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FARMERS’ SUICIDE IN CENTRAL RURAL INDIA: WHERE ARE WE HEADING?

P.B. Behere, Manik C. Bhise

In its seventh decade of independence, our nation is losing its very sons of the soil, our food growers. After the independence, according to Gandhiji’s vision of Gram-Swaraj, villages and specially farmers were to be the main focus of any development plan in India. India, consisting of 16% of world’s population, sustains only on 2.4% of land resource. Agriculture sector is the only livelihood to two-thirds of our population which gives employment to 57% of workforce and is a source of raw material to a large number of industries. Despite portrayal of farming as a healthy and happy way of life, agriculture sector experiences one of the highest numbers of suicides than any other sector. As years pass, agriculture as an industry lost its importance for policymakers of India. This caused severe distress among the farmers over time leading to recent dramatic rise in number of suicides among farmer community.

In the 1990s, India woke up to a spate of suicide by farmers. Farmers’ suicide in India occupied public space during the last one decade. Suicide by farmers has figured in the newspapers, the state assemblies and the Parliament (Behere & Behere, 2008). It has been included in some of the election manifestos. According to analysis by K. Nagraj of Madras Institute of Development Studies, between the years 1997 and 2006 about 200,000 farmers have committed suicide. Thus, on an average, nearly 16,000 farmers’ committed suicide every year; putting every seventh suicide in country as farmers’ suicide (Nagraj, 2007). Farmers’ suicides have increased an annual compound growth rate of about 2.5 percent per annum over this time period. There is a high degree of variation in farmers’ suicide across different states in country. According to 2001 census of India, which is the only year for which we have reliable data on number of farmers’ in country, five states in number of farmer suicides topping the list were Maharashtra, Karnataka, Andhra Pradesh, Chhattisgarh and Madhya Pradesh (Census of India, 2001). In these, farmers’ suicide rate was nearly 60% higher than the general suicide rate, indicating a very distressing situation in these states. For state of Maharashtra, picture is even bleaker. Between the years 1997 to 2006, number of farmers’ suicide has doubled with an annual compound growth rate of 9.8 percent. During this decade, every fifth farmers’ suicide committed in country had occurred in Maharashtra. Vidarbha region of Maharashtra, which lies in the centre of India, is a particularly vulnerable pocket for farmers’ suicides making a continuous suicide belt along with Telangana region of Andhra Pradesh. With much of media and political uproar in the issue, various steps were taken to mitigate this crisis. Most of the interventions done by the state were directed towards survivors of farmers’ suicide. With politicization of the issue, especially prior to elections, various packages were announced for survivors by the government. These mostly included financial ex-gratia help to the affected families. Media and government initiatives together led to picturization of farmers’ suicide as economical and debt-driven crisis and adoption of policy of only providing financial help only to the bereaved.

Dry Land

Suicide is the outcome of multiple factors. At a given time, there are many factors that drive a person to commit suicide (Mann, 2002). Same applies to farmers who end their lives. Most farms continue to be family owned and are exposed to volatility of commodity markets, the variability of weather patterns and influence of respective government regulations. Farmers are thus exposed to a high rate of stress. Physical stressors and hazards of farm environment are compounded by regulatory framework and economic dynamics of managing farm business. These operate in the context of declining trends of trade for agricultural produce; volatile commodity markets; limited availability of off-farm employment; growing cost of machinery and production & loss of farm or livelihood due to crop failures. Economic concerns and government bureaucracy have been consistently identified as major causes of stress and contributors to suicide. There is no customary or mandatory retirement age for farmers all over the world and many tend to work beyond the customary retirement age, placing younger generations in a dependant relationship with their parents for much longer. This can lead to tension between the two generations on the farm. Recently, we have witnessed such cases in our region (Behere & Bhise,
Son becoming alcoholic following father who retired from active government service took dominating and leading role in farming. Roles between work, home and family are often blurred with farming operating as an occupation and way of life for many farmers. Research has shown a relationship between monetary and family problems with suicide.

Farmers committing suicide differ from other suicides. Farmers are more likely to be in their middle ages, married with children in schools, living with family. Most are the sole bread earners for the family. Majority have small to marginal farms of one to two hectors. Farmers who commit suicide tend to use methods to which they have easy access because of their occupation (Fraser et al, 2005). In India, pesticides are easily available and hence its consumption is the most common method of suicide (Behere & Bhise, 2009). These factors need special attention when it comes to prevention of suicides and provision of help to survivors. This makes identification of persons at risk more difficult as even under stress most of them would be functioning normally. Family members often fail to recognize any minor changes in their behaviors that usually precede the suicide.

How to Approach the Problem

Given the complexities of factors driving farmers to commit suicide, strategies to deal with problem of farmers’ suicide need to be systematic and well planned. India is facing problem of farmers’ suicide along with other suicides in significant numbers for quite a long time now. It is time to devise a National Suicide Prevention Policy. Countries like United Kingdom have high rates of farmers’ suicide. It was tackled through systematic research by psychiatrists and social scientists that came out with brilliant suicide prevention policies. Today this problem is well tackled there.

Following are some facts about current approach and suggested guidelines for future:

1) **Financial help to all the families in need:** Current government policy to deal with issue is to provide ex-gratia financial help to families. This help is provided only to those with indebtedness. We need to understand this problem beyond debt. Suicide by bread earners in family has large number of adverse social and economic implications for the survivors (the term “survivors of suicide” in scientific language is used to designate all close family members left behind after suicide by person). Mere presence of debt can’t be a criteria to receive help. Our research has revealed that there are many families with widows and small children left behind who are unable to meet their daily needs like meals and education of children after suicide by the head of the family. They did not receive any help just because they did not have any debts from banks. Debts from money lenders is usually not revealed by family members and also it is not considered as criteria for providing help by government officials as a proof of same is difficult to provide. Also family members reported that "to receive help and to do all the paper work, you need to have political links!" and those who don't have same, usually don't get any help. This leads to neglect of many families who are actually in economic distress. Even for those who receive this aid, is the amount really enough? What families get in hand is actually Rs.30,000/-. Rest remains in banks for seven years. Given costs of commodities today, this money is not enough even for conducting funeral and other rituals for the family. So does this make any difference to them? What happened to distribution of cows and other government aids to farmers is now an open secret. Those near and dear to politicians and officials divert all the schemes to their homes at the cost of those in real distress. We need to address this issue more seriously and delicately to make a difference.

2) **Provision of psychological help:** Findings of our study presented at Annual National Conference of Indian Psychiatric society in January, 2010 clearly showed that irrespective of whether financial help was provided or not, family members of farmers’ suicides continued to have significant levels of psychological distress and difficulties in coping with the demands of daily life situations (Bhise & Rathod, 2010). This proves that mere provision of financial help is not enough. We need a comprehensive policy involving experts in the field of psychiatry and psychology to provide psychological interventions to families. On our recommendations in 2006 to the government, a counselling center was opened in a tahsil of Wardha district (Behere & Rathod, 2006). This soon became
non functional due to apathy of administration. So we need a more dedicated approach in this regard.

3) **Prevention of farmers’ suicide:** Farmers suicides are preventable. It needs a multi dimensional approach. The problem can be approached on short- term and long-term basis. Short term interventions involve information and education of farmers about suicide, its risk factors and identification of persons at risk and provision of psychiatric help to those with recent change in behaviour. This is important as our study revealed that about a third of the farmers expressed suicide thoughts to their relatives about a month prior to the suicide. Our culture does not permit free discussions about suicide. Talking about suicide is a taboo. Most often those who express suicidal thoughts are either taken lightly or asked not to say it again by relatives. This leads to suppression of emotions and increased distress. Society needs to understand that talking about suicide won’t increase chance of committing suicide, rather free expression of inner distress leads to ventilation of emotions and decreased level of stress. Farmers need to be taught how to identify those in distress. They should be aware of available psychiatric services to take those who are expressing suicidal ideas. Also a suicide help-line should be provided for counselling in acute distress.

Long term interventions involve changes in agricultural policies and market changes to treat farming at par with other industries. Over last six decades, government is chasing after industrialization, giving large amount of funds and facilities to a handful of people who, once established, are good for nothing to the society. Agriculture, an industry with a third of revenue generator for country, where two third of our population can be employed is neglected in every five year plan. Policy makers need to be more positive towards this sector. In a survey it was found that more than 40% of farmers said that they wish to change their occupation given a chance to do so. Once looked up as a prestigious and self sufficient occupation, today farming is looked down by many. A deep thought is needed to deal with this issue.

It is high time now to take necessary steps otherwise we may be facing extinction of yet another group from earth, this time a class from our own homo sapiens species, our food growers-the farmers.

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ABSTRACT

A face provides a unique indication of the identity of a person. The remarkable human capacity to recognize and discriminate countless faces has been a subject of interest to psychologists and neuroscientists for many years. Several neuro-psychiatric disorders are marked by impairments in various aspects of face recognition. While brain injury, epilepsy, degenerative disorders and notably schizophrenia are marked by complex difficulties in face processing, other disorders, especially autism, phobias and depression also involve alterations in the ability to perceive, recognize, express, or experience emotions. This review provides a comprehensive insight into research carried out in the field of neuropsychological aspects of face recognition with respect to various behavioural disorders.

Key Words: Neuropsychology, face recognition, psychiatry

INTRODUCTION

Why are faces so intriguing? The answer lies in the variety and importance of the information they can convey. Most notably, a face provides a unique indication of the identity of a person. One can remember hundreds if not thousands of individual faces, with memories that endure decades of separation (Bahrick et al, 1975). The ability to remember large numbers of individual exemplars within a category of objects distinguishes faces from other familiar visual object categories (Farah et al, 1998). From birth, faces are the preferred objects of our attention. With a quick glance at a face, we can easily guess the age, race, sex, and ethnicity, as well as the emotional state of a person. Errors in face-recognition can have catastrophic consequences. This remarkable human capacity to recognize and discriminate countless faces has been a subject of interest to psychologists and neuroscientists for many years.

The right hemisphere plays a particularly important role in face recognition, for two reasons (de Schonen & Mathivet, 1989). First, the right hemisphere is better suited than the left in processing configural information because such information consists predominantly of low spatial frequencies. Second, the right hemisphere develops before the left hemisphere. Research with patients has increasingly been complemented by neuroimaging studies with neurologically intact adults. Studies with fMRI, have reported increased activation in the fusiform gyrus to faces in general, although less activation is observed if the faces are presented upside down. This same group has reported greater activation in this region to faces than to human or animal heads (Kanwisher et al, 1997).

IMPAIRMENTS OF FACE RECOGNITION IN PSYCHIATRIC DISORDERS

Several neuro-psychiatric disorders are marked by impairments in various aspects of face recognition. While brain injury, epilepsy, degenerative disorders and notably schizophrenia are marked by complex difficulties in face processing, other disorders, especially autism, phobias, and depression, also involve alterations in the ability to perceive, recognize, express, or experience emotions. Several studies have shown that processing affectively valent facial expressions activates inferior occipital gyri, fusiform face area of ventral occipital cortex, middle and superior temporal gyri, and the limbic system (Adolphs et al, 1999; Haxby et al, 2000). There is evidence that facial expressions may be processed outside the focus of attention or below the level of conscious
awareness, for example, when attention is directed toward another facial cue (i.e., gender judgments of models posing facial expressions) or when the emotional faces are presented briefly before being masked (Whalen et al, 1998). Implicit emotional processing has been reported to engender stronger brain activation in limbic brain regions such as amygdala compared with activation engendered by the same stimuli processed more explicitly or consciously in normal subjects (Vuilleumier & Pourtois, 2007). Moreover, there is evidence that such relatively automatic processing of emotional stimuli might generate abnormal activation patterns in patients with psychiatric disorders.

SCHIZOPHRENIA

Schizophrenia is associated with a generalized defect of face processing, both in terms of familiarity and emotional expression, attributable to deficient processing at sensory (P1) and perceptual (N170) stages. These patients appear to have difficulty in encoding the structure of a face and thereby do not evaluate correctly familiarity and emotion (Caharel et al, 2007).

Many explanations have been put forth to explain deficits in face processing. The hypothesis, that deficit is the consequence of a more generalized face recognition problem (Salem et al, 1996), has often been supported by findings that subjects with schizophrenia are deficient in the discriminating the age of faces and recognizing the familiarity and identification of faces (Baudouin et al, 2002). Moreover, schizophrenia is associated with deficiencies in the arrangement of internal facial traits (Archer et al, 1994), as patients show poor exploration of such features measured by eye movements for neutral faces (Williams et al, 1999) and for faces expressing various emotions (Loughland et al, 2002). These authors speculate that initial perceptual stages are affected, for example at the level of strategies necessary for handling the visuospatial aspect of faces. In another but related line of inquiry, Grusser et al (1990) postulated that configural processing is affected in this disease related to the analysis of spatial relations existing between facial features, essential for face recognition. Other authors indicate that schizophrenia is associated with deficits in earlier sensory stages of processing (Leitman et al, 2005). There is evidence that abnormal processing at the sensory level contributes to higher-level cognitive defects, including processing the emotional attributes of faces (Mandal et al, 1998; Kim et al, 2005). Another premise is that problems in face recognition are secondary to deficits in selective attention (Baudouin et al, 2002).

It has been demonstrated that subjects with schizophrenia are deficient in the recognition of emotions underlying facial expressions (Mandal & Rai, 1987; Mandal & Palchaudhury, 1989; Srivastava & Mandal, 1990; Kohler et al, 2003), as also in particular fear and disgust (Mandal et al, 1998; van't Wout et al, 2007). This deficit is stable throughout different clinical stages during the course of the disease (Salem et al, 1996) and shows a certain degree of specificity relative to other neuro-psychiatric diseases (Loughland et al, 2002). Studies have shown that these deficits in emotion recognition were associated with illness-related measures like duration of illness (Silver et al, 2002), symptomatology (Mandal et al, 1999; Sachs et al, 2004) and cognitive disturbances (Mandal & Gewali, 1989; Sachs et al, 2004; Silver & Goodman, 2007).

Few studies have examined mechanisms of face processing in schizophrenia. Streit et al (2001) observed reduced Event Related Potentials (ERP) amplitudes between 180 and 250 milliseconds in patients with schizophrenia relative to controls in affect recognition, concordant with the hypothesis that a deficit occurs at the level where perception meets initial stages of cognition. An et al (2003) reported a reduced P3 component in patients with schizophrenia only for faces with negative emotions. Moreover, Herrmann et al (2004) found a diminished N170 component for faces but not for objects. This finding suggested a dysfunction of early stage visual processing of faces in patients with schizophrenia. Caharel et al (2007) found that the schizophrenic group was less accurate than controls in the face processing, especially for unknown faces and those expressing negative emotions such as disgust. P1 and N170 amplitudes were lower and P1, N170, P250 amplitudes were of slower onset in patients with schizophrenia. N170 and P250 amplitudes were modulated by familiarity and face expression in a different manner in patients than controls.

The association of abnormal face encoding with delusions may denote the physiological basis for clinical misidentification syndromes (Turetsky et al, 2007). Dhingra & Nizamie (2004) found no significant differences in ERP variables (N100, N200, P200, P300, MRCP, CNV) between
those with Delusional misidentification and normal controls. However, Narayan & Nizamie (2004) found increased power in both slow and fast EEG bands (delta, theta, alpha and beta) in the right temporal region and increased power in the alpha band in the left temporal region for those with delusional misidentification syndromes. They, thus, postulated that altered functional connectivity between the posterior brain regions constitutes a distributed neural system for visual processing and that lateralization of functional impairment is mainly in the right hemisphere.

Patients with schizophrenia demonstrate abnormalities in early visual encoding of facial features that precedes the ERP response typically associated with facial affect recognition. This suggests that affect recognition deficits, at least for happy and sad discrimination, are secondary to faulty structural encoding of faces (Turetsky et al, 2007). Pandey & Nizamie (1998) found increased spectral power density of delta and theta bands associated with decreased emotions. However, increased power in the beta band was associated with decreased surprise, fear and increased anger and disgust. Increased alpha activity was associated with increased happiness, sadness and disgust. They also found that negative symptoms were inversely associated with negatively aroused emotions and positive symptoms were inversely related to positive emotions.

A small but growing number of studies have examined the neural substrates of emotion processing in schizophrenia. Animal and human investigations of neural networks involved in emotional behaviour implicate the limbic system (primarily the amygdala), hypothalamus, mesocorticolimbic dopaminergic systems, and cortical regions including the orbitofrontal, dorsolateral prefrontal, temporal, and portions of the parietal cortex (Adolphs et al, 1996). Amygdala activation is consistently observed across paradigms, particularly when subjects attend to the emotional valence of perceived faces (i.e., whether the emotion is positive (happy) or negative (sad, angry, fearful, disgusted)) (Gur et al, 2002a). Cognitive or evaluative processing of facial expressions seems to attenuate this amygdala response and possibly shifts the activation leftward (Phelps et al, 2001). Schizophrenia patients tend to show less activation overall when making an emotional discrimination and fail to recruit limbic regions (Phillips et al, 1999; Gur et al, 2002b). Namiki et al (2007) found that impaired facial emotion recognition in schizophrenia patients is emotion-specific (sadness, surprise, disgust, and anger). Moreover, the volume of each amygdala on either side of the brain was reduced. Finally, they found a correlation between left amygdala volume and the recognition of sadness in facial expressions.

Neutral faces were more commonly mistaken as angry in schizophrenic men, whereas schizophrenic women misinterpreted neutral faces more frequently as sad. Moreover, female faces were better recognized overall, but fear was better recognized in same gender photographs, whereas anger was better recognized in different gender photographs. Weiss et al (2007) lend support to the notion that sex differences in aggressive behaviour could be related to a cognitive style characterized by hostile attributions to neutral faces in schizophrenic men. In an earlier study, Kohler et al (2000) reported that schizophrenic men were more impaired in recognizing sad facial expressions than schizophrenic women, but only happy, sad and neutral expression were used. The results of the majority of studies reviewed by Edwards et al (2002) showed no gender effects in schizophrenic patients.

A few studies have examined facial affect recognition in relatives of schizophrenia patients but, to date, the evidence for clear vulnerability-linked deficits is scarce (Bölte & Poustka, 2003; Kee et al, 2004). A recent study, examining evidence for a neurocognitive endophenotype, by examining deficits in facial affect recognition in unaffected siblings of schizophrenia patients, found that siblings and patients demonstrated impaired recognition of negative in comparison to positive facial expressions whereas comparison subjects recognized negative and positive expressions at an equal level of accuracy. These results suggest that deficits in the processing negative affect from social cues are transmitted in families and may represent a heritable endophenotype of schizophrenia (Leppänen et al, 2007). Patients with schizophrenia are impaired in facial recognition (Gur et al, 2001), implicating frontotemporal circuits (Kim et al, 1999). Conklin et al (2002) reported that, compared with healthy subjects, healthy first-degree relatives of patients with schizophrenia were also impaired in face memory (according to Wechsler Memory Scale scores). Face recognition deficits in patients with schizophrenia and their families are not secondary to generalized object memory deficits and may be endophenotype reflecting frontotemporal impairment (Calkins et al, 2005).
It has previously been found that schizophrenic patients have a particular difficulty in recognizing their own faces (Platek & Gallup, 2002). Kircher et al., (2001) support the notion of a specific self-face processing dysfunction in schizophrenia and related it to altered self-awareness. However, visual search for self-face is more efficient than for famous faces and self-face recognition is spared in schizophrenia (Lee et al., 2007). These findings suggest that impaired self processing in schizophrenia may be task-dependent rather than omnipresent.

Face recognition deficits and Theory of Mind (ToM) deficits in schizophrenia are apparent. Patients took longer and were less accurate on the Self Face Recognition (SFR) task than their relatives who in turn performed worse than healthy controls. There was a relationship between accuracy rates on the ToM task and SFR tasks. High levels of schizotypal traits such as social anxiety, constricted affect and no close friends were important for both tasks. A deficit in relatives of schizophrenia patients raises the possibility that ToM and face recognition deficits may be candidate endophenotypes for schizophrenia (Irani et al., 2006).

**MOOD DISORDERS**

**Bipolar Disorder**

Chen et al (2006) measured the neural correlates of tasks, tapping explicit and implicit recognition of sad, fearful, and happy facial expressions using event-related fMRI paradigms in bipolar depressed patients, bipolar manic patients, and control subjects. Depressed and manic patients exhibited abnormal neural responses to sad, fearful, and happy facial expressions. Depressed and manic patients exhibited overactivated responses to fearful faces, as well as to mood-incongruent facial expressions (Chen et al, 2006). Processing of angry facial expressions has been associated with structural and functional changes in the ventral prefrontal cortex, amygdala and anterior cingulate in Bipolar Disorder (Haldane & Frangou, 2006). Preliminary evidence suggests the possibility that Lamotrigine (LTG) may enhance functional activation within prefrontal regions responsible for emotional self-regulation (Frangou et al, 2007). LTG treatment may result in more efficient processing of facial affect for anger with reduction in ambiguity and "normalization" of the pattern of activation (Haldane et al, 2008).

**Mania**

For manic patients, task type also affects the neural response to sad faces, with the cortico-limbic regions showing overactivation for implicit processing and underactivation for explicit processing. Those with mania exhibit over activity in the fusiform gyrus in response to sad faces. Additionally, the attentional level of sad facial affect processing has important consequences for abnormalities of amygdala and cingulate activation in manic patients (Chen et al, 2006).

**Depression**

Patients with depression show deficits in face and voice processing (Rubinow & Post, 1992; Asthana et al, 1998). Studies reveal that while judging emotional facial expressions, the pleasant/unpleasant dimension was of great importance to depressed patients (Mandal, 1986). Depressive patients showed more consistent judgments of the degree of expressiveness within the photographs of each emotion than other groups of patients (Mandal, 1987). Mikhailova et al, (1996) found that all depressed patients, relative to control subjects, made more errors in a task of recognition of facial affect. Depressed patients revealed significantly impaired recognition of negative (in left handed and in right handed) and positive (in left handed) facial emotions, as well as poorer recognition in the right hemisphere, and reduced hemispheric asymmetry. In remission, they showed statistically significant recovery, of recognition function. Mikhailova et al (1996) also found impaired face recognition associated with activation of right hemisphere in patients with endogenous depression. Processing of emotions of sadness, happiness or fear can be affected by current mental state, as demonstrated by the significantly different activation patterns in depressed patients compared to healthy subjects in fMRI studies (Lawrence et al, 2004; Chen et al, 2006). Depressed persons exhibit over activity in fronto-striato-thalamic systems in response to happy faces (Chen et al, 2006). Over-activated amygdala response to implicit emotional facial expressions has been reported in individuals with depression (Fu et al, 2004).

**ANXIETY DISORDERS**

**Social phobia**

Most studies on social phobia have utilized emotional facial expressions (EFE) as stimuli conveying negative social
signals. Functional neuroimaging studies, showing increased brain activation to facial expressions of anger, contempt, disgust, and fear in socially phobic compared with non-phobic individuals, support the assumption of enhanced processing of negative social signals in social phobia (Straube et al, 2005; Amir et al, 2005; Phan et al, 2006). Behavioural studies also indicate that social phobic individuals show increased attentional (Eastwood et al, 2005) and biased memory processing (Coles & Heimberg, 2005) of negative EFE in contrast to non-phobic controls. Furthermore, enhanced recognition of negative facial cues in socially anxious subjects compared to less anxious controls has been observed (Joormann & Gotlib, 2006). However Philippot & Douilliez, (2005) propagated an opposing view. Remarkably though, most studies have failed to find any evidence that individuals with social phobia differ from normal controls in the explicit evaluation of negative EFE on dimensions such as valence or arousal (Amir et al, 2005; Philippot & Douilliez, 2005). Moreover, findings obtained with negative EFE have recently been complemented by studies showing that positive EFE can also elicit biased processing in social phobia (Phan et al, 2006). Although socially phobic individuals seem to evaluate happy facial expressions as pleasant (Philippot & Douilliez, 2005) and even more arousing than nonphobic controls, they take longer to recognize happy EFE than normal controls (Silvia et al, 2006), and lack a positivity bias towards happy faces shown by healthy individuals (Eastwood et al, 2005). Studying recognition of facial expressions in socially anxious children, Simonian et al (2003) found (clinically socially anxious children) significantly poorer facial expression recognition skills than in children with no psychiatric disorder. Socially anxious children performed poorer when presented with happy, sad and disgusted facial expressions.

**Obsessive Compulsive Disorder**

Little is known about the facial emotion recognition of Obsessive Compulsive Disorder (OCD) patients. The only emotion reported to be impaired in OCD patients is disgust (Sprengelmeyer et al, 1997). Mancini et al (2001) also found impairment in the recognition of disgust in associations with OC symptoms. In contrast, no significant differences in emotion recognition were found between OCD patients and normal controls (Buhlmann et al., 2004). Recently, Aigner et al (2007) examined facial recognition processing in OCD patients using the Computerized Neuropsychological Test Battery and the Computerized Penn Facial Memory Test. OCD patients performed more poorly than healthy controls in facial memory tests, especially delayed. The only significant difference between the groups in emotion processing was poorer recognition of sad female faces in patients, who misperceived neutral faces as sad. Thus, indicating a negative bias in emotion recognition in OCD patients.

**Panic Disorder**

Numerous brain-imaging studies have indicated that exposure to fearful faces is associated with significant activation of the amygdala (Morris et al, 2002). Furthermore, increased activation of the Anterior Cingulate Cortex (ACC) has also been implicated in conditioned fear responses in "normal control subjects" (Buchel et al, 1999), and several studies have demonstrated increased ACC activation in response to fearful faces (Monk et al, 2003). In anxiety states, the amygdala and ACC response has varied depending on the provocation and the specific state explored (Fischer et al, 2003). Patients with Panic Disorder activate the ACC and amygdala significantly less than controls when asked to identify fearful facial affect during fMRI. An inverse relationship was found, i.e., the higher the anxiety, the lower the left Corpus Callosum activation. Thus, chronic hyperarousal in Panic Disorder may diminish attentional resources and emotional response reflected in reduced ACC and amygdala activation (Pillay et al, 2006).

