatic stress disorder (PTSD), like-difficulty in staying/ falling asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance, and physiological reactivity to symbols/ reminders of trauma (Lusterman, 2005).

Therapy and Extra-marital Involvement

Structure of therapy

Treatment forms usually vary with the type of EMI. Couples who want to work on their marriage benefit with couples therapy, while individual sessions are also needed for those with sense of loss of self. Generally like all other therapies working with EMI too has been often approached in three phases. Across these phases, conjoint/ concurrent individual sessions may be used; however therapist must have a clear plan for 4-5 sessions and their aims as an index for their usefulness.

Phase I

Spring (1996) proposes that this phase focus on normalizing hurt feelings. Lusterman (2005) suggests restoring trust by

exploration and expression of feelings and validation of feelings of non-involved partner by involved partner. This is the lengthiest phase, where the outline of entire therapy is also given to the couple. Similarly, in integrated therapy based on trauma and forgiveness literature, Cognitive Behaviour Therapy (CBT) and insight-oriented strategies, Gordon et al (2005) emphasize that phase-I be devoted to the impact of interpersonal trauma as well as its experience and absorption by both partners and the relationship. Sessions with the non-involved partner to help with disruption in standards and assumptions regarding relationships, cope with overwhelming emotions and meaning of event are often beneficial. Therapist's sensitivity to frequent chaotic negative interactions between partners, followed by periods of lull, non-involved partner's barriers to protect self or being overly-hostile or demanding for extraordinary tasks as compensation is crucial. These patterns may not be revealed to the therapist clearly. Thus alert use of hints by either partner is extremely important. This phase is accomplished if session processes improve emotional processing, to decrease destructiveness and also help conceptualize affair as a traumatic event.

Phase II

While Spring (1996) believes this phase is the time for the couple to decide whether to recommit or to quit, Lusterman (2005) explores on the pre-disposing factors for EMI, with attention to conflict resolution, self-disclosure, trust, and intimacy experiences. Sensitivity and flexibility in session processes helps both partners feel secure to explore more vulnerable aspects of their lives. In contrast, Gordon et al (2005) promotes shared understanding of causes, accountability and meaning of trauma. Session processes can promote empathy for each other, search for indicators for a safe future and facilitate calm reevaluation of the relationship.

Phase III

This is 'rapprochement phase' where couples move towards a better marriage or a better divorce (Lusterman, 2005) a phase of rebuilding the relationship (Spring, 1996).

Improvement in self-disclosure and problem-solving skills is essential for better marriage, while better divorce needs groundwork for good co-parenting and better decisions in future. For Gordon et al (2005) phase III involves moving forward with one's life, with a new set of relationship beliefs. Decisions about required changes are made, forgiveness is discussed and non-involved partner has to release oneself from negative affect. Successful outcome for this phase is evident if there is balanced view of the relationship experiences and voluntarily relinquishing of the right to punish or take revenge.

Some of the guidelines for therapeutic alliance are : Therapists should be non-judgmental, open to alternative life styles, consistently observant and validating and create an atmosphere of hope in the sessions. They should remain sensitive to third parties being affected and minimize any harm or emotional fall out to all the parties concerned, i.e. client, their spouse, their families and their affair partners. They also need to address the ethical mandate to protect the physical health and safety of clients and their marriage partners. In the treatment, therapist should be direct, active and collaborative. The treatment structure should provide a plan and also set boundaries. Therapists' skills to consistently examine needs of clients, involve them in a collaborative way with treatment process, therapist's willingness to tell people that they are making a mistake and their ability to clearly communicate treatment plan influence the outcome of therapy significantly. Therapists' questions and empathic statements help clients clarify their multiple complex feelings and explore potential advantages and disadvantages. Successful behaviours of the therapist are those that keep people talking, convey confidence in therapeutic process, model compassion, help individuals to investigate their own behaviour choices, teach people what to do with their anger, normalize lust and promote closeness.

Various theoretical approaches used for therapy with EMI are Psychodynamic, Cognitive, Systemic, forgiveness and Trauma and Crisis Recovery Model. Some of the useful interventions recommended by Daines (2006) and Dupree et al (2007)

are: 1) learned habits, cognitive distortions and myths of relationships may be examined in therapy followed by cognitive and behaviour restructuring, communication skills and anger management; 2) regulation of power inequalities and/or intimacy needs; 3) de-escalation of crisis, understanding the meaning of affair rebuilding attachments and commitment; 4) Involved partner can be helped to understand unmet needs from non-marital areas that burdens the marriage and become aware of the effect of EMI on present conflicts; 5) increase awareness and communication about the effect of EMI on each partner and the relationship; 6) reasons for unwillingness to forgive can be explored and 7) reduce blame and bitterness and facilitate discovery of what each can and is willing to live with.

In general, attachment re-building is done through strengthening new patterns of relationship, finding meaning in it, setting boundaries to reduce risk of repeat trauma and promoting closeness. In a culturally sensitive therapy, religious/ cultural beliefs, expectations and contexts which may influence intimacy are also examined. Discussion of individual vulnerabilities, expression of empathy, and joint agreement on values to be exercised in the reconstructed relationship are also useful strategies.

Treatment of pursuit behaviour

Pursuit behaviour is a compulsive search for partners. It is similar to addiction and such individuals display a need for power and sex. They have abnormal patterns in 2 or more areas- cognitions (ways of perceiving and interpreting self, others and events), affectivity (range, intensity, lability and appropriateness of emotional responses), interpersonal functioning or impulse control. They either had narcissistic deprivation in childhood leading to low self-esteem, or had a surfeit of attention, feeling idolized while growing up and later in their career. Diagnosis is done using Humphrey checklist and along with psycho education a different mix of individual and joint sessions is used. Individual sessions along with conjoint sessions are especially conducted for involved partner for development of insight, empathy and behavioural

change (Lusterman, 2005).

Outcome of relationship

Often the separate feelings, attitudes, and concerns that affairs generate, are beyond both partners' capacities to work through, even with therapeutic help. But no decision should be taken immediately, if the marriage was not dysfunctional previously. Thoughtful discussions provide both spouses with dignity. Therapists' should help the couple to separate effect of affairs and decision of divorce and make no decision until the meanings and feelings about the affair can be articulated, understood, and allowed to evolve (Levine, 2005).

Insights from Marital Therapy in India

In Indian culture, marriage (Vivah or Anand Karz) is an important social institution, a long lasting alliance between two families, a sacred duty for performance of dharma and contribution to the family and the lineage (Sheela & Audinarayana, 2003). It's considered to be a lifelong commitment and the individual is expected to make adjustment and compromises (Kapadia, 1966). Marriages are not so much based on meeting sexual needs, or feeling of attraction and emotional love (Ross & Wells, 2000). In selecting a prospective mate- cultural and societal norms are followed and marriages are often arranged by the individual's extended family on the basis of economic, religious, political, and social considerations. Indian society is predominantly collectivist and sexually conservative, where interdependence is encouraged and self-identity and expressions of strong feelings of love and romance are inhibited (Inman & Tewari, 2003). Love marriages are especially discouraged as it is believed that such emotionally laden marriages might interfere with family closeness and prescribed familial obligations (Medora et al, 2002). Gupta and Singh (1982) found that with time, love and liking decreased among love marriage pairs, but increased among arranged marriage pairs.

In the traditional joint family make-up, sexual behaviours follow

a rigid code enforced by customs, symbols, and communal rituals (Abraham & Abraham, 1998). While silence is considered as a virtue, divorce is stigmatizing and is considered morally objectionable. The ideal of 'pativrata' is encouraged (extreme loyalty to the point of worshipping one's husband) as marriages are supposed to be sacred/ religious bond of body and soul for several lives to come, through reincarnation. Death may separate two bodies but it cannot separate the two immortal souls that always remain intact even after the death of one or both spouses (Madathil & Sandhu, 2008).

But Indian society is in the process of transformation, leading to multiple ideas and values regarding any issues. Increasingly, individual members have more say in the decision-making process and their like and dislikes are considered by the families, in the mate selection process. Abbassi and Singh (2006) found in US those Asian-Indians who were younger or had been married for fewer years, were more courageous in expressing assertiveness in the marriage than those who had been married longer.

In the context of marital therapy in India, Channabasavanna and Bhatti (1985) developed a model of marital discord based on role expectation theory. Raghuram (2003) expounded an experiential view of marital therapy stressing on creation of positive expectancy, hopefulness, emphasis on strengths of relationship, development of collaborative relationship where improvement was dependent on efforts of the client and the responsibility taken by the clients and communication of empathy for the dyad and not the individual. Isaac (2004) found that marital therapy was effective and therapeutic alliance was the strongest process predictor of outcome. Cognitive techniques were more common in early sessions and behaviour interventions were more common in later sessions.

In Asian-Indians, discussions about sexual matters are considered private and are not generally discussed with strangers, including the mental health professionals. If the counselors are not sensitive, they can expect premature termination of their clients. South Asians' clinical presentations often consist of multiple somatic complaints, stomachaches, and bodily fatigue. Counselors might initiate the counseling session with discussion about client's physical ailments and eventually proceed to relationship problems including the extremely personal topic of infidelity. Clinicians could start assessing for relationship betrayals by asking general questions related to sexual or emotional infidelities followed by questions about specific behaviours. While working with Asian Indians, it might be better to ask these questions without the partner present (Madathil & Sandhu, 2008).

Kalra (2008) found in those couples presenting with EMI this crisis initiated marital problems, created marital instability and dominated the therapy session content. Themes of betrayal and lack of trust were common and emotional abuse was used as a way of getting back at the spouse. For these couples, emotional abuse often accompanied impasses reached in the process of rebuilding trust. Often the injured partner used accusations to make the involved partner clarify their intentions and motivations for entering into EMI, their commitment to the marriage and most importantly to make the spouse initiate efforts to reassure and rebuild trust into the relationship.

Presenting patterns

Indian couples affected by extramarital affairs present with diverse presenting problems and patterns. First, pattern is where help seeking comes in the context non-involved partner developing psychiatric symptoms (depression, adjustment disorder, or even psychosis) or harmful tendencies towards self, children or towards the involved partner. Often family history shows social rejection and avoidance and isolation for one or both partners. Some couples struggle to involve close family members, but with overwhelming anxieties, it frequently creates extremely volatile interactions.

Second pattern is that of couples, who historically had many positive interactions and do follow some rules of conduct.

Care for children, family and work routine is often preserved with some struggles, but severe marital discord is present with attempts to prevent disclosure to too many family members. The EMI could be a recent event, or a significant period may have passed since disclosure and recommitment. Yet, the mistrust and inadequate resolution styles perpetuates the tension and old marital difficulties. Both partners will appear reasonable to the therapist and sometimes therapist may even feel that the non-involved partner is unnecessarily remaining unforgiving.

The third presenting style is when the involved partner brings the non-involved partner so as to decrease depression and self-harm and to facilitate acceptance of third party as a legitimate partner in the relationship. In other words, three persons exist almost like an 'undifferentiated emotional mass' and struggle to create a stable triangular relationship. But they keep breaking down in interactions or intra-psychically, when anxieties don't go away. In the sessions, often from the first contact itself, there is a very palpable presence of all the three persons' emotional needs, fears, conflicts and failed resolution strategies, with unpredictable waxing or waning over the course of therapeutic contact.

Overall, in clinical settings, it is more commonly seen that the involved partner is the man and the non-involved partner is the woman. However, the opposite pattern is also fairly prominent in at least one third of the couples seeking help and may be more common in individual therapies sought by women raising doubts about continuing marriage. The two gender patterns do pose different challenges to the therapist and many are very deeply linked with social stereotypes for men and women in families, beliefs about trust, cheating and psychological protection of partners. Therapist's biases and value systems may inhibit some couples from adequate disclosures and some therapists prefer to avoid responsibilities for such couples.

Expectancies and aims

Irrespective of gender, for both partners a positive outcome of therapy is ensured by therapist's capacity for exploration of rejection and betrayal experience, coherent articulation of confusion, hurt, humiliation, acceptance of feelings of love for partner, reconstruction of internal relational belief system, awareness of familial and social conflicts, empowerment of self and repairing identity.

In therapy, individual and conjoint session formats could be tried out. However, conjoint sessions often go beyond control. Levine (2005) has elaborated further on these processes. When couples are battling over whose interpretations are correct it has to be conveyed that meanings of events are ultimately private and individual, and one person's meanings cannot be superimposed on the other. When the aggrieved insists upon knowing the sexual details of the infidelity that may also lead to domestic violence, it is important to postpone such exploration at times. When the unfaithful person asks for forgiveness and wants an abrupt end to the discussions, it has to be communicated that discussions can end only when the issues are thoroughly explored and respected. Such discussions usually would exhaust both parties. Other issues can be about resumption of mutually desired sexual activity, grief of involved partner about abruptly ending an affair and aggrieved party's own infidelity.

Specific formulations and goals

For many couples presenting with prominent discord and history of EMI, it is useful to reformulate the presenting problem as that of unmet intimacy needs. This can be further differentiated as arising from 1) sexual/ emotional extramarital affair; 2) suspiciousness but no specific third person associated with the partner; 3) jealousy feeling. Suspiciousness need not be attributed to personality but often result from either insufficient communication or act of thoughtlessness. Increasing accountability for communication and enhancing thoughtful behaviours can decrease suspiciousness. Jealousy on the other hand is often maintained by involved partner's inappropriate behaviours with opposite gender or rejection created by disclosures of

physical attractiveness of partner versus other same gender persons. Sessions can thus help couples, explicitly develop gender appropriate rules of conduct for both, as well as develop respect for personal, physical, and/or unchangeable attributes of one another.

Relationship options and reconciliation

Factors useful for clarifying relationship options are: emotional power over spouse, support in divorce related choices, empowerment of one or both to deal with familial and social forces, altering self in interaction, communication changes, open dialogue on affairs, intimacy rules, appraisal of spouse in present, and acceptance of feedback from spouse. Also working towards intimacy and healing existential vulnerability for both through disclosure of emotional worlds, having emotional closeness, trust, commitment, self-validation, communication and compromise makes reconciliation possible.

Three dimensions useful for reconciliation work are ideology of relationships for each partner, belief systems around stability and continuity of close relationships, and experienced state of self in relationships. Therapist's understanding of each partner on these can help him/her guide the couple confidently towards reconciliation.

Common dilemmas in therapy

Demands for transparency and truthful behaviour are quite difficult to negotiate and resistant to therapists' rules as truthful revelations do not necessarily help. Also confidentiality of any individual session is still a cause of dilemma for therapists. The rule about no secrets is rooted in the history of family therapy, where triangulation has been viewed as a great danger, supposedly holding the therapist ineffective. Pittman and Wagers (2005) recommend sharing all information with the non-involved partner, while Lusterman (2005) approaches any individual session as confidential unless there is legal requirement to share some details.

Therapists must carefully examine their own values about the phenomena. There might be cross-cultural differences regarding honesty, shame and humiliation. Some non-involved partner themselves don't want to know or talk about it explicitly, even if evidence is present. Also, if the couple is seeking divorce, revelation of an affair may not be necessary as the revelation may be used for revenge purposes or it might influence rulings on custody issues and financial decisions. Further old affairs need not be disclosed. For some couples telling the truth may not be healing or can even have destructive consequences. So in grappling with the best strategy, it may help to ask, 'Best for whom?' (Spring, 1996). Many involved partners decide to hold on to their secret while they address what is bothering them in the relationship.

Therapist needs to respect that disclosure of an affair is a matter of self-determination. When clients feel respected they can freely examine their options to disclose, how to disclose and its resulting effects (Imber-Black, 1998). When one partner reveals an affair to the therapist in an individual session but is not inclined to reveal it to the other partner, the therapeutic process must shift to include a period of individual sessions. Linquist and Negy (2005) advices therapist to communicate their openness to and neutrality to EMI but should not encourage clients to pursue or maintain their EMI.

Often, a dominant issue in therapy is concerned with the other party. Non-involved partner can sometimes have extreme empathy with the third person and form a psychological coalition against the involved partner. There may also be indicators of psychiatric vulnerabilities in the third party with danger of isolation, lack of support and suicidal attempts. These may require individual work with the involved partner to discover resources to find appropriate solutions in everyone's interest.

Partners' ideas about relationships can pose yet another type of dilemma. One of the issue is about different types of relationships being pursued by people, like open relationships, same sex relationships etc. In such relationships the rules are different in terms of sexual or

emotional connections outside dyadic relationship and might need development of rules, negotiation regarding levels of transparency and emphasis on quality time in the primary relationship (Greenan & Tunnell, 2003).

Therapist's anxieties around intimate relationships also need to be resolved through peer-group discussions and supervision. Levine (2005) suggests that counter-transference forces may lead to three kinds of anxious responses from therapists: a panicky subjective experience about the danger the patient faces; a quick referral to someone ''who deals with these kinds of things'' or an authoritative advice to divorce etc. She warns not to formulate simple causal explanation, as single hypotheses of individual or marital psychopathology are rarely a sufficient account of the actual circumstances.

Patients' extramarital dilemmas, can promote our professional and personal maturation. Infidelity is a form of marital boundary violation. Our work should model good boundaries for the patients. Personal family and personal experiences with infidelity generally should not be shared. When listening to the patient's dilemma about what to do about the marriage, we should behave as though we know that in the future both the husband and the wife will reach some conclusion about the importance of the infidelity in their lives.

CONCLUSIONS

The issue of extra-marital involvement is a matter of concern for most therapists There is a need to address this issue in couple's therapy. Various therapeutic models have been given and there is a need for more empirical studies. Most of therapy models involve emotional processing, cognitive appraisal and behavioural change. Therapy process and outcome are influenced by client's attributes, skills and beliefs of the therapist, and influence of those outside therapy like friends, family and other professionals. The therapy room has to become a nurturing womb for the couple to recreate intimacy, a safe place to relearn trust, rediscover hope and sometimes

when required, a place to learn to say a respectful good-bye. Working with EMI is complex due to various issues. Research in this field is also quite challenging due to trauma, shame and secrets inhibiting potential participants. Keeping this in mind, there is a need for better documentation and retrospective research for building up of knowledge. Thus, practitioners need to be cautiously approach this area, see current research findings as only a tentative idea about clients' lives and keep building it up with their own experiences in the field.

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SUICIDAL BEHAVIOURS AND OCCUPATIONAL STATUS IN INDIA - A SELECTIVE SYSTEMATIC REVIEW

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ABSTRACT

This paper reviews evidences of suicidal ideas, risk and rates at workplaces in India. A selective systematic review method of the information available on suicidal risk, ideas and rates at workplaces in India was adopted based on published literature on this subject, both web based and hand searched from India. Recent surveys of rates of suicide by occupational categories showed that the rates were highest for skilled workers [23.6/100,000], unskilled workers [18.9/100,000] and housewives [12.8/100,000], and lowest for those in professional jobs [0.8/100,000 population]. Another survey on suicidal ideas among women observed that 13.6% of women in Industrial sector had suicidal ideas; in industries, 36% of women had depression of which 38% had suicidal ideas. Suicides among farmers are considered due to psychological causes, economic factors, and alcoholism. Rising stress among the software engineers and some cases of suicide among them have also been reported. The literature review confirms evidence of higher suicidal behaviours among certain workplaces in India. Adequate efforts to identify and reduce these risks are necessary.

Key words: *Suicide, suicidal ideas, workplace, occupational health*

INTRODUCTION

Health problems in workplaces are addressed at times in India, but mental health problems in workplaces are invariably overlooked. Work related mental health issues are noted with both unemployment as well as employment as life events. Stress may manifest at workplace in a number of ways which are linked to employment related issues, pay and finances, job satisfaction, work place milieu or environment, facilities and support provided to the person and his/her family, relationship and attitudes of colleagues - superiors and subordinates, stress and burnout. A number of mental health problems in workplace may be encountered for example, adjustment disorders, depressive disorders, anxiety disorders, alcoholism, substance use, somatoform disorders and abnormal illness behaviour. These would lead to absenteeism and financial loss. The stress in the workplace can also lead to deliberate self harm, suicidal ideas, attempts and completed suicides. On the other hand, unemployment is also recognized as a stressful factor.

India has a high rate of suicide which has been gradually increasing since last two decades, from 7.9 to 10.3 per 100,000 (Vijaykumar, 2007). The currently reported suicide rates in India vary from 6.8 to 58.3 per 100,000 (Gururaj et al,

2004). There are very few studies on suicidal risk and prevention in the workplace in India. Indian literature gets missed out from systematic reviews, since the key journals of psychiatry from India are not indexed in Pubmed/ Medline. This paper reviews the evidence of suicidal ideas, risk and rates in workplace in India.

PROCEDURE

The method involved a selective systematic review of the information available on suicidal risk, ideas and rates in workplaces in India. This was based on published literature on this subject. The following steps of conducting systematic reviews were adopted:

1. ***Defining the appropriate question:*** What is the evidence base for suicidal ideas, risk and rates in workplaces in India.

2. ***Searching the literature:*** The literature search was performed systematically by the search of websites Medline/Pubmed, and additional hand search from the five commonest Indian journals which publish articles related to psychiatry like Indian Journal of Psychiatry, Indian Journal of Psychological Medicine, NIMHANS

Journal, Indian Journal of Social Psychiatry and Archives of Indian Psychiatry. The keywords used for literature search were 'suicidal ideas, suicidal attempts, suicide, deliberate self harm, work place, employment, unemployment, occupation, occupational status, India, Indian setting. Articles based on studies done in Indian population only were included.

3. **Inclusion criteria for studies:** Studies based on adult subjects [above 16 years], done on Indian community and general population sample only were included.

4. **Assessing the Studies:** Once all possible study reports were identified and collected, each study was assessed for eligibility for inclusion, study quality and reported findings.

5. **Combining the results:** The findings from the individual research studies were compiled, both qualitatively and quantitatively, and the research findings were tabulated. Meta-analysis was not done at this stage. However, relevant sub group analysis was attempted wherever feasible.

6. **Placing the findings in context:** The findings from the studies are discussed to put them in context, with relation to need for services for suicidal risk behaviours, need for mental health education and awareness about prevention of suicidal risks and suicides and any need for policy revision or development for the prevention and treatment of suicidal behaviours in workplace.

7. **Report preparation:** A structured report was prepared stating aims, describing the methods, inclusion and exclusion criteria and summarizing main findings on suicidal behaviours at workplace in Indian settings.

RESULTS AND DISCUSSION

Fifteen studies on the subject of suicide in workplace were found in the Indian Journal of Psychiatry. All were included for further review. There were no publications in the Medline / Pubmed on keywords suicidal ideas, suicidal attempts,

suicide, deliberate self harm, work place, India, Indian setting. However, six articles were found in Medline using keywords 'suicide, employment, India' of which four had mention of work or employment status (Gururaj et al, 2004; Brockington; 2001, Sudhirkumar et al, 2006; Sharma et al, 2007). There were five articles on 'suicide, unemployment, India' of which two were on ethnic Indians in United Kingdom (UK) and one on homicide. Two reports mentioned about unemployment as a factor for suicide (Gururaj et al, 2004; Gupta & Srivastava, 1988). No references were found using keywords 'suicide [or suicidal ideas], workplace, India'. Sixteen studies or reports were retrieved by hand search of the journals not indexed in the Pubmed / Medline.

A survey (Gururaj & Isaac, 2001) on suicide by occupational categories showed that the rates were as follows: Skilled workers [23.6/100,000], unskilled workers [18.9/100,000], housewives [12.8/100,000], and professional jobs [0.8/100,000]. In another study, the frequency of suicidal ideas among women by occupation or workplace were 14% of women in Industrial sector, 24% in non-professional college students, 5% in professional college students and 36% in women working in industries who had depression of whom 38% had suicidal ideas (Chaturvedi et al, 1995).

Unni and Mani (1996) noted that the occupational status of persons with suicidal ideation was as follows: 40% housewives, 22% employed, 15% farmers, 15% labourers, and 8% unemployed. In contrast, the occupational status of suicidal attempters was 32% housewives, 28% students, 5% professionals, 16% farmers, 4% laborers and 7% unemployed (Sharma, 1998). The common methods of suicidal attempt in workplace have been found to be by hanging, jumping from height and pesticides, especially by farmers (Ponnudurai et al, 1997). Among adolescent suicide attempters, 58% were unemployed, 34% employed and 8% students (Sudhirkumar & Chandrashekaran, 2000). Attempted suicide was also reported in armed forces and attempters had significantly more disciplinary problems, poor peer relations, poor relation with authority and poor work history, and were unstable (Chakraborty, 2003). There is a recent report on rising stress among the software engineers (Chaturvedi et al, 2007), and some cases of suicide among them have also been reported in the media.

Lack of job or unemployment has also been related to suicidal

behaviours and reported in 0 to 27% (Sharma, 1998; Galgali et al, 1998; Ponnudurai et al, 1986; Jain et al, 1999; Shukla, 1990). One study found suicidal behaviours related to employment and unemployment in equal proportions of 11% each (Narang et al, 2000). Similarly, a review on suicide in women reported a lack of effect of prosperity and employment in suicide among women in India and China (Brockington, 2001).

A recent disturbing development is about suicide among farmers (Rao, 1999; Chaturvedi, 2005) which has also become a socio-political phenomenon. The recent spate of farmers' suicide in India has raised societal and governmental concern to address this growing tragedy (Vijaykumar, 2007). The suicides in farmers have been reported to be due to psychological causes, economic factors and alcoholism. Politics of farmer suicides is embedded in the alleged cause of farmer suicide, one group believes that farm suicides have only psychological causes, not economic ones, and identify alcoholism as the root cause of suicides. Others feel that these suicides are due to being in debt and borrowing from money lenders and private sources (Chaturvedi, 2005).

Measures aimed at tackling deprivation have proved more effective in reducing suicide rates among farmers than specific clinical interventions. It has been noted that as many as one in ten suicides is attributable in some part to unemployment. Farmers' suicides in recent times in India have been attributed to economic disasters. Other causes like ecological problems, weather failure, escalating prices and overall vulnerability of farmers, liberalization and quality of pesticides are all blamed (Chaturvedi, 2005). In a Maharashtra study, it was observed that 62 of 75 were Dalit suicides and lack of education and training in utilization of land was considered as causal. The failure of state and traditional farmers in this regard was held as contributory (Rao, 1999).

An interesting study noted that employment status did not differ among persons with suicidal attempts and the final outcome of death (Sureshkumar, 2004), however, there was a difference in gender, as significantly more employed women attempters ended up being victims as compared to employed men (Sureshkumar, 1998; 2004).

Poverty, unemployment, debts and educational problems are also reported to be associated with suicide. The high rate of suicide among young adults can be associated with greater socioeconomic stressors that have followed the liberalization of the economy and privatization leading to the loss of job security, huge disparities in incomes and the inability to meet role obligations in the newly changed social environment (Vijaykumar, 2007). Employment support for mothers has been suggested by Sharma et al (2007) as lower rates of employment outside the home have been noted (Sudhirkumar et al, 2006). More suicide ideators were noted to be employed, whereas housewives were more often suicide attempters or had completed suicides (Bhatia et al, 2000).

Thus, this systematic review of Indian literature confirms evidence of higher suicidal behaviours among certain workplaces and employments in India. More research is called for in different workplaces to identify those at greater risk, and also to identify relationship of suicidal behaviours with job related stress and other psychopathology. Adequate efforts to identify and reduce these risks at the workplaces are necessary. It may be seen that neither depression nor suicide behaviour is all biology (Gururaj et al, 2004). Measures aimed at biological factors like genetic predisposition, neurotransmitter abnormality, treatment by antidepressants alone can not counter this behaviour. The medical approach is to be combined with appropriate psychological counselling, crisis intervention, occupational rehabilitation and follow-up after crisis has resolved. While these are addressed at individual levels, socio-economic measures targeted to employment and unemployment also needs to be addressed. Work related psychosocial issues are rarely dealt by healthcare providers or the workplaces. For developing countries like India, often no specific national data on work related stress or suicidal behaviors is available due to poor recording mechanisms and non recognition of related outcomes in most of these countries (World Health Organization, 2007). This is a matter of growing concern as it will inevitably have future negative consequences for the health, safety, and well being of workers (World Health Organization, 2007).

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Research Article...

THERAPEUTIC CONTACT IN THE AFTERMATH OF ATTEMPTED-SUICIDE: PRACTICE ISSUES AND AN EXPERIENTIAL ACCOUNT

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ABSTRACT

Background: Practice guidelines suggest that all individuals presenting to an emergency medicine unit following a suicidal attempt should be routinely assessed for future risk and offered appropriate psychosocial care. However empirical literature suggests that the drop-out rates following initial referral for psychological/psychiatric help are high. Rapid alliance-building hence assumes paramount importance in working with individuals and their families in the aftermath of suicidal crisis. **Method:** Salient issues related to psychological interventions in the aftermath of suicidal attempt are briefly outlined. The process of therapeutically engaging a client and the family who present to a general hospital setting for medical management following a first suicidal attempt is discussed through a case illustration. An in-depth discussion of the initial therapeutic work is presented. **Results:** The case highlights the use of therapeutic factors such as being able to develop and use insider-perspective of the crisis, alternating between perspectives of the client and the family, focusing on the here and now and rapidly addressing issues that may act as barriers to further help-seeking. **Conclusion:** Rapid alliance building with the client and the family is crucial for minimizing the risk of drop out following medical management of suicidal crises.

Key words: *Attempted suicide, suicide, crisis intervention*

Clinical observations and empirical research (Mitchell & Dennis, 2006) suggest that individuals presenting to an emergency unit of a general hospital following a first suicidal attempt usually have significant psychosocial difficulties and that many of them may have never sought the help of a mental health professional Practice guidelines suggest that all such individuals should receive an initial risk assessment and further assessment of psychosocial issues in order to plan follow up care for minimizing the risk of further attempts. Risk of suicide is especially high in individuals with high-unresolved suicide intent, depressive disorders, substance abuse, social isolation and chronic physical illnesses (Mitchell & Dennis, 2006). However, the available research (e.g. Gairin et al, 2003) also indicates that the drop out rates following the first presentation in the emergency units are very high. Hepp et al (2004) reviewed the existing empirical evidence for a variety of psychological and psychosocial interventions used following a suicide attempt and concluded that any new approach for suicidal patients should involve

elements that focus on enhancing therapeutic alliance and take cognizance of the generally low rates of attendance for aftercare services following an attempt. Practical constraints apart, stigma regarding seeking mental health services can be a powerful barrier that needs to be surmounted by the suicide attempter and his/her significant others (Lester & Walker, 2006; Pompili et al, 2005) in order to obtain professional help for managing issues underlying suicidal crises.

In the above context, rapid building of therapeutic alliance with the index person and his/her significant others during the short hospitalization period following attempt assumes paramount importance. It is expected that a strong initial alliance may help in minimizing perceived stigma associated with help-seeking and increase the likelihood that the index person and his/her caregivers would utilize mental health services in future (Gururaj & Isaac, 2003). It is in this background that an active, supportive, outreach stance is likely

to be helpful at the point of first contact with the attempter and his/her significant others. This often results in the need to depart from conventional therapy practices and makes the process similar to that of a crisis intervention (Roberts, 2000).

Almost all approaches in this context emphasize on facilitating understanding (meaning-making) of what has happened, active assistance in problem solving and support mobilization in order to bring down the intensity of intense emotional disturbance that characterize a suicidal crisis or it aftermath. Partializing the crisis, i.e., breaking it down into manageable smaller issues which can be addressed individually (Ragg, 2001) may be useful to overcome the initial impasse experienced by the client as well as his/her caregivers including the therapist.

Suicidal crises often arise in the context of feelings of entrapment, which is defined as inability (actual/perceived) to get away from an aversive environment after one has suffered a defeat, loss or humiliation (Gilbert & Allan, 1998). The arrested flight (cry of pain) model which uses entrapment as a key variable has three components, namely; sensitivity to cues that signal defeat/humiliation and result in overwhelming feelings of need to escape; a sense of being unable to escape and the sense that this state will continue indefinitely (Williams et al, 2005). Suicidal acts may be understandable as motivated by the need to stop unbearable psychological pain ensuing from this state (Schneidman, 1993). This means that the initial therapeutic activity needs to focus on discovering ways to make the pain at least slightly more bearable. What also needs to be kept in view is that suicidal crises are often interpersonal in nature (Stellrecht et al, 2006; Gururaj & Isaac, 2001; Vijayakumar, 2007) and also that the support of the family may be a critical factor in influencing follow-up rates for suicide attempters, especially in the Indian context. Clinical observations suggest that suicidal attempts often reflect an ongoing crisis -situation not only for the index person but also for the family per se. Dealing with emotional responses of significant others (following a suicidal attempt) that may range from over intrusiveness, anger,

shame, rejection, ambivalence or guilt can help the therapist in mobilization of support for the client (Birtchnell, 1983). This means that the therapeutic joining with the family and addressing the family's concerns becomes as important as joining with the index person.

The following case illustrates some of the issues discussed while providing a detailed experiential account of the nature of the therapeutic activity. The focus is on the initial contact characterized by rapid alliance building, reducing distress and empowering the client and the family. The primary goals in this beginning phase of the contact were to strengthen coping with ongoing stressors including the social/psychological impact of a suicidal attempt while reducing perceived stigma and enhancing open-ness to utilize mental health services so that longer term issues could be taken up subsequently.

Surviving a suicidal crisis: Illustration of therapy -process

Ms. A was referred from the causality ward in a general hospital where she was brought in following a suicidal attempt. The intake notes indicated that she was an 18 years old girl on the threshold from pre-university to college hailing from a Hindu, nuclear family belonging to a middle income, urban background. She happened to be the oldest child of her parents, the younger sib being a 14 years old brother. Ms. A was described to be reserved by nature and a bright student academically. There was no history of past psychiatric consultations or family history suggestive of any psychiatric disorder. It was reported that she had made an attempt to drown herself into a river the previous day and was rescued by a passerby. She was brought to the hospital by the rescuer. Subsequently, her family was contacted and the parents arrived at the hospital During the admission, it was learnt that she tried to kill herself as she felt that there was no hope of her family accepting her relationship with her boyfriend with whom she felt close. The family wanted to get the client discharged from the hospital the same day and was being argumentative with the staff about the same. The client was talking very little

with the family except moaning that she should have died. Following medical management, the family members were insisting on discharge. A brief assessment of suicidal risk was carried out in the emergency unit by the resident on duty. They were explained the risk for repeat attempts, need for vigilance and a referral was made for initiation of detailed assessment and appropriate psychological intervention. Given below is the account of the initial contact with the client and the family before discharge from the casualty, the total hospital- stay being two days.

Intervention

Empathizing with the family and seeking family support :
With the above information available from the intake notes, the therapist spoke with the parents briefly, empathized with them regarding their anguish about the event and their desire to get away from the hospital There was no attempt made to explore more information from them as they seemed to be angry and hostile. Instead the focus was merely to help them feel understood. At the end of this brief encounter, their consent was obtained for holding one session with the client separately with the explicit, mutually agreed objective of giving her a chance to understand what her parents were feeling. The therapist also agreed to try to understand why the client was "acting so stubborn". Being able to negotiate with the parents for holding on, for one session helped the therapist. It relieved the sense of not being able to do anything to help while opening up the possibility of having further sessions as needed, through developing an alliance with the client and her parents.

The first session with the client: The therapist began the session consciously suspending a judgmental attitude and focusing on an entry to the client's worldview. This was not an easy task. The family as well as the treating staff was constantly talking about the "foolishness" of such an act and the client's inability to withstand stress. Most of the time the session was spent in listening to the client. To begin with, it was basically listening to her silences and her tears. The therapist could psychologically connect to the client. This was by opening

oneself to the possibility that individuals sometimes feel utterly alone, un-understood or even misunderstood, although to the world around them the whole situation may look trivial and not worth fretting about and definitely not worth one's life. This stance helped the therapist in being able to reach out to the client and feel her pain. This in turn served the twin purposes of deepening the alliance while coming to understand the client's perspective better.