**Body Dysmorphic Disorder**

The ability for general facial feature discrimination was assessed in patients with Body Dysmorphic Disorder (BDD) using the Short Form of the Benton Facial Recognition test and with facial photographs from the Ekman & Friesen series (1976). The BDD group was less accurate than the control group in identifying facial expressions of emotion and misidentified emotional expressions as angry more often. Poor insight and ideas of reference, common in BDD, might partly result from an emotion recognition bias for angry expressions. Perceiving others as angry and rejecting might reinforce concerns about one’s personal ugliness and social desirability (Buhlmann et al, 2004).

**SUBSTANCE USE**

There is growing evidence to suggest that people with substance dependence present impaired performance on
tests of emotional processing. Inaccurate perception of facial emotional expressions has been observed in current and short-term abstinent users of MDMA (Hoshi et al, 2004), opiates (Kornreich et al, 2003) and alcohol (Townshend & Duka, 2003).

**Alcohol**

Patients with alcohol dependence have impairment in cognitive processing of emotional signals. Patients with alcohol dependence are specifically impaired on emotional nonverbal behaviour information processing. They are slower to correctly identify an emotion (Foisy et al, 2007). Studies of recovering alcoholics found deficits in the recognition of emotional facial expressions (EFE) (Frigerio et al, 2002). More specifically, studies on the ability to decode emotional facial expressions have systematically revealed that alcoholics decode emotional facial expressions less accurately than normal controls (Frigerio et al, 2002) and, to a lesser degree, than opiate dependent patients (Kornreich et al, 2003). In addition, recovering alcoholics overestimate the intensity of emotional facial expression. They also need a greater intensity of nonverbal signals to perceive an expression as being present (Frigerio et al, 2002), and they display different patterns of interpretation of emotion as compared to controls, with a specific bias towards perceiving expressions as hostile (Frigerio et al, 2002; Townshend & Duka, 2003). Such difficulties in the ability to recognize the emotions felt by others may have an important impact on sociability. Concerning alcohol dependence specifically, it is well known that alcoholics are confronted with severe interpersonal problems in their daily functioning, which are partly mediated by emotional facial expression decoding deficits (Kornreich et al, 2002). Studying crossmodal integrative processes has the potential to help to enhance the understanding of psychiatric pathologies (Campanella & Belin, 2007). Two recent studies showed that the crossmodal processing of face-voice emotions, particularly for anger, is disrupted in alcoholics (Maurage et al, 2007; Maurage et al, 2008).

**Polysubstance use**

Emotion recognition deficits in individuals with multiple substance dependence have been associated with greater interpersonal problems (Kornreich et al, 2002), increased frequency of relapse, and higher number of alcohol detoxifications (Townshend & Duka, 2003). Verdejo-Garca et al, (2007) found that the individuals with substance dependence presented significant deficits in the recognition of facial emotional expressions and decision-making. Patients with polysubstance dependence also showed poorer strategy awareness, impaired self-regulation and higher impulsivity. No significant correlations between length of abstinence and performance on these tests were established. They suggest that the evaluation of emotion, self-regulation and decision-making contributes greatly to the characterization of the persistent deficits exhibited by poly-substance users during prolonged abstinence (Verdejo-Garca et al, 2007).

**PERSONALITY DISORDERS**

**Borderline Personality Disorder**

Few studies on facial emotion recognition have been reported to date in Borderline Personality Disorder (BPD). In the first study (Levine et al, 1997) patients with BPD showed significantly less accurate facial emotion recognition. Emotion recognition performance was unrelated to self-reported affect intensity, level of emotion awareness, and ability to coordinate mixed emotions. In another study (Wagner & Linehan, 1999), women with BPD and histories of childhood sexual abuse were compared with women without BPD who also reported childhood sexual abuse and a control group of women with neither BPD nor childhood abuse. Facial emotion recognition was tested using a self-paced, free-response format. The BPD group was more accurate than the other two groups in recognizing fearful facial expressions, which was related to a response bias toward fear. Results of a functional brain imaging study suggest that the negative attributional bias of patients with BPD may be related to heightened amygdala responsivity to facial emotion (Donnegan et al, 2003). Minzenberg et al, (2006) suggest that patients with BPD have deficits in higher order integration of social information, which may be related to some of the more serious symptoms of the disorder. They found that patients with BPD showed normal ability to recognize isolated facial or prosodic emotions but had impaired recognition of emotions in integrated facial/ prosodic stimuli, and impaired discrimination of non-emotional facial features. In patients with BPD, impaired recognition of integrated emotional stimuli was associated with interpersonal antagonism.
Antisocial Personality Disorder

Multiple studies have shown specific impairments in fearful expression processing in populations who engage in antisocial behaviors (Woodbury-Smith et al, 2005). These populations include those primarily classified by the presence of antisocial behaviours (e.g., aggressive, criminal, externalizing, abusive) and those classified on the basis of both antisocial behaviours and personality traits such as a lack of empathy and remorse. Antisocial populations across studies showed specific deficits in recognizing fearful facial affect (Marsh & Blair, 2007). The perception and recognition of fearful expressions have been previously linked to intact amygdala function, which may be impaired in individuals who exhibit persistent antisocial behaviours. Marsh & Blair (2007) also found that sadness recognition deficits were also associated with antisocial traits.

Schizotypal Personality Disorder

Self-face processing in the right hemisphere is impaired in individuals with schizotypal traits. Traits associated with a schizophrenic spectrum disorder in a non-clinical population may compromise self-face recognition (Platek & Gallup, 2002). Schizotypal patients were less impaired and showed slightly poorer recognition of sad (in RHF) and happy (in LHF) expressions. This group demonstrated significantly poor recognition of happy expressions, and more marked dysfunction of the left hemisphere. In remission, Schizotypal patients failed to improve in recognition of emotion (Mikhailova et al, 1996).

AUTISM SPECTRUM DISORDERS

A number of recent studies have shown that individuals with an Autism Spectrum Disorder (ASD) attend to faces abnormally. Impairments are apparent on numerous tests designed to tax social perceptive and social-cognitive abilities, especially those involving face processing. Examples include problems recognizing facial identity (Klin et al, 1999) or emotion (Baron-Cohen et al, 2001a; 2001b). In particular, ASD individuals spend less time fixating the eyes than control groups (Pelphrey et al., 2002). However van der Geest et al (2002) and Bar-Haim et al, (2006) refuted these findings. Compared to controls matched for age, IQ and visual-perceptual ability, Corden (2007) found a group of Asperger’s syndrome (AS) adults who were impaired in recognition of fearful and sad expressions and spent significantly less time fixating the eye region of all faces. For ASD subjects, the extent of the failure to fixate the eyes predicted the degree of impairment at recognizing fearful expressions. In addition, poor fear recognition and reduced fixation of the eyes were independently associated with greater levels of social anxiety in ASD individuals. These findings support the hypothesis that avoidance of emotionally arousing stimuli, such as eyes, contributes to social-perceptual impairment in ASD. Furthermore, these findings are consistent with theories implicating amygdala-mediated over-arousal and anxiety in the development of these social-perceptual deficits (Corden, 2007).

It is unclear whether individuals with autism are impaired at recognizing basic facial expressions and whether it applies to expression processing in general, or to certain expressions, in particular. Clear differences were evident between individuals with autism and normal controls not only most obviously in the recognition of fear, but also in the recognition of disgust and happiness. Furthermore, individuals with autism are able to discriminate between different emotional images. This suggests that low-level perceptual difficulties do not underlie the difficulties with emotion recognition (Humphreys et al, 2007).

Boraston et al, (2007) compared emotion recognition ability using a novel test involving computerized animation and a more conventional emotion recognition test using facial expressions in adults with autism and normal controls. Adults with autism were significantly impaired relative to comparisons in their perception of sadness. Poor performance in the animations task was significantly correlated with the degree of impairment in reciprocal social interaction. These findings point to a deficit in emotion recognition in autism, extending beyond the recognition of facial expressions, which is associated with a functional impairment in social interaction skills.

MENTAL RETARDATION

Children and adults with mental retardation (MR) have difficulty in identifying facial expressions (Turk & Cornish, 1998). Impairment in facial recognition in MR individuals was not on the basis of chronological but of mental age (Adams & Markham, 1991; Bahatra & Nizamie, 1999). Recognition of
facial expression increases with IQ (McAlpine et al, 1991). Individuals with Mental Retardation (MR) had difficulty in matching sad expressions and labelling disgust (Bahetra & Nizamie, 1999). While examining the electrophysiological correlates of emotion recognition Bahetra & Nizamie (1999) found that, for happy emotions, theta coherence on the left side was the most discriminating, while disgust was related to posterior delta activity and anterior beta activity on the right side. Theta was discriminating on the left and beta on the right side for fear.

CONCLUSION

Although face recognition appears to be a very mundane function, it is the foundation stone of social interactions. Available research on impairment of this ability mostly indicates the amygdala, the fusiform gyrus and the orbitofrontal cortex in the brain. Electrophysiological measures implicate P1, P3 and N170, as well as increased spectral power in the beta band associated with increased emotion. Various cognitive models have been proposed to understand the basic process; however, it is only through recent developments in computer technology that we are gaining exciting insights.

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LESSONS LEARNED FROM RESEARCH IN PRODROMAL PHASE OF SCHIZOPHRENIA

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ABSTRACT

In the last ten years, a significant amount of research data has accumulated to identify and predict the vulnerability of individuals to develop psychosis. At a time when DSM-V academia is becoming active with field trials, researchers in prodromal psychosis research are arguing for inclusion of ‘risk syndrome for psychosis,’ which has generated an interesting debate. Studies indicate that approximately 80-85% of cases experience subsyndromal symptoms for a period lasting from several months to several years prior to the onset of the illness, including impaired perception, thought processes, subjective cognitive functions and mood. Also, much of the functional decline associated with schizophrenia occurs during this prodromal phase. The major research achievements in this field have indicated that it is possible to identify candidates who might develop psychosis. It is also known that a delay in treatment compromises the outcome; once the ‘critical period’ for intervention is missed the treatment outcome shall remain poor. Function can be restored and quality of life can be enhanced with a range of therapeutic interventions during the early phase. This paper examines clinical and public health implications of prodromal research.

Key Words: Prodrome, at-risk, risk syndrome, psychosis, schizophrenia, early intervention

INTRODUCTION

Schizophrenia is a common disorder affecting many people across the world, typically arising during early childhood and adolescence (Goldner et al, 2002). The personal and social cost of schizophrenia is extremely high. Schizophrenia frequently results in social and occupational disability and family members of schizophrenia patients are also affected both directly and indirectly (Green, 1996). The economic burden to the society is also considerable (Wu et al, 2005). Prevention of schizophrenia would therefore offer substantial benefit to the patient their family members and the community at large.

Identification of individuals at the prodromal stage of illness, i.e. prior to onset of schizophrenia level symptoms, would offer clinicians the opportunity to provide preventive interventions. Patients in schizophrenia prodrome are symptomatic and frequently experience functional impairment (White et al, 2006). McGorry and colleagues (2009) observed that if valid diagnostic criteria for schizophrenia prodrome can be developed that are sensitive and specific, it may be possible to address the functional impairments associated with the psychotic prodrome. Prodromal research has grown in last ten years or so and it has been central in providing the scientific basis for the ‘prevention’ of schizophrenia (McGorry et al, 2009). Thus, there is hope that subsequent movement in recognizing risk factors may provide a framework for prevention. Research in the prodromal phase of schizophrenia is, therefore, a very significant advancement in the pathway of schizophrenia research. In the present review, we first discuss the concept followed by phenomenology of prodrome and then continuing on to highlight some of the main research findings in at-risk or ultra high risk populations. In the last section we examine the clinical implications and use a public health perspective to discuss whether the achievements made so far can be brought into clinical practice.
**PRODROME**

A prodrome has been defined as "an early or premonitory manifestation of impending disease, before specific symptoms begin" (Gennaro & Gould, 1979). A prodrome for schizophrenia can be identified after the disease has been diagnosed, when the opportunity for prevention has passed (Woods et al, 2009). Although a few instruments have been designed to measure and classify symptoms, it remains to be seen whether utility in research will generalize to clinical practice. Work to date has been based on formal diagnostic assessment interviews and supplemental information often unavailable in general practices. Reliable and valid application of criteria may be especially challenging in primary care settings and in areas with inadequate numbers of trained psychiatrists.

Findings from at-risk research studies in a number of countries document the validity of pre-psychosis risk detection by observing non-trivial rates of conversion to psychosis in a short time period (Rosen et al, 2002; Yung et al, 2005). Data from controlled studies suggest that clinical intervention may be effective in delaying or preventing exacerbation into psychosis, but evidence to date is very weak (Birchwood et al, 1998; Goldner-Vukov et al, 2007). Currently, screening for psychosis risk is controversial; nonetheless, there is a clinical need for methods of identification and intervention preceding fully manifest psychosis. Examining the family history may increase the sensitivity of prediction, but this gain in predictive accuracy is offset by reduced sensitivity to detect cases, leading to many false negative classifications (Carpenter, 2009). Enhancing risk determination using endophenotypes and biomarkers is a future goal, but current considerations of risk criteria for clinical application depend largely on manifested psychopathology.

The symptoms of the psychosis prodrome and the symptoms of schizotypal personality disorder (SPD) are similar, however, these two syndromes can be distinguished based on two criteria: Prodromal patients must show illness progression in the past year while SPD patients may demonstrate illness stability and while SPD patients exhibit symptoms in many areas, prodromal patients may exhibit fewer symptoms (Woods et al, 2009). In a recent study, Woods et al (2009) noted that in their sample, 26% of prodromal patients met SPD criteria, and 67% of patients diagnosed with schizotypal disorder met prodrome criteria (Woods et al, 2009). Thus, SPD in adolescents and young adults may be like the prodrome in that it may also constitute an identifiable risk syndrome for psychosis akin to schizophrenia.

**CONVERSION TO PSYCHOSIS**

From identification of prodromal or ultra high risk (UHR) individuals, the area has also developed to include intervention studies aimed at preventing delay or ameliorating the onset of full-blown psychotic disorder (McGorry et al, 2009). There is great variability in the symptoms of the prodromal phase, which include depressed mood, anxiety, irritability and aggressive behaviour, suicidal ideation and attempt and substance abuse. Certain self-experienced deficits, including cognitive, affective and social disturbances, are commonly described in the early prodromal phase. Common prodromal symptoms include reduced concentration and attention, reduced drive and motivation, depression, sleep disturbances, anxiety, social withdrawal, suspiciousness, deterioration in role functioning, and irritability (Cannon et al, 2008). Closer to the onset of full psychotic symptoms, people often experience attenuated or sub-threshold symptoms. Neuro-cognitive abnormalities are also evident in the prodromal phase and individuals diagnosed with prodromal symptoms display a range of abnormalities similar to those found in first-degree relatives of patients with schizophrenia.

About 35% of individuals at-risk will convert to psychosis in the next two and a half years (Cannon et al, 2008). There appears to be some variation worldwide, as various estimates of conversion to psychosis range from 6% to 54% (Klosterkotter et al, 2001; Yung et al, 2003; 2007). Additionally, the predictive power is increased if individuals experience combinations of five types of symptoms: genetic risk plus functional decline, unusual thoughts, paranoia, decline in social functioning and substance abuse. In fact, substance abuse may increase the risk of conversion to psychosis to 43% (Cannon et al, 2008). Our knowledge that many symptoms and a great deal of disability develop during the prodrome, coupled with the finding of possible neurobiological and neurocognitive damage during this period has added impetus for renewed efforts towards interventions at an early stage. Psychopathological and clinical variables that predict the onset of psychosis have now been identified and it is
expected that the criteria will be refined and validated. Some of these variables are schizotypal personality features, positive psychotic phenomena, negative symptoms, substance abuse and stress.

Cognitive deficits are also recognized as one of the core features of schizophrenia (Pantelis & Maruff, 2002) and have been associated with functional outcomes (Green, 1996). Research has also attempted to detect the presence of such deficits prior to the illness onset, as they represent trait markers. Some of these are working memory, immediate verbal recall deficit, rapid registration, efficient recall and olfactory identification deficit. It has also been demonstrated that these changes are similar to those occurring in the first-degree relative of schizophrenia (Goldberg et al, 2009). Future research is required to determine which treatment strategies are more effective and for what duration. Critics have raised some concerns about false positive classifications and mislabeling; in order to address these concerns we require significant improvement in the accuracy of predictive tools and developing knowledge of intervention, which is required at what stage, to reduce the possibility of iatrogenic damage.

ADVANCES IN RESEARCH

Assessment tools

A main challenge in this area has been the diagnosis of individuals who are at-risk. A few instruments designed to measure and classify the symptoms have been developed and tested and it seems that the prodrome can be assessed in individuals with adequate reliability and validity to justify the application as a diagnostic class (e.g., Andreasen et al, 1977; Lemos et al, 2006; Yung et al, 2005). Current instruments used are the Structured Interview scales for Prodromal Syndromes (SIPS; Miller et al, 2002; Miller et al, 2003) and the Scale of Prodromal Symptoms (SOPS; Lemos et al, 2006). The SIPS is a structured diagnostic interview that may be thought of as parallel to the Structured Clinical Interview for DSM-IV (American Psychological Association, 1994) or other structured diagnostic interviews. The SIPS includes the SOPS, the Schizotypal Personality Disorder Checklist (American Psychological Association, 1994), a Family History Questionnaire (Andreasen et al, 1977) and a version of the Global Assessment of Functioning scale (Hall, 1995).

The SOPS is a 19-item scale intended to measure the severity of prodromal symptoms and the changes in symptoms over time and can be seen as parallel to the Positive and Negative Syndrome Scale and other established severity rating scales for patients who are fully psychotic (Miller et al, 2003). The SOPS contains four subscales for positive, negative, disorganization and general symptoms. The negative, disorganization and general symptoms subscales on the SOPS are not currently part of making prodromal diagnoses but are useful in describing the severity of the diagnosis once established.

There is still a need to develop culture-specific and language-specific instruments because the description of symptoms varies greatly around the world. What has worked in Australia and United States is not likely to work in Cambodia, Sri Lanka or Thailand for example. Valid and specific at-risk diagnostic criteria will help pave the way for preventive intervention studies (Simon et al, 2006). Under the currently available clinical at-risk diagnostic criteria, only a minority of the general population will be diagnosed with a psychotic disorder. A substantial minority of patients who do develop psychosis will not develop a schizophrenia-spectrum disorder, which may limit the potential usefulness of these criteria in clinical practice. In the future, there is likely to be an increasing ability to detect early manifestations (e.g., impaired cognition) with endophenotypes or biomarkers and it will be essential to determine if interventions years in advance of psychosis are effective and able to alter the future course of illness (Carpenter, 2009).

Biological findings

Recently, the association of molecular genetics with immediate phenotype such as cognitive impairment or abnormal brain functioning as measured with functional neuroimaging, has generated a much more diverse understanding of major psychosis and the combination of these fields of study have resulted in some proactive models. Research on catechol-o-methyl transferase (COMT), brain derived neurotrophic factor (BDNF) and apolipoprotein E (APOE) has been promising (e.g., Martorell et al, 2001; Jindal et al, 2010). These studies address the importance of the issue of identifying individuals who are at true risk of developing major psychosis prior to its full clinical expression (Yung et al, 2003; Yung et al, 2007). This then enables us to treat at-risk individuals prior to full manifestation of psychosis.
and prevent its appearances during critical developmental periods such as late adolescence. The gene-environment interaction is likely to be at the heart of the movement from vulnerability states to the expression of clinical phenotype. The measurement of genetic profiles using groups of candidate genes in combination with psychosocial risk factor such as stress and illicit drug use in samples of patients with clinically significant but sub-threshold features of psychosis with mood disorders is a key research strategy that is now feasible.

Growing evidence suggests that diagnostic boundaries of psychosis may be modified based on genetic information. The brain derived neurotrophic factor and their receptors have been found to be a significant factor in both the antipsychotic drug action and schizophrenia pathogenesis (Durany et al, 2001; Grillo et al, 2007). To date, the study of gene-environment interaction has largely been epidemiological: genotype, risk exposure and disorder are studied as they occur in population (Khoury et al, 2004). Future research needs to improve the integration of epidemiological and experimental paradigms. This is important because traditional genetic epidemiology cannot tell us much about the biological mechanisms involved in potential interactions. The endophenotype approach is quite useful as it provides a way forward in linking features of the disorder to underlying brain mechanisms. Significant advancement has been made in understanding the neurobiology of schizophrenia and a number of potential endophenotype markers seem promising. The most promising markers such as executive function and more direct measures of frontal lobe integrity relate to frontal and perhaps temporal cortices, which are the brain regions that are changing dynamically during adolescence and early adulthood (Giedd, 2004; Paus, 2005).

**Implications of Research: Prevention of Psychoses/ Schizophrenia**

A great deal has been accomplished in last ten years in terms of identification, classification criteria, measurement tools and their standardization and validation, follow-up outcome and neurobiological changes. At-risk research has progressed to a stage where some discussion can take place with vulnerable candidates about early identification as well as early intervention. Data available so far has been exciting and we have arrived at a stage where we are discussing whether 'risk syndrome' is a diagnostic entity worthy of being included in DSM-V (Carpenter, 2009), a commendable success for prevention of schizophrenia in times to come. Research data is neither sufficient not irrefutable to consider this as a diagnosis by itself; however, it is also true that every one who develops psychosis or schizophrenia has always been ‘at-risk’. There have been several significant advancements in this area, namely for reliable diagnosis, for predictive validity, and for increasing specificity, which require special mention.

**Staging model**

Diagnosis should be treatment and outcome focused. Making the diagnosis of a psychotic disorder based on our current categorical diagnostic system (e.g., DSM IV) implies that an individual either has a psychotic disorder or does not. Traditionally, meeting full criteria for a psychotic disorder has been conceptualized as representing a threshold for treatment, such as introducing antipsychotic medication (Keshavan & Amirsadri, 2007; Hetrick et al, 2008). This puts too much faith in the diagnostic system, which has been poor at defining thresholds for disorders and for treatment. It is argued that psychological phenomenon, including psychotic-like phenomenon, occurs on a continuum ranging from absent to most severe. What is clinically important is whether an individual is seeking help, how certain symptoms are experienced by the individuals (e.g., level of distress and what effect such symptoms are having on individuals’ sense of well-being) and day-to-day functioning (McGorry et al, 2006). Based upon these understandings, the staging model was developed, revolving around the theme that early diagnostic markers or risk factors for psychotic illness or isolated distressing and debilitating symptoms which are not of sufficient range or number to meet the full diagnosis should be treated, and that such treatment may prevent the transition to full expression and/or subsequent stage of psychotic disorder (Berk et al, 2007). According to this concept, psychosis spans from normal to severe psychosis, on a spectrum of psychopathology (McGorry et al, 2006). Studies such as UHR or prodromal trials and the greater effectiveness and adequacy of first-episode psychosis programs provide real support for the staging model. The early intervention strategy and a more flexible approach to diagnosis are key priorities for the future (McGorry et al, 2006; McGorry et al, 2007).
Staging model includes five clinical stages with associated biological and endophenotypic markers. Both stages 0 and 1 are relevant, as these occur before the first episode of psychosis. Stage 0 is an increased risk of psychotic disorder with no present symptoms; biological markers include trait marker candidates and endophenotypes such as smooth pursuit eye movements and olfactory deficits. Stage 1A is mild or nonspecific symptoms and includes both trait and state candidates as markers, whereas Stage 1B are those considered ultra high risk, with moderate symptoms and markers of brain changes (seen in Magnetic Resonance Imaging and Spectroscopy) and Hypothalamo-Pitutary-Adrenal (HPA) axis dysregulation (McGorry et al, 2006).

**DIAGNOSTIC DILEMMA**

As the title ‘at-risk’ suggests, this condition could be a precursor to a range of psychotic, non-affective and affective psychosis. There is no convincing evidence that at-risk psychosis is a distinct clinical entity. It is also not clear as to what happens to those who do not convert into major psychosis in a given follow-up time line. There are mainly three groups of patients considered Ultra High Risk in follow-up clinics:

1. Those who certainly convert to psychosis
2. Those who do not convert to psychosis during the period of observation but we do not know whether they will or will not in future
3. Patients who are neither converted nor free from this possibility because of genetic high risk

Patients in either the second or third category will be in continued need of monitoring. Pragmatically, if a patient has definite prodromal symptoms it is hard to dismiss the possibility of progression to psychosis. The study by Woods et al (2009) has provided a reasonable argument to develop the pointers for early identification, particularly a global assessment of functioning score of 40 during the risk phase, which remains lower than from patients with full psychosis. Although there is limited evidence and poorly validated data for risk syndrome as a diagnosis there is sufficient research information to contest any irrational dismissal of the scientific thought. Clinical psychiatry is directly responsive to consumers. It does not take cognizance of ‘diagnosable’ or ‘defined’ syndromes. It addresses issues in the framework of possibilities and interventions. At the end of the day we cannot shy away from consumers asking whether it is possible to avoid, contain, or minimize disruption due to a florid psychotic state. In this pursuit we need strategic instruments for public health awareness to bring more and more vulnerable individuals into the fold of ‘monitoring.’ This does not mean that these patients have to be actively treated; the debate of whether prodrome should be treated with antipsychotics is likely to continue for some time (Miller et al, 2002). If we do not have risk syndrome in the most authentic, open to the public document of psychiatric syndromes, the message for prevention will not be loud and clear. If the proposed DSM-V is going to have any category for sub-syndromal, sub-threshold and sub-clinical conditions, which also remains a distant possibility considering its opposition in academia then including an at-risk state in such a category may be helpful. However, we need to be mindful of giving a pseudo-diagnostic ‘label’ to someone who does not qualify for any mental disorder, although there are a number of other conditions which are not mental disorders but have been included into the classification system. Sub-clinical diabetes, sub-clinical hypothyroid states, sub-threshold depression and a number of other conditions are more obvious cases for qualifying as diagnostic category. As more discussion goes on and more research, theories, and ethical-moral boundaries are being discussed, we would like to commend this initiative to make the prodrome a diagnostic category and hope to see it reach a logical conclusion rather than being deferred.