Feeling permitted to articulate her distress without the fear of being reprimanded, cajoled, persuaded, ridiculed, and trivialized or her control being taken away; the client spoke at length towards the middle of the session. Initially, she was only repeating that she did not want to live, wanted to kill herself. Later on, she started talking about issues which were distressing her. This could be achieved by not rushing in with reasons as to why life was worth living, how it would be a waste of all her dreams, how and why there could be hope in future or as to how these distressing thought were likely to be transient. Although there is nothing intrinsically wrong and sometimes definite merit in pursuing any of the above lines of dialogue in therapy, it was considered un-helpful at that point in the session. Metaphorically speaking, there is little hope of helping someone out of their misery without 'peeping into it/moving in a bit' and then moving out together. So, the predominant focus was a genuine desire to gain an insider's perspective. This arouses the fear of colluding with the clients about their suicidal wish and requires clarity in the therapist's mind. This clarity is to do with the understanding that suicidal wish is merely an expression of unbearable psychological pain from which one can see no escape, except suicide. It means distinguishing between empathizing with such a wish and agreeing to/approving of suicide as a course of action. The hope for discovering together other ways of alleviating this pain emerges when the therapist accepts the fact that under the given circumstances, at the given point of time, the pain is intolerable for the client. Unwillingness to acknowledge this and empathize with the death-wish while trying to prevent suicide tantamount to physically preventing a person in intense pain from moaning/screaming, without doing anything

for making the pain more bearable or at least acknowledging its presence and magnitude. On the face of it, it seems a simple point in therapy, often taken for granted. Yet, it may be inadvertently ignored when one becomes extremely anxious with the possibility of the client harming herself or is carried away by the seeming triviality of the trigger. The former induces a strong need to control the client's behaviours and feelings while ironically the suicidal crisis may actually be a reflection of struggle against the controls imposed from outside and a need to gain control over one's pain and one's life. The latter (the seeming triviality of the trigger) can cause empathic - failure in the therapist and result in inability of the client to move with the therapist to explore other options that can give her a sense of control.

The client opened up and spoke about how she felt emptiness in her life, not seeing any way of realizing what she thought was worth having in life. She described how she was unable to share any emotional issues with her parents in the last two years or so. She felt that they were only focused on her studying hard and getting a seat in a good medical college and were discouraging of her spending time talking to a friend of the opposite sex. She felt that she and her friend were able to share a lot of their dreams with each other about life and they had become emotionally close over a two year period. This was in the background of escalating criticisms by the parents. The suicidal crisis was precipitated by a series of events including the friend's family getting ready to shift to another town (for un-related reasons), more frequent meetings with the friend in anticipation of "missing the companionship", being "seen together" by a relative and being threatened by the parents (threats of her studies being discontinued and her being 'married off'). All these events happened within a span of two weeks. Ms A spoke about how she was "stuck", she could see no way of doing things that she cherished for herself (becoming a doctor and continuing to have her friend in her life) and she had this certainty looming large that she would be married off to someone in haste and that would mean an end of the life she aspired for herself and

that she could not prevent it from happening to her. She perceived her family to be an orthodox one and her parents as 'rigid and harsh' in imposing what they considered right. Also intermingled with this sense of "being stuck" was the pain of losing her hopes for being together with the friend at some vague point in future. They had only occasionally discussed the issue of their future together in general terms. It seemed to her that these hopes and dreams had filled a void in her life and there was nothing left to live for now. Added to all this, was the crisis following her attempt, in the form of her parents communicating to her that she would be house-bound for an indefinite period and never allowed to go any where alone. They were critical of her as they saw her bringing shame to the family. They were worried that the news of attempt had spread among relatives and people known to the family. She was also informed that her parents had contacted her friend following her suicidal attempt. He had apparently told them that he was shocked about the incident and that he would not be getting in touch with her. This added another dimension to the client's distress. She felt powerless, hopeless, alone, confused and invalidated. She felt very distressed by the fact that her suicide attempt had failed. This added to her sense of lack of control over the direction her life was taking.

There were times during this session where the therapist felt an urge to reassure/convince her that the situation was probably not as hopeless as she saw it to be. However, she stayed with the immediate goal of meeting the client in her own world and understanding her sense of entrapment, despair and hopelessness. By the end of the session, the client seemed to have moved from the position of "nothing can be done and I will kill myself" to asking the therapist (actually herself) as to what she could do. She allowed the therapist to help her to help herself and see if it would work. The possibility of sharing the distress with the family was explored. The client saw this to be a futile option and did not seem ready to give it a try. The therapist too felt that the client was not very unrealistic in her anticipation that the parents were not in a frame of mind then to listen to and empathize

with her. At this point, their difficulties in understanding her and supporting her were gently brought up to test whether the client could shift perspective slightly to see what was making them angry and upset. The client did seem able to feel their distress following her suicide attempt. A proposal was made regarding the therapist speaking to them and taking the chance of helping them understand at least "just a little bit" about her current mental state. The therapist wished to, but did not and could not promise that things would work out for her or that her parents would understand. She just let the client entertain the idea that the therapist was genuine in her desire to help her parents understand her emotions a little better, irrespective of the outcome. Client was pessimistic but probably felt less alone after having the therapist listened to her non-judgmentally. Incidents and emotions that the client was comfortable in letting the therapist disclose to the parents were explicitly discussed with her. This was to prevent breach of trust and retain her sense of control. This opened one small window of opportunity to paralyse the crisis by trying to diminish the sense of being un-understood by the parents and being alone.

Session with the parents: The therapist again started the session with the stance of connecting emotionally, in this instance with the parents. A large part of the session was spent in permitting them to speak about their anguish, their sense of humiliation and social embarrassment and their need to get the client discharged. The therapist conveyed understanding and respect for their decision. No insistence was made about need for continued contact. This was to avoid repetition of the pattern of interactions that had happened outside the session with the rest of the staff. The therapist also acted as a medium of communication between the client and her parents. She began with sharing those distressing emotions of the client, which the parents seemed more ready to understand/identify with. These included a sense of shame, guilt as well as the threat to her career aspirations. Only later on, the therapist moved on to describe more difficult feelings such as a sense of loneliness, loss of a relationship perceived to be an intimate one, invalidation of

that sense of closeness and the helplessness. All this was narrated while making it clear that the therapist understood their perspective too. The non-threatening interaction helped them in being able to peep into the client's worldview, without sharing the same. They were simultaneously able to see the therapist as empathetic. Their ideas about managing this crisis after taking discharge were explored. It turned out that their plan was basically to strictly confine her to home and plan her marriage within the next 6 months. They also were very preoccupied with their need to do some damage- control as far as the image of the family in the neighbourhood was concerned. The anticipated stigma of psychiatric consultation was also pressing them to seek discharge.

After exploring their concerns and sharing the client's mind-state; the therapist could shift attention to bring to light their hopes for their daughter, primarily in terms of her happiness and how best they could facilitate the same, in the given circumstance. The meaning of her suicidal act as a desperate attempt to end her pain was highlighted. It was also possible to discuss as to how the continuation of this sense of pain and powerlessness to do anything about it could make it difficult for her to move on and how the use of physical restraints and sense of being not understood could maintain her suicidal urges. This opened up the opportunity to discuss ways of handling her suicidal crisis including its aftermath in terms of its impact on her and the family as a whole. A need to alleviate her loneliness, estrangement and hopelessness through providing emotional support was stressed. The differences between intended, provided and perceived support were brought up. The family could also understand the necessity of involving her in the process of decision making about plans after discharge.

Joint session: A joint session with the client and her parents was held after communicating to the client that her parents were disturbed by her actions but were to some extent also aware of her desperation and that they were feeling anxious and hence wanted to take control of the situation by placing restraints. Basically, this was to sensitize her to the motives

underlying their actions and reactions. In the joint session, the therapist encouraged communication of feelings between the client and her parents and subsequently facilitated the provision of emotional support for her from the parents. The family was able to move on to here -and -now-issues. There was an exploration about ways of managing the reactions of others outside the family. The therapist actively participated in this process in terms of bringing in alternatives and encouraging them to think through the consequences of using each option. This was deemed appropriate as the emotional atmosphere was quite charged which made it difficult for the family to stay tuned to the multitudes of options. Although, this was not necessarily the most difficult issue, being able to jointly arrive at the least aversive option for handling this gave some sense of control back to the family as a unit. It also decreased the client's sense of alienation. Following this, it was possible to move on to facilitate the client's negotiation with the parents about her immediate future. The alliance with the client as well as the parents helped the therapist to help them see each other's perspectives while trying to move out of the deadlock. At the end of the session, the family was able to arrive at some tentative plans and decisions agreeable to all of them. One of these decisions was to postpone bringing up the issue of her marriage for at least one year, supporting her to get back to studies and encouraging her to talk about her feelings with them without being critical, to the extent possible. The therapist validated the psychological pain the client was going through. A crisis response plan (Rudd et al, 2006) was developed in collaboration with the client to manage any further escalation in distress during the interval period of 24 hours before the next outpatient appointment.

The parents agreed to facilitate the client to work through her ambivalences, confusion and sense of loss about the relationship with her friend and about her future, in thrice-weekly outpatient sessions for the next one week and probable less frequent sessions over the subsequent two weeks. The therapist intentionally did not bring up the possibility of sessions with the family as a unit at this point of time. The client and the family came on outpatient basis for subsequent sessions as planned. These are not described here as it is beyond the focus of the paper. The work in these sessions could be geared towards addressing the underlying individual and family issues.

Observations and reflections: Engaging with the family was as important in this context as working with the client individually. Suicidal crises being often interpersonal in nature can disturb the available support systems. Moreover, for an adolescent who is emotionally and practically dependent on the family, it becomes crucial to proactively mobilize support during crisis. The suicide attempt was seen as struggle against a sense of powerlessness. It was hence necessary to help client feel empowered. This was achieved in the joint session. Similarly, the family's 'non-cooperative behaviour' with the treating team was reframed in terms of their desperation and attempts to re-gain a sense of control over what was happening.

No formal/structured assessment of the family was possible before beginning intervention. The limited available time necessitated a lot of therapeutic work (single session each with client and parents and a joint session) in the course of a single day. The therapist had to set aside traditional mode of therapy in terms of having a one-hour session or not having more than one session in a day. Without some groundwork primarily in terms of developing an alliance before discharge, it seemed unlikely that the family would be open for taking professional consultations in future. This sense of urgency was not unrealistic in retrospect. The natural inclination to know a lot of details, to be on certain grounds before moving in the session had to be kept aside and dealt with internally. The situation warranted a here- and now focus and other issues (personality or family dysfunction) were left for later exploration. The therapist's stance was to flow with the situation as it unfolded and keep a limited goal for each session. It was an important strategy to have independent sessions with the client and the family and work on containing their intense emotions before having the joint session.

It was crucial for the therapist to be able to emotionally connect to the meaning and importance of the crisis from the patient's as well as the family's perspectives. Using an insider-perspective to deepen the alliance before trying to bring about a change was probably the most crucial aspect of the initial intervention.

This brief and yet intense encounter generated strong feelings in the therapist and required management of the same. Some of these were well anticipated such as frustration and anger towards the parents for threatening to impose severe restraints. These feelings were managed by staying aware, visualizing their difficulties and trying to understand the desperation underlying their behaviours. What was less anticipated was the sense of helplessness evoked following the session with the client. It was understood as partly stemming from the client's projection of her feelings with which the therapist was identifying. This helped the client to feel less burdened and alone with her feelings. A brief talking with a colleague between the sessions helped the therapist in maintaining objectivity without losing the empathetic stance.

The therapist had to remember that it was necessary to actively get involved in the process by initiating to bridge the communication gaps rather than fear the client's dependency on her. Similarly, the therapist also remained active during the decision making process within the family which was getting compromised due to intense emotions. Hopelessness and problem solving difficulties have been theorized to be causally related to suicidal behaviours and research suggests that these have both state and trait components and are likely to be at the highest levels in the midst of crisis (Hawton, 2005).This case too highlights the role of active involvement of the therapist especially in the beginning phase to help alter the realities and /or perceptions of realities that act as triggers for suicidal behaviours (Bilsker & Forster, 2003) while facilitating problem-solving.

Issues pertaining to meaning of life and uncertainties in life permeate psychotherapeutic work across clients presenting with a variety of problems (Baumeister, 1991) though these may or may not be explicitly addressed in the course of therapy. Suicidal crisis is one of the instances wherein these issues become the salient foci in therapy. The case was in a sense about encounter with the prospect of death and about the wish and the struggle to live one's life in a personally meaningful way. The client wanted to embrace death and came close to it as she felt she could not live life on her own terms. The themes involved grappling with meanings in life, making sense of what life brings , the awareness /realization of choices that we do have in life- in the face of death, what we do with such choices and how that can transform ourselves. This actually remains true for the clients as well as therapists, inside as well as outside the boundaries of therapy space.

CONCLUSION

The paper highlights the importance of the role of internal dialoguing within the therapist for rapid deepening of therapeutic alliance, reducing real life pressures, widening options/psychological sense of choice and helping movement towards adaptive fulfillment of basic unmet-needs in suicidal individuals as well as their families.

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EFFICACY OF NEUROFEEDBACK IN OBSESSIVE COMPULSIVE DISORDER

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ABSTRACT

Background: There is scant literature on efficacy of neurofeedback in obsessive compulsive disorder (OCD). **Objective:** To study the efficacy of adjunctive neurofeedback in OCD patients in comparison with patients on pharmacological treatment alone. **Method:** Ten patients aged 18-50 years with a diagnosis of OCD according to ICD-10 Diagnostic Criteria for Research and giving written informed consent were randomly assigned to experimental (n=5) and control group (n=5). All patients were rated on Yale Brown Obsessive Compulsive Scale (YBOCS), Hamilton Rating Scale for Anxiety (HAM-A), Hamilton Rating Scale for Depression (HAM-D) and Beck's Depression Inventory (BDI) at baseline and at follow-up after 3 months. The experimental group received 15 'one hour' sessions of neurofeedback in addition to ongoing pharmacotherapy. **Results:** Two-way repeated-measures ANOVA showed no difference in YBOCS obsession and compulsion scores, BDI and HAM-D scores over time between the groups, whereas for HAM-A scores, treatment x time interaction was significant ($F(1,8)=14.55$, $p=.005$) with a large effect size ($n^2=.645$). **Conclusions:** The findings from our study suggest that adjunctive neurofeedback in OCD patients do not improve OC symptoms or depression, but improves non-specific anxiety.

Key words: *Obsessive compulsive disorder, depression, anxiety, EEG biofeedback, neurofeedback.*

INTRODUCTION

Obsessive compulsive disorder (OCD) is a psychiatric disorder characterized by recurrent obsessions or compulsions and often tends to run a chronic course. The obsessions or compulsions are time consuming and interfere significantly with the person's normal routine, occupational functioning, social activities or relationships, thus impairing quality of life (Gururaj et al, 2008). Treatment strategies include serotonin reuptake inhibitors or cognitive behaviour therapy. Although these treatments reduce obsessive compulsive symptoms by 30% to 50%, they do not induce complete remission (Greist, 1990; Marazziti & Consoli, 2010). Surgical treatment such as cingulotomies have benefitted 25% to 30% patients only (Ackerman & Greenland, 2002) and entail high cost and significant post- surgical risk of complications and morbidities. There is a search for alternate treatment strategies in OCD such as biofeedback (Hammond, 2003), transcranial magnetic stimulation and deep brain stimulation (Malhi & Sachdev, 2002).

Biofeedback is a therapeutic method in which information about an individual's physiological process, such as blood pressure, heart rate, brain waves, temperature of extremities, or muscle tension, is monitored electronically and respond back by means of sounds, lights, or electronic measures. It has been found that using these techniques, individuals learn to control a variety of physiological responses which were formerly thought to be completely involuntary and thereby deal more effectively with stress reactions such as anxiety and pain. Basic research done back in the 1960s established that it was possible to train the brain by rewarding the production of certain brain wave patterns (Sterman, 1996).

In the late 1960s and 1970s, biofeedback researchers worked on training alpha and theta brainwave activity for relaxation; such training is known as 'EEG biofeedback' or 'neurofeedback'. This is one of the fastest growing areas in the field of biofeedback, mostly due to improvement in instrumentation and software that have provided the means

to quickly perform mathematical analysis of brain waves, so that biofeedback about the EEG characteristics can be provided within fraction of a second following their detection. Electricity is constantly produced in the neurons as they communicate with each other and EEG provides a method of monitoring that activity. The EEG sensor records a raw EEG signal which is constantly varying difference of potential between the positive and negative electrode, and the software processes that signal by applying a variety of digital filters to the recorded signal, in order to extract frequency-domain information.

Along with general medical conditions, neurofeedback is so far found to be effective in several psychiatric conditions such as depression (Hammond, 2001), attention deficit/hyperactivity disorder (Monastra et al, 2002), substance abuse (Prichep et al, 1996), and epilepsy (Walker & Kozolwski, 2005). The advantage of neurofeedback over other effective interventions, such as medication or behaviour modification, is that the improvements associated with treatment generalize, i.e., the effects are seen not only while the person's brain activity is being monitored and they are getting feedback in the form of auditory and visual displays on the computer, but also persist subsequently after receiving sufficient training. Neurofeedback appears to provide accumulated benefits to participants which can be applied in their day to day life and it may also help them to be more focussed, in greater control and feel clinically better (Michael et al, 2005).

Based on qEEG studies, OCD patients have been sub-typed and preferential response have been documented with medications or psychotherapy (Prichep et al, 1993). There have been very few studies that have explored neurofeedback in OCD patients; these studies were poorly designed, with small sample size, without using adequate control or rating procedures or used only brief neurofeedback techniques (Mills & Solyom, 1974; Moore, 2003; Hammond, 2003; Hammond 2004). Although neurofeedback seems to hold promise and is less invasive than other methods, there is insufficient evidence that biofeedback is more effective than other relaxation techniques.

Lack of substantial research evidence on the efficacy of neurofeedback on OCD encouraged us to carryout the present study. The objective of our study was to examine the effectiveness of adjunctive neurofeedback in OCD patients in comparison with patients on pharmacological treatment alone. We undertook the null hypothesis that there will be no significant difference in obsessive-compulsive symptoms in patients undergoing neurofeedback plus pharmacological treatment than pharmacological treatment alone.

METHODOLOGY

Participants

This was a prospective study carried out at Central Institute of Psychiatry, Ranchi, India, a tertiary referral hospital. Study sample consisted of 10 patients in age range of 18 to 50 years having OCD according to ICD-10 Diagnostic Criteria for Research (WHO, 1993) and giving written informed consent. Those with comorbid major medical or psychiatric illnesses were excluded from the study. The patients were randomly assigned to neurofeedback group (n=5) or control group (n=5).