All stakeholders would be satisfied with the inclusion of risk syndrome on the severity dimension, particularly clinicians who will have reason to illustrate upon sub-clinical conditions like risk syndrome and consumers who will understand clearly the precursors and agree to engage, possibly, in order to work on preventive strategies. However, the resulting potential for stigma and unwarranted treatment merits caution. Psychotic-like phenomena are fairly common in the general population, as Woods et al (2009) point out. Establishing a mental illness diagnosis and initiating treatment is stigmatizing and can cause harm to individuals. Initiation of treatment can have adverse effects, especially associated with anti-psychotic drugs. Clinicians could be caught between two compelling, but mutually exclusive, goals: identify the illness and institute the treatment at the earliest and most effective time versus the traditional mandate in medicine: ‘first of all, do no harm’ (Carpenter, 2009).
CLINICAL IMPLICATIONS AND THE PUBLIC HEALTH PERSPECTIVE

Interest in the potential benefits of early interventions in psychosis has stimulated extensive research on Duration of Untreated Psychosis (DUP) as a predictor of outcome which is more or less able to show a close relationship between long duration of untreated psychosis and poor outcome, at least during the initial few years of follow-up (Drake et al, 2000). This provides visible evidence to all concerned about the need to curb any treatment delay (Nasrallah et al, 2009). Specifically, important findings are:

1. It is possible to identify candidates who might develop psychosis
2. Delay in treatment compromises outcome
3. Most of the functional damage is caused long before the florid symptoms appear
4. Psychosis is a neurotoxic state
5. There is a period that is a ‘critical period’ for intervention; once that is passed treatment outcome shall remain poor
6. Function can be restored and quality of life can be enhanced with a range of therapeutic interventions during the early phase

Some of these findings are bold and compelling, telling a story that is picturesque and vivid. Although several contradictions still exist on finer prints of this framework, by and large it provides very convincing evidence of why early intervention is necessary. Historically, lessons of early identification have been in the forefront of community and preventive approaches in psychiatry. However, the scientific evidence that delay is disastrous to outcomes is far clearer now.

The first clinical implication is the enhanced confidence of the clinician and is a matter of hope for consumers. The scientific evidence is enough for implementing the proactive practice of psychiatry; identification of prodromal phase provides some opportunity for prevention (Shrivastava, 2010). The message can be very effectively taken to the community and awareness programs with the message that it is possible to change what has remained unchanged so far. Studies have already demonstrated that in a given catchment area with program based early intervention DUP can be significantly decreased, that is, a trend sets in where patients approach treatment early (Friis et al, 2004; Fuchs & Steinert, 2004).

The second important implication is the indirect benefit to a large number of patients who have an excellent opportunity for timely treatment due to new early intervention programs. Governments have come forward for funding and resources and in many countries early intervention is available not only for psychosis programs but also across the psychiatric diagnoses. It is now a political agenda; community leaders like to see a mental health program in their catchment.

The third and most important factor is the impact of awareness and stigma. It is a new wave of information and awareness with evidence. The general excitement, economics, politics, and activism have made definite impact in general mental health awareness. Internet as medium of communication has played an important role in this initiative. The content and level of discussion has been enormously enriched between patients, relatives, and the treatment team. The fourth, and the most significant, is the strategic development of the Health Service Research model. For the first time, the experiment to establish such a model of research in mental health has been truly successful. It was attempted in addictions, dual disorders, and several other subjects, but it did not come out as impressive as early intervention. There is an ongoing cycle of research-to-clinic-to-research, which substantiates the quality research. Clinical science has several stakeholders and it is possible to involve all of them for further innovation. The programs provide true examples for partnership in care.

CONCLUSION

The major research achievements in this field have indicated that it is possible to identify candidates who might develop psychosis, and it is also known that a delay in treatment compromises the outcome. Once the ‘critical period’ for intervention is missed the treatment outcome shall remain poor. Thus, therapeutic intervention during the early phase is of paramount importance. The lesson learned from prodromal research and the importance of early intervention is encouraging; however, a lot more needs to be done. We can certainly conclude that ‘first episode is the best episode’ and that there is more to ‘early intervention’ than merely intervening early.
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MARITAL THERAPY FOR PSYCHIATRIC DISORDERS

Anisha Shah

ABSTRACT

Marital therapy has been available as a useful form of intervention for various psychiatric disorders for many decades now. Yet, it remains underutilized in many treatment centers due to various reasons. In this article, the author reviews the existing knowledge in this field based on international research and adds supporting insights from research and practice in India. Efficacy of marital therapy is well established for marital conflicts as well as for certain psychiatric disorders. The article highlights critical aspects of this literature as well as introduces commonly used models of marital therapy. Basic principles, effective techniques and processes for good outcome are also explained. The review concludes with certain guidelines for practicing marital therapy in India.

Key Words: Marital therapy, psychiatric disorders, models, principles, India

INTRODUCTION

Treatments for psychiatric disorders are often based on a biopsychosocial model of intervention. Most mental health professionals can identify relevant psychosocial factors for the index patient quite easily over follow ups. However, many patients may not respond well to these interventions or may stop responding later and achieve only minimal improvement. Reformulation of presenting problems becomes essential in such cases and results in clinicians' search for alternate models for further interventions. Currently, marital therapy is an extremely important alternative for adult psychiatry population.

Marriage and psychiatric vulnerability has been a part of psychiatric research tradition for a long time. One of the consistent conclusions from decades of work is that marital distress affects mental and physical well-being of both partners (Burman & Margolin, 1992; Horowitz, et al, 1998) though in a complex way. Good marital relationship is associated with better psychological well-being, especially in men (Marks, 1996). Relationship problems tend to elevate risk for clinical depression (Weissman, 1987) and are frequently cited as the reason for attempted suicide. Research also shows that maritally distressed persons are two-three times more likely to have disorders related to mood, anxiety and substance use compared to non-distressed persons (Snyder et al, 2006).

Prevalence of marital discord has also increased in psychiatric population. The percentage of marital discord in clients referred for family therapy has increased from 15% in 1972 to 45% in 1995 (Bhatti & Varghese, 1995). Many patients reveal emotional difficulties, power struggles, and separation/divorce issues, difficulties with families of origin, jealousy, extra-marital involvements, communication difficulties, sexual difficulties and physical/emotional abuse with spouse.

It is not uncommon to have individual vulnerability coexisting with relationship difficulties. These can be either specifically be reported as marital dissatisfaction or evident in poor marital quality experiences. Covert conflicts often coexist with conflict avoidance styles. In all such clinical contexts, marital therapy can prevent worsening of mental health of the couple.

Efficacy and effectiveness studies have proved that marital therapy can decrease symptoms and marital distress. Literature on current phase of marital therapy models (Gurman, 2003) consists of the following commonly used terminologies: behavioural marital/couple therapy and behavioural couple therapy (BMT/BCT), cognitive marital/couple therapy (CMT/CCT), insight-oriented marital/couple therapy (IOMT/IOCT), emotion-focused therapy (EFT) for couples, integrated behavioural marital/couple therapy (IBMT/IBCT), and traditional behavioural marital/couple therapy (TBMT/TBCT). Several qualitative and meta-analytic reviews have shown that efficacy
has been sufficiently established for many of these treatments (BMT, IOMT, EFT for couples, and CBMT).

Shadish and Baldwin (2003) meta analysed twenty reviews emphasizing interventions for couples. They conclude that marital and family therapies produce clinically significant improvements in distressed clients with 40% to 50% success rates and that effect sizes for these interventions fare reasonably well against effect sizes for various other social, educational, and medical treatments (e.g. $d=0.80$ for Electro Convulsive Therapy for depression and $d=0.65$ for marital and family therapy). Mean effect size was comparable to or larger than all alternative interventions ranging from individual psychotherapy to medical interventions. Further, average effects for marital therapy tend to be higher than the effects for family therapy (explained by many as due to more intractable problems in family therapy cases). However, they also find that when family therapy and marital therapy were applied for similar problems, their effects were similar. Referring to American Psychological Association, division 12 task force's recommendation that behavioural couple therapy is well-established and emotion-focused and insight oriented couple therapy are probably efficacious, they argue that clinicians should consider meta-analytically supported treatments like cognitive-behavioural, systemic, and eclectic approaches for distressed couples. When more recent studies (published and unpublished) are pooled, an average individual in behavioural couple therapy is better off at the end of treatment than 72% of individuals in control conditions (Snyder, et al 2006).

Myers (1996) in his editorial has commented about a time when an assumption was held by many that psychiatrists provide the ‘difficult’ treatments like medication and psychodynamic therapies whereas as ‘easy’ treatments like marital therapy are provided by psychologists and social workers. He also goes on to say that ‘...sickness affects people's marriage and marital conflict makes people sick....’ Thus, a psychiatrist must be concerned about the state of a patient's marriage and help with suitable methods. Generally, it is believed that up to 40% of problems in individual therapy can be traced to marital distress. Marital relationship is a major source of support and affection for vulnerable persons and can contribute to overall life satisfaction despite psychiatric symptoms.

In general, clinicians frequently do discover that discord may precipitate symptoms or cause a relapse. Clinician's motivation for encouraging patient and spouse to undergo marital therapy is highest in such cases. Second common scenario is where patient's symptoms cause discord due to patient's inability to satisfy relationship needs or hurt the spouse in some way. Hence, conceptualizing a reciprocal relationship between the two is favoured by theorists. An integrated hypothesis that explains genesis and maintaining factors for both individual for relationship dysfunction is required before practicing marital therapy.

Since, marital therapy has scope to improve the contemporary interpersonal experiences in ways that individual treatments cannot, it has evident use for married patents. In individual psychotherapy for married persons, improving marital quality is unlikely to be an important goal. In individual psychopathology formulations if marital stressors are identified, one possibility is that supportive psychotherapy may be offered to cope with marital stress but no real relationship change is expected. Second possibility is that patient's personality/relationship patterns may be viewed as causing the marital dissatisfaction. If these models are not relevant for the patient, individual therapy would fail to achieve its objective.

The next section shows recent evidences relevance of marital therapy for patients with psychiatric disorders.

**SPECIFIC PROBLEMS AND MARITAL THERAPY**

Halford et al (1999) reviewed the relationship between marital distress and disorders like depression, alcohol abuse, anxiety disorders, and functional psychosis and concluded that the relationship is quite complex. Individual and couple problems often exacerbate each other. They suggest that regardless of whether the presenting problem is individual-based or couple-based, both areas must be assessed for treatment. Various hypotheses involving marital relationship and these disorders have been systematically examined in their review article before they conclude about relevance of marital interventions for these patients.

Research on marital therapy typically shows evidence for patients with mood disorder, substance abuse, anxiety disorder and adjustment disorder. Therapy knowledge for these disorders as well as for marital discord without a
psychiatric diagnosis in either spouse has a lot in common. However, international research conclusions cannot be generalized to couples with severe distress, older in age (longer marital duration), antisocial personality disorder, and with aggression/violence as they are excluded from research plans.

Participants usually excluded from researches on marital/couple therapy are substance abuse or dependence, schizophrenia, bipolar disorder, borderline, schizotypal, antisocial personality disorder, or moderate to severe husband to wife physical aggression (Baucom et al, 2009). In India, of couples referred for marital therapy, almost 9% have a diagnosis of substance abuse, 12% have presence of psychotic symptoms, 1/3 are likely to have other psychiatric diagnoses like adjustment disorder, recurrent depressive disorder, depressions, and personality traits. Marital therapy in India has been found suitable for those with mild-moderate depression, dysthymia, recurrent depressive disorder adjustment disorder (depressive type), anankastic/paranoid/impulsive personality traits. Participants have mostly been those with severe distress, with/without psychiatric diagnosis, and with longer durations of marriage and conflict. Aggression/violence and extramarital involvement have not been excluded as they are strong motivating factors for marital consultations (Isaac & Shah, 2004; Kalra & Shah, 2008).

Marital therapy model for substance abuse is quite unique and research on this cannot be combined with research on many other types of marital therapy.

Currently, many commonly used marital therapies for various psychiatric disorders have been identified. The reports by Lebow & Gurman (1995), Shadish & Baldwin (2003), Beach (2001) and Snyder et al (2006) are reviewed here as their conclusions guide marital therapy practices in India quite strongly.

Depression is one of the most widely researched disorders in this field. Some of the conclusions can be summarized as follows (Beach, 2001; Shah, 2008). Marital dissatisfaction accounts for 44% of variation between depressed and nondepressed individuals. Differences have been reported on marital dissatisfaction for persons with and without major depressive disorder/with and without affective disorder. Spouses of depressed individuals also report lower levels of marital quality. Wives' levels of depressive symptoms correlate with husband's marital dissatisfaction. Observational studies showed that marital interactions of couples with a depressed spouse are more negative than couples without a depressed spouse. Marital dissatisfaction may be a better predictor of longitudinal changes in depressive symptoms for women than for men and is also associated with course of formerly depressed individual.

Further, marital dissatisfaction reduces couple cohesion, acceptance of emotional expression, actual and perceived coping assistance self-esteem support, spousal dependability and intimacy. It increases overt hostility through physical and verbal aggression, threats of separation and divorce, denigration, criticism, blame, disruption of routines and so increases risk of depression.

Depression can also predate marital dissatisfaction as personality and interpersonal sensitivity can predispose to both. Behaviour of a depressed individual is aversive to others, guilt inducing and inhibiting. Others want to inhibit negative responses to patients, but responses slip through and are perceived by patient and reinforce depression. Patient's symptoms, behaviours, characteristics, and social context generate stressful conditions primarily in interpersonal context which in turn creates a cycle of chronic or intermittent depression.

Cultural factors like power differences, socialization of gender roles are relevant but presently we have inadequate formulations for all depression and marital dissatisfaction.

Three constructs could be useful to explain depression and marital dissatisfaction: 1) self-verification: positive partner behaviours are noticed, believed, and remembered when consistent with one's self-views 2) dispositional empathy where negative feedback becomes more significant in the absence of positive feedback and 3) hopelessness where patient attributes negative events to stable and global causes.

Marital conflict styles of depressed fathers vs. mothers have been found to be associated with child's emotional security. Nonverbal anger and lack of explanations for disturbed family environment are also predictors of child's emotional security.

Behavioural couple therapy (BCT) seems to be the treatment of choice for women who are depressed and in distressed
marriages. BCT with cognitive therapy reduces symptoms of depression but only BCT improves marital dissatisfaction. Depressive symptoms in men in therapy are also seen despite variations in presenting problem. It appears that depression and interpersonal processes are core vulnerabilities for many. Four outcome studies found marital therapy to be superior to wait-list or equally as effective as cognitive therapy for treatment of depression. BCT is safe and effective when used with depressed persons though one spouse's unwillingness to attend conjoint sessions may preclude its use in many cases. EFT has also been efficacious in reducing depressive symptoms as much as pharmacotherapy with some evidence that even after termination of therapy EFT group showed greater improvement. With salience of marital problems marital therapy would be a good therapeutic strategy for depression, but will be irrelevant if a firm decision to leave relationship has been made. Further, if resources for marital therapy are limited, it should be offered first to those who report marital problems preceded depressive episode. Lastly, it need not be contraindicated for severe depression.

For alcoholism, BCT adds to relationship satisfaction and can often reduce drinking by reducing recurring complaints about past drinking, promoting attention to positive behaviour. This may typically involve 15-20 outpatient couple therapy over five to six months. It can also reduce domestic violence. Agoraphobia outcome is better if spouse is included in treatment.

Efficacy of marital therapy has been discussed for borderline and other personality disorders, as well as many other conditions without any conclusive evidence. It can also be used as an adjunct treatment for schizophrenia, substance abuse (Pinsof & Wynne, 1995).

Regarding some of the other common psychiatric conditions, Baucom et al (1998) concluded that partner assistance and emotional support may be useful even when no obvious relationship difficulties are evident in patients with obsessive compulsive disorder and agoraphobia, as well as other anxiety disorders. Sexual dysfunction can be addressed best with a combination of marital therapy and sex therapy. Further, four possibly efficacious treatment are possible for sexual dysfunctions for women but none for male sexual dysfunction. These are sexual skills training, Masters and Johnson's sex therapy, combined BMT and Masters and Johnson, and general marital therapy with specific sex therapy techniques.

"Individual psychological disturbance in relatively high-functioning individuals does not condemn couples to treatment failures, though it may put them at risk for needing couple therapy in the first place..." (Baucom et al, 2009)

**MARITAL THERAPY MODELS**

Over the decades of research in this area, many models of marital therapy have emerged making it a well-differentiated domain of marital therapies. These are highlighted here.

No model of marital therapy holds advantage over other models. All theoretical orientations have been found equally effective for outcome. However, process research provides more answers for which type of therapy is suitable for which kind of couple.

BMT (Baucom et al, 1998; Beach, 2001; Gupta et al, 2003; Isaac & Shah, 2004) decreases depression and marital distress. More than 24 well-controlled treatment outcome studies have proved this. This is a skill oriented approach based on social learning principles. Changes in communication, problem-solving and/or behaviour exchange are important in therapy. Between one third to two third of BMT patients move to non-distressed range at the end of therapy and maintain gains for at least a year. It has been researched on mainly middle class participants with an average age of 32 years, 7.5 years of marital duration, and 70% of participants with at least one child. Similar results have been found for slightly older persons, less educated, from lower socioeconomic status.

Comparison between US and European countries as well as among many specific developed countries have shown similar results. However, one observation with serious clinical implications is that only 19% of the research participants come from referrals from professionals and the rest are based on recruitments through advertisements. When cognitive perspective is added, the emphasis shifts to helping couples reattribute negative relationship events, change irrational relationship standards. Studies comparing pure BMT with other combinations of BMT show no significant difference. Across treatments, 70% are likely to improve on a variety of marital index and 50% are likely to move to the non-distressed category. BMT latest revisions include a finer distinction between traditional behavioural, integrated behavioural and enhanced behavioural marital therapy.
EFT (Dunn, 2002; Johnson & Whiffen, 1999; Kalra & Shah, 2008) is reportedly effective for parents of chronically ill children, women with depression and couples with post-traumatic stress disorder, depressions, phobias, anxiety and post-traumatic stress disorder. It may also be useful for borderline personality disorder. It is grounded on attachment theory and can address existential dilemmas in couple formation (like autonomy versus intimacy, facing difference and handling disagreements, trust versus mistrust, and my family and your family versus our family). However, it is contraindicated if relationship is dissolving/has violence/extreme individual symptoms such as suicidal behaviour or psychosis in any partner. Relationship distress improves in eight to twelve sessions. Demand-withdraw or withdraw-withdraw patterns filled with anger and frustration or numbness are replaced with new emotional connections based on shared fears, anxieties and vulnerabilities and soothing responses from spouse are facilitated by the therapist. 90% of the couples improve and 75% move to no-longer distressed category post-treatment. However, it is perhaps more clearly beneficial for mild to moderate distress.

IOMT (Baucom et al, 1998) is similar to EFT for couples as spouses are asked to explore feelings, thoughts and needs underlying distress and share vulnerabilities with each other. However, in IOMT, the material is totally or partially beyond awareness and unconscious processes guide discovery of important material for insight and change. IOMT is effective over long-term, better than BMT.

In one of most meaningful research designs completed in recent years, Baucom et al (2009) examined long-term predictors for couples with moderate to severe distress, in the age range of 22 to 72 years, average marital duration of about 10 years, and who received up to 26 sessions of either TBCT or IBCT. From their results, it seems that (a) prediction may be easier for couples with lesser marital distress, (b) soft influence tactics (use of collaborative language by one partner that gives more freedom to the other partner while responding to a statement) in couples is likely to make them respond well to IBCT (involving empathic joining, collaboration, and shared power); and those with less of these tactics may benefit from skill-based therapy format like TBCT, and (c) wife's higher levels of pretreatment encoded arousal (measured by fundamental frequency based on pattern of vibration by vocal folds) predicted deterioration at two year follow-up if they had received TBCT (IBCT techniques perhaps target emotional expression and may facilitate shift in emotions), and (d) of the severely distressed couples, 50% are likely to be in recovered state at the end of two years compared to 80% of the moderately distressed couples.

Atkins et al (2005) have condensed research on predictors to couple therapy as follows: (a) couples in traditional behavioural couple therapy (TBCT), those married for longer periods, and men more than women, are likely to experience gains in relationship satisfaction early in treatment but their rate of improvement slows more rapidly in later in therapy, (b) severely distressed couples experience greater deceleration improvement in termination phase of therapy, (c) sexually dissatisfied couples in TBCT improve rapidly in the beginning but lose some of their early improvement in termination phase.

**Basic Principles of Marital Therapy**

This section summarizes commonly applied principles of marital therapy in contemporary practice internationally that are useful for Indian population as well.

Certain dominant assumptions of symptom formations and theories of disorders need to be overlooked for proper integration of marital therapy in psychiatric services. Rather than intrapsychic processes alone, interpersonal processes are to be given equal if not more attention. Causality is replaced by focus on circularity and maintaining factors. Clinician's belief that relationship and interactions can change despite individual limitations is essential. Emphasis shifts to experiences in young adulthood rather than relationships with parents in childhood and difficulties in adult intimate relationships are seen as potential threats to future well being of self, partner as well as children.

Results from international as well as Indian studies and reviews (Isaac & Shah, 2004; Kalra & Shah, 2008; Lebow & Gurman, 1995; Pinsel & Wynne, 1995; 2000; Shadish et al, 2000) show that marital therapy is effective in decreasing marital distress. It is also effective in treating depressive spectrum disorders. More specifically, it improves communication, positive behaviours, intimacy, relationship attributions style, irrational beliefs about relationships, though these respond to specific components of therapy. Conjoint
marital therapy is superior to individual marital therapy. Conjoint sessions help sustain motivation for change in each partner and avoid blaming of any one partner by ensuring that they play a supportive role towards each other's symptoms and by preventing hurting each other due to symptoms. It also helps safely address symptoms. Three patients-each spouse and their marital relationship can be evenly attended in such sessions. A powerful trend in research and practice is to integrate therapies and have flexible treatment strategies to maximize benefits to couples. Marital therapies are usually brief with 12 to 20 sessions (Gurman, 2003).

Techniques that increase positive reinforcing behaviour and decrease punishing behaviour, communication skills and problem-solving skills techniques, processes that help couple accept unchangeable individual styles, promote intimacy, improve self-care, nurture emotional synthesis and create healthy bonds between parents and children are most effective for positive outcome. Overall, changes in the relationship dynamics like emotional processes and power tactics have been found most critical for good outcome rather than any individual or couple characteristic.

Therapy processes examined have demonstrated the value of emotional expressiveness and conflict resolution skills and found that decreasing negative behaviour is more important than increasing positive behaviour. Nontraditional roles affect women positively and men negatively and promoting affective self-disclosure is better than merely increasing self-disclosure. Use of sequential format for conjoint and individual sessions can also be effective as it can serve dual goals of coping with symptoms as well as simultaneous appraisal of relationship events. The overall goal of symptom-interactional changes can thus be achievable. For depression, severe marital stressors require earlier attention before new communication and problem solving patterns can be made. Techniques found specifically relevant in the context of depression are increased cohesiveness, emotional expression and acceptance, self-esteem, intimacy and decreased negative patterns. Therapy processes are not only influenced by initial presentations but also by changing presenting problems across therapy as well as changing presenting problems across partners. Subclinical as well as clinical depression is relevant across practically all types of marital therapy. It is possible that sometimes fluctuating patterns of depression and deliberate self harm attempts get lost under explanations of relationship dynamics (Shah, 2008). Neither partner is to be blamed for marital problems although both are to be encouraged to see themselves as responsible for changing patterns (Beach, 2001).

Studies directly comparing two or more types of marital and family interventions as well as those comparing it with other treatment (like individual psychotherapy, half-way homes, problem-solving training, hospitalization, or group therapy) firmly conclude that differences between therapies are small and usually nonsignificant (Shadish & Baldwin, 2003). Behaviour couple therapy is a useful approach for depression, alcohol abuse, anxiety disorders and functional psychosis (Halford et al, 1999).

Currently, we have insufficient knowledge about relationship experiences for two complex clinical situations-1) when both partners have psychiatric disorders along with marital discord, and 2) when couples have marital discord along with more than one psychiatric diagnosis in one partner. Experience from practice suggests that marital therapy is helpful to promote helpfulness for each spouse as mutual support may be present but coexists with helplessness. Resilience factors in each partner as well as the relationship become very critical for good outcome.

Generally, Snyder et al (2006) point out that marital therapy can be planned (1) to reduce marital conflict that contributes to development, exacerbation or maintenance of specific individual or relationship problems, (2) disorder specific intervention to influence co-occurring problem, or (3) partner-assisted intervention where partner is a surrogate therapist for the patient.

Evidence strongly supports the fact that improvement in couple functioning occurs not only during the course of therapy but is also largely maintained over a two year follow up after termination. This has also been confirmed specifically for two of the marital therapy models-integrative behavioural couple therapy as well as traditional behavioural couple therapy (Christensen et al, 2006). Research suggests that persistent marital distress (30%) or even divorce (38%) four years after termination is more likely if couple reported higher levels of depressive symptomatology, low psychological resilience, or low emotional responsiveness (Snyder et al, 1993).
While many marital research studies have found neuroticism to be one of the most robust and reliable cross sectional as well as longitudinal predictors of marital stability and quality, studies on prediction of treatment response at therapy termination failed to find evidence that neuroticism predicts response to marital therapy (Atkins et al, 2005; Baucom et al, 2009).

**GUIDELINES FOR MARITAL THERAPY IN INDIA**

This section, insights from research and practice in India are crystallized for purposes of new developments in the country.

In some studies in India, marital therapy is defined as with at least five conjoint sessions and total 10 sessions completed over a three month period (Isaac & Shah, 2004; Kalra & Shah, 2008) and based on (1) O’Leary et al, (1998)’s Integrated Couple Therapy Manual suitable for a variety of clinical diagnosis as well as presenting complaints (2) Shah (1996; 2000), (3) Integrated Marital Therapy approach used in the family therapy centre at NIMHANS and (4) Emotion Focused Therapy principles. In one study, 50% of couples completed therapy, 47% showed clinically significant change, and participants (with or without clinical depression) and elevated depression scores pre-therapy showed significant change post-therapy (Isaac & Shah, 2004). In a second study, up-to 33% of couples improved on intimacy and relationship satisfaction, couples shifted to mild -distress category from sever distress, therapy improved depression especially in wives, and couples achieved emotional convergence with therapy (Kalra & Shah, 2008). In both the studies, couples had severe marital discord, severe psychiatric illnesses were excluded, co-morbidity was included, total sessions ranged from 10 to 39 with conjoint sessions from five to ten with almost equal number of individual sessions for husbands and wives and gains were maintained at follow-up at six months.