Assessment

Socio-demographic and clinical details were gathered using a specially designed proforma. Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al, 1989) was used to rate the severity of obsessive and compulsive symptoms. The clinician-administered Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960) and self-administered Beck Depression Inventory (BDI; Beck et al, 1988) were used to assess objective and subjective depressive symptoms, respectively. To assess anxiety symptoms, Hamilton Anxiety Scale (HAM-A; Hamilton, 1969) was used. Assessment in both the groups was done on YBOCS, BDI, HAM-D and HAM-A at baseline and after 3 months at follow-up. The rater was blind to the treatment allocation of the patients. The control group patients were provided with psychological management after follow-up period was over.

Neurofeedback Intervention

Neurofeedback treatment was administered with the patient sitting comfortably in a quiet room using an eight channel multi-modality biofeedback machine (Thought Technology Ltd., Quebec, Canada). It consisted of BioGraph Infiniti Multimedia Software and ProComp Infiniti Encoder Hardware as encoding and processing devices. Eight channels used in this system involve: Surface Electromyography (sEMG), Electrocardiography (EKG), Electroencephalography (EEG), Skin Conductance, Peripheral Temperature, Blood Volume Pulse, Respiration Amplitude, Goniometer Adapter or Force Adapter. Present study was done on Hi Alpha Template using EEG-Z type Sensor (Thought Technology, 2003). The experimental group underwent 15 'one hour' sessions of biofeedback at least thrice in a week with maximum of five sessions per week. Following the sessions, they were instructed to practice relaxation without the feedback instrument in their own home.

Statistical analysis

The data obtained were analyzed with Statistical Package for Social Sciences-version 10.0 for Windows® (SPSS Inc., Chicago, IL, USA). Normality of data was assessed using histogram and Shapiro-Wilk test. Fisher's exact test and independent sample t test were conducted to compare categorical and continuous variables, respectively. A two-way repeated-measures ANOVA was conducted using group (experimental and control) and time (baseline and after three months) as factors. Effect size was calculated as eta squared (n^2). An alpha level of 0.05 was considered significant.

RESULTS

Sample characteristics have been summarized in tables 1a & 1b. Mean age of patients in experimental group was 27.40 (SD 7.13) years and in control group was 30.20 (SD 5.45) years. There was no difference in socio-demographic and clinical variables between the two groups. The repeated-measures ANOVA for clinical scores are presented in table 2. For YBOCS obsession and compulsion scores, there was

significant improvement over time in both the groups (p<.001), but treatment x time interaction was not significant. Similarly, depression as measured by BDI and HAM-D scores improved over time in both the groups (p<.001), whereas treatment x time interaction was not significant. Nevertheless, HAM-A scores improved over time in both the groups (p<.001), and treatment x time interaction was significant (F(1,8)=14.55, p=.005, n^2=.645) (fig 1). There was no adverse event reported by any patient.

Tables 1a : Sample characteristics

Variables	Experimental (N=5) Mean (SD)	Control (N=5) Mean (SD)	t (df=18)	p
Age	27.40 (7.13)	30.20 (5.45)	- 0.69	.51
Education years	11.60 (2.88)	12.60 (3.36)	- 0.70	.63
Duration of illness in yrs.	5.80 (1.79)	6.60 (1.82)	- 0.51	.50

Tables 1b: Sample characteristics

	N (%)	N (%)	Fisher's exact significance
Sex			
Male	3 (60)	3 (60)	p = 1
Female	2 (40)	2 (40)	
Marital status			
Single	3 (60)	2 (40)	p = 1
Married	2 (40)	3 (60)	
Family type			
Nuclear	5 (100)	2 (40)	p = .17
Extended	0	3 (60)	
Habitat			
Rural	1 (20)	2 (40)	p = 1
Urban	4 (80)	3 (60)	

Figure 1: Change in HAM-A scores over time in experimental and control group
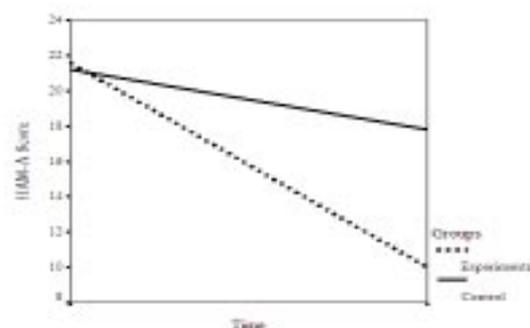
Table 2: Repeated measures ANOVA showing changes in mean Y-BOCS, BDI, HAM-D and HAM-A scores in experimental and control groups

Outcome measures	Experimental (N = 5) Mean (SD)	Control (N = 5) Mean (SD)	Group Effect	Time Effect	Group x Time Interaction
YBOCS obsessions					
Baseline	15.60 (1.82)	15.40 (3.29)	$F(1,8)=0.02$	$F(1,8)=54.54^{***}$	$F(1,8)=0$
Post-intervention	11.20 (0.84)	11.00 (2.65)	$p=.89$	$p<.001, n^2=.872$	$p=1$
YBOCS compulsions					
Baseline	13.00 (3.08)	15.80 (2.49)	$F(1,8)=5.56^*$	$F(1,8)=112.13^{***}$	$F(1,8)=1.20$
Post-intervention	6.60 (1.14)	10.60 (2.61)	$p=.046$	$p<.001, n^2=.933$	$p=.31$
BDI					
Baseline	13.40 (2.88)	15.00 (4.58)	$F(1,8)=0.28$	$F(1,8)=82.65^{***}$	$F(1,8)=0.37$
Post-intervention	9.20 (4.21)	10.20 (3.90)	$p=.61$	$p<.001, n^2=.912$	$p=.56$
HAM-D					
Baseline	17.20 (5.93)	15.00 (2.92)	$F(1,8)=0.27$	$F(1,8)=82.65^{***}$	$F(1,8)=0.57$
Post-intervention	9.60 (6.88)	8.60 (3.71)	$p=.62$	$p<.001, n^2=.859$	$p=.56$
HAM-A					
Baseline	21.60 (2.61)	21.20 (3.70)	$F(1,8)=4.19$	$F(1,8)=48.70^{***}$	$F(1,8)=14.55^{**}$
Post-intervention	10.00 (4.12)	17.80 (2.59)	$p=.075$	$p<.001, n^2=.859$	$p=.005, n^2=.645$

*$p<.05$, **$p<.01$, ***$p<.001$

DISCUSSION

In our study, there was no effect of EEG neurofeedback intervention over time on either obsessions or compulsions. Also, it did not improve associated depressive symptoms. Nevertheless, anxiety symptoms improved following EEG neurofeedback intervention (p=.005) and the effect size for the treatment effect was large. This is in contrast to previous studies (Hammond, 2003; 2004) that have found significant improvement (a 2.2 SD improvement in YBOCS score), which was maintained at 10 month follow-up assessment. These were case studies consisting of only one or two cases (Hammond, 2003; 2004) without any control group that limits generalizability of the results.

Participants in the experimental group of the current study were five, which is similar to previous research in which the average number has been approximately 6.25 per study (Moore, 2000). In our study, 15 sessions of neurofeedback were administered based on available literature that has been found to be sufficient enough to produce a change in the patients. Also, double-blinding procedure controlled rater bias in assessment of psychopathology.

Interoceptive sensitivity has been postulated to play a key role in the etiology and maintenence of anxiety disorders. Interoception has been defined as conscious awareness, emotional awareness and behaviour related to afferent physiological information arising from body and involves parameters like heart rate, respiration, blood pressure, gastrointestinal and genitourinary activity (Craig, 2009). Patients with anxiety disorders have been noted to have increased heart beat interoceptive sensitivity as compared to normal controls. Moreover, they have increased right insular and cingulate activation as demonstrated in fMRI studies (Pollatos et al, 2007). It has been hypothesized that biofeedback might help people with anxiety disorders who observe inaccuracies in perceiving physiological activity and to strengthen perception when actual somatic changes occur (Story & Craske, 2008). Yet another potential area is the possibility of interoceptive sensitivity serving as an intermediate phenotype or endophenotype for identification of anxiety disorders including OCD (Domschke & Deckert, 2009), which may be used to screen candidates who would respond preferentially to biofeedback rather than medications.

The findings from our study suggest that adjunctive neurofeedback in OCD patients do not improve OC symptoms or depression, but improves non-specific anxiety. Limitations in our study include small sample size that might have reduced the power to detect a true difference. There remains a possibility of confounding factors such as drowsiness, medications, caffeinated drinks, changes in emotional state or arousal, eye movement artefacts, time of day and state of alertness that might influence the efficacy of neurofeedback (Rosenfeld et al, 1996). Further studies are warranted to explore the efficacy of neurofeedback for the treatment of OCD in larger double-blind randomized controlled trials.

Declaration of Interest: None.

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GENDER DIFFERENCE IN SYMPTOM PROFILE OF SCHIZOPHRENIA

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ABSTRACT

Background: Schizophrenia remains a heterogeneous disorder, more so when compared across genders. Beginning from prevalence and incidence rate upto the outcome, several studies have been done with less of corroborativeness and more of contradictions. This study aims at assessing the diverse factors of psychopathology in schizophrenia using more comprehensive tools to ascertain gender differences in symptom profile of schizophrenia and to fill in the lacunae existing in knowledge of current topic. **Methodology:** 68 patients (44 males and 24 females) with schizophrenia were evaluated for illness history, subtypes, positive symptoms, negative symptoms, depressive symptoms and side effects by administering the socio-demographic data sheet, Positive and Negative Syndrome Scale (PANSS), Hamilton Depression Rating Scale (HDRS) and UKU side effect scale. **Results:** Females were diagnosed more frequently with paranoid type and males were diagnosed more frequently with undifferentiated type. Females were more likely to be married. There was no significant difference, either on global or separate subscales. However, on item wise comparison, grandiosity, tension and anxiety were significantly higher in females. Similarly, impulsivity and active social avoidance were higher in males. **Conclusion:** Our study supports the conflicting results across gender studies and thus refutes the claim that there are consistent clinical differences across gender in population of schizophrenia.

Key Words: *Schizophrenia, gender difference, positive symptoms, negative symptoms, depression.*

INTRODUCTION

Right from primitive forms of life, though more clearly observed in higher evolutionary forms of life, there have been distinct and conclusive differences in expression, role and power issues across gender. From an evolutionary point of view, this may be explained as the consequence of sexual selection.

This difference had to have some bearing on the expression of illness as well and psychiatric disorders were no exceptions. As early as 1911, Bleuler reported late age of onset in female patients with schizophrenia. Earlier studies focused on age of onset of schizophrenia and till date, the earlier age of onset in males by 3-5 years has been most robust and consistent finding (Leung & Chue, 2000). Though known for so long, this subject has gained importance in research over last two decades, aimed primarily at understanding the heterogeneity in schizophrenia.

Studies regarding symptomatological differences are more contradictory. Initial studies reported significant gender differences in symptoms of schizophrenia (Goldstein & Link,

1988; Hass et al, 1989). Ring et al (1991) reported predominance of negative symptoms in males and other studies have found that women with schizophrenia displayed more affective symptoms (Goldstein & Link 1988;Szymanski et al,1995). However, studies conducted more recently offered conflicting results (Andia et al, 1995; Shtasel et al, 1992). Earlier, Marneros (1984) reported first rank symptoms to be more frequent in females, a finding replicated by Rector and Seeman (1996) though Lindamer et al (1999) determined no overall sex difference in severity of negative symptoms. Studies also indicated that due to more affective, atypical and cyclical symptoms in women, there is less diagnostic concordance for women than men (Bardenstein & McGlashan, 1990; Chen et al, 1996).

Current focus is on role of gender on implication for therapy and it has been stated that we need a more gender sensitive therapeutic attitude (Reicher-Rossler & Hafner, 2001).

Due to heterogeneity of schizophrenia per se, gender differences in schizophrenia are a valuable paradigm for research into the interplay between biological and

psychosocial factors. The analysis of gender specific influences can help further understanding of complex pathogenic mechanisms and can give valuable clues to potential new directions in therapy. This is possible because gender differences are determined often by biological as well as psychosocial factors and the complex interplay of both.

With regard to symptomatology, we have more contradictions than clarifications. This might be partly due to methodological problems in earlier studies, for example, population examined were not controlled for depression, co-occurrence of extra pyramidal side effects and duration of illness was not matched which is bound to have its bearing on assessment of negative symptoms. Apart from this, Indian studies highlighting this issue are scarce and the results were inconclusive and the finding that males have more core symptoms was statistically not significant (Thara & Joseph, 1995).

METHODS

The present study was a cross sectional hospital based study. The subjects were recruited for study by purposive sampling technique. The study was conducted at Central Institute of Psychiatry, Ranchi, a post-graduate teaching hospital with 673 beds and additional out patient and emergency department. The outpatient department gives commutation to more than 45,000 patients per year. Patients were included if they (a) met DSM-IV (APA, 1994) criteria for schizophrenia (b) were between ages of 18-60 years (c) had duration of illness between 6 months and 2 years (d) had not met criteria for any comorbid psychiatric illness including substance abuse/ dependence (f) had no significant medical illness.

During the period of ten months, 68 subjects (44 males and 24 females) who met inclusion criteria and gave informed consent were taken up for the study. Information on patient demographics (age, sex, education), past history and premorbid personality was obtained from interviews with patients and family members. A detailed physical examination was done to exclude the presence of any organicity accounting for psychiatric manifestation. Each patient was then assessed on PANSS, HDRS and UKU side effect scale. In this study,

some methodological improvements were done over previous studies: (1) Age range was kept between 18-60 years to incorporate the subjects with late - onset schizophrenia (2) To allow sufficient time for the symptoms of the acute disorders to appear, be recognized, and largely subside before a diagnosis of schizophrenia was made, the minimum duration of illness was kept 6 months. (3) Keeping in mind the suggestions that negative symptoms may become steadily more prominent and findings of outcome studies (ICMR, 1988) revealing that most of the symptoms subsided after 2 years, the maximum duration of illness was kept 2 years. (4) UKU side effect scale was used as an instrument to rule out excess of negative or depressive symptoms secondary to medication. (5) To give a comprehensible comparison of depressive symptomatology HDRS was used. Data thus collected from 68 subjects was analyzed using Statistical Package for Social Sciences (SPSS) 10.00 for Windows 98 version. Frequency analysis was done as a part of descriptive statistics, to describe the sample in terms of socio-demographic and clinical characteristics. Subsequently, Chi-square test was used to analyze categorical variables to know the group differences between male and female subjects.Independent samples t-test was used to compare the continuous variables between male and female subjects.

RESULTS

The frequency distribution of socio-demographic characteristic of sample was as follows: Majority of samples were less than 25 years of age (47.1%) though age group 25-40 years also formed a large group (44.1%). 64.7% were males and 35.3% were females, most of them were married (64.7%), educated for less than 10 years (79.5%), unskilled (88.2%), and only 20.6% had positive family history for schizophrenia. Majority (92.6%) was well adjusted premorbidly and in the majority, the diagnosis was paranoid schizophrenia (50%), followed by undifferentiated (47.1%) schizophrenia. More of the females were married (75% vs 59.1%), unskilled (95.8% vs 84.1%), belonged to upper class (20.8% vs 4.5%), had greater percentage of family history for schizophrenia (25% vs 18.2%) and majority had paranoid

subtype (62.5% vs 43.2%) whereas men were more educated, belonged to lower class (59.5% vs 41.7%) though none of the findings was significant (Table 1).

Table 1: Frequency distribution of socio-demographic characteristic of samples

Variables	Male n (%)	Female n (%)	x^2	p
Age (years)				
< 25	21 (47.7)	11 (45.8)		
25-40	19 (43.2)	11 (45.8)	5.885	.881
> 40	4 (9.1)	2 (8.3)		
Marital status				
Single	18 (40.9)	6 (25.0)	1.721	.190
Married	26 (59.1)	18 (75.0)		
Education (years)				
< 5	14 (31.8)	10 (41.7)		
5-10	21 (47.7)	7 (29.2)	2.227	.418
> 10	9 (20.5)	7 (29.2)		
Occupation				
Unskilled	37 (84.1)	23 (95.8)	2.063	.151
Skilled	7 (15.9)	1 (4.2)		
Socioeconomic status				
Low	26 (59.1)	10 (41.7)		
Middle	16 (36.4)	9 (37.5)	4.898	.169
Upper	2 (4.5)	5 (20.8)		
Family history of schizophrenia				
Absent	36 (81.8)	18 (75.0)	0.442	.506
Present	8 (18.2)	6 (25.0)		
Permorbid personality				
Well adjusted	41 (93.2)	22 (91.7)	.052	.819
Abnormal	3 (6.8)	2 (8.3)		
Diagnosis				
Paranoid	19 (43.2)	15 (62.5)		
Undifferentiated	24 (54.5)	8 (33.3)	5.023	.128
Catatonic	1 (2.3)	0 (0.0)		
Disorganized	0 (0.0)	1 (4.2)		

On comparison of the scores of male and female subjects across PANSS, males scored higher on PANSS total, PANSS positive symptoms, PANSS negative symptoms and items of general psychopathology. Comparison of the scores of male and female subjects across items of positive symptoms in PANSS revealed females exhibiting significantly higher (p = 0.008) level of grandiosity (2.04 ± 0.91 vs 1.45 ± 0.82) and also showed higher level of excitement which was not significant whereas males exhibited higher levels of delusion, conceptual disorganization, hallucinatory behaviour, persecution and hostility but again findings were not significant. Females scored more on difficulty in abstract thinking whereas males scored more on items blunted affect, emotional withdrawal, poor rapport, passive/apathetic, lack

of spontaneity and stereotyped thinking but none of the findings were significant. Males exhibited significantly higher level of motor retardation (1.75 ± 1.10 vs 1.12 ± 0.35, p = 0.009) and poor impulse control (2.11 ± 0.94 vs 1.58 ± 0.83, p = 0.024) and a trend towards active social avoidance (2.04 ± 1.10 vs 1.54 ± 0.98, p = 0.065) whereas females scored significantly higher for somatic concern (1.43 ± 0.82 vs 2.04 ± 0.91, p = 0.006) and tension (1.18 ± 0.49 vs 1.70 ± 0.80, p = 0.001). Females also scored higher on items of depression though it was not significant (Table 2).

Table 2: Group differences of PANSS (total, subscore and item wise) scores between male and female subjects

Variables	Male (Mean±SD) (N=44)	Female (Mean±SD) (N=24)	t	p
Delusion	4.64±1.40	4.62±1.55	0.031	0.976
Conceptual disorganization	2.70±1.77	2.50±1.89	0.444	0.658
Hallucinatory behaviour	3.59±1.40	3.04±1.49	0.971	0.136
Excitement	1.77±1.07	1.92±0.97	-0.545	0.588
Grandiosity	1.45±0.82	2.04±0.91	-2.717	0.008**
Persecution	4.29±1.41	4.12±1.36	0.483	0.631
Hostility	2.34±0.91	2.12±0.90	0.963	0.353
PANSS (positive)	20.79±2.94	20.37±2.99	0.560	0.578
Blunted affect	2.73±1.78	2.21±1.67	1.173	0.245
Emotional withdrawal	2.09±1.22	1.96±1.20	0.432	0.667
Poor rapport	2.50±1.11	2.50±1.21	0.000	1.000
Passive/apathetic	2.04±1.01	1.92±1.41	0.435	0.665
Difficulty in abstract thinking	2.41±1.60	2.46±1.77	-0.117	0.907
Lack of spontaneity	2.36±1.14	2.08±1.02	1.003	0.319
Stereotyped thinking	1.61±0.81	1.46±0.72	0.782	0.437
PANSS (negative)	15.75± 7.08	14.58±7.07	0.650	0.518
Somatic concern	1.43±0.82	2.04±0.91	-2.825	0.006**
Anxiety	1.75±0.92	2.00±0.78	-1.129	0.263
Tension	1.18±0.49	1.70±0.80	-3.338	.001**
Depression	1.59±0.84	1.67±0.92	-0.343	0.733
Motor retardation	1.75±1.10	1.12±0.34	2.701	0.009**
Poor impulsive control	2.11±0.94	1.58±0.83	2.305	0.024*
Active social avoidance	2.04±1.10	1.54±0.98	1.877	0.065
PANSS (General)	34.20±5.43	32.96±5.79	0.883	0.380
PANSS total	70.75±11.63	67.92±11.93	0.951	0.518

Significant at p < 0.05 (2 tailed), ** Significant at p < 0.01 (2 tailed)

On comparison of scores on HDRS, females scored higher though difference was not significant. On item-wise comparison, men exhibited significantly higher level of retardation (0.66 ± 0.94 vs 0.17 ± 0.38, p = 0.003), insomnia (0.41 ± 0.58 vs 0.08 ± 0.28, p = 0.012) and tiredness and pains (0.39 ± 0.54 vs 0.08 ± 0.28, p = 0.012). Females exhibited

significant decrease in sexual interaction (0.83 ± 0.81 vs 0.36 ± 0.65, p = 0.012) and higher level of depressed mood and suicidal impulse which were not significant (Table 3).

Table 3:   Group differences of HDRS items between male and female subjects

Variables	Male (Mean±SD) (N=44)	Female (Mean±SD) (N=24)	t	p
Depressed mood	0.61±0.81	0.66±0.91	-0.246	0.807
Suicidal impulsive	0.27±0.62	0.37±0.65	-0.638	0.526
Retardation	0.66±0.94	0.17±0.38	2.455	0.003**
General somatic	0.11±0.39	0.04±0.20	0.848	0.400
Sexual interact	0.36±0.65	0.83±0.81	-2.597	0.012*
Insomnia	0.41±0.58	0.08±0.28	2.570	0.012*
Tiredness and pains	0.39±0.54	0.08±0.28	2.569	0.012*
HDRS total	22.23±8.44	23.46±5.82	-0.636	0.527

 * Significant at p < 0.05 (2 tailed), ** Significant at p < 0.01 (2 tailed)

DISCUSSION

The sample study showed that most common diagnosis was paranoid subtype (50%) followed closely by undifferentiated sub type (47.1%).In agreement to the study of Andia et al (1995) in which they found women were diagnosed more frequently with paranoid type (40.6% vs 13.2%) and men were diagnosed more frequently with undifferentiated type (62.3% vs 18.8%), current study exhibited paranoid subtype to be more common in females (62.5% vs 43.2%) and undifferentiated subtype to be more common in males (54.5% vs 33.3%). However, Usall et al (2001) in their study found no gender difference among sub types of schizophrenia.

In accordance to study of Andia et al (1995) and Usall et al (2001), greater proportions of married subjects in the current study were females (75% vs 59.1%), which might indicate a better social outcome, or may be the consequence of a later age at illness onset.

Most remarkable finding in the current study was that there was no significant difference in symptomatology, neither in total score nor in separate subscales like positive subscale, negative subscale or general psychopathology sub scale.

The findings for positive symptoms was in accordance with earlier studies by Shtasel et al (1992), Hafner et al (1993), Kendler & Walsh (1995), Riecher-Rossler & Hafner (2000), Usall et al (2001). However, for negative symptoms, earlier

studies by Shtasel et al (1992), Ring et al (1991), Cowell et al (1996), Maric et al (2003) and Szymansky et al (1995) have reported predominant negative symptoms in males though Andia et al (1995), Usall et al (2001) and Lindamer et al (1999) reported no gender difference in expression of negative symptoms. Such conflicting results might be attributed to difference in rating scales employed.

More interesting findings were apparent when item-wise comparison was made in above mentioned subscales and significant differences were found in areas of grandiosity, tension and anxiety, these entire domains being higher in females. This was in accordance with findings of Szymanski et al (1995) and Seeman & Fitzgerald (2000) though Usall et al (2001) reported significantly higher grandiosity in men, thus again indicating a lack of consistent clinical differences between men and women.

Men exhibited significantly higher level of impulsivity and active social avoidance, findings similar to studies of Haas et al (1989) and Cowell et al (1996) and easily explained by stereotypic and gender roles model.

Other consistent findings that could not be replicated in our study were excessive experience of auditory hallucinations as reported by Marneros (1984), Gur et al (1996) and Rector & Seeman (1996). Our study found no significant difference in experience of auditory hallucinations across genders. This could be explained by many reasons; first and foremost, hallucinations are not objectively verifiable but assessed primarily from subjective reports, their measurement is sensitive to variations in the ability or motivation of patients to recall and verbally express psychotic experiences. Overall, scale employed by us assessed hallucinatory behaviour and not an experience of auditory hallucination. Even we cannot rule out an insidious referral bias i.e., a different threshold across gender resulting in unequal severity of illness. And last but not the least, treatment done and duration as a confounding factor must have maximized the artifacts for this particular assessment.

Goldstein et al (1990) and Bardenstein & McGlashan (1990) reported significant level of depression in females. Results of the current study showed excess of depression in both general subscale of PANSS and HDRS but it was not significant (p = 0.733 for PANSS Table 2, p = 0.807 for HDRS

Table 3). This difference could be explained by the fact that our female samples exhibited significantly higher level of grandiosity (p = 0.008) and at the same time exhibited higher level of excitement though not significant and more importantly, males showed significantly higher level of motor retardation both on items of PANSS general (p = 0.009) and HDRS (p = 0.003), which cannot be explained only on basis of high UKU score on item of Akinesia (0.64 ± 0.97 vs 0.04 ± 0.20 p = 0.004). These confounding components working in tandem might have made experience of depression higher for females unlikely.

To conclude, our study supports the conflicting results across gender studies and thus refutes the claim that there are consistent clinical differences across gender in population of schizophrenia. Nonetheless, it also emphasized that gender difference in schizophrenia are an ideal window to look at the interplay of biological and psychosocial factors.

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FAMILY FUNCTIONING IN ADOLESCENT BIPOLAR DISORDER

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ABSTRACT

Background: Few studies exploring family functioning in adolescent bipolar disorder have reported conflicting findings and were characterized by methodological limitations. **Aim:** The present study aimed to examine the relationship of family functioning in bipolar affective disorder among adolescents. **Methodology:** Family functioning of 30 adolescent patients diagnosed with bipolar disorder was assessed using McMaster Family Assessment Device (FAD) and compared with normal controls. **Results:** There were significantly higher levels of family dysfunction found among the families with bipolar adolescents in all domains including problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning. **Conclusions:** From the study it was evident that family functioning may have an important association with bipolar disorder among adolescents which should be considered in their assessment and management.

Key Words: *Family functioning, bipolar affective disorder, adolescents.*

INTRODUCTION

Bipolar disorder is a familial disorder, which is influenced by genetic and environmental factors (Althoff et al, 2005). Early onset bipolar disorder can be caused or precipitated by various factors, e.g. genetic predisposition, personality factors and socio-environmental factors like family relations, social networks, peer influences, culture and beliefs. Parents shape the lives of their children from birth to adulthood. Though the influence of friends gain importance in adolescence, parents still continue to exert their influence in shaping the behaviours and choices of teens. Close parent/adolescent relationships, good parenting skills, shared family activities and positive parent role modeling have well-documented effects on adolescent health and development (Singh & Singh, 2001).

Family is a system organized around the support, regulation, nurturance and socialization of its members (Minuchin, 1974). Problematic interactions and dysfunctions in the family may act as a causative and maintaining factor for different mental and behavioural disorders. A varied pattern of family dysfunctions are found among different mental disorders. Lower level of affective responsiveness and cohesion and a higher level of conflict are found in families of patients with posttraumatic stress disorder (Solomon et al, 1987). High degree of affective involvement is found in families of patients with anxiety disorders (Frey & Oppenheimer,1990). A significant association between self-reported depressive symptomatology and perceived poor family functioning is found in families of patients with eating disorders (Fornari et al, 1999) whereas roles and affective responsiveness are found to be problematic in families of adolescents with substance abuse (McKay et al, 1991).

There is limited research exploring family functioning in bipolar disorders. Miller et al (1986) found no significant difference in family functioning between families of adults with bipolar disorders in comparison to normal controls. On the contrary, Chang et al (2001) showed that in families in which one or both parents had bipolar disorder reported more conflict, less cohesion and less organization in comparison to normal controls. Fewer studies done in children and adolescents have also given conflicting results. Robertson et al (2001) did not find any difference in family interaction between families of euthymic bipolar adolescents and normal controls. However, Bellardinelli et al (2008) found low levels of cohesion, expressiveness, intellectual- cultural orientation, active recreational orientation and high levels of conflict in families of bipolar children in comparison to that of normal controls.

Variations in assessment tools, study samples and overall findings had given rise to the need to attempt a clear understanding of the distinct pattern of family functioning in children and adolescents with bipolar disorder. Hence, the current study was planned. The aim of the study was to

examine the pattern of family functioning in bipolar affective disorder adolescents in comparison to normal controls.

METHODS

The present study was a cross sectional hospital based study conducted at the Centre for Child and Adolescent Psychiatry of Central Institute of Psychiatry (CIP), Ranchi from 2008- 2009. The present study included 60 adolescents, among which 30 were diagnosed of bipolar affective disorder and 30 were matched normal controls. The adolescents with bipolar disorder and their families were selected by using purposive sampling. The adolescents without bipolar disorder and their families were selected from a school in the nearby locality. The patients between age range of 13 to 18 years, fulfilling the criteria for bipolar disorder according to ICD- 10 - DCR (WHO, 1993) and staying with the parents at least for last two years were included in the study. The patients with comorbid mental illness, neurological disorders, chronic physical illness, and physical disabilities and a family history of mental illness among first degree relatives were excluded from the study.

A socio-demographic and clinical data sheet was designed for the present study for recording socio-demographic and clinical variables like age of onset, duration of illness, family history and clinical characteristics. The McMaster Family assessment Device (Epstein et al, 1983) was used for assessing family functioning. It is a 60-item self-report questionnaire which assesses family functioning in seven broad dimensions which includes problem solving, communication, roles, affective responses, affective involvement, behaviour control and an overall rating of general functioning. A higher score in each dimension indicates higher levels of dysfunction and cut- off scores have been given for each domain separately. For the screening of normal samples, GHQ-12 (Goldberg & Hiller, 1979) was used in the study and those scoring 3 or more were excluded.

The Statistical Package for Social Sciences (SPSS) 13.0 for windows was used for statistical analysis. Descriptive statistics was used for analyzing discrete and continuous variables. Chi square test was used for comparing categorical variables and student t- test for continuous variables.

RESULTS

Socio demographic characteristics

Table 1 shows the details of the socio demographic characteristics of the subjects. 66.7% of the patient group and 60% of normal controls were males with an average age of 15.7 ± 1.17 years and 15.2 ± 1.21 years respectively. The average duration of illness was 3.05 ± 1.21 years. Majority of the respondents in both the groups were from Hindu religion (86.7% & 70%) and majority had an education below matriculation level. Most of the respondents were students from rural areas and belonged to low socio-economic nuclear families and did not have any family history of psychiatric illness. There was significant difference between the two groups in terms of family type and family size. Majority of the control group belonged to nuclear families (83.3%) whereas in patient group, both nuclear and joint/extended families were equally represented. Average number of family members was significantly greater in patient group (7.4 ± 3.20) compared to normal controls (5.86 ± 1.36).

Comparison of family functioning between patient group and normal control

Table 2 shows the results of McMaster family assessment device. In the independent sample t- test, significant (p<.001) differences were found between the patient group and control group in all the seven domains, maximum dysfunction being found in the domain of behaviour control. This indicated that patients' families followed much higher levels of dysfunctional patterns compared to the normal control group.

Table 1: Socio demographic characteristics

| Variable | Group | | x² / t | df | P |
	Patient N (%)/Mean±SD	Normal Control N(%)/Mean±SD			
Age (in years)	15.±1.17	15.2±1.21	1.54	58	.128
Sex					
Males	20 (66.7)	18(60)	.28	1	.395
Females	10 (33.3)	12(40)			
Religion					
Hindu	26(86.7)	21(70)	2.45	1	.105
Non- Hindu	4(13.3)	9(30)			
Education					
Below matric	22(73.3)	23(76.7)	.08	1	.500
Matric and above	8(26.7)	7(23.3)			
Residence					
Rural	29(96.7)	25(83.3)	2.96	1	.097
Urban	1(3.3)	5(16.7)			
Occupation					
Nil	3(10)	0	3.15	1	.119
Student /working	27(90)	30(100)			
Family income					
Below Rs. 5000/	24(80)	20(66.7)	1.36	1	.191
Above Rs.5000/	6(20)	10(33.3)			
Family type					
Nuclear	17(56.7)	25(83.3)	5.07	1	.024*
Extended /joint	13(43.3)	5(16.7)			
Family size	7.40±3.20	5.86±1.36	2.41	39.10	.021*
Diagnosis					
BPAD- M	29 (96.7)				
BPAD- DEP	1(3.3)				
Duration of illness (in years)	3.0±1.21				
Family history of psychiatric illness					
Present	11(36.7)	6(20)	2.05	1	.126
Absent	19(63.3)	24(80)			

* P <.05

Table 2: Comparison of Results of McMaster Family Assessment Device between patient group and control

Dimensions	Patient group Mean±SD	Normal control Mean±SD	t-value	df	P value
Problem solving	2.37±.32	2.00±.32	4.41	58	<0.001***
Communication	2.36±.22	2.00±.26	5.63	58	<0.001***
Roles	2.38 ± .16	2.08±.18	6.65	58	<0.001***
Affective responsiveness	2.18±.19	1.90±.27	4.57	52.23	<0.001***
Affective involvement	2.16±.13	1.71±.28	7.70	41.04	<0.001***
Behaviour control	2.39±.21	1.98±.21	7.39	58	<0.001***
General functioning	2.34±.21	1.77±.26	8.95	58	<0.001***

*** P <.001

DISCUSSION

In socio-demographic and clinical variables, the groups did not show any significant difference in socio- demographic characteristics, except in the areas of family type and family size. The differences were significant between groups regarding family type and family size (p<.05) and more number of patients' families belonged to extended and joint families and observed as larger than normal control. Previous studies

have shown that larger family size is a risk factor for developing mental illness and impaired quality of life (Amoran et al, 2005; Ebirahim, 1984; Lai, 2000). Lai et al(2000) concluded that larger family size leads to poor quality of child upbringing which may subsequently lead to delinquent behaviour among children and mental stress among caregivers.

For assessing the family functioning of the subjects, McMaster Family Assessment Device (FAD) (Epstein et al, 1983) was used in the present study. The results showed significantly greater level of family dysfunction involving all the domains of McMaster family assessment device in comparison to normal controls. Highest number of dysfunctional families fell under the domains of behaviour control and the same was the highest for the normal control group too. Contradictory to the present study, Heru & Ryan (2004) found significant impairment in family functioning in all the areas except in the domain of behaviour control of McMaster Family Assessment Device (FAD) among families of adult mood disorder patients. One of the possible explanations for this could be that low socio economic status is associated with poor parenting in terms of warmth, negativity and positive control (Belsky et al, 2006) and majority of the families in the present study belonged to low socio-economic status. As opinioned by Friedmann et al (1997), these variations can also be attributable to factors like cultural differences, the types and severity of other psychosocial stressors and families' coping strategies. More negative communication styles among families with bipolar children were reported in a study by Vance et al (2008). In a Turkish study, problem solving and general functioning were found to be more dysfunctional in families with bipolar disorder patients (Unal et al, 2004). Trangkasombat (2006) in a study found dysfunction in all the domains of FAD among families of adult psychiatric patients compared to normal controls. Their findings supported the findings of Friedman et al (1997) who concluded that it is the presence of psychiatric illness rather than the type which determines the pattern of family dysfunction. Our study, though carried out on a sample of adolescents, supported the conclusions of Friedman et al (1997) regarding a common pattern of dysfunction across all domains of family functioning.

This findings stand in contrast to previous studies which detected dysfunctions across specific but not all domains (Vance et al, 2008; Unal et al, 2004). Our findings of dysfunction across multiple domains have also been supported by Belardinelli et al (2008) and Romero et al (2005) though they used Family Environment Scale (Moos & Moos, 2002) which detected dysfunctions in the areas of family cohesion, expressiveness, active-recreational orientation, intellectual-cultural orientation and conflict. Further studies need to be carried out in families of child and adolescent patients across all psychiatric diagnoses to lend further credence to the hypothesis of global family dysfunction in all psychiatric population.

A previous study by Robertson et al (2001) reported no significant difference in terms of family dysfunction between children with mood disorders and normal controls. This study recruited samples of euthymic bipolar children in contrast to our study which included children in the symptomatic phase of affective illness. Another possible reason could be that their subjects under reported their problems in the self - report measurements. The issue of family dysfunction in the interepisodic phase of bipolar disorder needs to be explored further in future studies.

LIMITATIONS

The sample size of the present study was small which may have reduced the generalizability of the study findings. Moreover, it lacked in representation of all sub- categories of bipolar affective disorder, as most of the respondents in the patient group were diagnosed with bipolar mania. There may be relationship between the number of episodes, relapses and the study variables which was not addressed in the present study.