Earlier marital discord models emphasized culturally approved role-playing (Agarwal, 1971), role-expectation theory (Channabasavanna & Bhatti, 1985), and higher drop-out for non-directive marital therapy (Mohan, 1972). Cultural factors continue to be critical for appropriate assessment (Shah et al, 2000). Further, in recent years, greater distress is evident in couples with extra-marital involvement and therapies with them pose newer challenges in practice (Agarwal & Shah, 2009; Kalra & Shah, 2008). Analysis of routine therapy records from a psychiatric setting shows improvement in index patient’s symptoms (Bhatti & Shobana, 2003) and 21% of those seeking counseling from counselling center also have marital issues (Bala, 2007).

In the context of psychiatric disorders in either/both partners, clinicians’ goals and expectations of outcome need to be reasonable. Marital therapy is unlikely to make a patient completely asymptomatic. This can perhaps dishearten the clinician who witnesses marital conflicts either to be causing psychopathology or contributing to worsening of the symptoms. However, perhaps a clinician can best appreciate these therapies as interventions directed towards maintaining factors for patient’s psychopathology.

When national and international research trends are combined, one can conclude that of all couples in therapy, we can expect up to 50% of them to become completely free of marital distress, relapses are common and booster sessions are very relevant. Internationally, divorces are common in almost 1/3rd of these couples, and separation/divorce is a very frequent presenting concern for many of the couples seeking therapy in India.

There are two other unique features of couples in India which directly affect marital therapy processes. Marital duration of couples referred for marital therapy is longer than that reported in international literature and separations due to discord have idiosyncratic meanings for each couple and does not always imply divorce-like phenomena (Vallikad & Shah, 2009).

Certain cultural characteristics of Indian families also have unique relevance for marital therapy as these are common to our psychotherapy population as well (Shah, 2010). Family patterns usually promote longer exposure of children to family environment making them psychologically vulnerable if chronic marital discord is present. Emotional dependence on parents is usually nurtured even after marriage and dysfunctional parental units often disrupt young marriages and restrict healthy psychological separation from parents. This can have further mental health consequences throughout adulthood. Hence, marital issues discussed in therapy tend to have systemic content rather than merely dyadic content. Triangulation/coalitions also are inevitable occurrences in many families and chronic marital discord leading to severe
family dysfunction can be frequently found in routine psychiatric interviews in families from older family life cycle stages. Since many reviews have pointed out that marital discord seems easier to treat than family dysfunction, marital therapy can perhaps prevent future need for family therapy.

Most couples seeking therapy have multiple presenting problems, including individual psychopathology and its impact on the relationship. They benefit if provided with clarity in the initial sessions about short term as well as long term goals in individual and couple domains of therapy. Symptoms can also prevent conjoint participation in conjoint sessions and make tasks in sessions difficult to achieve. Other challenges in practice are uneven therapeutic alliance with partner due to existing gender polarity, inaccurate hypothesis about marital discord, 'see-saw' of symptoms between the couple, and dilemmas of choosing conjoint versus individual sessions appropriately due to limited mental health experts in the country.

On the other hand, situation is also more conducive for marital therapy than individual treatment. Interventions focusing on symptoms are often rejected as they are stigmatizing. Resilience factors of each partner and relationship are more easily discovered than their pathologies. Relationships also carry an inherent notion of support and empathy though this can also promote mutual helplessness.

In the case of children with psychiatric disorders, conjoint sessions with the parents essentially focus on improving parenting styles and altering switchboard communication as well as triangulation/capegoating structures caused by marital discord. Validation from spouse for one's good parenting style and present focused tasks make sessions very constructive for parents in marital therapy. For those facing difficulty in leaving older issues behind, EFT/solution-focused strategies may facilitate change.

Nonetheless, therapists are likely to face many challenges in applying marital therapy constructs in practice. Emotional expressiveness and discussions on conflicts is usually discouraged in our social processes but essential for improving conflict resolution skills in couples. Decreasing negative behaviour may be more critical for Indian couples than increasing positive behaviour. Gender polarity influences relationships in a much more specific way than in western couples. It seems that nontraditional role affects women's mental health positively and men negatively, which in turn impact how they experience relationship quality. Lastly, enhancing affective self-disclosure is a more relevant goal in therapy rather than merely increasing self-disclosure.

Therapist, husband and wife need to develop collaborative intermediate goals for sessions either from marital domain or from symptom domain as required as therapy must bring mental health benefits for each partner along with solving relationship difficulties. Also, evaluation of intimacy between partners can not disregard intimacy patterns with family and friends that exists in our culture.

However, therapists need to be prepared that longer duration of marital conflict, increased distress with extramarital involvements and psychological/physical abuse sometimes can prevent therapist from influencing issues for many initial sessions. Since no clear definitions come for some of these issues from the outer system, lone therapist would be struggling against many invisible processes. This can often make the clinician divert therapeutic attention on individual psychopathology rather than relationship experiences. The 'magic of home work' assignments also fail frequently for Indian couples. Nevertheless, the shorter duration of marital therapy with benefits for at least two, if not more, persons' mental health can be considered seriously in routine psychiatric treatment settings across India.

CONCLUSION

Across research based evidence on marital therapy, the following conclusions (Gurman, 2003) can be relied upon for furthering its use in psychiatric population in India: a) like many other psychotherapies, marital therapy too has a positive outcome in about two-thirds of treated couples, especially with conjoint treatment, b) improvement rates reported for marital therapy are similar to those found for individual psychotherapy, c) a randomly selected treated couple is better off at the end of marital therapy than 70% of untreated couples, and d) its effects exceed those of individual therapy for marital problems.

Application of any therapy brings with it unique challenges across different settings. Populations’ expectancies also determine response to treatments offered. Many clients may be highly motivated for marital therapy but reluctant to take
psychiatric medication for symptoms. Some of them are likely to be more cooperative for individual treatments after some improvement in marital relationship. Thus, marital therapy can make a remarkable difference to mental health needs of psychiatric population in India.

The term ‘marital therapy’ has been used interchangeably with the term ‘couple therapy’ in international literature. For convenience, this article uses the term marital therapy instead of couple therapy wherever possible.

Note: This article is based on a presentation at the CME symposium on marriage and mental illness as part of Silver Jubilee National Conference of the Indian Association for Social Psychiatry, Lucknow, November 2009.

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CULTURE AND DEPRESSION - A STUDY OF THE ASSOCIATION OF DEPRESSION WITH CULTURAL CHANGE IN HAVIK BRAHMIN WOMEN OF SOUTH INDIA

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ABSTRACT

Background: Considerable attention has been given to cultural research in psychopathology. With widely prevalent cultural heterogeneity in India, the provision of appropriate clinical care depends upon understanding sub cultural differences in the experience and presentation of depression. This study aimed at studying the prevalence of depression in women belonging to Havik Brahmin Community, elaborating the psychosocial problems, coping skills and cultural changes in this particular community in the last 15 years. Methods: Two hundred Havik women who met the eligibility criteria were interviewed with General Health Questionnaire 28, Mini International Neuropsychiatric Interview Plus 5.0.0 Questionnaire, Coping Checklist, semi-structured questionnaires for psychosocial problems and gender disadvantage factors. Results: The important changes noted in the last 15 years in Havik society were increase in education levels in females, labour problems for household work and land work and difficulty in getting a girl for marriage for boys residing in villages. Of the whole sample, 24.5% met criteria for life time episode of major depression. Depressed women significantly had more of poor quality of marital relationship, nicotine use in spouse, domestic violence, joint family problems, and loneliness. Depressed women used significantly more coping skills in denial/blame domain. Conclusion: The changes in Havik culture have significant impact on mental health of Havik women. It is important that the mental health professionals should focus on the issue of phenomenology, course and outcome of mental disorders which depend upon multiple socio-cultural factors.

Key Words: Culture, depression, Havik women

INTRODUCTION

Considerable attention has been given to cultural research in psychopathology and numerous studies have been conducted to understand how culture influences stress and mental disorders, including depression (Lopez & Guarnaccia, 2000). The study of representative community samples (as opposed to clinical or college samples), however, remains relatively uncommon There have been studies which have looked at different ethnic communities earlier in India (Carstairs & Kapoor, 1976; Ram, 1992; Ulrich, 1987). These studies have looked at different aspects of mental health profile. With widely prevalent cultural heterogeneity in India, the provision of appropriate clinical care depends upon understanding sub cultural differences in the experience and presentation of depression.

This study was conceptualized aiming at studying the prevalence of depression in women belonging to Havik Brahmin Community, elaborating the psychosocial problems, coping skills and cultural changes in this particular community in the last 15 years.

Ethnographic background

Havik Brahmins form an important section among the Brahmins of North Kanara and South Kanara districts of Karnataka of south India. These Brahmins were learned in Vedic lore and experts in performing 'havana'-oblations to deities. Over the centuries, they took to agriculture and horticulture and became experts in cultivation of coconut, areca, pepper and other spices.

This study took place in Sagar-Malnad Taluk in Shimoga district of Karnataka. Havik Brahmins in this part are dominant economically, politically, judicially and ritually. Their main
source of income is from areca nut cultivation. Areca landholdings range from one-half to four and half acres. Annual income varies from twenty thousand to one hundred and fifty thousand. In the past, the poorer families were concerned with day-to-day survival. Now they no longer worry about inadequate food. Current concerns are educating children and getting a girl in the village for marriage. A detailed description of a typical Havik family system can be found in earlier literature (Ulrich, 1987).

MATERIAL AND METHOD

The data was gathered through personal interviews with each subject through a home visit wherever possible, sometimes in social gatherings and community meetings. Home visits provided opportunity for ample observation of the societal structure of the Havik Community.

Written informed consent was obtained from each subject. Women were chosen randomly from the directories maintained in "Havik sanghas". Eligibility criteria were: (1) Belonging to Havik Brahmin Community (2) Residing in Sagar Taluk (3) Not having an acute current medical or neurological illness (4) Residing in Havik household (Women married to Non-Havik men were excluded). Sociodemographic Questionnaire which was prepared for the current study was used to gather data on age, education, occupation, income, marital status and family details.

All women were administered General Health Questionnaire-28 item Kannada version (Goldberg & Hiller, 1979; Sriram et al, 1989). Depression and suicidality sections of Mini International Neuropsychiatric Interview (5.0.0 version) (Sheehan et al, 1998) were administered to all women who participated in the study.

Coping skills of the study population were assessed by Coping Checklist-Kannada version (Kiran et al, 1989) which has 70 items describing a wide range of emotional, behavioural and cognitive responses that may be used to handle stress.

A semi structured interview was constructed on the basis of common psychosocial problems seen in the community of this particular region. The subjects were also asked to elaborate about their problems and to what extent they related their depressive symptoms, if present, to these problems. Economic status was measured by questions on type of housing, access to water and toilet, house-hold income, employment status and indebtedness in the previous three months.

Participants were asked about pregnancies, number of pregnancies and their outcome was recorded. In menstrual history, the experience of irregular menstrual cycles and dysmenorrhoea in the previous 12 months was probed. They also were asked about the experience of five gynecological symptoms (abnormal vaginal discharge, dysuria, lower abdominal pain, genital itching and dyspareunia) in the previous three months. Definitions of these symptom categories were derived from the guidelines for reproductive health research (Jejeebhoy et al, 2003).

Psychosocial Problems Questionnaire

This structured tool has been used previously in Goa (Patel et al, 2006). The first domain was elicited as part of socioeconomic factors. The second domain covered the life time experience of verbal, physical and sexual violence by the spouse/any family member and concerns about the spouse's substance use habits.

The third domain covered the autonomy the participant had to make decisions regarding visiting her mother's or friend's home, seeing a doctor, keeping money for personal use and having time to do things for herself.

The fourth domain enquired about the level of engagement in the past three months with four activities, namely, religious participation in a community/voluntary group, social outings to meet friends/relatives and having friends/relatives visit her.

The fifth domain consisted of items regarding support from the family when faced with different situations like receiving good news, having a personal problem, needing to borrow a small amount of money, feeling low or ill.

Data on recent changes which subjects considered as important and influential individually and on the Havik Society as a whole were gathered from each participant. Participants were asked to respond to open ended questions and these interviews were tape-recorded and documented.
Statistical Analysis

The data was analyzed using descriptive statistics such as mean, standard deviation for continuous variables and number and percentage for categorical variables. Comparison between coping skills domains and other continuous variables was carried out by independent sample t test for continuous variables and Fisher's exact test/chi square test for categorical variables. P<0.05 was considered significant. All data analysis was performed using SPSS 15.0.

RESULTS

A total of 200 women participated in the study. All of them belonged to Havik Brahmin community. All participated in the study willingly and gave written informed consent. Upto 116 (58%) women were interviewed in their household environment whereas rest were interviewed in social gatherings like small meetings in 'Havik sanghas'.

The mean age of participants was 43.08±10.48 years. Thirty six (18%) lived in urban areas whereas the rest were residing in rural areas. Out of 200 women, 183 (91.5%) were married and rest were either single or widowed. The average monthly income was `2347±26.2. Majority had completed their primary education and were able to read and write fluently in Kannada.

On 28-item GHQ, 94 (47%) scored positive. Out of the whole sample, 49 (24.5%) met criteria for major depression on MINI Plus interview. The sample was further divided into two groups of urban and rural Havik women and another dichotomous group of depressed and non depressed women. The two groups were compared in the psychosocial problem domains, gender disadvantage factors and coping skills.

Table 1: Comparison of Psychosocial Problems in Depressed & Non Depressed Subjects

<table>
<thead>
<tr>
<th>Variable</th>
<th>Depressed</th>
<th>Non-depressed</th>
<th>F/x² value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence</td>
<td>19(38.8%)</td>
<td>105(69.5%)</td>
<td>20.959</td>
<td>0.0001***</td>
</tr>
<tr>
<td>Child age&lt;14 years</td>
<td>25(51%)</td>
<td>66(43.7%)</td>
<td>7.773</td>
<td>0.05*</td>
</tr>
<tr>
<td>Nicotine use in spouse</td>
<td>10(20.4%)</td>
<td>11(7.3%)</td>
<td>6.780</td>
<td>0.009**</td>
</tr>
<tr>
<td>Violence</td>
<td>13(26.5%)</td>
<td>11(7.3%)</td>
<td>12.976</td>
<td>0.0001****</td>
</tr>
<tr>
<td>Joint family problems</td>
<td>27(55.1%)</td>
<td>13(8.6%)</td>
<td>49.98</td>
<td>0.0001****</td>
</tr>
<tr>
<td>Loneliness</td>
<td>28(57.1%)</td>
<td>12(7.9%)</td>
<td>55.96</td>
<td>0.001***</td>
</tr>
<tr>
<td>Grief</td>
<td>24(49%)</td>
<td>17(11.3%)</td>
<td>32.299</td>
<td>0.001***</td>
</tr>
<tr>
<td>Interpersonal problems</td>
<td>23(46.9%)</td>
<td>6(4%)</td>
<td>55.08</td>
<td>0.001***</td>
</tr>
<tr>
<td>Financial problems</td>
<td>28(57.1%)</td>
<td>29(19.2%)</td>
<td>26.12</td>
<td>0.001***</td>
</tr>
<tr>
<td>Geriatric problems</td>
<td>22(43.9%)</td>
<td>13(8.6%)</td>
<td>33.74</td>
<td>0.001***</td>
</tr>
<tr>
<td>Children problems</td>
<td>38(77.6%)</td>
<td>21(13.9%)</td>
<td>72.05</td>
<td>0.001***</td>
</tr>
</tbody>
</table>

p<0.05*, p<0.01**, p<0.001***, p<0.0001****

Urban Haviks were significantly better educated than their rural counterparts (p=0.019). Looking at psychosocial problems (Table 1), it was seen that the urban and rural Havik women differed significantly in terms of relationship problems (p=0.017), child related problems like schooling and health (p=0.04), geriatric problems(0.005),and financial problems (p=0.017). Rural women had higher rates of life time episode of major depression when compared to urban women but this did not reach statistical significance (p=0.072).

The education levels of depressed women were significantly lesser when compared to non depressed women (p=0.001). Depressed and non depressed women significantly differed on confidence in spouse(p=0.001), having children less than 14 years of age(0.05), nicotine use in spouse (p=0.009), domestic violence (0.0001), joint family problems (p=0.0001), feeling and loneliness (p=0.001), financial problems (p=0.001), geriatric issues (p=0.001) and children related problems to schooling and health (p=0.001).

Table 2: Problems Related to Reproductive System

<table>
<thead>
<tr>
<th>Variable</th>
<th>Depressed</th>
<th>Non-depressed</th>
<th>F/x² value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregularity of menstrual cycles</td>
<td>26(53.1%)</td>
<td>51(33.8%)</td>
<td>0.019</td>
<td>0.013*</td>
</tr>
<tr>
<td>Heavy Menstrual flow</td>
<td>18(36.7%)</td>
<td>98(64.9%)</td>
<td>12.048</td>
<td>0.001**</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>13(26.5%)</td>
<td>65(43%)</td>
<td>0.044</td>
<td>0.028*</td>
</tr>
<tr>
<td>White discharge</td>
<td>15(30.6%)</td>
<td>25(16.6%)</td>
<td>4.568</td>
<td>0.033*</td>
</tr>
<tr>
<td>Dysuria</td>
<td>14(28.6%)</td>
<td>16(10.6%)</td>
<td>9.375</td>
<td>0.002*</td>
</tr>
</tbody>
</table>

p<0.05*, p<0.001**, p<0.001***, p<0.0001****

Psychosocial Problems Questionnaire

In reproductive factors domain, irregularity of menstrual cycles (p=0.013), white discharge (p=0.033) and dysuria (p=0.002) were significantly higher in depressed Havik women whereas as menorrhagia (p=0.001) and dysmenorrhoea (p=0.02) were higher in urban Havik women.

Looking at gender disadvantage factors, the first domain of socioeconomic factors showed no significant difference between both groups.

On the second domain of the life time experience of verbal, physical and sexual violence by the spouse and concerns about the spouse's substance use habits, depressed women had significantly more scores on domestic violence (p=0.001)
and nicotine use in spouse (p=0.001). The women who suffered violence by spouse carried four times the risk compared to non depressed women (odds ratio=4.596).

On the third domain of autonomy, there was significant difference in terms of seeing a doctor (p=0.004), visiting relatives/friends (p=0.0001), keeping money for oneself (p=0.0001) and having time for oneself (p=0.0001).

On the fourth domain of the level of social engagement in the past 3 months, depressed women spent significantly less time in social outings (p=0.0001) and having friends visiting them (p=0.0001). Urban women had significantly more time for themselves (p=0.03). They also had significantly more number of social outings (p=0.001).

On the fifth domain of social support, depressed women differed significantly when compared to non depressed women (p=0.0001).

Table 3: Comparison of Coping Skills Across Urban and Rural Havik Women

<table>
<thead>
<tr>
<th>Domains</th>
<th>Urban</th>
<th>Rural</th>
<th>F/x value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem solving</td>
<td>7.25±2.74</td>
<td>7.07±2.73</td>
<td>0.351</td>
<td>0.726</td>
</tr>
<tr>
<td>Social support</td>
<td>3.55±1.52</td>
<td>3.82±1.48</td>
<td>1.002</td>
<td>0.318</td>
</tr>
<tr>
<td>Distraction positive</td>
<td>7.39±2.52</td>
<td>7.26±2.97</td>
<td>0.249</td>
<td>0.803</td>
</tr>
<tr>
<td>Distraction negative</td>
<td>1.41±1.25</td>
<td>1.96±1.54</td>
<td>1.983</td>
<td>0.049*</td>
</tr>
<tr>
<td>Acceptance</td>
<td>7.44±3.22</td>
<td>7.01±2.48</td>
<td>0.893</td>
<td>0.373</td>
</tr>
<tr>
<td>Religion faith</td>
<td>4.19±2.20</td>
<td>5.15±2.07</td>
<td>2.497</td>
<td>0.013*</td>
</tr>
<tr>
<td>Denial/blame</td>
<td>3.77±2.31</td>
<td>4.31±2.18</td>
<td>1.314</td>
<td>0.190</td>
</tr>
</tbody>
</table>

On Coping skills assessment, the rural Havik women differed significantly from urban Havik women in having higher scores of religion/faith domain (p=0.013) and negative distraction domains (p=0.04). The depressed women used significantly more of coping skills in denial/blame domain (p=0.0001), whereas the non depressed women used more of positive distraction domain (p=0.07) though it did not reach statistical significance.

Major Changes in the Havik Society

The study also looked at the changes in Havik society which had a bearing on women’s psychosocial problems in particular. These data were elicited through open ended questions and later these were grouped in to categories of similar responses. The summary of changes which participants identified as relevant to havik women’s mental health is presented here:

• Increase in education levels in females-58.8%
• Labour problems for household work and land work-23.1%
• Difficulty in getting a female partner for marriage for boys-47.7%
• Difficulty in getting equally qualified boy for marriage for girls in Havik community-20.6%
• Increase in inter caste marriages-22.1%
• Attitude towards female foeticide- 88.9 % felt it should not be done but 97.6 % still felt it was difficult to raise female child compared to a male child.
• Need for a male child-11.3% felt a male child was very much needed, 38.1% said a male child was needed, 50.6% said it would not matter whether you had a male child or not.
• Changes in traditional values-60.3%
• Involvement in religious institutions-70.9%
• Migration to towns-24.6%

Joint family pattern - 45.2% preferred the existence of a joint family, 34.2% said joint families provided support to raise a child, 35.2% said there existed financial restriction in a joint family system, 36.2% said there was restriction of independence in joint family system.

DISCUSSION

This was a prospective community based study. We studied a group of Havik Brahmin women in the area of Malnad- Sagar taluk. There have been substantial changes in this community in the last 15 years. Changes have been rapid and many a time sudden. We hypothesized that these changes had influential impact on Havik society as a whole and Havik women in particular.

Havik Brahmans provided a unique cohort who belonged to the higher strata in the varnashrama (caste) system yet had
agriculture as their main occupation. The rural background of Havik Brahmins was again an important dimension which gave ample opportunity to look at cultural changes in the last 15 years. Our study aimed at studying the prevalence of depression in women belonging to Havik Brahmin Community, elaborating the psychosocial problems and coping skills in the background of cultural changes in this particular community.

Changes in Havik society: Ulrich (1987) identified increased age of marriage, increased education level and increased decision making rights for women as some of the important cultural changes. In our study, we noted that in the last 15 years there was further increase in education levels in females. Education was identified as an important issue for both men and women in the previous study. But now the women had a right to choose a career by themselves in most of the Havik families. The participants opined that as a result of this there now existed a newer problem. There was now a difficulty in getting equally qualified boy for marriage for girls in Havik community. Girls having higher education (more than 12th standard) refused to live in villages. Mothers were eager to get a groom who was well settled in a city. This had resulted in difficulty in getting a female partner for marriage for boys in villages. This had led to an increase in inter caste marriages not only in the sub sects of Brahmins but also among different castes altogether. Havik Brahmin women who were married outside the caste are expected to follow the traditions of that particular culture.

The other major problem which the participants pointed out was the problem of getting a life partner for Havik men residing in villages and small towns. The Havik women in villages face multiple challenges. Though most of the villages have modern facilities, getting human resources for household work and farming remained a major problem. The times of harvest and sowing were the most stressful particularly for women.

Joint family system where parents lived with their sons and daughters-in-law and grand children were still common in Havik families. However this system was seen to be slowly changing into more of an extended family system. Almost half of all the participants said they preferred the existence of a joint family, mainly because joint families provided support to raise a child, with advantages of shared responsibility and stable financial condition. However they also felt there existed financial restriction and restriction of independence in joint family system for women in particular. The other notable problem in these families was difficulty in taking care of the elderly relatives.

Another important change which was noted by the participants was the changing attitude of Havik society towards female foeticide. In Havik community, a male child was believed to be essential for the soul after death to achieve the heavenly salvation. A ‘son’s mother’ was given much importance and respect. Though due to stringent laws against female foeticide we did not have the exact data on rates of female foeticide in Havik Brahmins, it could be assumed that it was prevalent in this community where the status of having a male child was much valued. Out of our whole sample, 88.9 % felt female foeticide should not be carried out, but 97.6 % still felt it is difficult to raise female child compared to a male child. Almost half of them said it did not matter whether you had a male child or not. This brings into discussion the reasons for difficulty in raising a female child despite higher education and financial stability. Though there have been multiple changes and apparent advances in female education and financial independence, the acceptance of these changes as a welcome change by the Havik culture appears far from reality. On the contrary, one of the elderly women opined that the cause of all these new problems in Havik society was females getting higher education!

The question now is that whether the above changes were interlinked and had a direct bearing on Havik women in particular and Havik society at large. Ulrich(1987) in her paper on havik women noted that considerable cultural change in Havik society had resulted in increased dissatisfaction and awareness of depressive symptomatology. She noted in her study that every woman who disagreed with the traditional role but had decided to pursue the passive role had a history of depression. All of those women who had no history of depression either agreed with the passive role for women or were actively striving for their goals. Keeping in the background these changes, we would now look at the prevalence of depressive disorders, patterns of psychosocial problems and coping skills in Havik women.

Socio-demographic details: Majority, up to (82%) of our sample lived in villages. Earlier studies have been either case
studies (Nichter, 1981) or restricted to one particular village (Ulrich, 1987). More than three fourth of our sample had completed higher primary education and almost half of our sample had attended college. This correlates positively with our participants’ observation of increased education levels of females in the last 15 years.