CONCLUSION

The results of the present study emphasized the importance of considering family factors in the assessment and management of children with bipolar disorders. Several domains of family functioning may have significant role in the

onset and course of bipolar disorder in children and adolescents. A comprehensive understanding of family functioning and its related determinants would help to improve the quality and comprehensiveness of the care for the young patients with bipolar disorders.

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EFFICACY OF PSYCHO-EDUCATION AND DISCHARGE COUNSELLING

ON FOLLOW- UP AND REHOSPITALIZATION

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ABSTRACT

Aim: The aim of this study was to find out the effect of psycho education and discharge counselling on the compliance and follow up of patients admitted for treatment of psychosis after discharge from hospital. **Method:** Forty hospitalized patients having schizophrenia and bipolar affective disorder were selected for the study. Patients were randomly divided into experimental and control groups. Experimental group underwent 2 sessions of psycho-education and 2 sessions of discharge counselling before discharge from hospital along with pharmacotherapy. Control group received only pharmacotherapy. Both groups were followed for 9 months to measure compliance with regular follow up. **Result:** Experimental group had significantly better follow-up and less rehospitalization in comparison to control group. **Conclusion:** Findings suggested that psycho-education and discharge counselling are effective methods of increasing patient's adherence for treatment and follow up.

Key words: *Psycho-education, schizophrenia, compliance.*

INTRODUCTION

The appropriate treatment of mental disorders implies the rational use of pharmacological, psychological and psychosocial interventions in a clinical and integrated way. Psychosocial treatment methods have been found to be effective in the treatment of mental disorders, and psycho-education, a form of psychosocial treatment has been demonstrated to be useful in a broad range of psychiatric disorders. It has also been found effective and useful in various settings. Psycho-education is the education of a person in subject areas that serve the goals of treatment and rehabilitation. Psycho-education involves teaching people about their problem, how to treat it, and how to recognize signs of relapse so that they can get necessary treatment before their difficulty worsens or occurs again. Psycho-education also has the function of contributing to the de stigmatization of psychological disturbances and diminishing barriers to treatment. The relapse risk is in this way lowered; patients and family members, who are more well-informed

about the disease, feel less helpless. Hayes and Gantt (1992) demonstrated that developing a psycho-educational model for use with psychiatric patients has a positive effect on their functioning and attitude because knowing about one's illness demystifies the illness and diminishes associated stigma. An evidence-based approach dictates that for most moderately to severely debilitating mental health conditions, a combined modality approach that blends drugs with therapy and/or education remains, by far, the best in terms of outcome and eventual prognosis. Multiple studies have proven the value of psycho-education in psychopathologies ranging from depression to schizophrenia. Pekkala and Merinder (2002) in a meta analysis of all psycho-educational interventions conducted on patients with schizophrenia, found that psycho-education was a useful part of the treatment programme. Colom and colleagues (2003; 2004) assert that in the treatment of bipolar patients, psycho-education may have a role beyond the enhancement of patient compliance to drug treatment, and holds a special role for patients with co existing personality disorders. On the other side, discharge

counselling provides guided and systematic education and knowledge provision to patients and families and helps in acceptance of treatment and enhances drug compliance and regular follow up, thus leading to better out come and reducing the chance of relapse. Pekkala and Merinder (2004) reported that psycho-education reduces relapse. Aguglia et al (2007) also found significant reduction in number of hospitalization and days of stay in hospital in patients who received psycho-education along with psychosocial intervention and medicine. Studies assessing efficacy of psycho-education along with discharge counselling with pharmacotherapy in Indian setting will shed light on efficacy of this therapeutic approach in India. Hence, the present study aimed to assess the efficacy of psycho education and discharge counselling on the compliance and follow up of patients admitted for treatment of psychosis.

MATERIAL AND METHODS

The study was conducted at LGB Regional Institute of Mental Health, Tezpur, Assam. Patients admitted into the hospital between April and June, 2008 was included in the study. A total of forty admitted patients were selected; twenty patients were randomly enlisted for the experimental group and twenty patients for the control group. All the patients included in the present study was diagnosed by a psychiatrist in accordance with the ICD-10 DCR (WHO,1993) criteria at the time of their admission into the hospital. Patients with substance dependence, dementia, personality disorders and organic pathology were excluded. Experimental group underwent 2 sessions of psycho-education and 2 sessions of discharge counselling before discharge from hospital along with pharmacotherapy. Controlled group received only pharmacotherapy. Both groups were followed for 9 months to measure compliance with regular follow up. Patients who were not admitted were also excluded because of the difficulties involved in getting such patients to attend a special programme in the hospital. Informed consent was taken from the patients. The study was approved by the ethical committee of the Institute. Socio-demographic and clinical characteristics of participants are given in Table 1. Both groups consisted of 14 male and 6 female participants. In both the groups, 13 had schizophrenia and 7 had bipolar affective disorder. There was no significant difference between both groups in terms of

education, occupation, marital status, domicile, and diagnosis. The mean age of the treatment group was 30.40 ± 6.87 years and of control group was 28.15 ± 5.80 years. There was no significant difference in the age distribution between the groups.

Table 1: Showing socio demographic profile of participants

Variables	Experimental group n=20 (n= %)	Control group n=20 (n= %)
Gender		
Male	14 (70)	14(70)
Female	6 (30)	6(30)
Education		
Literate	15(75)	13(65)
Illiterate	5(25)	7(35)
Occupation		
Agriculture	7(35)	8(40)
House wife	3(15)	2(10)
Business	6(30)	6(30)
Govt. service	4(20)	4(20)
Marital status		
Married	17(85)	14(75)
Unmarried	3(15)	6(30)
Domicile		
Rural	14(70)	9(45)
Urban	6(30)	11(55)
Diagnosis		
Schizophrenia	13(65)	13(65)
Bipolar affective disorder	7(35)	7(35)

Schedule for Psycho-education and Discharge counselling

A self design schedule was drawn up to serve as a guide for the contents of the Psycho-education and Discharge counselling sessions. There were 4 modules for psycho education and 5 modules for discharge counselling which were self designed, each covering different aspects of the disorders. The psycho-education sessions and discharge counselling given to the experimental group had an interactive format, combining a didactic exposition by the therapist with the presentation of experiences and opinions of patients. The module of the psycho-education and discharge counselling were as follows:

Modules for Psychoeducation: Modules for Psycho-education included characteristics of the disorder, treatment options available for the disorder, psychosocial aspects and stigmatization and duration of treatment.

Modules for Discharge counselling : While Modules for

Discharge counselling focussed on education about the illness and treatment, activities taken by the patients, follow up information and medication provision, enhancement of positive behaviour by family members through improvement of family environment and information of security deposit position/contact information.

Procedure

Clinical records of each patient were scrutinized to extract the following information: age, sex, marital status, level of education, occupation, duration of illness, rate of clinical visit, and re-hospitalization. Each patient in the experimental group was scheduled to have at least two sessions of Psycho-education and two session of Discharge counselling during the stay in the hospital. The first session was held at least 1 or 2 weeks after admission which is the period at which the patient's condition was expected to have stabilized sufficiently to allow him or her to comprehend the contents of the sessions. All sessions were done individually. On discharge, patients who participated in the programme were asked to return in 1 month time for clinical follow-up in the hospital. All the cases were followed up to nine months to see the follow-up rate and rehospitalization in both the group.

Statistical Analysis:

Data is described using number and percentage. Chi square test and t test were used to find the difference between the experimental group and the control group.

RESULTS

In the present study, there were forty patients; twenty in the treatment group and twenty in the control group. Number of follow ups and re hospitalizations were assessed for experimental and control groups. Rate of compliance with follow up after discharge from hospital and rehospitalization is given in Table 2 .In Experimental group, the mean rate of clinic visits /number of follow up were 28.15(SD- 5.80) while for control group it was 2.40(SD-.940). Significant difference between experimental group and control group was found using two-tail t-test at a confidence interval of 95 %(Table3). Patients who received psycho-education and discharge counselling were more regular for follow-up and had less number of rehospitalization.

Table 2: Rate of compliance with follow up after discharge from hospital and re-hospitalization

	Experimental group n=120 (n= %)	Control group n=20 (n= %)
More than 2 Follow ups	0	10(50%)
Upto 4 Follow ups	2(10%)	10(50%)
Upto 6 Follow ups	9(45%)	0
Upto 8 Follow ups	9(45%)	0
No rehospitalization	18(90%)	7(35%)
One time rehospitalization	2(10%)	10(50%)
Two times rehospitalization	0	3(15%)

Table 3: Comparison of follow-ups and rehospitalisation of the two groups

	Experimental group n=20 (Mean±SD)	Control group n=20 (Mean±SD)	t-value (df=38)	p Value
Rate of clinic visits /number of follow ups.	28.15±5.80	2.40±.940	10.76**	<0.001**
Re hospitalization	.100±.307	.800±.695	4.114**	<0.001**

**P<0.01

DISCUSSION

Findings confirmed that psycho-education and discharge counselling are effective methods of increasing patients' adherence to scheduled follow up for treatment. These findings are consistent with previous studies conducted in other countries. Pekkala and Merinder (2004) reported that psycho-education added to standard treatment for schizophrenia reduces relapse. It is proposed that increased knowledge enables people with schizophrenia to cope more effectively with their illness. Psychoeducational interventions involve interaction between the information provider and the mentally ill person. The evidence shows a significant reduction of relapse or readmission rates. It may be estimated that around twelve relapses can be avoided, or at least postponed, for around a year if 100 patients receive psychoeducation. There seems to be some suggestion that psycho-education may improve compliance with medication but the extent of improvement remains unclear. We did not find any difference in the effect of psycho-education and discharge counselling on follow up across diagnoses. This suggests that the procedure may be useful as a treatment modality for both schizophrenia and affective disorder, although it has been suggested that it may be more useful in schizophrenia patients. Tarrier (1996) argued that a comprehensive and holistic approach to care in schizophrenia combining pharmacological and psychosocial interventions

is required and that high-quality care and clinical management need to be provided by a partnership between pharmacological and psychosocial interventions. He emphasized that psychosocial interventions can provide patients and their caregivers with skills that both increase the patient's resilience and empower the patient and caregivers to forge a partnership with clinicians to define high-quality care. Drug and psychosocial intervention is indicated as parts of tertiary prevention to prevent further disability in the illness (Lee et al, 2005). Further, psychosocial interventions decrease the frequency of relapse, encourage compliance with medication, and improve general social impairment and the levels of expressed emotions within the family when compared to standard care (Pharaoh et al, 2004). Among the psychosocial interventions, the psycho educational ones for the patients and their family have been considered to be the most promising and successful within the last thirty years (Dixon et al, 2000; Penn & Muesser, 1997). The basic principles of the psychoeducational interventions are represented by simple, correct and complete information about the disorder and its possible treatment methods (Buchkremer et al, 1997). Aguglia et al (2007) also found significant reduction in number of hospitalization and days of stay in hospital in patients who received psycho-education along with psychosocial intervention and medicine. The percentage of the subjects hospitalized between 1 and 3 times during the 12 months were 13% after 6 months, and 3.3% after a year with a difference of 9.7% for the study group; while for the control group, the variation went from 17.7% at 6 months to 10.5% after 1 year with an improvement of 7.2%. The difference between groups showed statistical significance ($p < 0.001$). Findings suggest that psycho-education and discharge counselling significantly improve number of follow ups and decrease re-hospitalization. Small sample size of the present study limits the generalization of results. Only hospitalized patients were included in the study, hence findings may not be generalized for out-patients.

CONCLUSION

Psycho-education and discharge counselling are effective as part of the treatment protocol for psychiatric patients, and can be applied to all patients irrespective of their age, sex, religious belief and educational background. It may help to decrease incidences of poor compliance and clinic defaulting which is a major factor for relapse.

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Book Review...
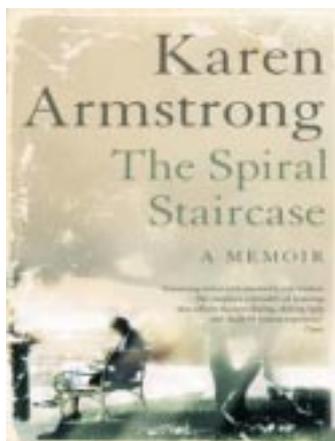
Title : THE SPIRAL STAIRCASE: A MEMOIR
Publisher : HARPER COLLINS, GREAT BRITAIN
Year : 2004
Author : KAREN ARMSTRONG
Price : $10.17

INTRODUCTION

The Spiral Staircase: A Memoir (2004) is a sequel to Karen Armstrong's earlier book, Through the Narrow Gate (1981) which told the story of her own seven years as a Roman Catholic nun in a convent in England. In 1962, at the age of 17 years, she entered a convent, smitten by the desire to find god. The book described her frustrating, lonely experience of a cloistered life and her decision, at 24 years, to renounce her vows.

The Spiral Staircase is Armstrong's second attempt at explaining her difficult readjustment to the secular world. She had earlier written of her experiences in "Beginning the World" (1983) but later felt that the book's "hearty, boisterous and relentlessly extrovert tone" failed to do justice. The publishers wanted her to make the book as dramatic and accessible as possible and ruled out ruminative matter, literary or theological. So in this book, she tries to tell the real story again, of her spiritual struggle and difficult rite de passage into a secular existence.

ABOUT THE AUTHOR

Karen Armstrong (born 11th November, 1944, Wlidnoor, Worcestershire) is a British broadcaster and author of numerous works on comparative religion. Best known for her book 'A History of God' which discuses the development of the idea of God in Judaism, Christianity and Islam, she has written numerous other books on religion including biographies of Muhammad and Buddha. She is also the author of three television documentaries and since September 2001, has been a frequent contributor to conferences, panels, newspapers, periodicals and media outlets on both the sides of the Atlantic on the subject of Islam. She lives in London.

Armstrong is a self confessed "free-lance monotheist". Her understanding of religion seems to be unobjectionable to people from a wide range of religious perspectives. In 2008, she was awarded the $100,000 TED Prize and the 'Freedom of Worship' award by the Roosevelt Institute for her interfaith initiative to draw up a Charter of Compassion and for her personal dedication to the ideal that peace can be found in religious understanding.

ABOUT THE BOOK

The inspiration of the title comes from T.S. Eliot's poem "Ash Wednesday" in which the poet metaphorically climbs a spiral staircase-turning again and again to what he does not want to see as he slowly makes progress towards light. The title itself speaks a lot about the thought process of the author as she makes her way into a life she did not intend to live. Titles of all the chapters are taken from the poem. Armstrong sees her own journey reflected in the poem's description of a spiritual recovery. Her search for fulfillment in the religious or academic life is constantly thwarted, resulting in paths that repeatedly take her back to the new beginnings.

Armstrong begins the tale with the renouncing of vows. In 1969, after seven frustrating years as a Roman Catholic nun, she finally quits the convent she joined at the age of 17 years, 'eager to meet God'. The reforms of the Vatican had not yet penetrated to her conservative order in Birmingham and we are given a brief account of the harshness of a regimen that discouraged friendship and bent the will through pointless and contradictory rules. The alien nature of the world that she steps back into hits her hard. She had neither an idea who the Beatles were, nor she had heard of Nixon or Arafat. The result was a profound culture shock-"I had found, to my considerable sorrow, that even though I no longer belonged

in the convent, I didn't belong out here either". Although already enrolled at the Oxford, the author is totally unprepared for a life in a twilight zone.

The study of literature provides some relief for panic-struck Armstrong. There at Oxford, she is able to carve a niche for herself. After completing her graduation, she embarks on a doctoral thesis which takes three years of hard labour to complete although she continues experiencing episodes of panic and depersonalization in between. During this time she would take care of the autistic son of an atheist Oxford academician who asks her to take their son to the local church which would test her "loss of faith" repeatedly against all odds. Then comes a major shock as the examiner rejects her doctoral thesis, ending her academic carrier and forcing her to take up a teaching job at a private girls' school in London.

Throughout this period, she would experience strange blackout like lapses in her consciousness in which noxious odours would come out of nowhere, and everything and everyone would seem remote, removed and strangely threatening-crippling symptoms that the nuns would dismiss as attention-seeking and her psychiatrist at the Oxford adamantly attributed to her denial of feminity and sexuality due to her convent, radical upbringing. It was many years before a doctor rightly diagnosed her condition as temporal lobe epilepsy and provided adequate treatment. She continued to suffer from setbacks as she lost her teaching job due to her physical condition, even though she was receiving adequate treatment for it. Throughout all these changes, Armstrong laments her inability to pray and her lack of faith-"I was finished with God and God, if he existed at all, had long ago finished with me."

She couldn't be more wrong. With typical resilience she bounces back, first writing a memoir of her years as a nun and then researching the life of St. Paul for a documentary for BBC. She finds the experience of working in the robust secularist atmosphere of Channel 4 strangely cathartic. Something strange happens while conducting research in the holy land as she finds that 'Paul, a difficult, prickly genius, had stormed his way into my affection.' She feels the stirring of new hope and her interest in Judaism and Islam is awakened. She suffers from another heart break when after three years of labour her TV series on the Crusades is abruptly cancelled. Once more she is forced to look for a new beginning: "I was desperate to get to work on something anything to convince myself that I still have a future. That something was a book "A history of God". Her extensive study of various religious texts makes her begin to believe again, not in the

conventional God of the western world, but in something more vibrant and radical. Stumbling into comparative literature she finds the ecstasy and transcendence that had so far eluded her.

The result is a personal philosophy that calls for "compassionate action and practical expression of respect for the sacred value of all human beings, even our so called enemies surrounding us from within and without". She concludes, "our task is now to mend our broken world; if religion cannot do it, it is worthless."

CONCLUDING REMARKS: A CRITIQUE

One drawback of autobiographies in general is that with the benefit of hindsight, they impose an orderly sequence on random events which makes them draw conclusions which carry little significance in terms of larger effect of events in the train of life. Armstrong too seems to fall into the same trap. She views all wrecking reversal of life as a coherent pattern of gradual enlightenment which shows that she is offering undue importance on events which might not carry overt impact on the flow of her life events. Though the book is self-indulgent in parts, it would be difficult for the reader not to empathize with the difficulties the author has encountered in her life. It is only natural that her traumatizing experiences in the convent influenced her consequent approach to religion; but in presenting her story as she does, Armstrong makes a scathing indictment of religious life in general and the church in particular. By being ruefully amusing, she glosses over her lack of intimacy with the opposite sex. I feel her social interactions require more insightful analysis for presence of features of anxious and avoidant personality which was rendering her feeling socially aloof. The pace of the narrative slackens in parts and there are certain obvious flaws in the language, it could have been made more crisp and precise. Also some of her experiences, especially those in the convent, sound repetitive.

Overall, it is a sensitively written book that explores one person's search for meaning. This is not a book to be breezed through. Armstrong's own understanding of God, with which she concludes, may not be for everyone. But those who believe that the world needs "not belief, not certainly, but compassionate action", will find the book appealing.

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Memoirs...

MY THIRTY DAYS EXPERIENCE IN A PSYCHIATRIC HOSPITAL

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

Why I am admitted in a psychiatric hospital was the very first question that came to my mind when I was referred inside the hospital as in-patient. When I stepped inside, strange thoughts were haunting my mind. Initially I thought doctors will do the physical check-up and discharge me. I was in my complete senses. The only problem was that I was struggling with my mental status. Till that time there was a mental blockade and though being in my complete senses, I could not even use my common sense that it is rather an impossible thing for anyone to understand my thoughts.

My disease is treatable but cannot be cured. The very first day as I entered the hospital I was given the first shock treatment (ECT). I still remember that it was evening time. It was a nice experience, I was feeling lost. Then I gained back my normal senses. I was brought to the ward and there I took my medicine and slept. In the morning when I woke up, the patients who were already admitted came to meet me. Few shook hands with me, some asked my name while others behaved funny. The attendants and nurses were also eager to know little bit about me and so, I gave a brief description about myself. They were pleased to hear about me. That morning my day started with a dose of injections. Then around 8.30 am we got the breakfast. Till afternoon 12.30 pm we were free to roam around after which we had our lunch. Either some of the patients along with the attendants would go to bring the lunch or all of the patients would run with hungry stomachs to the dinning hall which was not very far. Same thing would repeat during the dinner time. We would get evening tea at 2.00 pm. Everyday different patients would be assigned the job of bringing the food along with the ward boys. All of us would then take the food in our plates and eat. My ward had many funny patients and among them the very first name that comes to my mind is of Vineet. All the other patients called him "Naga Baba". One could find him anytime stark naked searching for soap or towel so that he could take bath. He was like a lanky lean stalk but felt hungry twenty four hours. But he was a very cute fellow. Then comes the name of Sumit, the tall fellow. Many called him 'the rag picker'. He had a habit of picking things from the road side or digging something out from the ground and keep it in his safe custody. But he was very good from heart and a loving person.

One patient had the habit of washing his hands 15 to 20 times a day but gradually, he improved and reduced his washing habits to 5 to 6 times a day. Rest of the patients also had genuine problems and were recovering gradually. I used to get shock treatment (ECT) every alternate day empty stomach in the morning along with the medicines in the evening time. Both the things did magic. According to my knowledge the shock treatment (ECT) was given to me for faster recovery. It was after 2nd or 3rd shock treatment (ECT) that my fear of spies following me and my thoughts becoming known to others stopped. In total I received 8 shock treatments (ECTs). In our ward -patients, nurses and ward boys were like a family. They were very supportive and ready to help each patient anytime. Even doctors were very good and supportive. My doctor had been very kind, understanding and cooperative throughout my treatment. She was a careful listener and listened to every patient's problems carefully. When asked what one should do during his idle time, she told me to avail the services of library or spend sometime in the Occupational Therapy Department. The best thing about the doctors in my hospital was that, they conducted rounds bi-weekly. All the concerned doctors and their patients along with the senior doctors would be present during that time. Together they would try to solve out the problems of every individual patient.

I came back home with nice memories of my hospital. Before my discharge, I participated in the annual sports and lifted the first prize in shot-put category. Some of my firends in the ward also got prizes in the meet. There were hardly any negatives in the administration of my hospital.

I would pray to God to shower blessings on my hospital so that more and more patients get well soon and return their homes with a happy heart.

Name withheld on ethical ground

JOURNEY OF IASP TO ITS SILVER JUBILEE

Twenty five years or the Silver Jubilee is an important mile stone in the life of a person, professional society or a nation. It is time to review one's progress, where one has succeeded or failed and to set an agenda and vision for future. The Indian Association for Social Psychiatry (IASP) has entered its twenty-fifth year of existence this year and it is the right time to review our achievements now. The Association has continued to grow and currently has more than 550 members, spread across various mental health disciplines like psychiatry, clinical psychology, psychiatric social work, psychiatric nursing and so on. Its 16th national conference was held at All India Institute of Medical Sciences, New Delhi from 28th-30th November, 2008. The Association also held its Silver Jubilee Year Conference at Lucknow from 15th-17th November, 2009.

The Association is a society registered (Regn. No. 1178/84) under the Societies Act of the Government of India. The secretariat of the Association is presently located at the Department of Psychiatry, All India Institute of Medical Sciences, New Delhi. It has an official website, which can be accessed at www.iasp.org.in. The current office-bearers of the IASP are: Dr. G. Gopalakrishnan - President; Professor R.C. Jiloha - Vice President; Professor K. Roy Abraham - President Elect; Professor Rakesh K. Chadda - Secretary General; Dr Adarsh Kohli - Treasurer; Professor V.K. Sinha - Editor.

Historical background:

The Association was launched in 1984 with great hopes under the giant leadership of stalwarts like Professor A. Venkoba Rao, Professor V.K. Varma, Professor S.M. Channabasavanna, Professor S.D. Sharma, Professor B.B Sethi and Dr M.A.M. Khan. However, gestation of the IASP can be traced back to a transcultural psychiatric meet organized by Late Professor A. Venkoba Rao in August, 1981 at Madurai. The participants in the meet felt a great need in the country to have a separate professional organization for social and/or transcultural psychiatry, which could also examine the interface between culture and personality and be conducive to the scientific study of the social issues relevant to the country and the society. The organization would primarily attempt academic and intellectual exercises and bring a multidisciplinary approach to bear on these issues. In January 1982, an ad hoc committee was formed to usher in the new organization. After a preparatory phase of approximately two years, at a historic meeting held in Ranchi on 14th January, 1984, the Indian Association for Social Psychiatry was formed, its constitution and by-laws adopted and the office-bearers selected. Professor A. Venkoba Rao was elected as the first President of the Association.

He served in that capacity from 1984 to 1986. Professor V.K.Varma was the Founder Secretary General. First conference of the Association was held at Kodaikanal on 24th-25th February, 1985 under the chairmanship of Professor A Venkoba Rao. The first issue of the Indian Journal of Social Psychiatry was published in 1986 under the editorship of Professor B.B.Sethi. The Association had had as its office bearers leading mental health professionals of the country, who are acclaimed internationally for their professional achievements. Some of them included Professor A Venkoba Rao, Professor V.K. Varma, Professor S. M. Channabasavanna, Professor B.B Sethi, Professor S.D. Sharma, Professor L..P.Shah, Professor Anil Shah, Professor N. Chakraborty, Professor P Kulhara, Professor S.C.Malik, Professor R.S.Bhatti, Professor Savita Malhotra and Professor Anil Malhotra. Its website was launched in July, 2008. Names of various office bearers, since the Association was formed (Table 1).

Objectives of Indian Association for Social Psychiatry:

The Purposes and Objectives of the Association as outlined in its Constitution are:

A. To study the nature of man and his cultures and the prevention and treatment of his vicissitudes and behavior disorders.

B. To promote national and international collaboration among professionals and societies in fields related to social psychiatry.

C. To make the knowledge and practice of social psychiatry available to professionals in social psychiatry and other sciences and to the public by such methods as scientific meetings and publications.

D. To advance the physical, social, psychological and philosophic well-being of mankind by such methods as promotion of research and deliberations into it.

E. To extend consultations and carry out charitable and voluntary work for the furtherance of the objectives mentioned above.

F. To do all such things and matters that are incidental or conducive to the attainment of the above objectives.

Conferences:

The Association has been holding regular conferences, which have been held in various cities representing different parts of the country. The first annual conference was held in Kodaikanal in February, 1985. Later, the conferences have been held in North in Delhi and Chandigarh, in East in Kolkata and Ranchi, in the West in Ahmadabad

and in South in Bangalore, Trichy, Hyderabad and Chennai. Each conference was held with a socially relevant theme and included symposia, free papers and a number of guest lectures and popular lectures. Table 2 gives the dates, venue and themes of various IASP conferences.

IASP also organized the Regional Symposium of WASP along with its annual conference in February, 1989 at New Delhi. It also hosted the XIII Congress of WASP in November, 1992 at New Delhi under the leadership of Professor V.K. Varma. IASP became formally affiliated to the World Psychiatric Association (WPA) in June, 1993. Later in 1995, IASP hosted the Regional Symposium of Transcultural Psychiatry Section of the World Psychiatric Association in March, 1995 at the Post Graduate Institute of Medical Education & Research under leadership of Professor V.K.Varma.

The Association held its Silver Jubilee Year Conference at Lucknow from 15th-17th November, 2009. The theme of the conference was Mental Health: Prioritizing Social Psychiatry.

Publication:

The Association has its own journal by the name Indian Journal of Social Psychiatry, which is being regularly published since 1985. Professor B.B. Sethi was its founder editor. Professor P. Kulhara, Professor P. Raghurami Reddy and Professor G. Banerjee have been the other illustrious editors of the Indian Journal of Social Psychiatry. It is currently being published from Central Institute of Psychiatry, Ranchi. Professor V.K. Sinha is its current editor. The issues from the year 2006 onwards can be freely accessed on the Association's website.

Awards:

IASP encourages scientific research by the membership. To encourage the research in various fields of social psychiatry, the Association has instituted many awards, number of which has also grown, as the Association is growing. The awards are given every year in the national conference. There are awards both for young as well as senior mental health professionals. Dr. N.N. De Oration is delivered every year by a senior fellow of IASP, decided on the basis of evaluation of nominations from the membership. The oration is decided one year in advance. Balint Award was instituted out of an endowment on behalf of the Foundation of Psychosomatic and Social Medicine by Dr. Med. Dr. H.C. Boris Luban-Plozza, CH 6612 Ascona, Collina, Switzerland. It is based on a write up and presentation of a paper based on their personal experience of relationship with patients. Dr. G.C. Boral Awards I and II of the IASP, instituted out of a donation from Dr. G.C. Boral, a Fellow, are for the best papers presented at the annual conferences of the Association by a fellow and an associate

member of IASP respectively. During the 2008 National Conference of the IASP held at New Delhi, three new awards were instituted, which have been introduced from 2009, the silver jubilee year of the Association. These include Dr. Venkoba Rao Oration, instituted in memory of Professor A Venkoba Rao, Founder President of IASP, Dr. V.K.Varma Award and Dr. B.B. Sethi Award. Dr. Venkoba Rao Oration will be given to an outstanding mental health professional above the age of 55 years, who has contributed in the field of social psychiatry. Dr. V.K. Varma Award has been instituted to encourage publications in the field of social psychiatry in Indian journals and is to all the members who have published a paper in psychiatry based on original research in any Indian Journal. Dr. B.B. Sethi Award would be given to the best poster presented in the Annual National Conference of the Indian Association for Social Psychiatry

Committees and Task Forces:

IASP has a number of sub committees, which are chaired by a senior fellow and have at least 5 members. The sub committees include constitution and bye laws committee, programme committee, ethics committee, elections committee, CME committee, awards and oration committee and membership committee. All the committees have been working hard to meet the objectives of the Association. Recently IASP has made 3 task forces on 'Mental health legislation', 'Mass media and mental health' and 'Mental health policy'. Professor R Srinivasa Murthy, Professor A. K. Kala and Dr. U. C. Garg respectively are the convenors of these task forces. All these three areas are of national importance and need active inputs from the mental health professions, and therefore IASP has taken initiative in this area.

Other activities of IASP:

The Indian Association for Social Psychiatry has been actively associated with the international developments in the field of mental health. The Association became formally affiliated to the World Association for Social Psychiatry (WASP) in October, 1985. The Indian Association is acclaimed as one of the more active and emergent regional societies of the World Psychiatric Association. In that, it is fortunate to receive the patronage of many of the world leaders in social psychiatry. The Indian Association for Social Psychiatry has also made rapid strides in the global perspectives. Through its own activities and the activities of its members, the Indian Association has been receiving greater recognition and visibility at the global level and at the level of the World Association for Social Psychiatry (WASP). Professor S.D. Sharma, a past President of IASP has also served as the President of the World Association for Social Psychiatry. Even many young members of the Association have represented the association in various WPA meetings at different times. Professor J. K. Trivedi, one of the senior fellows, has been a regional representative from Southern Asia zone to the WPA. Professor K.

Roy Abraham, the President Elect of IASP, is the current Co Chairperson, Preventive Psychiatry Section of the WPA.

Other areas of interest:

The IASP, like the WASP, takes a holistic view of mankind. This is evidenced from the laudable objective in the Constitution, namely that of the advancement of the mental, social and philosophic well being of mankind. Some social issues and problems have more clearly attracted the attention of social psychiatrists in India. Social psychiatrists have been increasingly venturing out of the narrow confines of clinical psychiatry into the social issues and problems. Some of these are in terms of the position of women in the society and crimes against them, the status of suicidal acts in the society, the social and legislative aspects of mental illness and alcohol and drug abuse, imprisonment of the non criminal mentally ill, etc.

IASP has always taken initiative in promoting various social issues related to mental health, especially psychosocial factors involved in etiogenesis and managements of mental illnesses and their psychosocial consequences. For example, in some of its recent conferences, the focus has been to bring discussion on destigmatisation of mental illnesses, psychosocial intervention in health and disease, and new horizons for social psychiatry in the new millennium.

The Global Burden Disease Study released in 1996 has highlighted the importance of the mental illnesses in causing burden and disability and attracted the attention of public health experts to put focus on this relatively neglected area of the health. The World Health Report of 2001, which was exclusively devoted to mental health, brought further attention of the various countries of the world especially those from the low and middle income group, to develop strategies at improving the mental health sector. It is important to mention here that the Editor in Chief of this report was Professor R Srinivasa Murthy, one of senior fellows of IASP.

There is further need to examine the impact of various social issues and problems like social inequalities, migration, poverty, natural and manmade disasters, wars, increasing violence and their impact on the health and general functioning of the population, and to find solutions to such problems. A number of geographical areas in India face many natural disasters like floods and landslides every year and many places are prone to terrorist violence, which have their own adverse consequences on mental health, which need focus of the social psychiatrists. Social issues like increasing suicide rate in the country over the last 10-15 years, and also that involving some specific population like farmers, adolescents and very high rates reported from some specific geographical locations need particular

investigations by the social psychiatrists in collaboration with other social scientists. .

Comments by the world leaders:

Professor Mario Maj, President, World Psychiatric Association, in his message for the Silver Jubilee Year Conference of the Indian Association for Social Psychiatry, has remarked that the meeting would review the progresses made in the field of social component of psychiatry especially looking into social consequences of mental disorders, like stigma, discrimination and burden on caregivers, effectiveness of psychosocial interventions for major mental disorders, and links between the organization of mental health services and patients' quality of life and satisfaction with care.

Professor Julio Arboleda-Flórez, President, World Association for Social Psychiatry (WASP), has complimented IASP on keeping the theme of prioritising social psychiatry in mental health for its Silver Jubilee Year Conference. The theme is very close to the aims and ideals of the WASP. Psychiatry must focus its interventions at the interface of the individual and society.

Epilogue:

In contemporary psychiatry, in the background of George Engel's biopsychosocial model of disease, role of psychosocial factors in mental health promotion, and in genesis and management of illness is often being eclipsed under the biological research and promotion by the pharmaceuticals. In this background, the silver jubilee year conference of IASP has chosen 'Mental Health: Prioritizing Social Psychiatry' as the theme for the conference so as to further the role of social psychiatry in mental health promotion, and in prevention and treatment of mental disorders. Emerging issues in mental health like burden and disability caused by mental illnesses, mental health promotion and developing preventive strategies for mental illnesses and identifying and ameliorating the risk factors are some important areas, where IASP has to take a lead in the coming years.