Depression in havik women: On 28-item GHQ, 94(47%) scored positive. Of these 49(24.5%) met criteria for major depression on MINI Plus interview. All GHQ negatives also turned out to be non depressive on MINI Plus. Depression is prevalent across cultures although symptoms of depression and their relative importance in different cultures vary (Bhugra, 1996; Nguyen et al, 2004). The prevalence of depression in various samples in India has varied from 1.6% to 16.3% (Poongothai et al, 2009). These depend on the source of sample, the diagnostic criteria and screening instruments used. It has been observed that prevalence rates of some psychiatric illnesses differ between countries and even within countries across various ethnic and minority groups (Ruiz, 2001).

Previous research suggests that at least three cultural factors may contribute to the presentation and diagnosis of depression: cultural representations of the self, mind-body relations, and emotional regulation or expressions which tend to normalize and encourage individuals to be interdependent and connected with others (Tsai & Chentsova-Dutton, 2002). Previous research outside India had shown that Asian Americans underutilized mental health services relative to European Americans (Sue et al, 1991; Zhang et al, 1998). Low utilization among Asian Americans in these findings have been attributed to culturally specific beliefs about mental health, social stigma and shame and their culturally relevant coping strategies and help-seeking behaviours (Sue & Morishima, 1982).

Likewise, we can see that the rates of depression in our sample was markedly higher than the prevalence across National studies in India. It was also seen that except for a minority, others had not seen a psychiatrist. This has been observed in earlier studies in other ethnic groups. In Havik women, Ulrich noted that Havik’s followed their own classification of depressive disorders (Ulrich,1987). The link between the higher prevalence and the cultural changes in the Havik community needs to be discussed since this can have important clinical implications.

Rural vs urban: Urban havik women were significantly better educated than their rural counterparts. Looking at psychosocial problems, it was seen that the urban and rural Havik women differed significantly in terms of relationship problems, child related problems like schooling and health, grief related issues, geriatric problems and financial problems. Rural women had higher rates of lifetime episodes of major depression when compared to urban women though this did not reach statistical significance. When we look at these data, the questions that arise are those linked to an increased migration of Haviks to urban areas. The question in discussion is that whether these findings can explain the reasons for the refusal and hesitation in women into getting into marriage with a boy residing in villages. This needs to be looked in future studies. Earlier studies have noted that urbanization is a macro factor along with war and displacement, racial discrimination and economic instability which have been linked to increased levels of psychiatric symptomatology and psychiatric morbidity (Shekar et al, 2006). Individual and family-related risk and protective factors can be biological, emotional, cognitive, behavioural, interpersonal or related to the family context. They may have their strongest impact on mental health at specific sensitive periods along the lifespan and even have impact across generations. However, the findings of our study which show a contradictory finding of urbanization not leading to higher rates of depression can be interpreted in two ways. The first is that the sample size is inadequate to make any definite conclusions and the second, the possibility of significant cultural changes playing an important role in higher rates of depression in rural women. Larger samples and a priori hypothesis driven long term studies are needed to study these issues further.

Depressed vs non-depressed: The other dichotomous group we compared was depressed and non depressed Havik women. The education levels of depressed women were significantly lesser when compared to non depressed women. This finding is in agreement with earlier studies on depression (Gilchrist & Gunn, 2007). It is now well established that the severity and chronicity of the depressive episode is associated with comorbid physical illness, poor quality of life, lower social support, negative life events, lower education level and unemployment.

Depressed and non depressed women significantly differed on having children less than 14 years of age, children related
problems to schooling and health, joint family problems, feeling of loneliness, unresolved grief, financial problems and geriatric issues like taking care of elderly relatives.

According to Weiss (1973) loneliness is caused not by being alone but being without some definite needed relationship or set of relationships. Loneliness appears always to be a response to the absence of some particular relational provision, such as deficits in the relational provisions involved in social support (DiTommaso et al, 2003). A combination of factors may be associated with loneliness, and the individual's developmental period may be cited as an important factor. Poverty was seen as an important determinant of loneliness (Peplau, 1982). The family pattern turning more towards nuclear as well as increased rates of migration are the factors instrumental in single households in rural areas where women send their children to boarding schools and husbands go for work. Hence, loneliness also is an indirect indicator of less socialization and greater isolation for the house maker which formed the majority of our sample.

Depressed women differed significantly from non depressed in having interpersonal problems within the family. Staying in a joint family was said to be more stressful. There was need for greater adjustment between individuals in joint families. Extended or joint family system in this particular region is still in vogue though the system is slowly disintegrating. However, many employed women still prefer to stay with in-laws for the support of raising children or other family functions. Earlier Indian studies have looked at inter-personal problem domain. It has been noted that (Ponnudurai et al, 1981; Sethi et al, 1974) mental distress is higher in nuclear families. However, Dube (1970) found more distress in joint families. Joint families are perceived as fostering greater emotional bonding between members, as having more caregivers to take care of the vulnerable and the weak and as being based upon mutuality and cooperation amongst its members. Sethi (1974) expressed worries about increasing awareness about individual rights among women and its link with community mental health is worth mentioning. Sethi and Manchanda (1978) also argue that the greater stress among female members of a completely joint family is explained as a result of the conflict emanating from the desire to loosen the traditional family ties. This is particularly relevant in the context of increasing urbanization and increased education levels in women in Havik society.

We also need to note that depressed women who stay in joint families, like in our own study, probably have greater stress in a joint family. Possible reasons being not able to function normally, negative remarks on not working to the capacity, on negative symptoms and seeing a psychiatrist going to different doctors frequently. These have important clinical implications. Making an association of joint family and depression is not only spurious but also impractical. Instead clinicians need to focus on the improving communication between family members and educating the family members to the maximum extent possible which are going to be key factors in treating these patients. This also is going to be influential on the drug compliance, regular follow ups, and lesser chances of recurrence and chronicity of depression.

Brown and Harris (1978) identified having more than three children below the age of 14 as one of the social origins of depression. In our sample we noted that depressed Havik women had the problems related to children significantly more than non-depressed women. One of the central propositions of the life-course perspective is that of linked lives, that is, that people in salient relationships with each other, such as parents and children, occupy mutually influential interlocking developmental trajectories that extend throughout their lives (Elder et al, 2003). This also indicates the greater emotional attachment the females experience towards relationships, greater involvement in taking care of children, lesser awareness on the possible treatment options for non physical ailments such as learning disabilities, attention deficit hyperactive disorder, conduct disorder and temper tantrums. With increase in education levels the number of children attending school and attaining higher education also have been higher. Hence, there also is an increased awareness on problems related to children.

In reproductive factors domain, irregularity of menstrual cycles, white discharge, and dysuria were significantly higher in depressed Havik women whereas menorrhagia and dysmenorreoea were higher in urban Havik women. We can see that complaints pertaining to reproductive system were present in more than a third of our sample. Subjects with white discharge (20%) were asked about the relationship of these to the symptoms of depression they have had. Majority believed that this discharge was pathological and was one of the reasons for their current depressive state.
Earlier studies in India have repeatedly shown a strong and consistent association between gynecological complaints and common mental disorders (Patel et al, 2006). They opined that this may be interpreted in two ways. First, we must consider the possibility that the presence of complaints leads to depression. Second, we must consider the possibility that reproductive related complaints are somatic idioms for common mental disorders. There is growing evidence demonstrating this relationship in developing countries, where cultural factors related to explanatory models of reproductive and mental health experiences may enhance the association between these health domains (Prasad et al, 2003; Patel et al, 2005).

It is now well established that women’s higher rates of depression reflect a real gender difference in health rather than an artifact of help-seeking behaviour or willingness to report symptoms (Mirowsky & Ross, 1995; Nazroo et al, 1998).

We assessed gender disadvantage factors in five domains as explained earlier. This was in particular relevance to women having the brunt of impact from the cultural changes compared to Havik men. The first domain was elicited as part of socioeconomic factors, there was no significant difference between both groups. The second domain covered the life time experience of verbal, physical & sexual violence by the spouse and concerns about the spouse’s substance use habits. In this domain depressed women had significantly more scores on domestic violence and nicotine use in spouse. The women who suffered violence by spouse carried four times the risk compared to non depressed women.

Perhaps, well-recognized indicator of gender disadvantage is gender-based violence. Earlier surveys showed that upto a third of married women reported physical violence from their husbands, and that violence was strongly associated with lack of autonomy in decision making (Jejeebhoy et al, 1998). There is established evidence linking domestic violence with an adverse effect on women’s mental health in rich and poor countries (Fischbach & Herbert, 1997; Astbury, 2001). Our study has replicated these findings. These findings are particularly significant in light of the evidence of an enormous global burden of gender-based violence and its relationship to social, economic and culturally determined norms about sex roles in society (Heise et al, 2002; Heise, 1998).

The third domain covered the autonomy the participant had to make decisions in daily life. Here too there was significant difference in terms of seeing a doctor, visiting relatives/friends, keeping money for oneself and having time for oneself.

The fourth domain enquired about the level of engagement in social activities. Depressed women spent significantly less time in social outings and having friends visiting them. The fifth domain enquired about the level of family. On all the different situations, depressed women differed significantly when compared to non depressed women. These findings need to be looked in the background of cultural changes in the Havik society. Support systems are regarded as important in maintaining mental health. Ulrich (1987) in her study noticed that among Havik women support systems consisted primarily of parents, husband, children, in-laws and friends. She observed that depressed women had a support system but were unable to utilize it or had alienated their support system. Also, the system in Havik society provided opportunities for catharsis, refuge from a difficult environmental situation and intervention for appropriate medical referral. In the current scenario, the social support system is further strengthened by the Havik sanghas which are community gatherings providing different kind of supports ranging from financial to health camps. However, depressed women are notably away from the activities of these gatherings and are unable to utilize these support systems.

Specific coping strategies (e.g., acceptance) can have a different impact on functioning, depending on the perceived cause of depression. Thus, for the patient who believes that depressive symptoms are caused by factors outside of his/her control (i.e., environment/chance), acceptance of these symptoms leads to greater functional impairment.

We assessed coping skills in seven different domains. According to Nolen-Hoeksema (1987), the increased vulnerability of females to depression is mainly related to gender differences in coping with an initial lowering of mood, rather than in personality characteristics of assertiveness and passivity, which may predispose to depression. Specifically, females tend to be less active and ruminate over the possible causes and implications of their depression, thus helping to prolong the depressed mood. Indeed, less-effective coping responses involving verbal and self-consolatory strategies have been shown to occur more frequently in females (Hänninen & Aro, 1996).
Neurocognitive studies have suggested that verbal strategies like rumination may produce increased activity of the left posterior hemisphere, whereas physical activity stimulates the right posterior hemisphere. The tendency to activate the left hemisphere as opposed to the right hemisphere under a variety of circumstances has been related to vulnerability to depression (Heller, 1993).

The rural Havik women differed significantly from urban Havik women in higher scores of religion/faith domain and negative distraction domains. The depressed women used significantly more of coping skills in denial/blame domain whereas the non-depressed women used more of positive distraction domain though this did not reach statistical significance. Thus, having healthy coping skills were protective for depression. Having positive distraction, being religious and having faith also in Havik society would mean seeking social support. Hence, it is important to look at the healthy coping skills which are unique and inherent to a particular culture and foster them in that particular community.

We acknowledge the limitations of our study. The emic approach of diagnosing depression would have been more appropriate to study the idioms of distress which would be relevant in this context. The clinical presentation of depression in all cultures is associated with multiple somatic symptoms of chronic duration; psychological symptoms, however, are important for diagnosis and can be easily elicited. Culturally appropriate terminology for depression can be identified and their use may improve levels of recognition and treatment compliance. It is also evident that culture is only one factor in the difference between, and within, human societies which has a bearing on the epidemiology of depression. Other factors, which may interact with culture, such as gender and inequality of income, are major risk factors for depression.

Future international research must focus on themes: (i) intervention studies including cost-effectiveness outcomes (ii) research aiming to bridge the gap between regional public health priorities and the concern that psychiatrists have about depression (iii) protective factors in culture which need to be fostered and transmitted to future generations.

CONCLUSIONS

With widely prevalent cultural heterogeneity in India, the provision of appropriate clinical care depends upon understanding sub cultural differences in the experience and presentation of depression. Culture determines the idioms of distress and defines the ways in which a person seeks social support. Culturally determined rituals and customs serve defensive functions. Hence, it is important that the mental health professionals should focus on the possibility of phenomenology, course and outcome of mental disorders being dependent upon multiple socio-cultural factors. Future research should focus on intervention studies which enable an individual in managing psychosocial conflict in the background of changing culture and protecting the healthy defensive functions which are inherently present in any culture.

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A PROSPECTIVE STUDY OF RELATIONSHIP OF CAREGIVERS’ MENTAL HEALTH WITH THE PERCEIVED BURDEN AND COPING IN SCHIZOPHRENIA AND BIPOLAR AFFECTIVE DISORDER

R.K. Chadda, T.B. Singh, K.K. Ganguly

ABSTRACT

Background: Patients of schizophrenia and bipolar affective disorder (BAD) impose considerable burden on their caregivers. The burden affects the mental health of the caregivers, which may adversely affect their caregiving role. The current study was done to assess relationship between the caregivers’ burden and their mental health and its effect on their coping strategies in schizophrenia and BAD. Method: One hundred patients each of schizophrenia and BAD attending a psychiatric outpatient setting and their caregivers were followed up for a period of six months. Burden and coping strategies were assessed in the caregivers at 0, 3 and 6 months using the Burden Assessment Schedule (BAS) and Ways of Coping Checklist-Hindi Adaptation (WCC-HA). 12-Item General Health Questionnaire (GHQ 12) was used to assess mental health of the caregivers. Results: About one third of the caregivers scored positive on GHQ. GHQ scores showed a positive correlation with almost all the BAS factors in both the caregiver groups. Significant correlation was also observed between GHQ scores and use of various coping strategies: a positive correlation with use of avoidance strategies in both the caregiver groups, positive correlation with use of seek social support coping strategies in BAD caregivers and negative correlation with problem focused coping in the schizophrenia caregivers. Positive correlation was also observed between BPRS scores and GHQ scores. Conclusion: Patients with schizophrenia and BAD with more severe illness tend to cause more distress in their caregivers. Caregivers, who are more stressed due the burden of caregiving, tend to use the avoidance type of coping strategies.

Key words: Bipolar disorder, burden, caregivers, coping, schizophrenia

INTRODUCTION

The focus of caregiver research in psychiatry was earlier on the adverse effects of family relationships on the health of patients suffering from severe mental illnesses, like effect of expressed emotions on course and outcome in schizophrenia (Brown et al, 1972). Since 1980s, it has been recognised that caregivers also suffer considerable burden as a result of their caregiving role, and develop different coping methods to overcome this burden (Scazufca & Kuipers, 1999). This may also affect their health, both physical as well as mental, which might affect their caregiving role adversely (Chakrabarti & Gill, 2002).

A number of studies have shown that the caregivers of patients suffering from schizophrenia and bipolar affective disorder (BAD) experience considerable burden while caring for their patient (Chadda et al, 2007; Fadden et al, 1987; Perlick et al, 1999; 2004; Reinares et al, 2006). Various investigators have found the burden to be dependent on characteristics of patients and caregivers, nature and quality of their relationship, and their environment (Fadden et al, 1987; Gutierrez-Maldonado et al, 2005; Hou et al, 2008; Magana et al, 2007; Schene et al, 1998; Winefield & Harvey, 1993). Burdened caregivers have been reported to often resort to use of avoidance type of coping strategies (Chadda et al, 2007; Perlick et al, 2008).

A substantial body of research on families and mental illness has examined how caregiving processes are linked to the emotional health of family caregivers (Perlick et al, 2008; Winefield & Harvey, 1993). Symptoms of emotional and physical ill health have been reported in a substantial proportion of the caregivers of the patients with schizophrenia,
also affecting their work and social life (Gutierrez-Maldonado et al, 2005). It has been observed that more the severity of the psychiatric symptoms of the patient, and thus more behaviour problems, more would be the caregiving demands leading to increased burden leading to psychological distress in them (Magana et al, 2007). A positive relationship has been reported between the burden perceived by caregivers of patients with schizophrenia and development of depression in them (Magana et al, 2007). Caregivers’ subjective distress is directly related to both positive, as well as negative symptoms (Chen et al, 2004; Madianos et al, 2004) in schizophrenia, and inversely related to the duration of the illness (Boyé et al, 2001). Similarly, BAD caregivers have been reported to perceive higher burden, report more physical health problems, depressive symptoms, health risk behaviour and health service use, and less social support than the less burdened caregivers (Perlick et al, 2008). The burden has also been associated with increased likelihood of use of mental health services.

As the burden affects physical as well as mental health of the caregivers (Hou et al, 2008; Magana et al, 2007), it is likely to have an impact on the coping strategies adapted by them to deal with the burden, and thus may affect care of the patients. It is thus important to understand the complex relationship between burden and health in the caregivers, and its impact on the coping strategies adapted by them, so that they can be helped to cope with the burden of caregiving in a healthy manner, without adversely affecting their caregiving role.

A number of earlier studies on relationship between caregiver burden and mental health, especially those from the Non-Western world, have been cross sectional in nature (Madianos et al, 2004; Magana et al, 2007; Tang et al, 2008; Ukpong, 2006). The cross sectional studies provide limited information since burden is likely to change over time depending on the changes in the patient’s clinical status, interpersonal relationship between the patient and the caregiver as well as the availability of various support systems (Magliano et al, 2000; Roick et al, 2006). Caregivers’ perception about burden is also likely to be influenced by their own mental health and distress as a consequence of the caregiving role and their coping patterns, thus making it a complex relationship. Since caregiver burden, stress and their coping strategies are related to each other, and are likely to change over the course of illness, longitudinal studies are needed to understand this complex relationship. This could also help in developing effective intervention strategies targeted at identifying mental health problems in the caregivers of the patients with severe mental illness and providing suitable help, so as to help them more effectively take care of their patients and use healthy coping strategies.

The present study was planned keeping above mentioned background with the following research questions: Are there any specific components of burden associated with caregiver stress? What is the relationship between the caregivers’ stress and the coping strategies adopted by caregivers to deal with the burden of caring for their patient? Is there any relation between the severity of illness and the distress perceived by the caregivers? The study was prospective in design with assessment at baseline, three and six months using structured instruments.

**MATERIAL AND METHOD**

**Sample selection**

The study was conducted in outpatient setting at the Institute of Human Behaviour and Allied Sciences, Delhi, a tertiary care neuropsychiatric institute. Details of study setting and sample selection have been discussed earlier (Chadda et al, 2007); hence, a brief description is given here. Patients of schizophrenia and BAD in outpatient care and their caregivers were screened for the study as per the inclusion and exclusion criteria. Inclusion criteria for the patients included age 15-50 years, diagnosis of schizophrenia or BAD as per International Classification of Diseases, 10th edition, Diagnostic Criteria of Research (ICD-10 DCR) (World Health Organization, 1993) with a minimum duration of one year, be clinically stable for at least three months and availability of family members or caregivers for assessment. Patients with any associated chronic physical illness, co-morbid substance use disorder and having any living family member suffering from psychiatric illness staying in the same household were excluded. To be included in the study, the caregivers needed to be consenting adults with no history of mental illness, who had been caring for the patient for at least one year. Written informed consent was taken from the caregivers and/or the patients, as appropriate. The study was approved by the institute’s ethics committee.
Three hundred and five cases needed to be recruited over a period of about one year to get 200 cases (100 each of schizophrenia and BAD), who completed 6 months follow up.

Assessments

Caregiver burden was assessed by Burden Assessment Schedule (BAS) (Thara et al, 1998). BAS is a 40 item structured instrument to measure caregiver burden, which has been standardized on Indian population. The items are rated on a three point scale, marked 1-3 with the responses being not at all, to some extent, and very much. Factor analysis of the items has revealed nine factors grouped as spouse related, physical and mental health, external support, caregiver's routines, support of patient, taking responsibility, other relation, patient's behaviour and caregiver's strategies. The instrument has been reported to have a good inter rater reliability (0.80) and satisfactory face validity in terms of the relevance of the items in measuring caregiver burden (Thara et al, 1998).

Coping strategies used by the caregivers were assessed by Ways of Coping Checklist-Hindi Adaptation (WCC-HA) (Chadda et al, 2007; Scazuufca & Kuipers, 1999), a 13 item instrument, with three groups of coping strategies; 'problem focused', 'seek social support', and 'avoidance type'. Caregivers were asked how often they had used any of the strategies in the previous three months to deal with the problems while being in contact with their patient. The WCC-HA has been adapted from the Ways of Coping Checklist of Folkman and Lazarus (1985). The original instrument has 28 items, each item rated on a five point likert scale from 'never' to 'all the time'. Scazuufca & Kuipers (1999) had used a modified 13-item version of the checklist in relatives of people with schizophrenia. Authors translated this modified version to Hindi and tested in 30 caregivers for its suitability in the local population.

Psychopathology in the patients was assessed using 18-item version of Brief Psychiatric Rating Scale (BPRS) (Hedlund & Vieweg, 1980; Overall & Gorham, 1962).

Hindi version of 12 item General Health Questionnaire (GHQ) (Jacob et al, 1972) was used to measure emotional distress in the caregivers. Each item of the GHQ has four responses with the first two being scored as 0 and the third and fourth as 1. Thus the total score can vary from 0-12. A score of 2 and above was taken as reflecting recognizable psychological problems. Total score obtained was used in correlational analysis. The questionnaire has been reported to have satisfactory reliability with Cronbach’s alpha and split reliability of 0.88 and 0.91 respectively (Jacob et al, 1971).

Patients and caregivers fulfilling the inclusion and exclusion criteria were assessed on various measures by the research staff at baseline, three and six months under supervision of RKC and TBS. Three assessments were done, as a valid analysis of trends is only possible with three or more points of measurement (Rogosa, 1988).

Analysis

The data was tabulated as per frequency distribution across different sociodemographic groups. ANOVA and t-test statistics were used to assess the significance of differences in various sociodemographic and clinical variables, and scores on BAS, WCC-HA, GHQ and BPRS between the two case groups at different assessments and between cases and dropouts at intake. Generalised estimating equation analysis was done to study the effect of BAS, WCC-HA and BPRS scores on GHQ scores. Analysis was done using statistical software, Stata 9.2.

RESULTS

The initial intake was of 305 patients and their caregivers, out of whom 100 patients and 100 caregivers each of schizophrenia and BAD completed the six month follow up. There were no significant differences in various sociodemographic and clinical characteristics between the completed cases and the dropouts. Details of the sample have been described earlier (Chadda et al, 2007); hence a brief summary is given here.

Thirty six percent of patients with schizophrenia were in the age group 15-30 years, compared to 44% of the BAD group. About 20% of patients in both groups were above 40 years of age. 75% of schizophrenia patients and 65% of those of BAD were males. Sixty five percent of the patients in both groups were married. Nearly one third of the patients had received up to five years of formal education, about half had completed schooling, and 16% had completed graduation. Fifty three percent of the patients lived in joint families. Most (81.5%) of the patients were gainfully employed. More than 85% patients belonged to low socioeconomic group. The two groups were
comparable on most of the variables, except that 40% of the BAD subjects came from rural background, as compared to just 13% of the schizophrenia group (p<0.001).

The two caregiver groups were also comparable across various variables. Nearly 50% of the caregivers each in both the case groups were in the age groups 25-50 years, with 25% each below 25 years and above 50 years. 58% of the BAD and 49% of the schizophrenia patients were males. About half of them were educated only up to five years. More than 90% of the caregivers were living in the same household as their patients and were having a daily contact with the patients. Most of the caregivers were living with their patients for more than 10 years. All the caregivers were family members of the patients; 32.5% being one of the parents, 43.5% were the spouses, 11.5% being brothers or sisters, 7.5% being sons or daughters and 5.0% other relatives.

Patients belonging to the schizophrenia and BAD groups had similar levels of severity of psychopathology as measured on BPRS. Over the six months follow up, there was a significant reduction in mean BPRS scores from 32.88 to 28.26 in schizophrenia group (p=.006), and from 31.05 to 27.03 in BAD group (p=.013).

Thirty one percent of the schizophrenia group caregivers and 33% of the BAD group scored 2 or more on the 12-item GHQ. This reduced to 26% and 30% in the two groups respectively at six months follow up. However, the two groups did not differ significantly from each other at the different assessments on GHQ and the change over the follow up was also not significant. Caregivers from both the groups perceived similar pattern of burden as revealed in their scores on various factors of BAS and had comparable scores on the WCC-HA on various coping strategies both at baseline as well as on follow up. Caregivers were using the problem focused and seek social support types of coping strategies more often than the avoidance strategies.

A positive correlation was observed between GHQ scores and scores on various burden factors as well as total BAS scores in schizophrenia as well as BAD caregivers. Correlation with the burden factors of physical and mental health (Regression Coefficient:RC-0.2838, 0.3005), caregivers’ routines (RC-0.4670, 0.6578), patient’s behaviour (RC-0.3863, 0.4183), and total BAS scores (RC 0.0634, 0.0701) was highly significant with p values less than 0.001 in both the caregiver groups. Significant correlations were seen with all the burden factors at different levels in both the caregiver groups except the factor of support of patient in the BAD caregiver group (Table 1).

<table>
<thead>
<tr>
<th>Burden Factors</th>
<th>Schizophrenia (N=100) RC</th>
<th>p</th>
<th>BAD (N=100) RC</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse related</td>
<td>0.8851</td>
<td>0.011</td>
<td>0.1446</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Physical &amp; mental health</td>
<td>0.2838</td>
<td>&lt;0.001</td>
<td>0.3005</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>External support</td>
<td>0.0809</td>
<td>0.023</td>
<td>0.0973</td>
<td>0.028</td>
</tr>
<tr>
<td>Caregivers’ routines</td>
<td>0.4670</td>
<td>&lt;0.001</td>
<td>0.6578</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Support of patient</td>
<td>0.2660</td>
<td>0.001</td>
<td>0.1440</td>
<td>0.092</td>
</tr>
<tr>
<td>Taking responsibility</td>
<td>0.1042</td>
<td>0.005</td>
<td>0.1880</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Other relations</td>
<td>0.2514</td>
<td>0.001</td>
<td>0.4338</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Patient's behaviour</td>
<td>0.3863</td>
<td>&lt;0.001</td>
<td>0.4183</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Caregivers’ strategy</td>
<td>0.1400</td>
<td>0.003</td>
<td>0.2506</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Others</td>
<td>0.5685</td>
<td>&lt;0.001</td>
<td>0.5163</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>BAS-T (Total score)</td>
<td>0.0634</td>
<td>&lt;0.001</td>
<td>0.0701</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

GHQ scores showed positive correlation with the scores on avoidance group of coping strategies on the WCC-HA in both schizophrenia (RC-0.2875, p<0.001) as well as BAD (RC-0.1788, p<0.001) caregiver groups. A positive correlation was also observed between GHQ scores and scores on seek social support type of coping strategies (RC-0.1041, p<0.016) in the BAD caregivers. However, in the schizophrenia caregivers, a negative correlation was observed between GHQ scores and the scores on problem focused coping strategies (RC-0.0854, p<0.001).

GHQ scores also showed a positive correlation with BPRS scores in both schizophrenia (RC-0.0271, p<0.001) as well as the BAD groups (RC-0.0432, p<0.001) (Table 2).

<table>
<thead>
<tr>
<th>Burden Factors</th>
<th>Schizophrenia (N=100) RC</th>
<th>p</th>
<th>BAD (N=100) RC</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused</td>
<td>-0.0854</td>
<td>0.010</td>
<td>-0.0043</td>
<td>0.919</td>
</tr>
<tr>
<td>Seeking Social Support</td>
<td>0.0713</td>
<td>0.089</td>
<td>0.1041</td>
<td>0.016</td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.2875</td>
<td>&lt;0.001</td>
<td>0.1788</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>BPRS</td>
<td>0.0271</td>
<td>0.006</td>
<td>0.0432</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

RC: Regression Coefficient
DISCUSSION

About one third of the caregivers displayed psychological distress, observed consistently over the study period. A positive correlation was observed between burden and psychological distress, and between psychological distress and use of avoidance strategies in both the caregiver groups. Psychological distress as measured on GHQ also showed a positive relationship with the use of seek social support kind of coping in the BAD caregivers and negative relationship with the problem focused coping in the schizophrenia caregiver group.

A positive relationship between burden and caregiver distress was observed across almost all the burden factors like physical and mental health, effect on caregivers’ routines, patients’ behaviour and caregivers’ strategies in both the caregiver groups. Similar findings have been reported by earlier workers both in schizophrenia (Madianos et al, 2004), as well as BAD (Perlick et al, 2008). Caregivers experiencing more distress as indicated by higher GHQ scores tended to use more of avoidance type of coping strategies. There was also evidence of lesser use of problem focused coping strategies by more distressed caregivers as indicated by a negative correlation in the schizophrenia caregivers. A positive correlation was observed between GHQ scores and seek social support strategies in the BAD caregiver group, indicating that the more distressed caregivers tend to use seek social support kind of coping methods more frequently.

It is thus important to deal with the caregiver burden while treating patients of schizophrenia and BAD, since its adverse effects on their mental health have the potential of further affecting their coping abilities adversely. Use of avoidance type of strategies is likely to affect their mental health adversely and hence making a vicious cycle. Less distressed caregivers tend to use the healthy problem focused coping as seen in the schizophrenia caregivers in the study. This emphasizes the need to address the issue of caregivers’ burden carefully, as it is likely to affect their caregiving role adversely.

Patients with more severe illness would be expected to cause greater psychological distress in their caregivers. This was reflected in a positive correlation between scores on BPRS in the patients and GHQ scores in the caregivers in both the schizophrenia as well as the BAD groups. Similar findings have been reported by investigators from different countries. In a recent study from Taiwan, Hou et al (2008) found a significant association between the Chinese Health Questionnaire (CHQ) scores of the caregivers and the BPRS scores of the patients, and between CHQ scores and burden scores in the caregivers. In another study from Nigeria, Ukpong (2006) showed a significant association in emotional distress and burden in caregivers of patients of schizophrenia with positive and negative symptoms. Our study being prospective in nature, further substantiates this relationship.

The study could be criticized for not having conducted any formal assessment of physical and mental condition of the caregivers. We used only GHQ to assess the psychological health. GHQ has been used by a number of investigators to measure caregivers’ mental health and distress in burden studies, and the burden of caregiving has been found to lead to psychological morbidity as measured on GHQ (Boye et al, 2001; Budd et al, 1998; Magana et al, 2007; Tang et al, 2008).

Coping styles are likely to be affected by caregiver burden and distress. The relatives of patients with schizophrenia and BAD have been reported to commonly use problem focused strategies, but burden, distress and high expressed emotions often lead them to use avoidance strategies (Scazufca & Kuipers, 1999; Chadda et al, 2007). The caregivers in the present cohort more often used the healthier coping methods of problem solving and seek social support rather then indulging in avoidance behaviour. Patient dysfunction and caregiver neuroticism have been reported to have significant influence on coping patterns, but explain only a small proportion of the variance in use of different coping strategies (Chakrabarti & Gill, 2002). Caregiver burden in BAD has also been reported to increase the likelihood of mental health service use even after controlling for caregiver psychological distress and medical conditions, while anxiety and depression level, but not burden, significantly increases the likelihood of primary care service use (Perlick et al, 2008).

Interventions with families aiming at improving the relationship between relatives and the patients, reducing the perceived burden on caregivers and enhancing their awareness of illness could lead to adoption of more adaptive coping styles by them. Interventions should include attention to the mental health and recovery of family caregivers in addition to the patient's recovery (Ukpong, 2006).
There were also few limitations. The study did not have a random design and the assessors were not blind to the two groups. Adherence to treatment was not assessed formally except for confirming from the patients and caregivers that the patients were taking their medications. Caregivers’ health status was assessed only using GHQ and no detailed assessments of the physical and mental health were done.

To conclude, mental health of the caregivers of patients with schizophrenia and BAD is affected adversely by the burden perceived as a result of their caregiving role. Caregivers perceiving feeling more stressed also tend to use avoidance type of coping strategies more likely. The mental health professionals also need to give due focus to the mental health needs of the caregivers of the patients with severe mental disorders, and develop specific interventions for them. This may help them in developing healthier problem solving coping methods to deal with the stress and burden as a result of caregiving role.

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ATTITUDE TOWARDS MENTAL ILLNESS AND EXPRESSED EMOTION OF KEY RELATIVES OF PERSONS WITH SCHIZOPHRENIA: NUCLEAR VS. JOINT FAMILY

Soma Hazra¹, Sudeshna Chakrabarti², Kamlesh Kumar Sahu³, Renjith R. Pillai⁴, C.R.J. Khess⁵

ABSTRACT

Background: The international pilot study of schizophrenia found that the prognosis of schizophrenia is better in developing countries than developed. Based on this finding it was hypothesized that joint family is better as far as expressed emotion and its effect is concerned. The scientific research on this issue has yielded inconclusive results. So, this study made an attempt to find out whether expressed emotion is different in nuclear and joint families and whether it has any relationship with the attitude of the relative towards mental illness. Method: It is a prospective cross-sectional hospital based study conducted at Central Institute of Psychiatry (CIP), Ranchi. 60 key relatives of persons with schizophrenia each from nuclear and joint families respectively were selected purposively for the study. Opinions about mental illness scale and attitude questionnaire were administered to assess attitude and expressed emotions. Results: Significant difference was observed in the area of expressed emotion in key relatives of nuclear and joint families. The key relatives of joint families showed positive attitude. A significant negative correlation was found between attitude and expressed emotion, indicating higher the expressed emotion higher will be the negative attitude. Conclusion: This study highlights the need for further studies in this area, particularly to explore its implications on outcome of schizophrenia.

Key words: Attitude, mental illness, expressed emotion, schizophrenia

INTRODUCTION

Family interaction patterns and attitude of key relatives have an important impact on the outcome of mental illness (Raj et al, 1991). In recent years the interest in the family as a subject of intensive investigation has increased, exploring both the impact of the family on the course of schizophrenia illness and the impact on the family living with and caring for a member with chronic mental illness.

Schizophrenia is known to be a debilitating illness with a poor prognosis since antiquity. It is the third most debilitating mental illness with a prevalence of 0.4% (Jenkins et al, 1998), accounting for 1.1% of the total disability adjusted life years (DALYs) and 2.8% of the years lost due to disability (YLDs) as per the global burden of disease (WHO, 2001). The most noticeable positive symptoms like hallucinations, delusions, thought disorder and behaviour are usually controlled with neuroleptics but less obvious negative symptoms like loss of interest, loss of energy, loss of warmth and loss of humour are not responsive to conventional neuroleptic medications, causing particular difficulty for persons with schizophrenia and their families (John et al, 1985). Schizophrenia impose a significant burden on the family in the form of financial burden, disruption in routine family activities, family leisure, family interaction, physical health of other family members and mental health of other family members. These may lead to disruption in the family integration, interpersonal relationships of family members and overall family functioning. The existence of burden indicates the break-down of the reciprocal arrangement that people maintain in their relationship, so that some person have to do more than what their activities are (Pai & Kapur, 1981). It seems to imply that burden comprises the problem encountered by the family due to the patient's illness.
Over the years, large number of research works have attempted to explain the relationship of expressed emotion (EE) and course of illness, particularly in regard to schizophrenia. EE is a measure of a relative's attitude towards a person with mental disorder reflected by comments made to an interviewer (Brown et al, 1972). The concept of expressed emotion first emerged during the late 1950s. Brown et al (1958) concluded that there might be certain intense relationships that adversely influence the risk of relapse because they observed persons with schizophrenia who left the hospital to live with parents or spouses had worse outcome than those living on their own. Frequency and quality of negative emotions e.g. anger or hostility expressed by family members or significant others often lead to a high relapse rate, especially in persons with schizophrenia. A meta-analysis showed a 48% median relapse rate in a high EE environment versus 21% in a low EE environment (Kavanagh, 1992). High expressed emotion (EE) is a family pathology which has been explained by Vaughn & Leff (1976) in their study on schizophrenia. EE represents a unique form of psychosocial stress to which persons with schizophrenia are extremely vulnerable, but more precise explanations have far been elusive (Hooley & Hiller, 1998). Wuerker (1996) found that interpersonal control patterns in high expressed emotion families of persons with schizophrenia showed more conflict than patterns in families with low expressed emotion relatives. In low expressed emotion families, higher levels of warmth predicted a better outcome (Bentson et al, 1998).

Attitude is a dispositional readiness to respond to certain situations, persons or objects in a consistent manner which has been learned and has become one’s typical mode of response (Freeman, 1971). Attitude has several components - at times a function of enduring personality traits and at others, a function of the dimensions of access. Increased knowledge may lower the affective component, even if the cognitive component remains unaffected. The knowledge, affect and behavioural components of attitudes need to be assessed and dealt with separately. Attitude may be either positive or negative. As far as attitude toward mental illness is concerned various studies suggest that there is negative attitude regarding mentally ill and mental illness (Oyefeso, 1994; Prabhu et al, 1984).

A family is defined as a group of intimates who generate a sense of home and identity complete with strong ties of loyalty and emotion and an experience of a history from a future. Family is a basic unit that is responsible in preserving the integrity of individuals, who form the unit. Families extend emotional, social and economic support to their members. The family is an important factor which affects the patient's mental well-being and outcome. A high functioning family helps in maintaining the dimensions of communication, emotional and behaviour control, and also helps in problem solving and coping behaviours of its members. The Indian patient has an advantage of being in a family system which believes in extending social support (Sawant & Jethwani, 2010).

Family holds a very significant role in the multidimensional care system for persons with mental illness. But often it is seen that due to mental illness, persons with mental illness somehow tend to get detached from their family members. The family’s attempt to understand the meaning of the behaviour of their relative with mental illness is thought to follow a predictable course that shows uncertainty, certainty, denials and acceptance. The largest number of studies conducted in this area showed that there is misinformation, fear and anxiety about persons with mental illness. The response to mental illness is sequence of denial, isolation and rejection (Cumming & Cumming, 1965).

Prediction of relapse in schizophrenia is an important research and clinical goal. The study of expressed emotions had an important effect on research into relapse in schizophrenia. Expressed emotion is one of the factors related to relapse in schizophrenia as well as poor prognosis. Leff (1992) reported that, in the International Pilot Study of Schizophrenia it was found that the prognosis of schizophrenia in developing countries is better than developed countries. Based on these findings, we hypothesised that joint family set up (which predominates in developing countries) could be better as far as expressed emotion and its effect is concerned. This issue has not been examined adequately in scientific research. So,
this study is an attempt to find out whether expressed emotions are different in nuclear and joint families and whether there is any relationship with the attitude of the relative towards mental illness.

**MATERIAL AND METHOD**

This was a prospective cross-sectional hospital based study conducted at outpatient department and schizophrenia clinic of Central Institute of Psychiatry, Ranchi. Sixty key relatives (the relatives who had direct contact with the patient daily or almost daily over the past one year (Trivedi et al, 1983) of persons with schizophrenia equally from nuclear and joint families constituted the study sample using purposive sampling method.

Key relatives [of persons with schizophrenia with either sex, between 18 to 50 years of age meeting ICD-10 (WHO, 1992) criteria for schizophrenia, without any co-morbid psychiatric disorders, and without any chronic physical illness] with either sex between 18 to 65 years who had given consent and were able to comprehend the instructions were included in the study. Key relatives with chronic physical/mental illness, substance dependence and who scored more than one on General Health Questionnaire-5 (GHQ-5) (Shamsundar et al, 1986) were excluded. Relevant demographic and clinical data was then obtained. Opinion about mental illness (Cohen & Struening, 1962) and Attitude Questionnaire (Sethi et al, 1982) were then administered with key relatives. Data was computed with the help of Statistical Package for Social Sciences (SPSS) Version 10.0.

**RESULTS**

**Socio-demographic and Clinical Profile of the Persons with Schizophrenia (Table 1)**

The mean age of the persons with schizophrenia was 41.23 ± 9.83 years between the age range of 23 to 54 years. A majority of them were males (58.3%), married (56.7%), educated either up to matric (48.3%) or higher (13.3%) and were not working (58.3%), had domicile either in rural (35%) or semi-urban (33.3%) areas. Mean duration illness of the persons with schizophrenia was 16.78±5.83 years, 53.3% having a past history of admission to a mental hospital and 61.7% having family history of mental illness. There was no significant group difference in age, sex, marital status, education, occupation, residence, history of hospitalization, family history of mental illness and duration of illness of the persons with schizophrenia between nuclear and joint families.

**Table 1: Socio-demographic and Clinical Characteristics of Persons with Schizophrenia**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Joint n(%)/Mean±SD</th>
<th>Nuclear n(%)/Mean±SD</th>
<th>x²/t df p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>40/66±9.95</td>
<td>41/80±9.83</td>
<td>.44</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17 (56.7)</td>
<td>18 (60)</td>
<td>.069</td>
</tr>
<tr>
<td>Female</td>
<td>13 (43.3)</td>
<td>12 (40)</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>14 (46.7)</td>
<td>12 (40.0)</td>
<td>.271</td>
</tr>
<tr>
<td>Married</td>
<td>16 (53.3)</td>
<td>18 (60.0)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>12 (40.0)</td>
<td>11 (36.7)</td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>15 (50.0)</td>
<td>14 (46.7)</td>
<td>.578</td>
</tr>
<tr>
<td>Higher Education</td>
<td>3 (10.0)</td>
<td>5 (16.7)</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>1 (3.3)</td>
<td>3 (5)</td>
<td>1.318</td>
</tr>
<tr>
<td>Working</td>
<td>13 (43.3)</td>
<td>22 (36.7)</td>
<td></td>
</tr>
<tr>
<td>Nonworking</td>
<td>16 (53.3)</td>
<td>35 (58.3)</td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>10 (33.3)</td>
<td>11 (36.7)</td>
<td></td>
</tr>
<tr>
<td>Semi-urban</td>
<td>11 (36.7)</td>
<td>9 (30.0)</td>
<td>.30</td>
</tr>
<tr>
<td>Urban</td>
<td>9 (30)</td>
<td>10 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Duration of Illness(yrs)</td>
<td>15.67±6.18</td>
<td>17.90±5.31</td>
<td>1.5</td>
</tr>
<tr>
<td>History of Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13 (43.3)</td>
<td>14 (46.7)</td>
<td>1.037</td>
</tr>
<tr>
<td>No</td>
<td>17 (56.7)</td>
<td>16 (53.3)</td>
<td></td>
</tr>
<tr>
<td>Family History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20 (66.7)</td>
<td>37 (61.7)</td>
<td>.635</td>
</tr>
<tr>
<td>No</td>
<td>10 (33.3)</td>
<td>23 (38.3)</td>
<td></td>
</tr>
</tbody>
</table>

NS=not significant

**Socio-demographic Profile of Key Relatives of Persons with Schizophrenia (Table 2)**

Among key relatives 35% were siblings, 31.7% spouses, 18.3% offsprings and 15% parents. The mean age of the key relatives was 40.58±6.35 years between the age range of 28 to 55 years. Majority of them were males (61.7%), single (51.7%), educated up to matric or higher (40% each), working (80%), with annual family income between Rs.5000 to 10000 (48.3%). Majority of them were Hindus (68.3%) followed by Muslims (21.7%) and others (10%). Key relatives’ mean duration of contact with persons with schizophrenia was 28.47±1.27 years. There was no significant difference found in relationship, age, sex, marital status, education, occupation,
annual family income; religion and duration of contact of the key relatives but both groups i.e. nuclear and joint family (4.23±0.93 & 7.76±1.56 respectively) significantly differed in respect of number of family members.

Table 2: Socio-demographic Characteristics of Key Relatives

<table>
<thead>
<tr>
<th>Variables</th>
<th>Joint</th>
<th>Nuclear</th>
<th>x²/t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
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<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td>11  (36.7)</td>
<td>10  (33.3)</td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Spouse</td>
<td>9   (30)</td>
<td>10  (33.3)</td>
<td>1.19</td>
<td>3</td>
<td>NS</td>
</tr>
<tr>
<td>Offspring</td>
<td>7   (23.3)</td>
<td>4   (13.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>3   (10)</td>
<td>6   (20)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>40.76±6.42</td>
<td>40.40±6.39</td>
<td>.22</td>
<td>58</td>
<td>NS</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17  (56.7)</td>
<td>20  (66.7)</td>
<td>.42</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>Female</td>
<td>13  (43.3)</td>
<td>10  (33.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>7   (23.3)</td>
<td>5   (16.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>13  (43.3)</td>
<td>11  (36.7)</td>
<td>1.16</td>
<td>2</td>
<td>NS</td>
</tr>
<tr>
<td>Higher Education</td>
<td>10 (33.3)</td>
<td>14 (46.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>1   (3.3)</td>
<td>3   (10.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>25  (83.3)</td>
<td>23  (76.7)</td>
<td>1.08</td>
<td>2</td>
<td>NS</td>
</tr>
<tr>
<td>Not working</td>
<td>4   (13.3)</td>
<td>4   (13.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>16  (53.3)</td>
<td>15  (50)</td>
<td>.10</td>
<td>2</td>
<td>NS</td>
</tr>
<tr>
<td>Married</td>
<td>14  (46.7)</td>
<td>15  (50)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>21  (70)</td>
<td>20  (66.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>6   (20)</td>
<td>7   (23.3)</td>
<td>.31</td>
<td>2</td>
<td>NS</td>
</tr>
<tr>
<td>Other</td>
<td>3   (10)</td>
<td>3   (10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Family Income (Rs.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 5000</td>
<td>8   (26.7)</td>
<td>7   (23.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5000 - 10000</td>
<td>14  (46.77)</td>
<td>15  (50.0)</td>
<td>.10</td>
<td>2</td>
<td>NS</td>
</tr>
<tr>
<td>&gt;10000</td>
<td>8   (26.7)</td>
<td>8   (26.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Contact (yrs)</td>
<td>27.33±11.71</td>
<td>29.60±13.64</td>
<td>.69</td>
<td>58</td>
<td>NS</td>
</tr>
<tr>
<td>No. of Family Members</td>
<td>7.76±1.56</td>
<td>4.23±0.93</td>
<td>10.60</td>
<td>58</td>
<td>.00**</td>
</tr>
</tbody>
</table>

NS=Not significant, *significant at 0.05 level, **significant at .01 level

Group Difference in Expressed Emotion (Table 3)

Among the five domains of expressed emotions, significant group difference was found in four areas i.e. critical comment, hostility dissatisfaction, warmth in caregivers of joint family and nuclear family but not in the area of overinvolvement.

Table 3: Difference between EE of Two Groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>Joint</th>
<th>Nuclear</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Comment</td>
<td>0.41±2.63</td>
<td>3.23±3.53</td>
<td>3.89</td>
<td>58</td>
<td>.00**</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.83±2.82</td>
<td>7.66±2.63</td>
<td>9.68</td>
<td>58</td>
<td>.00**</td>
</tr>
<tr>
<td>Dissatisfaction</td>
<td>2.42±2.24</td>
<td>3.66±2.75</td>
<td>12.10</td>
<td>58</td>
<td>.00**</td>
</tr>
<tr>
<td>Warmth</td>
<td>2.30±2.79</td>
<td>2.03±2.56</td>
<td>19.3</td>
<td>58</td>
<td>.00**</td>
</tr>
<tr>
<td>Overinvolvement</td>
<td>10.0±4.44</td>
<td>8.23±2.38</td>
<td>1.91</td>
<td>58</td>
<td>NS</td>
</tr>
<tr>
<td>Total Score</td>
<td>15.66±7.7</td>
<td>33.3±6.52</td>
<td>10.27</td>
<td>58</td>
<td>.00**</td>
</tr>
</tbody>
</table>

NS=Not significant, ** Significant at .01 level

Correlation between Clinical Variables, OMI and EE (Table 5)

Significant negative correlation (r = -0.741) was found between expressed emotion and opinion about mental illness. Further, no significant correlation was found between clinical variables with OMI and EE except duration of illness which had significant (r=-.320) negative correlation with history of hospitalizations.

DISCUSSION

Socio-demographic and Clinical Features

In a study by Srivastava (2005) on Indian persons with schizophrenia, majority of them were males, married, literate and non-working. Our study is mostly consistent with this study except with regards to area of residence which was reported to be 71% for rural areas which was not consistent as one third sample in the present study was from rural and one third from semi-urban areas; this could be because of...
rapid urbanization of the state where study was conducted over a period of one year.

In the present study, among key relatives siblings and spouses were around two third, majority of them were males and working. This findings are not consistent with the findings of the study by Creado (2006) where about two-thirds were either parents or spouses and majority of them were females and not working. This difference could be due to diversity of population in the country.

The study groups were matched in all socio-demographic variables except in respect to family members. This difference is obvious as the study tries to see the effect of types of family (nuclear and joint family) on the dependent variable. The persons with schizophrenia having nuclear families and joint families did not differ in the socio-demographical and clinical features.

Group Difference in Expressed Emotion

In the present study, overall expressed emotion in nuclear families was significantly higher than in joint families. Particularly critical comments, hostility, dissatisfaction was significantly higher in nuclear families than joint families which indicated that joint family had more positive attitude than nuclear families. Further studies are required to explore the associated psychosocial factors. There are number of studies from India (Sethi et al, 1985; Trivedi et al, 1983) and abroad (Reicher et al, 2003; Marom et al, 2002; King & Dixon, 1996) showing that high expressed emotion in families of a person with schizophrenia affect the families adversely and are responsible for more frequent relapse and poor prognosis. However, we did not come across any study which compared EE in nuclear families and joint families

Group Difference in Opinion about Mental Illness

In the present study, key relatives of nuclear families showed more negative attitude than key relatives of joint families, the reason could be that schizophrenia has continuous course of illness and deteriorating progress with a more dysfunctional impact on support system. Nuclear families having less support within their family tend to experience more burden of care, reflecting more negative attitude.

Brockington et al (1993) noted in their study that benevolence and authoritarianism was significantly higher towards people with mental illness. In other studies (Kshama & Channabasavanna, 1974; Wolff et al, 1996) it was shown that social restrictiveness, authoritarianism and benevolence were strong towards people with mental illness. These studies examined opinion about mental illness in all types of family. They have not compared nuclear and joint families where as present study has dealt with the comparison between nuclear and joint families which could be implied for planning family interventions for persons with schizophrenia. Bhatti et al (1988) have noted in their study that Indian families often tolerate considerable burden without complaint, further study is required to see whether this tolerance is due to joint family structure or not. However, due to rapid industrialization and urbanization and subsequent changes in the family structure and role, care of psychiatric patients impose a significant burden on the families in developing countries like India (Mishra, 2002).

Correlation between Clinical Variables, OMI and EE

In the present study, significant negative correlation was found between expressed emotion and opinion about mental illness which indicates that higher the expressed emotion higher will be the negative attitude since in OMI scale higher score indicates more negative attitude where as higher score in other scale indicates more positive attitude. Freeman (1971) demonstrated that the role of attitude and behaviour of key relatives influences the outcome of schizophrenia. One another study also revealed that outcome of illness is closely related to expressed emotion and attitude of key relatives (Vaughn & Leff, 1976).

The present study failed to indicate a significant correlation between clinical variables (duration of contact and duration of illness) with OMI and EE except for duration of illness which has significant negative correlation with history of hospitalization. This indicated that even with long duration of illness
there was less history of hospitalization in the present study sample. More than half of the persons with schizophrenia had been hospitalized in the past but still a significant percentage (46.7%) remained never hospitalized. This was also reported by Srivastava (2005) in a study on Indian persons with schizophrenia where 76% had no history of hospitalization to a mental hospital which could be an indicator of treatment seeking patterns in this population group.

CONCLUSION

Present study revealed that key relatives of persons with schizophrenia of joint families showed more positive attitude and had less expressed emotion than the key relatives of nuclear families which could have implications for planning family interventions for families of persons with schizophrenia. This study highlight the need for further studies in this area, particularly to explore its implications on outcome of schizophrenia.

Limitations of this study include its cross-sectional design, purposive sampling and limited sample size. Further prospective studies with larger sample size and random sampling method need to be carried out.