Rakesh K Chadda
MD, MRCPsych, FAMS
Secretary-General, IASP
Professor of Psychiatry
All India Institute of Medical Sciences,
New Delhi

Table 1: Office Bearers of the Indian Association for Social Psychiatry (1984-2009)

Sr. No.	Year	Conference	President	Secretary General	Treasurer	Vice President	Editor
1	1985	Kodaikanal	Dr. A Venkoba Rao	Dr. V.K.Varma	Dr. M.A..M.Khan	Dr S.M.Channabasavanna	Dr. B.B.Sethi
2	1986	Chandigarh	Dr. S.D.Sharma	Dr. V.K.Varma	Dr. M.A..M.Khan	Dr.Gurmit Singh	Dr. B.B.Sethi
3	1987	Hyderabad	Dr. D.N.Nandi	Dr. V.K.Varma	Dr. M.A.M.Khan	Dr. Ajita Chakraborty	Dr. B.B.Sethi
4	1988	Calcutta	Dr. S.M.Channabasavanna	Dr. V.K.Varma	Dr. M.A..M.Khan	Dr. G.C.Boral	Dr. P Kulhara
5	1989	Delhi	Dr. Gurmit Singh (Resigned)	Dr. V.K.Varma	Dr. M.A..M.Khan	Dr.L.P.Shah	Dr. P Kulhara
6	1990	Tiruchirapalli	Dr. A.V.Shah	Dr. V.K.Varma	Dr. M.A..M.Khan	Dr. V Ramachandran	Dr. P Kulhara
7	1991	Ahmedabad	Dr. G.C.Boral	Dr. Anil Malhotra	Dr. M.A..M.Khan	Dr. N Chakraborty	Dr. P Kulhara
8	1992	Madras	Dr. V.K.Varma	Dr. Anil Malhotra	Dr. M.A..M.Khan	Dr. P. Raghurami Reddy	Dr. P Kulhara
9	1994	Bangalore	Dr. L.P.Shah	Dr. Anil Malhotra	Dr. G Gopalakrishnan	Dr.R.S.Bhatti	Dr. P. Raghurami Reddy
10	1995	Calcutta	Dr. N Chakraborty	Dr. Anil Malhotra	Dr. G Gopalakrishnan	Dr.Hema Shah	Dr. P. Raghurami Reddy
11	1997	Delhi	Dr. S.C.Malik	Dr. Anil Malhotra	Dr. G Gopalakrishnan	Dr.Savita Malhotra	Dr. G Banerjee
12	1998	Bhubaneshwar	Dr. Hema Shah	Dr. Anil Malhotra	Dr. G Gopalakrishnan	Dr.G.C.Kar	Dr. G Banerjee
13	1999	Bangalore	Dr. R.S.Bhatti	Dr. Anil Malhotra	Dr. G Gopalakrishnan	Dr. V Kumaraiah	Dr. G Banerjee
14	2001	Ranchi	Dr. Savita Malhotra	Dr. Anil Malhotra	Dr. G Gopalakrishnan	Dr.S Haque Nizamie	Dr. G Banerjee
15	2003	Tiruchirapalli	Dr. Anil Malhotra	Dr. Rakesh Chadda	Dr G Gopalakrishnan	Dr K Roy Abraham	Dr. V.K.Sinha
16	2008	New Delhi	Dr. G Gopalakrishnan	Dr. Rakesh Chadda	Dr Adarsh Kohli	Dr R.C.Jiloha	Dr. V.K.Sinha

Table 2: Details of Various IASP Conferences Held During 1984-2009

Number	Dates	City	Theme
I	24-25 Feb 1985	Kodaikanal	Violence within Society
II	20-22 March, 1986	Chandigarh	Culture and Mental Health
III	20-22 March, 1987	Hyderabad	Social Change and Mental Health
IV	11-13 April, 1988	Calcutta	Community Participation in Mental Health Care
V	20-22 Feb., 1989	New Delhi	Social Psychiatry in the Changing World
VI	10-12 Feb., 1990	Tiruchirapalli	Mental Health in the Socially Disadvantaged
VII	8-10 Feb., 1991	Ahmedabad	Education Systems and Mental Health
VIII	21-23 Feb., 1992	Madras	Psychosocial Rehabilitation in the Developing World - The Way Ahead
IX	25-27 Nov., 1994	Bangalore	Role of Family in Health and Disease
X	17-19 Nov., 1995	Calcutta	Community and Mental Health
XI	21-23 Feb., 1997	New Delhi	Social Sciences and Mental Health
XII	30 June - 1 July, 1998	Bhubaneswar	Women and psychiatry
XIII	15-17 Nov., 1999	Bangalore	New Horizon for Social Psychiatry in the Next Millennium
XIV	9-10 Nov., 2001	Ranchi	Destigmatization of Mental Illness
XV	31 Oct. -2 Nov., 2003	Tiruchirapalli	Psychosocial Interventions in Health and Disease
XVI	28-30 Nov., 2008	New Delhi	Social Psychiatry & Clinical Practice
Silver Jubilee Year	15-17 Nov., 2009	Lucknow	Mental Health: Prioritizing Social Psychiatry

INDIAN ASSOCIATION FOR SOCIAL PSYCHIATRY

Report of the Secretary-General for the years 2008-2009

Mr. President and Members:

I am happy to present before you the seventeenth report of the association for the period 2008-2009. The year 2009 is a major milestone in the life of IASP, as it is now 25 years old. IASP is celebrating its silver jubilee by organizing silver jubilee conference at Lucknow. I will be briefing you about all the developments in the Association which have taken place since the time we met the last on 28 November, 2008.

We had two meetings of the Executive Council after the last conference on 9.1.2009 at Agra and at 21.7.2009 at Delhi. The office of Secretary General is located at the All India Institute of Medical Sciences, New Delhi.

The website of IASP (www.iasp.org.in), started in July 2008, has been updated time to time in last one year. Our journal, the Indian Journal of Social Psychiatry has also been uploaded on our website and can be accessed freely.

Sixteenth National Conference of IASP

The Sixteenth National Conference of the Association held in Delhi from 28th-30th November, 2008 was organized by the Department of Psychiatry and National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi with Professor Rajat Ray as Chairperson, Organizing Committee and Professor Rakesh Chadda as Organizing Secretary. The conference was cosponsored by the World Psychiatric Association. Mr Justice S Rajendra Babu, Chairperson, National Human Rights Commission, delivered the inaugural address in the conference. The conference was attended by about 200 delegates.

With the New Delhi conference, Professor K Roy Abraham took over as the new President Elect and Professor R C Jiloha as Vice President and Acting President for the term 2008-2010. Dr G Gopalakrishnan, who was to take over as President, was not able to attend the conference and is yet to take over the office. Professor R.K. Chadda and Dr Adarsh Kohli were unanimously re elected as Secretary General and Treasurer respectively for another term of 2008-2012. Professor V.K.Sinha was nominated as Editor for another term of 2008-2012.

Indian Journal of Social Psychiatry

The journal is currently being published from Central Institute of Psychiatry, Ranchi. Professor V.K. Sinha is its current editor. The issues from the year 2006 onwards can be freely accessed on the Association's website. Prof V.K. Sinha has brought out issues of the journal for the year 2008 and those for 2009 are under preparation. All the old issues have been dispatched to the members. I would like to add that no journal can survive without contributions from the members. Therefore, I would request all the members to send their research work for publication to the journal. Members who have presented papers in this conference must also send their manuscripts for publication, which could then be peer reviewed for publication. The work done by Prof Sinha is creditworthy and he deserves full appreciation from the membership.

Treasurers' office

The Association has been facing a serious problem since Dr G Gopalakrishnan, the previous treasurer has not transferred the full accounts to the current Treasurer, Dr Adarsh Kohli till date, while his tenure had finished way back in 2003. He has transferred only a part amount. This has caused great problems in running of the office of Treasurer, as no audit has taken place since 2003. Repeated attempts have been made to request him to transfer the accounts by sending him letters by post, e-mail and calling on phone. Many senior members of the IASP have also tried to contact him in this regards, but nothing has worked. AGB in its last meeting on 28.11.2008 had decided to go for a legal action, if the situation continues. EC has started working on it.

Achievements of the members

Many of our members had had distinguished achievements in the last year. Professor K Roy Abraham, our President Elect has taken over as Principal, Cooperative Medical College, Kochi. Professor Rajat Ray has become Member, International Narcotics Control Board (INCB) as a Global Expert nominee from WHO for 5 years. This is an honorary position. Prof J.K. Trivedi has been elected Fellow and Dr Mamta Sood has been elected member of the prestigious National Academy of Medical Sciences. Council meetings were held and important decisions were taken during the years 2008 -2009.

During the year under review, two meetings of the Executive Council

were held on 9.1.2009 at Agra and at 21.7.2009 at Delhi since the last conference. EC framed the guidelines for new awards. EC also took a serious note regarding non transfer of IASP accounts from the previous treasurer to the current treasurer. Prof J K Trivedi invited the Silver Jubilee IASP conference to Lucknow during the EC meeting held at Agra on 9.1.2009, which was duly approved by the Council. The EC meeting on 21.7.2009 discussed about organizational arrangements for the Silver Jubilee IASP conference.

Growth of Membership

I wish to inform you that the trend of growth in our membership has been maintained throughout the period under review. As a part of membership drive we have been able to expand our membership to 569.

Sixty eight (68) members (30 life fellows and 38 life associates) have been added to the IASP fold since the last conference. We have lost 4 of our esteemed fellows (Professor V.N.Bagadia, Professor Alan De Souza, Dr Hema Shah and Dr Amit Mookherjee in the last year. We are paying regular dues to the World Psychiatric Association as a member society. The current membership stands as:

Fellows: 350 (Hon. Fellow:1; Life Fellows:317; Fellows:29)

Associates: 219 (Life Associates:204; Associates:15)

Total: 569

We have also brought out the new updated Directory of the Association during the last conference. Some of our members have not been paying their dues regularly. It is my earnest request to all the defaulting members to pay their dues. I would request them to become life members. I would also request all the members to bring their professional colleagues and friends to the IASP fold, to attend the conferences in more and more numbers and also to contribute to the journal of the Association, as no society can flourish without active and dynamic efforts of its membership.

Awards

IASP encourages scientific research by the membership. To encourage the research in various fields of social psychiatry, the Association has instituted many awards, number of which has also grown, as the Association is growing. The awards are given every year in the national conference. Last year's winners for various awards were Professor Rajat Ray for Dr N.N. De Oration (delivered in 2009 at Lucknow conference), Dr. K.S. Pavitra for Balint Award and Dr Adarsh Kohli and Ms. Manju Mohanty for G C Boral I Award.

During the 2008 National Conference of the IASP held at New Delhi, three new awards were instituted, which have been introduced from 2009, the silver jubilee year of the Association. These include Dr Venkoba Rao Oration, instituted in the memory of Prof A Venkoba Rao, Founder President of IASP, Dr V.K. Varma Award for best publication and Dr. B.B. Sethi Award for poster presentations in the conference. Dr K Roy Abraham has taken the initiative to generate funds for Dr Venkoba Rao Award. Dr V.K.Varma has given an endowment of Rs. 1,51,000 for the award instituted by him. Dr B.B Sethi award is to be given by the organizing committee of the respective conferences.

Committees and Task Forces

IASP has a number of sub committees, which are chaired by a senior fellow and have at least 5 members. The sub committees include constitution and bye laws committee, programme committee, ethics committee, elections committee, CME committee, awards and oration committee and membership committee. All the committees have been working hard to meet the objectives of the Association. Recently IASP has made 3 task forces on 'Mental health legislation', 'Mass media and mental health' and 'Mental health policy'. Professor R Srinivasa Murthy, Professor A K Kala and Dr U C Garg respectively are the convenors of these task forces. All these three areas are of national importance and need active inputs from the mental health professions, and therefore IASP has taken initiative in this area.

In the end, I would like to express my sincere gratitude to all the membership, EC, members and officer bearers of the Association for entrusting me with this job and helping me in running the office smoothly. I am especially grateful to Professor R.C. Jiloha, Acting President, Professor K Roy Abraham, President Elect, Professor V.K.Sinha, Editor, Dr Adarsh Kohli, whose regular inputs have helped in rejuvenating the Association. I am also grateful to Professor S.K. Khandelwal, Member Executive Council, whom I frequently trouble for regular guidance. I would also like to thank my other department colleagues especially Prof R Ray, Head, Department of Psychiatry, Professor M Mehta, Professor P Sharan and Dr Rajesh Sagar. I would like to express my thanks to Dr Mamta Sood, the Assistant Secretary General and Mrs Renu Prashant, my PA who have always been helping me in running this office with full efficiency. In the end I would like to again thank all the membership of IASP, who have entrusted me with this responsibility.

I once again thank you all for your guidance and support, which has enabled me to discharge my commitments and responsibilities as your Secretary-General.

November 16, 2009

(Rakesh K Chadda)

Secretary-General

OBITUARY

Late Prof. B.M. Tripathi (1949-2009)

Professor B.M. Tripathi breathed his last on the 21st December, 2009 after fighting a heroic battle with his illness.

I first met Prof Tripathi in 1982 at the Postgraduate Institute of Medical Education and Research, Chandigarh when he joined the Department of Psychiatry on a WHO/ICMR sponsored project. In our first meeting itself he struck me as a simple, honest and sincere person, yet sharp in his observations. We hit upon a good friendship very soon after our first meeting. Though normally he came across as a quiet person, but in the academic meetings he displayed his keen acumen to articulate his observations and opinions. Soon afterwards, however, I left for Addis Ababa (Ethiopia) to join the Faculty of Medicine there, though we remained in touch sporadically through slow snail mails as those were the days with no internet, emails or even faxes. Dr Tripathi later joined the Deptt. of Psychiatry at the PGIMER, Chandigarh as a faculty member in 1983, but did not stay there for long, and moved on to the BHU in 1987 to strengthen the Deptt. of Psychiatry there as a faculty member. At BHU, he was one of the active members of the Organizing Committee of the annual conference of the Indian Psychiatric Society in the year 1988, where he served as the Treasurer with distinction.

We were destined to cross our paths once again and also to work together once more as faculty members in the same department. 1980s was the time when the country was facing a major challenge due to the upheaval of opiate drug abuse in almost epidemic proportions. The Government of India had launched a major initiative of de-addiction services to tackle this menace. The Department of Psychiatry at the All India Institute of Medical Sciences (which I had joined in 1984) had taken a lead to start de-addiction services in a very comprehensive manner by not only providing therapeutic services to the victims of various addictions, but also to research this area and to train mental health professionals of all disciplines to tackle this menace. Dr Tripathi joined the team of newly appointed members of faculty at the De-addiction Centre (later upgraded as the National Drug and Dependence Treatment Centre) in 1988 as Associate Professor to provide his expertise to combat this challenge. Dr Tripathi's career moved smoothly at the All India Institute of Medical Sciences and he rose to become Additional Professor in 1992 and Professor in 2002.

Dr Tripathi, though remained at the AIIMS since 1988 till he breathed his last on the 21st December, 2009, but he continued to accept challenges elsewhere also testifying to his exploring mind and nature. He served as the Visiting Professor in the newly established Department of Psychiatry at the B.P.Koirala Institute for Health Sciences, Dharan (Nepal) in 2000 for three months to strengthen teaching and clinical services. He also travelled to Australia in 2001 as WHO Fellow in Drug De-addiction at the New South Wales Institute of Psychiatry, and to the US on travel fellowship of the Society for Research on Nicotine and Tobacco, Savannah, Georgia on Global Network Travel Fellowship in 2002. Besides these, he also travelled to many other countries to participate in meetings and conferences to present his scientific work in the field of drug dependence and its treatment.

During early 2000s, when the National Health Services of the Department of Health of England and Wales was facing crisis in the delivery of mental health care to its needy population due to severe shortage of trained and qualified psychiatrists, the Department of Health initiated a controversial drive to recruit psychiatrists from other countries with main focus towards India. Dr Tripathi was among the first ones to be selected as fulltime Consultant under this International Fellowship Scheme to serve at the Department of Psychiatry, Royal Manchester Infirmary from June 2003 - June 2005. He adjusted very well in the new and totally different working environment of a western developed nation and handled the issues of living in a diverse culture with his customary ease. He gave a good account of himself there, and could have easily stayed there on a long-term basis, but the lure of western affluence could not prevent him to listen to the call of his own nation which needed his services more than England. The Royal College of Psychiatrists of England bestowed him with its membership in the year 2004.

Dr Tripathi was known at the AIIMS for many of his virtues, notably, simplicity, honesty in interpersonal relationship, sincerity, and sharpness. AIIMS is usually a hub of 'politics' and 'groupism', yet Dr Tripathi remained untouched with these 'political issues'. It was not that he was ignorant or indifferent, but he had his own opinions on various affairs confronting AIIMS and its Faculty due to his sharp intellect and analytical prowess. Many of us, including myself, would often go to him to seek his opinion on these matters and be enlightened. He had no obvious differences with people and I called him 'agyatshatru' (one who has no enemy).

Dr Tripathi had a brilliant track record in research and academics. He carried out a number of funded and non-funded research projects, especially in the areas of substance and drug dependence. Nicotine dependence, genetics of substance use and abuse, and the issues of HIV and AIDS among drug users were the areas where he made significant contributions to advance the scientific knowledge. He had published a large number of scientific papers in the national and international publications, chapters in many books, and edited a few books. He was the founding editor of the "Drug Abuse: News-N-Views", a newsletter published by the National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi. He was member of many task forces and various committees of the government organizations and Ministry of Health and Family Welfare.

I must share a few words about his family. He was like a 'Shravan Kumar' to his parents. Inspite of his own battle with his illness, he left no stone unturned in looking after their health and other concerns. He lost his father only a few months earlier. Durga Tripathi, his companion for nearly three decades, had been an ideal wife, partner, and collaborator. She stood solidly besides him like a rock in various vicissitudes of his life. Their children, Samidha and Pushkar, are on the threshold of their own bright careers.

Dr. B.M. Tripathi will always be remembered by his family and relatives, friends and colleagues, and students for being a sharp, kind-hearted, and sincere person. He has left a vacuum which will haunt us all for a long time.

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.

.......**Prof. Sudhir K. Khandelwal**

Prof. of Psychiatry,

All India Institute of Medical Science, New Delhi

INSTRUCTION FOR AUTHORS

The Indian Journal of Social Psychiatry is the official publication of Indian Association for Social Psychiatry. The journal is peer-reviewed, is published quarterly and accepts original work in the fields of social and community psychiatry and related topics.

Manuscripts are accepted for consideration of publication by *The Indian Journal of Social Psychiatry* with the understanding that they represent original material, have not been published previously, are not being considered for publication elsewhere, and have been approved by each author.

Preparation of Manuscripts

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.

ARTICLE TYPES

Review Articles

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.

Research articles

Original quantitative as well as qualitative research papers are published under this section. Maximum word limit for research articles is 5000 words (including references and abstract). Abstract has to be structured and should not exceed 200 words.

Brief Communication

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.

Letters to the Editor

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 publication. Such letters must include the title and author of the article and the month and year of publication. The letters will be forwarded to the authors of the discussed article for their response. Letters that do not meet these specifications will be returned immediately.

Book Reviews and Film Reviews

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.

Organization of Manuscripts

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.

a) Cover Letter:

Cover letters should include statements regarding Authorship, Disclosure of any potential conflict of interest, and a statement on under which section the authors want their manuscripts to be considered.

b) Title Page

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.

c) Abstract

A summary of the paper must be in the form of a **structured abstract** using the format below. However, abstract may be unstructured for review articles (as mentioned above). Case reports, letters, and film/book reviews do not require any abstract.

Research articles

Background: need for the study with specific aim or objectives

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.

d) Text

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, Avebury: Aldershot.

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 the footnotes. Footnotes should be indicated by *, +, §.

Figures

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 journal now accepts online submission. The authors can submit their manuscript as attachment through e-mail: **ijsp09@gmail.com** /or authors can also submit their manuscript in a CD containing the manuscript along with a hard copy (A4) having one inch margin on all side and written on one side only with double spacing. Label the CD with contributor's name, short title of the article, software (e.g. MS Word), version (e.g. 7.) and file name.

The manuscript should be sent to the editor's office:
Dr. Vinod K. Sinha
Editor
Indian Journal of Social Psychiatry
Central Institute of Psychiatry
Kanke, Ranchi-834006.

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Authors should disclose at the time of submission any financial arrangements they might have with a company or any organization. It should be clearly mentioned in the *cover letter* which should accompany manuscripts during submission. Such information will be held in confidence while the paper is under review and will not influence the editorial decision but, if the article is accepted for publication, the Editor will usually discuss with the authors the manner in which such information is to be communicated to the reader.

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