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Wolff, G., Patherie, S., Craig (1996) Community attitude toward 

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A STUDY OF DAILY HASSLES AND COGNITIVE EMOTION REGULATION ON GENERAL WELL-BEING IN URBAN MARRIED MALES AND FEMALES

Anindita Mukherjee¹, Atanu Kumar Dogra², Saugata Basu³

ABSTRACT

Background: The present study aims to explore the role of various dimensions of cognitive emotion regulation and daily hassles on general well-being among adult married persons. Method: The study encompasses 103 adult persons including 51 males and 52 females, working, married, having one or two child(ren) and staying in Kolkata. Personal Information Schedule, Cognitive Emotion Regulation Questionnaire, Daily Hassles Checklist, and PGI General Well Being Measure were administered to the subjects. The obtained data was analyzed using t-test, product moment correlation coefficients and stepwise multiple regression analysis (SMRA). Results: Results suggested that acceptance, positive refocusing, refocus on planning, positive reappraisal as cognitive emotion regulation had positive significant relationship with general well-being. On the other hand, focus on thought/rumination, catastrophising, blaming others as cognitive emotion regulation and daily hassles had significant negative correlation with general well-being. Results of stepwise multiple regression analysis also suggested that refocusing on planning as a component of cognitive emotion regulation and daily hassles significantly contributed to general well-being of urban married individuals. Conclusion: Component of cognitive emotion regulation positively and daily hassles negatively contribute to general well-being of urban adult individuals.

Key Words: Cognitive emotion regulation, daily hassles, well-being

INTRODUCTION

There has been a change towards the end of twentieth century from preoccupation with psychological ill health by repairing the worst things in life for building the best qualities in life by enhancing psychological well-being. Many attempts have been made in the past to measure the positive mental health, only one of which is the measure of subjective well being, general sense of psychological well-being or general well-being (Verma, 1988). The other measures are hope, happiness, meaning in life, etc.

General well-being may be defined as the subjective feeling of contentment, happiness, satisfaction with life's experiences and of one's role in the world of work, sense of achievement, utility, belongingness, and no distress, dissatisfaction, or worry (Verma, 1988). These things are difficult to evaluate objectively, hence the emphasis on the term "subjective" well-being. The term well-being is used nowadays more or less like a continuum, rather than an absolute sense, with wellness anchoring one end of an adaptive contribution and sickness (or psychopathology) on the other end. The term also means something other than just the absence of disease; rather it is centrally defined by the presence of the qualities noted above that make for wholesome adaptation (Cowen, 1994).

The quest to determine what makes people happy and generally well has led to investigations in diverse areas. Objective life circumstances like income, marital and ethnic status and education have been found to be inconsequential predictors of well-being (Andrews & Withey, 1976; Kammann, 1983). However, few modern studies have determined the detrimental effect of daily hassles on general well being (Kanner et al, 1981; Dohrenwend & Shrout,1985). But very few researches have been reported, especially in Indian context, about the effects of daily hassles on well-being. So the present study attempted to explore this relation.

Daily hassles can be defined as the irritating, frustrating, distressing demands that to some degree characterize every day transactions with the environment (Kanner et al, 1981). Such hassles might include being stuck in a traffic jam, waiting...
in a line, doing household chores or having difficulty in making a small decision. The occurrences of such daily minor problems reduce psychological well-being over the short term and somewhat enhance reports of physical symptoms (Stone & Neale, 1984; Bolger et al, 1989).

Whether situation is perceived as daily hassle or not depends on the relationship between the individual and the environment. Concerns of this nature have led researchers to consider the role of a range of variables such as personality factors, cognitive appraisal and social support in influencing different adaptation outcomes (Zika & Chamberlain, 1987; DeLongis et al, 1988). Very few studies have concentrated on whether cognitive emotion regulations act as mediators between daily hassles and general well being.

Emotion regulation is assumed to be an important factor in determining well-being and/or successful functioning (Cicchetti et al, 1995; Thompson, 1991). The general concept of emotion regulation can be understood as "all the extrinsic and intrinsic processes responsible for monitoring, evaluating and modifying emotional reactions, especially their intensive and emotional features, to accomplish one's goal" (Thompson, 1994). Emotion regulation therefore can refer to a wide range of biological, social, behavioural as well as conscious and unconscious cognitive processes.

Coping is defined by Monat & Lazarus (1991) as "an individual's efforts to master demands (conditions of harm threat or challenge) that are appraised (or perceived) as exceeding or taxing his or her resources". According to this definition, all coping efforts by an individual come under the broad definition of emotion regulation. The regulation of emotion through cognition is inextricably associated with human life. Cognitions or cognitive processes may help us manage or regulate emotions or feelings and to keep control over our emotions and/or prevent us from getting overwhelmed by them, for example, during or after the experience of threatening or stressful events.

In the present study, the terms 'cognitive coping' and 'cognitive emotion regulation' are used as interchangeable terms. Generally speaking, both concepts can be understood as the cognitive way of managing the intake of emotionally arousing information (Thompson, 1991).

So the current study focused on the following areas:

1. The aim of the present study was to find out the relationship between various dimensions of cognitive emotion regulation, daily hassles and general well-being in urban married males and females.

2. The present study also aimed at determining the relative contributions of cognitive emotion regulation and daily hassles in the development of general well-being in urban married males and females. Thus, in the present study, cognitive emotion regulation and daily hassles were the predictor variables and general well-being was the criterion variable.

MATERIAL AND METHOD

Subjects: The sample comprised of 103 subjects including 51 males and 52 females. The sampling criteria were as follows:

Inclusion Criteria

- Age of the subject: Age between 25 to 50 years with mean age for males being 37.2 years with S.D. of 8.2 and mean age for females being 38.6 years with S.D. of 7.62
- Locality: Residing in Kolkata at least for the last 5 years,
- Religion: Hindu
- Educational Status: Graduate
- Monthly income: Per capita family income: Rs.5,000/- to 10,000/-
- Marital status: Married
- Number of child(ren): one or two
- Occupational status: Working
- Commute to office/ working place and come back by bus and public vehicles
- Staying in a nuclear family
Exclusion Criteria

- History of any acute physical illness, physical handicaps or chronic illness having residual effect
- History of any past/present psychiatric illness
- Adults not willing to answer all the questions of the questionnaires

Tools

1. A Personal Information Schedule was used to collect personal and family related information about the subjects required for the present study.

2. Cognitive Emotion Regulation Questionnaire (CERQ) (Garnefski et al, 2001): The CERQ is a self report questionnaire measuring cognitive coping strategies of adults and adolescents aged 12 years and more. The CERQ distinguishes nine different cognitive coping strategies as follows: self blame, acceptance, rumination or focus on thought, positive refocusing, refocusing on planning, positive reappraisal, putting into perspective, blaming others, catastrophising. The nine conceptually distinct subscales consist of four items each, resulting in a total of 36 items. The Cronbach's alpha reliabilities for all the subscales were proved as satisfactory ranging from .68 to .83.

3. Daily Hassles Checklist (Basu, 2005): Daily Hassles Checklist was developed by Basu (2005) and it helps to measure daily hassles of working males and working females, age range between 25 to 50 years, married with one or two child(ren), staying with family members and residing in a metropolitan city. Daily Hassles Checklist is a 50 items checklist. The scale was constructed in different stages. In the first stage, expert opinion from 10 mental health professionals was sought for and operational definition of daily hassles was identified based on definition given by Delongis et al (1988) as follows: 'Daily hassles are irritants or things that annoy or bother you on daily basis; that can make someone/you upset or angry'. Then preliminary items were selected by interviewing 30 working males and 30 working females about nature of daily hassles they face generally. They were provided with the definition of daily hassles as mentioned above. The 'Hassles and uplift scale' by Delongis et al (1988) was also consulted. Overlapping and repetitive items and items common with Presumptive Stressful Life Events Scale (Singh et al, 1984) were eliminated. Thus 58 items were selected. Then in second stage, 12 males and 12 females who have been working in the area of mental health for at least five items were approached for rating on 5 point scale for relevance. Means and standard deviations were calculated separately for male experts and female experts. Only the items with mean three or more were selected for further study. This way expert rating led to development of a final checklist containing 50 items. Items were given serial numbers using Random Number Table. Clinical validation was observed by Basu (2005) through correlating scores with score of General Health Questionnaire (Goldberg & Hiller, 1979).

4. PGI General Well-Being Measure (Verma & Verma, 1989): It contains 20 items to measure general well-being. For validation studies, this scale was correlated with a number of tests and authors reported relative independence of other variables as expected but significant relations with other well-being measures. Reliabilities were measured by K.R. 20 formula and was found to be .98, while test retest reliability was .91. There has been a change in part of the instruction for fulfilling purpose of the present study, from 'How do you feel these days (past one month)?' to 'How do you feel these days (last five days)?'

Method of Data Collection: For the purpose of the study, the researcher approached individuals to different work places (offices), and households. The nature of the study was explained to the potential subjects individually. They were assured that their identity will not be disclosed and
after conclusion of the study, the investigator would personally inform them about the results of their data, if they are interested. Thus, written consent was obtained from each individual prior to administration of the questionnaire.

Administrations of questionnaires were done by the investigator, to the subject individually. Clear instructions were given before the questionnaires were handed out. Instructions for the survey which was given are as follows: "I have provided you three sets of questionnaires. We would like to find out the relationship between daily hassles we experience and our well being in this survey. First you fill up 'Personal Information Schedule'. Then you have to fill up the questionnaires from Sunday to Friday in a particular week. Please go through the instructions of each of the questionnaires carefully before answering them. On Sunday you fill up the questionnaires 'Personal Information Schedule' and 'CERQ' any time at your convenience. From Monday to Friday you fill up 'Daily Hassles Checklist' each day at night before going to sleep. On Friday night along with 'Daily Hassles Checklist' you also please fill up 'PGI General Well-Being Measure' before going to sleep. Please answer the questionnaires on six consecutive days in a particular week with no holiday. If you miss to fill up any of the questionnaires on any of these days, the purpose of the survey will not be fulfilled. Please ask me if you have any query. Thank you very much for your cooperation.

Notes to remember

Sunday: Personal Information Schedule' and 'CERQ' (any time)
Monday to Friday: 'Daily Hassles Checklist' (Before going to bed at night)
Friday: 'PGI- General Well-Being Measure' along with 'Daily Hassles Checklist.' (night)

Every subject followed the standardized instructions given prior to each questionnaire and marked their responses. Each night the first author contacted the respondents over telephone and reminded them about filling up the questionnaires and at the same time, all the queries of respondents were clarified as they rose.

Mean score of daily hassles of five consecutive days is considered as daily hassle score of a particular individual. This is taken as representative score of daily hassles of a particular individual on a working day. Only data of those respondents who attended work on all the five days of a week were considered for further analysis. In this way, data from 103 respondents were collected, out of which 51 were males and 52 were females. The responses were scored according to the procedure described earlier and scores of tools were obtained.

Statistical Analysis: The obtained data was analyzed using descriptive statistics, t-tests, Pearson's Product Moment Correlation Coefficients and Stepwise Multiple Regression Analysis (SMRA). Statistical analyses were done using SPSS Version 17.0. In the present study, cognitive emotion regulation and daily hassles were considered as predictor variables and general well-being were considered as criterion variable.

RESULTS

Table-1: Descriptive Statistics and Comparison of all Predictor and Criterion Variables for males and females

<table>
<thead>
<tr>
<th>Variables</th>
<th>Male(N=51) Mean±SD</th>
<th>Female(N=52) Mean±SD</th>
<th>t values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>11.29±3.132</td>
<td>9.96±3.174</td>
<td>2.144*</td>
</tr>
<tr>
<td>Positive refocusing</td>
<td>11.96±3.249</td>
<td>11.48±3.109</td>
<td>.766</td>
</tr>
<tr>
<td>Refocus on planning</td>
<td>12.03±4.196</td>
<td>12.51±4.655</td>
<td>.494</td>
</tr>
<tr>
<td>Positive reappraisal</td>
<td>13.23±3.250</td>
<td>14.40±3.820</td>
<td>1.467</td>
</tr>
<tr>
<td>Putting into perspective</td>
<td>11.84±3.770</td>
<td>11.01±3.190</td>
<td>1.198</td>
</tr>
<tr>
<td>Self blame</td>
<td>10.68±3.191</td>
<td>10.67±2.720</td>
<td>.023</td>
</tr>
<tr>
<td>Focus on thought/rumination</td>
<td>11.09±3.257</td>
<td>10.73±3.107</td>
<td>.586</td>
</tr>
<tr>
<td>Catastrophising</td>
<td>8.50±3.196</td>
<td>9.01±3.293</td>
<td>.797</td>
</tr>
<tr>
<td>Blaming others</td>
<td>8.70±3.094</td>
<td>9.15±3.139</td>
<td>.729</td>
</tr>
<tr>
<td>Mean of Daily hassles (5days)</td>
<td>10.82±4.457</td>
<td>10.55±4.500</td>
<td>.368</td>
</tr>
</tbody>
</table>

** p<0.01. * p<0.05

In the present study, there are no significant differences between male and female adults with respect to all variables, i.e., all dimensions of cognitive emotion regulation- positive refocusing, refocus on planning positive reappraisal, focus on thought/rumination, catastrophising, blaming others, putting into perspective, self blame, daily hassles and general well-being. Only significant difference was observed in acceptance as a dimension of cognitive emotion regulation. As there was no significant difference between male and female married adults with regards to criterion variable, i.e., general well-being and almost all the predictor variables, further statistical analyses were done combining males and females together.
As far as the magnitude and direction of relationship between various variables and general well-being were concerned, it was found that acceptance, positive refocusing, refocus on planning and positive reappraisal were significantly and positively correlated with general well-being; but catastrophising, blaming others, focus on thought/rumination, daily hassles have significant negative correlation with general well-being. Putting into perspective and self blame has no significant relationships with general well-being separately.

Table-2: Correlation coefficients between General Well-being and various predictor variables among adult males and females (N=103)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Correlation coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>.199**</td>
</tr>
<tr>
<td>Positive refocusing</td>
<td>.287**</td>
</tr>
<tr>
<td>Refocus on planning</td>
<td>.707**</td>
</tr>
<tr>
<td>Positive reappraisal</td>
<td>.556**</td>
</tr>
<tr>
<td>Putting into perspective</td>
<td>.046</td>
</tr>
<tr>
<td>Self blame</td>
<td>-.067</td>
</tr>
<tr>
<td>Focus on thought/rumination</td>
<td>-.386**</td>
</tr>
<tr>
<td>Catastrophising</td>
<td>-.333**</td>
</tr>
<tr>
<td>Blaming other</td>
<td>-.329**</td>
</tr>
<tr>
<td>Daily hassles</td>
<td>-.326**</td>
</tr>
</tbody>
</table>

** p<0.01, * p<0.05

Table 3 suggests that refocusing on planning as a component of cognitive emotion regulation and daily hassles contribute to general well-being among adult individuals. More specially, refocusing on planning has got the highest contribution, followed by daily hassles. It was also observed from the direction of beta values that refocusing on planning contribute positively to general well-being, which implies that its increase as a component of cognitive emotion regulation will increase one's general well-being. But daily hassles contribute negatively to general well being, which implies that increase in daily hassles will decrease one's general well-being and vice versa. It also suggests that 53.6% of variance of general well-being can be explained by refocus on planning of cognitive emotion regulation and daily hassles, and rest 46.4% of variance can be explained by other bio-psycho-social factors like physical health, locus of control and social support which were not covered in the present study.

Table-3: Stepwise Multiple Regression Analysis (SMRA) providing the variables contributing significantly to General Wellbeing of adult males and females

<table>
<thead>
<tr>
<th>Criterion variable</th>
<th>Sig. contributory variable</th>
<th>R²</th>
<th>Beta Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Well Being</td>
<td>Refocus on planning</td>
<td>.499</td>
<td>.606</td>
</tr>
<tr>
<td>Daily Hassles</td>
<td></td>
<td>.536</td>
<td>-.215</td>
</tr>
</tbody>
</table>

DISCUSSION

The present study aims to explore three important areas, namely, the role of various dimensions of cognitive emotion regulation and daily hassles on general well-being among adult persons. The discussion part is as follows:

1. **Significant differences between males and females on cognitive emotion regulation, daily hassles and general well-being:** The present study reveals that there are no significant differences between males and females on positive refocusing, refocus on planning, positive reappraisal, focus on thought/rumination, catastrophising, blaming others, putting into perspective, self blame components of cognitive emotion regulation, daily hassles and general well-being among individuals who were aged between 25 to 50 years, working, married, having one or two child (ren). So for these population, males and females face similar amount of daily hassles and try to cope with situations mostly in similar ways (except acceptance) and they experience more or less same general well-being in their life. This finding is supported by Basu (2005) who also found out that there is no significant difference between working men and working women in terms of daily hassles. In other studies, Inglehart (1950) and Michalos (1991) also observed no difference in well-being between males and females. This suggests that males and females with single career marriages residing in a metropolitan city, perceive daily hassles in a similar manner, or in other words, nature of daily hassles do not change between males and females.

2. **Role of daily hassles on general well-being:** The present study revealed that the number of daily hassles...
significantly and negatively correlated and acted as a significant negative predictor of general well-being. If daily hassles increased, general well-being would decrease. The study suggested that though the hassles were encountered ‘daily’ by people, they did not lose their adverse effects on them; they did not make people psychologically immune to them. In other words, if a person encountered more daily hassles, he felt less general well-being in his personal life. The scale items ranged from personal/individual (e.g., problems taking pending work home, shifting duties) in nature to items which involved comparatively greater community (e.g., heavy downpour, road blocking). People treated all of them equally as daily hassles.

Accumulation of small irritants in daily life, i.e., daily hassles is a major source of daily stress. These daily hassles are minor annoying events for which people have no automatic, adaptive responses; they require some degree of adjustment. It increases continuing state of arousal enduring over time and demands are perceived to be greater than resources for dealing with them. So when a person faces lots of daily hassles in his daily life, there is chance to breakdown under stressful life event due to prolonged daily hassles leading to stage of exhaustion. So these have been shown to have negative cumulative effects on physical and psychological health on the long term. Detrimental influence of number of daily hassles on general well-being might have occurred in following ways:

- Negative happenings produce a drain on energy and body resources that ultimately could lead to health problems. Physiologically, stress due to prolonged daily hassles increases sympathetic arousal which produces various stress producing diseases, like hypertension. So it hampers general well-being among adult people (Steptoe et al, 1998).

- Daily hassles reduce hedonic capacity-ability experience, pleasure and joy. It affects general well being (DeLongis et al, 1988).

- Variety of intellectual (cognitive) functions-attention, memory and decision making may be adversely affected by daily hassles. So persons cannot think properly, take decision adequately to solve daily life problems. Hence it hampers well being (Kohn et al, 1991).

- Poor health behaviour, such as drinking alcohol, or skipping exercise, that often accompany hassle-filled days, negatively influence daily life (Steptoe et al, 1998).

- Daily hassles may moderate the relationship between major life events and illneses. For example, if a major life event is experienced at a time when minor life events are at a minimum the stress may not be great as it would otherwise be (Monroe, 1983). So daily hassles have detrimental effect on general well-being among adult individuals. These findings are supported by Coyne & Holroyd (1982) and according to them, daily hassles proved to be a better predictor of symptoms than were more major life events. In other studies, DeLongis et al (1982) and Monroe (1983) reported that hassles were more strongly related to somatic health than life events scores. Basu (2005) suggested that there are significant positive correlation coefficients between daily hassles experienced by both males and females and felt psychological distress (as assessed by GHQ 28). This suggests that if daily hassles increase, experiences of perceived psychological problems also increase.

3. Role of various dimensions of cognitive emotion regulation on general well-being: Results suggested a positive significant relationship between acceptance, positive refocusing, refocus on planning, positive reappraisal and general well-being. On the other side, focus on thought/rumination, catastrophising and blaming others were significantly negatively correlated with general well-being individually. Putting into perspective and self blame had no significant relationships with general well-being separately. Results also suggested that refocusing on planning as a component of cognitive emotion regulation and
daily hassles significantly contributed to general well-being among adult individuals. In other words, acceptance, positive refocusing, refocus on planning, positive reappraisal act as cognitive coping which help individuals to cope with daily hassles to enhance general well-being but focus on thought/rumination, catastrophising, blaming others are styles of cognitive emotion regulation which enhance perception of daily hassles to detrimentally influence on general well-being (Bolger et al, 1989). Now impact of various components of cognitive emotion regulation and daily hassles on general well-being are as follows:

- People who have adequate amount of cognitive emotion regulation capacity can accept daily hassles that they have experienced rather than resigning themselves to what has happened. So it reduces perceived amount of daily hassles.
- People, who have ample amount of positive refocusing as cognitive emotion regulation capacity, think more about joyful and pleasant issues as a form of mental disengagement rather than emphasizing on daily hassles. Hence it enhances general well-being.
- People, whose positive reappraisal is high as a cognitive emotion regulation capacity, think that they can learn something positive from the situation involving daily hassles and they can become stronger person as a result of what they have experienced from daily hassles. This perception helps them to cope with the situation to enhance general well-being among people.
- People, who have high amount of focus on thought/rumination as cognitive emotion regulation capacity, always think about the negative feelings associated with daily hassles. So they cannot get relief from this negative emotion which impairs general well-being among adults.
- People, who have elevated amount of catastrophising as cognitive emotion regulation capacity, emphasize more terror of experiences due to daily hassles and they often think what they have experienced are worse than what others have experienced. It hampers general well-being among adult people.
- People, who have high amount of blaming others as cognitive emotion regulation capacity, always blames others for their daily hassles and it impedes general well-being among adult individuals.

Impact of Refocus on Planning on Daily Hassles: Refocus on planning is positively and significantly correlated with general well-being and it has significant positive impact on general well-being. People, who have adequate amount of refocus on planning as cognitive emotion regulation capacity, can think about what steps to take and how to handle with daily hassles and they think about a plan of what they can do best. This effective planning helps the people to cope with daily hassles and enhances general well-being among people (Cicchetti et al, 1995).

This finding is empirically and theoretically enriched by Lazarus & Folkman (1984) who theorized that planful problem solving thinking was associated with an improved emotion state, that is, it was associated with less negative emotion and more positive emotion. One explanation for this association is that people can begin to feel better when they turn to the problem that is causing distress. For example, persons who experience distress when receiving notice of imminent layoff are likely to feel better when they begin to make plans for finding new work. In such cases, planful problem solving can have a direct effect on emotions even though the adaptation problem may remain unresolved. Another explanation is that planful problem solving, when effective, can result in an improved person environment relationship, which should in turn lead to a more favourable cognitive appraisal and hence a more positive emotional response. This explanation is supported by a previous study in which planful problem solving was associated with favourable outcomes (Folkman et al, 1986).

The present finding has been supported by similar findings. Coping literature has shown that cognitive coping styles, namely, positive refocusing, positive reappraisal, acceptance and refocus on planning have moderately positive relationship
with measures of optimism and self-esteem (Carver et al., 1989; Janoff-Bulman, 1992). These variables are closely related to positive well-being (Scannell et al., 2002). Thompson (1991) assumed emotion-regulation to be an important factor in determining well being and/or successful functioning. Moreover, Mukherjee & Basu (2008) found emotional intelligence to be a predictor of happiness.

CONCLUSION

Thus, it is evident from above discussion that urban working married men and women who face increased amount of daily hassles in their life do not have adequate positive cognitive emotion coping regulation and hence, have lesser well-being. Cognitive emotion coping regulation probably acts as buffer against daily hassles which in turn is reflected in psychological well-being of urban adult individuals. However, the present study has certain limitations like purposive nature of sampling, subjects being from only metropolitan city and particular socio-economic strata. Further studies might be conducted considering other bio-psycho-social factors like parameters of physical health, personality variables like locus of control, emotional intelligence and social support.

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The emergence of psychology as a scientific discipline and its divorce from philosophy marked a significant transition in its theoretical framework. Psychology freed itself from cultural and religious bondages and enthusiastically embraced the scientific principles of objectivity, transparency and freedom from presupposition. This transition paved the way for significant developments in the field of psychology and a vision of universal psychology applicable to all. Little did Psychology realise in its forceful youth that the scientific ‘truths’ itself are embedded in a socio-cultural-temporal context. Of late psychology has thought of reclaiming its ‘ethno-cultural baby’ it had thrown away with the bathwater of dogmas and superstitions. It is in this context that Pittu Laungani’s work assumes significance as he relentlessly emphasized the influence of cultural factors on psychological counselling and psychotherapy and refused to ‘force fit’ the Western model across cultures, particularly the East. Pittu Laungani, born in Bombay (now Mumbai) on 30th May 1936, did his BA and MA in Psychology from University of Bombay and PhD from University of London under Prof. Hans J. Eysenck. He was a multicultural psychologist, philosopher, educator, poet and a playwright with more than 100 articles and chapters, 15 books and many plays, some of which went to the theatre, to his credit. Laungani’s work was largely influenced by his personal experiences of migration to England and his long term illness, Polymyositis, to which he finally succumbed on 28th Feb. 2007. This book is the result of deliberations by eminent researchers in the field of multicultural counseling and psychotherapy on Laungani’s work at the Critical Multicultural Counselling and Psychotherapy Conference in June 2005 conducted by the Centre for Diversity in Counselling and Psychotherapy at the Ontario Institute for Studies in Education, University of Toronto. Laungani received the Lifetime Achievement Award for his contributions to multicultural counselling and psychotherapy at the conference.

The book is divided into five sections, each section containing one or more seminal papers of Laungani and an exploration of these by multicultural counselling and psychotherapy experts. The final section is devoted to personal reflections about the life and works of Laungani by his wife, friends and colleagues. Laungani’s criticism of a universal model of psychology came from his personal experiences of ‘culture shock’ which he describes vividly when he went to England.

I was bewildered by the English! There were as many accents there as there are dialects in India—or almost each of them spoken in a different tongue, and few even in forked tongues! It was difficult to distinguish between levity and seriousness, between jest and truth, between praise and censure, between affection and affectation, between acceptance and rejection……I felt alienated. I felt like Moses standing at the edge of the Red sea. While the sea parted for Moses and his followers and they were able to cross to safety, I drowned and died a hundred deaths in the first waves of misunderstanding that engulfed me.

Laungani proposed a multicultural counselling bridge for the cultural chasm resting on four ‘cultural value-dyads’:
individualism-communalism, cognition-emotionality, free will-determinism, and materialism-spiritualism, one end representing more of Western and the other more of Eastern cultures. The need to build a more complex model taking into account the influence of urbanization, education and immigration on these cultural values has been eloquently pointed out in the book. Laungani argued against the universality of any psychological theories from an epistemological perspective and emphasized the need for the development of indigenous psychological models. The book presents a brief description of the traditional Indian yogic models of stress based on five kleshas and the incorporation of the traditional healing practices of Ayurveda, Unani, Sahaja, Shamanism, Siddha and Spiritism into the therapeutic process from a Launganic perspective.

The book includes two interviews of Pittu Laungani with Lana Stermac (Professor in Counselling Psychology Programme, University of Toronto) and Roy Moodley (Associate Professor in Counselling Psychology, University of Toronto) conducted in 2005. Laungani describes the early years of his life in Bombay (now Mumbai) and its impact on his identity which persisted throughout his life as:

I imagine within me, there resides, an indefinable 'Indian-ness'-the turtle shell. I can neither discard it nor, for that matter I would like to! It is difficult if not impossible to relinquish one's identity that one has developed over the years and acquire a new one.

Laungani poetically describes his personal transformation after living in England for more years of his life than in India into a 'biculural person' and its impact on his work.

Like a chameleon, I am able to switch my persona from being 'Indian-Indian' to 'Indian-English' and when in India, to English-Indian or (recycled) Indian-Indian.

Laungani emphasizes the improbability and the needlessness of a complete assimilation of a person into another culture.

We carry our culture like the tortoise carries its shell; destroy the shell and you destroy the tortoise.

The book contains interesting case studies on caste, class, culture, guilt, shame, and rites and rituals in death and bereavement and their analysis by Laungani. Laungani explores the cultural embeddedness of these case studies and the need to understand the client's cultural background for the therapeutic process to be useful. He strongly criticizes the application of Rogerian or client-centered therapeutic process and emphasizes the need for a 'culture-centered' one specially while dealing with eastern clients where communalism takes precedence over individualism. Laungani presents case studies demonstrating the perils of the 'cultural blindness' of the therapist in the therapeutic process.

Laungani throughout his work equated the Eastern culture with Indian culture, ignoring the diversity within the eastern cultures. Also, as the book rightly points out, it is naïve to assume any Eastern or Western culture as a homogenous entity. The increased communication across cultures through migration and technological advancements is constantly changing the cultural mores and increasing the inhomogeneities within cultures. The book is a must read for all mental health professionals, who having been trained in the Western model, need to reconnect with their cultural backgrounds to direct mental health research and practice commensurate with their cultural requirements.

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SHATTERED DREAMS

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

Today I got admitted to a mental hospital. I very solemnly moved through the big, red walls of female ward’s small gate, with my luggage and my eldest son. Only once I turned back and thought that the world outside these four walls will now be seen after two months. I did not break down as not to see these decent, civilized people but my eyes were tearful because my life had taken such a turn. My son, a young bright engineering student, though 22 yrs of age but for name sake only, I could see in him the same infant who was brought up in my lap and learned walking with my help, was getting me admitted in this mental hospital. I was hiding my eyes from him due to this relation. We both were going through the same pain. Today I felt the depth of my love. I kept on watching him with lowered eyes, because it was more difficult for me to bear his crisis than of my own. Whereas my son, who was much attached to me, was just wanting my strengths to develop, no matter if I was said to be slightly abnormal mentally.

My son accompanied me as his heart was not yet ready to accept that I was prey to any mental illness. He wanted to check the place from his point of view. I too trusted him alone. Moreover, the one who had done this conspiracy of my illness was none other than his father. For past three years, my son was the spectator of my ruined life. He was unable to understand about the truth of my life which was troubling me, causing shame. Was it the stain on my character or the attachment of mentally disabled person on my name in the society? From where would he get the potency to be content with these insults of mine?

Until my son remained in college, he stayed happy, but with friends he wouldn’t stop to booze and fag. He never gave any right to any person in his barn life except his sentiments; none was there to stop him, he possessed a different sort of personality free from every relation or bond. The happiness of the past or the growing pain he shared with none, his heart wouldn’t melt for any one. Since childhood he had seen many ups and downs. When mother’s identity collapses in front of her child, the pain it causes is transpired on the child’s face.

We reached the desired place and filled the paper for admission but after entering the female ward I could not control myself and burst into tears. To make me comfortable he sat there on a bench in between the women present there and started talking to them, the moment he stood up, the fixed eyes onto him again started crying. However we did not live together, yet the pain of his leaving was worse than the feeling that I would now be living with mental patients. He while consoling me kept on moving and I kept looking at him to the farthest I could and continued crying until he disappeared.

Few women, who became my friends because of my son, convinced me and held me back. Whenever I would get distressed, I would sit on the same bench in that enormous campus, between the trees and plants, and would keep looking at the same path from where he had moved out. I would think that no matter how many days I have to spend here, I would go back only when I get the solution for my life.

Consuming alcohol or to get intoxicated can rightly be called as relief from stress, habit or junkie but the pain and the
questions which were in my son about my life and my identity were disturbing him. He eluded for studies and on return, he learnt that I was suffering a new illness, besides drug addiction. Moreover, when he went back, I was contaminated with dual-diseases; first, falling in love with his father's student and second, to appear as a psychiatric patient not only in front of the society but of the whole city too. He was keen to know the link in the two and about his father's consent.

The very day when I came to the hospital and met the doctor, I presented the truth of past twenty-five years that were spent in between three persons, in written. I had neither the strength nor the guts to speak about all that. Thus, I came to my doctor just to know whether my love for my husband's student was insanity or sheer love. I was tired of the repeated questions of the society. I confessed this in front of my doctor, whom I referred as 'bhaiya'. He read that intently, carefully then looked at me but did not ask anything. Then my husband and his student were called. My husband clearly said that I had a relationship with a man just after the marriage. Doctor asked him his reaction on learning about this fact. He replied that he got separated along with his children and family. Then came the alleged one and was asked the same question and he answered that he being a professor carried on with his research. My husband interrupted, "he is my student, and with him too she had a relation". Doctor shot another question to know what he did on hearing about that. He replied that he turned recluse and on this, I gave him a tight slap. I disclosed that instead he turned into a lusty monster. Doctor again questioned as to why had he not stopped me or tried to keep his student away from me? I got not only got the answer but the truth of whole society, yet wanted to hear the reply. He responded that he was afraid, what if I tried to commit suicide again? I questioned the other person, my alleged love, what had he understood by this relation? But I got no answer. I got all the truth. My brain's every system answered and here I was, admitted!

I realized the truth that my alleged love had been given the place in my life just to keep me out of drugs and suicide, otherwise lots of questions would have been raised to the family. This was merely a pity by the people. To live with that drug habit was accepted by me, but the love and the years spent in that love were impossible to believe, and that would never be removed from my mind. Who knew that a well-educated woman like me, could fall victim to drugs to the extent that from waking up in the morning until I slept in the night, every four to five hours I had surrendered to almost 8-10 sleeping pills. Whenever I tried to step out of the marsh of this notorious life, I'd get struck deeper and ultimately decided to lead a decent life in that drug addiction only.

My son was already out for his studies and lonely, I under the supervision of servants didn't know for how many years I'd live there with that habit. Here in this mental hospital I had been shown once to the doctor but there was no specific illness because I told the doctor that I took pills not with the intention of suicide but to calm down the restlessness of my mind. Because of this addiction I wasn't similar to other normal women.

My husband used to talk about his student and revealed that he loved me and that we could establish sexual relations. He wanted to keep this a secret. But I got mad from within just after hearing his name and tried searching for him. The fear of his name was settled in my heart, because I was aware that my husband was homosexual, as I knew that the student must have been immature and poor in wealth and must not have known the conspiracy behind all this. However, I was unaware that the person whom I had been noticing for four to five years moving in and out of the house and whom I had loved deeply is none other than the same individual. But from the time I heard about him from my husband I was getting nightmares that few masked men had trapped me, amongst them one was trying to coerce me and he was the same person whom I used to love, I tried to remove the mask to have a look but woke up sweaty wet. In the end I decided to secretly talk to this guy and ask for his help to search for this guy. I once accidentally got the chance to meet him when one fine day this guy came to meet my husband and I happened
to come out heard him referring to this guy as the same person, whom I loved from these many years, he only was his student whom I have been loving for so many years. I concluded that if this is the same person, my love, than I should outlast my fear.

The house where I wasn't permitted to meet the outsiders, there I now got hours to meet him free. Thereby drug addictions were exfoliated. However, six months before meeting him, doctor had started my treatment in mental hospital from scratch. He worked hard on me and listened to me patiently and carefully when I was brought to the hospital (once or twice) in these five years. Although there was one thing what he felt was weird that whenever I came, after talking to my husband, I would request to have a word in private. I had been started on Tab. Lithium six months ago. In the beginning, I faced many problems with this medicine like feeling palpitations and fidgety. I never wanted to take that medicine. But with time it got dissolved into my body and I met my love after coming out of my solitude. I just used to take him as a good friend. After my son left I was lost from the world, used to sit alone in the lawn of my house and muse over, would walk with shaky steps due to effect of drugs with the support of the wall for many years. As if I got a new life in me. The face too had changed as there was a new freshness and strength.

My husband gave a family name to this relation, which was the only reason for me getting admitted in this mental hospital. He started calling him everyday and let him stay there whole day long. He started eating and drinking with us only. But in that, their selfishness was evident as to use the love that I had in my heart for him. I would be engaged in preparing food for him from morning to evening, and this way we used to spend a day like husband-wife. This love became indelible. As such I had never accepted my relationship with my husband. In addition, there was no wish left for marriage in my life. I hated this relation and was very afraid of it. But this happened for the first time that I felt deep love for his student in my heart to the extent that I wanted to give our relationship a name. However, I could not understand that this life is given to me just to let me live happily and so that I stay busy in the domestic life.

Slowly and gradually just after a year he reduced the length of visits. This wasn't disturbing me physically but mentally. He would come occasionally, have physical relationship with me and in return would be paid and my husband kept homosexual relation with him, and none even had the slightest of hint. Fearing this, I made him go entirely. Everything that was for him was the same and would ever remain so. By parting him from my husband, I made him financially stable. I here was tortured physically as well as mentally in the name of my love.

Short-tempered, scrimmage, sabotage, I started doing all when my husband tortured me. Nobody paid any heed to me. My son too went out for two months for his studies. Either I was not able to contact him or if at all we talked, I failed to tell him about my disturbed health. I was then taken to another mental hospital and there the illness was changed from mania to depression, the medicines were then changed, but I knew that I would have to go to the previous one. My husband did not want that the truth of his life be revealed there. My state had worsened and at the last I came to this mental hospital and told my doctor the truth. Moreover, I got to know the reality that I once was a drug addict and had high chances of suicide. Due to this nobody protested in front of me, neither left me to live my life in my way. In addition, for the lifetime I was kept there like an "alive-zombie". However, I look for my love even today and greet him with same feelings of same intensity. It was the longing of seven years after all.

No matter if it was after meeting me or after my coming back from this mental hospital but my love did learn the value of this house, relation and love and realized that even he may not survive the end of it. I alone knew how a person after sudden breakdown could either fall ill on psychiatric face or gradually lead to ones decline in process of forgetting our problems, our shattered self-esteem and slowly drifting away from the normal man's world and entering the world of drugs and substance. Just some moments for some years did I
receive from my love which gave me the warmth of the relationship so that neither the mirror nor I would break nor do I resort to drugs to gather the pieces of it?

Even today, I haven't forgotten the days I had spent in this hospital, away from home and loved ones. At times those moments, those thoughts did flash before my eyes. I just pondered how I was yet alive and managed not to commit suicide despite so many hurdles. Nevertheless, if I came back it was merely for two people, my son and my love, couldn't see them getting wretched. I didn't know if ever my son would take me the same way as earlier but I considered him my son always with same emotions and love, while with him I was having a heart to heart link. This association remained alive in my mind and soul, because of which I never broke, nor took the shelter of drugs and never did my life become a question.

This probably was the house of my dreams.

I returned back to this family just for the sake of my son to give him that feeling of home and family, though even then my life was controversial but he considered me as his care giver; and for my love, whose helplessness I couldn't take, which had the power to calm me down in bouts of madness. Probably my love too was plagued by the fear of my committing suicide by overdose of drugs, but I rendered helpless only to my illness. Once again, depression hit me and there came a halt in life. However, at this point I never felt the urge to retreat to drugs or suicide, rather sustaining actively.

The only thing or emotion I lastly hated was sympathy and care; I had started looking after myself. My son had sensed that the turmoil in my heart has calmed down. The wrong had happened to the patient of the hospital and this never faded from my memories. This was the mirror image of the virtual or real life of a mental patient.

_Name withheld on ethical ground_

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AWARD RULES OF THE INDIAN ASSOCIATION FOR SOCIAL PSYCHIATRY

BALINT AWARD

Institution of Balint Award is made 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.

In this IASP members are invited to submit a paper based on their personal experience of relationship with patients.

Four copies of the paper, maximum 10-12 pages of A4 size, typed in double space must be submitted to the Chairperson, Awards Committee, by the stipulated date.

It must be a single-authored paper. The author must be a member in good standing of the IASP, with a minimum of 5 years of professional experience.

The paper shall be rated on the basis of written manuscript on the following criteria.


2. Reflection: A description of how a therapist actually experienced such a relationship, either individually or as part of a teaching team. This could reflect multiple relations between therapist and the staff of various specialties, and working routine within different institutions.

3. Action: The therapist's perception of the demands he or she felt exposed to and an illustration of how he then actually responded.

4. Progression: A discussion of possible ways in which future medical and paramedical training might enhance the state of awareness for individual carer, a procedure which tends to be neglected at present.

The paper shall be presented at the Annual IASP Conference. Written text and presentation will carry 60% & 40% marks respectively. To be eligible for presentation, the written version must score at least 50% (30 out of 60) marks. The paper receiving maximum total marks will be adjudged as winner. The Award winning paper must secure not less than 50% of the total marks.

Decisions of judges shall be final. Award shall be won only once by any author.

The judges assessing the paper for Award shall not contest for the Award. Members of the Awards Committee, if desirous of contesting, will not participate in the evaluation process. Award shall come prior to the scroll and the money to be announced at the Valedictory function of the same national conference at which it is presented. The award shall be given at the inaugural function of the next Annual Conference of the IASP and shall be received by the recipient in person.

The award paper will become a property of the IASP, a copy of which will be sent to the Foundation of Psychosomatic & Social Medicine, Ascona, Switzerland by the Secretary-General. The paper shall be published in the IJSP.

DR G.C.BORAL AWARD I AND II

(Modified rules as approved by the Executive Council at its annual meeting on 8-10 February, 1991).

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. Dr G.C.Boral Award I will be given to the best paper presented by a Fellow as the principal author and Award II to the best paper presented by an Associate Member as the principal author.

For any paper to be considered for either award, it must be based on research work done in India on any aspect of social psychiatry. It must not have been published in a scientific journal, not presented at a national and international conference earlier. For Award I the principal author must be a Fellow of the Association and for Award II the principal author and the author presenting the paper must be an Associate Member. The principal author, the author presenting the paper and at least 50 percent of all authors must be members of the IASP at the time of the conference. Not more than two papers will be considered from any member, as the principal author, for the award.

For consideration for either award, four copies of the full paper must be submitted to the Chairman of the Awards Committee by a date to be determined by the Executive Council. The papers should be prepared in accordance with the "Instruction to Contributors" of the Indian Journal of Social Psychiatry. The paper or a significantly similar paper must not have earlier received an Award of the IASP.

The papers submitted shall be rated both on the basis of written manuscript and the presentation which will represent 75 per cent and 25 per cent, respectively of the total marks of assessment. To be eligible for presentation, the written version of the paper must secure at least 40 per cent of the full marks allotted for the written version (i.e. 30 out of 75). The paper securing the highest total marks shall win the award. Furthermore, the award winning paper must secure not less than 50 per cent of the full marks.

None of the judges assessing the award shall be contestant for this award. However, a judge is eligible to contest for any other award.
All the authors of the winning papers shall be considered to have won the award and will be issued certificates. The award money will be shared by all the authors. The award winning paper shall be accepted for publication in the Indian Journal of Social Psychiatry for which purpose it shall be passed on to the Editor by the Chairman, Awards Committee. If the author desires to publish the paper in any other journal he shall be required to obtain a prior permission from the Editor of the Indian Journal of Social Psychiatry.

The announcement of the Awards shall be made at the annual general body meeting. In all the matters pertaining to the Awards, the decision of the Council shall be final and binding on all concerned.

**DR. N.N. DE ORATION AWARD**

(As approved by the Executive Council on 5 January, 1991)

**Rules for the award**

1. The oration award will be declared one year in advance at every annual conference of the Indian Association for Social Psychiatry.
2. Any member of the IASP can propose the name of any other member of the IASP for the oration award. The proposal including six copies of the bio-data of the nominee must be submitted to the Chairman, Awards Committee by a date determined by the Council of the IASP. The proposal must be accompanied by a written consent of the nominee.
3. A panel of judges shall rate the nominations. The nomination securing the highest total marks (out of 100) shall win the award, subject to ratification by the Awards Committee and the council of the IASP. In case of tie, the concerned nominations shall be re-assessed by another panel of judges. To win an award not less than 50% of the full marks must be obtained by a nominee.
4. The oration paper will become the property of the IASP and shall be published in the Indian Journal of Social Psychiatry with necessary editorial corrections. The speaker will pass on the oration paper to the Editor, Indian Journal of Social Psychiatry as soon after the annual conference as possible for publication in the Journal.
5. The speaker can choose any topic for the oration. He shall intimate the title of the oration to the Chairman, Awards Committee at least three months prior to the Conference.
6. The speaker will be paid a lump sum for the oration. He will also be awarded a suitable scroll.
7. No person shall win the award more than once.

**DR. V.K. VARMA AWARD**

(As approved by the Executive Council on 9 January, 2009)

Dr V.K. Varma Award was approved by the General Body of the Indian Association for Social Psychiatry held at New Delhi on 29 November 2008. The award has been instituted out of a donation from Professor V.K. Varma, a Past President of the Association. The first award will be given in the year 2009. The award would consist of a scroll and a cash award of Rs.10000/-. The award is open to all the members who have published a paper in psychiatry based on original research in any Indian Journal in the preceding two years (for example, papers published during July 2007-June 2009 for the conference to be held in the year 2009) would be eligible to apply for the VK Varma Award. The first author and 50% of the total authors should be a member of the IASP. For consideration for the award, four copies of the published paper must be submitted to the Chairman of the Awards Committee by a date to be determined by the Executive Council.

None of the judges assessing for the award shall be contestant for this award. However, a judge is eligible to contest for any other award.

All the authors of the winning papers shall be considered to have won the award and will be issued certificates. The award money will be shared by all the authors.

**DR. VENKoba rAO ORATION AWARD**

(As approved by the Executive Council on 9 January, 2009)

Dr. Venkoba Rao Oration Award was approved by the General Body of the Indian Association for Social Psychiatry held at New Delhi on 29 November 2008. The award has been instituted out of a donation from Professor A Venkoba Rao, Founder President of the Association. The award would consist of a scroll and a cash award of Rs.10000/-. The oration award will be declared one year in advance at every annual conference of the Indian Association for Social Psychiatry.

All the members of the Indian Association for Social Psychiatry can send nominations for any outstanding mental health professional above the age of 55 years, who has contributed in the field of social psychiatry. The nominee may or may not be a member of the IASP. The nomination would be in form of Curriculum Vitae (CV) of the nominee along with his/her consent. Four copies of the CV of the nominee along with his/her consent must be submitted to the Chairman of the Awards Committee by a date to be determined by the Executive Council.

None of the judges assessing for the award shall be contestant for this award. However, a judge is eligible to contest for any other award.

**DR. B.B. SETHI AWARD**

(As approved by the Executive Council on 9 January, 2009)

Dr. B.B. Sethi Award was approved by the General Body of the Indian Association for Social Psychiatry held at New Delhi on 29 November 2008. The award would be given to the best poster presented in the Annual National Conference of the Indian Association for Social Psychiatry. The award would consist of
a scroll and a cash award of Rs. 5000/ and Rs. 3000/ for the best and second best posters and be given by the organising committee of the conference.

For any paper to be considered for either award, it must be based on research work done in India on any aspect of social psychiatry. It must not have been published in a scientific journal, not presented at a national and international conference earlier. The principal author and at least 50 percent of all authors must be members of the IASP at the time of the conference. Not more than two papers will be considered from any member, as the principal author for the award.

For consideration for either award, four copies of the full paper must be submitted to the Chairman of the Awards Committee by a date to be determined by the Executive Council. The papers should be prepared in accordance with the "Instruction to Contributors" of the Indian Journal of Social Psychiatry. It or a significantly similar paper must not have earlier received an award of the IASP.

The papers submitted shall be rated both on the basis of written manuscript and the presentation which will represent 75 per cent and 25 per cent, respectively of the total marks of assessment.

To be eligible for presentation, the written version of the paper must secure at least 40 per cent of the full marks allotted for the written version (i.e. 30 out of 75). The paper securing the highest total marks shall win the award. Furthermore, the award winning paper must secure not less than 50 per cent of the full marks.

None of the judges assessing for the award shall be contestant for this award. However, a judge is eligible to contest for any other award.

All the authors of the winning papers shall be considered to have won the award and will be issued certificates. The award money will be shared by all the authors. The award winning paper shall be accepted to be published in the Indian Journal of Social Psychiatry for which purpose it shall be passed on to the Editor by the Chairman, Award Committee. If the author desires to publish the paper in any other journal he shall be required to obtain a prior permission from the Editor of the Indian Journal of Social Psychiatry.

The announcement of the awards shall be made at the annual general body meeting. In all the matters pertaining to the awards, the decision of the Council shall be final and binding on all concerned.
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. Now the journal is available online at www.iasp.org.in

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.

d) 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.


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.

Submission:

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.

Declaration of Interest

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.

Copyright Transfer

The Journal requires approval of manuscript submission by all authors in addition to transfer of copyright to the Indian Association for Social Psychiatry so that the author(s) and the Association are protected from misuse of copyrighted material. A copyright transfer form, which must be signed by all authors upon acceptance of the paper, is available at www.iasp.org.in Accepted manuscripts will not be scheduled for publication until a completed form has been received in the editorial office. It is the author’s responsibility to obtain the approval of individuals before acknowledging their assistance in the paper.

Authors can send their Authorship, Disclosure, and Copyright Transfer by mail or fax after they have been notified of acceptance.
OBITUARY

Professor S.M. Channabasvanna (1932-2010)

The unassuming leader of Indian Psychiatry

Professor S.M. Channabasvanna-Sindagi Marallisidappa Channabasvanna was born on 25th April, 1932 in Tiptur Northern Karnataka. He would have been 78 years old on the 25th of April, just two days before he passed away. He was popularly known as Dr. SMC.

His early days were spent in Karnataka. He did his schooling in Tiptur and then joined MBBS course at Mysore Medical College and subsequently MD in General Medicine which he passed with a Gold Medal from Mysore University. Professor SMC joined DPM at the All India Institute of Mental Health [current, NIMHANS], Bangalore in 1956. After qualifying as a psychiatrist, he worked initially at the Dharwad Mental hospital for a short period following which he joined AIIMH again. He was first an Associate Professor and in 1977 became Professor of Psychiatry. In addition, he was the Deputy Medical Superintendent for nearly 8 years and then became the Medical Superintendent of NIMHANS in 1979. He was also the Dean at NIMHANS. He became the Head of the Department of Psychiatry at NIMHANS in the year 1982 and subsequently Director of NIMHANS in 1989 and continued as Director from 1989 to 1997. He was instrumental in NIMHANS becoming a Deemed University in 1994. He was the first Vice Chancellor/Director of NIMHANS till 1997. After his superannuation he was appointed as the first Emeritus Professor of Psychiatry at NIMHANS.

He was one of the founder members of the Indian Association of Social Psychiatry. He gave full support when the Indian Journal of Social Psychiatry was launched. He was also the President of the Indian Association of Social Psychiatry. His contributions on social psychiatry in India are significant given the fact that he started and developed the field of family psychiatry and launched the first Family ward in the country. Prof. SMC was one of the giants of Indian psychiatry. He was President of the Indian Psychiatric Society. He was the Honorary Editor of the Indian Journal of Psychiatry from 1985 to 1988, and I worked closely with him, as his Assistant Editor for the Indian Journal of Psychiatry. I was amazed at his vast knowledge and understanding of both historical aspects and newer advances in the field of psychiatry.

Dr. SMC won many awards and accolades and continued to be a member of many distinguished boards and committees. Even after retirement he continued to be a Government nominated advisor to the psychiatric centres at Tezpur, Ranchi and IHBAS in Delhi. He was a pioneer in many areas in Psychiatry in India. Besides starting the Family Psychiatry services and Family ward, he also developed Forensic psychiatry services at NIMHANS. He was one of the key members involved in the formulation of the Mental Health Act. He also spearheaded several new initiatives in the mental health scenario in the country including Improvement of Mental hospitals and the current NMHP. He was also instrumental in starting the first collaborative initiative with the National Human Rights Commission for the rights of the mentally ill.

He was a mentor and teacher to many of the psychiatrists who are Professors, Directors and Heads of Departments today. Many considered him as a ‘King maker’ as with his support people could become leaders with in the country, Directors of institutes, and Presidents of the different psychiatric organizations.

He had a unique likeable unassuming personality. His sense of calmness, ability to solve problems, excellent people skills, sense of humour and approachability were his hallmark qualities. He was very well known for his practical and common-sense approach to difficult problems. He would give very sensible advice which one could not find in any text book. Such advice was often sought for by faculty, students, fellow professionals and even the legal profession! Everyone was at ease with him. His humility was another endearing quality- He would eat in the canteen with everyone else and when on rounds would often taste the food which was being distributed to patients to ensure quality.

After retirement he continued to be active in academics and would be seen sitting in the front row of all academic programs taking notes seriously. Such was his dedication and commitment to the field of mental health. For the psychiatry fraternity of India he will be remembered for his warmth, sensible advice and his constant zeal and energy that he brought to the field of psychiatry and he will be missed a lot. For members of IASP, he will be missed very much as he nurtured the organization with care and guided it to grow to the present level.

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